THE CHILDREN'S CENTER OF THE ANTELOPE VALLEY

CLIENT DEMOGRAPHIC FORM (RSS)

PLEASE PRINT

Guardian/Caregiver Name: _____ Gender: ☐Male ☐Female
Last Name First Name Middle Name

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Email Address: _____

Driver's License/ID#: _____ Date of Birth: _____ Social Security #: _____

Relationship to Child(dren): _____ Legal Guardian? ☐ Yes ☐ No

Custody Arrangements: _____ Open Case with DCFS? ☐ Yes ☐ No

CSW Name: _____ CSW Phone #: _____

Emergency Contact Name: _____ Emergency Contact Phone #: _____

Relationship to Emergency Contact: _____

Name(s) of Children (Under your Direct Care):	**Date(s) fo Birth:**

I affirm under penalty of perjury that the above-mentioned information herein is true and correct to the best of my knowledge and if we receive services from The Children's Center of the Antelope Valley, I agree to inform the office of any changes immediately.

Signature of Responsible Adult: _____ Date: _____

FOR OFFICE USE OLY

Referral Source: _____ Start Date: _____

Exym #: _____ RSS Tracking #: _____ DCFS Case#: _____

Staff Initials: _____

THE CHILDREN'S CENTER OF THE ANTELOPE VALLEY

MEDICAL RECORDS POLICY AND CONSENT

The standards below are the expectations required to request and/or release health information for current or previous clients of The Children's Center of the Antelope Valley. The Children's Center values your confidentiality and abides by all HIPAA regulations mandated by the Department of Mental Health contract(s).

Medical Records requests consist of obtaining and/or releasing client health information by:

- Release or disclose health records and/or information
- Obtain or use records and/or information
- Mutually discussing or exchanging records and/or information

MY HIGHLY CONFIDENTIAL INFORMATION

By signing my name next to a category of highly confidential information listed below on an Authorization form, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to an Authorization:

- Information about Mental Illness or Developmental Disability
- Psychotherapy Notes
- Information about HIV/AIDS Testing Diagnosis or Treatment
  (Including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such test were positive or negative)
- Information about Communicable Disease
- Information about Substance (i.e. alcohol or drug) Abuse, Prevention and Treatment
- Information about Sexual Assault
- Information about Child Abuse and Neglect
- Information about Genetic Testing
- Information about Domestic Abuse
- Information about Elder Abuse

RECIPIENT *– Name of person or class of person to whom The Children's Center may disclose my health information.*

TERM *– The duration of time an Authorization will remain in effect for.*

PURPOSE *– I authorize The Children's Center of the Antelope Valley to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of an Authorization for specific purpose*

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I understand that once The Children's Center discloses my health information to the recipient, The Children's Center cannot guarantee that the recipient will not disclose my health information to a third party. The third party may not be required to abide by any Authorization or applicable Federal and State law governing the use and disclosure of my health information.

I understand that The Children's Center may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may at any time make a written request to The Children's Center to inspect and/or obtain a copy of my health information, and that The Children's Center will within thirty (30) days of receiving such written request, either grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information **for a fee of $25.00 per request and proof of positive identification (ID),** or provide me with a written denial of the request that states the basis for the denial, my review rights (if any), and instructions as to how and to whom I may register a complaint regarding the denial.

I understand that I have a right to receive a copy of an Authorization.

I understand that I may refuse to sign or revoke (at any time) an Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at The Children's Center; except, however, if my treatment at The Children's Center is for the sole purpose of creating health information for disclosure to the recipient identified in an Authorization, in which case The Children's Center may refuse to treat me if I do not sign an Authorization.

I understand that an Authorization will remain in effect until the term or an Authorization expires or I provide a written notice of revocation to The Children's Center's Privacy Office at the address listed below. The revocation will be effective immediately upon The Children's Center's receipt of my written notice, except that the revocation will not have any effect on any action taken by The Children's Center in reliance on an Authorization before it received my written notice of revocation.

I may contact The Children's Center of the Antelope Valley's Privacy Office by mail at: 45111 Fern Avenue, Lancaster, CA 93534 or by telephone at (661) 949-1206.

I have read and understand the terms of an Authorization and I have had an opportunity to ask questions about the use and/or disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, understand The Children's Center of the Antelope Valley's policy to authorize the use or disclosure of protected health information in the manner which I describe on a signed Authorization form.

Client (Print Name) Signature of Client Date

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Responsible Adult Relationship to Client Date

Signature of Witness Date Client MIS# Provider Number

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CONFIDENTIALITY

What is discussed by parents and by children with staff is confidential information. It cannot be shared outside of the session by staff with other people. There are, however, exceptions to this rule and information may be shared outside of the treatment sessions when any of the following exist:

1. When consent forms are signed allowing us to release information.
2. When the court orders us to release information.
3. When there is suspicion of child abuse, section 1116 of the Penal Code requires all treatment staff that work with children and families report that suspicion to a child protective agency. Staff members at The Children's Center are mandated reporters and will report suspicions of child abuse, as well as suspicions of elder abuse.
4. When the treatment staff of The Children's Center believes for any reason that a client is in danger of seriously hurting himself/herself or someone else, staff are required by law to take action to protect the intended victim.
5. When the treatment staff meets for weekly supervision and clinical staffing meetings, they routinely share client information with each other.

RSS Case Managers possess a minimum of Bachelor's level degree and are non-licensed paraprofessionals. A licensed MFT supervises paraprofessional staff. The above confidentiality regulations apply to cases assigned to all employees of The Children's Center of the Antelope Valley and its subcontractors.

I have read the above information and/or reviewed its contents with a staff member. I understand that under certain conditions, there are limits to client rights to confidentiality about treatment at The Children's Center of the Antelope Valley.

Name of Responsible Adult: _____

Signature of Responsible Adult: _____

Date: _____

Agency Representative: _____ Date: _____

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CONSENT FOR SERVICES

The undersigned client or responsible adult consents to and authorizes health services by: The Children's Center of the Antelope Valley.

These services may include psychological testing, psychological/counseling, rehabilitation services, medication, case management, laboratory tests, diagnostic procedures, and other appropriate services. While these services may be delivered at a different location, services provided within the Los Angeles County mental health system will b coordinated by the staff of a single agency.

The Undersigned understands:

1. He/She has a right to be informed of and participate in the selection of any of the above services provided.
2. He/She has a right to receive any of the above services without being required to receive other services from the Los Angeles County mental health system.
3. All of the above services are voluntary and he/she has the right to request a change in service provider (agency or staff) or withdraw this consent at any time.
4. All personnel or the agency, as a condition of their employment, annually sing an oath of confidentiality which prohibits them from sharing client information except as allowed under Federal, State, and Department confidentiality laws, policies, and procedures.
5. Any information disclosed to staff which is determined by them to be important to care, will be recorded in the clinical record to ensure treatment staff have available to them the most complete information about the client when deciding on treatment appropriate to the client's needs and or quality of care.
6. All client names are entered into a computer-based Information System that identifies the program(s) that is/are providing services to the client. This information is available without client authorization to any workforce member of the Department's directly-operated or contract service agency system.
7. Information from a client's clinical record relative to serve delivery needs may be shared within this agency and within the Los Angeles County mental health system (directly-operated and contract agencies) without obtaining the Authorization of the client.

Name of Responsible Adult: _____

Signature of Responsible Adult: _____ Date: _____

Agency Representative: _____ Date: _____

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CLIENT GRIEVANCE POLICY

California Department of Social Services' (CDSS) Manual of Policies and Procedures (MPP) Division 31, Section 020 requires a grievance process to review complaints from foster parents (which includes approved relative and non-relative extended family members caregivers), legal parents, legal guardians and children regarding the placement or removal/replacement of a child or non-minor dependent from a foster home.

The DCFS 4161-I, California Department of Social Services Grievance Procedure Regulations form contains the exact text of the State of California regulations. All issues will be resolved in the best interest of the child. If your grievance is regarding the pending removal of a foster child or non-minor dependent from your home, contact the child's Children's Social Worker (CSW) to discuss your concerns.

Grievance Review and Procedures are available at The Children's Center of the Antelope Valley Front Desk. If you need assistance completing the Grievance Review form or have questions about the Grievance Review procedure, contact: the DCFS Office of the Ombudsman, 888-889-9800

I affirm under penalty of perjury that I have received and understand my patient rights as outlined in The Children's Center of the Antelope Valley Grievance Policy.

Name of Responsible Adult: _____

Signature of Responsible Audlt: _____

Date: _____

Agency Representative: _____

Date: _____

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Checklist of Resource Support Services (Exhibit A-15)

Support Services Category	Service(s) Offered
Academic Support	
Advocacy	
Case Management	
Child Care	
Clothing	
Conflict Resolution/Mediation	
Counseling – general	
Counseling – mental health	
Early Child Care	
Employment	
Family Conferencing	
Financial Aid	
Food Pantry	
Furniture/Small Appliances	
Health Care Access	
Health Education	
Home Approval Assistance	
Individualized Education Plan (IEP)	
Information and Referral	
Job Readiness Training	
Legal Assistance	
Life Skills Training	
Medical/Vision/Dental Care	
Mental Health Assessment	
Mentoring	
Navigation of Services	
Outreach	
Permanency Planning	
Public Benefits Assistance	
Recreation/Enriched Activities	
Rental Assistance	
Support Group	
Transportation	
Tutoring	
Utility Assistance	
Youth Leadership	