RESPITE SCHOLARSHIP PROGRAM INFORMATION

The Buncombe and Henderson County Respite Scholarship Program provides a break for caregivers/parents who provide ongoing care for an individual of any age. Respite is intended to provide relief to the caregiver/parent.

Need Respite Care? The Respite Program is here to help:

1. Choose your Respite Provider
Parents are responsible for choosing and hiring their own respite provider(s). Respite providers work directly for parents to provide safe, structured and developmentally appropriate experiences for your children. In addition, parents provide orientation, supervision, and any necessary on-the-job training specific to the individualized needs of their child.

2. Apply for a Respite Care Scholarship
Through the generous support of The Department of Health and Human Services, Respite Care Scholarships will be available in July 2021-June 2022 fiscal year for Buncombe and Henderson Counties. Scholarships will allow parents to hire a respite provider directly. In this way, parents address their need for respite care on a prearranged basis, as a part of the normal, wrap-around services for children and families. Scholarship Applications must be completed and returned to Amy Hobson, Executive Director.

3. Complete a W-9 form
The W-9 is a federal requirement of any entity that makes payments to another entity. Please don't forget to complete this form; as we will not be able to provide funding to families without a completed W-9 form.

4. Return the Monthly Timesheet
Fill out the monthly time sheet and return anytime before 9a on the last Monday of each month, in order to receive the next payment.

Need more information?
Contact Amy Hobson, Executive Director
(828) 777-5715 (cell)
(828)575-2049 (fax)
e-mail: amy.hobson@caring4children.org
e-mail: ahobson@eckerd.org

RESPITE SCHOLARSHIP APPLICATION July 2021- June 2022

1. Child's Name:____________________________________ Date of Birth:__________ Age_______
2. Child's Name:____________________________________ Date of Birth__________ Age _______
3. Child's Name:____________________________________ Date of Birth:__________ Age: ______
4. Child's Name:____________________________________ Date of Birth:__________ Age_______
5. Child's Name:____________________________________ Date of Birth:__________ Age:_______

Parent / Guardian Name(s):______________________________ Date of Birth:_______________
Mailing Address:____
E-mail address:_______________________________________ Phone: _____________________

Is there an open Child Protective Services case with DSS **Yes** **No**
If yes, please explain:____

Is your child receiving funding for respite, or respite from any other resources? **Yes** **No**
If yes, please explain:____

Tell us why you need respite. Please describe your circumstances that represent the need for respite and how getting a break would be beneficial to you and your family.

____
____
____
____
____
____
____
____
____
____

Respite Provider(s): (use additional sheets if needed)

Provider's Name:___________________________	Provider's Name:___________________________
Address:___________________________________	Address:___________________________________
City, State, Zip:____________________________	City, State, Zip:____________________________
Phone Number:_____________________________	Phone Number:_____________________________
Email:_____________________________________	Email:_____________________________________

RESPITE AGREEMENTS, CONSENTS, AND RELEASE OF LIABILITY (1 of 2)

Please place a check mark in the appropriate box to indicate your consent to each area below and then place your signature on the next page:

Use of Respite Scholarship Funds
I agree, if my application for respite funds is approved, to use the funds solely to help me pay for respite care according to the respite guidelines of the grant criteria. The grant criterion stipulates that respite is to be used for the caregiver to receive a break. The state has made it very clear that respite is not to be used for parent appointments, surgery/recovery, going to work, attending school, running errands, grocery shopping, etc. These situations require childcare or a babysitter. In addition, the scholarships are not to be used to pay for a special program for your child to attend or afterschool costs, etc. Also stressed is that no part of the scholarship is to be used to pay for dinner, movies, entertainment, etc., while you are getting a break. The entire amount is to pay your respite provider. I understand and agree to use respite funding to pay for a respite provider according to the guidelines above.
Yes **No**

Release of Liability
I understand that Eckerd Connects/CARING For Children, Inc. is in no way responsible for the direct delivery or supervision of my respite provider and that Eckerd Connects/CARING For Children, Inc. is not responsible or liable for any act or omission by my Respite Provider, the parents, or the child(ren) involved.
Yes **No**

Choosing and Employing a Respite Provider
I understand that I am responsible to choosing, hiring, employing, orienting, scheduling, supervising, paying, and firing my own respite provider I understand that my respite caregiver will be employed or contracted solely by me, and furthermore that it is my responsibility to make sure that my Respite Provider is competent to care for my children.
Yes **No**

Payment Conditions
I understand that I will be responsible for paying the rate for respite care as agreed upon by my respite provider and me. If my request for Respite Scholarship funds is approved, CARING for Children, Inc. will issue a check to me for the allowable payment amount, and I understand that I will be responsible for paying the respite provider directly. I understand that if Respite Scholarship funds are insufficient to cover the entire cost of care, that I am nevertheless responsible for paying the entire cost of Respite Care.
Yes **No**

AGREEMENTS, CONSENTS, AND RELEASE OF LIABILITY (2 of 2)

Quarterly Reporting and Survey Data

I agree to participate in a phone survey once annually and quarterly survey reports that will be mailed or emailed to me quarterly.

Yes **No**

Mandated Reporting

By law, CARING for Children staff are mandated to report within any suspicions of abuse and neglect to state authorities. I understand staff are mandated reporters.

Yes **No**

Confidentiality Agreement

Clients of Eckerd Connects/CARING for Children have the right to privacy and confidentiality which is a right protected by Federal and State law. These laws are intended to protect a person's identity and personal information. It is important to CARING to ensure your privacy and that of your fellow clients. In an effort to maintain each client's rights, CARING asked for your agreement to respect the confidentiality rights of other clients in the program and their families by keeping the full name or personal information of any client in the program to yourself. My signature indicates my agreement and understanding that confidentiality is important and that I will be held accountable for keeping this agreement.

Yes **No**

Benefits and Risks of Respite

Respite care allows caregivers and family members a much-needed break from the stresses of caregiving while their child continues to receive the level of personalized care required. The short-term relief provided by respite care has been shown to combat the stresses that lead to caregiver burnout and, by extension, help lower some of the risk factors involved with a caregiver's role. The risk associated with the Respite Scholarship Program is that the family must choose the provider and is responsible for ensuring that the provider is qualified to provide respite services.

Yes **No**

Grievance Process

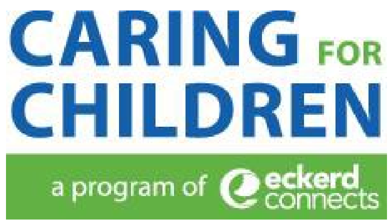
Eckerd Connects/CARING for Children addresses all issues through the combined efforts of the client, families, agencies, and staff. Every effort will be made to resolve identified problems directly with the appropriate program staff. However, when a client, parent, or agency representative is not satisfied with the resolution or has a complaint regarding a specific incident or policy interpretation, that person has the right to file a grievance. The process for the client to follow is outlined on the next page of this document. The parent, guardian, or agency representative may phone or mail a letter to the appropriate Operations Director to state the concern. The individual will investigate the issues and respond in a timely manner. There will be no retaliation against the person filing a grievance.

Yes **No**

My signature below acknowledges that the above consents were explained to me to my satisfaction, and that I provide consent to the above authorizations where I checked "YES."

Name of Parent/Guardian/Family:___________________________________

Signature:____Date:_________________



CARING FOR CHILDREN ~ GRIEVANCE PROCEDURE

Families/parents/guardians/caregivers,

Anytime you think an action taken by the Director is unjust, or you believe you have been treated unfairly; you have the right to make a complaint. This complaint is called a grievance. To file a grievance, this is what you should do:

Step 1: The Director will attempt to resolve the complaint with you by discussing the situation with you. If you are not satisfied with this, you have the right to notify the Eckerd Connects Vice President of Operations.

Step 2: The Director will let you know that you have the right to file a written grievance with the Vice President of Operations. You may hand write your complaint on plain paper or on a Grievance Form your Program Director will give you. You must sign this complaint.

Within five working days of receipt of this complaint:

Step 3: If you do not agree with the results of the grievance, you have a right to appeal to the Eckerd Operations Chief Operating Director – Alex Reed. You must file this appeal within 14 days of receipt of your letter. Once the Chief receives your letter, there is a 5 day period for investigation and notification to you of the results and any action required.

Following are the addresses for the above identified staff:

Vice President of Operations Eckerd Connects 100 Starcrest Drive Clearwater, FL 33765	

My signature below acknowledges that the above procedure was explained to me, I understand it, and have received a copy of it in the Program Application.

Signature:____Date:__________________

CARING FOR CHILDREN ~ CLIENT RIGHTS

My Rights:

1. The right to be treated respectfully, fairly, courteously, consistently, with dignity and without prejudice regardless of national origin, age, religion, disability status, gender or sexual orientation, or marital status.
2. The right to privacy.
3. The right to receive services offered by the program.
4. The right to report any concerns of abuse or neglect.
5. The right to know that if we suspect that you have been abused or neglected, or if you have abused or neglected someone, we are required to report it.
6. The right to freedom of thought, conscience, and the practice of religious beliefs.
7. The right to express your opinion about your situation, what you want to accomplish, how you are being treated and the services you receive, and to know what services and supports are available to you.
8. The right to receive services in a safe and healthy environment.
9. The right to have a say in the development of your service/treatment plan.
10. The right to know what rules apply to how you behave and the consequences of behavior choices.
11. The right to refuse any service or treatment except in life threatening situations or when the law or court order those rights. If services are refused, referral to a community resource will be provided to you.
12. The right to express concerns without fear of someone getting back at you.
13. The right to know how to contact someone in case of emergency.

My Responsibilities:

1. I am responsible to ask questions about and for knowing what is expected of me by the program.
2. I am responsible to ask questions about, know what is expected of me, and follow my part in my service/treatment plan.
3. I am responsible for expressing my needs and goals as it relates to the service(s) being delivered.
4. I am responsible for telling Eckerd Connect Caring for Children staff working with me about myself and my family and any problems that I am facing.
5. I am responsible for letting CARING staff working with me know about changes at home.
6. I am responsible for avoiding illegal activities.
7. I am responsible for reporting to staff grievances that I may have and any mistreatment I may experience.

My signature below acknowledges that I have read the above identified rights and responsibilities, or have had them read to me, and have been given the opportunity to ask questions to ensure understanding to my satisfaction, for which I am acknowledging.

Parent Guardian:____

(Signature) (Print) (Date)

CARING FOR CHILDREN ~ NOTICE OF PRIVACY PRACTICES (1 of 4)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

We have a legal duty to safeguard your protected health information (PHI).

We are legally required to protect the privacy of your health information. We call this information “protected health information”, or “PHI” for short. It includes information that identifies you and that has been created or received by us about (1) your past, present, or future health or condition(s); (2) the provision of health care to you; or (3) the payment for this health care.

We are providing you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure.

We are legally required to follow the privacy practices that are described in this notice. However, we reserve the right to change the terms of this notice and our privacy policy at any time. Any changes will apply to the PHI we already have. If we make an important change to our policies, we will promptly change this notice, post a new notice in the main lobby area of the program, and have copies available for distribution.

You can request a copy of this notice from the contact person listed in Section V below at any time and can view a copy of the notice on our website at http://www.eckerd.org.

Note to parents/guardians: If you are reading this notice as your child’s personal representative, this notice describes our privacy practices with respect to your child. Please let us know if you have any questions.

How we may use and disclose your PHI.

We use and disclose PHI for many different reasons. For some of these uses or disclosures, we need your specific authorization, while for others, we do not. Below, we describe the different categories of our uses and disclosures.

A. We may use and disclose PHI for the following reasons without a written authorization.

1. For treatment, payment, or health care operations

   a. For treatment. We may disclose your PHI to physicians, nurses, mental health professionals, and other health care personnel who provide you with health care services or are involved in your care. For example, we may disclose your PHI to your primary care physician for treatment purposes.

b. To obtain payment for treatment. We may use and disclose your PHI in order to bill and collect payment for the treatment and service provided to you. For example, if a service we provide is billable to a third party insurance company or to Medicaid, we may submit the information to them that is necessary for payment.

c. For health care operations. We may disclose your PHI in order to operate our program. For example, we use your PHI to evaluate the quality of the health care services you received.

2. When a disclosure is required by law. For example, we are required to make disclosures about victims of abuse, neglect, or domestic violence to the appropriate agency.

3. For public health activities. For example, we are required to report information pertaining to certain diseases to local health authorities.

4. For health oversight activities. For example, we will provide the necessary information to assist a government agency conducting an investigation
or inspection of our health care activities.

5. For judicial and administrative proceedings or for certain law enforcement purposes. For example, we may provide PHI in response to an order of the court, or we may provide limited PHI in response to a law enforcement official's request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person.

6. For research purposes. For example, in certain circumstances, we may provide PHI in order to conduct research.

7. To avert a serious threat to health or safety. For example, we may disclose PHI if in good faith we believe it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

8. For specific government purposes. For example, we may disclose PHI if we believe it is a matter of national security.

9. For fundraising activities. For example, we may mail information about various fundraising activities or events to you. If you do not wish to be contacted as part of our fundraising efforts, please contact the person listed in Section V below.

B. Other uses and disclosures of your PHI not listed above, and permitted by the laws that apply to us, will be made only with your written authorization. If you choose to sign an authorization to disclose your PHI, you may revoke (i.e., take back) it in writing at any time, except to the extent that we have already taken action based on the original authorization. You have the following rights with respect to your PHI:

C. The right to request limits on uses and disclosures of your PHI. We are not required, however, to agree or comply with your request. In order to exercise this right, you can put your request in writing to the program supervisor or directly to the organization's privacy officer (see contact information in Section VI). Please detail your request with any specific instructions on how to limit disclosures of your PHI.

D. The right to choose how we send PHI to you. You have the right to ask that we send information to you to an alternate address (e.g., your work address rather than your home address) or by alternate means (e.g., email instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested. In order to exercise this right, you can put your request in writing to the program supervisor or directly to the organization's privacy officer (see contact information in Section VI). Please detail your request with any specific instructions on how to send the information to you.

E. The right to see your PHI. In most cases you also have the right to look at or get copies of your PHI that we have, but your request must be made in writing. If we do not have your PHI, but know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain cases, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that in advance. In order to exercise this right, you can put your request in writing to the program supervisor or directly to the organization's privacy officer (see contact information in Section VI). Please detail your request with any specific preferences.

F. The right to receive an electronic copy of electronic records. If we maintain PHI in an electronic format, you have the right to request this PHI be sent to you or another entity in electronic format. If we are not able to send in electronic format, we will comply with the request by producing a hard copy of the requested PHI. In order to exercise this right, you can put your request in writing to the program supervisor or directly to the organization's privacy officer (see contact information in Section VI). Please detail your request with any further requests.

G. The right to correct or update your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. If we approve your request, we will make the change to your PHI, tell you that we have done so, and tell others that need to know about the change. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement. If you don't file a written statement of disagreement, you may alternatively ask that your original request and our denial be attached to all future disclosures of your PHI. In order to exercise this right, you can put your request in writing to the program supervisor or directly to the organization's privacy officer (see contact information in Section VI). Please detail your request with any specific edits or updates.

H. The right to receive notification if and when your PHI is breached. A breach is when there is an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of this information.

CARING FOR CHILDREN ~ NOTICE OF PRIVACY PRACTICES (4 of 4)

I. The right to get a list of the disclosures we have made. You have the right to get a list of those instances in which we have disclosed your PHI. The list will not include uses or disclosures made to you; those related to treatment, payment, or health care operations; those that were authorized by you; those made for national security purposes; or in certain circumstances, those made to correctional institutions or for other law enforcement custodial situations. In order to exercise this right, you can put your request in writing to the program supervisor or directly to the organization's privacy officer (see contact information in Section VI). All requests must be made in writing and you must specify the time period for which you want to receive a list of disclosures. This time period may not be longer than six years and may not include dates prior to April 14, 2003. We will respond within 60 days of receiving your request. The list we will give you will include the date of the disclosure, to whom the PHI was disclosed (including the address if known), a brief description of the PHI disclosed, and a brief statement of the reason for the disclosure.

J. The right to get this notice by email. You have the right to get a copy of this notice by email. Even if you have agreed to receive the notice via email, you also have the right to request a paper copy of this notice.

How to express concerns about our privacy practices:
If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section V below. You also may send a written complaint to the Secretary of the Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

The person to contact for information about this notice.
If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact Keith Gauthier, Director of Risk Management & Privacy, who can be reached at (800) 222-1473, via email at kgauthier@eckerd.org or by traditional mail at 100 Starcrest Drive, Clearwater, FL 33765.

Eckerd Connects Organizational Privacy Officer is currently Keith Gauthier.
His contact info is:
Phone: (800) 222-1473
Email: kgauthier@eckerd.org
Mailing Address: 100 Starcrest Drive, Clearwater, FL 33765
Effective date of this notice: This notice is effective as of April 14, 2003. It was last updated March, 2016.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
My signature below acknowledges that I have:

- Had Eckerd Connects Notice of Privacy Practices explained to me.
- Been given the opportunity to ask questions to ensure understanding of its content to my satisfaction.
- Received a copy of the document by way of the Program Handbook that has been provided to me during intake/admission.

Parent/Guardian:____

(Signature) (Print) (Date)

CARING FOR CHILDREN/Eckerd Connects ~ DEMOGRAPHIC INFORMATION
(This information is for demographic evaluation purposes only)

Please describe the stress you are experiencing and how it is impacting your life and family:

____
____
____
____

Rate this level of stress from 1 2 3 4 5 6 7 8 9 10

Race/Ethnicity *(please choose the ONE that best describes what you consider yourself to be)*:

Native American or Alaskan Native
Native Hawaiian/Pacific Islander
African American
Asian
White (Non-Hispanic)
Native American or Alaskan Native
Multi-Racial
Hispanic or Latino
Middle Eastern
Other: __________________________

Marital Status:

Married Single Widowed Partnered Divorced Separated

Family Housing:

Own Shared housing w/ friends/relatives Homeless Rent Temporary

Family Income:

$0 - $10,000/year $10,001 - $20,000/year $20,001 – $30,000/year
$30,001 - $40,000/year $40,001 - $50,000 More than $50,000

Highest Level of Education:

Elementary/Junior High School Some High School High School Diploma or GED
Trade/Vocational Training Some College 2-Year College (Associate's Degree)
4-Year College (Bachelor's Degree) Master's Degree Ph.D. or Other Advanced Degree

Which, if any, do you receive? *Check all that apply.*

Food Stamps
Earned Income Tax Credit
Head Start/Early Head Start Services
Medicaid (State Health INS)
TANF
None

CARING FOR CHILDREN/Eckerd Connects~ DEMOGRAPHIC INFORMATION
(This information is for demographic evaluation purposes only)

Please write the number that describes how often the statements are true for you or your family. The numbers represent a scale from 1-7 where each number represents a different amount of time. The number 4 means that the statement is true about half the time. This helps determine that the Respite Scholarship is helpful to you and your family.

1. Never 2. Very Rarely 3. Rarely 4. About Half the Time 5. Frequently 6. Very Frequently 7. Always

1. In my family, we talk about problems. ______
2. When we argue, my family listens to “both sides of the story.”_____
3. In my family, we take time to listen to each other._________
4. My family pulls together when things are stressful.__________
5. My family is able to solve our problems._________
6. I have others who will listen when I need to talk about my problems.______
7. When I am lonely, there are several people I can talk to._______
8. I would have no idea where to turn if my family needed food or housing._______
9. I wouldn’t know where to go for help if I had trouble making ends meet. _______
10. If there is a crisis, I have other I can talk to._______
11. If I need help finding a job, I wouldn’t know where to go for help. _______

This part of the survey asks about parenting and your relationship with your child. For this section, please focus on the child that you hope will benefit most from your participation in our services.

1. There are many times when I don’t know what to do as a parent. _____
2. I know how to help my child learn.______
3. My child misbehaves just to upset me._____
4. I praise my child when he/she behaves well._____
5. When I discipline my child, I lose control.______
6. I am happy being with my child.______
7. My child and I are very close to each other.______
8 I am able to soothe my child when he/she is upset.______
9. I spend time with my child doing what he/she likes to do. _______

CARING FOR CHILDREN
a program of eckerd connects

AUTHORIZATION FOR RELEASE OF INFORMATION – SUBSTANCE USE

NOTE:

- Only Substance Use related records pertaining to involuntary commitments and/or situations where state and federal law require parental consent for treatment are covered by the organization's general version of the Authorization for Release of Information form.
- All other Substance Use records require a separate Substance Use specific authorization form signed only by the client. This is an authorization for release of such information regarding the below identified individual:

Name:	**DOB:**	Program Name: Respite Scholarship	
Program Address: 225 E Chestnut St	City: Asheville	State: NC	Zip Code: 28801

The Effective Date of this form is: NA . (Please note that if the signatures at the end of this form are dated after the Effective Date noted above, the latest signature date shall be the Effective Date.)	This form will expire on: NA _. (The Expiration Date above may not be greater than one year from the Effective Date. If the date above is blank, this form will expire one year from the Effective Date.)

I hereby authorize Caring for Children/Eckerd Connects to:

A. Release and/or obtain, or not permit the below protected and confidential information regarding me as directed below:

SPECIFIC DOCUMENTATION	**RELEASE** and/or **OBTAIN, No** or **NA**			
	Release To ☐	Obtain From ☐	No ☐	NA ☐
	Release To ☐	Obtain From ☐	No ☐	NA ☐
	Release To ☐	Obtain From ☐	No ☐	NA ☐
	Release To ☐	Obtain From ☐	No ☐	NA ☐
	Release To ☐	Obtain From ☐	No ☐	NA ☐
	Release To ☐	Obtain From ☐	No ☐	NA ☐

B. With the following party:

Name or Title: ______________________

Agency Name (if applicable): ______________________

Address: ______________________

Phone Number: ______________________

Email Address: ______________________

Fax Number: ______________________

AUTHORIZATION FOR RELEASE OF INFORMATION – SUBSTANCE USE

This information may be used only for the specific purpose of (check as many of the following that are applicable):

- ☐ Development and Implementation of Individualized Service Plan / Plan of Care / Treatment Plan
- ☐ Coordination of Services
- ☐ Referral for New Service
- ☐ Monitoring of Services
- ☐ Client Request to Release
- ☐ **NA:** ____

Any limitations that I impose on Caring for Children/Eckerd Connects with respect to this Authorization are stated as follows:

____

My signature below acknowledges that:

- I have been informed of the specific type of information that has been requested and give my consent voluntarily.
- The purpose of releasing information and confidentially has also been explained to me.
- I understand that the provision of services is not based on my decision concerning the release of information or signing this Authorization.
- I understand that my records are protected under Federal and State regulations governing the confidentiality of Medical Records including Mental Health, STD's (including HIV-AIDS), and Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).
- I have been informed and understand that information disclosed or received pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be protected by Federal and State law.
- I understand that this Authorization may be revoked at any time with written notice to Caring for Children/Eckerd Connects - Attn: Records Custodian, 100 Starcrest Drive, Clearwater, FL 33765 - except to the extent that the information has already been released based upon this consent.
- I understand that this Authorization is not automatically renewable. Per my request, this Authorization will expire on the date noted above unless that space is left blank, then this Authorization will expire exactly one year from today. Under no circumstances will this Authorization last longer than one year from today. Except as required by law, this Authorization will remain valid through the expiration date above, unless effectively revoked in writing by me, before this date.
- I have read this Authorization or it has been read to me, and I understand its content to my satisfaction.

Guardian Name: ______________________ ______________________ __________

(Signature) (Print) (Date)

A copy of this Authorization has been offered and was **accepted.** ☐ ☐

AUTHORIZATION FOR RELEASE OF INFORMATION – PSYCHOTHERAPY RECORDS

NOTE: Psychotherapy Records are records of a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session kept separate from the rest of the individual's medical record. Psychotherapy Records disclosed or received by Caring for Children/Eckerd Connects may be in any form including written, verbal, video, audio or any other medium. (If Caring for Children/Eckerd Connects must exchange information other than Psychotherapy Records, please complete both this Authorization form and an Authorization form for the other information using Caring for Children/Eckerd Connects' Authorization for Release of Information – Form F1.02b.)

This is an authorization for release of such information regarding the below identified individual:

Name:	DOB:	Program Name: Respite Scholarship	
Program Address: 225 E Chestnut St	City: Asheville	State: NC	Zip Code: 28801

The Effective Date of this form is: NA ________________. (Please note that if the signatures at the end of this form are dated after the Effective Date noted above, the latest signature date shall be the Effective Date.)	This form will expire on: NA ________________ _. (The Expiration Date above may not be greater than one year from the Effective Date. If the date above is blank, this form will expire one year from the Effective Date.)

I hereby authorize Caring for Children/Eckerd Connects to:

A. Release and/or obtain, or not permit the below protected and confidential information regarding the above named Client as directed below:

SPECIFIC DOCUMENTATION	**RELEASE** and/or **OBTAIN, No** or **NA**			
	Release To ☐	Obtain From ☐	No ☐	NA ☐
	Release To ☐	Obtain From ☐	No ☐	NA ☐
	Release To ☐	Obtain From ☐	No ☐	NA ☐
	Release To ☐	Obtain From ☐	No ☐	NA ☐
	Release To ☐	Obtain From ☐	No ☐	NA ☐
	Release To ☐	Obtain From ☐	No ☐	NA ☐

B. With the following party:

Name or Title: ______________________

Agency Name (if applicable): ______________________

Address: ______________________

Phone Number: ______________________

Email Address: ______________________

Fax Number: ______________________

This information may be used only for the specific purpose of (check as many of the following that are applicable):

- ☐ Development and Implementation of Individualized Service Plan / Plan of Care / Treatment Plan
- ☐ Coordination of Services
- ☐ Referral for New Service
- ☐ Monitoring of Services
- ☐ Parent Request to Release
- ☐ Client (Over 18 years of age) Request to Release
- ☐ **NA** ______________________________

Any limitations that I impose on Caring for Children/Eckerd Connects with respect to this Authorization are stated as follows:

____

My signature below acknowledges that:

- I have been informed of the specific type of information that has been requested and give my consent voluntarily.
- The purpose of releasing information and confidentially has also been explained to me.
- I understand that the provision of services is not based on my decision concerning the release of information or signing this Authorization.
- I understand that my records are protected under Federal and State regulations governing the confidentiality of Medical Records including Mental Health, STD's (including HIV-AIDS), and Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).
- I have been informed and understand that information disclosed or received pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be protected by Federal and State law.
- I understand that this Authorization may be revoked at any time with written notice to Caring for Children/Eckerd Connects - Attn: Records Custodian, 100 Starcrest Drive, Clearwater, FL 33765 - except to the extent that the information has already been released based upon this consent.
- I understand that this Authorization is not automatically renewable. Per my request, this Authorization will expire on the date noted above unless that space is left blank, then this Authorization will expire exactly one year from today. Under no circumstances will this Authorization last longer than one year from today. Except as required by law, this Authorization will remain valid through the expiration date above, unless effectively revoked in writing by me, before this date.
- I have read this Authorization or it has been read to me, and I understand its content to my satisfaction.

______________________ ______________________ __________

Legal Guardian: ______________________ ______________________ __________

(Signature) (Print) (Date)

Legal Guardian's relationship to Client: ______________________________

A copy of this Authorization has been offered and was accepted. ☐, ☐.

☐ ☐

CARING FOR CHILDREN
a program of eckerd connects

Authorization for Release of Information

This is an authorization for release of information regarding the below identified individual:

Name:	**DOB:**		Program Name: Respite Scholarship
Program Address: 225 E Chestnut St	City: Asheville	State: NC	Zip Code: 28801

The Effective Date of this form is: NA. (Please note that if the signatures at the end of this form are dated after the Effective Date noted above, the latest signature date shall be the Effective Date.)	This form will expire on: NA _. (The Expiration Date above may not be greater than one year from the Effective Date. If the date above is blank, this form will expire one year from the Effective Date.)

I hereby authorize Caring for Children/Eckerd Connects to:

A. Release and/or obtain, or not permit the below protected and confidential information regarding the above named Client as directed below:

INFORMATION	SPECIFIC DOCUMENTATION	**RELEASE** and/or **OBTAIN, No** or **NA**			
Discharge Summary		Release To ☐	Obtain From ☐	No ☐	NA☐
Educational/Vocational Plans or Records		Release To ☐	Obtain From ☐	No ☐	NA☐
HIV/AIDS Related Information		Release To ☐	Obtain From ☐	No ☐	NA☐
Medical History		Release To ☐	Obtain From ☐	No ☐	NA☐
Physical Examination		Release To ☐	Obtain From ☐	No ☐	NA☐
Progress Reports		Release To ☐	Obtain From ☐	No ☐	NA☐
Psychological Evaluation/Reports		Release To ☐	Obtain From ☐	No ☐	NA☐
Service/Treatment Plan		Release To ☐	Obtain From ☐	No ☐	NA☐
Social History		Release To ☐	Obtain From ☐	No ☐	NA☐
Substance Use (see below NOTE)		Release To ☐	Obtain From ☐	No ☐	NA☐
Other		Release To ☐	Obtain From ☐	No ☐	NA☐

NOTE: A separate Authorization must be completed to have this information released for each of the following:

- Any exchange of Psychotherapy records (i.e., separately kept records of a mental health professional documenting/analyzing the contents of counseling sessions) must be authorized using the separate authorization form for Psychotherapy Records. (If Caring for Children/Eckerd Connects must exchange psychotherapy records as well as other information listed above, please complete both this authorization form and the authorization form for psychotherapy records.)
- Only Substance Use records pertaining to involuntary commitments and/or situations where state and federal law require parental consent for treatment are covered by this Authorization.

  All other Substance Use records require a separate Substance Use specific authorization form signed only by the client.

B. With the following party:

Name or Title: __________

Agency Name (if applicable): __________

Address: __________

Phone Number: __________

Email Address: __________

Fax Number: __________

CARING FOR CHILDREN
a program of eckerd connects

AUTHORIZATION FOR RELEASE OF INFORMATION

This information may be used only for the specific purpose of (check as many of the following that are applicable):

- ☐ Development and Implementation of Individualized Service Plan / Plan of Care / Treatment Plan
- ☐ Coordination of Services
- ☐ Referral for New Service
- ☐ Monitoring of Services
- ☐ Parent Request to Release
- ☐ Client (Over 18 years of age) Request to Release
- ☐ **NA** ____

Any limitations that I impose on Caring for Children/Eckerd Connects with respect to this Authorization are stated as follows:

____

My signature below acknowledges that:

- I have been informed of the specific type of information that has been requested and give my consent voluntarily.
- The purpose of releasing information and confidentially has also been explained to me.
- I understand that the provision of services is not based on my decision concerning the release of information or signing this Authorization.
- I understand that my records are protected under Federal and State regulations governing the confidentiality of Medical Records including Mental Health, STD's (including HIV-AIDS), and Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).
- I have been informed and understand that information disclosed or received pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be protected by Federal and State law.
- I understand that this Authorization may be revoked at any time with written notice to Caring for Children/Eckerd Connects - Attn: Records Custodian, 100 Starcrest Drive, Clearwater, FL 33765 - except to the extent that the information has already been released based upon this consent.
- I understand that this Authorization is not automatically renewable. Per my request, this Authorization will expire on the date noted above unless that space is left blank, then this Authorization will expire exactly one year from today. Under no circumstances will this Authorization last longer than one year from today. Except as required by law, this Authorization will remain valid through the expiration date above, unless effectively revoked in writing by me, before this date.
- I have read this Authorization or it has been read to me, and I understand its content to my satisfaction.

______________________ ______________________ __________

Legal Guardian: ______________________ ______________________ __________

(Signature) (Print) (Date)

Legal Guardian's relationship to Client: ______________________

A copy of this Authorization has been offered and was accepted. ☐ ☐.

☐ ☐