Village for Families & Children, Inc.
PROGRAM REGISTRATION PACKET

Date: _____

Name: _____ **Address:** _____
City: _____ **State:** _____ **Zip Code:** _____
Phone: _____ **Date of Birth:** _____ **Current age:** _____
Emergency Contact: _____ **Relationship:** _____ **Phone:** _____
Gender: ☐ Male ☐ Female **Are you Hispanic/Latino?** ☐ Yes ☐ No
Please specify which race/racial group(s) you identify with (you may check more than one):
☐ Black/AA ☐ Caucasian ☐ Native American ☐ Pacific Islander ☐ Asian
☐ Middle-Eastern ☐ Other _____
Preferred Language? ☐ English ☐ Spanish ☐ Other _____
Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Partnered ☐ Divorced ☐ Single, never married

Have you or any of your children ever participated in any other Village program(s)?
☐ No ☐ Yes, please name the program(s) and the dates of attendance: _____

Please provide the following information so that we can better meet the needs of you and your family.
How many children under 18 live in your household? ____
(Please provide each child's age, gender, and relationship to you, School, Grade):

	Name	Birth date	M/F	Relationship	School	Grade
1.		/ /		☐ Son/daughter ☐ Step-child ☐ Other relative ☐ Foster child		
2.		/ /		☐ Son/daughter ☐ Step-child ☐ Other relative ☐ Foster child		
3.		/ /		☐ Son/daughter ☐ Step-child ☐ Other relative ☐ Foster child		
4.		/ /		☐ Son/daughter ☐ Step-child ☐ Other relative ☐ Foster child		
5.		/ /		☐ Son/daughter ☐ Step-child ☐ Other relative ☐ Foster child		

How many people 18 years old or older live in your home? ____
Are you/your spouse/your partner pregnant now? ☐ No ☐ Yes, due date _____

2. Housing. Which best describes your current living arrangement.
☐ Self ☐ Spouse/Partner ☐ Relative ☐ Parents ☐ Friend/Roommate ☐ Shelter
☐ Do not have a place to live ☐ Other _____
How long have you been in this home? _____ Who is the responsible for rent/mortgage? ☐ You ☐ Someone else

3. School: Are you currently enrolled in school? (Y) (N) **If Yes, Name:** _____
Highest grade in school you have completed (please circle):
(1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) ☐ GED ☐ Some College ☐ Associate's Degree
Bachelor's Degree ☐ Bachelor's Degree + ☐

4. Do you have health care coverage? ☐ Yes ☐ No **Do your children have health care coverage?** ☐ Yes ☐ No
If yes, for either, what kind? Check all that apply,
☐ Private health insurance ☐ Medicaid ☐ Husky ☐ Bluecare ☐ Other _____

PROGRAM REGISTRATION PACKET cont.

Date: _____ **Name:** _____

5. Employment Status: ☐ Employed, full-time ☐ Employed, part-time

If employed, usual hours _____

☐ Retired ☐ Unemployed, looking for work ☐ Unemployed, not looking for work; ☐ Job Training ☐ In School

Income Level: ☐ Under $15,000 ☐ $15,000 to $25,000 ☐ $25, 000 to $40,000 ☐ $40,000 to $50,000 ☐ Over $50,000

Assistance: TANF: ☐ Yes ☐ No **Food stamps:** ☐ Yes ☐ No **WIC:** ☐ Yes ☐ No

Other Income: _____

6. Do you have someone to care for your children when you are at work or away from home? ☐ Yes ☐ No

If Yes, who? ☐ Child's other parent ☐ Boyfriend/ Girlfriend ☐ Grandparent ☐ Relative ☐ Friend

☐ Family child care in private home ☐ Day Care Center/ After-school program

☐ Other: _____

7. Do you have transportation to participate in programs? ☐ None ☐ Yes, have automobile

☐ Yes, city bus or van or other public transportation ☐ Yes, have regular arrangement with other driver

☐ Other: _____

8. Do you have someone you can call when your family needs help? ☐ Yes ☐ No

If yes, who do you call on? ☐ Family ☐ Friends ☐ Church ☐ Agency Which? _____

☐ Other Who? _____

Common Sense Parenting

Date: _____ **Participant ID# (if any):** _____

Trainer: _____

How did you learn about this program?

☐ School _____ ☐ Friend/ family member ☐ Advertisement ☐ Infoline ☐ Self

☐ Social Services/ DCF ☐ Court ☐ Other Village Program

☐ Other, *How?:* _____

Are both parents attending class? ☐ No ☐ Yes

Relationship of Adults attending class? ☐ Spouse ☐ Relative ☐ Other

Thank you!!

The Village for Families & Children, Inc.

VIDEO/AUDIO CONSENT FORM

Common Sense Parenting Program

I/We _____
Name(s)

hereby give consent to videotape at the Village for Families & Children, Inc. and the projection or playing of same at Girls & Boys Town, USA. I/We understand that:

Such material will be for the purpose of teaching the parent trainer only;

Such material is confidential and only to be used by the educational staff of Girls & Boys Town, USA;

All persons participating in reviewing the parent trainers teaching during sessions will be instructed about the confidential nature of any material;

I/We may request that taped material be erased at any time;

I/We agree to this procedure voluntarily and with full understanding of my/our rights to have our records maintained in a confidential manner; and

My/our refusal to give consent will not exclude me/us from any Agency services.

☐ I/We agree to be videotaped _____

☐ I/We do not agree to be videotaped _____

THE VILLAGE FOR FAMILIES & CHILDREN, INC.

POLICY REGARDING VIDEOTAPING
For Common Sense Parenting Program

Purpose of Videotaping Sessions at the Village including Family Resource Centers

There is one reason to pursue permission to videotape sessions of ***Common Sense Parenting*** during your training session:

> It is often difficult for a parent trainer working with a curriculum for effective parenting to be aware of all the dynamics and issues in the sessions and provide the skill development for parents in accord with the model. A professional reviewer viewing a tape of the session may be able to provide valuable input to the parent trainer, thereby *strengthening the quality of the service provided to the parents* and improving the skills of the parent trainer. This is an extremely valuable tool for developing parent trainer effectiveness particularly in teaching the preventive and corrective teaching skills.

Procedures for Videotaping a *Common Sense Parenting Session* at the Village

1. A video camera will be set up in a fixed position to focus on the parent trainer(s). Nonetheless your voice will be recorded and you may incidentally walk in the range of the camera. The parent trainer or a staff member must receive written permission to videotape from the parent.
2. The permission form states that participation is voluntary and that refusal of permission will not impact services at the Village. Permission may be withdrawn at any time. Parents may choose to remain out of the camera's range.
3. Only the educational staff at Girls and Boys Town, USA views taped sessions for the purpose of reviewing the parent trainer's skill in delivering the training as structured. Confidentiality of sessions is adhered to carefully. Tapes will be treated as other confidential records are. They will be stored locked while at Girls and Boys Town, USA or the Village for Families and Children, Inc.
4. After the tape is viewed and the parent trainer scored, the tape will be erased on return to the Village for Families and Children, Inc. It is erased within one week of return.
5. Parents will be informed that a session will be taped. Generally, sessions 3, 4 & 5 will be taped.
6. Parents will be shown the equipment and any questions will be answered. If a parent strictly objects to the videotaping, it will be canceled.

CONSENT FOR SERVICES

The Village
So every child believes in tomorrow

Client Name:	Client ID#:
Program Name:	

Village Services: The Village for Families & Children is committed to building a community of strong, healthy families who protect and nurture children. Village services encompass three core areas of strength: Placement and Permanency (adoption, foster care and family preservation), Treatment (in-home, outpatient and residential), and Family and Community Support (educational, recreational, case management, financial and referral services). Village services are offered in a variety of settings, including in-home, clinics, schools and community centers. As a Village client, you are encouraged to work with Village professionals to choose the services that best meet your needs. Services along The Village continuum of care include evaluation, education, care and treatment for the individual, group or family.

Privacy: I understand that all information shared with Village providers is confidential. During the course of treatment and participation in services it may be necessary for my worker to communicate with other providers at The Village. While written authorization will not be requested for these internal communications, prior to any discussion with Village providers, I understand that my worker will discuss Village communications with me. I further understand that information is released to external providers only with my written authorization, or under specific circumstances as described in The Village's Notice of Privacy Practices:

- When there is risk of imminent danger to myself or to another person, my worker is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, my worker is legally required to take steps to protect them, and to inform the proper authorities.
- When a valid court order is issued for medical records, my worker and the agency are bound by law to comply with such requests.

Consent for Services: Village services are provided by a range of behavioral health professionals, some of whom are in training. All professionals-in-training are supervised by licensed staff. My Village provider will explain the following about the services I/we will receive:

- The benefits of the proposed services;
- Alternative treatment modes and services;
- The manner in which evaluation, treatment or other services will be provided;
- Expected side effects from the treatment and/or the risks of side effects from medications (as applicable);
- Probable consequences of not receiving evaluation, treatment or other services.

I have read and understand the above, have had an opportunity to ask questions about this information, and I am providing consent for myself or my child/ward to receive evaluation or treatment, or to participate in other Village services. I also attest that I am the legal guardian and have the right to provide consent for Village services. I understand that I have the right to ask questions of my service provider about the above information at any time. This consent for participation in services will expire 12 months from the date of signature, unless I choose to terminate services prior to that date.

As the client receiving services, I understand and give my consent.		
Client PRINTED Name	Client Signature	Date
As the Authorized client representative I understand and give my consent (check type and sign when client is a minor under the age of 18).		
☐ Parents have joint custody ☐ Mother ☐ Father ☐ Order of Protective Custody		
☐ Order of Temporary Custody ☐ Power of Attorney ☐ Guardianship Order		
☐ Legal Representative or Executor ☐ DCF Committed		
Authorized Representative's PRINTED Name	Authorized Representative's Signature	Date
☐ I am physically unable to sign but understand and have given my verbal consent.		
Witness/Staff PRINTED Name	Witness/Staff Signature	Date

Master Data-Sharing Agreement
Authorization Agreement for Disclosure and Sharing of Protected Health Information
Stronger Families, Stronger Futures

Please complete A or B, as appropriate, and sign C below.

A. FOR PARENT/GUARDIAN OF MINOR CHILD (please print clearly)

I, _____ _____,
Print Parent/Guardian First Name Print Parent/Guardian Last Name

as the (check one) Parent ☐ Guardian, ☐ or in place of the parent ☐

_____ _____,
Print Child's Legal First Name Print Child's Legal Last Name

authorize the release of personally identifiable health information of the Child named above, subject to the terms of this Consent Agreement.

B. FOR ADULT OF LEGAL AGE: (please print clearly)

I, _____ _____,
Print First Name Print Last Name

authorize the release of my personally identifiable health information, subject to the terms of this Consent Agreement.

C. By signing this Authorization Agreement, I agree that I have read and understood the above and agree to all of the above statements. I understand that signing this Authorization is voluntary and is not a condition for receiving services from the Stronger Families, Stronger Futures. This Authorization is valid for the duration of the Stronger Families, Stronger Futures initiative. I maintain the right to discontinue this Authorization at any time by contacting the Stronger Families, Stronger Futures in writing at The City of Hartford by contacting Liany Arroyo at liany.arroyo@hartford.gov.

Signature _____ Date _____

For Stronger Families, Stronger Futures Use Only

Partner collecting this Authorization Agreement: _____

Authorization recorded in Stronger Families, Stronger Futures case management system on (date): _____

Stronger Families, Stronger Futures case management ID number: _____

Master Data-Sharing Agreement
Authorization Agreement for Disclosure and Sharing of Protected Health Information
Stronger Families, Stronger Futures

Stronger Families, Stronger Futures Authorization Agreement for Disclosure and Sharing of Protected Health Information.

Stronger Families, Stronger Futures is a family centered program made up of a multi-agency service delivery system to support parents and their children in achieving their desired parenting goals. Our system includes the following service partners: Catholic Charities, Family Life Education, Inc., Hartford HealthCare at Home, Hispanic Health Council, The Village for Families and Children, Hartford Hospital, Urban League of Greater Hartford, St. Francis Hospital, and City of Hartford.

By signing this agreement, you give your authorization to disclose and share personally identifiable health information on the person listed below with authorized partners in the Stronger Families, Stronger Futures. The purpose of sharing this information is to allow Stronger Families, Stronger Futures to provide well informed, coordinated services to participants and their families. De-identified information will be used to conduct ongoing evaluation and improvement of programs to better serve the community, and to report results of programs and activities to residents, partners, and funders.

Stronger Families, Stronger Futures takes every precaution to protect personal information from unauthorized use or release. Information obtained on persons shall not be shared outside of the network of providers. This information is used solely for service provision and program evaluation purposes and identified information shall not be further disclosed to third parties not covered by this Consent Agreement without your prior written consent. Information our partners will be able to obtain are demographics, medical history, emergency contact information, insurance information, substance abuse history and mental health history. The information shared may include the presence of a communicable or sexually transmitted disease including human immunodeficiency virus (HIV). State law prohibits further disclosure without specific written consent and confidentiality protected by state law.

I authorize the disclosure personally identifiable health information to the Stronger Families, Stronger Futures entities and partners:

This entity list is subject to change. For up-to-date information and questions, please contact the City Administrator, Liany Arroyo at liany.arroyo@hartford.gov. Signing this consent agreement constitutes the granting of authorization for disclosure of protected health information under the Health Insurance Portability and Accountability Act (HIPAA).

The Village
Where real change happens

Phone: 860-236-4511, ext. 3780
Fax: 860-296-6014

Date Completed: _____

AUTHORIZATION TO OBTAIN / DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Subject to the statements printed on the back, I, the undersigned patient or legal representative, hereby authorize the use and disclosure of Protected Health Information (PHI) including, if applicable, information related to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information. The information authorized may be obtained /disclosed in verbal, written, and/or electronic format. **Program:** _____ **Clinician:** _____

Patient Name	Date of Birth	Client Number (if known)

For closed cases only: indicate dates of service and / or Program this request relates to _____

Your Authorization

I hereby authorize the Village for Families and Children and its staff to: (Check one or both)

☐ **Disclose** (Share/send) information about the client's medical, service records
☐ **Obtain** (Receive/request) information about the client's medical, service records

To/From (e.g., M.D., school name, attorney) of third-party organization or individual:

Name _____ Tel # _____

Agency/Organization _____ Fax# _____

Address (street, city, zip) _____ E-mail _____

The purpose of this disclosure is:
☐ Evaluation and Treatment ☐ Legal ☐ Disability ☐ Insurance ☐ Education ☐ Other _____

Information to be obtained or disclosed
☐ Communication (verbal or written) with other providers regarding treatment or care

Documents:
☐ Treatment Plan ☐ Assessment ☐ Educational Records ☐ Psychiatric Evaluation ☐ Psychological Assessment
☐ Discharge/Transfer ☐ Medications ☐ Other: _____

Method of Disclosure(s): ☐ Any method or: ☐ Verbal ☐ Mail ☐ Pick-up ☐ E-mail* ☐ fax # _____
* E-mailed information provided by the Village will be encrypted requiring recipient to log-in to encryption site and establish a password.

- This authorization will be valid through: _____ or one year from the date below if no date is indicated. I understand that I may revoke this authorization at any time by notification in writing to the address below. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.
- I understand that my treatment or continued treatment by The Village is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.
- I understand that I may inspect the information to be used or disclosed and that there may be a charge for copies.
- The parent or legal guardian must sign this authorization if the patient is a minor (under age 18) or has a legal guardian.

As the authorized client representative, I understand and give my consent (check type and sign when client is a minor under 18)
☐ Parents have joint custody ☐ Mother only ☐ Father only ☐ Power of Attorney ☐ DCF Committed
☐ Guardianship order ☐ Legal Representative or Executor ☐ Order of Protective Custody (emergency basis only)

Signature of Client or Guardian	Date	Phone #
		( )

Rev. 10/16/2018

Note to Recipient of Information:

HIV Related Information

In the event that information release constitutes confidential HIV related information protected under Connecticut Law: this information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Psychiatric Information

In the event that information released constitutes confidential psychiatric information protected under Connecticut Law: this information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it or of using it for any purposes other than that indicated above without the specific written consent by the person to whom it pertains, or as otherwise permitted by said law.

Drug and Alcohol Abuse Records

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records Regulations: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Authorization may be sent to:

The Village for Families & Children, Inc
Attn: Medical Records
331 Wethersfield Avenue, Hartford, CT 06114
Phone: 860-236-4511, extension 3780 Fax: 860-296-6014