Birth & Beyond Family Resource Centers

Family Information Form: Caregiver/Adult Information

COMPLETED BY STAFF:	Staff ID:	
	Client ID:	
	Funding Source:	

Date completed:	
First Name:	
Middle Name:	
Last Name:	
Date of Birth *(M/D/YY)*:	
Gender:	
Relationship to Child(ren):	
Race/Ethnicity:	
Primary Language(s):	
Email address:	Want email newsletter? ☐Yes ☐No
Address:	
City:	
Zip Code:	
Phone Number(s):	☐ Texts OK? ☐ Calls OK?
Healthcare/Medical Insurance:	☐ Medi-Cal ☐ Other ☐ None ☐ Unknown
Dental Insurance:	☐ Medi-Cal ☐ Other ☐ None ☐ Unknown
Current Employment Status:	☐ Full time ☐ Part Time ☐ Not Employed ☐Unknown/prefer not to say
5. Are you Pregnant?	☐ No$_2$ ☐ Yes$_1$ **If yes, Due Date:**
5b. Are you receiving regular prenatal check-ups?	☐Yes$_1$ ☐ No$_2$

Complete for Families with Children 5 Years Old and Younger

Your answers to the questions below will help us understand which services are most helpful for participants:

12. Please mark the option that best describes how much you agree or disagree with the statement	Strongly Disagree$_1$	Disagree$_2$	Neutral$_3$	Agree$_4$	Strongly Agree$_5$
a. **I know what to expect at each stage of my child's development**	☐	☐	☐	☐	☐
b. **I know what program to contact in my community when I need help for basic needs** *(e.g. housing, food, employment)*	☐	☐	☐	☐	☐
c. **I know what program to contact in my community when I need advice on how to raise my child**	☐	☐	☐	☐	☐
d. **I attend events in the community with my child** *(e.g. FRC events, faith-based events, mommy-and-me, library story time)*	☐	☐	☐	☐	☐
e. **I involve my child in day-to-day tasks for our family** *(e.g. folding laundry, deciding what to make for dinner)*	☐	☐	☐	☐	☐
f. **I know of safe places for my child to play that are outside of my home**	☐	☐	☐	☐	☐
g. **I am able to take a break and do something enjoyable at least once a week**	☐	☐	☐	☐	☐
h. **I have people in my life who provide me with support when I need it**	☐	☐	☐	☐	☐
i. **I am able to handle the stresses of day-to-day parenting**	☐	☐	☐	☐	☐
j. **I find myself in stressful situations at least once a week**	☐	☐	☐	☐	☐
k. **In the past 2 weeks, I have felt down, depressed, or hopeless**	☐	☐	☐	☐	☐
l. **If Yes, are you receiving counseling or other care for your concern?** ☐ Yes ☐ No					
m. **Do you need help accessing mental health counseling for you or your child?** ☐ Yes ☐ No					

Top half: all caregivers/adults
Bold: adults with children ages 0-5
Full form: PAT home visitation

Bold regular (non-italic) = enter on/update client's profile in Persimmony
Bold Italic = enter in a new *B&B FIF-Caregiver* assessment (including 12a-12m)

10. Have you used any of these Programs/Services in the past 6 months? *(Highlight ALL that apply)*	☐ Food/nutrition (ex: WIC, CalFresh, food bank) ☐ A Parent education/support classes (ex: Workshops or classes about parenting, child development, or behavior) ☐ B Home Visits from a nurse, community worker, or other program ☐ C Services offered through a Family Resource Center
Any other programs/groups? *(ex: recreation, faith, AOD recovery)*	
Reasons for enrolling in home visitation? *(Highlight ALL that apply)*	☐ Learn about child development & parenting ☐ Increase social support ☐ Support for education/employment ☐ Support for obtaining healthcare ☐ Support/Information on family planning ☐ Support for economic/housing needs ☐ Support for maternal health and well-being ☐ Support for mental health ☐ Other *(please specify)*:

Cash Sources of Income *(Highlight ALL that apply)*	☐ CalWORKs (TANF) ☐ Child support/alimony ☐ Salary/wages ☐ Social Security/Disability ☐ Unemployment ☐ Unknown/prefer not to say ☐ Other:
Non-Cash Sources of Income *(Highlight ALL that apply)*	☐ CalFresh (SNAP) ☐ WIC ☐ Energy assistance ☐ Unknown/prefer not to say ☐ Housing assistance ☐ Other *(specify)*:
Number in household depending on this income	
11. Approximate Family Income Per Year	☐ Less than $15,000 1 ☐ $15,000-$25,000 2 ☐ $25,001-$50, 3 ☐ $50,001-$75,000 4 ☐ $75,001-$100,000 5 ☐ More than $100,000 6 ☐ Don't Know 7 ☐ Prefer not to say 8

Current Marital Status	☐ Divorced ☐ Married ☐ Never Married ☐ Widowed ☐ Not married but living with partner ☐ Unknown/Prefer not to say
Adult's Highest Level of Education *(GED, high school, some college, AA, bachelor's…)*	
Current Education/Training *(full or part time?)*	
Military History/Status	
Housing Status & History *(rent, own, with parent, public, transitional, unhoused...)*	

Community Type (According to PAT definitions): Sacramento = *Major City*
Arden-Arcade, Antelope, Carmichael, Citrus Heights, Elk Grove, Florin, Folsom, Natomas, North Highlands, Rancho Cordova = *Urban*
Fair Oaks, Foothill Farms, Orangevale, Rio Linda, Rosemont = *Suburban*
Courtland, Elverta, Galt, Gold River, Isleton, Mather, McClellan, Rancho Murieta, Sheldon, Walnut Grove, Wilton = *Small Town*

FAMILY HOUSEHOLD DEMOGRAPHICS

Client ID	Family Member (First and Last Name) Identify Primary Caregiver First		Relation	Sex	DOB (mm/dd/yy)	Health Care	Ethnicity	Primary Language
	First Name	Last Name	5	F M				
	First Name	Last Name		F M				
	First Name	Last Name		F M				
	First Name	Last Name		F M				
	First Name	Last Name		F M				
	First Name	Last Name		F M				
	First Name	Last Name		F M				
	First Name	Last Name		F M				
	First Name	Last Name		F M				
	First Name	Last Name		F M				

CLIENT TYPE
1 = Child 0-<3
2 = Child 3-5
3 = Child 6-12
4 = Child 13-17
5 = Parent/Caregiver/Self
6 = Provider
7 = Other (i.e. grandparent, foster parent, etc.)
_____

GENDER
1 = Male
2 = Female
3 = Trans Male
4 = Trans Female
5 = Non-binary
6 = Not Listed
7 = Prefer Not to Answer
8 = Other _____

HEALTHCARE
1 = Medi-Cal
2 = No Insurance
3 = Other Insurance (i.e. private insurance)
_____
4 = Unknown

ETHNICITY
(Add all that apply)
1 = Alaska Native/American Indian
2 = Asian
3 = Black/African American
4 = Hispanic/Latino
5 = Pacific Islander
6 = White/Caucasian
8 = Ukrainian/Russian
9 = Multiracial _____
10 = Other _____
11 = Unknown

PRIMARY LANGUAGE
1 = English
2 = Spanish
3 = Cantonese
4 = Mandarin
5 = Vietnamese
6 = Hmong
7 = Russian/Ukranian
8 = Other _____
9 = Unknown
10 = Decline/Don't Know

Birth & Beyond Family Resource Centers

Family Information Form: Child Information

How many total children?

Date:	
Child First Name:	
Child Middle Name:	
Child Last Name:	
Date of Birth (M/D/YY)**:**	
Gender:	
Race/Ethnicity:	
Primary Language:	
Relationship to You:	
Healthcare/Medical Insurance:	☐Medi-Cal ☐Other ☐None ☐Unknown

COMPLETED BY STAFF:	
Staff ID:	
Client ID:	
Funding Source:	

COMPLETE FOR EACH CHILD 0-5 YEARS OLD	YES	NO	DON'T KNOW
Has your child seen a dentist in the last six months?	☐	☐	☐
Do you need assistance in accessing dental care for your child?	☐	☐	☐
Has your child been seen by the doctor for a routine check up in the past 12 months?	☐	☐	☐
Do you need assistance accessing medical care for your child?	☐	☐	☐
Do you have any concerns about your child's development? (ex: Developmental delay, speech/language difficulties, physical/mental issues, emotional/behavioral issues)	☐	☐	☐
If Yes, have you consulted a doctor or specialist about your concern	☐	☐	☐
Do you need assistance in accessing a doctor or specialist for your concern?	☐	☐	☐
Vision Screening in the past year?	☐	☐	☐
Hearing Screening in the past year?	☐	☐	☐
Development/ASQ Screening in the past year?	☐	☐	☐

Please tell us the extent to which the following statements are true of your child:	NOT TRUE	SOMEWHAT TRUE	VERY TRUE	N/A
Your child stays calm and in control when faced with a challenge	☐	☐	☐	
Your child calms themself when upset	☐	☐	☐	
Your child adjusts well to changes in routine	☐	☐	☐	
Your child has opportunities for fun at least once every day	☐	☐	☐	
Your child has at least two non-parent adults who take a genuine interest in them (ex: auntie, teacher)	☐	☐	☐	
If you child is old enough to talk, they openly share their feelings with you	☐	☐	☐	☐

In the past 7 days, how many days did you or someone in your family engage in the following activities with your child:	0 days	1 day	2 days	3 days	4 days	5 days	6 days	7 days
Read with your child for more than 10 minutes	☐	☐	☐	☐	☐	☐	☐	☐
Talked with your child about things that happened during the day	☐	☐	☐	☐	☐	☐	☐	☐
Told stories or sang songs together	☐	☐	☐	☐	☐	☐	☐	☐
Played one-on-one with your child (ex: exercise, played sports, colored, built Legos)	☐	☐	☐	☐	☐	☐	☐	☐
Used the same bedtime routine (ex: read books, bath, brush teeth)	☐	☐	☐	☐	☐	☐	☐	☐
Sat and shared a meal together	☐	☐	☐	☐	☐	☐	☐	☐

****PAT HOME VISITATION ONLY****

Participation in other programs *(Select ALL that apply)*	Program	Start Date	End Date
	Early Head Start		
	Head Start		
	Family Literacy Program		
	Childcare/Early Childhood Program ☐ Center-Based or ☐ Home-Based? ☐ Licensed or ☐ Accredited?		
	Kindergarten		
	Early Intervention Services		
	Other *(specify)*:		

Top table = enter/update on child's profile in Persimmony

All tables except last (PAT) table = enter in a new *FIF - Child* assessment on child's profile

Birth & Beyond Family Resource Centers

Family Information Form: Child Information

How many total children?

Date:	
Child First Name:	
Child Middle Name:	
Child Last Name:	
Date of Birth (M/D/YY)**:**	
Gender:	
Race/Ethnicity:	
Primary Language:	
Relationship to You:	
Healthcare/Medical Insurance:	☐Medi-Cal ☐Other ☐None ☐Unknown

COMPLETED BY STAFF:	
Staff ID:	
Client ID:	
Funding Source:	

COMPLETE FOR EACH CHILD 0-5 YEARS OLD	YES	NO	DON'T KNOW
Has your child seen a dentist in the last six months?	☐	☐	☐
Do you need assistance in accessing dental care for your child?	☐	☐	☐
Has your child been seen by the doctor for a routine check up in the past 12 months?	☐	☐	☐
Do you need assistance accessing medical care for your child?	☐	☐	☐
Do you have any concerns about your child's development? (ex: Developmental delay, speech/language difficulties, physical/mental issues, emotional/behavioral issues)	☐	☐	☐
If Yes, have you consulted a doctor or specialist about your concern	☐	☐	☐
Do you need assistance in accessing a doctor or specialist for your concern?	☐	☐	☐
Vision Screening in the past year?	☐	☐	☐
Hearing Screening in the past year?	☐	☐	☐
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Your child has opportunities for fun at least once every day	☐	☐	☐	
Your child has at least two non-parent adults who take a genuine interest in them (ex: auntie, teacher)	☐	☐	☐	
If you child is old enough to talk, they openly share their feelings with you	☐	☐	☐	☐

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Told stories or sang songs together	☐	☐	☐	☐	☐	☐	☐	☐
Played one-on-one with your child (ex: exercise, played sports, colored, built Legos)	☐	☐	☐	☐	☐	☐	☐	☐
Used the same bedtime routine (ex: read books, bath, brush teeth)	☐	☐	☐	☐	☐	☐	☐	☐
Sat and shared a meal together	☐	☐	☐	☐	☐	☐	☐	☐

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	Other *(specify)*:		

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Birth & Beyond Family Resource Centers

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Race/Ethnicity:	
Primary Language:	
Relationship to You:	
Healthcare/Medical Insurance:	☐Medi-Cal ☐Other ☐None ☐Unknown

COMPLETED BY STAFF:	
Staff ID:	
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Has your child been seen by the doctor for a routine check up in the past 12 months?	☐	☐	☐
Do you need assistance accessing medical care for your child?	☐	☐	☐
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If you child is old enough to talk, they openly share their feelings with you	☐	☐	☐	☐

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Talked with your child about things that happened during the day	☐	☐	☐	☐	☐	☐	☐	☐
Told stories or sang songs together	☐	☐	☐	☐	☐	☐	☐	☐
Played one-on-one with your child (ex: exercise, played sports, colored, built Legos)	☐	☐	☐	☐	☐	☐	☐	☐
Used the same bedtime routine (ex: read books, bath, brush teeth)	☐	☐	☐	☐	☐	☐	☐	☐
Sat and shared a meal together	☐	☐	☐	☐	☐	☐	☐	☐

****PAT HOME VISITATION ONLY****

Participation in other programs *(Select ALL that apply)*	Program	Start Date	End Date
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	Childcare/Early Childhood Program ☐ Center-Based or ☐ Home-Based? ☐ Licensed or ☐ Accredited?		
	Kindergarten		
	Early Intervention Services		
	Other *(specify)*:		

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Birth & Beyond Family Resource Centers

Authorization for Services

I, _____, authorize Birth & Beyond Family Resource Center (B&B FRC) staff to work with me and my family during the program service time period. I understand that all services are voluntary and are offered based on family directed interests and needs.

Services are provided to families with a focus on the importance of the parent/child relationship and connecting the family to supportive services in the community. The B&B FRC model is based upon the belief that the family is the best place to raise children. The services families receive through B&B FRC are designed to support, encourage, and assist parents in fulfilling their roles. Parents can practice new skills and learn how to use resources in their community. Families must be residents of Sacramento County and be willing to accept services.

The program you are registering for today is funded by First 5 Sacramento and the County of Sacramento. Information is gathered so that we can understand how these services are working and to better coordinate care across funded programs. Your personal information is protected by state and federal law. Your information will be viewed by staff at the program you're at today, First 5, Sacramento County funded programs, and ASR. For the purposes of evaluation, the information will be combined with the information from everyone else who receives services. Your individual information will never be reported individually and/or publicly. All original copies of B&B program consent forms will be kept in the family file in a secure location.

The B&B FRC staff have a pre-existing duty as Mandated Reporters to release confidential information under the following circumstances:

1. If they hear and believe that you are in danger of hurting yourself or someone else or that a member of your family is in danger of hurting himself/herself or someone else (PC Section 11166);
2. If there is reasonable suspicion that a child, dependent adult and/or elderly adult has been abused or neglected (Welfare & Institutions Code 11165); or
3. If you have made a threat to harm an identifiable victim, both the victim and law enforcement will be notified of this threat (Welfare & Institutions Code Section 5328).

Program staff shall ensure all families participating in B&B FRC services have the following rights:

- The right to be treated with respect, dignity, and cultural sensitivity.
- The right to have access to needed health and social services.
- The right to on-going participation in the planning of services to be provided and in the development and revision of a family support plan.
- The right to choose and/or refuse services without jeopardizing other services.
- The right to ask questions any time the family does not understand what is taking place.
- The right to confidentiality of the family's records.
- The right to review, upon request, the family's records.
- The right to referral, as appropriate, to other services at any time.
- The right to a grievance procedure in the event that the family feels their rights have been violated or perceives discrimination or inappropriate treatment. To formally file a grievance, contact the following managers:

Katherine Landeros 916-290-8255
Supervisor Name & Phone Number

Jason Smith 916-290-8294
Program Manager Name & Phone Number

I understand that this authorization for services is valid when I sign it, and that I may withdraw my authorization at any time either verbally or in writing. The authorization for services should be valid for a reasonable period, **not to exceed one year.**

AUTHORIZATION EXPIRES
_____
Date

_____ Signature _____ Date _____ Staff/Witness Signature _____ Date

For Minor Parent(s), the parent, guardian, or legally authorized representative for the Minor Parent must provide their signature authorizing the Minor Parent to participate in the Birth & Beyond Family Resource Center program.

_____ Name of Minor Parent _____ Signature of Parent/Guardian/Legally Auth Rep. _____ Date

The family has a right to receive a copy of this authorization (Civic Code 56.10). A copy of this document is as valid as the original. I hereby acknowledge receipt of a copy of this authorization. _____ Initials _____ Date

Birth & Beyond Family Resource Centers

Consent for Release and Exchange of Information

The program you are registering for today is funded by First 5 Sacramento and the County of Sacramento. This consent authorizes the gathering, exchange, and release of information and/or records for purposes of developing a plan for comprehensive services, making appropriate referrals for children and their families, and program evaluation. Your personal information is protected by state and federal law. Your information will be viewed by staff at the program you're at today, First 5, Sacramento County funded programs, and ASR. Your individual information will never be reported individually and/or publicly. All original copies of B&B program consent forms are to be kept in the family file, in a secure location.

I, _____, as the parent, guardian, or legally authorized representative of the individuals listed below, hereby authorize the release and exchange of confidential information and/or records to the service providers indicated below for the specific purpose of formulating, providing, verifying, and coordinating services for my family.

Please list all children who have records relevant to B&B FRC service provision.

Name & Relationship	Name & Relationship
Self	

I authorize B&B FRC to release and exchange confidential information and/or records to better serve the needs of my family:

- Alcohol/Drug services
- Cal-WORKs
- Department of Human Assistance
- Dept. of Child, Family & Adult Services
- Domestic violence providers
- Education services
- Employment services
- Evaluators/Consultants/Funders
- Applied Survey Research (ASR)
- Family Development Matrix
- Mental health services
- Probation Department
- Public health nurse
- UC Davis CAARE Center
- Women, Infants & Children (WIC)
- Others specified below

Information I authorize B&B FRC to share with and among the service providers above:

- Identifying information (name, date of birth)
- Service History/Plan
- Non-identifying information (income, gender, zip code)
- School Information
- Medical Information (in accordance with HIPAA)
- Other (must specify): _____

The information and/or records may be shared via verbal communication, written reports, and/or electronic transmission.

Additional Persons/Organizations I authorize B&B FRC to release and exchange information with:

Agency Name, Contact Person	Address, Phone, and Fax

I understand that this release is valid when I sign it, and that I may withdraw my consent to this release at any time either verbally or in writing. The release should be valid for a reasonable period, **not to exceed one (1) year**.

RELEASE EXPIRES: _____ Date

Signature _____ Date _____ Staff/Witness _____ Date _____

For Minor Parent(s), the parent, guardian, or legally authorized representative for the Minor Parent must provide their signature consenting for Minor Parent to allow the Birth & Beyond Family Resource Center program to release/exchange the above stated information.

Name of Minor Parent _____ Signature of Parent/Guardian/Legally Authorized Representative _____ Date _____

The family has a right to receive a copy of this authorization (Civic Code 56.10). A copy of this document is as valid as the original. I hereby acknowledge receipt of a copy of this authorization. _____ Initials _____ Date

_____ Client Profile: Consent Date & Upload

SACRAMENTO
CHILDREN'S HOME
Givingchildrtn &fomil frs u bdlr tomorrow sintt 1867

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT OF RECEIPT

The Sacramento Children's Home Notice of Privacy Practices provides information about how we may use and disclose protected health information about you and/or your child. By signing this form, you acknowledge that you have received our *Notice of Privacy Practices*. We encourage you to read it in full.

In addition to the copy we provide you, copies of the current notice are available on our website at www.kidshome.org. If you have any questions about our *Notice of Privacy Practices*, please contact our Quality Improvement Manager at (916) 452-3981.

I acknowledge that I have received the *Notice of Privacy Practices* of the Sacramento Children's Home.

Signature of Client/Client Representative | Date

First Name | Last Name | Self

Print Name | Relationship to Client

For SCH staff use only:

When written acknowledgment was not obtained, please document your efforts to obtain acknowledgement:

D *Notice of Privacy Practices Given - Client/Client's Representative Unable to Sign*

D *Notice of Privacy Practices Given - Client/Client's Representative Declined to Sign*

O *Notice of Privacy Practices Mailed to Client/Client's Representative - Awaiting Signature*

D *Other Reason Client/Client's Representative did not Sign:* _____

_____

_____

Signature of SCH Representative | *Date*

Print Name

SACRAMENTO
CHILDREN'S HOME
Giving children & families a better tomorrow since 1867

Release of Liability Agreement

The Sacramento Children's Home (SCH) offers many activities designed to enrich the lives of you and/or your family members. Some of these activities include a physical component that could result in some type of an injury, even if appropriate supervision is provided. Accidents do happen.

You have chosen to have your child attend PLAYCARE. The playcare room is designed for children to play. However, active children do run and jump and it is possible your child may become injured in the course of play.

This agreement releases SCH from all liability relating to injuries that may occur during any activity I or my family members participate in at Valley Hi-Florin Family Resource Center (program name). By signing this agreement, I agree to hold SCH entirely free from any liability, including financial responsibility for injuries incurred, regardless of whether injuries are caused by negligence.

I, the undersigned assume all risk of injury or harm to myself or my child(ren) associated with participation in activities and agree to release, indemnify, defend and forever discharge SCH and it's staff, employees, and agents of and from all liability, claims, demands, damages, costs, expenses, actions and causes of action in respect of death, injury, loss or damage to myself or my child(ren), or by myself or the child(ren), howsoever caused, arising or to arise by reason of or during my or my child's participation in the activity.

I, First Name Last Name, fully understand and agree to the above terms.

Client Signature _____ Date _____

Staff Signature _____ Date _____

denied service ☐

PLAYCARE POLICY

Please review and check only after you have read and understood each statement below.

☐ Playcare has a maximum capacity of 12 children.

☐ Playcare is only available during the time that parents/guardians are present and participating in workshop/group at the Family Resource Center. A parent/guardian may not leave their child in the Playcare room and leave to conduct business at another facility. **Parents leaving the building while the child is in Playcare violates the primary rules of the program and will result in refusal to allow the child to remain in or return to Playcare in the future.**

☐ Only the parent/guardian attending the workshop may sign a child in and out of Playcare. No older children or other family members.

☐ Only children under the age of 18 will be allowed in Playcare.

☐ A child may be returned to a parent/guardian if the child becomes inconsolable, unruly, or is upsetting the other children.

☐ To participate in Playcare children must be free of illness. Illness includes, but is not limited to, runny nose, fever, listlessness, sores, lice, diarrhea, vomiting, coughing, eye discharge and ear infections. **Please respect other parents and children by leaving sick children at home.**

☐ Out of respect for the parent/guardian, Playcare staff will not change the diaper of a child, nor will Staff take a child to the restroom. **The parent/guardian will be called to attend to the child's toileting needs.**

☐ No medication will be administered to any child, even with parent/guardian permission.

☐ Snacks may be provided to your child during Playcare. No other food will be allowed.

☐ Playcare staff is happy to provide your child with his/her bottle. Please clearly label the bottle with the child's name and bring the bottle to the attention of the Playcare staff.

☐ Your child may not enter Playcare before a Playcare staff member is present. Please retrieve your child within 10 minutes after the scheduled end of workshop/group.

I have read and understand the Valley Hi-Florin Family Resource Center Playcare Policy. By signing below, I agree to abide by the Playcare Policy and understand that failure to do so may result in the termination of my privilege to use the Playcare services.

First Name Last Name		
Print Parent/Guardian Name	Parent/Guardian Signature	Date
Print Home Visitor/FR Aide Name	Home Visitor/FR Aide Signature	Date

denied service ☐

TRANSPORTATION POLICY

Please review and check only after you have read and understood each statement below.

☐ Transportation is only available to active families of Valley Hi-Florin FRC and the Birth & Beyond program.

☐ Transportation services are available for local social service appointments, such as education or job related appointments and welfare or county appointments. Transportation is also provided for workshops at the FRC. However, there is no transportation for shopping trips or other non-approved trips.

☐ All transportation requests must be made **at least three working days** in advance during office hours, 8:30am-5:00pm. All calls received after office hours will be received as the next business day request.

DAY TRANSPORT NEEDED	DAY TO CALL
Monday	Thursday
Tuesday	Friday
Wednesday	Monday
Thursday	Tuesday

☐ **Transportation is available on a limited basis only and is always at the discretion of staff. Transportation is NEVER guaranteed.** Please call (916) 290-8281 to make your request or let your Home Visitor know if you have one.

☐ Transportation is limited to **one trip per family per week**. Transportation can only be provided between 9:00am-4:00pm.

☐ There will be no spontaneous stops during scheduled transportation.

☐ Transportation is available for some, but not all FRC Special Events. Please remember to call as soon as possible. There is **no guarantee** for transportation to FRC Special Events.

☐ **To cancel** any transportation request, please call us no later than 8:30am the day of your transport. Please call to cancel as soon as you can as it allows other clients to have access to transportation.

☐ There are often back to back transports. If you are not in the vehicle within 10 minutes of the scheduled pick up time, you will have to reschedule your transportation. This will be considered a "no show". **Three consecutive "no shows" will result in the loss of transportation services for one month.**

I have read and understand the Valley Hi-Florin Family Resource Center Transportation Policy. By signing below, I agree to abide by the Transportation Policy and understand that failure to do so may result in the termination of my privilege to use the Transportation services.

First Name Last Name

Print Parent/Guardian Name _____ Parent/Guardian Signature _____ Date _____

Print Home Visitor/FR Aide Name _____ Home Visitor/FR Aide Signature _____ Date _____

PHOTOGRAPH NOTICE AND CONSENTS

The Valley Hi-Florin Family Resource Center and Birth & Beyond Nurturing Parenting program will host different events and activities throughout the year for families to attend. These activities and events are a time for families to be together, meet new people and have fun.

At these events, photographs may be taken of the different activities that your family may be participating in.

These photographs may be used for the following reasons:

1. In displays throughout the Valley Hi-Florin Family Resource Center,
2. In children's project,
3. In agency publications (i.e. newletters, etc.)
4. Program promotions.

As a result, confidentiality may be breached due to recognition of yourself and/or your child(ren).

Therefore, please indicate below whether you give/or do not give your consent for your family photographs to be used as stated above. Please note that photographs will still be taken and that each family will receive a copy upon request. All original photographs remain the property of the Valley Hi-Florin Family Resource Center and Birth & Beyond Nurturing Parenting program.

☐ **I,** If YES, write full name here, give my consent to Valley Hi-Florin Family Resource Center and Birth & Beyond Nurturing Parenting program to use photographs of myself and/or my child(ren), as stated above. I understand that confidentiality may be breached due to recognition of me and/or my child(ren).

☐ **I,** If NO, write full name here, ***do not*** give my consent for Valley Hi-Florin Family Resource Center and Birth & Beyond Nurturing Parenting program to use any photographs taken of myself and/or my child(ren), as stated above. I understand that all original photographs are the property of Valley Hi-Florin Family Resource Center and Birth & Beyond Nurturing Parenting program and that a copy of the photographs will be given to me upon request.

Family Members ***(list self and all minor children)*** **and Relationship to Client**

First Name	Last Name	Self	First Name	Last Name	
First Name	Last Name		First Name	Last Name	
First Name	Last Name		First Name	Last Name	
First Name	Last Name		First Name	Last Name	
First Name	Last Name		First Name	Last Name	

First Name Last Name

Print Parent/Guardian Name _____ Parent/Guardian Signature _____ Date _____

Print Home Visitor/FR Aide Name _____ Home Visitor/ FR Aide Signature _____ Date _____

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of you and/or your child's medical or mental health record we will attach it to

statement you believe to be incomplete or incorrect.

Right to an Accounting of Disclosures

the disclosures we made of medical or mental health information about you and/or your child other than our own uses for treatment, payment and health care operations, (as those functions are described above) and with other expectations pursuant to the law.
To request this list of accounting of disclosures, you must submit a written request to: Quality Improvement Manager. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on the medical or mental health information we use or disclose about you and/or your child for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in you and/or your child's care or the payment for you and/or your child's care like a family member or friend. For example, you could ask that we not use or disclose information about a surgery your child had.
We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you and/or your child's emergency treatment.

To request restrictions, you must make your request in writing to Quality Improvement Manager or Clinical Manager-Residential Programs or Director or of Community Services-Clinical Services. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Mental Health treatment information is subject to different laws for disclosure in California and the conditions described above may not apply to Mental Health treatment information about you and/or your child.

Right to Request Confidential Communications
You have the right to request that we communicate with you about you and/or your child's medical or mental health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to Quality Improvement Manager or Clinical Manager-Residential Programs or Director or of Community Services-Clinical Services. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice
You have a right to a paper copy of this notice. You may ask us to give you

notice electronically, you are still entitled to a paper copy of this notice.
You may obtain a notice at our website: www.kidshome.org

Children's Home, 2750 Sutterville Road, Sacramento, CA 95820.

Changes to this Notice
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical or mental health information we already have about you and/or your child as well as any information we receive in the future. We will post a copy of the current notice in the agency. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you and/or your child is registered or admitted to the agency for treatment we will offer a copy of the current notice in effect.

Complaints
If you believe you or your child's privacy rights have been violated, you may file a complaint with the agency or with the Secretary of the Department of Health and Human Services. To file a complaint with the agency, contact: Quality Improvement Manager, at 916-452-3981. All complaints must be submitted in writing to Quality Improvement Manager, Sacramento Children's Home, 2750 Sutterville Road, Sacramento, CA 95820.

You will not be penalized for filing a complaint.
OTHER USES OF MENTAL HEALTH AND MEDICAL INFORMATION
Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical or mental health information about you and/or your child, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical or mental health information about you or your child for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we will retain our records of the care provided to you as required by law.

Effective Date: June 1, 2006

SACRAMENTO
CHILDREN'S HOME
Investing in our children & families since 1867

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical and mental health information about you and/or your child may be used and disclosed and how you can get access to this information. Please review it carefully.

Sacramento Children's Home
The Sacramento Children's Home provides residential and mental health and medical services in a variety of locations and settings including campus-based residential group homes, Pat Anderson Education Center and in the community. Community settings include Crisis Nurseries and other community based programs and collaborative partners.

All client care is overseen and supervised by licensed mental health and medical providers and followed by a team of mental health care professionals. Social Work Interns and graduate students of other mental health and social work schools may participate in assessments or therapy in the care of clients.

This Notice applies to information and records regarding you and/or your child's mental health and medical care maintained by the Sacramento Children's Home (SCH).

Our Pledge Regarding You and/or Your Child's Medical and Mental Health Information
SCH is committed to protecting mental health and medical information about you and/or your child. We create a record of the care and services you and/or your child receives at SCH for use in the care and treatment of our clients.

This Notice tells you about the ways in which we may use and disclose mental health and medical information about you and/or your child. It also describes your rights and certain obligations we have regarding the use and disclosure of you and/or your child's mental health and medical information. We are required by law to:

- Make sure that you and/or your child's mental health and medical information is protected (with certain exceptions);
- Give you this Notice describing our legal duties and privacy practices with respect to mental health and medical information about you and/or your child; and
- Follow the terms of the Notice that is currently in effect.

How We May Use and Disclose Mental Health and Medical Information about You and/or Your Child
The following sections describe different ways that we may use and disclose you and/or your child's mental health and medical information. For each category of uses or disclosures we will explain what we mean and give an examples. Not every use or disclosure will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the following categories. Some information such as certain drug and alcohol information, HIV information, and mental health information is entitled to special restrictions related to its use and disclosure.

SCH abides by all applicable state and federal laws related to the protection of this information.

For Treatment. We may use mental health and medical information about you and/or your child to provide you and/or your child with mental health and medical treatment or services. We may disclose mental health and medical information about you and/or your child to therapists, social workers, doctors, nurses or other SCH personnel who are involved in taking care of you and/or your child at the SCH. We may also share medical information about you and/or your child with other SCH personnel or non-SCH providers, agencies or facilities in order to provide or coordinate the different things you and/or your child needs such as appointments and lab work. For example, a psychiatrist treating you and/or your child may need to know about certain behavior changes so that medications can be adjusted. In addition, the nurse may need to tell the kitchen about a child's diabetes so that appropriate meals can be prepared. We may also disclose mental health and medical information about you and/or your child to people outside SCH who may be involved in the continuing care after you and/or your child leaves SCH such as other health care providers, community agencies and family members.

For Payment: We may use and disclose mental health and medical information about you and/or your child so the treatment and services you and/or your child receives from SCH or from other entities such as an ambulance company, may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your Health Plan information to a hospital if your child requires emergency treatment. We may also tell your health plan or mental health payer about a proposed treatment in order to obtain prior approval or determine whether your payer or health plan will cover the treatment.

For Health Care Operations. We may use and disclose mental health and medical information about you and/or your child for SCH operations. These uses and disclosures are necessary to run the agency and make sure that all of our clients receive quality care. For example, we may use mental health information to review our treatment and services and to evaluate the performance of our staff in caring for you and/or your child. You and/or your child's mental health and medical information may also be used or disclosed to comply with law and regulation, for contractual obligations, client's claims, grievances or lawsuits, health care contracting, legal services, business planning and development, business management and administration, underwriting and other insurance activities and to operate the agency. We may also disclose information to therapists, clinicians, nurses, and other agency personnel for quality improvement and educational purposes. We may remove information that identifies you and/or your child from this set of medical or mental health information so others may use it to study mental health care delivery without learning who the clients are.

Appointment Reminders: We may use and disclose medical information to contact you and/or your child as a reminder that you have an appointment for treatment.

Treatment Alternatives: We may use and disclose medical or mental health information to tell you about or recommend possible treatment options or alternative which may be of interest to you and your child.

Health-Related Benefits and Services: We may use and disclose medical or mental health information to tell you about our services which may be of interest to you and/or your child.

Individuals Involved in Care or Payment for You and/or Your Child's Care: We may release medical or mental health information about you and/or your child to a friend or family member who is involved in your child's medical or mental health care. We may also give information to someone who helps pay for you and/or your child's care. In addition, we may disclose medical or mental health information about you and/or your child to an entity assisting in a disaster relief effort so that your child's family can be notified of their condition, status and location.

As Required by Law: We will disclose mental health and medical information about you and/or your child when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose mental health and medical information about you and/or your child when necessary to prevent or lessen a serious and imminent threat to you and/or your child's health and safety or the health and safety of other clients, the public or another person. Any disclosure would be to someone able to help stop or reduce the threat.

SPECIAL SITUATIONS

Public Health Risks. We may disclose medical information about you and/or your child for public health purposes. These purposes generally include the following:

- Preventing or controlling disease (such as influenza or hepatitis), injury or disability;
- Reporting child abuse or neglect;
- Notifying a person who has been exposed to a disease or may be at risk of contracting or spreading a disease or condition;
- Notifying the appropriate government authority if we believe a client has been the victim of abuse, neglect or domestic violence and make this disclosure as authorized or required by law.

Mental Health and Health Oversight Activities. We may disclose mental health and medical information to governmental, licensing auditing and accrediting agencies as authorized or required by law.

Lawsuits and Other Legal Actions. In connection with lawsuits or other legal proceedings, we may disclose mental health and medical information about you and/or your child in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, summons, or other lawful process.

Law Enforcement. If asked to do so by law enforcement, and as authorized or required by law, we may release mental health and medical information:

- To identify or locate a suspect, fugitive, material witness or missing person;
- About a suspected victim of a crime if, under certain limited circumstances, we are unable to obtain the client's representative's agreement;
- About criminal conduct at SCH;
- Incase of a medical emergency, to report a crime and provide details of the crime or victims;
- About a death we believe may be the result of criminal conduct.

National Security and Intelligence Activities: We may release medical or mental health information about you and/or your child to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

YOUR RIGHTS REGARDING MENTAL HEALTH AND MEDICAL INFORMATION ABOUT YOU AND/OR YOUR CHILD

You have the following rights regarding medical and mental health information we maintain about you and/your child.

Right to Inspect and Copy

You have the right to inspect and copy medical and certain mental health information that may be used to make decisions about the care of you and/or your child. Usually, this includes medical and billing records, but may not include some mental health information. This does not include information that was not created by SCH.

To inspect and copy medical information that may be used to make decisions about the care of you and/or your child, you must submit your request in writing to: Quality Improvement Manager or Clinical Manager-Residential Programs or Director or of Community Services-Clinical Services. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical or mental health information, you may request that the denial be reviewed. Another licensed mental health or medical professional chosen by the agency will review your request and the denial. The person conducting the review will not be the person who denied your first request. We will comply with the outcome of the review.

Right to Request an Amendment or Addendum

If you feel that medical or certain mental health information we have about you and/or your child is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the agency. To request an amendment, you request must be made in writing and submitted to Quality Improvement Manager or Clinical Manager-Residential Programs or Director or of Community Services-Clinical Services. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical or mental health information kept by or for the agency;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.