WorkLife Hawaii / Child and Family Service

1. FACE SHEET

☐ **High Risk Participant**
(As defined by program definition)

Please Print Legibly *[Fill in the shaded areas at a minimum.]*

PARTICIPANT NAME
FIRST _____ MIDDLE _____ LAST _____

CASE NAME (if different than Participant Name)
FIRST _____ MIDDLE _____ LAST _____

ALSO KNOWN AS (Optional)
_____

HOME/RESIDENCE ADDRESS
STREET/LOCATION _____ APT # _____
CITY _____ STATE _____ ZIP CODE _____

MAILING ADDRESS (if different than above)
STREET/LOCATION _____ APT # _____
CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ ☐Okay to leave a message
WORK PHONE (Optional) _____ ☐Okay to leave a message
CELL PHONE (Optional) _____ ☐Okay to leave a message

SCHOOL (for minor client) _____ Current Grade _____

EMPLOYER _____ Last Grade Completed (Optional) _____

MARITAL STATUS ☐*of Self* ☐*of Parent/Caregiver (if participant is a minor)*
☐S-Single ☐M-Married Couple ☐D-Divorced
☐W-Widowed ☐C-Unmarried Couple ☐L-Separated

OF PERSONS IN HOUSEHOLD _____

YEARLY GROSS FAMILY INCOME

IF YOU ARE A CLIENT, DO NOT WRITE IN THIS BOX
AGENCY USE ONLY

PARTICIPANT CASE # _____
(generated by CFS Database)
OTHER CASE # _____
(Uni/Care, SAMS, MCH#, CHEIRS, etc.)

INTAKE WORKER NAME _____

INTAKE WORKER # _____
DATA ENTRY PERSON'S INITIALS _____

PROGRAM CODE BH-008
CONTRACT CODE EAP-FEES
SITE CODE O-HON

INTAKE DATE _____

INTAKE STATUS
☐NEW
☐CFS TRANSFER
Program Code: _____
☐REOPEN. If Reopen,
Date last closed: _____
Contract code: _____
☐SPLIT. If Split, list other codes: _____

LIVING CONDITIONS
☐Multi-family ☐Single Family ☐Alone
☐Foster Family ☐Multi-generational
☐Homeless ☐Shelter ☐Transitional Living
☐Other

RECEIVES DHS ASSISTANCE? ☐Yes ☐No
If Yes, Type of DHS Assistance:
☐Cash ☐Food Stamps ☐Medical

VETERAN? (Optional) ☐Yes ☐No

RELIGION
☐Catholic ☐Jewish ☐Muslim
☐Protestant ☐Buddhist ☐Christian
☐Unaffiliated
☐Other

REFERRAL SOURCE (Optional)
Contact Person _____ Phone # _____
Agency Name _____

MEDICAL INSURANCE? (Optional)
☐Yes ☐No If Yes, Insurance Name _____
What Type? ☐Medical ☐Dental ☐Vision

PARTICIPANT EMERGENCY CONTACT
Name _____ Primary Phone # _____
Relationship to Participant _____ Secondary Phone # _____

FACE SHEET (Continued)

Please Print Legibly *[Fill in the shaded areas at a minimum.]*

EMPLOYMENT TYPE (Optional) Enter code in chart below.

AD	Administrative Support/Clerical
AG	Agricultural/Forestry/Fishing
AM	Active Military? ☐Yes ☐No
	If Yes, Branch _____
CS	Civil Service
EX	Executive/Administrative/Managerial
HM	Homemaker
MS	Marketing/Sales
PO	Production/Operating/Maintenance
PS	Professional Specialty
RT	Retired
ST	Student
SV	Service
UN	Unemployed
VL	Volunteer

ETHNICITY (Enter code(s) for Client here)
We are offering multiple choices for participants with mixed ethnicity.
If one ethnicity, put "1" on the line to the left of the ethnicity listed below.
If multiple ethnicities, number the top 3 choices in order of self-identity.
(Enter one code for each Household Member in chart below)

____	N	Native Am/Am Esk	____	AL	Laotian
____	AF	African American	____	AO	Other Asian
____	ACB	Cambodian	____	PS	Samoan
____	C	Caucasian	____	PT	Tongan
	AC	Chinese		PO	Other Pacific Islander
____	F	Filipino			
____	H	Hawaiian	____	PM	Marshallese
____	L	Hispanic/Latin	____	AV	Vietnamese
____	AJ	Japanese	____	AB	Arab American
____	AK	Korean	____	RF	Refused
____	O	Other	____	PR	Portuguese

If Other, please specify: _____

PRIMARY SPOKEN LANGUAGE (Optional) Enter code in chart below.

E	English
C	Chinese
F	Filipino
J	Japanese
K	Korean
L	Laotian
M	Marshallese
P	So. Pacific
S	Spanish
V	Vietnamese
O	Other

If Other, please specify: _____

DISABILITY Enter code in chart below.

H	Hearing
V	Vision
M	Mobility
S	Speech
U	None
O	Other

If Other, please specify: _____

(01) PARTICIPANT

NAME

Relationship to Participant *SELF*

DOB | **Sex**
Ethnicity | **Primary Spoken Language**
Employment Type | **Disability**

(02) ADULT

Receiving Services? ☐*Yes* ☐*No*

NAME | WORK PHN #

EMPLOYER | OTHER PHN #

Relationship to Participant
DOB | **Sex**
Ethnicity | **Primary Spoken Language**
Employment Type | **Disability**

(03) ADULT

Receiving Services? ☐*Yes* ☐*No*

NAME | WORK PHN #

EMPLOYER | OTHER PHN #

Relationship to Participant
DOB | **Sex**
Ethnicity | **Primary Spoken Language**
Employment Type | **Disability**

HOUSEHOLD MEMBERS

(04) OTHER *Receiving Services?* ☐*Yes* ☐*No*

☐Adult ☐Child NAME

Relationship to Participant
DOB | **Sex** | **Primary Spoken Language**
Ethnicity | **Employment Type** | **Disability**

(05) OTHER *Receiving Services?* ☐*Yes* ☐*No*

☐Adult ☐Child NAME

Relationship to Participant
DOB | **Sex** | **Primary Spoken Language**
Ethnicity | **Employment Type** | **Disability**

(06) OTHER *Receiving Services?* ☐*Yes* ☐*No*

☐Adult ☐Child NAME

Relationship to Participant
DOB | **Sex** | **Primary Spoken Language**
Ethnicity | **Employment Type** | **Disability**

(07) OTHER *Receiving Services?* ☐*Yes* ☐*No*

☐Adult ☐Child NAME

Relationship to Participant
DOB | **Sex** | **Primary Spoken Language**
Ethnicity | **Employment Type** | **Disability**

(08) OTHER *Receiving Services?* ☐*Yes* ☐*No*

☐Adult ☐Child NAME

Relationship to Participant
DOB | **Sex** | **Primary Spoken Language**
Ethnicity | **Employment Type** | **Disability**

(09) OTHER *Receiving Services?* ☐*Yes* ☐*No*

☐Adult ☐Child NAME

Relationship to Participant
DOB | **Sex** | **Primary Spoken Language**
Ethnicity | **Employment Type** | **Disability**

(10) OTHER *Receiving Services?* ☐*Yes* ☐*No*

☐Adult ☐Child NAME

Relationship to Participant
DOB | **Sex** | **Primary Spoken Language**
Ethnicity | **Employment Type** | **Disability**

2. NOTICE OF PRIVACY PRACTICES

For the Use and Disclosure of Private Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Child & Family SERVICE
Private, nonprofit since 1899

Effective Date: 3/1/2016
Anyone has the right to ask for a paper copy of this Notice at any time.

Understanding your health record

A record or a note is made each time you visit a Child and Family Service (CFS) program and receive services. The services provided, interventions, service plan, and a plan for future services and care are recorded. This information is most often referred to as your "participant record or case file," and serves as a basis for planning services, care and treatment. It also serves as a means of communication among any and all other health care providers or workers who may contribute to your care and the services you are provided. Understanding what information is retained in your participant record and how that information may be used will help you to ensure its accuracy, and enable you to relate to who, what, when, where, and why others may be allowed access to your participant record. This effort is being made to assist you in making informed decisions about authorizing the disclosure of your health information to others.

Understanding your health information rights

Your participant record is the physical property of the health service facility that compiled it, but the content is about you and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your participant record. Your rights include being able to review or obtain a paper copy of your participant record, and be given an account of all disclosures. You may also request communications of your health information be made by alternative means or to alternative locations. You also have the right to restrictions or limitations on the use or disclosure of your Protected Health Information (PHI) for treatment, payment, or health care operations. For other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information. To promote continuity and consistency of care and services, our programs have electronic records. This means information created in the course of our providing services to you will reside in the integrated records and may be available to others involved with your services, care, and treatment.

Breach Notification- If there is a breach of unsecured PHI concerning you, we will notify you of this breach, including what happened and what you can do to protect yourself.

Right to a Copy of this Notice- Anyone has the right to ask for a paper copy a copy of this notice at any time.

Our responsibilities

CFS is required to maintain privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. CFS is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations.
CFS reserves the right to change its practices and effect new provisions that enhance the privacy standards of all participant health information. In the event that changes are made, CFS will notify you through postings at program service sites and will post changes on our web site that provides information about our participant services.

Your health information will be used for treatment, payment, and health care operations.

Treatment – Information obtained by your health provider or worker with CFS will be recorded in your participant records and used to determine the course of services that should work best for you. This consists of your provider or worker recording his/her own expectations and those of others involved in providing your care. Your health information may be shared with others involved in your care, such as other workers, volunteers, practicum students, specialists, psychologists, or physicians. An example of such use and disclosure of your information for treatment purposes would be an outreach worker may consult with the health specialist in the same program for recommendations for your service plan. Another example would be a Program Director in one program may consult with a Program Director in another CFS program for the purpose of referring you for additional services in the second CFS program.

Payment – Your health care information will be used in order to receive payment for services rendered by CFS. A request for payment may be sent to a third-party payer with accompanying documentation that identifies you, your care and services provided. An example of such use and disclosure of your information for payment purposes would be the submission of your name, date of birth, and service provided you by CFS. We send this to the State in order to be paid for these services. CFS could also provide your PHI to business associates, such as billing companies that process health care claims for CFS.

Health Care Operations – The staff of CFS will use your health information to facilitate the efficient and correct outcome of your case compared to others like it. Your information may be reviewed for risk management or quality improvement purposes where we would evaluate the quality of health care services that you received or to evaluate the performance of the staff that provided you with these services. CFS may also provide your PHI to their attorneys, accountants, consultants, and others to make sure that we are in compliance with applicable laws.

Understanding Child and Family Service Policy for Specific Disclosures

Business Associates – Some or all of your health information may be subject to disclosure through contracts for services to assist CFS in providing health care. To protect your health information, we require these Business Associates to follow the same standards held by CFS through terms detailed in a written agreement.

Notification – Your health records may be used, as appropriate, to notify or assist family members, personal representatives, or other persons responsible for your care of your whereabouts or to enhance your well-being.

Appointment Reminders – CFS may contact you through the mail, telephone, email or at an address or telephone number you provide to remind you of upcoming service related appointments.

Health Related Benefits and Services – CFS may contact you for purposes of describing or recommending service alternatives or providing information about health-related benefits or services that may be of interest to you.

Communications with Family – Using best judgment, a family member, or close personal friend, identified by you, may be given information relevant to your care.

Marketing – CFS reserves the right to contact you with information about other health-related services that may be appropriate to you with written authorization.

Fund Raising – CFS reserves the right to contact you as part of general fund-raising efforts. Please notify us if you do not wish to be contacted during fund raising campaigns.

Research – Our information will be disclosed to researchers upon the Clinical Risk Management Committee approval, and upon the assurance that all protocols will be followed to ensure the privacy of your health information.

Food and Drug Administration (FDA) – CFS is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.

Worker's Compensation – CFS will release information to the extent authorized by law in matters of worker's compensation.

Public Health –CFS is required by law to disclose health information to public health and/or legal authorities charged with tracking reports of birth and morbidity. CFS is further required by law to report communicable disease, injury, or disability.

Correctional Facilities – CFS will release health information on incarcerated individuals to correctional agents or institutions for the necessary welfare of the individual or for the health and safety of other individuals. The rights outlined in the Notice of Privacy Practices will not be extended to incarcerated individuals.

Law Enforcement – (1) Your health information will be disclosed for law enforcement purposes as required under state law or in response to a valid subpoena. (2) Provisions of federal law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys in the event that a staff member or business associate of CFS believes in good faith that there has been unlawful conduct or violations of professional or clinical standards that may endanger one or more clients, workers, or the general public.

Required by Law – Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Child Abuse and Neglect – We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Deceased Participants – We may disclose PHI regarding deceased participants as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased participants may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies – We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm.

Specialized Government Functions – We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Other than for reasons described in this notice, Child and Family Service agrees not to use or disclose your health information without your authorization.

For further explanation of this notice you may contact the Privacy Officer by phone at (808) 681-3500, by e-mail at privacyofficer@cfs-hawaii.org, or by mail at Child & Family Service, 91-1841 Fort Weaver Road, Ewa Beach, Hawaii, 96706.

To Receive Additional Information or Report a Problem

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer by e-mail at privacyofficer@cfs-hawaii.org, or by mail at Child & Family Service, 91-1841 Fort Weaver Road, Ewa Beach, Hawaii, 96706.

or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. Child and Family Service will not retaliate against you for filing a complaint. **NOTICE OF PRIVACY PRACTICES AVAILABILITY:** The terms described in this notice will be posted where services occur. All individuals receiving care will be given a hard copy.

3. PARTICIPANT GRIEVANCE INFORMATION -- FORMAL AND INFORMAL

Child and Family Service (CFS) staff do their best to help you. But, as in any organization, sometimes we are not completely successful. If you are unhappy about the service you have received or CFS protection of your protected health information (PHI) or CFS adherence to our policies and procedures related to your PHI, you are entitled to file a grievance.

There are two different types of grievances. An **Informal Grievance** is a verbal complaint that is resolved at the program level by discussing what you are unhappy about and reaching an agreement between yourself and CFS Staff. A **Formal Grievance** is a complaint that has been submitted in writing to the Director of Program Services.

- If your concern relates to the service or treatment you have received, tell your worker.
- If talking to your worker doesn't help, ask our receptionist or your worker the name of their supervisor and explain the situation to them.
- If that still doesn't give you satisfaction, ask the receptionist or your worker for the name of the Director of the Program responsible for the service you are receiving.
- Write a letter to the Director explaining the problem. If you feel uncomfortable about writing the letter, we will help you or you can get a friend to assist.
- The Child and Family Service (CFS) Privacy Officer is also available to ensure grievance procedures are followed correctly. If you have concerns and need to speak to someone, call 681-3500 and ask for the Privacy Officer.
- Within five working days of getting your letter, the Director of Program Services, or designee, will call or ask you to come in.
- Together you will discuss the problem and try to come up with a solution. If nothing can be worked out, the Director of Program Services will appoint two people on the staff of the organization who have not been involved with your case to carefully examine all aspects of the problem and to talk to everyone involved. These individuals are called arbitrators. The arbitrator will arrange an interview in order to hear both sides of the situation.
- At that time you will have the right to look at any of the records, and to talk to anyone who you think might help you explain your grievance.
- Within five working days of your meeting the Director of Program Services, you will get a call from the arbitrators to set up an interview date at some mutually acceptable time.
- You will have the opportunity to fully explain your concerns to the arbitrators in your own words at the interview.
- Within 24 hours of the interview the arbitrators will submit a written report to the Director of Program Services which summarizes the grievance and their recommendations.
- Within five (5) working days the Director of Program Services will have examined all of the records and given thought to the arbitrator's recommendation.
- The Director of Program Services will ask you to meet in person. He/she will talk to you about your grievance and give you his/her decision regarding it.
- If you are not satisfied with the decision that is made, you have the right to appeal this decision.
- In order to appeal the decision, put the reason you are appealing the decision into writing and address it to the CEO. If you need assistance with this process, you can contact your worker or your Paricipant Rights Advisor, the Privacy Officer.
- The CEO will then review your appeal and if it is accepted, a supplemental investigation will be conducted by two additional arbitrators and you may be interviewed again.
- The results of this investigation will then be given to the CEO within 1 week.
- The CEO with the assistance of other Senior Management Staff will then make a final decision regarding the appeal and you will be informed of it as soon as possible.

If your concern relates to how CFS is protecting your health information or how CFS is adhering to its privacy practices, or related policies and procedures, contact the CFS Privacy Officer and provide your specific grievance in writing. You may also contact the Secretary of the U.S. Department of Health and Human Services without making your grievance known to CFS.

- The CFS Privacy Officer will review your specific grievance and conduct an investigation.
- Within 30 days you will be provided with the results of the investigation and any corrective action taken, if it is found necessary to do so.
- If you are not satisfied with the response of the CFS Privacy Officer, two individuals will be appointed as arbitrators by the CFS President and CEO.
- The arbitrators will contact you to set up a hearing within 10 days from the date of the decision by the CFS Privacy Officer.

- A hearing at an agreeable date, time and place will be scheduled to occur within 30 days from the date that you were contacted by the arbitrators.
- The results of the arbitration meeting will be provided to you within five (5) working days of the meeting.
- If you are not satisfied with the results of the arbitration you may contact the U.S. Secretary of Health and Human Services.

4. PARTICIPANT RIGHTS AND RESPONSIBILITIES DOCUMENT

PARTICIPANT RIGHTS:

- The right to a humane service and treatment environment that affords reasonable protection from harm and appropriate privacy.
- The right to treatment and services under conditions that are free from unlawful discrimination and support your personal liberty. Such liberty will be restricted only as necessary to comply with treatment needs, law, and judicial orders.
- The right to be provided with a reasonable explanation of all aspects of your services and/or treatment.
- The right to confidentiality of records except when staff are mandated by law to report suspected dependent adult abuse, child abuse and/or neglect; when handling any legal proceedings or when conditions of emergency occur and/or there are threats of homicide or suicide.
- The right to written notice of privacy practices, including the right to request that we communicate with you about your protected health information (PHI) at an alternative location in accordance with CFS policy and procedures.
- The right to obtain an accounting of disclosures made and restrict certain disclosures of your protected health information, at your request and in accordance with CFS policy and procedures.
- The right to an individualized, written service and/or treatment plan developed promptly. You have the right to participate in any service and/or treatment planning including revisions. Your service and/or treatment will be according to this plan. There will be periodic review and reassessment of this plan, and appropriate revisions will be made.
- The right to have access to your record upon request and in accordance with CFS policy and procedures.
- The right to submit written request to correct, amend or supplement any portions of your record that you feel are not accurate, relevant, or complete, according to CFS policy and procedures.
- The right to a location for delivery of service that is least restrictive and the most convenient among available alternatives.
- The right to select a provider agency and to receive a CFS referral to another provider agency.
- The right to file complaint/grievance with respect to infringement of these rights, including the right to have such grievances considered in a fair, timely, and impartial manner.
- The right to be informed promptly, in appropriate language so that you can understand your rights described in this section.
- The right to exercise your rights described in this section without any negative effect on your services and/or treatment.
- The right to access a qualified advisor in order to understand and exercise your rights.
- The right to refuse service and to be informed of the possible consequences of such refusal.
- The right to refuse participation in research without informed, voluntary and written consent.

PARTICIPANT RESPONSIBILITIES:

- The responsibility to comply with program rules and behavioral expectations in order to gain the most from treatment/services and avoid the need to discharge or terminate services.
- The responsibility to provide appropriate and timely notice when canceling an appointment, unless cancellation is due to an emergency.
- The responsibility to comply with program hours of availability.
- The responsibility for open communication with your assigned worker to promote your active participation in the planning and development of your services.
- The responsibility to actively participate in the services that are offered/provided.
- The responsibility to treat Child and Family Service staff in a respectful manner.

WORKLIFE HAWAII PARTICIPANT RIGHTS AND RESPONSIBILITIES:

- Services are available Monday-Friday 8:00am – 5:00 pm and Saturday 10:00am – 2:00pm, plus some evening hours can be arranged. After business hours contact number is 1-800-944-3571.
- **I agree to call my therapist at least 24 hours prior to a scheduled appointment in order to cancel or change the appointment.**
- **I understand that if I do not show up for an appointment or do not cancel with at least 24 hours notice, that the session will be counted as one of my allowed sessions.**
- I agree to meet with my assigned therapist as agreed.
- I agree to make my best effort to work toward my goals.
- I understand that failure to comply with WORKLIFE HAWAII program rules and responsibilities may result in termination of services.

Your Rights Advisor is Director of Quality Assurance at Child & Family Service and can be reached at (808) 681-3500.

5. CONSENT TO SERVICE / TREATMENT / EVALUATION

Presenting Request need or concern: EAP Counseling
Purpose(s) of proposed services/treatment or recommended procedures: Provide assistance related to the employee's concern(s)
Specific services/treatment proposed: Assessment, brief solution-oriented counseling and referral if needed

The Child & Family Service employee has referred to and reviewed with me the Child and Family Service "Notice of Privacy Practices" prior to signing this consent and has explained to me:

- the proposed services;
- that information about me may be shared with other CFS employees providing me with treatment or services, for payment of services, and for organizational purposes, such as quality assurance;
- benefits and risk of service/treatment and non service/treatment;
- the right to obtain a second opinion;
- the right to seek services elsewhere;
- that the anticipated results of services are not guaranteed;
- the right to refuse services;
- that my consent may be overridden when the staff is mandated by law to report suspected dependent adult abuse, child abuse and/or neglect; when staff are required to respond to a subpoena; when conditions of emergency occur and or when there is a threat of homicide or suicide;
- that this consent can be revoked at anytime by notification to program staff; and
- that this consent will expire when services are terminated or when I withdraw from services.

6. INTAKE CHECKLIST AND CONSENT TO SERVICE

The Child & Family Service employee has referred to and reviewed with me the Child & Family Service "Notice of Privacy Practices" prior to signing this consent and has explained to me:

- the proposed services;
- that information about me may be shared with other CFS employees to refer and/or provide me with treatment or services, for payment of services, and for organizational purposes, such as quality assurance;
- benefits and risk of service/treatment and non service/treatment;
- the right to obtain a second opinion;
- the right to seek services elsewhere;
- that the anticipated results of services are not guaranteed;
- the right to refuse services;
- that my consent may be overridden when the staff is mandated by law to report suspected dependent adult abuse, child abuse and/or neglect; when staff are required to respond to a subpoena; when conditions of emergency occur and or when there is a threat of homicide or suicide;
- that this consent can be revoked at anytime by notification to program staff; and
- that this consent will expire when services are terminated or when I withdraw from services.
- Telehealth services may be offered if circumstances warrant and will be introduced with an informed consent.

I consent to these services, having reviewed all forms prior to signing, and understand that services will be designed with my input and will reflect my individual needs and circumstances.

All documents have been presented to me in a language that I understand. My rights and responsibilities have been explained to me, and I am aware of and understand my rights and responsibilities. I acknowledge receiving a copy of these documents.

Participant name: _____ (Please print) _____ Date of Birth

Participant signature: (Electronically signed) _____ _____ Date

Witnessed by: _____ (CFS program staff's name) _____ (CFS program staff's title)

Staff Signature: _____ _____ Date

Acknowledgement by Parent, legal guardian of Minor (Required for clients under the age of 13).

Participant name: _____ (Please print)

Parent/Legal Guardian name: _____ (Please print)

Signature: _____ (Parent/Legal Guardian) _____ Date

Witnessed by: _____ (CFS program staff's name) _____ (CFS program staff's title)

Participant (Parent/Legal Guardian) Comments:

_____

_____

_____

7. CONFIDENTIAL INITIAL SURVEY: YOUR SITUATION AND YOUR WORK

GENERAL INSTRUCTIONS Below is a series of statements that refer to aspects of your work and life experience that may be affected by the personal problems you want to address at the EAP during the past 30 days. Please read each item carefully and answer as accurately as you can.					
1. For the period of the past 30 days, please total the number of hours your personal concern caused you to miss work. Include complete eight-hour days when you came in late or left early.	Number of Hours: _____				
INSTRUCTIONS FOR ITEMS 2 – 5 The following statements reflect what you may do or feel on the job or at home. Please indicate the degree to which you agree with each of the statements for the past 30 days. Use the 1 – 5 response key to the right	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
2. My personal problems kept me from concentrating on my work.	☐	☐	☐	☐	☐
3. I am often eager to get to the work site to start the day.	☐	☐	☐	☐	☐
4. So far, my life seems to be going very well.	☐	☐	☐	☐	☐
5. I dread going to work.	☐	☐	☐	☐	☐

8. AUTHORIZATION FOR FOLLOW-UP POST-SURVEY

In an ongoing process to improve the effectiveness of the EAP, we do occasional follow-up post-surveys with our EAP participants, usually around 90 days after their initial visit. Please let us know whether we may contact you, and if so, how you would prefer this contact to take place.

☐ **Yes, please contact me by phone.** My phone number is: _____

☐You may leave a message at this number. ☐Please do not leave a message at this number.

☐ **Yes, please contact me by email.** My email address is: _____

I understand that emails are not secure and that my confidentiality cannot be assured through email, but I prefer this means of follow-up.

☐ **Yes, please contact me by mail.** My mailing address is: _____

_____

My name: _____ Date: _____

Signature: (Electronically signed) _____

Child & Family
SERVICE
Private, nonprofit since 1899

REQUEST AND CONSENT FOR ALTERNATE METHOD OF COMMUNICATION

I hereby request and consent to CFS using communication of my Protected Health Information (PHI) or Personally Identifying Information (PII) with me by alternate methods as indicated below:

Participant name: _____ Date of Request: _____
(Please print)

Alternate telehealth services and/or communication using *(check all that apply):*

❒ Apple FaceTime	❒ Google Duo	❒ Facebook Messenger	■ Telephone
❒ Microsoft Skype	❒ Google Hangouts	❒ Facebook WhatsApp	❒ Alternate Address
■ E-Mail	■ Text	❒ Fax	■ Zoom

CFS will make every reasonable effort to meet this request.

I am aware that the alternative method of telehealth services or electronic communication through texting, e-mailing, or faxing that I have chosen to utilize can be relatively easily accessed by unauthorized people, and hence can compromise the privacy and confidentiality of such communication. E-mailing, texting, faxing, and the method of telehealth services that I have chosen, in particular are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access.

By signing this consent, I have evaluated the risks and made an informed decision; Child & Family Service will view this as my agreement to take the risk that such communication may be intercepted, and my desire to communicate on such matters will be honored. I will not use e-mail or texting as a form of communication for emergencies or therapeutic interventions.

Authorization will expire when services are terminated; when I withdraw from services; when I withdraw this Authorization in writing; or one-year from this date, unless otherwise indicated here.

Date of expiration: _____

Participant's Signature: _____

Phone Number (as applicable): _____

E-mail Address (as applicable): _____

Fax Number (as applicable): _____

Telehealth Contact Number (as applicable): _____

Alternative Address (as applicable): _____

CFS Staff Signature: _____

"This institution is an equal opportunity provider."