Child Intake Packet

Table of Contents:

PAPERWORK NEEDED FOR ADMISSION

1. ID
2. Birth Certificate (both mother and child)
3. Social Security Card (both mother and child)
4. Medicaid Cards (both mother and child)
5. Physical (both mother and child)
6. Proof of Pregnancy
7. Comprehensive Behavioral Assessment
8. Shot Records of Mother and Child
9. Shelter Petition (If required)

Emergency DATA SHEET (Mother)

Client Name:_____

Date of Birth_____ **Social Security#:**_____

Address:_____

_____

Allergies:_____

_____

Medical Diagnosis: (e.g. -handicaps, diabetes, epilepsy, other conditions needing to be mentioned in a medical emergency, etc):

_____

_____

_____

Medications Prescribed/Used:

_____

_____

Current Problems:

_____

_____

Other Information:

_____

_____

EMERGENY CONTACT/LEGAL GUARDIAN: _____

Address of Contact:

_____

_____

Home Phone:_____ **Work Phone:**_____

Relationship To Client:_____

☐ **Release of Information Obtained for Emergency Contact.**

Emergency DATA SHEET (Mother) - Continued:

Next of Kin:_____ **Relationship:**_____

Address:_____

_____

Phone:_____ **Fax:**_____

☐ **Release of Information Obtained for Emergency Contact.**

Other Contact:_____ **Relationship:**_____

Address:_____

_____

Phone:_____ **Fax:**_____

☐ **Release of Information Obtained for Emergency Contact.**

Other Contact:_____ **Relationship:**_____

Address:_____

_____

Phone:_____ **Fax:**_____

☐ **Release of Information Obtained for Emergency Contact.**

ALPHA HOUSE OF PINELLAS COUNTY

701 5th Avenue North, St. Petersburg, FL 33701 Phone (727) 822-8190

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION – GENERAL

I, _____, DOB _____ SS#_____
(Resident Name)

Authorize ALPHA HOUSE OF PINELLAS COUNTY to disclose and/or communicate with:

(Provide Name and Address) _____

_____

The following information: Note: Draw a line through information <u>not</u> needed.

Assessments, History and Physical, Medication Administration Records, Treatment Plan, Progress Notes, Lab Results, Discharge Summary and Continuing Care Plan, Other:

_____

Purpose for the disclosure--be specific: _____

information will be disclosed in writing and/or verbally. Resident initial for FAX approval: _____

I understand that my records are protected under the Federal and State regulations governing the confidentiality and privacy of medical records and protected information under Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written authorization unless otherwise provided for by the regulations. Any release of substance abuse information must be pursuant to 42 C.F.R., Part 2.

I also understand that I may revoke <u>this authorization in writing at any time except to the extent that action has already been taken</u> in reliance on it, and that in any event <u>this authorization expires automatically after one year</u>, unless otherwise stated below:

Date, event or condition of expiration: _____

I understand that <u>generally</u> ALPHA HOUSE OF PINELLAS COUNTY may not condition treatment on whether I sign an authorization, but that in certain limited circumstances I may be denied treatment if I do not sign this authorization. I also hereby release ALPHA HOUSE OF PINELLAS COUNTY from liability which may arise as a result of information disclosed under an authorization, if such information disclosed is later used to my detriment.

Date:_____ Signature:_____
Resident Signature

Date:_____ Signature:_____
Parent/Legal Guardian Signature

Date:_____ Signature:_____
Witness Signature (required)

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibited. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law.

ALPHA HOUSE OF PINELLAS COUNTY

701 5th Avenue North, St. Petersburg, FL 33701 Phone (727) 822-8190

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION – HEALTHY FAMILIES

I, _____ , DOB_____ SS# _____
(Resident Name)

Authorize ALPHA HOUSE OF PINELLAS COUNTY and Healthy Families to communicate and disclose the following information to one another as necessary, in connection with their official duties in my case: Note: *Draw a line through information not needed.*

Assessments, Treatment Plan, Lab Results, Discharge Summary and Continuing Care Plan, Diagnosis, Attendance/Lack of Attendance, Progress/Cooperation, Successful/Unsuccessful Completion, Prognosis and Recommendations

Purpose for the disclosure: Service Coordination

Information will be disclosed in writing and/or verbally. Resident initial for FAX approval:_____

I understand that my records are protected under the Federal and State regulations governing the confidentiality and privacy of medical records and protected information under Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written authorization unless otherwise provided for by the regulations. Any release of substance abuse information must be pursuant to 42 C.F.R., Part 2.

I also understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it, and that in any event this authorization expires automatically after one year, unless otherwise stated below:

Date, event or condition of expiration:_____

I understand that generally ALPHA HOUSE OF PINELLAS COUNTY Inc may not condition treatment on whether I sign an authorization, but that in certain limited circumstances I may be denied treatment if I do not sign this authorization. I also hereby release ALPHA HOUSE OF PINELLAS COUNTY from liability which may arise as a result of information disclosed under an authorization, if such information disclosed is later used to my detriment.

Date:_____ Signature:_____
Resident Signature

Date:_____ Signature:_____
Parent/Legal Guardian Signature

Date:_____ Signature:_____
Witness Signature (required)

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibited. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law.

ALPHA HOUSE OF PINELLAS COUNTY

701 5th Avenue North, St. Petersburg, FL 33701 Phone (727) 822-8190

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION – DCF & Child Protective Custody

I, _____, DOB_____ SS# _____
(Resident Name)

Authorize ALPHA HOUSE OF PINELLAS COUNTY and the Department of Children and Families (DCF), Safe Childrens Coalition, Hillsborough Kids Inc., and Heartland for Children

To communicate and disclose the following information to one another as necessary, in connection with their official duties in my case:

Assessments, History and Physical, Medication Administration Records, Treatment Plan, Progress Notes, Lab Results, Discharge Summary and Continuing Care Plan, Any and All Records Needed.

Purpose for the disclosure: Service Coordination and Disposition of Child Custody

Information will be disclosed in writing and/or verbally. Resident initial for FAX approval: _____

I understand that my records are protected under the Federal and State regulations governing the confidentiality and privacy of medical records and protected information under Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written authorization unless otherwise provided for by the regulations. Any release of substance abuse information must be pursuant to 42 C.F.R., Part 2.

I also understand <u>that I may revoke this authorization in writing at any time except to the extent that action has already been taken</u> in reliance on it, and that in any event <u>this authorization expires automatically after one year</u>, unless otherwise stated below:

Date, event or condition of expiration:_____

I understand that <u>generally</u> ALPHA HOUSEOF PINELLAS COUNTY Inc may not condition treatment on whether I sign an authorization, but that in certain limited circumstances I may be denied treatment if I do not sign this authorization. I also hereby release ALPHA HOUSE OF PINELLAS COUNTY Inc. from liability which may arise as a result of information disclosed under an authorization, if such information disclosed is later used to my detriment.

Date:_____ Signature:_____
Resident Signature

Date:_____ Signature:_____
Parent/Legal Guardian Signature

Date:_____ Signature:_____
Witness Signature (required)

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibited. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law.

ALPHA HOUSE OF PINELLAS COUNTY

701 5th Avenue North, St. Petersburg, FL 33701 Phone (727) 822-8190

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION – Emergency Contact

I, _____, DOB_____ SS# _____
(Resident Name)

Authorize Alpha House of Pinellas County, to disclose to:

(Provide Name and Address) _____

_____

The following information: My presence in ALPHA and the circumstances of my need for Emergency care

Purpose for the disclosure: To inform above of my emergency status

Information will be disclosed in writing and/or verbally. **Resident initial for FAX approval:**_____

I understand that my records are protected under the Federal and State regulations governing the confidentiality and privacy of medical records and protected information under Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written authorization unless otherwise provided for by the regulations. Any release of substance abuse information must be pursuant to 42 C.F.R., Part 2.

I also understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it, and that in any event this authorization expires automatically after one year, unless otherwise stated below:

Date, event or condition of expiration: _____

I understand that generally ALPHA HOUSE OF PINELAS COUNTY may not condition treatment on whether I sign an authorization, but that in certain limited circumstances I may be denied treatment if I do not sign this authorization. I also hereby release ALPHA HOUSE OF PINELLAS COUNTY from liability which may arise as a result of information disclosed under an authorization, if such information disclosed is later used to my detriment.

Date:_____ **Signature:**_____
Resident Signature

Date:_____ **Signature:**_____
Parent/Legal Guardian Signature

Date:_____ **Signature:**_____
Witness Signature (required)

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibited. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law.

ALPHA HOUSE OF PINELLAS COUNTY

701 5th Avenue North, St. Petersburg, FL 33701 Phone (727) 822-8190

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION – DCF Benefits

I, _____, DOB_____ SS# _____

Authorize ALPHA HOUSE OF PINELLAS COUNTY to disclose to:

Department of Children and Families - Assistance Benefits
525 Mirror Lake Dr. Suite 201
St. Petersburg, FL 33701

The following information: Resident identification data, income, assets, work status, and requested Information to help facilitate obtaining assistance for above Resident.

Purpose for the disclosure: To assist Resident as her authorized representative for benefits.

Information will be disclosed in writing and/or verbally. **Resident initial for FAX approval:**_____

I understand that my records are protected under the Federal and State regulations governing the confidentiality and privacy of medical records and protected information under Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written authorization unless otherwise provided for by the regulations. Any release of substance abuse information must be pursuant to 42 C.F.R., Part 2.

I also understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it, and that in any event this authorization expires automatically after one year, unless otherwise stated below:

Date, event or condition of expiration:_____

I understand that generally ALPHA HOUSE OF PINELLAS COUNTY Inc may not condition treatment on whether I sign an authorization, but that in certain limited circumstances I may be denied treatment if I do not sign this authorization. I also hereby release ALPHA HOUSE OF PINELLAS COUNTY from liability which may arise as a result of information disclosed under an authorization, if such information disclosed is later used to my detriment.

Date:_____ **Signature:**_____
Resident Signature

Date:_____ **Signature:**_____
Parent/Legal Guardian Signature

Date:_____ **Signature:**_____
Witness Signature (required)

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibited. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law.

ALPHA HOUSE OF PINELLAS COUNTY

701 5th Avenue North, St. Petersburg, FL 33701 Phone (727) 822-8190

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION – School Enrollment

I, _____, DOB_____ SS# _____

Authorize ALPHA HOUSE OF PINELLAS COUNTY, and the Pinellas County School System to communicate and disclose the following information to one another as necessary, in connection with their official duties in my case:
Note: Draw a line through information not needed.

My name, DOB, SS#, ESE, Discipline Records, Current schedule, Attendance Records, Grades, Presence in ALPHA Program

Purpose for the disclosure: Enrollment in Pinellas County School and Service Coordination

Information will be disclosed in writing and/or verbally. **Resident initial for FAX approval:**_____

I understand that my records are protected under the Federal and State regulations governing the confidentiality and privacy of medical records and protected information under Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written authorization unless otherwise provided for by the regulations. Any release of substance abuse information must be pursuant to 42 C.F.R., Part 2.

I also understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it, and that in any event this authorization expires automatically after one year, unless otherwise stated below:

Date, event or condition of expiration: UPON DISCHARGE

I understand that generally ALPHA HOUSE OF PINELLAS COUNTY Inc may not condition treatment on whether I sign an authorization, but that in certain limited circumstances I may be denied treatment if I do not sign this authorization. I also hereby release ALPHA HOUSE OF PINELLAS COUNTY from liability which may arise as a result of information disclosed under an authorization, if such information disclosed is later used to my detriment.

Date:_____ **Signature:**_____
Resident Signature

Date:_____ **Signature:**_____
Parent/Legal Guardian Signature

Date:_____ **Signature:**_____
Witness Signature (required)

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibited. Florida Law requires that any person, agency, or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law.

EXHIBIT A, PAGE ONE
HOMELESS VERIFICATION FORM

Alpha, Inc
701 5th Avenue North

Client Name:_____ **Client Number:**_____

Where did you sleep last night? ☐ **Outside/street/park** ☐ **Shelter** ☐ **Other specify):**_____

Problems Presented/Verification: _____
_____

Verified by Case Worker: ☐**Yes** ☐ **Unable** **Date:**_____

Eligible Criteria:

☐ **1.** **In places not meant for human habitation, such as cars, parks, sidewalks, abandoned building (on the street).**

☐ **2.** **In an emergency Shelter*.**

***If an participant came from an institution but was less than 30 days and was living on the street or in an emergency shelter before entering the facility, he/she should be counted in either the street or shelter category, as appropriate.**

☐ **3.** **In transitional or supportive housing for homeless persons and originally come from the street/shelter.**

☐ **4.** **Is being evicted within a week from a private dwelling until and no residence has been identified and the person lacks the resources to obtain housing**

☐ **5.** **Is being discharged within a week from an institution, such as a mental or substance abuse treatment facility or a jail/prison, in which they had been a resident for more than 30 consecutive days and no subsequent residence has been identified and the person lacks the resources obtaining housing.**

☐ **6.** **Is fleeing a domestic violence housing situation and the person lacks resources and support needed to obtain housing.**

How was this verified?:_____
_____

_____
Case Worker's Signature

_____
Print Name

Disposition/Plan:_____
_____
_____

I, _____verify I am without appropriate adequate housing opportunities. I further state that my present living arrangements is temporary and I have no place to relocate at the present time. The information I have provided and represented herein is correct and is a fair representation of my interview.

In addition I authorize the release of this information.

Signature:_____ **Date:**_____

Print Name:_____

EXHIBIT A, PAGE TWO
DEMOGRAPHICS & INTERAGENCY REFERRAL FORM*

Alpha, Inc
701 5th Avenue North

Personal Data

Name:_____ SSN:_____ DOB:_____ ☐ Male ☐ Female

Name:_____ SSN:_____ DOB:_____ ☐ Male ☐ Female

Present Address:_____ From:_____ To:_____

Present Address:_____ From:_____ To:_____

Hispanic/Latino: ☐ Yes ☐ No

Race (Circle One): White Black/African American Native Hawaiian/Pacific Islander Asian

American Indian/Alaskan Native American Indian/Alaskan Native & White Asian & White

Black/African American & White American Indian/Alaskan Native & Black/African American

Other Multi-Racial

Education Level:_____ __ Veteran (Yes or No)_____

Individual:_____ Family w/children:_____ Couple w/o children:_____

Is Client Head of Household? ☐ Yes ☐ No Head of Household: ☐ Male ☐ Female

Number of persons needing services: Adults:_____ Children:_____

Gender/Ages: _____/_____ _____/_____ _____/_____ _____/_____ _____/_____

Employment Data

Status: Full Time:_____ Part-Time:_____ Day:_____ Temp_____ None_____

Applied for SSI/SSDI: ☐ Yes ☐ No Status: Pending_____ Received_____ Denied____ On Appeal____

Resources

Monthly Income: $_____ Work_____ SSI/SSDI_____ TANF_____ Food Stamps_____

None_____ Other (specify)_____

HouseHold Characteristics (if applicable)

Family Violence_____ Physically Disabled_____ Drug Dependent_____ HIV/AIDS_____

Developmentally Disabled_____ Alcohol Dependent_____ Chronically Mentally Ill_____

Other(specify)_____

Referral History

Agency Referred to:_____ Date Contact Person:_____ Phone Number:_____

Emergency DATA SHEET (Child)

Client Name:_____

Date of Birth_____ **Social Security#:**_____

Address:_____

_____

Allergies:_____

_____

Medical Diagnosis: (e.g. -handicaps, diabetes, epilepsy, other conditions needing to be mentioned in a medical emergency, etc):

_____

_____

_____

Medications Prescribed/Used:

_____

_____

Current Problems:

_____

_____

Other Information:

_____

_____

EMERGENY CONTACT/LEGAL GUARDIAN: _____

Address of Contact:

_____

_____

Home Phone:_____ **Work Phone:**_____

Relationship To Client:_____

☐ **Release of Information Obtained for Emergency Contact.**

Emergency DATA SHEET (Child) - Continued:

Next of Kin:_____ **Relationship:**_____

Address:_____

_____

Phone:_____ **Fax:**_____

☐ **Release of Information Obtained for Emergency Contact.**

Other Contact:_____ **Relationship:**_____

Address:_____

_____

Phone:_____ **Fax:**_____

☐ **Release of Information Obtained for Emergency Contact.**

Other Contact:_____ **Relationship:**_____

Address:_____

_____

Phone:_____ **Fax:**_____

☐ **Release of Information Obtained for Emergency Contact.**

Emergency Medical Treatment
(Parental Permission for a Minor)

TO WHOM IT MAY CONCERN:

I hereby authorize emergency medical treatment for my child, _____, who is currently a resident at ALPHA HOUSE OF PINELLAS COUNTY located at 701 5th Avenue North, St. Petersburg, Florida, 33701.

(subject to the limitations set forth in 39.407F.S for foster care residents). ALPHA, however, is not responsible for payment of any of my child's medical bills

This document releases the hospital and asks that treatment be provided.

_____ _____

Date Parent/Legal Guardian Signature

_____ _____

Date Witness Signature

_____ _____

Date Notary Public

Emergency Medical Treatment
(Permission for an Adult)

TO WHOM IT MAY CONCERN:

I hereby authorize emergency medical treatment for myself. I am currently a resident at ALPHA HOUSE OF PINELLAS COUNTY located at 701 5th Avenue North, St. Petersburg, Florida, 33701.

ALPHA, however, is not responsible for payment of any of my medical bills.

This document releases the hospital and asks that treatment be provided.

_____ _____

Date Resident Signature

_____ _____

Date Witness Signature

_____ _____

Date Notary Public

ALPHA HOUSE OF PINELLAS COUNTY

Guardianship Certification – Foster Care Residents

State of Florida, County of Pinellas (Complete if client is a minor AND *IS* in foster care)

I HEREBY CERTIFY that on this day, before me, an officer duly authorized in the State and County aforesaid to take acknowledgements, personally known to me or has produced _____ as identification and who executed the foregoing instrument and acknowledged before me that they executed the same freely and voluntarily.

The undersigned Legal Guardian, hereby grants ALPHA HOUSE OF PINELLAS COUNTY staff permission to represent _____ for the following activities:

- Enrollment and coordination of social service benefits
- Routine Medical and Dental care
- School enrollment and coordination of services
- Child care coordination

WITNESS my hand and official seal on _____ day of _____, 20____.

_____ _____
Signature of Parent or Guardian Date

_____ _____
Signature of Resident Date

My Commission Expires:

_____ _____
Signature of Witness Signature of Notary Public

BABY IN BED CONTRACT

I understand that sleeping with a baby in an adult bed or having a baby sleep alone in an adult bed is NOT a safe parenting practice and is a potentially fatal situation. I also understand that sleeping with a baby in an adult bed is against ALPHA's policy of keeping babies and mothers safe and if I am found doing so I can be discharged from the program.

By signing this contract I am agreeing to follow safe parenting practices by having my baby sleep in a crib or a bassinet.

_____ _____

Resident Signature Date

_____ _____

Witness Signature Date

Baby's Birth Information

Mother's Name: _____

Baby's Legal Name:_____

Baby's Date of Birth: _____

Baby's Gender: MALE OR FEMALE (Circle One)

Baby's Birth Weight & Length: _____

Place of Delivery: _____

Type of Delivery: Vaginal or C-Section (Circle One)

CELL PHONE POLICY

We trust your ability to make wise, responsible decisions for yourself and your wellbeing, and encourage you to use this as an opportunity to learn valuable life skills of budgeting, effective time management, and setting appropriate boundaries and discipline for yourself and those you keep in contact with.

Please keep in mind, having and using a cell phone is a privilege not a right or necessity, and it is up to you to handle it in a mature manner, showing ALPHA staff that you are able to manage effectively this additional responsibility.

We strongly encourage you to consult with you case manager, counselor or life skills educator prior to obtaining a cell phone and wireless plan to learn more about wireless services and determine which kind of plan would best suit your needs. This will limit the possibility of unexpected talk-time overages, which could leave you with a several hundred dollar bill.

I agree that signing the following will allow Alpha House of Pinellas County to enforce any rules associated with my cell phone use.

I _____ have reviewed and agree to abide by this policy.

Resident signature_____ Date_____

Parent/Legal Guardian signature_____ Date_____

Witness signature_____ Date_____

ALPHA HOUSE OF PINELLAS COUNTY

Consent Form

I, _____, the parent or legal guardian of _____, hereby give full consent for my child to enter ALPHA's Transitional Living Program.

OR

I, _____, being of legal age give my full voluntary consent to enter ALPHA's Transitional Living Program.

By signing this form, I am granting full permission to live in, participate and attend all activities of the Transitional Living Program.

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Resident Date

_____ _____

Signature of Witness Date

ALPHAHOUSE OF PINELLAS COUNTY

Drug and Alcohol Screening Consent

This is a drug and alcohol free program. ALPHA does random Drug and Alcohol Screenings to ensure the safety of each resident and their child. If a screening comes back positive, it constitutes grounds for immediate discharge from the ALPHA program.

By signing this document, _____ is consenting to random Drug and Alcohol testing and is accepting the results of the Drug and Alcohol Screening as a valid indicator of usage. The resident, _____, is acknowledging and accepting the consequences that follow the unsafe choice made.

_____ _____

Date Resident's Signature

_____ _____

Date Parent/Legal Guardian Signature (if applicable)

_____ _____

Date Witness Signature

FILING A GRIEVANCE

You have the right to file a grievance to address situations you feel are inappropriate or when you experience dissatisfaction with the program. **There are no consequences to filing a grievance.** Here are the steps to take to resolve issues:

1. Talk to your counselor or case manager first about your concern. If after this discussion you feel the issue has not been resolved move to step 2.
2. File a written grievance by completing the grievance form (staff may assist you with this, if needed). Place the form in the provided envelope marked "Confidential" and give it to the Program Manager.
3. The Program Manager has 5 working days to respond in writing.
4. You have 3 working days to reply to the Program Manager. If there is no reply from you in 3 working days, the grievance is considered resolved.
5. If you are unsatisfied with the Program Manager's response you may send your grievance to the Director.
6. The Director has 5 working days to respond in writing.
7. You have 3 working days to respond to the Directors reply. If there is no reply from you in 3 working days, the grievance is considered resolved.
8. If you are unsatisfied with the Director's response you may keep a copy of your grievance and address it again at a later date. Y
9. At any time in this process you may choose to take your grievance directly to the Department of Children and Families or the Florida Local Advocacy Committee.

I have been informed and understand the grievance process.

Resident Signature:_____ __Date:_____

NO SMOKING POLICY

I have been informed of ALPHA's no smoking on property policy. I understand that the following actions will be taken if I am caught smoking on property:

1. The first time I get caught, I will be responsible for finding, attending, and transporting myself to a smoking cessation class.

2. I will provide ALPHA with proof that I attended this class within one week of my offense.

3. I understand that if I am caught smoking on property again additional consequences will be given up to and including discharge from the program.

By signing this contract, I am agreeing to follow ALPHA's no smoking policy.

_____ _____

Resident Signature Date

_____ _____

Witness Signature Date

Phone/Visitor List

Listed below are people you would like to have permission to visit while you are a resident of ALPHA:

Name	**Relationship**	**Address**	**Phone**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

The following individuals are NOT authorized visitors:

Name	**Relationship**	**Address**	**Phone**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____ _____

Date Signature of Resident

_____ _____

Date Signature of staff (for approval)

RESIDENT POSSESSIONS LIST

NAME: _____ DOB _____ DATE_____

The following is a list of possessions that I brought to Alpha. I assume personal responsibility for them and will remove all belongings upon discharge. I also understand that any items that I leave at discharge will not be kept more than 30 days. At that point they will be given to the outreach program.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	

Resident Signature & Date:_____

Staff Signature & Date: _____

ALPHA HOUSE OF PINELLAS COUNTY
NOTICE OF PRIVACY PRACTICES

As required by the Health Insurance Portability and Accountability Act (HIPAA)

This Notice describes how medical and other information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

You have a right to know how we use and share your personal information. This Notice tells you our responsibilities and your rights.

In order to provide you with the best possible care, all professional staff involved in your treatment and employees involved in the operations of the agency may have access to your records. All ALPHA HOUSE OF PINELLAS COUNTY employees follow these Privacy Policies.

Confidential Records

The personal information you gave us goes into a confidential (private) written record. We use it to plan for your counseling services and to receive payment for those services from our funding sources. Usually we must have your permission to use or share your personal information. Sometimes, for example, in safety situations we my share it without your permission. This is described more below. The permanent record is kept on paper. We will keep this for at least 7 years after you stop receiving services, and then your record will be destroyed. Some records and billing information are also stored in computers.

Our Responsibilities

- We will keep your information private
- We will follow these Privacy Practices
- We will give you a copy of our Notice of Privacy Practices
- If our Privacy Practices change, we will give you a new copy at your next scheduled appointment or whenever you request one.

How We Use and Share Your Personal Information

There are three ways we use and share information about you. The three ways are to

1) Provide services, with your consent. When you apply for services, you are asked to sign Consent for Treatment. With this consent, we can use and share information about you in these ways:

    a) For treatment and services we may use and share information about you with professionals and agencies who serve you. For example, we will use information about you during staff supervision so that we can ensure that you are getting the best services we can provide. We may share information with team members so that everyone can be sure they are working on the same goals.
    b) For Payment. We may use and share information about you to obtain payment for services we have provided to you. For example, we may give information to those agencies that provide funding to our programs.
    c) For Quality Improvement. We may use and share information about you in order to make sure we are providing good services. For example, we may give information to our peer review teams so they can make sure you are receiving proper services.

2) Provide information to others who need it, with your approval. If we need to share personal information about you for other reasons, we will ask you to sign an Authorization Form to give your approval. This will tell you what information we need to share, who will receive it, and why. For example, you need to sign an Authorization Form for us to share information with your child's school if you want us to talk with the teacher. Your approval is only good until the date stated on the form, not forever. If you change your mind, tell us in writing and we will not share the information.

3) Provide information to others who need it, without your consent or approval. We may sometimes share personal information about you with your approval. We will do this only when it is lawful and will not share any more information than necessary. The Department of Health and Human Services requires us to list specific situations in which one's personal information might be released. Most of these situations are not those in which ALPHA HOUSE OF PINELLAS COUNTY would be involved with your family. We have highlighted in bold those situations in which we may be involved.

- Appointments – for appointment reminders or notification when an appointment must be cancelled or rescheduled
- Emergency Treatment – when you need medical care in a crisis
- Health and Safety – to prevent or reduce a serious threat to someone's health or safety. We will do what is necessary to protect you and others.
- Oversight – when we are reviewed by licensing and accreditation agencies or auditors
- Research – for approved research purposes. A Board must review the research to make sure your information remains private (and you must give consent to participate in any research here at ALPHA HOUSE OF PINELLAS COUNTY)
- Legal Proceedings- in response to court orders and other legal actions
- Law Enforcement – if you are missing or in danger. Law enforcement may have access to your information for legal or civil proceedings.
- Abuse or Neglect - to report suspected abuse, neglect or exploitation of any child or vulnerable adult
- Government – to government regulatory agencies, including national security and intelligence agencies
- Required by Law – at other times when the law requires us to
- Public Health – to report diseases, drug reactions or other public health concerns
- Funeral Directors – to the funeral director who will take care of your body
- Organ Donation – for organ, eye or tissue donation purposes
- Coroners – to a coroner or medical examiner for identification or other purposes
- Workers' Compensation – to process a Workers' Compensation claim

Your Rights

You have a right to read your record and to have a copy of its contents if you would like. We may charge a fee for copying, mailing and supplies. Under limited circumstances, your request may be denied. You have the right to correct information in the record that you believe is inaccurate by providing a correction statement.

You have the right to request that certain information not be shared, although ALPHA HOUSE OF PINELLAS COUNTY is not required to follow your request. If we agree, we will comply with your request unless the information is needed for an emergency.

You have the right to confidential communications. You may request that we communicate with you in a certain way or at a certain location. This request needs to be made in writing.

You have the right to receive a list of the disclosures of your personal information that have been made for reasons other than for treatment or healthcare operations. This listing begins on April 14, 2003.

You have the right to refuse certain types of treatment or services. If we have alternate services available, you can continue to receive those services at this agency.

We will not use your personal information for any marketing purposes. We would only use your photo or comments in any of the agency's materials (brochures, videos, etc.) with your written permission. At times, we have asked participants to appear with us at public forums but your refusal to do this would not impact your receiving services at ALPHA HOUSE OF PINELLAS COUNTY.

If you believe your rights have been violated, you may file a complaint with ALPHA HOUSE OF PINELLAS COUNTY or with the HHS office of Civil Rights. You will not be penalized for making a complaint.

If you have any questions, would like to request restrictions on uses and disclosure for health care treatment or operations, or would like to file a complaint, please contact our Privacy Officer, (ALPHA Director), (727) 822-8190

Your signature on this form does not indicate your agreement with the information provided. It acknowledges that you have received and read ALPHA HOUSE OF PINELLAS COUNTY Notice of Privacy Practices.

_____	_____
Client Signature	Date
_____	_____
Parent/Guardian Signature	Date
_____	_____
Witness Signature	Date

Resident Rights

As a resident of ALPHA HOUSE OF PINELLAS COUNTY you have the following rights:

1) To be treated by the staff with respect and dignity

2) To equal treatment regardless of race, sex, sexual orientation, ethnic group, religion, age, or handicap

3) To confidentiality of information released except as allowed/required by law

4) To refuse any intervention (i.e. medication) and to be informed of the consequences of such refusal

5) To have a Treatment Plan developed based on your individual needs

6) To participate in the development of and be offered a copy of your Treatment ,Case Management, and Life Skill Plans

7) To be assured of freedom from neglect, abuse, exploitation or any form of corporal punishment

8) To be assured that any search or seizure of contraband is carried out in a manner consistent, with program standards to ensure safety, security and the well being of clients and staff

9) To initiate a grievance and to be heard by representatives of Alpha You may ask for and receive a copy of ALPHA HOUSE OF PINELLAS COUNTY grievance Policy and follow the grievance process. You may contact Department of Children and Families directly (800-962-2873), your attorney, or the Florida Local Advocacy Council (800-342-0825) at any time.

I have read, understand, and have received a copy of this Client's Rights form.

_____	_____
Date	Resident Signature
_____	_____
Date	Parent/Guardian Signature (if applicable)
_____	_____
Date	Witness

ALPHA HOUSE OF PINELLAS COUNTY
ZERO TOLERANCE CONTRACT

I understand the ALPHA Transitional Living Program is a **SAFE PLACE** for everyone and that I have the responsibility to myself, the staff and other residents to behave in a lawful manner. I understand that ALPHA has **zero tolerance** for the following actions and that the following actions are flagrant enough to warrant immediate dismissal.

- Battery upon any resident or staff person (hitting, striking, punching, slugging, pushing etc.)
- Deliberate property damage (punching walls, ripping our doors, etc.)
- Possession of alcohol, drugs, knives, or guns (having illegal objects in my possession)
- Theft of anyone's property (taking money, clothing, personal belongings, etc.)
- Child abuse or neglect
- Any illegal activity

I agree to notify staff immediately of any actions that make this residence unsafe for anyone at any time. I have read and understand the above rules. I am willing to keep ALPHA's Transitional Living Program safe.

_____	_____
Date	Resident Signature
_____	_____
Date	Parent/Legal Guardian Signature (if applicable)
_____	_____
Date	Witness Signature