CPS Removal Packet

Face Sheet

Completed by _____ **Date** _____

*****CPS Removal Packet is due to Foster Care by Case Transfer*****

_____ **Initial Intake, Placement and Well-Being Information and History (CS-0727) – Due to placement immediately**

_____ **KER/Genogram (CS-1013 & 0774) – Due to placement immediately**

_____ **Consent for psychotropic meds (CS-0627) – Due immediately**

_____ **Medication Transfer Form (CS-0813) – Due immediately**

_____ **Authorization of Routine Health (CS-0206) – To be taken to the placement; Due to CWB within 24 hours of removal**

_____ **Tenn Care Immediate Eligibility – Due within 24 hours**

_____ **Child Welfare Benefits Application (CS-0475) – Due to CWB within 5 business days**

_____ **Authorization for Release of Information and HIPAA Protected Health Information TO and FROM (CS-0559) – Due to Foster Care by case transfer**

_____ **Authorization For Release of TennCare Eligibility Information FROM TENNCARE TO The Department of Children's Services and Authorization for the Release of Information TO TENNCARE FROM The Department of Children's Services (CS- 0789) – Due to Foster Care by case transfer**

Tennessee Department of Children's Services

CPS Removal Packet

Complete the information below so that the information populates to all the other forms in the packet.

(The information in the forms will not be visible until you print initialy or look at print preview after all subsequent changes.)

Signature Dates
Childs First Name
Childs Middle Name
Childs Last Name
Childs Social
Childs Date of Birth
Childs Age
Childs Gender
Childs Custody Date
Childs Race
Childs Person ID
Childs Place of Birth
Case Supervisor
Childs Assigned FSW
Interviewer
Childs School
School City/State
Childs Grade Level
Childs Mental Health Diagnosis
Childs Physical Health Issues
Childs Medications
Childs Allergies
Childs Allergic Reactions
Childs Disabilities
Childs Past Mental Health Providers
Childs Current Mental Health Provider
Childs Health Insurance
Childs Language
Committing County
DCS Region
Childs Adjudication
DCS County Office Phone
DCS Office Address
DCS Office City State Zip
Mothers First Name
Mothers Middle Name
Mothers Last Name
Mothers Street Address
Mothers City
Mothers State
Mothers Zip Code
Mothers Social
Mothers Employer
Employers Street Address
Mothers Employers City
Mothers Employers State
Mothers Employers Zip
Mothers Phone
Mothers DOB
Mothers Maiden Name
Fathers First Name
Fathers Middle Name
Fathers Last Name

Fathers Street address
Fathers City
Fathers State
Fathers Zip Code
Fathers Social
Fathers Phone
Fathers DOB
Fathers Employer
Fathers Employer Address
Fathers Employer City
Fathers Employer State
Fathers Employer Zip

_____

Custodian #1s Information if not the parent or the Parent themselves (PRIMARY CUSTODIAN)

Custodians First Name
Custodians Middle Name
Custodians Last Name
Relationship to the foster child
Custodians Removal Street Address
Custodians City
Custodians State
Custodians Zip
Custodians Social
Custodians Birth Date
Custodians Birth Place
Custodians Phone

_____

Custodian #2s information if not the parent (SECONDARY CUSTODIAN)

Custodians First Name
Custodians Middle Name
Custodians Last Name
Custodians Street Address
Custodians City
Custodians State
Custodians Zip
Custodians Social
Custodians Birth Date
Custodians Birth Place
Custodians Phone

_____

1st Sibling In The Home

Sibling 1 First Name
Sibling 1 Middle Name
Sibling 1 Last Name
Sibling 1 Birth Date
Sibling 1 Birth Place
Sibling 1 Social

_____

2nd Sibling in the Home

Sibling 2 First Name
Sibling 2 Middle Name
Sibling 2 Last Name
Sibling 2 Birth Date
Sibling 2 Birth Place
Sibling 2 Social

_____

3rd Sibling in the Home

Sibling 3 First Name
Sibling 3 Middle Name
Sibling 3 Last Name
Sibling 3 Birth Date
Sibling 3 Birth Place
Sibling 3 Social

_____

4th Sibling in the Home

Sibling 4 First Name

Sibling 4 Middle Name

Sibling 4 Last Name

Sibling 4 Birth Date

Sibling 4 Birth Place

Sibling 4 Social

Tennessee Department of Children's Services

Initial Intake, Placement and Well-Being Information and History

Child Name:		Child DOB:		Person ID:	

Initiated By: _____ Title: _____ Date: _____

Revised By: _____ Title: _____ Date: _____

Person Providing Information to DCS: _____ Relationship to Child/Youth: _____

Current insurance coverage ☐ Yes ☐ No ☐ Unknown **If yes, provide details:** _____

Child/Youth Information

Name of Child/Youth:		E-mail Address:		SSN:	

DOB:		Sex:		Race:		Hispanic:	☐ Yes ☐ No	U.S. Citizen:	☐ Yes ☐ No Provide Birth Certificate Verification

Is Child/Youth of Native American Descent?	☐ Yes ☐ No ☐ Unable to Determine	If "Yes" Tribal Affiliation	

Child/Youth's Marital Status *(check one)*	☐ Never Married ☐ Divorced ☐ Widowed ☐ Married ☐ Separated

Has Youth been placed in out of home care prior to this custody episode? If yes please list dates and placements:	☐ Yes ☐ No

Current Description of the Child/Youth

Physical Description Date		Primary Language Spoken					
Height		Weight		Hair Color		Eye Color	
Religion:		Identifying Marks or Tattoos:					

Special Needs/Disabilities:			
Special Medical Equipment:			
Scheduled Appointments: (*date, provider, location, type of appt*)			
Allergies/Adverse Reactions:	☐ Yes ☐ No		
Medication:		Describe reaction:	
Food:		Describe reaction:	
Insect Sting:		Describe reaction:	
Other:		Describe reaction:	
Medical modified/Religious diet?	☐ Yes ☐ No	If yes, describe	

Child Name:		Child DOB:		Person ID:	

Medications: Prescribed and Over the Counter

Current medications (*name, route, frequency, dosage & days of meds left)*					
Are meds given in school?	☐ Yes ☐ No	**Which meds?**			
Consent signed for psychotropic meds:	☐ Yes ☐ No ☐ N/A	**Next med appointment:**			
Has Foster Parent received medication:	☐ Yes ☐ No	**Explain:**			

Health History of Child Explain any items checked Now/Past in "COMMENTS" section

No	Now	Past			No	Now	Past	
☐	☐	☐	Birth defects		☐	☐	☐	Gastrointestinal problems
☐	☐	☐	Vision problems		☐	☐	☐	Kidney/urinary problems
☐	☐	☐	Hearing problems		☐	☐	☐	Hepatitis/liver problems
☐	☐	☐	Skin problems		☐	☐	☐	Cancer
☐	☐	☐	Head injuries		☐	☐	☐	Tuberculosis (TB)
☐	☐	☐	Headaches		☐	☐	☐	Autism/Asperger's (circle one)
☐	☐	☐	Sickle cell disease		☐	☐	☐	Developmental delays
☐	☐	☐	Anemia/blood disorder		☐	☐	☐	Learning disability
☐	☐	☐	Epilepsy/seizures		☐	☐	☐	Sleep problems
☐	☐	☐	Bedwetting		☐	☐	☐	Incontinence: ☐ Urine ☐ Stool
☐	☐	☐	Diabetes		☐	☐	☐	Other medical *(describe below)*
☐	☐	☐	Asthma/Respiratory Disease		☐	☐	☐	Accidents *(describe below)*
☐	☐	☐	Heart murmur		☐	☐	☐	Hospitalizations *(describe below)*
☐	☐	☐	Heart problems		☐	☐	☐	Surgeries *(describe below)*
☐	☐	☐	High blood pressure		☐	☐	☐	Problems with anesthesia
☐	☐	☐	Physical disabilities		☐	☐	☐	Other developmental disabilities

Child/Youth is currently hospitalized:	☐ Yes ☐ No	**If yes, where and why:**	
Comments/Additional health information/ongoing health related services:			

Childhood Illnesses

No	Yes	Approx date			No	Yes	Approx date	
☐	☐		Measles		☐	☐		Chicken pox
☐	☐		German measles		☐	☐		Scarlet fever
☐	☐		Mumps		☐	☐		Rheumatic fever

Trauma Screening

Indicate *known* history of abuse/adverse experiences. Explain any yes answers in "COMMENTS" section

No	Yes		No	Yes	
☐	☐	Neglect	☐	☐	Domestic violence
☐	☐	Physical assault/abuse	☐	☐	School violence
☐	☐	Sexual assault/abuse	☐	☐	Community violence

Child Name:		Child DOB:		Person ID:	

No	Yes		No	Yes	
☐	☐	Emotional abuse	☐	☐	Extreme interpersonal violence
☐	☐	Traumatic loss/separation	☐	☐	Natural disaster
☐	☐	Extended illness/medical trauma	☐	☐	Impaired caregiver (substance abuse/mental illness)
☐	☐	Serious injury	☐	☐	Other trauma, describe:

Has abuse been reported? ☐ Yes ☐ No ***If no, call CPS 877-237-0026***

Comments/Additional health information:	

Child Strengths

Behavioral/Mental Health History

No	Now	Past	
☐	☐	☐	Intense anger, if yes, describe
☐	☐	☐	Oppositional, if yes, describe
☐	☐	☐	Negative Peer Association, if yes, describe
☐	☐	☐	Extreme Attention Seeking, if yes, describe
☐	☐	☐	Makes False Statements, if yes, describe
☐	☐	☐	School Difficulties, if yes, describe
☐	☐	☐	Damage of Property, if yes, describe
☐	☐	☐	Habitual Lying, if yes, describe
☐	☐	☐	Stool Smearing, if yes, describe
☐	☐	☐	Stealing, if yes, describe
☐	☐	☐	Runaway, if yes, describe
☐	☐	☐	Hoarding, if yes, describe
☐	☐	☐	Problems with concentration and attention,if yes, describe
☐	☐	☐	Excessive Hyperactivity/does not respond to safety instructions, if yes, describe
☐	☐	☐	Requires Constant Supervision, if yes describe
☐	☐	☐	Anxiety, if yes, describe
☐	☐	☐	Depression, if yes, describe
☐	☐	☐	Seeing or hearing things that aren't there, if yes, describe
☐	☐	☐	Fire-setting, if yes, describe
☐	☐	☐	Animal cruelty, if yes, describe
☐	☐	☐	Animal fear, if yes, describe
☐	☐	☐	Self-injurious behavior/Other Self Harm, if yes, describe
☐	☐	☐	Aggressive, dangerous or destructive behaviors, if yes, describe
☐	☐	☐	Sexual aggression, if yes, describe
☐	☐	☐	Had homicidal thoughts, if yes, describe
☐	☐	☐	Had suicidal thoughts, if yes, describe

Child Name:		Child DOB:		Person ID:	

No	Now	Past	
☐	☐	☐	Attempted suicide If yes, describe
☐	☐	☐	Had other mental health or behavioral problems, if yes, describe
☐	☐	☐	Other mental health diagnosis, if yes, describe

Has the Child/Youth received counseling or therapy?	☐ Yes ☐ No
If yes, where?	
Has the Child/Youth had a Psychological Evaluation:	☐ Yes ☐ No
If yes, diagnosis, when, where?	
Has the Child/Youth been hospitalized for mental health problems/acute hospitalization?	☐ Yes ☐ No
If yes, diagnosis, when, where?	
Has the Child/Youth/Family received in-home services?	☐ Yes ☐ No
If yes, when, where?	
Has the Child/Youth previously been placed in a residential treatment facility?	☐ Yes ☐ No
If yes, when, where?	

Alcohol/Drug Abuse History

No	Now	Past	Frequency	(Xs per day/week/month)
☐	☐	☐		Alcohol
☐	☐	☐		Tobacco smoke/chew *(circle one or both)*
☐	☐	☐		E-cigarettes/vapor cigarettes
☐	☐	☐		Marijuana
☐	☐	☐		Narcotics
☐	☐	☐		Stimulants
☐	☐	☐		Methamphetamine
☐	☐	☐		Hallucinogens
☐	☐	☐		Steroids
☐	☐	☐		Huffing
☐	☐	☐		Ecstasy
☐	☐	☐		Street drugs, unknown
☐	☐	☐		Prescription drugs prescribed for another, specify:
☐	☐	☐		Over-the-counter medication, specify:
☐	☐	☐		Other, specify:

Additional Comments:	
Has child been identified as high risk?	☐ Yes ☐ No
Has a Safety Plan been completed on child identified as high risk?	☐ Yes ☐ No ☐ N/A

Birth History (for all children)

Birth Weight:		**Birth Length:**		☐ **Full term or** ☐ **Premature birth** ***(<36 weeks)***		weeks
Did mother receive prenatal care:	☐ Yes ☐ No		**Month of pregnancy for 1st prenatal visit:**			
Pregnancy/Birth complications:						
Was there prenatal substance abuse:	☐ Yes ☐ No		**Substance and frequency:**			

Child Name:		Child DOB:		Person ID:	

Birth hospital and location:	

Minor Female

Age of 1st Period:		Date of Last Period:					
Pregnancies #		Live births #		Full term		Premature (# weeks)	
Miscarriages #		Abortions #		Currently pregnant:	☐ Yes ☐ No	If yes, due date:	

Does the youth have children?			☐ Yes ☐ No If yes, answer below questions:				
Youth's Children's Names	DOB	In DCS Custody ?	Male/ Female?	Race	Name of Person Child Lives with and Relationship	Name of Child's Other Parent	Contact Information of Other Parent
		Yes ☐ No ☐	Male ☐ Female ☐				
		Yes ☐ No ☐	Male ☐ Female ☐				
		Yes ☐ No ☐	Male ☐ Female ☐				
Does minor parent have visitation with their child(ren)?			☐ Yes ☐ No				
If yes, list any visitation restrictions:							

Gender and Sexual Identity

Does the Child/Youth identify him/herself as gay, lesbian, transgender, or non-binary?	☐ Yes ☐ No
If yes, describe answer	

Sexual Activity

Is child sexually active?	☐ Yes ☐ No	Use birth control?	☐ Yes ☐ No	Method:	

Dating Violence

Has Child/Youth experienced controlling, abusive or aggressive behavior in a dating relationship?	☐ Yes ☐ No
If yes, explain:	

Medical

Does the Child/Youth have a regular medical provider (pediatrician, family doctor, etc.)?		☐ Yes ☐ No
If yes, name of medical provider:	Date of last visit:	

Immunizations

Are immunizations up-to-date?	☐ Yes ☐ No	Is the immunization record available?	☐ Yes ☐ No
Religious/medical exemption?	☐ Yes ☐ No (parent/guardian must provide a notarized statement)		

Dental

Does the Child/Youth have a regular dental provider?	☐ Yes ☐ No	Does the Child/Youth wear braces?	☐ Yes ☐ No
If yes, name of dental provider:		Date of last exam:	
If braces, name of orthodontist:		Date of last exam:	

Child Name:		Child DOB:		Person ID:	

Vision					
Does the Child/Youth wear glasses?	☐ Yes ☐ No	**Does the Child/Youth wear contacts?**	☐ Yes ☐ No		
If yes, name of vision provider:				**Date of last visit:**	

This concludes the Well-Being Section

Child Name:		Child DOB:		Person ID:	

This information does not go to Health Care Provider

Education and Independent Living

Student graduated high school?	☐ Yes ☐ No ☐ GED ☐ HISET ☐ Student Home Schooled				
What school does the student attend? (name, city, county)					
Student's age		**Current grade**		**Student receives special education services?** ☐ **Yes** ☐ **No**	
If yes, name the disability					

No	Yes	
☐	☐	Is the student taking GED classes
☐	☐	Does the student have a history of skipping school?
☐	☐	Is the student in an alternative school?
☐	☐	Is the student serving a zero tolerance expulsion (drugs, weapons and/or assault)?
☐	☐	Is the student serving a suspension for issues other than zero tolerance? If yes, what is the reason and duration of suspension?

Student strengths (check all that apply)	**Areas needing improvement (check all that apply)**
☐ Mathematics	☐ Mathematics
☐ Reading	☐ Reading
☐ Athletics	☐ Athletics
☐ Attendance in school	☐ Attendance in school
☐ Other, specify	☐ Other, specify

Other things you would like to share regarding your student's schooling?	

Presenting and Previous Court Actions on Youth (Unruly/Delinquent Youth only)

Current Dispositional Information			
Disposition Judge		**Special Judge**	
Current Disposition Court			
Current Disposition Decision		**Disposition Date**	
Have you been or are you currently on probation?	☐ Yes ☐ No	**If yes, where**	
Defense Attorney			
Current Adjudication Type		**Current Adjudication Date**	

Adjudicated Charge – Current and Previous	**Date Occurred**	**Disposition Date**	**Disposition**

Pending Charges	**Court Date Set**	**Date (if yes)**
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Violation of Probation (VOP) or Violation of Valid Court Order (VVCO) ***(explain if applicable)***

Child Name:		Child DOB:		Person ID:	

Narrative	

Legal/Probation Services Previously Offered to Child/Youth

Date	Type	Outcome

Safety (Unruly/Delinquent Youth only)

A) Maltreatment Allegations or Unruly Behaviors/Delinquency

Other *(explain)*	
Narrative	
Strengths ***(Signs of Safety)***	
Risks, Needs and Concerns ***(Signs of Risk include aggressive behavior, arson, cruelty to animals, gang involvement, etc.)***	

B) Domestic Violence

Narrative	
Strengths ***(Signs of Safety)***	
Risks, Needs and Concerns ***(Signs of Risk include aggressive behavior, arson, cruelty to animals, gang involvement, etc.)***	

FSW Name		Contact #	
Office Address			
Supervisor		Contact #	

DCS / Provider Staff — *Date*

I acknowledge receipt of the Intake, Placement, and Well-Being Information and History. I further acknowledge my legal duty to maintain confidentiality of this information and history and any additional information I may receive pursuant to Tennessee Code Annotated §37-2-415, The Foster Parent Rights Act.

Foster Parent — *Date*

Foster Parent — *Date*

Child Name:		Child DOB:		Person ID:	

Do not provide this section to the Foster Parent or the Health Care Provider

Has the child/Youth been adopted: ☐ Yes ☐ No: **Was the child/Youth in Permanent Guardianship:** ☐ Yes ☐ No
Receiving Adoption Assistance or Subsidized Permanent Guardianship: ☐ Yes ☐ No: If yes, **Amount:** _____
(If yes, immediately notify the Permanency Specialist, Child Welfare Benefits Counselor Regional and Central Office Fiscal Staff)

Adoption/Guardianship Completed by DCS: ☐ Yes ☐ No (If no List Name of the Agency)

Removal Date:		New Placement:		Date of Placement:		Legal Custody Date:	
Removal County:		Adjudication Type: Brief Description:	☐ Dependent and Neglect ☐ Unruly ☐ Delinquent ☐ N/A				
Removal Reason:	☐ Alcohol Abuse (Child); ☐ Alcohol Abuse (Parent); ☐ Caretaker Inability to Cope due to Illness or Other: ☐ Child's Disability; ☐ Drug Abuse (Child); ☐ Drug Abuse (Parent); ☐ Inadequate Housing; ☐ Incarceration of Parents; ☐ NAS Prosecution (only select upon DCS attorney instruction); ☐ Physical Abuse (alleged/reported); ☐ Relinquishment; ☐ Sexual Abuse (alleged/reported); ☐ Truancy						

Removal Street Address							
City		County		State		Zip Code	
Kinship Exception Request							
Was KER approved?	☐ Yes ☐ No	If yes, by whom?					
Was the KER temporary or long term?	☐ temporary ☐ long term						
MSW Consult was completed with:							

Family Information

Both parents living?	☐ Yes ☐ No	If no, date(s) of death:	
Household income to determine IV-E eligibility: (including SS Benefits, SSI for child, AFDC, Foodstamps, Child Support, etc.) If additional supports are received, please indicate in whose name the payment/support is made.			

Child/Youth Parent(s)/Caretaker(s)
Indicate Parent/Caregiver's Preferred Method for Receiving Documents

Birth Mother's Name						Primary Caregiver	☐ Yes ☐ No
Email Address						☐ Yes ☐ No	
Maiden Name		Social Security No.		DOB		Message Contact #	
Address						☐ Yes ☐ No	
City, State, Zip						Contact #	

Child Name:		Child DOB:		Person ID:	

Employer		**Address**	
City, State, Zip		**Contact #**	
Birth mother married when child/Youth was born?	☐ Yes ☐ No ☐ Unable to Determine		
Birth mother ever been married?	☐ Yes ☐ No ☐ Unable to Determine	**If so, where and to whom?**	
Birth mother ever been divorced?	☐ Yes ☐ No ☐ Unable to Determine	**If so, where and from whom?**	
Birth mother's race:			
Is there a father listed on the birth certificate?	☐ Yes ☐ No		
Has DNA testing ever been done?	☐ Yes ☐ No	**If so, what were the results and where was it done?**	
Has there ever been a legal father identified (either mother was married at the time of birth or a father has been legitimated through the court)?	☐ Yes ☐ No		
Legal Father's Name		**Primary Caregiver**	☐ Yes ☐ No
Email Address		☐ Yes ☐ No	
Social Security No.	**DOB**	**Message Contact #**	
Address	☐ Yes ☐ No		
City, State, Zip		**Contact #**	
Legal Father's Race:			
Employer		**Address**	
City, State, Zip		**Contact #**	
Marital Status of Parents	☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Other**		
Putative/Alleged Father's Name			
Email Address	☐ Yes ☐ No		
Social Security No.	**DOB**	**Message Contact #**	
Address	☐ Yes ☐ No		
City, State, Zip		**Contact #**	
Putative/Alleged Father's Race:			
Employer		**Address**	
City, State, Zip		**Contact #**	
Caregiver's Name *(if different from above)*		**Relationship**	
Email Address	☐ Yes ☐ No		
Social Security No.	**DOB**	**Message Contact #**	
Address	☐ Yes ☐ No		
City, State, Zip		**Contact #**	

Child Name:		Child DOB:		Person ID:	

Employer		**Address**	
City, State, Zip		**Contact #**	

Relative Contact Person For Child/Youth (other than parent)

		Contact #	
Relationship			

Child/Youth Siblings:										**In Custody**
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No

State of Tennessee

Child Welfare Benefits Application

Date Received:

IDENTIFYING INFORMATION:

Child's Last Name	First	Middle	Date of Birth	Social Security Number
Race	Sex	Child's County of Venue		Date of Custody
Mother's Last Name	First	Middle	Date of Birth	Social Security Number
Father's Last Name	First	Middle	Date of Birth	Social Security Number

REMOVAL HOME (From whose home the foster child was removed):

Name of Person from whose home the child was removed?	Relationship of person to child:

PLACEMENT INFORMATION (Where the child is placed, outside of the home, because of this situation):

Name of Placement:	Date Entered Placement:

ELIGIBILITY/REIMBURSABILITY:

1. Is the child a U.S. Citizen or Qualified Alien? Yes ☐ No ☐	2. Is the child a Tennessee resident? Yes ☐ No ☐	3. Is the child a Native American? Yes ☐ No ☐

4. DEPRIVATION OF PARENTAL SUPPORT BY CHILD'S LEGAL AND/OR BIOLOGICAL PARENTS:

	MOTHER	**FATHER**
a. Parent living in the home from which the child was removed?	Yes ☐ No ☐	Yes ☐ No ☐
b. Is the child's parent(s) deceased?	Yes ☐ No ☐	Yes ☐ No ☐
	If "yes", date death occurred:	**If "yes", date death occurred:**
c. Parent(s) **disabled (physically/ mentally)?**	Yes ☐ No ☐	Yes ☐ No ☐
d. Parent(s) **unemployed?**	Yes ☐ No ☐	Yes ☐ No ☐

The primary wage earner is the parent with the most earnings over the past 24 months. Who is the primary wage earner?
Mother ☐ Father ☐ Check here if neither parent was a wage earner: ☐

Is the primary wage earner currently unemployed or employed less than 100 hours per month? Yes ☐ No ☐

4A.Was the child living with either or both parents during the month the court proceedings were initiated or the month the Voluntary Placement was signed? Yes ☐ No ☐

If no, list all living arrangements for the six months prior to the month the court proceedings initiated or the month that the Voluntary Placement Agreement was signed, beginning with the child's most recent living arrangements prior to placement and working back.

From	**To**	**Name and Address**	**Relationship**

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.
Distribution: CWB Case File, Copy Child's Record *RDA 2984*

Date Received:

4B. Give the following information on **all** persons (including the foster child) who were living in the home from which the foster child was removed (removal home).

Name	Birth Date	Relationship to Foster Child	Social Security Number

5. **Financial Resources:** Enter information about the foster child's financial resources and income in sections 5 thru 10 below. If the foster child's parent(s), a stepparent or foster child's sibling (whole, half, step sibling) age 18 or younger were also living in the removal home, enter their resources and income in sections 5 thru 10. Do not enter for other persons in the removal home.

Source	Balance	Owner	Bank Name and Address
Cash			
Checking/ Savings			
IRA/CD			
Stocks/Bonds			
Trust Accounts			
Other			

Value and Amount Owed:	Owner:	Location:
Value and Amount Owed:	Owner:	Location:

6. List any vehicles family member or child owns:

Value/Amount/Owed:	Owner:	Model/Year:
Value/Amount/Owed:	Owner:	Model/Year:

7. Income other than wages (Monthly amount or equivalent): Check the (Step box) if the income below is received by a stepparent in the removal home.

	Foster Child	Mother (Step ☐)	Father (Step ☐)	Sibling (Step ☐)	Sibling (Step ☐)
Social Security					
SSI					
Veteran's Benefits					
UC/WC					
Railroad Retirement					
Pension					
Military					
Child Support					
Other					

8. Indicate the child's payee for the above benefits:	Name:	Type of Benefits:
	Name:	Type of Benefits:

9. Current Employer: Check the box in the (Step) column if the wages are received by a stepparent or step sibling.							
	(Step)	**From**	**To**	**Employer Name and Address**	**Gross Wages (amount before deductions)**	**Frequency (weekly, bi-weekly, semi-monthly, yearly)**	**# Hours Worked Per Week**
Child	☐						
Mother	☐						
Father	☐						
Sibling	☐						
Sibling	☐						

Child Care Expenses:

Did the child's parent pay for someone to care for the child so that the child's parent could get to work, training, or look for a job?
Yes ☐ No ☐

If "yes", **Amount Paid**: **Frequency:** ☐ **Weekly** ☐ **Monthly**

Child Care Provider Name and Address:

Phone Number:

Date Received:

10. **Does the child have any physical, emotional, or mental disabilities? Attach copies of the child's Individual Education Plan and psychological report from the child's case manager concerning possible disability.** Yes ☐ No ☐

If yes, briefly describe:

11. Is the child attending school? Yes ☐ No ☐ N/A ☐ Name of school:
If yes, is the attendance: Full Time ☐ Part Time ☐ Grade

12. If the child is 18 and in school, is he/she expected to complete the course of study by age 19? Yes ☐ No ☐ N/A ☐
Expected graduation date:

13. Is the home from which the child was removed receiving adoption support payments on behalf of the child? Yes ☐ No ☐

14. Does the child receive or expect an inheritance or settlement? Yes ☐ No ☐

15. Child Support Information-Non-Custodial Parent Data: (Confirm the parent/foster child relationship is reflected in TFACTS.)

Foster Child's Mother:	Does a "Good Cause" reason exist to not pursue child support from the mother? No ☐ Yes ☐			
Street Address	City	State	Zip	Telephone Number
Is this address valid? Yes ☐ No ☐	Last date at above address			
Employer Name and Address	City	State	Zip	Last date employed
Is mother making child support payments? Yes ☐ No ☐	If yes, indicate: Amount:	Frequency		Last date support was paid

Foster Child's Father:	Does a "Good Cause" reason exist to not pursue child support from the father?: Yes ☐ Legal Parent ☐ Alleged Parent ☐			No ☐
Street Address	City	State	Zip	Telephone Number
Is this address valid? Yes ☐ No ☐	Last date at above address			
Employer Name and Address	City	State	Zip	Last date employed
Is father making child support payments? Yes ☐ No ☐	If yes, indicate: Amount:	Frequency		Last date support was paid

Understanding of DCS Family Services Worker/Authorized Representative/Court Liaison

I understand that information may be submitted to the United States Citizenship and Immigration Services (USCIS) for verification. If the child receives Medicaid, as the child's representative, I assign to the State any other medical benefits the child has as long as the child receives Medicaid. I will cooperate with the Department of Children's Services, the Department of Human Services, the Department of health, and the Tennessee Bureau of Investigation. I authorize the release of information to recover the benefits and investigate fraudulent claims for benefits.

I understand that I will be responsible for reporting changes in living arrangements and other criteria as required within ten (10) days. I certify under penalty of perjury that the information provided is true and correct to the best of my knowledge.

I understand that if I disagree with action taken on this application I may appeal the decision within 90 days of the date notified.

USE OF SOCIAL SECURITY NUMBERS AND COMPUTER MATCHING: An individual applying for benefits must have a Social Security Number or apply for one, as required by PL 97-98. We use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. If those records do not match the information provided on behalf of the child, it may affect whether the child qualifies for benefits.

Family Services Worker/Authorized Representative/Court Liaison	Telephone No	Date

ATTACH APPROPRIATE COURT ORDER(S) AND ALL OTHER PERTINENT INFORMATION

Including copies of: Court Orders, Voluntary Placement Agreements, petitions, birth certificates, and social security card, plus child's Individual Education Plan, psychological reports, Procedure to Establish Good cause, and health insurance card.

Additional comments or information may be added below:

Tennessee Department of Children's Services

Authorization for Release of Information and HIPAA Protected Health Information TO the Department of Children's Services and Notification of Release

This information refers the in the individual whose information is being released.

Name: Last		**First**		**Middle**	
Other Legal Names:					
Address					
City		**State**		**Zip Code**	
SSN		**DOB**		☐ **Male** ☐ **Female**	
Telephone Numbers: Cell	( ) -	**Home**	( ) -	**Work**	( ) -
This form's expiration date is:		**Date not to exceed one year from date of signature on this form. The expiration date should be 90 days from the date of signature if making a onetime request.**			

Name of Provider/School/Entity Releasing Information TO DCS:

_____

Type of Information Requested (check ONLY one) ***You must hand write/type in specific information being requested*:**

1. ☐ **Education records, including transcripts, GED, TCAP, Special Education**
   Specific Information Requested:
2. ☐ **Psychological/Psychiatric/Mental Health Treatment Records, alcohol/drug/substance abuse treatment records, and any associated test results. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
3. ☐ **Medical records, including examinations, laboratory tests, and prescribed treatments. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
4. ☐ **Background/Criminal History Checks, including Polygraph, and Fingerprint Results**
   Specific Information Requested:
5. ☐ **Employment Records**
   Specific Information Requested:
6. ☐ **Personal Finance/Credit History/Insurance Records (as applicable)**
   Specific Information Requested:
7. ☐ **Other**
   Specific Information Requested:

Purpose of the Requested Release/Disclosure:
Check all that apply: ☐ **Arrange/Access Services** ☐ **CPS Investigation** ☐ **Juvenile Court Case**
☐ **Other:** _____

Signature:_____ **Date:**_____

OR

Signature of Authorized Representative*:_____ **Date:**_____

*Authorized Representative means you have legal proof you can act for this person.

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Original Child's case File

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RDA 11016

A. AUTHORIZATION FOR RELEASE TO DCS

☐ **I, _____ hereby authorize release of the information specified on page 1A, to any representative of the Tennessee Department of Children's Services bearing this release or a copy of this release, including any information deemed to be confidential. I hereby direct you as an individual or agency to release this information upon request of said representative. This release is executed with the full knowledge and understanding that the information released is for the official use of the Department of Children's Services. Failure to grant access to the requested information may result in a court order for the information.**

I understand that there are laws and regulations protecting the confidentiality of certain written and oral information such as: Title 33 of the Tenn. Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. My signature indicates I have received a copy of this authorization. I hereby request and authorize the release of records or information as specified on page 2 of this release. I understand I may revoke this authorization in writing at any time, but it will not affect disclosures already made in reliance on this authorization. This release takes effect on the date I signed it.

HIPAA Authorization for Release of Protected Health Information:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand the following: (1) This authorization is voluntary. (2) If the person or organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. (3) My ability to receive health care, eligibility for health care, or the payment for my health care will not be affected if I do not sign this form. (4) I may see and copy the information described on this form if I ask for it, and I get a copy of this form after I sign it. (5) I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do it won't have any effect on actions taken before the revocation was received. (6) Any release made in reliance on this authorization prior to receiving revocation of the release shall not constitute a violation of HIPAA or my confidentiality rights.

I have read this section._____ OR This section was read to me. _____

Initial *Initial*

If the individual who is the subject of the information requested is a Child Under the Age of 18, the Child's Parent(s) or Legal Guardian Must Sign This Release. EXCEPTION: Release of records under category number 2 for a minor age 16 or older, requires the signature of that minor. Release of records under categories 2 and 3 should be signed by the youth, regardless of age, if the youth consented to the health care instead of the parent, guardian, or custodian consenting.

One signature required:

Print Name	*Signature*	*Date*

OR

Name of Authorized Representative (Print)	*Signature of Authorized Representative*	*Date*

Signer's Relationship to client and authority to release confidential information	☐ Self ☐ Parent ☐ Legal Guardian* ☐ Legal Custodian*

☐ **Conservator***	☐ **Personal Representative for HIPAA***	☐ **Other*, specify:**

Proof of authority to release information, such as a court order or Power of Attorney document, must be provided.

Name of Witness (Print)	*Signature of Witness*	*Date*

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Original Child's case File

Tennessee Department of Children's Services

Authorization for Release of Information and HIPAA Protected Health Information FROM the Department of Children's Services and Notification of Release

This information refers the in the individual whose information is being released.

Name: Last		**First**		**Middle**	
Other Legal Names:					
Address					
City		**State**		**Zip Code**	
SSN		**DOB**		☐ **Male** ☐ **Female**	
Telephone Numbers: Cell		**Home**	( ) -	**Work**	( ) -
This form's expiration date is:		**Date not to exceed one year from date of signature on this form. The expiration date should be 90 days from the date of signature if making a onetime request.**			

Name of Provider/School/Entity Receiving Information FROM DCS::

_____

Type of Information Requested (check ONLY one) ***You must hand write in specific information being requested*****:**

1. ☐ **Education records, including transcripts, GED, TCAP, Special Education**
   Specific Information Requested:
2. ☐ **Psychological/Psychiatric/Mental Health Treatment Records, alcohol/drug/substance abuse treatment records, and any associated test results. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
3. ☐ **Medical records, including examinations, laboratory tests, and prescribed treatments. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
4. ☐ **Background/Criminal History Checks, including Polygraph, and Fingerprint Results**
   Specific Information Requested:
5. ☐ **Employment Records**
   Specific Information Requested:
6. ☐ **Personal Finance/Credit History/Insurance Records (as applicable)**
   Specific Information Requested:
7. ☐ **Other**
   Specific Information Requested:

Purpose of the Requested Release/Disclosure:
Check all that apply: ☐ **Arrange/Access Services** ☐ **CPS Investigation** ☐ **Juvenile Court Case**
☐ **Other:** _____

Signature:_____ **Date:**_____

OR

Signature of Authorized Representative*:_____ **Date:**_____

*Authorized Representative means you have legal proof you can act for this person.

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Original Child's case File

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B AUTHORIZATION FOR DCS FROM RELEASE

☐ **I, _____ hereby authorize the Tennessee Department of Children's Services to release the information specified on page 1, to the person/entity specified on page 1B.**

I understand that there are laws and regulations protecting the confidentiality of certain written and oral information such as: Title 33 of the Tenn. Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. My signature indicates I have received a copy of this authorization. I hereby request and authorize the release of records or information as specified on page 2 of this release. I understand I may revoke this authorization in writing at any time, but it will not affect disclosures already made in reliance on this authorization. This release takes effect on the date I signed it.

HIPAA Authorization for Release of Protected Health Information:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand the following: (1) This authorization is voluntary. (2) If the person or organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. (3) My ability to receive health care, eligibility for health care, or the payment for my health care will not be affected if I do not sign this form. (4) I may see and copy the information described on this form if I ask for it, and I get a copy of this form after I sign it. (5) I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do it won't have any effect on actions taken before the revocation was received. (6) Any release made in reliance on this authorization prior to receiving revocation of the release shall not constitute a violation of HIPAA or my confidentiality rights.

I have read this section._____ OR This section was read to me. _____

Initial *Initial*

If the individual who is the subject of the information requested is a Child Under the Age of 18, the Child's Parent(s) or Legal Guardian Must Sign This Release. EXCEPTION: Release of records under category number 2 for a minor age 16 or older, requires the signature of that minor. Release of records under categories 2 and 3 should be signed by the youth, regardless of age, if the youth consented to the health care instead of the parent, guardian, or custodian consenting.

One signature required:

Print Name	*Signature*	*Date*

OR

Name of Authorized Representative (Print)	*Signature of Authorized Representative*	*Date*

Signer's Relationship to client and authority to release confidential information	☐ Self ☐ Parent ☐ Legal Guardian* ☐ Legal Custodian*	
☐ **Conservator***	☐ **Personal Representative for HIPAA***	☐ **Other*, specify:**

Proof of authority to release information, such as a court order or Power of Attorney document, must be provided.

Name of Witness (Print)	*Signature of Witness*	*Date*

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Original Child's case File

The Following form titled Informed Consent for Psychotropic Medication may be removed and destroyed if the child is not on any Psychotropic medication.

Tennessee Department of Children's Services

Informed Consent for Psychotropic Medication

Appointment Date _____ TFACTS Person ID# _____ Home County _____

Child's Name _____ DOB _____

Placement ☐ Foster home ☐ Congregate care facility Facility name _____

☐ Child entering custody on the medication(s) listed below

PLEASE ATTACH PSYCHOTROPIC MEDICATION EVALUATION Form CS-0629 OR EQUIVALENT FORM

Medication (dose, frequency, route) _____

_____

For the treatment of _____

Allergies _____

Any other medication child is taking _____

Prescribing Provider's Name _____ Telephone # _____

Clinic Name _____

Address _____

I have been informed of the recommendation that medication be prescribed as part of my/my child's treatment program. I have been informed of the nature of my/my child's condition, the risks and benefits of treatment with the above medication, of other forms of treatment, as well as the risks of no treatment. My signature below indicates that I have received information explaining the most common side effects of this/these medication(s) but understand that there may be other side effects. I understand that medication is only one aspect of my/my child's overall treatment, and that success and improvement depends on my active involvement and participation in all aspects of the treatment plan developed for me/my child. I also understand that although this medication is expected to be helpful in the treatment of my/my child's condition, there is no absolute guarantee as to the results.
For females: Because this/these medication(s) could be harmful to a developing fetus, I will notify the medical staff immediately if I suspect pregnancy or have plans to attempt pregnancy.

THIS FORM CAN ONLY BE SIGNED BY THE PARENT/GUARDIAN, YOUTH AGE 16 AND OLDER (*at the discretion of the prescribing provider*) OR THE DCS REGIONAL Nurse

Based on the information provided to me:

☐ I give **PERMISSION/CONSENT** to the administration of the above listed medications(s).

☐ I **REFUSE** to allow the administration of the above listed medication(s).

Youth age 16 or older signature_____ Date__ _

Parent/Legal Guardian signature_____ Date___ ___

Print name_____ Relationship_____

Witness #1 Verbal Consent_____ Date_____

Witness #2 Verbal Consent_____ Date_____

Reason parent cannot sign_____

DCS Health Nurse Signature _____ Date_____

Print name_____ Region _____

☐ I have been **NOTIFIED** that consent was given by DCS for the above listed medications(s).

Parent/Legal Guardian signature_____ Date_____

Print name_____ Relationship_____

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.
Distribution: Child's Group Home File

Tennessee Department of Children's Services

Authorization for Routine Health Services for Minors

Name of Child: _ _ __ _ Date of Birth: _ _ _ TFACTS ID: _

Date of Custody: County of Custody: __ _____ Region of Custody: _____

This document verifies that __ _ _ _____ is in the legal custody of the Tennessee Department of Children's Services. The Department of Children's Services, by virtue of the court's order granting legal custody, is authorized to consent to ordinary and/or necessary medical care.

Child/Youth

(The information below must be fully explained to the minor; minor does not sign form)

Routine health services may be provided while you are within the custody of the Tennessee Department of Children's Services. Examples of routine health services are: routine dental procedures including extractions, pelvic exams, blood draws and samples, treatment of communicable disease(s), routine suturing or minor lacerations, x-rays, and other medical procedures not listed generally governed by implied consent guidelines in the community setting. If you choose not to consent, the Department of Children's Services, by virtue of the court's order granting the department legal custody, is authorized to consent to ordinary and/or necessary medical care and/or treatment.

Parent/Guardian

I, ___ __ _____, understand that it may be necessary for the Tennessee Department of Children's Services to provide routine health care to my child while he/she is in the custody of the Department. I understand the meaning of routine with regard to health services as generally outlined above and hereby give my permission to such care. I have also been informed that if I choose not to consent, the Department of Children's Services, by virtue of the court's order granting the department legal custody, is authorized to consent to ordinary and/or necessary medical care and/or treatment.

_____ _____

Parent's or Legal Guardian's Signature *Date*

_____ _____

Witness' Signature *Date*

Based upon refusal of the above named minor's parent or legal guardian to consent to the routine treatment of his/her child while in custody of the Department of Children's Services or because, after diligent efforts to locate, the parent or legal guardian cannot be located, the Department of Children's Services due to its rights and responsibilities as legal custodian is authorized to consent to ordinary and/or necessary medical care and/or treatment.

*** parent refused to sign paperwork at time of removal

☐ No parent available at time of removal

_____ _____

DCS Staff Signature Date

This is the current version of this form. Please disregard all previous versions prior to the date listed below.

Tennessee Department of Children's Services

Medication Transfer

Name_____ _ _ _____ DOB_____

Date_____

The following medications are being sent with this child/youth to a new placement:

Medication and Dosage:	Instruction:	Count:	# Refills
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications collected/counted by: _____

Medication has been sealed by: _____

Signature #1_____ Signature #2_____

Medication has not been sealed ☐

By signing below you are agreeing that all medications and counts are accurate as listed

_____ _____
Signature of Person releasing medications Date

_____ _____
Signature of Transport Person Date

_____ _____
Signature of Person or Parent/Guardian receiving medication Date

Medication has been sealed by medical staff and is being released to parent/guardian. By signing below you are agreeing that you are receiving sealed medications

_____ _____
Signature of parent/guardian receiving sealed medication Date

Note: Some medication may not be in "child proof" containers. Please keep all medications out of the reach of children.

Youth released from a *Youth Development Center* may receive a one month supply of prescription medication sent directly from the pharmacy via UPS. Please check the medication you receive to make sure the type of medication and the dose is correct. Report any errors directly to the pharmacy.

In case of questions, please contact:

_____ _ _____ _____
Sending Staff/Facility/FSW Phone

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Copies: Pages 1-3 – Client
Page 4 –Signed Client Acknowledgement -Case File

Tennessee Department of Children's Services

Authorization for Release of Information and HIPAA Protected Health Information TO the Department of Children's Services and Notification of Release

This information refers the in the individual whose information is being released.

Name: Last		**First**		**Middle**	
Other Legal Names:					
Address					
City		**State**		**Zip Code**	
SSN	- -	**DOB**		☐ **Male** ☐ **Female**	
Telephone Numbers: Cell		**Home**		**Work**	
This form's expiration date is:		**Date not to exceed one year from date of signature on this form. The expiration date should be 90 days from the date of signature if making a onetime request.**			

Name of Provider/School/Entity Releasing Information TO DCS:

_____

Type of Information Requested (check ONLY one) ***You must hand write/type in specific information being requested*****:**

1. ☐ **Education records, including transcripts, GED, TCAP, Special Education**
   Specific Information Requested:
2. ☐ **Psychological/Psychiatric/Mental Health Treatment Records, alcohol/drug/substance abuse treatment records, and any associated test results. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
3. ☐ **Medical records, including examinations, laboratory tests, and prescribed treatments. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
4. ☐ **Background/Criminal History Checks, including Polygraph, and Fingerprint Results**
   Specific Information Requested:
5. ☐ **Employment Records**
   Specific Information Requested:
6. ☐ **Personal Finance/Credit History/Insurance Records (as applicable)**
   Specific Information Requested:
7. ☐ **Other**
   Specific Information Requested:

Purpose of the Requested Release/Disclosure:
Check all that apply: ☐ **Arrange/Access Services** ☐ **CPS Investigation** ☐ **Juvenile Court Case**
☐ **Other:** _____

Signature:_____ **Date:**_____

OR

Signature of Authorized Representative*:_____ **Date:**_____

*Authorized Representative means you have legal proof you can act for this person.

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Copies: Pages 1-3 – Client
Page 4 –Signed Client Acknowledgement -Case File

A. AUTHORIZATION FOR RELEASE TO DCS

☐ **I, _____ hereby authorize release of the information specified on page 1A, to any representative of the Tennessee Department of Children's Services bearing this release or a copy of this release, including any information deemed to be confidential. I hereby direct you as an individual or agency to release this information upon request of said representative. This release is executed with the full knowledge and understanding that the information released is for the official use of the Department of Children's Services. Failure to grant access to the requested information may result in a court order for the information.**

I understand that there are laws and regulations protecting the confidentiality of certain written and oral information such as: Title 33 of the Tenn. Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. My signature indicates I have received a copy of this authorization. I hereby request and authorize the release of records or information as specified on page 2 of this release. I understand I may revoke this authorization in writing at any time, but it will not affect disclosures already made in reliance on this authorization. This release takes effect on the date I signed it.

HIPAA Authorization for Release of Protected Health Information:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand the following: (1) This authorization is voluntary. (2) If the person or organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. (3) My ability to receive health care, eligibility for health care, or the payment for my health care will not be affected if I do not sign this form. (4) I may see and copy the information described on this form if I ask for it, and I get a copy of this form after I sign it. (5) I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do it won't have any effect on actions taken before the revocation was received. (6) Any release made in reliance on this authorization prior to receiving revocation of the release shall not constitute a violation of HIPAA or my confidentiality rights.

I have read this section._____ OR This section was read to me. _____

Initial *Initial*

If the individual who is the subject of the information requested is a Child Under the Age of 18, the Child's Parent(s) or Legal Guardian Must Sign This Release. EXCEPTION: Release of records under category number 2 for a minor age 16 or older, requires the signature of that minor. Release of records under categories 2 and 3 should be signed by the youth, regardless of age, if the youth consented to the health care instead of the parent, guardian, or custodian consenting.

One signature required:

Print Name	*Signature*	*Date*

OR

Name of Authorized Representative (Print)	*Signature of Authorized Representative*	*Date*

Signer's Relationship to client and authority to release confidential information	☐ Self ☐ Parent ☐ Legal Guardian* ☐ Legal Custodian*	
☐ **Conservator***	☐ **Personal Representative for HIPAA***	☐ **Other*, specify:**

Proof of authority to release information, such as a court order or Power of Attorney document, must be provided.

Name of Witness (Print)	*Signature of Witness*	*Date*

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Copies: Pages 1-3 – Client
Page 4 –Signed Client Acknowledgement -Case File

Tennessee Department of Children's Services

Authorization for Release of Information and HIPAA Protected Health Information FROM the Department of Children's Services and Notification of Release

This information refers the in the individual whose information is being released.

Name: Last		**First**		**Middle**	
Other Legal Names:					
Address					
City		**State**		**Zip Code**	
SSN	- -	**DOB**		☐ **Male** ☐ **Female**	
Telephone Numbers: Cell	( ) -	**Home**	( ) -	**Work**	( ) -
This form's expiration date is:		**Date not to exceed one year from date of signature on this form. The expiration date should be 90 days from the date of signature if making a onetime request.**			

Name of Provider/School/Entity Receiving Information FROM DCS::

_____

Type of Information Requested (check ONLY one) ***You must hand write in specific information being requested*:**

1. ☐ **Education records, including transcripts, GED, TCAP, Special Education**
   Specific Information Requested:
2. ☐ **Psychological/Psychiatric/Mental Health Treatment Records, alcohol/drug/substance abuse treatment records, and any associated test results. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
3. ☐ **Medical records, including examinations, laboratory tests, and prescribed treatments. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
4. ☐ **Background/Criminal History Checks, including Polygraph, and Fingerprint Results**
   Specific Information Requested:
5. ☐ **Employment Records**
   Specific Information Requested:
6. ☐ **Personal Finance/Credit History/Insurance Records (as applicable)**
   Specific Information Requested:
7. ☐ **Other**
   Specific Information Requested:

Purpose of the Requested Release/Disclosure:
Check all that apply: ☐ **Arrange/Access Services** ☐ **CPS Investigation** ☐ **Juvenile Court Case**
☐ **Other:** _____

Signature:_____ **Date:**_____

OR

Signature of Authorized Representative*:_____ **Date:**_____

*Authorized Representative means you have legal proof you can act for this person

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Copies: Pages 1-3 – Client
Page 4 –Signed Client Acknowledgement -Case File

B AUTHORIZATION FOR DCS FROM RELEASE

☐ **I, _____ hereby authorize the Tennessee Department of Children's Services to release the information specified on page 1, to the person/entity specified on page 1B.**

I understand that there are laws and regulations protecting the confidentiality of certain written and oral information such as: Title 33 of the Tenn. Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. My signature indicates I have received a copy of this authorization. I hereby request and authorize the release of records or information as specified on page 2 of this release. I understand I may revoke this authorization in writing at any time, but it will not affect disclosures already made in reliance on this authorization. This release takes effect on the date I signed it.

HIPAA Authorization for Release of Protected Health Information:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand the following: (1) This authorization is voluntary. (2) If the person or organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. (3) My ability to receive health care, eligibility for health care, or the payment for my health care will not be affected if I do not sign this form. (4) I may see and copy the information described on this form if I ask for it, and I get a copy of this form after I sign it. (5) I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do it won't have any effect on actions taken before the revocation was received. (6) Any release made in reliance on this authorization prior to receiving revocation of the release shall not constitute a violation of HIPAA or my confidentiality rights.

I have read this section._____ **OR** **This section was read to me. _____**

Initial *Initial*

If the individual who is the subject of the information requested is a Child Under the Age of 18, the Child's Parent(s) or Legal Guardian Must Sign This Release. EXCEPTION: Release of records under category number 2 for a minor age 16 or older, requires the signature of that minor. Release of records under categories 2 and 3 should be signed by the youth, regardless of age, if the youth consented to the health care instead of the parent, guardian, or custodian consenting.

One signature required:

Print Name	*Signature*	*Date*

OR

Name of Authorized Representative (Print)	*Signature of Authorized Representative*	*Date*

Signer's Relationship to client and authority to release confidential information	☐ Self ☐ Parent ☐ Legal Guardian* ☐ Legal Custodian*

☐ **Conservator***	☐ **Personal Representative for HIPAA***	☐ **Other*, specify:**

Proof of authority to release information, such as a court order or Power of Attorney document, must be provided.

Name of Witness (Print)	*Signature of Witness*	*Date*

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Copies: Pages 1-3 – Client
Page 4 –Signed Client Acknowledgement -Case File

Tennessee Department of Children's Services

Authorization for Release of Information and HIPAA Protected Health Information TO the Department of Children's Services and Notification of Release

This information refers the in the individual whose information is being released.

Name: Last		**First**		**Middle**	
Other Legal Names:					
Address					
City		**State**		**Zip Code**	
SSN	- -	**DOB**		☐ **Male** ☐ **Female**	
Telephone Numbers: Cell	( ) -	**Home**	( ) -	**Work**	( ) -
This form's expiration date is:		**Date not to exceed one year from date of signature on this form. The expiration date should be 90 days from the date of signature if making a onetime request.**			

Name of Provider/School/Entity Releasing Information TO DCS:

_____

Type of Information Requested (check ONLY one) ***You must hand write/type in specific information being requested*:**

1. ☐ **Education records, including transcripts, GED, TCAP, Special Education**
   Specific Information Requested:
2. ☐ **Psychological/Psychiatric/Mental Health Treatment Records, alcohol/drug/substance abuse treatment records, and any associated test results. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
3. ☐ **Medical records, including examinations, laboratory tests, and prescribed treatments. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
4. ☐ **Background/Criminal History Checks, including Polygraph, and Fingerprint Results**
   Specific Information Requested:
5. ☐ **Employment Records**
   Specific Information Requested:
6. ☐ **Personal Finance/Credit History/Insurance Records (as applicable)**
   Specific Information Requested:
7. ☐ **Other**
   Specific Information Requested:

Purpose of the Requested Release/Disclosure:
Check all that apply: ☐ **Arrange/Access Services** ☐ **CPS Investigation** ☐ **Juvenile Court Case**
☐ **Other:** _____

Signature:_____ **Date:**_____

OR

Signature of Authorized Representative*:_____ **Date:**_____

*Authorized Representative means you have legal proof you can act for this person.

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Copies: Pages 1-3 – Client
Page 4 –Signed Client Acknowledgement -Case File

A. AUTHORIZATION FOR RELEASE TO DCS

☐ **I, _____ hereby authorize release of the information specified on page 1A, to any representative of the Tennessee Department of Children's Services bearing this release or a copy of this release, including any information deemed to be confidential. I hereby direct you as an individual or agency to release this information upon request of said representative. This release is executed with the full knowledge and understanding that the information released is for the official use of the Department of Children's Services. Failure to grant access to the requested information may result in a court order for the information.**

I understand that there are laws and regulations protecting the confidentiality of certain written and oral information such as: Title 33 of the Tenn. Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. My signature indicates I have received a copy of this authorization. I hereby request and authorize the release of records or information as specified on page 2 of this release. I understand I may revoke this authorization in writing at any time, but it will not affect disclosures already made in reliance on this authorization. This release takes effect on the date I signed it.

HIPAA Authorization for Release of Protected Health Information:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand the following: (1) This authorization is voluntary. (2) If the person or organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. (3) My ability to receive health care, eligibility for health care, or the payment for my health care will not be affected if I do not sign this form. (4) I may see and copy the information described on this form if I ask for it, and I get a copy of this form after I sign it. (5) I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do it won't have any effect on actions taken before the revocation was received. (6) Any release made in reliance on this authorization prior to receiving revocation of the release shall not constitute a violation of HIPAA or my confidentiality rights.

I have read this section._____ OR This section was read to me. _____

Initial *Initial*

If the individual who is the subject of the information requested is a Child Under the Age of 18, the Child's Parent(s) or Legal Guardian Must Sign This Release. EXCEPTION: Release of records under category number 2 for a minor age 16 or older, requires the signature of that minor. Release of records under categories 2 and 3 should be signed by the youth, regardless of age, if the youth consented to the health care instead of the parent, guardian, or custodian consenting.

One signature required:

Print Name	*Signature*	*Date*

OR

Name of Authorized Representative (Print)	*Signature of Authorized Representative*	*Date*

Signer's Relationship to client and authority to release confidential information	☐ Self ☐ Parent ☐ Legal Guardian* ☐ Legal Custodian*	
☐ **Conservator***	☐ **Personal Representative for HIPAA***	☐ **Other*, specify:**

Proof of authority to release information, such as a court order or Power of Attorney document, must be provided.

Name of Witness (Print)	*Signature of Witness*	*Date*

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Copies: Pages 1-3 – Client
Page 4 –Signed Client Acknowledgement -Case File

Tennessee Department of Children's Services

Authorization for Release of Information and HIPAA Protected Health Information FROM the Department of Children's Services and Notification of Release

This information refers the in the individual whose information is being released.

Name: Last		**First**		**Middle**	
Other Legal Names:					
Address					
City		**State**		**Zip Code**	
SSN	- -	**DOB**		☐ **Male** ☐ **Female**	
Telephone Numbers: Cell	( ) -	**Home**	( ) -	**Work**	( ) -
This form's expiration date is:		**Date not to exceed one year from date of signature on this form. The expiration date should be 90 days from the date of signature if making a onetime request.**			

Name of Provider/School/Entity Receiving Information FROM DCS::

_____

Type of Information Requested (check ONLY one) ***You must hand write in specific information being requested*****:**

1. ☐ **Education records, including transcripts, GED, TCAP, Special Education**
   Specific Information Requested:
2. ☐ **Psychological/Psychiatric/Mental Health Treatment Records, alcohol/drug/substance abuse treatment records, and any associated test results. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
3. ☐ **Medical records, including examinations, laboratory tests, and prescribed treatments. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
4. ☐ **Background/Criminal History Checks, including Polygraph, and Fingerprint Results**
   Specific Information Requested:
5. ☐ **Employment Records**
   Specific Information Requested:
6. ☐ **Personal Finance/Credit History/Insurance Records (as applicable)**
   Specific Information Requested:
7. ☐ **Other**
   Specific Information Requested:

Purpose of the Requested Release/Disclosure:
Check all that apply: ☐ **Arrange/Access Services** ☐ **CPS Investigation** ☐ **Juvenile Court Case**
☐ **Other:** _____

Signature:_____ **Date:**_____

OR

Signature of Authorized Representative*:_____ **Date:**_____

*Authorized Representative means you have legal proof you can act for this person.

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Copies: Pages 1-3 – Client
Page 4 –Signed Client Acknowledgement -Case File

B AUTHORIZATION FOR DCS FROM RELEASE

☐ **I, _____ hereby authorize the Tennessee Department of Children's Services to release the information specified on page 1, to the person/entity specified on page 1B.**

I understand that there are laws and regulations protecting the confidentiality of certain written and oral information such as: Title 33 of the Tenn. Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. My signature indicates I have received a copy of this authorization. I hereby request and authorize the release of records or information as specified on page 2 of this release. I understand I may revoke this authorization in writing at any time, but it will not affect disclosures already made in reliance on this authorization. This release takes effect on the date I signed it.

HIPAA Authorization for Release of Protected Health Information:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand the following: (1) This authorization is voluntary. (2) If the person or organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. (3) My ability to receive health care, eligibility for health care, or the payment for my health care will not be affected if I do not sign this form. (4) I may see and copy the information described on this form if I ask for it, and I get a copy of this form after I sign it. (5) I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do it won't have any effect on actions taken before the revocation was received. (6) Any release made in reliance on this authorization prior to receiving revocation of the release shall not constitute a violation of HIPAA or my confidentiality rights.

I have read this section._____ *Initial* **OR This section was read to me. _____** *Initial*

If the individual who is the subject of the information requested is a Child Under the Age of 18, the Child's Parent(s) or Legal Guardian Must Sign This Release. EXCEPTION: Release of records under category number 2 for a minor age 16 or older, requires the signature of that minor. Release of records under categories 2 and 3 should be signed by the youth, regardless of age, if the youth consented to the health care instead of the parent, guardian, or custodian consenting.

One signature required:

_____ _____ _____

Print Name *Signature* *Date*

OR

_____ _____

Name of Authorized Representative (Print) *Signature of Authorized Representative* *Date*

Signer's Relationship to client and authority to release confidential information	☐ Self ☐ Parent ☐ Legal Guardian* ☐ Legal Custodian*

☐ **Conservator***	☐ **Personal Representative for HIPAA***	☐ **Other*, specify:**

Proof of authority to release information, such as a court order or Power of Attorney document, must be provided.

_____ _____

Name of Witness (Print) *Signature of Witness* *Date*

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

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Page 4 –Signed Client Acknowledgement -Case File

Tennessee Department of Children's Services

Authorization for Release of Information and HIPAA Protected Health Information TO the Department of Children's Services and Notification of Release

This information refers the in the individual whose information is being released.

Name: Last		**First**		**Middle**	
Other Legal Names:					
Address					
City		**State**		**Zip Code**	
SSN	- -	**DOB**		☐ **Male** ☐ **Female**	
Telephone Numbers: Cell	( ) -	**Home**	( ) -	**Work**	( ) -
This form's expiration date is:		**Date not to exceed one year from date of signature on this form. The expiration date should be 90 days from the date of signature if making a onetime request.**			

Name of Provider/School/Entity Releasing Information TO DCS:

_____

Type of Information Requested (check ONLY one) ***You must hand write/type in specific information being requested*:**

1. ☐ **Education records, including transcripts, GED, TCAP, Special Education**
   Specific Information Requested:
2. ☐ **Psychological/Psychiatric/Mental Health Treatment Records, alcohol/drug/substance abuse treatment records, and any associated test results. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
3. ☐ **Medical records, including examinations, laboratory tests, and prescribed treatments. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
4. ☐ **Background/Criminal History Checks, including Polygraph, and Fingerprint Results**
   Specific Information Requested:
5. ☐ **Employment Records**
   Specific Information Requested:
6. ☐ **Personal Finance/Credit History/Insurance Records (as applicable)**
   Specific Information Requested:
7. ☐ **Other**
   Specific Information Requested:

Purpose of the Requested Release/Disclosure:
Check all that apply: ☐ **Arrange/Access Services** ☐ **CPS Investigation** ☐ **Juvenile Court Case**
☐ **Other:** _____

Signature:_____ **Date:**_____

OR

Signature of Authorized Representative*:_____ **Date:**_____

*Authorized Representative means you have legal proof you can act for this person.

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

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Page 4 –Signed Client Acknowledgement -Case File

A. AUTHORIZATION FOR RELEASE TO DCS

☐ **I, _____ hereby authorize release of the information specified on page 1A, to any representative of the Tennessee Department of Children's Services bearing this release or a copy of this release, including any information deemed to be confidential. I hereby direct you as an individual or agency to release this information upon request of said representative. This release is executed with the full knowledge and understanding that the information released is for the official use of the Department of Children's Services. Failure to grant access to the requested information may result in a court order for the information.**

I understand that there are laws and regulations protecting the confidentiality of certain written and oral information such as: Title 33 of the Tenn. Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. My signature indicates I have received a copy of this authorization. I hereby request and authorize the release of records or information as specified on page 2 of this release. I understand I may revoke this authorization in writing at any time, but it will not affect disclosures already made in reliance on this authorization. This release takes effect on the date I signed it.

HIPAA Authorization for Release of Protected Health Information:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand the following: (1) This authorization is voluntary. (2) If the person or organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. (3) My ability to receive health care, eligibility for health care, or the payment for my health care will not be affected if I do not sign this form. (4) I may see and copy the information described on this form if I ask for it, and I get a copy of this form after I sign it. (5) I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do it won't have any effect on actions taken before the revocation was received. (6) Any release made in reliance on this authorization prior to receiving revocation of the release shall not constitute a violation of HIPAA or my confidentiality rights.

I have read this section._____ OR This section was read to me. _____

Initial *Initial*

If the individual who is the subject of the information requested is a Child Under the Age of 18, the Child's Parent(s) or Legal Guardian Must Sign This Release. EXCEPTION: Release of records under category number 2 for a minor age 16 or older, requires the signature of that minor. Release of records under categories 2 and 3 should be signed by the youth, regardless of age, if the youth consented to the health care instead of the parent, guardian, or custodian consenting.

One signature required:

Print Name	*Signature*	*Date*

OR

Name of Authorized Representative (Print)	*Signature of Authorized Representative*	*Date*

Signer's Relationship to client and authority to release confidential information	☐ Self ☐ Parent ☐ Legal Guardian* ☐ Legal Custodian*	
☐ **Conservator***	☐ **Personal Representative for HIPAA***	☐ **Other*, specify:**

Proof of authority to release information, such as a court order or Power of Attorney document, must be provided.

Name of Witness (Print)	*Signature of Witness*	*Date*

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Page 4 –Signed Client Acknowledgement -Case File

Tennessee Department of Children's Services

Authorization for Release of Information and HIPAA Protected Health Information FROM the Department of Children's Services and Notification of Release

This information refers the in the individual whose information is being released.

Name: Last		**First**		**Middle**	
Other Legal Names:					
Address					
City		**State**		**Zip Code**	
SSN	- -	**DOB**		☐ **Male** ☐ **Female**	
Telephone Numbers: Cell	( ) -	**Home**	( ) -	**Work**	( ) -
This form's expiration date is:		**Date not to exceed one year from date of signature on this form. The expiration date should be 90 days from the date of signature if making a onetime request.**			

Name of Provider/School/Entity Receiving Information FROM DCS::

_____

Type of Information Requested (check ONLY one) ***You must hand write in specific information being requested*:**

1. ☐ **Education records, including transcripts, GED, TCAP, Special Education**
   Specific Information Requested:
2. ☐ **Psychological/Psychiatric/Mental Health Treatment Records, alcohol/drug/substance abuse treatment records, and any associated test results. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
3. ☐ **Medical records, including examinations, laboratory tests, and prescribed treatments. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
4. ☐ **Background/Criminal History Checks, including Polygraph, and Fingerprint Results**
   Specific Information Requested:
5. ☐ **Employment Records**
   Specific Information Requested:
6. ☐ **Personal Finance/Credit History/Insurance Records (as applicable)**
   Specific Information Requested:
7. ☐ **Other**
   Specific Information Requested:

Purpose of the Requested Release/Disclosure:
Check all that apply: ☐ **Arrange/Access Services** ☐ **CPS Investigation** ☐ **Juvenile Court Case**
☐ **Other:** _____

Signature:_____ **Date:**_____

OR

Signature of Authorized Representative*:_____ **Date:**_____

*Authorized Representative means you have legal proof you can act for this person.

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

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B AUTHORIZATION FOR DCS FROM RELEASE

☐ **I, _____ hereby authorize the Tennessee Department of Children's Services to release the information specified on page 1, to the person/entity specified on page 1B.**

I understand that there are laws and regulations protecting the confidentiality of certain written and oral information such as: Title 33 of the Tenn. Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. My signature indicates I have received a copy of this authorization. I hereby request and authorize the release of records or information as specified on page 2 of this release. I understand I may revoke this authorization in writing at any time, but it will not affect disclosures already made in reliance on this authorization. This release takes effect on the date I signed it.

HIPAA Authorization for Release of Protected Health Information:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand the following: (1) This authorization is voluntary. (2) If the person or organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. (3) My ability to receive health care, eligibility for health care, or the payment for my health care will not be affected if I do not sign this form. (4) I may see and copy the information described on this form if I ask for it, and I get a copy of this form after I sign it. (5) I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do it won't have any effect on actions taken before the revocation was received. (6) Any release made in reliance on this authorization prior to receiving revocation of the release shall not constitute a violation of HIPAA or my confidentiality rights.

I have read this section._____ **OR** **This section was read to me. _____**

Initial *Initial*

If the individual who is the subject of the information requested is a Child Under the Age of 18, the Child's Parent(s) or Legal Guardian Must Sign This Release. EXCEPTION: Release of records under category number 2 for a minor age 16 or older, requires the signature of that minor. Release of records under categories 2 and 3 should be signed by the youth, regardless of age, if the youth consented to the health care instead of the parent, guardian, or custodian consenting.

One signature required:

Print Name	*Signature*	*Date*

OR

Name of Authorized Representative (Print)	*Signature of Authorized Representative*	*Date*

Signer's Relationship to client and authority to release confidential information	☐ Self ☐ Parent ☐ Legal Guardian* ☐ Legal Custodian*

☐ **Conservator***	☐ **Personal Representative for HIPAA***	☐ **Other*, specify:**

Proof of authority to release information, such as a court order or Power of Attorney document, must be provided.

Name of Witness (Print)	*Signature of Witness*	*Date*

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Tennessee Department of Children's Services

Authorization for Release of Information and HIPAA Protected Health Information TO the Department of Children's Services and Notification of Release

This information refers the in the individual whose information is being released.

Name: Last		**First**		**Middle**	
Other Legal Names:					
Address					
City		**State**		**Zip Code**	
SSN	- -	**DOB**		☐ **Male** ☐ **Female**	
Telephone Numbers: Cell	( ) -	**Home**	( ) -	**Work**	( ) -
This form's expiration date is:		**Date not to exceed one year from date of signature on this form. The expiration date should be 90 days from the date of signature if making a onetime request.**			

Name of Provider/School/Entity Releasing Information TO DCS:

_____

Type of Information Requested (check ONLY one) ***You must hand write/type in specific information being requested*:**

1. ☐ **Education records, including transcripts, GED, TCAP, Special Education**
   Specific Information Requested:
2. ☐ **Psychological/Psychiatric/Mental Health Treatment Records, alcohol/drug/substance abuse treatment records, and any associated test results. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
3. ☐ **Medical records, including examinations, laboratory tests, and prescribed treatments. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
4. ☐ **Background/Criminal History Checks, including Polygraph, and Fingerprint Results**
   Specific Information Requested:
5. ☐ **Employment Records**
   Specific Information Requested:
6. ☐ **Personal Finance/Credit History/Insurance Records (as applicable)**
   Specific Information Requested:
7. ☐ **Other**
   Specific Information Requested:

Purpose of the Requested Release/Disclosure:
Check all that apply: ☐ **Arrange/Access Services** ☐ **CPS Investigation** ☐ **Juvenile Court Case**
☐ **Other:** _____

Signature:_____ **Date:**_____

OR

Signature of Authorized Representative*:_____ **Date:**_____

*Authorized Representative means you have legal proof you can act for this person.

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

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A. AUTHORIZATION FOR RELEASE TO DCS

☐ **I, _____ hereby authorize release of the information specified on page 1A, to any representative of the Tennessee Department of Children's Services bearing this release or a copy of this release, including any information deemed to be confidential. I hereby direct you as an individual or agency to release this information upon request of said representative. This release is executed with the full knowledge and understanding that the information released is for the official use of the Department of Children's Services. Failure to grant access to the requested information may result in a court order for the information.**

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HIPAA Authorization for Release of Protected Health Information:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand the following: (1) This authorization is voluntary. (2) If the person or organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. (3) My ability to receive health care, eligibility for health care, or the payment for my health care will not be affected if I do not sign this form. (4) I may see and copy the information described on this form if I ask for it, and I get a copy of this form after I sign it. (5) I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do it won't have any effect on actions taken before the revocation was received. (6) Any release made in reliance on this authorization prior to receiving revocation of the release shall not constitute a violation of HIPAA or my confidentiality rights.

I have read this section._____ OR This section was read to me. _____

Initial *Initial*

If the individual who is the subject of the information requested is a Child Under the Age of 18, the Child's Parent(s) or Legal Guardian Must Sign This Release. EXCEPTION: Release of records under category number 2 for a minor age 16 or older, requires the signature of that minor. Release of records under categories 2 and 3 should be signed by the youth, regardless of age, if the youth consented to the health care instead of the parent, guardian, or custodian consenting.

One signature required:

Print Name	*Signature*	*Date*

OR

Name of Authorized Representative (Print)	*Signature of Authorized Representative*	*Date*

Signer's Relationship to client and authority to release confidential information	☐ Self ☐ Parent ☐ Legal Guardian* ☐ Legal Custodian*	
☐ **Conservator***	☐ **Personal Representative for HIPAA***	☐ **Other*, specify:**

Proof of authority to release information, such as a court order or Power of Attorney document, must be provided.

Name of Witness (Print)	*Signature of Witness*	*Date*

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Tennessee Department of Children's Services

Authorization for Release of Information and HIPAA Protected Health Information FROM the Department of Children's Services and Notification of Release

This information refers the in the individual whose information is being released.

Name: Last		**First**		**Middle**	
Other Legal Names:					
Address					
City		**State**		**Zip Code**	
SSN	- -	**DOB**		☐ **Male** ☐ **Female**	
Telephone Numbers: Cell	( ) -	**Home**	( ) -	**Work**	( ) -
This form's expiration date is:		**Date not to exceed one year from date of signature on this form. The expiration date should be 90 days from the date of signature if making a onetime request.**			

Name of Provider/School/Entity Receiving Information FROM DCS::

_____

Type of Information Requested (check ONLY one) ***You must hand write in specific information being requested*:**

1. ☐ **Education records, including transcripts, GED, TCAP, Special Education**
   Specific Information Requested:
2. ☐ **Psychological/Psychiatric/Mental Health Treatment Records, alcohol/drug/substance abuse treatment records, and any associated test results. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
3. ☐ **Medical records, including examinations, laboratory tests, and prescribed treatments. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
4. ☐ **Background/Criminal History Checks, including Polygraph, and Fingerprint Results**
   Specific Information Requested:
5. ☐ **Employment Records**
   Specific Information Requested:
6. ☐ **Personal Finance/Credit History/Insurance Records (as applicable)**
   Specific Information Requested:
7. ☐ **Other**
   Specific Information Requested:

Purpose of the Requested Release/Disclosure:
Check all that apply: ☐ **Arrange/Access Services** ☐ **CPS Investigation** ☐ **Juvenile Court Case**
☐ **Other:** _____

Signature:_____ **Date:**_____

OR

Signature of Authorized Representative*:_____ **Date:**_____

*Authorized Representative means you have legal proof you can act for this person.

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Copies: Pages 1-3 – Client
Page 4 –Signed Client Acknowledgement -Case File

B AUTHORIZATION FOR DCS FROM RELEASE

☐ **I, _____ hereby authorize the Tennessee Department of Children's Services to release the information specified on page 1, to the person/entity specified on page 1B.**

I understand that there are laws and regulations protecting the confidentiality of certain written and oral information such as: Title 33 of the Tenn. Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. My signature indicates I have received a copy of this authorization. I hereby request and authorize the release of records or information as specified on page 2 of this release. I understand I may revoke this authorization in writing at any time, but it will not affect disclosures already made in reliance on this authorization. This release takes effect on the date I signed it.

HIPAA Authorization for Release of Protected Health Information:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand the following: (1) This authorization is voluntary. (2) If the person or organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. (3) My ability to receive health care, eligibility for health care, or the payment for my health care will not be affected if I do not sign this form. (4) I may see and copy the information described on this form if I ask for it, and I get a copy of this form after I sign it. (5) I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do it won't have any effect on actions taken before the revocation was received. (6) Any release made in reliance on this authorization prior to receiving revocation of the release shall not constitute a violation of HIPAA or my confidentiality rights.

I have read this section._____ **OR** **This section was read to me. _____**

Initial *Initial*

If the individual who is the subject of the information requested is a Child Under the Age of 18, the Child's Parent(s) or Legal Guardian Must Sign This Release. EXCEPTION: Release of records under category number 2 for a minor age 16 or older, requires the signature of that minor. Release of records under categories 2 and 3 should be signed by the youth, regardless of age, if the youth consented to the health care instead of the parent, guardian, or custodian consenting.

One signature required:

Print Name	*Signature*	*Date*

OR

Name of Authorized Representative (Print)	*Signature of Authorized Representative*	*Date*

Signer's Relationship to client and authority to release confidential information	☐ Self ☐ Parent ☐ Legal Guardian* ☐ Legal Custodian*

☐ **Conservator***	☐ **Personal Representative for HIPAA***	☐ **Other*, specify:**

Proof of authority to release information, such as a court order or Power of Attorney document, must be provided.

Name of Witness (Print)	*Signature of Witness*	*Date*

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

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Page 4 –Signed Client Acknowledgement -Case File

Tennessee Department of Children's Services

Authorization for Release of Information and HIPAA Protected Health Information TO the Department of Children's Services and Notification of Release

This information refers the in the individual whose information is being released.

Name: Last		**First**		**Middle**	
Other Legal Names:					
Address					
City		**State**		**Zip Code**	
SSN	- -	**DOB**		☐ **Male** ☐ **Female**	
Telephone Numbers: Cell	( ) -	**Home**	( ) -	**Work**	( ) -
This form's expiration date is:		**Date not to exceed one year from date of signature on this form. The expiration date should be 90 days from the date of signature if making a onetime request.**			

Name of Provider/School/Entity Releasing Information TO DCS:

_____

Type of Information Requested (check ONLY one) ***You must hand write/type in specific information being requested*:**

1. ☐ **Education records, including transcripts, GED, TCAP, Special Education**
   Specific Information Requested:
2. ☐ **Psychological/Psychiatric/Mental Health Treatment Records, alcohol/drug/substance abuse treatment records, and any associated test results. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
3. ☐ **Medical records, including examinations, laboratory tests, and prescribed treatments. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
4. ☐ **Background/Criminal History Checks, including Polygraph, and Fingerprint Results**
   Specific Information Requested:
5. ☐ **Employment Records**
   Specific Information Requested:
6. ☐ **Personal Finance/Credit History/Insurance Records (as applicable)**
   Specific Information Requested:
7. ☐ **Other**
   Specific Information Requested:

Purpose of the Requested Release/Disclosure:
Check all that apply: ☐ **Arrange/Access Services** ☐ **CPS Investigation** ☐ **Juvenile Court Case**
☐ **Other:** _____

Signature:_____ **Date:**_____

OR

Signature of Authorized Representative*:_____ **Date:**_____

*Authorized Representative means you have legal proof you can act for this person.

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Copies: Pages 1-3 – Client
Page 4 –Signed Client Acknowledgement -Case File

A. AUTHORIZATION FOR RELEASE TO DCS

☐ **I, _____ hereby authorize release of the information specified on page 1A, to any representative of the Tennessee Department of Children's Services bearing this release or a copy of this release, including any information deemed to be confidential. I hereby direct you as an individual or agency to release this information upon request of said representative. This release is executed with the full knowledge and understanding that the information released is for the official use of the Department of Children's Services. Failure to grant access to the requested information may result in a court order for the information.**

I understand that there are laws and regulations protecting the confidentiality of certain written and oral information such as: Title 33 of the Tenn. Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. My signature indicates I have received a copy of this authorization. I hereby request and authorize the release of records or information as specified on page 2 of this release. I understand I may revoke this authorization in writing at any time, but it will not affect disclosures already made in reliance on this authorization. This release takes effect on the date I signed it.

HIPAA Authorization for Release of Protected Health Information:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand the following: (1) This authorization is voluntary. (2) If the person or organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. (3) My ability to receive health care, eligibility for health care, or the payment for my health care will not be affected if I do not sign this form. (4) I may see and copy the information described on this form if I ask for it, and I get a copy of this form after I sign it. (5) I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do it won't have any effect on actions taken before the revocation was received. (6) Any release made in reliance on this authorization prior to receiving revocation of the release shall not constitute a violation of HIPAA or my confidentiality rights.

I have read this section._____ OR This section was read to me. _____

Initial *Initial*

If the individual who is the subject of the information requested is a Child Under the Age of 18, the Child's Parent(s) or Legal Guardian Must Sign This Release. EXCEPTION: Release of records under category number 2 for a minor age 16 or older, requires the signature of that minor. Release of records under categories 2 and 3 should be signed by the youth, regardless of age, if the youth consented to the health care instead of the parent, guardian, or custodian consenting.

One signature required:

Print Name	*Signature*	*Date*

OR

Name of Authorized Representative (Print)	*Signature of Authorized Representative*	*Date*

Signer's Relationship to client and authority to release confidential information	☐ Self ☐ Parent ☐ Legal Guardian* ☐ Legal Custodian*	
☐ **Conservator***	☐ **Personal Representative for HIPAA***	☐ **Other*, specify:**

Proof of authority to release information, such as a court order or Power of Attorney document, must be provided.

Name of Witness (Print)	*Signature of Witness*	*Date*

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Copies: Pages 1-3 – Client
Page 4 –Signed Client Acknowledgement -Case File

Tennessee Department of Children's Services

Authorization for Release of Information and HIPAA Protected Health Information FROM the Department of Children's Services and Notification of Release

This information refers the in the individual whose information is being released.

Name: Last		**First**		**Middle**	
Other Legal Names:					
Address					
City		**State**		**Zip Code**	
SSN	- -	**DOB**		☐ **Male** ☐ **Female**	
Telephone Numbers: Cell	( ) -	**Home**	( ) -	**Work**	( ) -
This form's expiration date is:		**Date not to exceed one year from date of signature on this form. The expiration date should be 90 days from the date of signature if making a onetime request.**			

Name of Provider/School/Entity Receiving Information FROM DCS::

_____

Type of Information Requested (check ONLY one) ***You must hand write in specific information being requested*:**

1. ☐ **Education records, including transcripts, GED, TCAP, Special Education**
   Specific Information Requested:
2. ☐ **Psychological/Psychiatric/Mental Health Treatment Records, alcohol/drug/substance abuse treatment records, and any associated test results. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
3. ☐ **Medical records, including examinations, laboratory tests, and prescribed treatments. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
4. ☐ **Background/Criminal History Checks, including Polygraph, and Fingerprint Results**
   Specific Information Requested:
5. ☐ **Employment Records**
   Specific Information Requested:
6. ☐ **Personal Finance/Credit History/Insurance Records (as applicable)**
   Specific Information Requested:
7. ☐ **Other**
   Specific Information Requested:

Purpose of the Requested Release/Disclosure:
Check all that apply: ☐ **Arrange/Access Services** ☐ **CPS Investigation** ☐ **Juvenile Court Case**
☐ **Other:** _____

Signature:_____ **Date:**_____

OR

Signature of Authorized Representative*:_____ **Date:**_____

*Authorized Representative means you have legal proof you can act for this person.

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

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Page 4 –Signed Client Acknowledgement -Case File

B AUTHORIZATION FOR DCS FROM RELEASE

☐ **I, _____ hereby authorize the Tennessee Department of Children's Services to release the information specified on page 1, to the person/entity specified on page 1B.**

I understand that there are laws and regulations protecting the confidentiality of certain written and oral information such as: Title 33 of the Tenn. Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. My signature indicates I have received a copy of this authorization. I hereby request and authorize the release of records or information as specified on page 2 of this release. I understand I may revoke this authorization in writing at any time, but it will not affect disclosures already made in reliance on this authorization. This release takes effect on the date I signed it.

HIPAA Authorization for Release of Protected Health Information:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand the following: (1) This authorization is voluntary. (2) If the person or organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. (3) My ability to receive health care, eligibility for health care, or the payment for my health care will not be affected if I do not sign this form. (4) I may see and copy the information described on this form if I ask for it, and I get a copy of this form after I sign it. (5) I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do it won't have any effect on actions taken before the revocation was received. (6) Any release made in reliance on this authorization prior to receiving revocation of the release shall not constitute a violation of HIPAA or my confidentiality rights.

I have read this section._____ OR This section was read to me. _____

Initial *Initial*

If the individual who is the subject of the information requested is a Child Under the Age of 18, the Child's Parent(s) or Legal Guardian Must Sign This Release. EXCEPTION: Release of records under category number 2 for a minor age 16 or older, requires the signature of that minor. Release of records under categories 2 and 3 should be signed by the youth, regardless of age, if the youth consented to the health care instead of the parent, guardian, or custodian consenting.

One signature required:

_____ _____ _____

Print Name *Signature* *Date*

OR

_____ _____

Name of Authorized Representative (Print) *Signature of Authorized Representative* *Date*

Signer's Relationship to client and authority to release confidential information	☐ Self ☐ Parent ☐ Legal Guardian* ☐ Legal Custodian*

☐ **Conservator***	☐ **Personal Representative for HIPAA***	☐ **Other*, specify:**

Proof of authority to release information, such as a court order or Power of Attorney document, must be provided.

_____ _____

Name of Witness (Print) *Signature of Witness* *Date*

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

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Page 4 –Signed Client Acknowledgement -Case File

Tennessee Department of Children's Services

Authorization for Release of Information to the Department of Children's Services: TennCare Eligibility and Authorization for the Department of Children's Services to Release Information to TennCare

I hereby authorize representatives of the Tennessee Department of Children's Services, to include only the Health Advocacy Unit, Fiscal Team, Child-Benefit workers and case managers with applicable authority, bearing this release, or a copy of same, to obtain ONLY confidential TennCare **eligibility** information from your files. I hereby direct you as an individual or agency to release this information upon request of said representative. This release is executed with the full knowledge and understanding that the information released is for the official use of the Department of Children's Services within the scope of providing services to children.

I also authorize DCS to release the following information to TennCare or auditors of TennCare services, for the purpose of arranging, accessing, or obtaining services for my child, or proving that services were provided to my child: Child's name, SSN, DOB, Medicaid number, and diagnosis: type of service provided, provider information, and proof that the service was provided.

It has been explained to me, and I understand that there are statutes and regulations protecting the confidentiality of certain written and oral record information and that by signing this authorization only my eligibility status in TennCare will be released – no other TennCare records will be released for me. I can revoke my consent at any time. Should I choose to revoke this consent, I understand that the revocation must be in writing to be effective. I also understand that any release which has been made prior to my written revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization is valid until such request is fulfilled, but not to exceed one year from date of my signature. I understand that I may ask and receive a copy of this authorization. I hereby request and authorize the release of ONLY confidential TennCare **eligibility** information.

Identifying Information of Individual to Whom this Release Pertains:

Name: Last		**First**		**Middle**	
Address					
City		**State**		**Zip Code**	
SSN		**DOB**		**Place of Birth**	☐ **Male** ☐ **Female**
Telephone Numbers: Home	( ) -	**Work**	( ) -	**Cell**	( ) -
This form is effective from:	**Date:**	**to**	**Date:**		

Date not to exceed one year from begin date.

Signature: _____ **Date:** _____

Signature of Authorized Representative*: _____

Witness: _____ **Date:** _____

*Authorized Representative means you have legal proof you can act for this person. A representative signs for an applicant who may or may not legally sign on his or her own. We may have to get this proof from you.

****

☐ **Unable to locate requested Information** ☐ **Requested information could not be released**

Reason			
Information released by		**Date**	
DCS Contact Person		**Telephone Number**	
DCS Office Address			

DCS Staff Requesting Release of TennCare Eligibility Info: _____ **Date:** _____

DCS Staff Who Accessed TennCare Eligibility Info: _____ **Date:** _____

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

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Identifying Information of Individual to Whom this Release Pertains:

Name: Last		**First**		**Middle**	
Address					
City		**State**		**Zip Code**	
SSN		**DOB**		**Place of Birth**		☐ **Male** ☐ **Female**
Telephone Numbers: Home	( ) -	**Work**	( ) -	**Cell**	
This form is effective from:	**Date:**	**to**	**Date:**		

Date not to exceed one year from begin date.

Signature: _____ **Date:** _____

Signature of Authorized Representative*: _____

Witness: _____ **Date:** _____

*Authorized Representative means you have legal proof you can act for this person. A representative signs for an applicant who may or may not legally sign on his or her own. We may have to get this proof from you.

****

☐ **Unable to locate requested Information** ☐ **Requested information could not be released**

Reason			
Information released by		**Date**	
DCS Contact Person		**Telephone Number**	
DCS Office Address			

DCS Staff Requesting Release of TennCare Eligibility Info: _____ **Date:** _____

DCS Staff Who Accessed TennCare Eligibility Info: _____ **Date:** _____

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Tennessee Department of Children's Services

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I also authorize DCS to release the following information to TennCare or auditors of TennCare services, for the purpose of arranging, accessing, or obtaining services for my child, or proving that services were provided to my child: Child's name, SSN, DOB, Medicaid number, and diagnosis: type of service provided, provider information, and proof that the service was provided.

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Identifying Information of Individual to Whom this Release Pertains:

Name: Last		**First**		**Middle**	
Address					
City		**State**		**Zip Code**	
SSN		**DOB**		**Place of Birth**	☐ Male ☐ Female
Telephone Numbers: Home	( ) -	**Work**	( ) -	**Cell**	
This form is effective from:	**Date:**	**to**	**Date:**		

Date not to exceed one year from begin date.

Signature: _____ **Date:** _____

Signature of Authorized Representative*: _____

Witness: _____ **Date:** _____

*Authorized Representative means you have legal proof you can act for this person. A representative signs for an applicant who may or may not legally sign on his or her own. We may have to get this proof from you.

****

☐ **Unable to locate requested Information** ☐ **Requested information could not be released**

Reason			
Information released by		**Date**	
DCS Contact Person		**Telephone Number**	
DCS Office Address			

DCS Staff Requesting Release of TennCare Eligibility Info: _____ **Date:** _____

DCS Staff Who Accessed TennCare Eligibility Info: _____ **Date:** _____

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I also authorize DCS to release the following information to TennCare or auditors of TennCare services, for the purpose of arranging, accessing, or obtaining services for my child, or proving that services were provided to my child: Child's name, SSN, DOB, Medicaid number, and diagnosis: type of service provided, provider information, and proof that the service was provided.

It has been explained to me, and I understand that there are statutes and regulations protecting the confidentiality of certain written and oral record information and that by signing this authorization only my eligibility status in TennCare will be released – no other TennCare records will be released for me. I can revoke my consent at any time. Should I choose to revoke this consent, I understand that the revocation must be in writing to be effective. I also understand that any release which has been made prior to my written revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization is valid until such request is fulfilled, but not to exceed one year from date of my signature. I understand that I may ask and receive a copy of this authorization. I hereby request and authorize the release of ONLY confidential TennCare **eligibility** information.

Identifying Information of Individual to Whom this Release Pertains:

Name: Last		**First**		**Middle**	
Address					
City		**State**		**Zip Code**	
SSN		**DOB**		**Place of Birth**		☐ **Male** ☐ **Female**
Telephone Numbers: Home	( ) -	**Work**	( ) -	**Cell**	
This form is effective from:	**Date:**	**to**	**Date:**		

Date not to exceed one year from begin date.

Signature: _____ **Date:** _____

Signature of Authorized Representative*: _____

Witness: _____ **Date:** _____

*Authorized Representative means you have legal proof you can act for this person. A representative signs for an applicant who may or may not legally sign on his or her own. We may have to get this proof from you.

****

☐ **Unable to locate requested Information** ☐ **Requested information could not be released**

Reason			
Information released by		**Date**	
DCS Contact Person		**Telephone Number**	
DCS Office Address			

DCS Staff Requesting Release of TennCare Eligibility Info: _____ **Date:** _____

DCS Staff Who Accessed TennCare Eligibility Info: _____ **Date:** _____

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Tennessee Department of Children's Services

Authorization for Release of Information to the Department of Children's Services: TennCare Eligibility and Authorization for the Department of Children's Services to Release Information to TennCare

I hereby authorize representatives of the Tennessee Department of Children's Services, to include only the Health Advocacy Unit, Fiscal Team, Child-Benefit workers and case managers with applicable authority, bearing this release, or a copy of same, to obtain ONLY confidential TennCare **eligibility** information from your files. I hereby direct you as an individual or agency to release this information upon request of said representative. This release is executed with the full knowledge and understanding that the information released is for the official use of the Department of Children's Services within the scope of providing services to children.

I also authorize DCS to release the following information to TennCare or auditors of TennCare services, for the purpose of arranging, accessing, or obtaining services for my child, or proving that services were provided to my child: Child's name, SSN, DOB, Medicaid number, and diagnosis: type of service provided, provider information, and proof that the service was provided.

It has been explained to me, and I understand that there are statutes and regulations protecting the confidentiality of certain written and oral record information and that by signing this authorization only my eligibility status in TennCare will be released – no other TennCare records will be released for me. I can revoke my consent at any time. Should I choose to revoke this consent, I understand that the revocation must be in writing to be effective. I also understand that any release which has been made prior to my written revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization is valid until such request is fulfilled, but not to exceed one year from date of my signature. I understand that I may ask and receive a copy of this authorization. I hereby request and authorize the release of ONLY confidential TennCare **eligibility** information.

Identifying Information of Individual to Whom this Release Pertains:

Name: Last		**First**		**Middle**	
Address					
City		**State**		**Zip Code**	
SSN		**DOB**		**Place of Birth**	☐ **Male** ☐ **Female**
Telephone Numbers: Home	( ) -	**Work**	( ) -	**Cell**	
This form is effective from:	**Date:**	**to**	**Date:**		

Date not to exceed one year from begin date.

Signature: _____ **Date:** _____

Signature of Authorized Representative*: _____

Witness: _____ **Date:** _____

*Authorized Representative means you have legal proof you can act for this person. A representative signs for an applicant who may or may not legally sign on his or her own. We may have to get this proof from you.

****

☐ **Unable to locate requested Information** ☐ **Requested information could not be released**

Reason			
Information released by		**Date**	
DCS Contact Person		**Telephone Number**	
DCS Office Address			

DCS Staff Requesting Release of TennCare Eligibility Info: _____ **Date:** _____

DCS Staff Who Accessed TennCare Eligibility Info: _____ **Date:** _____

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Distribution: Copies: Pages 1-3 – Client
Page 4 –Signed Client Acknowledgement -Case File

Tennessee Department of Children's Services

Authorization for Release of Information to the Department of Children's Services: TennCare Eligibility and Authorization for the Department of Children's Services to Release Information to TennCare

I hereby authorize representatives of the Tennessee Department of Children's Services, to include only the Health Advocacy Unit, Fiscal Team, Child-Benefit workers and case managers with applicable authority, bearing this release, or a copy of same, to obtain ONLY confidential TennCare **eligibility** information from your files. I hereby direct you as an individual or agency to release this information upon request of said representative. This release is executed with the full knowledge and understanding that the information released is for the official use of the Department of Children's Services within the scope of providing services to children.

I also authorize DCS to release the following information to TennCare or auditors of TennCare services, for the purpose of arranging, accessing, or obtaining services for my child, or proving that services were provided to my child: Child's name, SSN, DOB, Medicaid number, and diagnosis: type of service provided, provider information, and proof that the service was provided.

It has been explained to me, and I understand that there are statutes and regulations protecting the confidentiality of certain written and oral record information and that by signing this authorization only my eligibility status in TennCare will be released – no other TennCare records will be released for me. I can revoke my consent at any time. Should I choose to revoke this consent, I understand that the revocation must be in writing to be effective. I also understand that any release which has been made prior to my written revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization is valid until such request is fulfilled, but not to exceed one year from date of my signature. I understand that I may ask and receive a copy of this authorization. I hereby request and authorize the release of ONLY confidential TennCare **eligibility** information.

Identifying Information of Individual to Whom this Release Pertains:

Name: Last		**First**		**Middle**	
Address					
City		**State**		**Zip Code**	
SSN		**DOB**		**Place of Birth**	☐ Male ☐ Female
Telephone Numbers: Home	( ) -	**Work**	( ) -	**Cell**	( ) -
This form is effective from:	**Date:**	**to**	**Date:**		

Date not to exceed one year from begin date.

Signature: _____ **Date:** _____

Signature of Authorized Representative*: _____

Witness: _____ **Date:** _____

*Authorized Representative means you have legal proof you can act for this person. A representative signs for an applicant who may or may not legally sign on his or her own. We may have to get this proof from you.

****

☐ **Unable to locate requested Information** ☐ **Requested information could not be released**

Reason			
Information released by		**Date**	
DCS Contact Person		**Telephone Number**	
DCS Office Address			

DCS Staff Requesting Release of TennCare Eligibility Info: _____ **Date:** _____

DCS Staff Who Accessed TennCare Eligibility Info: _____ **Date:** _____

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Telephone Numbers: Home	( ) -	**Work**	( ) -	**Cell**	( ) -
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SSN		**DOB**		**Place of Birth**	☐ **Male** ☐ **Female**
Telephone Numbers: Home	( ) -	**Work**	( ) -	**Cell**	( ) -
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Tennessee Department of Children's Services

Kinship Exception Request

PART 1---FAMILY INFORMATION

Date: Family Case Name: Case #:

Child's Name	Date of Birth	Race	Sex	Special Needs

PART 2---PARTIES RESPONSIBLE FOR COMPLETING KINSHIP EXCEPTION REQUEST

Requesting Case Manager:		☐ CPS	☐ FSW
Region:		County:	
Reviewing Team Leader/Team Coordinator:		Date Reviewed:	

☐ KER APPROVED ☐ KER DENIED

Date consult note/form entered into TFACTS:				
Signature of KER Approver:			Date:	
Other Information/Regional Protocol Requirements:				

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Tennessee Department of Children's Services

Contact Sheets for Genogram

Child Name:		DOB:	
Initiated by:		Date:	

Genogram

Relationship	Name	Phone	Address	Diligent Search Searching, Notified, or N/A	Comments (Include dates of Marriages and Divorces)		
Birth Mother							
Birth Father							
Legal Father							
Putative Father							
Other Parent							
Family Relationship	Name	Phone	Address	Diligent Search Searching, Notified, or N/A	Placement Option? Permanent, Temporary, or Not Option	Barrier Code	Comments
Step Mother							
Step Father							
Paramour							
Maternal Grandmother							
Maternal Grandfather							
Maternal Aunt/Uncle							
Maternal Aunt/Uncle							
Maternal Aunt/Uncle							
Maternal Aunt/Uncle							
Maternal Cousin							
Maternal Cousin							

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Paternal Grandmother							
Paternal Grandfather							
Paternal Aunt/Uncle							
Paternal Aunt/Uncle							
Paternal Aunt/Uncle							
Paternal Aunt/Uncle							
Paternal Cousin							
Paternal Cousin							
Adult Sibling							
Adult Sibling							
Sibling's Parents							
Other Relatives							

Barrier	Code	Barrier	Code	Barrier	Code
Removal Home/Failure to Protect	1	Failed Expedited Study (Policy 16.20)	9	Lives Out of State/Country	17
Domestic Violence	2	Inadequate Finances, Space, Housing	10	Undocumented Immigrant	18
Alleged Child Perpetrator	3	Lack of Transportation	11	Deported	19
Verified/Reported Sexual Offender	4	Serious Health/Mental Health Issue	12	Incarcerated	20
Failed Backgrond Checks	5	Unable to Provide Adequate Supervision	13	Unable to Locate	21
Unwaivable DCS/Criminal History	6	Under Age 18	14	Deceased	22
Court Order Restriction or Violation	7	Waivable DCS/Criminal History	15	Resource Unwilling	23
Failed Drug Screen/Abuse/Addiction	8	No Significant Relationship to Child	16	Other: Specify	24

Ecomap

Community Support	Name/Agency	Phone	Address	Contacts/Important People to child/youth/family	Dates Attended/Services Delivered
Neighbors					
Neighbors					
Neighbors					
Neighbors					
School Personnel					
School Personnel					
School Personnel					
School Personnel					

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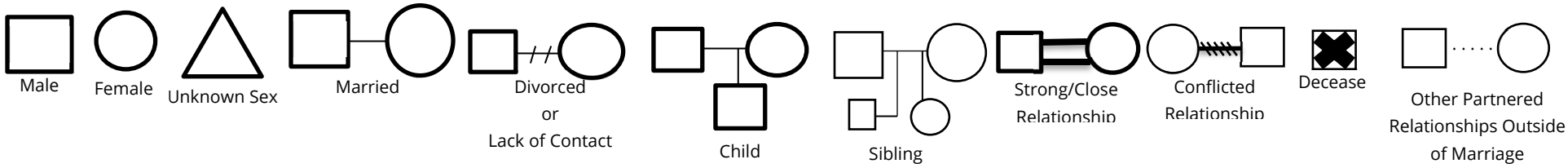
Church Friends					
Church Friends					
Church Friends					
Church Friends					
Community Friends					
Community Friends					
Community Friends					
Community Friends					
Others					
Others					

Genogram Drawing (Optional)



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BlueCare Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402
bluecare.bcbst.com

SelectKids TennCare*Select*

IMMEDIATE ELIGIBILITY FORM

What Is the Purpose of This Form?

The purpose of this form is to determine whether a child entering the custody of Tennessee's Department of Children's Services (DCS) is eligible for immediate access to TennCare℠ benefits. This form is to be filled out by a DCS representative. It must be completed in full and faxed to: SelectKids Unit at 1-800-330-2842. Need help? Call 1-800-451-9147.

Date of DCS Custody: _____ ☐ Youth Development Center

PART 1: DCS Health Advocate Rep Information

Name: _____ Phone Number: _____

Fax Number: _____

Address: (Street/City/State/ZIP) _____

PART 2: Child/Applicant Information

Social Security number: _____ Name: _____

Primary Language: _____

Race:

☐ Black/African-American ☐ American Indian ☐ Native Hawaiian
☐ White ☐ Alaskan Native ☐ Other Pacific Islander
☐ Unavailable/Unknown ☐ Asian ☐ Decline

Is the child/applicant Hispanic/Latino? ☐ Yes ☐ No

Date of Birth: _____ Sex: ☐ Female ☐ Male

County of Commitment: _____ County of Placement: _____

PART 3:

For Case Management, please call **1-888-416-3025**.

PART 4: Provider and Other Insurance Information

Primary Care Provider of Choice: _____ Provider Number: _____

Other Insurance (besides TennCare): ☐ Yes ☐ No

Name of Insurance Carrier: _____ Effective Date: _____

Name of Policy Holder: _____ ID Number: _____

CERTIFICATION: *I certify that the information on this form is true and correct to the best knowledge of DCS. I understand that the eligibility must still be processed through the Child Benefit Worker. The Bureau of TennCare determines the eligibility.*

Signature: _____ Date: _____
(month/day/year)

Tennessee Department of Children's Services

Consent for Vaccination

Name of Child: _____ Date of Birth: _____ TFACTS ID: _____

Date of Custody: _____ County of Custody: _____ Region of Custody: _____

This document verifies that _____ is in the legal custody of the Tennessee Department of Children's Services.

Parent/Guardian

I, _____, understand that the Tennessee Department of Children's Services is requesting my permission to provide, request and/or facilitate vaccinations to my child while he/she is in the custody of the Department. I understand the meaning of vaccination to mean the act of introducing a substance intended for use in humans to stimulate the body's immune response against an infectious disease or pathogen. I give permission for my child to receive routine childhood vaccinations. Routine childhood vaccinations include the following:

- Hepatitis B
- Rotavirus
- Diphtheria, tetanus, and acellular pertussis
- Influenza
- Varicella
- Meningococcal disease
- Haemophilus influenzae type b
- Pneumococcal conjugate
- Inactivated poliovirus
- Measles, mumps, rubella
- Hepatitis A

I have also been informed that if I choose not to consent, the Department of Children's Services, may seek a court order to authorize vaccination of the child.

_____ _____

Parent or Legal Guardian Signature *Date*

_____ _____

Witness Signature *Date*

This is the current version of this form. Please disregard all previous versions prior to the date listed below.