Face Sheet

Completed by	Date
CPS Rem	oval Packet is due to Foster Care by Case Transfer
Initial Intake, Plac Due to placement	ement and Well-Being Information and History (CS-0727) – t immediately
KER/Genogram (CS	-1013 & 0774) – Due to placement immediately
Consent for psycho	otropic meds (CS-0627) – Due immediately
Medication Transf	er Form (CS-0813) – Due immediately
	outine Health (CS-0206) – To be taken to the placement; n 24 hours of removal
Tenn Care Immedi	ate Eligibility – Due within 24 hours
Child Welfare Bene days	efits Application (CS-0475) – Due to CWB within 5 business
	Release of Information and HIPAA Protected Health nd FROM (CS-0559) – Due to Foster Care by case transfer
TENNCARE TO THE Authorization for	r Release of TennCare Eligibility Information FROM ne Department of Children's Services and or the Release of Information TO TENNCARE FROM The
case transfer	Children's Services (CS- 0789) – Due to Foster Care by



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

3

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



Initial Intake, Placement and Well-Being Information and History

Child N	ame:					Chi	ld DOB:				Person	ı ID:			
Initiated B	y:						Title:				Dat	te:			
Revised By	/ :						Title:				Dat	te:			
Person Pro	oviding Infori	matio	n to DCS:					Relatio	nship to	Child/Yo	outh:				
Current	insurance co	overa	ge Ye	5 🗌	No 🗌	Unkno	own If y	es, provi	de deta	ils:					
Child/Y	outh Info	orma	ation												
Name of 0	Child/Youth:					E-ma	il Address	:				S	SN:		
DOB:	Sex	:	Ra	ce:			Hispanic:	Yes [☐ No	U.S. Citizen	-	Ye Provic	de Bir	No Th Certifi	cate
Is Child/Y	outh of Nati	ive Ar	merican Des	cent?	Ye	es 🗌	No 🗌 Una	able to De	termine	If "Ye Affilia	s" Triba ation	l			
Child/You	th's Marital	Statu	ıs (check one	2)	Neve	r Marri	ied 🔲 D	ivorced	☐ Wi	dowed	Ма	rried		Separ	ated
Has Youth	n been place its:	ed in c	out of home	care	prior to	this o	ustody ep	isode? If y	es plea	se list d	ates and	d		☐ Yes	☐ No
Curren	t Descrip	tior	of the C	hild	/Yout	h								1	
Physical D	Description I	Date				Pr	imary Lan	guage Spo	ken						
Height		,	Weight				Hair Colo	r		Еу	e Color				
Religion:					Ident	ifying	Marks or T	attoos:							
Special N	leeds/Disabi	ilities	:												
Special M	ledical Equi	pmen	it:												
Schedule	d Appointm	ents:	(date, provi	der, lo	cation,	type o	of appt)								
	/Adverse Re			Yes	No										
Medicati	on:			_				Descri	be reac	tion:					
Food:								Descri	be reac	tion:					
Insect Sti	ing:							Descri	be reac	tion:					
Other:								Descri	be reac	tion:					
Medical r	modified/Re	ligiou	ıs diet?		Yes 🗌	No	If yes, de	scribe							

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Distribution: Child Case File

RDA 11016

CS-0727 Rev. 10/23

Page 1

Child Na	me.	<u> </u>					Ch	ild	DOE	D •						De	erson ID:		
Cilia iva	iiie.						CII	iiiu	001	<u>J.</u>							. 3011 1D.		
Medica	tior	ns:	Pres	cribed ar	nd Ove	r the (Coun	itei	•										
Current r	nedic	atio	ns (na	me, route, fr	requency,	dosage	& days	s of	med	ls le	eft)								
Are meds	give	n in	schoo	ol?] Yes [] No V	Vhich	med	ds?										
Consent	signe	d fo	r psyc	hotropic me	ds:	Yes		10		N/A	N	lext	med	d ap	poin	tment:			
Has Fasts	v Day	1004	rosois	/ed medicati	ioni	□Vac		lo.	Eve	lai	 								
nas roste	er Par	ent	receiv	rea medicati	ion:	Yes	<u> </u>	10	Exp	olai	n:								
Health	His	tor	y of	Child Expl	lain any	items cl	necke	d No	ow/l	Pas	st in	"CC	OMM	IENT	ΓS" s	ection			
No	Now	,	Past								No)	Now	Pá	ast				
				Birth defect	ts											Gastroi	ntestinal pro	blems	
				Vision prob	lems											Kidney/	urinary prol	olems	
				Hearing pro	blems											Hepatit	is/liver prob	lems	
				Skin proble	ms											Cancer			
				Head injurie	es]				Tubercı	ulosis (TB)		
				Headaches												Autism	'Asperger's	(circle c	ne)
				Sickle cell d	isease											Develop	omental dela	ays	
				Anemia/blo	od disord	der									<u> </u>	Learnin	g disability		
				Epilepsy/sei	izures										<u> </u>	Sleep p	roblems		
	<u> </u>			Bedwetting											<u> </u>	Incontir	nence: 🗌 U	rine [Stool
				Diabetes												Other n	nedical <i>(desc</i>	ribe bel	ow)
	<u>Ш</u>			Asthma/Res	spiratory	Disease								<u> </u>	<u> </u>	Acciden	nts (describe	below)	
	<u>Ц</u>			Heart murn	nur										<u></u>	Hospita	lizations (de	scribe b	elow)
Ц	Щ		Щ	Heart probl							L			ļĻ			es (describe		
\sqcup	\mathbb{H}		\sqcup	High blood	-						L		片	1	╣		ns with anes		
	<u>Ц</u>		<u> Ц</u>	Physical dis		—	<u> </u>				L	<u> </u>	<u>Ш</u>	<u> </u>		Other d	levelopment	al disab	ilities
Child/You	ıth is	cur	rently	hospitalized	d:	Yes	∐ No	0	If y	es,	whe	ere	and v	why:					
Commen	ts/Ad	diti	onal h	ealth inform	nation/o	ngning													
health re					10011701	1801118													
Childh	ood	Illr	esse	es	1												1		
No	Yes		Appr	ox date							No	Υ	es	App	rox	date			
					Measles	5											Chicken po	ОХ	
	German measles																Scarlet fev	er	
	☐ Mumps																Rheumatio	fever	
Trauma Screening									•	•		•							
Indicate known history of abuse/adverse experiences. Explain any										ans	wers	in	"CON	име	NTS'	' section			
No Yes								No		Yes									
☐ Neglect ☐										Domestic violence									
	_			ult/abuse						School violence									
급남	_			ılt/ahusa		H		一			mmunity violence								

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	hild Name: Child DOB: Person ID:														
Chil	d Na	me	;		Child I	DC	DB:		Person ID:						
No	Yes	;			No		Yes								
		Е	motional	abuse				Extreme interpersonal	violence						
		Т	raumatic	loss/separation				Natural disaster							
$\overline{\Box}$	$\overline{\Box}$	Е	xtended i	llness/medical trauma				Impaired caregiver (sub	ostance abuse/m	nental illness)					
	一	S	erious inj	urv	一一			Other trauma, describe		,					
									•						
ш	ac ah	uco	hoon rong	orted? 🗌 Yes 📗 No 🏻 If no, o	all CDS	۰ ۵	77_2:	37-0026							
1 10	as ab	use	реентер	inted: Tes Tillo in	.uii Ci S	, 0	,,,-23	77-0020							
Com	mont	tc/A	dditional	health information:											
Colli	mem	13/A	uuitioiiai	nearth information.											
Chi	hild Strengths														
CIII	ania sa ciigais														
Beh	avi	ora	l/Ment	al Health History											
No	No		Past												
				Intense anger, if yes, describe											
				Oppositional, if yes, describe											
				Negative Peer Association, if yes,	describe	!									
				Extreme Attention Seeking, if yes,		е									
				Makes False Statements, if yes, de											
Ш	┵		\sqcup	School Difficulties, if yes, describe											
Щ	<u> </u>	<u> </u>	닏	Damage of Property, if yes, descri	be										
Щ	<u> </u>	<u> </u>		Habitual Lying, if yes, describe											
Щ	4⊨	<u> </u> 	\square	Stool Smearing, if yes, describe											
	<u>+</u> -	<u> </u>	 	Stealing, if yes, describe											
Н	╁┝	<u> </u> 		Runaway, if yes, describe											
	 -	<u> </u> 	H	Hoarding, if yes, describe	attentio	n i	fues	docaribo							
H	╁┾	<u> </u> 	H	Problems with concentration and Excessive Hyperactivity/does not			_		ribo						
	╁┾	<u>. </u>	H	Requires Constant Supervision, if	-			instructions, ir yes, desci	TIDE						
	╁╞	<u> </u>	\Box	Anxiety, if yes, describe	yes desc	-1 IL	<i>J</i> e								
H	╁┾	<u> </u> 	+	Depression, if yes, describe											
	╁┾	1	$+ \overline{\Box}$	Seeing or hearing things that aren	n't there	if	ves de	escrihe							
Ħ	╅╞	1	一	Fire-setting, if yes, describe		•••	<i>yes,</i> a.	3501100							
\exists	╅	<u>-</u> 1	╁┼┤	Animal cruelty, if yes, describe											
Ħ	十二	Ī	1	Animal fear, if yes, describe											
	十二			Self-injurious behavior/Other Self	Harm,	if \	yes, de	scribe							
	1			Aggressive, dangerous or destruc		_									
	1			Sexual aggression, if yes, describe			<u> </u>	· ·							
F	ΤĒ	1		Had homicidal thoughts if yes de											

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Had suicidal thoughts, if yes, describe

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Child Name:		Child DOB:		Person ID:
No Now Past				
	Attempted suicide If yes, describ	e		
	Had other mental health or behav		if yes, describe	
	Other mental health diagnosis, if			
Has the Child/Youth	received counseling or therapy?		Yes No	
If yes, where?				
	had a Psychological Evaluation:		Yes No	
If yes, diagnosis, whe	en, where?			
			. 1 1. 11. 11. 5	
	been hospitalized for mental heal	th problems/ac	cute hospitalization?	Yes No
If yes, diagnosis, whe	en, where?			
Has the Child/Youth/	Family received in-home services	? Tye	s 🗍 No	
If yes, when, where?	Turning received in nome services	· [_] 10.	3 🔲 140	
,,				
Has the Child/Youth	previously been placed in a reside	ntial treatmer	nt facility? Yes	No
If yes, when, where?				
Alcohol/Drug Al	ouse History			
No Now Past	Frequency (Xs per day/weel	k/month)		
	Alcohol			
	Tobacco smoke/	chew (circle one	or both)	
	E-cigarettes/vap	or cigarettes		
	Marijuana			
	Narcotics			
	Stimulants			
	Methamphetam	ine		
	Hallucinogens			
	Steroids			
	Huffing			
	Ecstasy			
	Street drugs, un			
	·	• .	or another, specify:	
	Over-the-counte	r medication, sp	pecify:	
	Other, specify:			
Additional Comment				
Has child been identi	fied as high risk?			Yes No
Has a Safety Plan bee	en completed on child identified a	s high risk?		Yes No N/A
Divth History	11.1.21.1			
Birth History (fo				
Birth Weight:	Birth Length:		term or 🔛 Premature bir	th (<36 weeks
Did mother receives	vonatal care: Vos D No	Weeks)	ognancy for 1st property	cit.
Did mother receive p Pregnancy/Birth com		wonth of pr	egnancy for 1 st prenatal vi	SIL.
	ubstance abuse: Yes No	cl	ostance and frequency:	

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Child Name:						Child DOB: Person ID:								
Birth hospital and	d location	1:												
Minor Female	е													
Age of 1st Period:		D	ate of	Last Pe	riod:									
Pregnancies #		Li	ive birt			Full term			Pren		e (# we			
Miscarriages #			Abort	ions #		Curren	tly pr	egnant:		Yes	No	If yes,	, due date:	
Doos the youth h	ava shildu	402		¬∨ос Г	□ No	If yes, ans	worh	alour au	oction	<u></u>				
Does the youth ha	DOB	In DC	~ç	Yes _ Male/	No			Person C		_	ame of 0	Child's	Contact In	formation
Children's		Custo		Female				with and		_	other Pa			r Parent
Names		?						ionship						
		Yes] M	lale [•						
		No 🗌		emale [
		Yes	≓ ∣	lale [
		No _		emale [_									
		Yes	=	1ale [emale [$\exists \mid$									
Does minor parer	nt have vi				 hild(ren)? Yes	П	No.						
If yes, list any visi						<i>,</i>								
				•										
Gender and S	exual I	denti	ity											
Does the Child/Yo		tify hin	n/herse	elf as g	ay, lesbi	an, transg	ender	, or non	-bina	ry?	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Yes 🗌	No	
If yes, describe ar	nswer													
Sexual Activi	ty													
Is child sexually a	ctive?] Yes [No	U	se birth co	ntrol?	? \ \ \ \ \	'es 🗌	No	Meth	od:		
								•						
Dating Violen	ice													
Has Child/Youth	experienc	ed con	trolling	g, abus	ive or a	ggressive b	ehavi	or in a d	lating	relat	tionship	?	Yes	No
If yes, explain:														
Medical														
Does the Child/Yo	outh have	a regu	ılar me	dical p	rovider	(pediatrici	an, fa	mily dod	ctor, e	etc.)?		, I	Yes No	
If yes, name of me	edical pro	vider:								Da	ate of la	st visit:		
Immunizatio	ns													
Are immunization	ns up-to-d	late?		Yes	☐ No	Is the im	muni	zation r	ecord	avail	lable?	Ye	s No	
Religious/medica	l exempti	on?		Yes [No (p	oarent/guar	dian n	nust pro	vide a	notar	rized sta	tement)		
Dental														
Does the Child/Yo	outh have	a regu	ılar der	ntal pro	ovider?	Yes		Does the	e Chile	d/You	ıth wea	r braces	s?	No No
If yes, name of de	ntal prov	vider:								Date	of last	exam:		
If hraces name of	•									Date	of last	ovam.		

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Child Name:	Child DOB:	Person ID:
Vision		
Does the Child/Youth wear glasses?	Yes No Does the Child/Youth we	ear contacts? Yes No
If yes, name of vision provider:		Date of last visit:

This concludes the Well-Being Section

Page 6

Child Name:	Child DOB:	Person	ID:

This information does not go to Health Care Provider

Education	Education and Independent Living Student graduated high school?																	
									D [HISET		Stud	ent H	ome Sc	hoo	led		
What scho	ol does t	the stu	dent at	tten	d? (name	, cit	y, coı	unty)										
Student's a					Current	gra	de			Studen	t rece	eives	spe	cial edu	ıcat	ion services?	Yes No	
If yes, nam	e the di	sability	y															
No	Yes																	
		Is the	student	takir	ng GED cl	asse	·S											
					nave a his	_			scho	ool?								
		Is the	student	in ar	n alternat	ive s	choo	l?										
		Is the	student	serv	ing a zero	o tole	eranc	е ехри	ulsion	ı (drugs,	weap	ons	and/	or assa	ult)?			
					ing a sus _l eason an						ı zero	tole	rance	?				
Student st	rengths	(check	all tha	t ap	oly)				Ar	eas nee	ding	imp	rovei	ment (d	hec	k all that apply)		
Mathem										Mathe								
Reading	Ţ									Readin	g							
Athletics										Athleti	CS							
Attenda	nce in sc	hool] Attend	ance i	n sc	hool					
Other, s	pecify									Other, specify								
Other thin	gs you w	vould l	ike to s	hare	regardii	ng yo	our s	tuden	t's sc	hooling	;?							
Present	ing an	d Pre	vious	Co	urt Ac	tio	ns o	n Yo	uth	(Unru	ıly/I	Del	inqι	uent `	Yοι	ıth only)		
Current Di		nal Inf	ormatio	on														
Disposition										Sp	ecial	Judg	ge					
Current Di																		
Current Di	•														Di	isposition Date		
Have you b		are you	ı currei	ıtly (on proba	tion	?	<u> </u>	Yes	No	If ye	es, w	here					
Defense At																		
Current Ad															Adj	udication Date		
Adjudicated Charge - Current and Previous										e Occur	red		sposi ite	tion		Disposition		
																1		
Pending Ch	narges											Co		ate Se		Date (if yes)		
												Ļ	Yes	∐ No				
												ᄔ	Yes	∐ No				
				·								<u> </u>	Yes	∐ No				
Violation o	t Probat	tion (V	OP) or \	/iola	tion of V	alid	Cour	t Orde	er (V\	/CO) (ex	plain	if a _l	oplica	ıble)				

Child Name	e:			Child DOB:		Pers	on ID:						
Narrative													
Legal/Pro	hati	on Services P	reviously O	ffered to Cl	hild/Youth								
Date	7.50.01		Type			Out	come						
Date			Турс			Out	COITIC						
Safoty (II	nruh	/Dolinguont	Vouth only										
		//Delinquent											
	atment Allegations or Unruly Behaviors/Delinquency												
Other													
(explain)													
Narrative													
Strengths (S	igns of	Safety)											
		oncerns (Signs of	Risk include										
		r, arson, cruelty to											
gang involve	ment, e	etc.)											
B) Domestic	Violen	ice											
Narrative													
			1										
Strengths (S			District of a										
		oncerns (Signs of											
		r, arson, cruelty to	animais,										
gang involve	ment, e	ett.)				Contact #							
Office Addre)) 					Contact #							
Supervisor	33					Contact #							
Super visor						Contact #							
			DCS / Provider Staf	f			Date						
11	.11				:		Date						
	_	receipt of the Int			_								
	-	urther acknowle		-									
			-		on I may receive								
•	t to Te	nnessee Code Ai	nnotated §37-2	2-415, The Fost	ter Parent Rights								
Act.													
			Foster Parent				Data						
			רטזנצו צעופוונ				Date						
			Foster Parent				Date						

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Child Na	ame:					Chil	d DOB:	Person ID:						
Do n	ot provi	ide th	nis se	ection	to th	e Foster Pa	arent o	r the H	ealth (Care	Pro	vider		
Receivi f yes, <u>imme</u>	ng Adoptio	on Assi	stanc Perma	e or Suk	osidized Specialis	No: Was the of Permanent Got, Child Welfare	uardians e Benefits	hip: 🔲 Y	′es □ N r Regiona	lo: If y al and	es, A	mount:	<u> </u>	
Removal Date:			New	ement:				Date of				Legal (Custody	
Removal County:					-	ication Type:	□ Дере	endent and	d Neglect	: 🔲	Unrul	y	iquent []N/A
Removal Reason: Alcohol Abuse (Child); Alcohol Abuse (Parent); Caretaker Inability to Cope Disability; Drug Abuse (Child); Drug Abuse (Parent); Inadequate Housing Prosecution (only select upon DCS attorney instruction); Physical Abuse (alleged/reported); Truancy											ncarce	ration of P	arents; 🔲	NAS
Removal	Street Add	ress												
City						County			State	:	Z	ip Code		
						Kinship Ex	xception	Request				-		
	approved				No I	f yes, by whor	n?							
	KER tempo					tempora	ary 🔲	ong term	1					
MSW Cor	nsult was c	omple	ted w	ith:										
Family	Inform	ation)											
Both par	ents living	?			Yes 🗌	No	If	no, date	(s) of dea	ath:				
Foodstar		Suppo	rt, etc			y: (including S supports are					se nai	me		
	outh Pa e Paren					ed Method	d for Re	ceiving	z Docu	men	ts			
	ther's Nam				- 				,	l .		aregiver	Yes	□No
Email Add		<u> </u>								∏ Ye		No		
Maiden N					Soc	cial Security N	lo.		DOB			Message C	ontact #	
Address										ΠY	es [□ No		
City, State	e, Zip											Contact	#	

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Child Name:						Chil	d DOB:				Pers	on ID:			
									1						
Employer		1						Address							
City, State, Zip												Contact	#		
Birth mother mar	ried wh	nen ch	nild/Yout	h was bo	rn?		Yes	☐ No		Unable t	o Determ	nine			
Birth mother ever	been r	marrie	ed?	Yes	□No		Unable	to Determ	nine	If so, w and to	here whom?				
Birth mother ever	been o	divorc	ed?	Yes	□No		Unable	to Determ	ine	If so, w	here and	d			
Birth mother's rac	:e:														
Is there a father l	isted o	n the	birth ce	rtificate?			Yes	No							
Has DNA testing	ever be	en do	ne?	☐ Y	es 🗌	No		nat were t ere was it							
Has there ever be has been legitima		_			ither mo	other					th or a fa	ather	Ye	s [No
Legal Father's Nar	<u>ne</u>									Pı	rimary C	aregiver		Yes	☐ No
Email Address] Yes	No			
Social Security No	•				DC	В					Messag	ge Conta	ct #		
Address] Yes	No			
City, State, Zip												Conta	ct #		
Legal Father's Rac	e:														
Employer								Address							
City, State, Zip												Conta	ct#		
Marital Status of F	Parents	5		Married		Sepa	arated	☐ Divo	rced		Other				
Putative/Alleged F	ather's	s Nam	<u>1e</u>												
Email Address											Yes	No			
Social Security No	•				DC	В					Messag	e Conta	ct#		
Address											Yes	No			
City, State, Zip												Conta	ct #		
Putative/Alleged F	ather's	s Race	e:												
Employer								Address							
City, State, Zip												Conta	ct#		
Caregiver's Name	(if diffe	erent j	from abo	ve)							Rela	tionship)		
Email Address											Yes	No			
Social Security No					DC	В					Message	Contact	:#		
Address					(Yes	No			
City, State, Zip										I		Conta	ct#		

Child Name:				Child DOB	:			Perso	n ID:		
Employer					Ad	dress					
City, State, Zip									Contact	#	
Relative Conta	nct Pe	erson For Child	l/You	uth (other tha	an pa	arent)					
				•			Contact #				
Relationship											
Child/Youth Siblin	gs:									In Custod	ły
Name			SSN		DOB		Sex	Rac	:e	☐ Yes ☐	No
Name			SSN		DOB		Sex	Rac	:e	Yes	No
Name			SSN		DOB		Sex	Rac	:e	Yes	No
Name			SSN		DOB		Sex	Rac	:e	☐ Yes ☐	No
Name			SSN		DOB		Sex	Rac	:e	☐ Yes ☐	No
Name			SSN		DOB		Sex	Rac	:e	☐ Yes ☐	No
Name			SSN		DOB		Sex	Rac	:e	☐ Yes ☐	No
Name			SSN		DOB		Sex	Rac	:e	☐ Yes ☐	No
Name			SSN		DOB		Sex	Rac	:e	☐ Yes ☐	No
Name			SSN		DOB		Sex	Rac	:e	☐ Yes ☐	No
Name			SSN		DOB		Sex	Rac	:e	☐ Yes ☐	No
Name			SSN		DOB		Sex	Rac	:e	☐ Yes ☐	No
Name			SSN		DOB		Sex	Rac	:e	☐ Yes ☐	No

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CS-0727 Rev. 10/23



State of Tennessee

Child Welfare Benefits Application

Date Received:											
IDENTIFYING INFOR	MATION:										
Child's Last Name	First		Mid	dle		Date o	of Birth Socia			Security N	lumber
Race	Sex	ex Child's County of Venue				ie	Date			of Custody	
Mother's Last Name	First		Mid	Middle Date of			of Birth Socia			Security N	lumber
Father's Last Name	First		Mid	dle		Date o	of Birth		Social	Security N	lumber
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 INFORM	MATION (Where	the child	d is place	d, outsic	de of the h	ome, be	ecause of t	this situa	ation):		
Name of Placement: Date Entered Placement:									nt:		
ELIGIBILITY/REIMBU	IRSABILITY:										
1. Is the child a U.S. (Citizen or Qualifi	ied 2	l. Is the	child a T	ennessee		3. Is the	child a	Native .	American?	
Alien?	•		residei	nt?			Yes No No				
Yes No] No □					_		
4. DEPRIVATION OF	PARENTAL SUI	PPORT B			AND/OR	BIOLO	GICAL PAF	RENTS:			
a. Parent living in the					THER				FA	ATHER	
child was removed		-	Y	es \square	No \square				Yes	No [7
b. Is the child's paren				es 🗍	No 🗌				Yes	No [<u> </u>
27.15 ti.16 ti 5 par ci	(5) 455545		If "yes",	, date de	eath occu	rred:	If "yes",	date de	ath oc	curred:	
c. Parent(s) disabled mentally)?	(physically/		Yes 🗌	No [Yes 🗌	No [
d. Parent(s) unemplo	yed?		Yes 🗌	No [Yes 🗌	No [
The primary wage of Mother Father					•	·	4 months.	Who is	the pri	mary wage	earner?
Is the primary wag	ge earner curren	tly unem	ployed o	or emplo	yed less tl	nan 100	hours per	month	? Yes [No 🗌	
4A.Was the child living Placement was sig			ents duri	ng the m	nonth the	court pr	oceedings	were in	itiated	or the mor	nth the Voluntary
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.											
	Го		Name ai	nd Addr	ess				Re	lationship)

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Distribution: CWB Case File, Copy Child's Record

RDA 2984

CS-0475 Rev. 4/22 KIDCENTRALTN.COM Page 1

Date Received:												
	ving informs	tion on al	Lnerce	ns (includ	ing the	fostor shild	who	oro livino	r in the her	ma fra	m which the foster	child
			<u>ı</u> perso	ris (includ	ing the	e roster crilia)	wno w	ere livirig	g in the no	ne iroi	iii wiicii the ioster	Crilia
was removed (re		=).	D:w	h Data		-1-+:	- F+	au Child		C:-	l Ca acceite e Niconala au	
<u> </u>	lame		Birt	th Date	K	elationship t	o Fost	er Chila		Socia	Security Number	
					_							
F. Financial Day		: £	-4:	ا م ما الم الم ما	6	-l-: -l/- £:			al : :		10 h - l	. 16
											ons 5 thru 10 below	
	•					_			_	-	ger were also living	
				ncome in	section	is 5 thru 10. I					n the removal home	е.
Source	Balance	Owr	ner				Ban	к мате	and Addr	ess		
Cash												
Checking/												
Savings												
IRA/CD												
Stocks/Bonds												
Trust												
Accounts												
Other												
Value and Amour			Own	er:				Location	:			
Value and Amour	nt Owed:		Own	er:				Location	:			
6. List any vehic	les family me	amhar or i	child ov	wnc.								
Value/Amount/C		citibet of t	_	ner:				Model/	Vaar.			
Value/Amount/C			_	ner:				Model/				
		s (Month			uuivala	nt): Chack th	o (Sto			no hole	ow is received by a	
stepparent in t	_	-	iy aiiio	unit or eq	luivaie	iit). Check th	ie (31e	p box) ii	the mon	ile beit	ow is received by a	a
			Mothe	or (Stan	٦,	Eather (Ste	n 🗆	Siblir	og (Sten	٦,	Sibling (Step)	
Social Security	rostei	Ciliu	WIOCIIC	i (Step L		rather (Ste	<u> </u>	Sibili	ig (Step _		Sibiling (Step)	
SSI												
Veteran's												
Benefits												
UC/WC												
Railroad												
Retirement												
Pension												
Military								_				
Child Support												
Other			,									
8. Indicate the cl	nild's payee f	or the abo	ove	Name:					Type of B			
benefits:				Name:					Type of B	enefits	:	

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RDA 2984

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9. Current	Employer:	Check the	box in	the (S	tep) column if th	e wa	iges a	re rec	eivec	l by a stepp	parent c	or step sibling.
	(Step)	From	То		oloyer Name and Address		Gros (a b	ss Wa mour efore uctio	ges it	Frequence (weekly monthly	iency ly, bi- , semi-	# Hours Worked Per Week
Child									-			-
Mother												
Father												
Sibling												
Sibling												
Child Care	Expenses:											
Yes No If "yes", Ame	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 \bigcap No \bigcap If "yes", Amount Paid : Frequency: Weekly Monthly Child Care Provider Name and Address: Phone Number :											
riione ivan	ibei.											
Date Recei												
Plan and	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, briefly describe: 12. 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:												
			·hild wa	c romo	ved receiving ado	ntion	Scupp	ort no	w m o r	ets on bobal	lf of the	child? Yes No
						•			ymer	its on benai	ii oi trie	child: res No
		,			nce or settlement			No	- + 16		- 1 - 4:	
TFACTS.)	pport intoi	rmation-iv	ion-cus	todiai	Parent Data: (Co	ONTIFF	n tne	pare	nt/tos	ster chila re	elations	hip is reflected in
Foster Chil	d's Mother	:	Does No		d Cause" reason e	exist t	to not	pursu	ie chil	d support fi	rom the	mother?
Street Addr	ess		City				State		Zip		Telepho	one Number
Is this addre	ess valid?		Last d	ate at a	above address			•				
Employer N	ame and A	ddress		City	/		State		Zi	р	Last dat	e employed
Is mother m payments? Yes No	naking child	support		If yes, Amou	indicate: nt:	Fre	quenc	У	•		Last c	late support was paid
Foster Chil	d's Father:		Does Yes	_	d Cause" reason e I Parent 🔲 Alleg		to not arent		ie chil	d support fi	rom the	father?: No 🗌
Street Addr	ess		City State Zip Telephone Number							one Number		
Is this addre			Last date at above address									
Employer N	ame and A	ddress	City State Zip Last date employed									
	s father making child support payments? If yes, indicate: Amount: Frequency Last date support was paid											

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RDA 2984

CS-0475 Rev. 4/22 **kidcentral tn**Rev. 4/22 Page 3

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.

<u>USE OF SOCIAL SECURITY NUMBERS AND COMPUTER MATCHING:</u> 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:

CS-0475 Rev. 4/22 Page 4



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: <mark>Last</mark>					<mark>First</mark>					M	<mark>iddle</mark>	
Other Le	gal Names:									•		
Address												
City						State	•			Zip (Code	
SSN			DOB			Ma	le	☐ <mark>Fe</mark>	male			I
Telephor	n <mark>e Numbers</mark> : C	ell () -				Но	ome	() -		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/Schoo	ol/Entity	Releasin	g Informati	on TO DCS:							
T £ l	famortica Dec		(ala a ala Ol	W V		d	<i>(</i>					
Type of Ir	itormation Rec	questea	(cneck Or	NLY one) Y	ou must nand	a write/	typ	e in s	pecific information bei	ng reque	estea.	
	cation records ecific Informa		_	ripts, GED, 1	TCAP, Specia	l Educa	atio	n				
res	chological/Psycults. <i>Does not c</i> ecific Informa	apply to e	employees	or voluntee		ds, alco	hol	/drug	/substance abuse tre	atment	records, aı	nd any associated test
	dical records, in ecific Informa			tions, labor	atory tests,	and pro	esc	ribed	treatments. Does not	apply to	employees	s or volunteers.
	kground/Crimi ecific Informa				g Polygraph,	and Fir	nge	rprin	t Results			
	oloyment Reco ecific Informa		quested:									
	sonal Finance/ ecific Informa				ords (as app	licable)					
7. 🗌 Oth Sp	er ecific Informa	ation Re	quested:									
	e of the Reques Il that apply: [ner:	Arran	ge/Acces		CPS In	vestiga	tio	n	☐ Juvenile Court Cas	e		
Signatu	<mark>re</mark> :								Da	te:		
OR												
Signatu	re of Authorize	ed Repre	sentative	*:					Da	te:		

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Distribution: Original Child's case File

CS-0559, Rev. 5/24 Page 1A

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

A. AUTHORIZATION FOR RELEASE TO I	<mark>DCS</mark>		
☐ I,	hereby authorize release of	f the information specified on pag	e 1A, to
any representative of the Tennessee Depa			
information deemed to be confidential. I			
representative. This release is executed w			
the Department of Children's Services. Fa information.	lure to grant access to the requested in	formation may result in a court of	rder for the
I understand that there are laws and regu			
the Tenn. Code Annotated; the federal Hea			
of Federal Regulations (CFR) Parts 160 and regulations at 42 CFR Part 2. My signature			
release of records or information as specif			
time, but it will not affect disclosures alre			
HIPAA Authorization for Release of Pr		alth information as described	l abovo I
I hereby authorize the use or disclosu understand the following: (1) This aut	-		
information is not a health plan or he		_	
privacy regulations. (3) My ability to r			_
not be affected if I do not sign this for			•
get a copy of this form after I sign it. (•
person/organization(s) in writing, but	if I do it won't have any effect on a	ctions taken before the revoca	ation was received.
(6) Any release made in reliance on th	is authorization prior to receiving r	evocation of the release shall	not constitute a
violation of HIPAA or my confidential	• •		
I have read this section	OR This secti	on was read to me	
<u>Initial</u>		<mark>Ini</mark> t	<mark>tial</mark>
If the individual who is the subject of	the information requested is a Chil	d Under the Age of 18 the Chil	ld's Parent(s) or
Legal Guardian Must Sign This Release	-	_	
older, requires the signature of that r		<u> </u>	_
regardless of age, if the youth consen			
One signature required:			
Print Name	Signature		Date
OR			
Name of Authorized Represen	tative (Print) Signature	of Authorized Representative	Date
Signer's Relationship to client and au	hority to release confidential	Self Parent Lega	al Guardian*
information	,	Legal Custodian*	
Conservator*	Personal Representative for HIP	AA* Other*, specify:	
*Proof of authority to release informat	ion, such as a court order or Power of	f Attorney document, must be p	rovided.
Name of Witness (Pri	nt)	Signature of Witness	Date

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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: <mark>Last</mark>					First						Middle	•		
Other Le	egal Names:													
Address		l .												
City						Stat	e			Z	<mark>ip Code</mark>			
SSN		[DOB			☐ Ma	ale	☐ <mark>Fe</mark>	<mark>male</mark>					
Telepho	ne Numbers: Co	ell					Но	ome	() -		١	Work	() -	
This forn	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	lame of Provider/School/Entity Receiving Information FROM DCS::													
Type of I	nformation Req	uested (d	check ON	ILY one) Y	ou must han	d write	e in s	specifi	c information	being reques	ted:			
Sr 2. Psy res Sr 3. Me Sr 4. Bad	Type of Information Requested (check ONLY one) You must hand write in specific information being requested:													
	ecific Informa		uested:											
	rsonal Finance/O pecific Informa		-	urance Rec	cords (as app	olicable	e)							
7. 🗌 Oth Sp	ner Decific Informa	tion Req	juested:											
	e of the Reques all that apply: [her:	Arrang	ge/Access		CPS In	vestig	atio	n	Juvenile Co	ourt Case				
Signatu	ıre:									Date:				
OR														
Signatu	ıre of Authorize	d Repres	entative ³	*:						Date:				

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Distribution: Original Child's case File

CS-0559, Rev. 5/24 Page 1B

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

<u>B AUTHORIZATION FOR DCS FROM RELEASE</u>							
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 confidence the Tenn. Code Annotated; the federal Health Insurance Portability and of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidence regulations at 42 CFR Part 2. My signature indicates I have received a release of records or information as specified on page 2 of this release time, but it will not affect disclosures already made in reliance on this	nd Accountability Act of 1996 (HIPAA) and its regulations at 45 Code entiality of Alcohol and Substance Abuse Patient Records and its copy of this authorization. I hereby request and authorize the e. I understand I may revoke this authorization in writing at any						
HIPAA Authorization for Release of Protected Health Informat	ion:						
I hereby authorize the use or disclosure of my individually ide understand the following: (1) This authorization is voluntary. (information is not a health plan or health care provider the reprivacy regulations. (3) My ability to receive health care, eligib not be affected if I do not sign this form. (4) I may see and copiget a copy of this form after I sign it. (5) I may revoke this authorization/organization(s) in writing, but if I do it won't have any (6) Any release made in reliance on this authorization prior to violation of HIPAA or my confidentiality rights. I have read this section. OR Initial If the individual who is the subject of the information request Legal Guardian Must Sign This Release. EXCEPTION: Release of older, requires the signature of that minor. Release of recording regardless of age, if the youth consented to the health care in One signature required:	2) If the person or organization authorized to receive the leased information may no longer be protected by federal lility for health care, or the payment for my health care will by the information described on this form if I ask for it, and I derivation at any time by notifying the leffect on actions taken before the revocation was received. This section was read to me. This section was read to me. Initial ed is a Child Under the Age of 18, the Child's Parent(s) or records under category number 2 for a minor age 16 or sunder categories 2 and 3 should be signed by the youth,						
Print Name	Signature Date						
OR							
Name of Authorized Representative (Print)	Signature of Authorized Representative Date						
Signer's Relationship to client and authority to release confide	ential Self Parent Legal Guardian*						
information	Legal Custodian*						
Conservator* Personal Representat							
*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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RDA 11016

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



Informed Consent for Psychotropic Medication

Appointment Dat	e	TFACTS Person ID#	Home County	
Child's Name			DOB	
Placement	Foster home Congregate care fa	acility Facility name		
Child entering	custody on the medication(s) listed bel	ow		_
	PLEASE ATTACH PSYCHOTROP	IC MEDICATION EVALUATION Form CS-06	529 OR EQUIVALENT FORM	
Medication (dose	, frequency, route)			
For the treatment	t of			
Allergies				
Any other medica	ation child is taking			
Prescribing Provide	der's Name		Telephone #	
Clinic Name				
Address				
For females: Becauplans to attempt p THIS FORM Content prescribing prescribin	use this/these medication(s) could be pregnancy. CAN ONLY BE SIGNED BY TI ovider) OR THE DCS REGION mation provided to me:	HE PARENT/GUARDIAN, YOU NAL Nurse	osolute guarantee as to the results. Ify the medical staff immediately if I susp TH AGE 16 AND OLDER (at th	
_	I/CONSENT to the administration of the			
_	the administration of the above listed m	. ,		
•	der signature			
Parent/Legal Guard	lian signature			
Print name	Relat	•		
Witness #1 Verbal (Consent	Date		
Witness #2 Verbal 0	Consent	Date		
Reason parent can	not sign			
DCS Health Nurse S	Signature	Date		
Print name	Reg	ion		
☐ I have been NOTIF	FIED that consent was given by DCS for t	the above listed medications(s).		
Parent/Legal Guard	lian signature	Date		

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Relationship_

CS-0627 Rev 3/23

Print name_



Authorization for Routine Health Services for Minors

Name of Child:	Date of Birth: _	IFACISID: _	
Date of Custody:	County of Custody:	Region of Cu <u>sto</u> dy:	
Services. The Departme	hat is in the nt of Children's Services, by virt /or necessary medical care.		ssee Department of Children's iting legal custody, is authorized to
Child/Youth The information below mus	st be fully explained to the minor; n	ninor does <u>not</u> sign form)	
Examples of routine healt samples, treatment of con not listed generally goverr Department of Children's	n services are: routine dental pro	ocedures including extractions ituring or minor lacerations, x s in the community setting. If order granting the departmen	rays, and other medical procedures you choose not to consent, the
Parent/Guardian			
orovide routine health car with regard to health serv nformed that if I choose r		ne custody of the Department and hereby give my permissio f Children's Services, by virtue	of the court's order granting the
Po	ırent's or Legal Guardian's Signatur	re	Date
	Witness' Signature		Date
while in custody of the De guardian cannot be locate	partment of Children's Services o	r because, after diligent effort Services due to its rights and r	ne routine treatment of his/her child is to locate, the parent or legal esponsibilities as legal custodian is
	ign paperwork at time of remov		
No parent available	at time of removal	DCS Staff Signatur	re Date

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



Medication Transfer

Name	DOB		
Date			
The following medications are bei	ng sent with this child/youth to a new p	lacement:	
Medication and Dosage:	nstruction:	Count:	# Refills
			
			
Medications collected/counted by	:		
			
	Signature #2		
Medication has not been sealed [
By signing below you are agree	eing that all medications and counts	are accurate	e as listed
Signature of Person releasing me	dications	Dat	e
Signature of Transport Person		Date	
Signature of Person or Parent/Gu	ardian receiving medication	Date	
Medication has been sealed by you are agreeing that you are re	medical staff and is being released in eceiving sealed medications	to parent/gu	ardian. By signing below
you are agreemy manyou are re	ooning coalea mealeadele		
Signature of parent/guardian rece	viving sealed medication	Dat	e
Note : Some medication may not be children.	oe in "child proof" containers. Please ke	eep all medic	ations out of the reach of
sent directly from the pharmacy vi	elopment Center may receive a one mo ia UPS. Please check the medication y ct. Report any errors directly to the phar	ou receive to	
In case of questions, please conta	act:		
Sending Staff/Facility/FSW		Pho	one

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





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:					First				Mi	ddle		
Last												
Other Le	gal Names:											
Address												
City									Zip C	<mark>ode</mark>		
<mark>SSN</mark>			DOB			☐ <mark>Male</mark>	☐ <mark>Fe</mark>	<mark>male</mark>		1		
Telepho	ne Numbers: C	ell	1				lome			Work		
This forn	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.										g a	
Name of	lame of Provider/School/Entity Releasing Information TO DCS:											
Type of l	<mark>nformation Rec</mark>	quested	(check Of	ILY one) Yo	u must han	d write/t	ype in s	pecific information be	ing reque	<mark>sted</mark> :		
	cation records ecific Informa		_	ripts, GED, T	CAP, Specia	l Educat	ion					
res	chological/Psyc sults. <i>Does not c</i> pecific Informa	pply to	employees			ds, alcoh	ol/drug	/substance abuse tr	eatment r	ecords, ar	nd any associate	ed test
	dical records, in pecific Informa			tions, labora	atory tests,	and pres	scribed	treatments. Does no	t apply to	employees	s or volunteers.	
	kground/Crimi ecific Informa			s, including	Polygraph,	and Fing	gerprin	t Results				
	ployment Reco pecific Informa		quested:									
	sonal Finance/oecific Informa		-	urance Reco	ords (as app	licable)						
7. 🗌 Oth Sp	er ecific Informa	ition Re	quested:									
Check a	Purpose of the Requested Release/Disclosure: Check all that apply: Arrange/Access Services CPS Investigation Juvenile Court Case Other:											
Signatu	re:								ate:			
OR												-
Signatu	re of Authorize	ed Repre	sentative	*:				D	ate:			
*Authoriz	ed Representati	ive mear	ıs vou have	legal nroof	vou can act	for this n	erson					

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Distribution: Copies: Pages 1-3 - Client

Page 4 - Signed Client Acknowledgement - Case File



A. AUTHORIZATION FOR RELEASE TO	DCS		
	hereby authorize release of th	ne information specified on page	1A. to
any representative of the Tennessee Dep	artment of Children's Services bearing this		
	hereby direct you as an individual or agend		
•	with the full knowledge and understanding		
	illure to grant access to the requested info	rmation may result in a court ord	ler for the
information.			
Lunderstand that there are laws and regu	lations protecting the confidentiality of ce	rtain written and oral informatio	on such as: Title 33 of
	ealth Insurance Portability and Accountabil		
	d 164; and the federal Confidentiality of Alc		
	e indicates I have received a copy of this au		
	ified on page 2 of this release. I understand		
time, but it will not affect disclosures affe	eady made in reliance on this authorization	. This release takes effect off the	uate i signeu it.
HIPAA Authorization for Release of P	rotected Health Information:		
I hereby authorize the use or disclosi	ure of my individually identifiable heal	th information as described	above. I
understand the following: (1) This au	thorization is voluntary. (2) If the pers	on or organization authorized	to receive the
	ealth care provider the released inforr		-
	receive health care, eligibility for healt		_
	rm. (4) I may see and copy the informa		f I ask for it, and I
	(5) I may revoke this authorization at		
	t if I do it won't have any effect on acti		
	his authorization prior to receiving rev	ocation of the release shall n	ot constitute a
violation of HIPAA or my confidential I have read this section	• •	n was read to me	
Initial	OK This section	Initio	
If the individual who is the subject of	the information requested is a Child l	Under the Age of 18, the Child	's Parent(s) or
	e. <u>EXCEPTION:</u> Release of records unde		
older, requires the signature of that	minor. Release of records under categ	ories 2 and 3 should be signe	d by the youth,
regardless of age, if the youth conser	nted to the health care instead of the រុ	oarent, guardian, or custodia	n consenting.
One signature required:			
Print Name	Signature		Date
OR			
Name of Authorized Representative (Pr	int) Signature o	f Authorized Representative	Date
			C 1: 4:
Signer's Relationship to client and au information	thority to release confidential	Self Parent Legal Legal Custodian*	Guardian*
Conservator*	Personal Representative for HIPAA	<u> </u>	
	tion, such as a court order or Power of A		ovided.
, ,, ,	,	.,	
Name of Witness (Print)	Cinn	ature of Witness	Dota
Name of Witness (Print)	Signa	iture or vvitriess	<u>Date</u>

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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: <mark>Last</mark>					<mark>First</mark>						Mi	<mark>ddle</mark>		
Other Le	gal Names:												_	
Address														
City						State					Zip C	<mark>ode</mark>		
SSN			DOB			Mal	le [Fen	ale					
Telephon	e Numbers: C	ell () -				Но	me () -			Work	() -	
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.														
	Provider/Schoo			-										
Type of In	<mark>formation Req</mark>	uested	(check ON	ILY one) Y	ou must han	d write	in s _i	pecific	informatio	on being re	equested:			
	cation records, ecific Informa			ripts, GED,	TCAP, Specia	ıl Educa	itio	n						
res	chological/Psycults. <i>Does not a</i> ecific Informa	pply to e	employees			ds, alcol	hol/	drug/	substance	abuse tre	eatment r	ecords, aı	nd any associ	ated test
	lical records, ir <mark>ecific Inform</mark> a	_			ratory tests,	and pre	escı	ribed t	reatments	s. Does no	t apply to	employee	s or volunteer	s.
	kground/Crimi ecific Informa			s, including	g Polygraph,	and Fir	ngei	rprint	Results					
	oloyment Recor ecific Informa		quested:											
	onal Finance/G ecific Informa				ords (as app	olicable))							
7. 🗌 Oth Sp	er ecific Informa	tion Re	quested:											
	of the Reques Il that apply: [ner:				☐ CPS In	vestiga	tior	n [] Juvenile	Court Ca	se			
Signatuı	<mark>re</mark> :									_ Da	ate:			
OR														
Signatui	re of Authorize	d Repre	sentative	*:						Da	ate:			

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Distribution: Copies: Pages 1-3 - Client

Page 4 - Signed Client Acknowledgement - Case File



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

B AUTHORIZATION FOR DCS FROM RELEASE		
l, hereby authorize the release the information specified on page 1, to the person/entity s	e Tennessee Department of Children's Services to specified on page 1B.	0
I understand that there are laws and regulations protecting the confidence the Tenn. Code Annotated; the federal Health Insurance Portability and of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidence gulations at 42 CFR Part 2. My signature indicates I have received a confidence of records or information as specified on page 2 of this release time, but it will not affect disclosures already made in reliance on this the HIPAA Authorization for Release of Protected Health Information and the standard protection of the standard protectio	nd Accountability Act of 1996 (HIPAA) and its reguentiality of Alcohol and Substance Abuse Patient copy of this authorization. I hereby request and and I may revoke this authorization in authorization. This release takes effect on the definition:	lations at 45 Code Records and its authorize the writing at any ate I signed it.
I hereby authorize the use or disclosure of my individually idea understand the following: (1) This authorization is voluntary. (information is not a health plan or health care provider the reprivacy regulations. (3) My ability to receive health care, eligib not be affected if I do not sign this form. (4) I may see and copy get a copy of this form after I sign it. (5) I may revoke this authorization(s) in writing, but if I do it won't have any (6) Any release made in reliance on this authorization prior to violation of HIPAA or my confidentiality rights. I have read this section. OR	2) If the person or organization authorized of leased information may no longer be proted ility for health care, or the payment for my y the information described on this form if I derization at any time by notifying the effect on actions taken before the revocation	to receive the cted by federal health care will ask for it, and I on was received.
If the individual who is the subject of the information request. Legal Guardian Must Sign This Release. <u>EXCEPTION:</u> Release of older, requires the signature of that minor. Release of records regardless of age, if the youth consented to the health care insome of the signature required:	records under category number 2 for a min s under categories 2 and 3 should be signed	or age 16 or by the youth,
Print Name	Signature	Date
OR		
Name of Authorized Representative (Print)	Signature of Authorized Representative	Date
Signer's Relationship to client and authority to release confide information	Legal Custodian*	iuardian*
Conservator* Personal Representat *Proof of authority to release information, such as a court order		ided.
Name of Witness (Print)	Signature of Witness	<u>Date</u>

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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:					First				<u> </u>	Middle		
Last					- " " "					uuio		
Other Le	gal Names:											
<u>Address</u>							_					
City						State			Zip	Code		
<mark>SSN</mark>			DOB			☐ Male	☐ Fe	<mark>male</mark>				
	ne Numbers: C) -			, <u> </u>	lome	() -		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.										a		
Name of	lame of Provider/School/Entity Releasing Information TO DCS:											
Type of l	<mark>nformation Rec</mark>	quested	(check ON	ILY one) Yo	u must hand	d write/t	/pe in s	pecific informatio	on being req	uested:		
	cation records ecific Informa		-	ripts, GED, T	CAP, Specia	l Educat	ion					
res	chological/Psyc sults. <i>Does not c</i> pecific Informa	apply to a	employees			ls, alcoh	ol/drug	/substance abus	se treatmen	t records, ar	nd any associated	d test
	dical records, in pecific Informa			tions, labora	atory tests,	and pres	cribed	treatments. Doe	es not apply	to employees	s or volunteers.	
	kground/Crimi ecific Informa				Polygraph,	and Fing	erprin	t Results				
	ployment Reco pecific Informa		quested:									
	sonal Finance/oecific Informa			urance Reco	ords (as app	licable)						
7. 🗌 Oth Sp	er ecific Informa	ition Re	quested:									
Check a	Purpose of the Requested Release/Disclosure: Check all that apply: Arrange/Access Services CPS Investigation Juvenile Court Case Other:											
Signatu	re:								Date:			
OR												
Signatu	re of Authorize	ed Repre	sentative	*:					Date:			
*Authoriz	ed Representati	ive mean	ıs vou have	e legal proof	vou can act	for this n	erson					

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Page 4 - Signed Client Acknowledgement - Case File



A. AUTHORIZATION FOR RELEASE TO DCS		
I, hereby authorized any representative of the Tennessee Department of Children's Services information deemed to be confidential. I hereby direct you as an indivirence representative. This release is executed with the full knowledge and unthe Department of Children's Services. Failure to grant access to the reinformation. I understand that there are laws and regulations protecting the confidence the Tenn. Code Annotated; the federal Health Insurance Portability and	idual or agency to release this information upo inderstanding that the information released is f equested information may result in a court orde entiality of certain written and oral information	ncluding any n request of said for the official use of er for the n such as: Title 33 of
of Federal Regulations (CFR) Parts 160 and 164; and the federal Confider regulations at 42 CFR Part 2. My signature indicates I have received a corelease of records or information as specified on page 2 of this release. time, but it will not affect disclosures already made in reliance on this a	ntiality of Alcohol and Substance Abuse Patient opy of this authorization. I hereby request and I understand I may revoke this authorization in	: Records and its authorize the n writing at any
HIPAA Authorization for Release of Protected Health Information I hereby authorize the use or disclosure of my individually identunderstand the following: (1) This authorization is voluntary. (2 information is not a health plan or health care provider the releprivacy regulations. (3) My ability to receive health care, eligibil not be affected if I do not sign this form. (4) I may see and copy	tifiable health information as described a) If the person or organization authorized eased information may no longer be prote lity for health care, or the payment for my	to receive the ected by federal health care will
get a copy of this form after I sign it. (5) I may revoke this author person/organization(s) in writing, but if I do it won't have any erection (6) Any release made in reliance on this authorization prior to reviolation of HIPAA or my confidentiality rights. I have read this section. Initial	ffect on actions taken before the revocati	ot constitute a
If the individual who is the subject of the information requested Legal Guardian Must Sign This Release. <u>EXCEPTION</u> : Release of rolder, requires the signature of that minor. Release of records regardless of age, if the youth consented to the health care inst	ecords under category number 2 for a minunder categories 2 and 3 should be signed	nor age 16 or by the youth,
One signature required:		
Print Name S	ignature	Date
OR		
Name of Authorized Representative (Print)	Signature of Authorized Representative	Date
Signer's Relationship to client and authority to release confident information Conservator* Personal Representative	Legal Custodian*	Guardian*
*Proof of authority to release information, such as a court order o		vided.
Name of Witness (Print)	Signature of Witness	Date

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

Name:			First			Mic	<mark>ldle</mark>	
Last								
	egal Names:							
Address				<u> </u>				
City		D.O.D		State		Zip Co	de	
SSN		DOB			Female		1471	1, ,
_	ne Numbers: Co n's expiration d				ome () -	au fuama data af alaw	Work	this form. The
i ilis torii	т з ехрігаціон ц	ate is.		expiratio		ear from date of sigr 90 days from the da		
Name of	Provider/School	ol/Entity Receivin	g Information FROM	DCS: <u>:</u>				
Type of l	<mark>nformation Req</mark>	uested (check O	NLY one) You must h	and write in	specific informati	on being requested:		
_		including transo	cripts, GED, TCAP, Spe :	ecial Educatio	on			
res	ults. Does not a	hiatric/Mental H pply to employee tion Requested	s or volunteers.	ords, alcoho	l/drug/substance	abuse treatment re	ecords, aı	nd any associated test
		cluding examination Requested	ations, laboratory tes :	its, and pres	cribed treatment	s. Does not apply to e	employees	s or volunteers.
		nal History Chec tion Requested	ks, including Polygra :	ph, and Finge	erprint Results			
	ployment Reco pecific Informa	ds tion Requested	:					
		Credit History/In tion Requested	surance Records (as a	applicable)				
7. 🗌 Oth Sp		tion Requested	:					
	ıll that apply: [ted Release/Disc		S Investigation	on 🗌 Juvenile	· Court Case		
Signatu	ıre:					Date:		
OR								
	re of Authorize	d Panrasantativ						

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Page 4 - Signed Client Acknowledgement - Case File



B AUTHORIZATION FOR DCS FROM RELEASE		
I, hereby authorize release the information specified on page 1, to the person/entit	the Tennessee Department of Children's Service ty specified on page 1B.	s to
I understand that there are laws and regulations protecting the cor	nfidentiality of certain written and oral informat	ion such as: Title 33 of
the Tenn. Code Annotated; the federal Health Insurance Portability	•	
of Federal Regulations (CFR) Parts 160 and 164; and the federal Conf	fidentiality of Alcohol and Substance Abuse Patie	ent Records and its
regulations at 42 CFR Part 2. My signature indicates I have received	a copy of this authorization. I hereby request are	nd authorize the
release of records or information as specified on page 2 of this release		
time, but it will not affect disclosures already made in reliance on t	his authorization. This release takes effect on th	e date I signed it.
HIPAA Authorization for Release of Protected Health Inform	aation:	
I hereby authorize the use or disclosure of my individually id		above. I
understand the following: (1) This authorization is voluntary		
information is not a health plan or health care provider the	released information may no longer be pro	tected by federal
privacy regulations. (3) My ability to receive health care, elig		-
not be affected if I do not sign this form. (4) I may see and co	• •	if I ask for it, and I
get a copy of this form after I sign it. (5) I may revoke this au		
person/organization(s) in writing, but if I do it won't have an	-	
(6) Any release made in reliance on this authorization prior violation of HIPAA or my confidentiality rights.	to receiving revocation of the release shall	not constitute a
I have read this section. OR	This section was read to me	
Initial	Init	<u>ial</u>
Legal Guardian Must Sign This Release. <u>EXCEPTION</u> : Release older, requires the signature of that minor. Release of recoregardless of age, if the youth consented to the health care One signature required:	rds under categories 2 and 3 should be sign	ed by the youth,
Print Name	Signature	Date
OR		
Name of Authorized Representative (Print)	Signature of Authorized Representative	Date
Signer's Relationship to client and authority to release confi	idential Self Parent Lega	al Guardian*
information	Legal Custodian*	ii Guardian
Conservator* Personal Represent	ative for HIPAA* Other*, specify:	
*Proof of authority to release information, such as a court ord	er or Power of Attorney document, must be pi	rovided.
Name of Witness (Print)		
	Signature of Witness	Date

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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:					First					Middle		
Last					<u>. II St</u>					wiidule		
Other Le	gal Names:											
Address												
City						State			Zip	Code		
<mark>SSN</mark>			DOB			☐ <mark>Male</mark>	☐ <mark>Fe</mark>	<mark>male</mark>				
<mark>Telepho</mark> i	<mark>ne Numbers</mark> : C	ell () -			H	lome	() -		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.										a		
Name of	lame of Provider/School/Entity Releasing Information TO DCS:											
Type of I	nformation Rec	uested	(check ON	ILY one) Yo	ou must hand	d write/t	/pe in s	pecific informatio	on being req	uested:		
1. 🗌 Edu	Type of Information Requested (check ONLY one) You must hand write/type in specific information being requested: Left Education records, including transcripts, GED, TCAP, Special Education Specific Information Requested:											
res Sp	results. Does not apply to employees or volunteers. Specific Information Requested:											
Sp	ecific Informa	ition Re	quested:			-		treatments. <i>Doe</i>	з пос ирріу	to employees	s or volunteers.	
	kground/Crimi ecific Informa				Polygraph,	and Fing	erprin	: Results				
	ployment Reco pecific Informa		quested:									
	sonal Finance/o ecific Informa			urance Reco	ords (as app	licable)						
7. 🗌 Oth Sp	er ecific Informa	ition Re	quested:									
Check a	Purpose of the Requested Release/Disclosure: Check all that apply: Arrange/Access Services CPS Investigation Juvenile Court Case Other:											
Signatu	<mark>re</mark> :								Date:			
OR												
Signatu	re of Authorize	d Repre	sentative	*:					Date:			
*Authoriz	ed Representati	ve mean	ıs vou have	e legal proof	vou can act f	for this n	erson					

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Page 4 - Signed Client Acknowledgement - Case File



A. AUTHORIZATION FOR RELEASE TO DCS		
I, hereby authoriz any representative of the Tennessee Department of Children's Services information deemed to be confidential. I hereby direct you as an indiv representative. This release is executed with the full knowledge and uthe Department of Children's Services. Failure to grant access to the reinformation.	ridual or agency to release this information upon rec anderstanding that the information released is for th	ding any quest of said ne official use of
I understand that there are laws and regulations protecting the confid the Tenn. Code Annotated; the federal Health Insurance Portability and of Federal Regulations (CFR) Parts 160 and 164; and the federal Confide regulations at 42 CFR Part 2. My signature indicates I have received a crelease of records or information as specified on page 2 of this release time, but it will not affect disclosures already made in reliance on this	d Accountability Act of 1996 (HIPAA) and its regulation entiality of Alcohol and Substance Abuse Patient Recopy of this authorization. I hereby request and authorization in writer and authorization in writer and authorization in writer.	ons at 45 Code cords and its norize the iting at any
HIPAA Authorization for Release of Protected Health Informati I hereby authorize the use or disclosure of my individually iden understand the following: (1) This authorization is voluntary. (2 information is not a health plan or health care provider the rel privacy regulations. (3) My ability to receive health care, eligibi not be affected if I do not sign this form. (4) I may see and copy get a copy of this form after I sign it. (5) I may revoke this authorization/organization(s) in writing, but if I do it won't have any e (6) Any release made in reliance on this authorization prior to a violation of HIPAA or my confidentiality rights. I have read this section. OR	ntifiable health information as described above 2) If the person or organization authorized to released information may no longer be protected ility for health care, or the payment for my heavithe information described on this form if I as orization at any time by notifying the effect on actions taken before the revocation of the release shall not control or the section was read to me. Initial Init	eceive the d by federal alth care will k for it, and I was received. onstitute a
If the individual who is the subject of the information requested Legal Guardian Must Sign This Release. <u>EXCEPTION</u> : Release of older, requires the signature of that minor. Release of records regardless of age, if the youth consented to the health care instructions.	records under category number 2 for a minor a under categories 2 and 3 should be signed by	age 16 or the youth,
One signature required:		
Print Name	Signature Do	ate
OR		
Name of Authorized Representative (Print)	Signature of Authorized Representative	Date
Signer's Relationship to client and authority to release confident information	ntial ☐ Self ☐ Parent ☐ Legal Guar ☐ Legal Custodian*	rdian*
Conservator* Personal Representati *Proof of authority to release information, such as a court order of		d
rrouj oj duthority to release injormation, such as a court order (or rower of Accorney document, must be provided	u.
Name of Witness (Print)	Signature of Witness	<u>Date</u>

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





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: <mark>Last</mark>					First					Middle			
Other Le	egal Names:					•							
Address													
City						State	2			Zip Code			
SSN			DOB			☐ <mark>Ma</mark>	ile	Fe	<mark>male</mark>				
Telepho	ne Numbers: (Cell () -				Но	me	() -	Wo	rk	() -	
This forn	n's expiration (date is:					itioi	n dat	ceed one year from date o e should be 90 days from st.				a
Name of	Provider/Scho	ol/Entity	/ Receivin	g Informati	ion FROM DC	:S: <u>:</u>							
Type of I	<mark>nformation Re</mark>	quested	(check Of	NLY one)	ou must han	d write	in s	pecifi	c information being reques	sted:			
_	ucation record		-	ripts, GED,	TCAP, Specia	ıl Educa	atio	n					
res	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:												
	dical records, i pecific Inform			tions, labo	ratory tests,	and pr	esc	ribed	treatments. Does not app	ly to emplo	yees	or volunteers.	
	ckground/Crim pecific Inform			s, includin	g Polygraph,	and Fi	nge	rprin	t Results				
	ployment Reco pecific Inform		equested:										
	rsonal Finance pecific Inform		-		cords (as app	licable	!)						
7. 🗌 Otł Sį	ner pecific Inform	ation Re	equested:										
Check a	e of the Reque all that apply: her:	Arrar	nge/Acces		CPS In	vestiga	atio	n	☐ Juvenile Court Case				-
Signatu	ıre:								Date:				
OR													
Signatu	ıre of Authoriz	ed Repre	esentative	*:					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



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

B AUTHORIZATION FOR DCS FROM RELEASE		
l, hereby authorize the release the information specified on page 1, to the person/entity s	e Tennessee Department of Children's Services t specified on page 1B.	0
I understand that there are laws and regulations protecting the confidence the Tenn. Code Annotated; the federal Health Insurance Portability and of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidence gulations at 42 CFR Part 2. My signature indicates I have received a confidence of records or information as specified on page 2 of this release time, but it will not affect disclosures already made in reliance on this the HIPAA Authorization for Release of Protected Health Information and the standard protection of the standard protectio	nd Accountability Act of 1996 (HIPAA) and its regulentiality of Alcohol and Substance Abuse Patient copy of this authorization. I hereby request and a lunderstand I may revoke this authorization in authorization. This release takes effect on the display.	llations at 45 Code Records and its authorize the writing at any ate I signed it.
I hereby authorize the use or disclosure of my individually idea understand the following: (1) This authorization is voluntary. (information is not a health plan or health care provider the reprivacy regulations. (3) My ability to receive health care, eligib not be affected if I do not sign this form. (4) I may see and copy get a copy of this form after I sign it. (5) I may revoke this authorization(s) in writing, but if I do it won't have any (6) Any release made in reliance on this authorization prior to violation of HIPAA or my confidentiality rights. I have read this section. OR	2) If the person or organization authorized leased information may no longer be prote ility for health care, or the payment for my the information described on this form if lorization at any time by notifying the effect on actions taken before the revocation	to receive the cted by federal health care will ask for it, and I on was received.
If the individual who is the subject of the information request. Legal Guardian Must Sign This Release. <u>EXCEPTION</u> : Release of older, requires the signature of that minor. Release of records regardless of age, if the youth consented to the health care insome One signature required:	records under category number 2 for a min s under categories 2 and 3 should be signed	or age 16 or by the youth,
Print Name	Signature	Date
OR		
Name of Authorized Representative (Print)	Signature of Authorized Representative	Date
Signer's Relationship to client and authority to release confide information	Legal Custodian*	Guardian*
Conservator* Personal Representat *Proof of authority to release information, such as a court order		ided.
Name of Witness (Print)	Signature of Witness	<u>Date</u>

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





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:					First					Mid	ldle		
Last Other Le	gal Names:												
Address	gai Names.												
City						State				Zip Co	de		
SSN			DOB			Male	l □ Fe	male				l	
Telepho	ne Numbers: C	ell () -				lome	() -			Work	() -	
This forn	ո's expiration d	ate is:					on dat	e should be				this form. The nature if making a	
Name of	Provider/School	ol/Entity	<mark>/ Releasin</mark>	g Informatio	on TO DCS:								
Type of Information Requested (check ONLY one) You must hand write/type in specific information being requested: I. Education records, including transcripts, GED, TCAP, Special Education													
res Sr 3. Me Sr 4. Bac	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												
5.	pecific Informa ployment Reco pecific Informa sonal Finance/o pecific Informa	rds Ition Re Credit H	equested:	surance Rec	ords (as app	licable)							
7. 🗌 Oth													
Check a	Purpose of the Requested Release/Disclosure: Check all that apply: Arrange/Access Services CPS Investigation Juvenile Court Case Other:												
Signatu	ıre:								Date	:			
OR													
Signatu	Signature of Authorized Representative*: Date:												
*Authoriz	Authorized Representative means you have legal proof you can act for this person.												

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A. AUTHORIZATION FOR RELEASE TO DCS		
I, hereby authoriz any representative of the Tennessee Department of Children's Services information deemed to be confidential. I hereby direct you as an indiv representative. This release is executed with the full knowledge and uthe Department of Children's Services. Failure to grant access to the reinformation.	ridual or agency to release this information upon rec anderstanding that the information released is for th	ding any quest of said ne official use of
I understand that there are laws and regulations protecting the confid the Tenn. Code Annotated; the federal Health Insurance Portability and of Federal Regulations (CFR) Parts 160 and 164; and the federal Confide regulations at 42 CFR Part 2. My signature indicates I have received a crelease of records or information as specified on page 2 of this release time, but it will not affect disclosures already made in reliance on this	d Accountability Act of 1996 (HIPAA) and its regulation entiality of Alcohol and Substance Abuse Patient Recopy of this authorization. I hereby request and authorization in writer and authorization in writer and authorization in writer.	ons at 45 Code cords and its norize the iting at any
HIPAA Authorization for Release of Protected Health Informati I hereby authorize the use or disclosure of my individually iden understand the following: (1) This authorization is voluntary. (2 information is not a health plan or health care provider the rel privacy regulations. (3) My ability to receive health care, eligibi not be affected if I do not sign this form. (4) I may see and copy get a copy of this form after I sign it. (5) I may revoke this authorization/organization(s) in writing, but if I do it won't have any e (6) Any release made in reliance on this authorization prior to a violation of HIPAA or my confidentiality rights. I have read this section. OR	ntifiable health information as described above 2) If the person or organization authorized to released information may no longer be protected ility for health care, or the payment for my heavithe information described on this form if I as orization at any time by notifying the effect on actions taken before the revocation of the release shall not control or the section was read to me. Initial Init	eceive the d by federal alth care will k for it, and I was received. onstitute a
If the individual who is the subject of the information requested Legal Guardian Must Sign This Release. <u>EXCEPTION</u> : Release of older, requires the signature of that minor. Release of records regardless of age, if the youth consented to the health care instructions.	records under category number 2 for a minor a under categories 2 and 3 should be signed by	age 16 or the youth,
One signature required:		
Print Name	Signature Do	ate
OR		
Name of Authorized Representative (Print)	Signature of Authorized Representative	Date
Signer's Relationship to client and authority to release confident information	ntial ☐ Self ☐ Parent ☐ Legal Guar ☐ Legal Custodian*	rdian*
Conservator* Personal Representati *Proof of authority to release information, such as a court order of		d
rrouj oj duthority to release injormation, such as a court order (or rower of Accorney document, must be provided	u.
Name of Witness (Print)	Signature of Witness	<u>Date</u>

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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: <mark>Last</mark>					First						Middle		
Other Le	gal Names:											•	
Address													
City						Stat	e			Zi	<mark>p Code</mark>		
SSN			DOB			□ <mark>Ma</mark>	ale	Fe	<mark>male</mark>				
Telephor	ne Numbers: Ce	ell () -				Но	me	() -		Worl	(() -	
This form	ı's expiration da	ate is:					atio	n date	should be 90 o			on this form. The gnature if making	; a
Name of	Provider/Schoo	l/Entity	Receiving	<mark>g Informatio</mark>	on FROM DC	S: <u>:</u>							
Type of li	nformation Req	uested ((check ON	ILY one) Yo	ou must hand	d write	in s	pecifi	c information b	eing request	<mark>ed</mark> :		
Sp 2.	ults. Does not a	tion Red hiatric/l pply to e	quested: Mental He employees	ealth Treatr	ment Record				/substance abu	use treatme	nt records,	and any associate	d test
Sp 4.	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. 🗌 Em _l	oloyment Recor ecific Informa	ds											
	sonal Finance/C ecific Informa				ords (as app	licable	e)						
7. 🗌 Oth <mark>S</mark> p	er ecific Informa	tion Re	quested:										
	e of the Reques II that apply: ner:				CPS In	vestig	atio	n	☐ Juvenile Cou	urt Case			_
Signatu	re:									Date:			_
OR													
Signatu	re of Authorize	d Repre	sentative	*:						Date:			_

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

B AUTHORIZATION FOR DCS FROM RELEASE		
l, hereby authorize the release the information specified on page 1, to the person/entity s	e Tennessee Department of Children's Services t specified on page 1B.	0
I understand that there are laws and regulations protecting the confidence the Tenn. Code Annotated; the federal Health Insurance Portability and of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidence gulations at 42 CFR Part 2. My signature indicates I have received a confidence of records or information as specified on page 2 of this release time, but it will not affect disclosures already made in reliance on this the HIPAA Authorization for Release of Protected Health Information and the standard protection of the standard protectio	nd Accountability Act of 1996 (HIPAA) and its regulentiality of Alcohol and Substance Abuse Patient copy of this authorization. I hereby request and a lunderstand I may revoke this authorization in authorization. This release takes effect on the display.	llations at 45 Code Records and its authorize the writing at any ate I signed it.
I hereby authorize the use or disclosure of my individually idea understand the following: (1) This authorization is voluntary. (information is not a health plan or health care provider the reprivacy regulations. (3) My ability to receive health care, eligib not be affected if I do not sign this form. (4) I may see and copy get a copy of this form after I sign it. (5) I may revoke this authorization(s) in writing, but if I do it won't have any (6) Any release made in reliance on this authorization prior to violation of HIPAA or my confidentiality rights. I have read this section. OR	2) If the person or organization authorized leased information may no longer be prote ility for health care, or the payment for my the information described on this form if lorization at any time by notifying the effect on actions taken before the revocation	to receive the cted by federal health care will ask for it, and I on was received.
If the individual who is the subject of the information request. Legal Guardian Must Sign This Release. <u>EXCEPTION</u> : Release of older, requires the signature of that minor. Release of records regardless of age, if the youth consented to the health care insome One signature required:	records under category number 2 for a min s under categories 2 and 3 should be signed	or age 16 or by the youth,
Print Name	Signature	Date
OR		
Name of Authorized Representative (Print)	Signature of Authorized Representative	Date
Signer's Relationship to client and authority to release confide information	Legal Custodian*	Guardian*
Conservator* Personal Representat *Proof of authority to release information, such as a court order		ided.
Name of Witness (Print)	Signature of Witness	<u>Date</u>

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





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: <mark>Last</mark>					<mark>First</mark>					Middle		
Other Le	gal Names:					•						
Address												
City	•					State			Z	ip Code		
SSN			DOB			Male	e Fe	<mark>male</mark>	•		,	
Telephor	<mark>e Numbers</mark> : C	ell () -				Home	() -		Wo	rk	() -
This form	<mark>'s expiration d</mark>	ate is:					ion dat					this form. The ature if making a
Name of	Provider/Schoo	ol/Entity	<mark>/ Releasin</mark>	g Informatio	on TO DCS:							
Type of Ir	iformation Red	quested	(check Of	NLY one) Yo	ou must hand	d write/t	ype in s	pecific informat	ion being re	equested:		
	. Education records, including transcripts, GED, TCAP, Special Education Specific Information Requested:											
res	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:											
	lical records, i ecific Informa			tions, labora	atory tests,	and pre	scribed	treatments. Do	es not appl	y to employ	rees	or volunteers.
	kground/Crimi ecific Informa				Polygraph,	and Fin	gerprin	t Results				
	oloyment Reco ecific Informa		quested:									
	sonal Finance/ ecific Informa			urance Reco	ords (as app	licable)						
7. 🗌 Oth Sp	er ecific Informa	ation Re	quested:									
	of the Reques Il that apply: [ner:	Arrar	ge/Acces		CPS In	vestigat	ion	☐ Juvenile Cou	ırt Case			
6 1									ъ			
Signatu	<mark>re:</mark>								vate:			
OR												
Signatu	re of Authorize	ed Repre	sentative	*:					Date:			
*Authoriz	ad Ranrasantat	ivo moor	se vou bou	logal proof	vou can act	for this r	orcon					

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A. AUTHORIZATION FOR RELEASE TO DCS		
☐ I. hereby authoriz	te release of the information specified on page 1A, to	
any representative of the Tennessee Department of Children's Services information deemed to be confidential. I hereby direct you as an indiv representative. This release is executed with the full knowledge and u the Department of Children's Services. Failure to grant access to the re	s bearing this release or a copy of this release, including ridual or agency to release this information upon reque inderstanding that the information released is for the o	st of said official use of
information.		
I understand that there are laws and regulations protecting the confid the Tenn. Code Annotated; the federal Health Insurance Portability and of Federal Regulations (CFR) Parts 160 and 164; and the federal Confide regulations at 42 CFR Part 2. My signature indicates I have received a corelease of records or information as specified on page 2 of this release. time, but it will not affect disclosures already made in reliance on this	d Accountability Act of 1996 (HIPAA) and its regulations entiality of Alcohol and Substance Abuse Patient Record opy of this authorization. I hereby request and authori . I understand I may revoke this authorization in writing	at 45 Code Is and its ze the g at any
HIPAA Authorization for Release of Protected Health Informati	on:	
I hereby authorize the use or disclosure of my individually iden		
understand the following: (1) This authorization is voluntary. (2 information is not a health plan or health care provider the rel		
privacy regulations. (3) My ability to receive health care, eligibi		
not be affected if I do not sign this form. (4) I may see and copy get a copy of this form after I sign it. (5) I may revoke this authorized the sign it.		or it, and i
person/organization(s) in writing, but if I do it won't have any e		
(6) Any release made in reliance on this authorization prior to a violation of HIPAA or my confidentiality rights.	receiving revocation of the release shall not cons	titute a
I have read this section OR	This section was read to me	
<mark>Initial</mark>	imuai	
If the individual who is the subject of the information requeste		
Legal Guardian Must Sign This Release. <u>EXCEPTION:</u> Release of older, requires the signature of that minor. Release of records		
regardless of age, if the youth consented to the health care ins	tead of the parent, guardian, or custodian conse	nting.
One signature required:		
Print Name	Signature Date	
O.D.		
OR		
Name of Authorized Representative (Print)	Signature of Authorized Representative	Date
Signer's Relationship to client and authority to release confiden		ın*
information Conservator* Personal Representati	Legal Custodian* ve for HIPAA* Other*, specify:	
*Proof of authority to release information, such as a court order of		
Names of Mitago (Drint)	Cignoture of With a	Dots
Name of Witness (Print)	Signature of Witness	Date

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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: <mark>Last</mark>					First					Mid	ldle		
Other Le	egal Names:												
Address													
City						State				Zip Co	de		
SSN			DOB			☐ <mark>Ma</mark>	le	Fe	male	•		-	
Telepho	ne Numbers: (Cell () -				Но	me	() -		Work	() -	
This forn	n's expiration (late is:					itioi	n dat	ceed one year from date e should be 90 days fron st.				a
Name of	Provider/Scho	ol/Entity	/ Receivin	g Informat	ion FROM DC	:S: <u>:</u>							
Type of I	nformation Re	<mark>quested</mark>	(check Of	NLY one)	ou must han	d write	in s	pecifi	ic information being requ	<mark>ested</mark> :			
	ucation records			ripts, GED,	TCAP, Specia	l Educa	atio	n					
res	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:												
	dical records, i pecific Inform			tions, labo	ratory tests,	and pr	esc	ribed	treatments. Does not ap	ply to e	employees	s or volunteers.	
	ckground/Crim pecific Inform				g Polygraph,	and Fi	nge	rprin	t Results				
	ployment Reco pecific Informa		equested:										
	rsonal Finance/ pecific Inform		-		cords (as app	licable	e)						
7. 🗌 Otł Sį	her pecific Inform	ation Re	equested:										
Check a	<mark>e of the Reque</mark> all that apply: her:	Arrar	nge/Acces		CPS In	vestiga	atio	n	☐ Juvenile Court Case				_
Signatu	<mark>ıre</mark> :								Date				_
OR													
Signatu	ıre of Authoriz	ed Repre	esentative	*:					Date				_

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 $[\]hbox{*Authorized Representative means you have legal proof you can act for this person.}\\$

B AUTHORIZATION FOR DCS FROM RELEASE		
l, hereby authorize the release the information specified on page 1, to the person/entity	ne Tennessee Department of Children's Services to specified on page 1B.	
I understand that there are laws and regulations protecting the confictive Tenn. Code Annotated; the federal Health Insurance Portability are of Federal Regulations (CFR) Parts 160 and 164; and the federal Confideregulations at 42 CFR Part 2. My signature indicates I have received a release of records or information as specified on page 2 of this release time, but it will not affect disclosures already made in reliance on this	nd Accountability Act of 1996 (HIPAA) and its regular entiality of Alcohol and Substance Abuse Patient Re copy of this authorization. I hereby request and au e. I understand I may revoke this authorization in w	tions at 45 Code ecords and its thorize the riting at any
HIPAA Authorization for Release of Protected Health Informat I hereby authorize the use or disclosure of my individually ide		ve. I
understand the following: (1) This authorization is voluntary. (information is not a health plan or health care provider the reprivacy regulations. (3) My ability to receive health care, eligible	2) If the person or organization authorized to leased information may no longer be protected	receive the ed by federal
not be affected if I do not sign this form. (4) I may see and copget a copy of this form after I sign it. (5) I may revoke this authorization(s) in writing, but if I do it won't have any (6) Any release made in reliance on this authorization prior to	y the information described on this form if I a norization at any time by notifying the effect on actions taken before the revocation	sk for it, and I was received.
violation of HIPAA or my confidentiality rights. I have read this section OR	This section was read to me	
If the individual who is the subject of the information request Legal Guardian Must Sign This Release. <u>EXCEPTION</u> : Release of older, requires the signature of that minor. Release of record regardless of age, if the youth consented to the health care in	records under category number 2 for a minor s under categories 2 and 3 should be signed by	age 16 or the youth,
One signature required:		
Print Name	Signature L	Date
OR		
Name of Authorized Representative (Print)	Signature of Authorized Representative	Date
Signer's Relationship to client and authority to release confidention	Self Parent Legal Gua	ardian*
Conservator* Personal Representate *Proof of authority to release information, such as a court order		ed.
Name of Witness (Print)	Signature of Witness	Date

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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.

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Name:	Last					First						Midd	lle			
Address	S															
City							State					Zip Cod	le			
SSN			DOB			Place of Birt	:h				☐ Male ☐	Female	;			
Teleph	one Numbers:	Home	-		() -	•		Woi	rk () -	•	I	Cell	()	-	
This for	m is effective f	rom:			Date:	te: to Date:										
Date n	ot to exceed o	ne yea	r from beg	in da	ite.											
Signatu	ignature: Date:Date:															
Signatu	re of Authorize	d Rep	resentative	e*:												
Witness	·											Date:				
	ized Representa . We may have t				ou.	u can act for th							o may or	may no	t legally s	ign on his
Unal	ole to locate re	queste	d Informa	tion			Reque	ested	inform	ation coul	d not be rel	eased				
Reason																
Informa	ation released l	by										Date				
DCS Co	ntact Person									Telepho	ne Number					
DCS Off	ice Address															
DCS Sta	ff Requesting R	Release	e of TennCa	are E	ligibility Info	o:							Da	ate:		
DCS Sta	ff Who Accesse	d Tenr	nCare Eligil	bility	ı Info:								Da	ate:		

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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.

<u>Identify</u>	ing Information	of Individual 1	o Whom this Rele	ease Pertains:							
Name:	Last			First					Midd	lle	
Addres	s										
City					State				Zip Cod	le	
SSN		DOB		Place of Birth	h			☐ Male	Female	<u> </u>	
Telepho	one Numbers: H	lome	() -			Work	() -	'		Cell	
This for	m is effective fr	om:	Date:			to	Date:				
Date r	ot to exceed on	e year from be	gin date.								
Signatu	ire:								Date:		
Signatu	re of Authorize	d Representati	ve*:								
Witness	·								Date:		
		ive means you h	nave legal proof voi	u can act for th	is perso	n. A repre	esentative si	gns for an app		o may or	may not legally sign on his
her own	. We may have to	get this proof	rom you.		·	·	,			,	
	ole to locate req		* * * * * * * * * * * * * * * * * * *		_			* * * * * * * * uld not be rel			
Reason											
Informa	ation released b	у							Date		
DCS Co	ntact Person						Teleph	one Number			
DCS Off	ice Address						•				
DCS Sta	ff Requesting R	elease of Tenno	Care Eligibility Info	o:						Da	nte:
DCC C+-	EE VAIII - A	d TammCana 5"	ihilial.afa.							D -	
DCS Sta	ff Who Accessed	a Tenncare Elig	ibility into:							Da	ite:

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Identifying Information of	Individual t	o Whom this Rele	ase Pertains:								
Name: Last			First					Midd	lle		
Address											
City				State				Zip Cod	le		
SSN	DOB		Place of Birth	h			☐ Male	Female	•		
Telephone Numbers: Hom	e	() -			Work	() -			Cell		
This form is effective from:		Date:		•	to	Date:					
Date not to exceed one ye	ar from be	gin date.									
Signature:								Date:			
								•			
Signature of Authorized Re	presentativ	/e*: 									
Witness:								Date:			
*Authorized Representative r	neans you h	iave legal proof you	can act for th	is perso	n. A repre	esentative sig	gns for an ap	plicant wh	o may or	may not legally s	ign on his
her own. We may have to ge			*****	****	*****	*****	******	*****			
☐ Unable to locate reques				_			ıld not be re				
Reason											
Information released by								Date			
DCS Contact Person						Telepho	ne Number				
DCS Office Address						•					
DCS Staff Requesting Relea	se of Tenno	Care Eligibility Info	: <u> </u>						Da	nte:	
DCS Staff Who Accessed Te	nnCare Elig	ibility Info:							Da	ite:	

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Name:	Last						First									Mide	dle					
Address	3																					
City								State	е						Z	ip Cod	le					
SSN			DOB				Place of Bir	th						Male	F	emale	2					
Telepho	ne Numbers:	Home			()	-			Wo	rk ()	-					Cel	II				
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Reason																						
Informa	tion released	by														Date						
DCS Cor	ntact Person										1	Γeleph	one	Numbe	er							
DCS Off	ice Address																					
DCS Sta	ff Requesting	Releas	e of TennCa	are E	ligibilit	y Info	: <u> </u>											Date	»:			
DCS Sta	ff Who Access	ed Teni	nCare Eligil	bility	Info:													Date):			

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Addres	is											
City					State				Zip Cod	le		
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Teleph	one Numbers:	Home	() -		,	Work	() -		I	Cell		
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Date i	not to exceed o	ne year from be	gin date.			ı	I					
Signatu	ure:								Date:			
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DCS Off	fice Address															
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Inform	ation released by								Date			
DCS Co	ontact Person						Teleph	one Number				
DCS Of	fice Address						•			•		
DCS St	aff Requesting Rele	ase of TennC	are Eligibility In	fo:						0	ate:	
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Telepho	one Numbers:	Home	() -		V	Vork () -			Cell	()	-	
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Date n	ot to exceed o	ne year from beg	gin date.										
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		to get this proof	from you. * * * * * * * * * * *	*****	*****	*****	*****	******	****				
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DCS Of	fice Address												
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Kinship Exception Request

PART 1---FAMILY INFORMATION

Date:	Family Case Name:		C	ase #:		
Child's Name	Date of Birth	Race	Sex	Special Need	ds	
PART 2PARTIES RESPONSIBLE FO	OR COMPLETING KINSHII	P EXCEPTION R			T FC/A/	
Requesting Case Manager:			CPS		FSW FSW	
Region:			County:			
Reviewing Team Leader/Team					Date	
Coordinator:					Reviewed:	
_		_				
☐ KER APPROVED		KER DENIE	D			
Date consult note/form entered in	to TFACTS:					
Signature of KER Approver:				Da	te:	
Other Information/Regional Protocol Requirements:						

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CS-0699 Rev 10/17





Contact Sheets for Genogram

Child Name:	DOB:	
Initiated by:	Date:	

Genogram

Genogram							
Relationship	Name	Phone	Address	Diligent Search Searching, Notified, or N/A	Comments (I	nclude date	es 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					
School Personnel					
School Personnel					
School Personnel					
School Personnel					

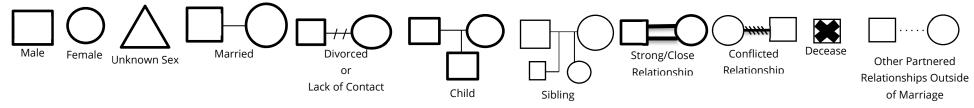
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Church Friends			
Church Friends			
Church Friends			
Church Friends			
Community Friends			
Community Friends			
Community Friends			
Community Friends			
Others			
Others			

Genogram Drawing (Optional)



RDA 2982

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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 TennCareSM 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 India White Alaskan Native Unavailable/Unknown Asian Is the child/applicant Hispanic/Latino? Yes Date of Birth: Sex: Female	e
County of Commitment:	County of Placement:
PART 3: For Case Management, please call 1-888-416-3025.	
PART 4: Provider and Other Insurance Information	<u>on</u>
Primary Care Provider of Choice:	Provider Number:
Other Insurance (besides TennCare):	☐ No
Name of Insurance Carrier:	Effective Date:
Name of Policy Holder:	ID Number:
CERTIFICATION: I certify that the information on this for DCS. I understand that the eligibility must still be processed TennCare determines the eligibility.	_
Signature:	Date:
	(month/day/year)

BlueCare Tennessee, an Independent Licensee of BlueCross BlueShield Association.



Consent for Vaccination

Name of Child:	Date of Birth: _		TFACTS ID:	
Date of Custody:	County of Custody:		Region of Custody:	
This document verif	ies that tment of Children's Service	is in the legal co	ustody of	
arent/Guardian				
Department. I understand numans to stimulate the bo	, understand that the request and/or facilitate vaccination the meaning of vaccination to mea ody's immune response against an Idhood vaccinations. Routine childle	ns to my child an the act of ir infectious dis	while he/she is in the custody of stroducing a substance intended ease or pathogen. I give permis	of the I for use in
 Hepatitis B Rotavirus Diphtheria, tei Influenza Varicella Meningococca 	tanus, and acellular pertussis al disease	- Pnet - Inac - Mea	mophilus influenzae type b umococcal conjugate tivated poliovirus sles, mumps, rubella atitis A	
have also been informed outhorize vaccination of the	that if I choose not to consent, the le child.	Department o	f Children's Services, may seek a	i court order to
	Parent or Legal Guardian Signature		Date	
	Witness Signature		 Date	