Face Sheet

Completed by	Date
CPS Re	moval Packet is due to Foster Care by Case Transfer
Initial Intake, Pla Due to placeme	acement and Well-Being Information and History (CS-0727) – nt immediately
KER/Genogram (C	CS-1013 & 0774) – Due to placement immediately
Consent for psycl	hotropic meds (CS-0627) – Due immediately
Medication Trans	sfer Form (CS-0813) – Due immediately
	Routine Health (CS-0206) – To be taken to the placement; nin 24 hours of removal
Tenn Care Immed	diate Eligibility - Due within 24 hours
Child Welfare Bei days	nefits Application (CS-0475) – Due to CWB within 5 business
	Release of Information and HIPAA Protected Health and FROM (CS-0559) – Due to Foster Care by case transfer
TENNCARE TO Authorization f	For Release of TennCare Eligibility Information FROM The Department of Children's Services and for the Release of Information TO TENNCARE FROM The TChildren'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

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	lame:					Chi	ld DOB:				Perso	n ID:			
Initiated E	Ву:						Title:				Da	ate:			
Revised B	y:						Title:				Da	ate:			
Person Pr	oviding Inforr	natio	n to DCS:					Relatio	nship to	Child/Yo	outh:				
Current	insurance co	vera	ge 🗌 Y	es 🗌	No 🗌	Unkn	own If y	es, provi	de deta	ils:					
Child/Y	outh Info	rma	ation												
Name of	Child/Youth:					E-ma	ail Address:					S	SSN:		
DOB:	Sex		R	ace:			Hispanic:	Yes [No	U.S. Citizen	ı:	Provi	_	No Th Certificate	
Is Child/Y	outh of Nati	ve An	nerican De	scent?	Ye	es 🗌	No 🗌 Una	ible to Det	termine	If "Ye Affilia	s" Triba	al			
Child/You	uth's Marital	Statu	ıs (check or	ne)	Neve	r Marr	ied 🔲 Di	vorced	☐ Wie	dowed		arriec]	Separated	
Has Yout placemer	h been place nts:	d in c	out of hom	e care	prior to	this (custody epi	sode? If y	es plea	se list d	ates ar	nd		Yes No	
Currer	nt Descrip	tion	of the	Child	/Yout	h									
Physical I	Description D	ate				Pı	rimary Lang	guage Spo	ken						
Height		,	Weight				Hair Color			Ey	e Colo	r			
Religion:					Ident	ifying	Marks or Ta	attoos:							
Special N	Needs/Disabi	lities	:												
Special N	Medical Equip	men	t:												
Schedule	ed Appointm	ents:	(date, prov	ider, lo	cation,	type o	of appt)								
Allergies	s/Adverse Rea	actio	ns:	Yes	No)									
Medicati	ion:							Descri	be reac	tion:					
Food:								Descri	be reac	tion:					
Insect Sting:									be reac						
Other:								Descri	be reac	tion:					
Medical	modified/Rel	igiou	s diet?	□ '	Yes 🗌] No	If yes, des	scribe							

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Child Name: Child DOB: Person ID: Medications: Prescribed and Over the Counter																	
		•														•	
Medica	atio	ons:	Pres	cribed ar	nd Ove	r the C	oun	ter									
Current	med	dicatio	ons (<i>nd</i>	ime, route, fi	requency	, dosage &	& days	of me	eds I	left)							
				T ==		_											
Are med					Yes L		hich ı		_								
Consent	sigi	ned fo	r psyc	hotropic me	ds:	∐ Yes	∐N	0 _] N/.	A	Ne	xt med	appoi	ntment:			
Has Fost	er P	arent	receiv	ved medicat	ion:	Yes	□N	o E	kpla	in:							
Health	Н	istor	y of	Child Expl	lain any	items ch	eckec	d Now	ı/Pa	st ir	า "C	OMM	ENTS"	section			
No	No	ow	Past							Ν	10	Now	Past				
				Birth defect	īS .									Gastroi	ntestinal pr	oblems	
				Vision prob	lems									Kidney/	urinary pro	blems	
]		Hearing pro	blems									Hepatit	is/liver prob	olems	
]		Skin proble	ms									Cancer			
	L			Head injurie	es						<u> </u>			Tubercu	ulosis (TB)		
				Headaches										Autism/	/Asperger's	(circle one)	
<u>Ц</u>	Ļ]	<u> </u>	Sickle cell d	isease					Ļ	<u> </u>		Щ.	Develop	omental del	lays	
<u> </u>	Ļ	_	<u>Ц</u>	Anemia/blo		der			_	Ļ	<u> </u>		Щ		g disability		
<u> </u>	닏]	<u>Ц</u>	Epilepsy/se					_	Ļ	<u> </u>		Щ		roblems		
<u> </u>	Ļ]	<u> </u>	Bedwetting					_	Ļ	4			Incontir		Jrine Stool	
<u> </u>	ĻĻ	_	<u> </u>	Diabetes						Ļ	<u> </u>		Щ_	Other n	nedical (des	cribe below)	
	Ļ	_	<u>Ц</u>	Asthma/Res	spiratory	Disease			_	L	4		Щ		nts (describe	· · · · · · · · · · · · · · · · · · ·	
<u> </u>	닏]	<u> </u>	Heart murn					_	Ļ	<u> </u>			1		escribe below)	
<u> </u>	닏]	<u> </u>	Heart probl					_	Ļ	<u> </u>				es (describe		
H	l]	H	High blood	-	!				ļĻ	\exists	H	H		ns with ane · · ·		
Child (Va	طهر	J	u a sa tella s	Physical dis		□ Vas		1.6		L			deser	Other d	levelopmen	ital disabilities	
Child/ fo	utn	is cur	rentiy	hospitalized	a:	Yes	No) IT	yes	, wr	iere	e and w	ny:				
Commen health re				ealth inform	nation/o	ngoing											
ileaitii i e	iat	eu sei	VICES.														
Childh	00	d Illr	nesse	es													
No	Y	'es	Appr	ox date						No		Yes	Approx	k date			
☐ ☐ Measles															Chicken p	OOX	
German measles															Scarlet fev		
☐ ☐ Mumps															Rheumati	c fever	
Trauma Screening												I			•		
				abuse/advers	se experi	ences. Exi	olain a	anv ve	s an	swe	rs ir	า "COM	MENTS	5" section			
No Yes			, ,					No.	Ye								
	Neglect Domestic violence																
	-			ault/abuse				$\overline{\Box}$	tĒ	1		nool vio					
				ılt/abuse					Ħ	1		mmuni		nce			

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-1 ·1 ·				<u> </u>			$\overline{}$							
Child	Nam	e:		Child I	טע)B:	<u>L</u>	Person ID:						
						ı								
No	Yes			No		Yes	5							
		Emotional	abuse				ĺ	Extreme interpersonal violence						
		Traumatic	loss/separation				j	Natural disaster						
		Extended	illness/medical trauma					Impaired caregiver (substance abuse/mental illness)						
П	П	Serious in	iury			П		Other trauma, describe:						
			orted?	call CPS	8	377-	23	7-0026						
								_						
Child	d Str	engths												
	Child Strengths													
Beha	avior	ral/Men	tal Health History											
No	Now													
			Intense anger, if yes, describe											
$\overline{\sqcap}$	Ħ		Oppositional, if yes, describe											
			Negative Peer Association, if yes,	describe										
			Extreme Attention Seeking, if yes,	describe	<u> </u>									
			Makes False Statements, if yes, de	escribe										
			School Difficulties, if yes, describe)										
			Damage of Property, if yes, descri	ibe										
			Habitual Lying, if yes, describe											
			Stool Smearing, if yes, describe											
			Stealing, if yes, describe											
			Runaway, if yes, describe											
Ц		<u> </u>	Hoarding, if yes, describe											
Ц.	Щ.	<u> </u>	Problems with concentration and		_									
<u> </u>	Щ.	<u> </u>	Excessive Hyperactivity/does not				ety	instructions, if yes, describe						
<u> </u>	<u> </u>	<u> </u>	Requires Constant Supervision, if	yes desc	rib	oe								
<u> </u>		<u> </u>	Anxiety, if yes, describe											
<u> </u>	 	ᆜ├	Depression, if yes, describe	to all			_							
 -	H	-	Seeing or hearing things that aren	n't there,	IŤ Š	yes,	de	scribe						
<u> </u>	H		Fire-setting, if yes, describe											
	Animal cruelty, if yes, describe													
	H	$\dashv \dashv \vdash$	Animal fear, if yes, describe	·⊔arm	if v	,OC -	٩٥٠							
	H	$\dashv \dashv \dashv$	Self-injurious behavior/Other Self		_									
	Aggressive, dangerous or destructive behaviors, if yes, describe Sexual aggression, if yes, describe													
 	┝┼	 	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:	
						1		
No	Now	Past						
			Attempted suic	ide If yes, describ	oe			
			•	tal health or beha		, if yes, describe		
一				ealth diagnosis, if	<u> </u>	, ,		
					,			
Has t	he Child	/Youth re	ceived counsel	ing or therapy?		Yes No		
If yes	, where?							
Has t	he Child	/Youth ha	ad a Psychologi	cal Evaluation:		Yes No		
If yes	, diagnos	sis, when	, where?					
				d for mental heal	th problems/a	cute hospitalization?	Yes	No
If yes	, diagnos	sis, when	, where?					_
	l	D/ /E -		·	• I 🗆 🗸	. 🗆 N.		
	, when, v		amily received	in-home services	? Ye	es No		
ii yes	, wiieii, \	Mileres						
Hast	he Child	/Youth nr	eviously heen i	olaced in a reside	ential treatme	nt facility?	□ No	
	, when, \		eviously been	Jucca III a reside		Tes		
,	<i>,</i> , .							
Alco	hol/Di	rug Ahi	use History					
No	Now	Past	Frequency	(Xs per day/wee	k/month)			
			Trequericy	Alcohol	K/IIIOII(II)			
H	H	$+ \vdash \vdash$		Tobacco smoke	/chew (circle on	or hoth)		
H	H	+=		E-cigarettes/vap	•	. Or Dottry		
				Marijuana	or eigarettes			
H				Narcotics				
H	Ħ			Stimulants				
Ħ	Ħ			Methamphetam	ine			
\Box				Hallucinogens				
Ħ	Ħ	TH		Steroids				
Ħ				Huffing				
一				Ecstasy				
				Street drugs, un	known			
						or another, specify:		
				Over-the-counte	er medication, s	pecify:		
				Other, specify:		-		
Addit	ional Co	mments:						
Has c	hild beer	n identifi	ed as high risk?				Yes [No
Has a	Safety P	lan been	completed on	child identified a	s high risk?		☐ Yes [□ No □ N/A
Birt	h Histo	ory (for a	all children)					
Birth	Weight:		Bir	th Length:	Full weeks)	term or 🔲 Premature bii	rth (<36	weeks
Did m	other re	eceive pre	enatal care:	Yes No		egnancy for 1st prenatal v	risit:	
			lications:			•		
			bstance abuse:	Yes N	o Su	bstance and frequency:		

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Child Name:					Child DO	3:			Per	rson ID:		
Birth hospital and	d location											
Minor Female	е											
Age of 1st Period:		Da	ate of Last l	Period:								
Pregnancies #		Liv	ve births #		Full term		Pren	nature (# week	(S)		
Miscarriages #		4	Abortions #	#	Current	ly pregnant	:	Yes	No	If yes, du	e date:	
December 2011					16							
Does the youth ha	DOB	en <i>:</i> In DCS	Yes Male			ver below qu e of Person			e of Ch	ild's C	netnet le	formation
Children's	ров	Custod				e or Person ives with ar			ie oi Cii ier Pare			r Parent
Names		?	19 101114			Relationshi		000	ici i ai c		or othe	i i ai ciic
110		Yes 🗍	Male				<u>-</u>					
		No 🔲	Female									
		Yes 🗌	Male									
		No 🔲	Female									
		Yes 📙	Male	\sqcup								
Does minor parer		No	Female		1)? Yes	□ No						
If yes, list any visi				cmia(rer	i): res	NO						
ii yes, lise aliy visi	itation its	er iccioi	113.									
Gender and S	exual l	denti	ty									
Does the Child/Yo	outh ident	ify him	/herself as	gay, lesb	ian, transge	nder, or no	n-bina	ry?	Ye	s No		
If yes, describe ar	nswer											
Sexual Activi	ty											
Is child sexually a	ctive?		Yes 🗌 No	ι	Jse birth co	ntrol?	Yes 🗌] No	Metho	d:		
Dating Violen	ice											
Has Child/Youth	experience	ed cont	rolling, abu	ısive or a	ggressive be	havior in a	dating	g relatio	nship?		Yes	No
If yes, explain:												
Medical												
Does the Child/Yo			ar medical	provider	(pediatricia	n, family do	octor, e			Yes	☐ No	
If yes, name of m	edical pro	vider:						Date	of last	visit:		
Immunizatio												
Are immunization	•		Ye			nunization				Yes	No	
Religious/medica	l exemption	on?	Yes	∐ No (parent/guard	ian must pro	ovide a	notarize	ed state	ment)		
Dental												
					Yes						Yes	П No
Does the Child/Yo	outh have	a regul	ar dental p	rovider?	☐ No	Does th	ne Chil	d/Youth	wear b	oraces?		
If yes, name of de								Date of				
If hraces name of	t orthodo	ntict	l					Date of	Flact Av	vam:		

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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

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Child Name:	Child DOB:	Person ID:	

This information does not go to Health Care Provider

Education	on and	Inde	epend	lent	t Living	3											
Student gr	aduated	l high s	chool?		Yes		No [GE	D [HISET		Stude	ent H	ome Scl	nool	ed	
What scho	ol does	the stu	dent at	tend	d? (name	, city	, cou	nty)									
Student's					Current	grac	de			Studen	t rece	ives	spe	cial edu	cati	on services?	Yes No
If yes, nam	ne the di	sability	y														
No	Yes																
		Is the	student	takir	ng GED cl	asses	5										
		Does t	he stud	ent ł	nave a his	tory	of ski	pping	scho	ol?							
		Is the	student	in ar	n alternat	ive so	chool	?									
		Is the	student	serv	ing a zero	tole	rance	e expu	ılsion	drugs,	weap	ons	and/	or assau	ılt)?		
					ing a sus eason an						n zero	tole	rance	e?			
Student st	rengths	(check	all tha	t apı	oly)				Ar	eas nee	ding	impi	rovei	ment (c	hec	k all that apply)	
Mathen	natics] Mathe	matics	5					
Reading	<u> </u>] Readin	g						
Athletic										Athleti							
Attenda	ance in so	thool								Attend	ance i	n scl	nool				
Other, s	specify									Other,	specif	y					
Other thin	igs you v	vould l	ike to s	hare	regardii	ng yo	ur st	uden	t's sc	hooling	;?						
Present	ing an	d Pre	vious	Co	urt Ac	tion	ıs oı	n Yo	uth	(Unru	ا/ylu	Deli	nqı	uent \	ou/	th only)	
Current Di	ispositio	nal Inf	ormatio	on													
Disposition	n Judge									Sp	ecial	Judg	e				
Current Di																	
Current Di	•							_							Di	sposition Date	
Have you l		are yoເ	ı currer	ntly (on proba	tion?	?	\ \ \ \ \	⁄es	☐ No	If ye	es, w	here				
Defense A																	
Current Ac																idication Date	
Adjudicate	ed Charg	e – Cur	rent ar	nd Pr	evious				Dat	e Occur	red	Dis Da	posi te	tion		Disposition	
Pending Cl	harges											Co	urt D	ate Set		Date (if yes)	
													Yes	No No			
												$\sqcup \sqcup$	Yes	No No			
													Yes	☐ No			
Violation o	of Proba	tion (V	OP) or \	/iola	tion of V	alid (Court	: Orde	er (V\	/CO) <i>(</i> ex	(plain	if ap	plico	ible)			

Child Name	:				Child DOB:		Pers	on ID:	
Narrative									
Legal/Pro	batio	on Servi	ces Previ	ously O	ffered to C	hild/Youth			
Date				ype			Out	come	
			,						
Safety (Ur	nruly	/Deling	uent Yoเ	th only	')				
A) Maltreatn									
Other		-0							
(explain)									
Narrative			,						
Strengths (Signature)	ans of	Cafatul	T						
Risks, Needs			ians of Pick	include					
aggressive be		-	•						
gang involven			icity to unin	, uis,					
B) Domestic									
Narrative									
Strengths (Signature)									
Risks, Needs		-	•						
aggressive be			ielty to anim	ials,					
gang involven	nent, e	etc.)					Camback #		
FSW Name Office Addres							Contact #		
Supervisor	>> 						Contact #		
Super visor							Contact #		
			DCS /	Provider Staf	ff			Date	<u> </u>
Lackpowi	ladaa	rosoint of			-	ing Information			
	_	•				ing Information			
	-		_		-	n confidentiality			
			-	-		on I may receive			
•	to re	nnessee C	ode Annota	ated 937-2	2-415, The Fos	ter Parent Rights			
Act.									
			Fos	ter Parent				Date	<u> </u>
			Fos	ter Parent				Date	

Child Na	ame:					Chil	d DOB:				Perso	n ID:		
Do n	ot prov	ide t	his s	section	n to th	e Foster P	arent o	r the H	ealth (Care P	Provid	er		
Receivi f yes, <u>imme</u>	ng Adopti	on Ass tify the	istan Pern	ce or Sul	bsidized Specialis	No: Was the of Permanent Got, Child Welfare	uardiansl e Benefits	nip: 🔲 Y	es	lo: If yes al and Ce	s, Amo ı	unt:	_	
Removal Date:			Nev Plac	v cement:				Date of Placem				Legal C Date:	ustody	
Removal County:						ication Type: Description:	□ Дере	endent and	d Neglect	t 🗌 Ur	nruly [] Delin	quent []N/A
Removal Reason:	Disability;	Dr on (onl	ug Ab y sele	use (Chil	d);	buse (Parent); [rug Abuse (Par rney instructio	ent); 🔲 In	adequate	Housing	g; 🔲 Inca	arceratio	on of Pa	rents;	NAS
Removal	Street Ado	dress												
City						County			State		Zip C	ode		
-						Kinship E	ception l	Request			-			
Was KER	approved	l?		Yes 🗌	No I	f yes, by whor	n?							
	KER temp					tempora	ary 🗌 I	ong term						
MSW Cor	nsult was	compl	eted v	with:										
Family	<i>I</i> nform	natio	n											
Both par	ents living	g?			Yes	No	If	no, date	s) of dea	ath:				
Foodstar		Suppo	ort, et	tc.) If ad	_	y: (including S supports are					name			
	outh Pa				• •		l £	··	. D -	·	_			
			regi	ver's P	reterr	red Method	tor Re	ceiving	Docu				1—	
	ther's Nan	<u>ne</u>								Primar	y Careg		Yes	☐ No
Email Add	dress				<u> </u>					Yes	□ N	0		
Maiden N	lame				So	cial Security N	lo.		DOB		Mes	sage Co	ontact #	
Address										☐ Yes	s <u> </u>	10		
City, State	e, Zip										C	ontact :	#	

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Child Name:					Ch	ild DOB:				Pers	on ID:			
Employer						,	Address							
City, State, Zip											Contact :	#		
Birth mother m	arried w	hen ch	ild/Yout	h was bor	n?	☐ Yes	☐ No		Jnable t	o Determ	ine			
Birth mother ev	er been	marrie	ed?	Yes	□No	Unable	to Determi	ine	lf so, w and to	here whom?				
Birth mother ev	er been	divorc	ed?	Yes	□No	Unable	to Determi	ine	If so, w from w	here and hom?	I			
Birth mother's r	ace:													
Is there a fathe	r listed o	on the	birth ce	rtificate?		Yes	□ No							
Has DNA testin	g ever b	een do	ne?	☐ Ye	s 🗌 No		nat were there was it o							
Has there ever has been legiti		_		-	her mothe					th or a fa	ther	Ye	s [No
Legal Father's N	<u>ame</u>								Pr	imary Ca	regiver		Yes	☐ No
Email Address										Yes [No	•		
Social Security N	No.				DOB					Messag	e Contac	t #		
Address										Yes	No			
City, State, Zip											Contac	t #		
Legal Father's R	ace:													
Employer							Address							
City, State, Zip	<u>'</u>										Contac	t #		
Marital Status o	f Parent	s		Married	☐ Sep	parated	☐ Divor	rced		Other				
Putative/Allege	d Father	s Nam	<u>e</u>											
Email Address										Yes	No			
Social Security N	No.				DOB				,	Messag	e Contac	t #		
Address										Yes	No			
City, State, Zip									,		Contac	t #		
Putative/Allege	d Father'	s Race	:											
Employer			•				Address							
City, State, Zip											Contac	t #		
Caregiver's Nam	ne <i>(if diff</i>	erent f	rom abo	ve)						Rela	tionship			
Email Address										Yes [No			
Social Security N	No.				DOB					Message	Contact	#		
Address									[] Yes	No			
City, State, Zip									1		Contac	t #		

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Child Name:			Child DOB:				Perso	n ID:		
Employer				Address						
City, State, Zip								Contact	t #	
Polative Contact	Person For Child/Y	/outh (other tha	n naren	+\					
Relative Contact	reison for Cilia, i	i outii (other tha	ii pai cii		ontact #				
Relationship										
Child/Youth Siblings:										In Custody
Name	SS	SN	1	ООВ		Sex	Rad	e		Yes No
Name	SS	SN	1	ООВ		Sex	Rad	e		Yes No
Name	SS	SN		ООВ		Sex	Rac	e		Yes No
Name	SS	SN	1	ООВ		Sex	Rad	e		Yes No
Name	SS	SN	1	ООВ		Sex	Rad	e		Yes No
Name	SS	SN	1	ООВ		Sex	Rad	e		Yes No
Name	SS	SN	1	ОВ		Sex	Rac	e		Yes No
Name	SS	SN		ООВ		Sex	Rac	e		Yes No
Name	SS	SN		ООВ		Sex	Rac	e		Yes No
Name	SS	SN		ОВ		Sex	Rac	e		Yes No
Name	SS	SN		ООВ		Sex	Rac	e		Yes No
Name	SS	SN		ООВ		Sex	Rac	e		Yes No
Name	SS	SN		ОВ		Sex	Rac	:e		Yes No

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Name

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State of Tennessee

Child Welfare Benefits Application

Date Received:									
IDENTIFYING INFOR	MATION:								
Child's Last Name	First		Middle	Date o	of Birth		Social	Security N	umber
Race	Sex		Child's County of Venu	ie		1	Date of Custody		
Mother's Last Name	First		Middle	Date o	of Birth		Social	Security N	umber
Father's Last Name	First		Middle	Date o	of Birth	9	Social	Security N	umber
REMOVAL HOME (Fr	om whose home	e the foste	er child was removed):						
Name of Person from	n whose home t	he child w	vas removed?		Relation	ship of p	erson	to child:	
PLACEMENT INFORM	MATION (Where	the child	is placed, outside of the h	ome, be	ecause of t	his situat	ion):		
Name of Placement:						Date Er	ntered	Placemen	t:
ELIGIBILITY/REIMBU	JRSABILITY:					_			
1. Is the child a U.S. (Citizen or Oualif	ied 2.	Is the child a Tennessee		3. Is the	child a N	ative A	American?	
Alien?			resident?		Yes [□ No □			
Yes 🗌 No 🗍			Yes No No		165	,,			
	DADENITAL CLI	DODT DV	CHILD'S LEGAL AND/OR	BIOL O	CICAL DAD	ENITC:			
				BIOLO	JICAL PAR	EIVI 3.			
a. Parent living in the		ich the	MOTHER				-	ATHER	1
child was removed			Yes No No				es 📙	No L	<u>]</u> 5
b. Is the child's paren	it(s) deceased?		Yes No No				es 📙	No L	
		<u>'</u>	If "yes", date death occu	rred:	If "yes", (date dea	th occ	curred:	
c. Parent(s) disabled mentally)?	(physically/	`	Yes No No		Yes 🗌	No 🗌			
d. Parent(s) unempl	oyed?	\	Yes No 🗌		Yes 🗌	No 🗌			
The primary wage of Mother Father	•		the most earnings over the er parent was a wage earn	•	4 months.	Who is th	he prii	mary wage	earner?
Is the primary was	ge earner curren	itly unemp	oloyed or employed less th	nan 100	hours per	month?	Yes [No 🗆	
	g with either or b	ooth parer	nts during the month the					or the mor	ith the Voluntary
			onths prior to the month beginning with the child's						
	Го	N	lame and Address				Re	lationship)
								•	

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Date Received:												
4B. Give the follow was removed (re	-		<u>l</u> persor	ns (includi	ing the	foster child) wh	io we	ere living	in the ho	me fro	m which the foste	r child
	lame		Birt	h Date	R	elationship to F	oste	r Child		Socia	l Security Numb	er
<u> </u>												-
											ons 5 thru 10 belo	
											ger were also livin	
		resources	s and in	come in s	section				•		n the removal hor	ne.
Source	Balance	Own	er				Bank	k Name a	and Add	ress		
Cash												
Checking/												
Savings												
IRA/CD												
Stocks/Bonds												
Trust												
Accounts												
Other												
Value and Amour			Owne					Location:				
Value and Amour	nt Owed:		Owne	er:			l	Location:				
6. List any vehic	les family me	ember or o	hild ow	ıns:								
Value/Amount/C			Owr					Model/Y	ear:			
Value/Amount/C			Owr					Model/Y				
		s (Monthl			uivale	ent): Check the				me bel	ow is received by	<i>ı</i> a
stepparent in t	_		,			,.		,				
••	Foster		Mothe	r (Step 🗌	٦)	Father (Step	٦)	Sibling	g (Step [7)	Sibling (Step])
Social Security				<u> </u>		` <u></u>			<u>, , , , , , , , , , , , , , , , , , , </u>		J	
SSI												
Veteran's												
Benefits												
UC/WC												
Railroad												
Retirement												
Pension												
Military								1				
Child Support								1				
Other												
8. Indicate the ch	nild's pavee f	or the abo	ove N	Name:		I		1	Type of I	3enefits	: :	
benefits:	,			Name:					Type of I			

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Page 2

9. Current	Employer:	Check the	box in	the (S	tep) column if th	e wages	ar	e rece	eived	by a step	parent or	step sibling.
	(Step)	From	То	Em	ployer Name and Address		(ar	s Wag noun efore uction	t	Frequ (week weekly monthly	, semi-	# Hours Worked Per Week
Child									-,	,	,,, ,,	
Mother												
Father												
Sibling												
Sibling												
Child Care	Expenses:											
Did the child Yes No I If "yes", Ame Child Care Phone Nun	ount Paid: Provider N	Fr	equenc	y: We	for the child so tha		ild's	s pare	nt co	uld get to v	vork, traini	ng, or look for a job?
Date Recei	ved:											
Plan and		gical repo			nal, or mental di ild's case manag							dividual Education No
11. Is the c		ing school?			N/A Name	of schoo	ol:					
	ild is 18 an d graduatio		, is he/s	he exp	ected to complete	the cou	ırse	of st	udy b	y age 19? \	Yes 🗌 No	N/A
13. Is the ho	ome from v	vhich the c	hild was	s remo	ved receiving ado	ption su	ppc	rt pav	ymen	ts on beha	lf of the ch	ild? Yes 🔲 No
					nce or settlement		_	<u>• П</u>	,			
					Parent Data: (Co		he p	aren	t/fos	ter child r	elationshi	p is reflected in
Foster Chil	d's Mothei	:		a "Goo Yes [d Cause" reason e	xist to n	ot p	ursue	e chil	d support f	rom the m	other?
Street Addr	ess		City		-	Sta	te		Zip		Telephon	e Number
Is this addre	_		Last d	ate at	above address							
Employer N	ame and A	ddress		Cit	у	Sta	te		Zi _l	0	Last date	employed
Is mother m payments? Yes No		l support		If yes Amou	, indicate: unt:	Freque	ency	′			Last dat	e support was paid
Foster Chil	d's Father:		Does a	_	d Cause" reason e Il Parent 🔲 Alleg	xist to n ged Pare		ursue	e chil	d support f	rom the fa	ther?: No 🗌
Street Addr	ess		City			State			Zip		Telephon	e Number
Is this addre			Last d	ate at	above address		1		-		·	
Employer N	ame and A	ddress			City		5	State		Zip	Last	date employed
Is father ma		support pa	yments	?	If yes, indicate: Amount:			Freq	uenc	У	Last dat	e support was paid

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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	Telephone No	Date
Liaison		

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:

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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>					First					Middle			
Other L	egal Names:					_							
Address													
City						State				Zip Code			
SSN			DOB				<u>.</u> _	Female		•			
	ne Numbers: C	ell () -				Hom		_	\	Nork	() -	
=	n's expiration d		,			Date no	ot to	exceed one ate should	e year from date o l be 90 days from	of signatu	ure on	this form. The nature if making a	١
Name of	Provider/Scho	ol/Entity	Releasin	<mark>g Informati</mark>	ion TO DCS:								
Type of I	nformation Red	quested	(check OI	NLY one) Y	ou must han	d write/t	ype i	n specific iı	nformation being r	equested	:		
	ucation records pecific Informa				TCAP, Specia	ıl Educat	ion						
re	ychological/Psy sults. <i>Does not d</i> pecific Informa	apply to e	employees	or volunte		ds, alcoh	ol/d	ug/substa	nce abuse treatm	ent reco	rds, an	d any associated	test
	edical records, i pecific Informa				ratory tests,	and pre	scrib	ed treatm	ents. Does not app	ly to emp	oloyees	or volunteers.	
	ckground/Crimi pecific Informa				g Polygraph,	and Fin	gerp	int Result	S				
	ployment Reco pecific Informa		quested:										
	rsonal Finance/ pecific Informa				cords (as app	olicable)							
7. 🗌 Otl S _l	her pecific Informa	ation Re	quested:										
	e of the Requestall that apply: [Arran	ge/Acces		☐ CPS In	vestigat	ion	☐ Juve	nile Court Case				
Signatu	ure:								Date:				
OR													
Signatu	ure of Authorize	ed Repre	sentative	*:					Date:_				

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

A. AUTHORIZATION FOR RELEASE TO	DCS	
information deemed to be confidential. representative. This release is executed the Department of Children's Services. Finformation.	hereby authorize release of the information specified on page artment of Children's Services bearing this release or a copy of this release, is thereby direct you as an individual or agency to release this information upon with the full knowledge and understanding that the information released is illure to grant access to the requested information may result in a court ord	including any on request of said for the official use of ler for the
the Tenn. Code Annotated; the federal Ho of Federal Regulations (CFR) Parts 160 an regulations at 42 CFR Part 2. My signature release of records or information as spec	lations protecting the confidentiality of certain written and oral informatio alth Insurance Portability and Accountability Act of 1996 (HIPAA) and its reg 164; and the federal Confidentiality of Alcohol and Substance Abuse Patien indicates I have received a copy of this authorization. I hereby request and fied on page 2 of this release. I understand I may revoke this authorization i ady made in reliance on this authorization. This release takes effect on the	gulations at 45 Code It Records and its I authorize the In writing at any
HIPAA Authorization for Release of P	rotected Health Information:	
I hereby authorize the use or disclos understand the following: (1) This au information is not a health plan or h privacy regulations. (3) My ability to not be affected if I do not sign this fo get a copy of this form after I sign it. person/organization(s) in writing, bu	tre of my individually identifiable health information as described and chorization is voluntary. (2) If the person or organization authorized the released information may no longer be proted to be the care, eligibility for health care, or the payment for my rm. (4) I may see and copy the information described on this form if (5) I may revoke this authorization at any time by notifying the call if I do it won't have any effect on actions taken before the revocations authorization prior to receiving revocation of the release shall not the call in the ca	I to receive the ected by federal y health care will I ask for it, and I ion was received.
<u>Initial</u>	<u>Initia</u>	al
Initial If the individual who is the subject o Legal Guardian Must Sign This Relead older, requires the signature of that regardless of age, if the youth conse		's Parent(s) or nor age 16 or d by the youth,
If the individual who is the subject o Legal Guardian Must Sign This Releas older, requires the signature of that	Inition the information requested is a Child Under the Age of 18, the Child e. EXCEPTION: Release of records under category number 2 for a minder. Release of records under categories 2 and 3 should be signed	's Parent(s) or nor age 16 or d by the youth,
Initial If the individual who is the subject o Legal Guardian Must Sign This Relead older, requires the signature of that regardless of age, if the youth conse	Inition the information requested is a Child Under the Age of 18, the Child e. EXCEPTION: Release of records under category number 2 for a minder. Release of records under categories 2 and 3 should be signed	's Parent(s) or nor age 16 or d by the youth,
If the individual who is the subject of Legal Guardian Must Sign This Release older, requires the signature of that regardless of age, if the youth conse	Inition the information requested is a Child Under the Age of 18, the Child' e. <u>EXCEPTION:</u> Release of records under category number 2 for a mi minor. Release of records under categories 2 and 3 should be signed ted to the health care instead of the parent, guardian, or custodian	's Parent(s) or inor age 16 or d by the youth, n consenting.
If the individual who is the subject of Legal Guardian Must Sign This Releast older, requires the signature of that regardless of age, if the youth consecutive of the signature required: Print Name OR	the information requested is a Child Under the Age of 18, the Child e. EXCEPTION: Release of records under category number 2 for a mi minor. Release of records under categories 2 and 3 should be signed ted to the health care instead of the parent, guardian, or custodian signature	's Parent(s) or inor age 16 or d by the youth, n consenting.
If the individual who is the subject of Legal Guardian Must Sign This Releast older, requires the signature of that regardless of age, if the youth consecutive of the signature required: *Print Name*	the information requested is a Child Under the Age of 18, the Child e. EXCEPTION: Release of records under category number 2 for a mi minor. Release of records under categories 2 and 3 should be signed ted to the health care instead of the parent, guardian, or custodian signature	's Parent(s) or inor age 16 or d by the youth, n consenting.
If the individual who is the subject of Legal Guardian Must Sign This Releast older, requires the signature of that regardless of age, if the youth consess. One signature required: Print Name OR Name of Authorized Represe	the information requested is a Child Under the Age of 18, the Child'e. EXCEPTION: Release of records under category number 2 for a minior. Release of records under categories 2 and 3 should be signed ted to the health care instead of the parent, guardian, or custodian Signature Signature Signature of Authorized Representative Thority to release confidential Self Parent Legal	's Parent(s) or inor age 16 or d by the youth, a consenting.
If the individual who is the subject of Legal Guardian Must Sign This Releast older, requires the signature of that regardless of age, if the youth consect One signature required: Print Name OR Name of Authorized Represe	the information requested is a Child Under the Age of 18, the Child'e. EXCEPTION: Release of records under category number 2 for a minior. Release of records under categories 2 and 3 should be signed ted to the health care instead of the parent, guardian, or custodian Signature Signature Signature of Authorized Representative thority to release confidential Self Parent Legal Legal Custodian*	's Parent(s) or inor age 16 or d by the youth, a consenting. Date
If the individual who is the subject of Legal Guardian Must Sign This Release older, requires the signature of that regardless of age, if the youth consect One signature required: Print Name OR Name of Authorized Represe Signer's Relationship to client and autinformation Conservator*	the information requested is a Child Under the Age of 18, the Child'e. EXCEPTION: Release of records under category number 2 for a minior. Release of records under categories 2 and 3 should be signed ted to the health care instead of the parent, guardian, or custodian Signature Signature Signature of Authorized Representative Thority to release confidential Self Parent Legal	's Parent(s) or inor age 16 or d by the youth, n consenting. Date Date Guardian*
If the individual who is the subject of Legal Guardian Must Sign This Release older, requires the signature of that regardless of age, if the youth consect One signature required: Print Name OR Name of Authorized Represe Signer's Relationship to client and autinformation Conservator*	the information requested is a Child Under the Age of 18, the Child'e. EXCEPTION: Release of records under category number 2 for a minior. Release of records under categories 2 and 3 should be signed atted to the health care instead of the parent, guardian, or custodian signature Signature Signature Signature Self Parent Legal Legal Legal Custodian* Personal Representative for HIPAA* Other*, specify:	's Parent(s) or inor age 16 or d by the youth, n consenting. Date Date Guardian*

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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

	ormation rejers to	ie iii eiie iiiaiviaaai	whose mjormation i	s being released				
Name: Last			First			Mid	dle	
Other I	Legal Names:		·			·		
Addres	is e							
City				State		Zip Co	<mark>de</mark>	
SSN		DOB		☐ <mark>Male</mark> ☐	<mark>Female</mark>			
Teleph	<mark>one Numbers</mark> : C	ell () -		Hom	ne () -		Work	() -
This for	rm's expiration d	ate is:			date should be 9	r from date of sign 0 days from the da		
Name o	of Provider/Schoo	ol/Entity Receiving	Information FROM	DCS: <u>:</u>				
Type of	Information Rec	ղuested (check ON	LY one) You must I	nand write in spe	ecific information	being requested:		
		, including transcr tion Requested:	ipts, GED, TCAP, Spo	ecial Education				
re	esults. <i>Does not a</i>	chiatric/Mental He apply to employees ation Requested:		ords, alcohol/d	lrug/substance a	buse treatment re	cords, an	d any associated test
		ncluding examinat ation Requested:	ions, laboratory tes	ts, and prescril	bed treatments.	Does not apply to e	mployees	or volunteers.
		nal History Checks tion Requested:	s, including Polygra	ph, and Fingerp	orint Results			
	mployment Reco Specific Informa	rds ition Requested:						
		Credit History/Inst Ition Requested:	urance Records (as	applicable)				
7. 🗌 O		tion Requested:						
Check		ted Release/Disclo		Sinvestigation	☐ Juvenile (Court Case		
Signat	ture:					Date:		
OR								
Signat	ture of Authorize	ed Representative	••			Date:		

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

B AUTHORIZATION FOR DCS FROM RELEASE	
	e Tennessee Department of Children's Services to
release the information specified on page 1, to the person/entity s	
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 confidence of records or information as specified on page 2 of this releases time, but it will not affect disclosures already made in reliance on this	d Accountability Act of 1996 (HIPAA) and its regulations at 45 Code entiality of Alcohol and Substance Abuse Patient Records and its opy of this authorization. I hereby request and authorize the . I understand I may revoke this authorization in writing 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.	
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	
violation of HIPAA or my confidentiality rights.	receiving revocation of the release shall not constitute a
I have read this sectionOR	This section was read to me
<mark>Initial</mark>	<mark>Initial</mark>
If the individual who is the subject of the information requeste	ed is a Child Under the Age of 18, the Child's Parent(s) or
Legal Guardian Must Sign This Release. EXCEPTION: Release of	records under category number 2 for a minor age 16 or
older, requires the signature of that minor. Release of records	
regardless of age, if the youth consented to the health care ins One signature required:	tead of the parent, guardian, or custodian consenting.
one signature required.	
Print Name	Signature Date
Timereame	Signoture Dute
OR	
Name of Authorized Representative (Print)	Signature of Authorized Representative Date
Name of Authorized Representative (Print)	Signature of Authorized Representative Date
Signer's Relationship to client and authority to release confiden	ntial Self Parent Legal Guardian*
Signer's Relationship to client and authority to release confident information	ntial Self Parent Legal Guardian*
Signer's Relationship to client and authority to release confiden	ntial Self Parent Legal Guardian* Legal Custodian* ve for HIPAA* Other*, specify:
Signer's Relationship to client and authority to release confiderinformation Conservator* Personal Representation	ntial Self Parent Legal Guardian* Legal Custodian* ve for HIPAA* Other*, specify:
Signer's Relationship to client and authority to release confiderinformation Conservator* Personal Representation	ntial Self Parent Legal Guardian* Legal Custodian* ve for HIPAA* Other*, specify:

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RDA 11016

CS-0559, Rev. 5/24 Page 2B

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 Date		TFACTS Person ID#	Home County	
Child's Name			DOB	_
Placement	Foster home Congregate care facility	Facility name		
Child entering cus	stody on the medication(s) listed below	•		
	PLEASE ATTACH PSYCHOTROPIC MEDICA	TION EVALUATION Form CS-0629 O	R EQUIVALENT FORM	
Medication (dose, fre	quency, route)			
For the treatment of				
Allergies				
Any other medication	child is taking			
Prescribing Provider's	s Name		Telephone #	
Clinic Name	·			
Address				
prescribing provi	NONLY BE SIGNED BY THE PARI der) OR THE DCS REGIONAL Number on provided to me:	<u>rse</u>	AGE 16 AND OLDER (at the dis	cretion of the
-	DNSENT to the administration of the above listed medication(s			
	signature	•		
-				
Print name	signature	Date		
	sent	Date		
Witness #2 Verbal Con	sent	Date		
Reason parent cannot	sign			
DCS Health Nurse Sign	ature	Date		
Print name	Region			
☐ I have been NOTIFIED	that consent was given by DCS for the above li	isted medications(s).		
Parent/Legal Guardian	signature	Date		
Print name	Relationship			

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CS-0627 Rev 3/23



Authorization for Routine Health Services for Minors

Child Youth Child Services. The Department of Children's Services, by virtue of the court's order granting legal of consent to ordinary and/or necessary medical care. Child/Youth The information below must be fully explained to the minor; minor does not sign form) Routine health services may be provided while you are within the custody of the Tennessee Department and procedures including extractions, pelvic examples of routine health services are: routine dental procedures including extractions, pelvic examples, treatment of communicable disease(s), routine suturing or minor lacerations, x-rays, and or not listed generally governed by implied consent guidelines in the community setting. If you choose Department of Children's Services, by virtue of the court's order granting the department legal custo consent to ordinary and/or necessary medical care and/or treatment. Parent/Guardian Junderstand that it may be necessary for the Tennessee Department or health services as generally outlined above and hereby give my permission to such can formed that if I choose not to consent, the Department of Children's Services, by virtue of the court department legal custody, is authorized to consent to ordinary and/or necessary medical care and/or necessa	nent of Children's Services. This, blood draws and ther medical procedures not to consent, the dy, is authorized to the meaning of routine re. I have also been it's order granting the
Services. The Department of Children's Services, by virtue of the court's order granting legal consent to ordinary and/or necessary medical care. Child/Youth The information below must be fully explained to the minor; minor does not sign form) Routine health services may be provided while you are within the custody of the Tennessee Department and the communication of the communication of the counting extractions, pelvic examples of routine health services are: routine dental procedures including extractions, pelvic examples, treatment of communicable disease(s), routine suturing or minor lacerations, x-rays, and of not listed generally governed by implied consent guidelines in the community setting. If you choose Department of Children's Services, by virtue of the court's order granting the department legal custo consent to ordinary and/or necessary medical care and/or treatment. Parent/Guardian The information below must be fully explained to the minor; minor does not to explain the control of the court's order granting the department legal custo of the count ordinary and/or necessary medical care and/or treatment. Parent/Guardian The information below must be fully explained to the minor; minor does not to explain the custody of the Department. I understate the information that it may be necessary for the Tennessee Department or ordinary and hereby give my permission to such can formed that if I choose not to consent, the Department of Children's Services, by virtue of the court department legal custody, is authorized to consent to ordinary and/or necessary medical care and/or department legal custody, is authorized to consent to ordinary and/or necessary medical care and/or department legal custody, is authorized to consent to ordinary and/or necessary medical care and/or department legal custody, is authorized to consent to ordinary and/or necessary medical care and/or department legal custody, is authorized to consent to ordinary and/or necessary medical care and/or necessary medical care and/or nece	nent of Children's Services. This, blood draws and ther medical procedures not to consent, the dy, is authorized to the meaning of routine re. I have also been it's order granting the
Routine health services may be provided while you are within the custody of the Tennessee Department and the fully explained to the minor; minor does not sign form) Routine health services may be provided while you are within the custody of the Tennessee Department and the country of the Tennessee Department of routine health services are: routine dental procedures including extractions, pelvic examples, treatment of communicable disease(s), routine suturing or minor lacerations, x-rays, and or not listed generally governed by implied consent guidelines in the community setting. If you choose Department of Children's Services, by virtue of the court's order granting the department legal custo consent to ordinary and/or necessary medical care and/or treatment. Parent/Guardian , understand that it may be necessary for the Tennessee Department or ovide routine health care to my child while he/she is in the custody of the Department. I understanged that if I choose not to consent, the Department of Children's Services, by virtue of the court department legal custody, is authorized to consent to ordinary and/or necessary medical care and/or department legal custody, is authorized to consent to ordinary and/or necessary medical care and/or department legal custody, is authorized to consent to ordinary and/or necessary medical care and/or department legal custody, is authorized to consent to ordinary and/or necessary medical care and/or department legal custody, is authorized to consent to ordinary and/or necessary medical care and/or department legal custody, is authorized to consent to ordinary and/or necessary medical care and/or department legal custody, is authorized to consent to ordinary and/or necessary medical care and/or department legal custody, is authorized to consent to ordinary and/or necessary medical care and/or department legal custody.	ens, blood draws and ther medical procedures not to consent, the dy, is authorized to ent of Children's Services to and the meaning of routine re. I have also been it's order granting the
Examples of routine health services are: routine dental procedures including extractions, pelvic examples, treatment of communicable disease(s), routine suturing or minor lacerations, x-rays, and of not listed generally governed by implied consent guidelines in the community setting. If you choose Department of Children's Services, by virtue of the court's order granting the department legal custo consent to ordinary and/or necessary medical care and/or treatment. Parent/Guardian	ens, blood draws and ther medical procedures not to consent, the dy, is authorized to ent of Children's Services to and the meaning of routine re. I have also been it's order granting the
,, understand that it may be necessary for the Tennessee Department or ovide routine health care to my child while he/she is in the custody of the Department. I understate with regard to health services as generally outlined above and hereby give my permission to such can formed that if I choose not to consent, the Department of Children's Services, by virtue of the countries department legal custody, is authorized to consent to ordinary and/or necessary medical care and/or	nd the meaning of routine re. I have also been 's order granting the
provide routine health care to my child while he/she is in the custody of the Department. I understate with regard to health services as generally outlined above and hereby give my permission to such can formed that if I choose not to consent, the Department of Children's Services, by virtue of the court department legal custody, is authorized to consent to ordinary and/or necessary medical care and/o	nd the meaning of routine re. I have also been 's order granting the
Parent's or Legal Guardian's Signature	
· · · · · · · · · · · · · · · · · · ·	Date
Witness' Signature	Date
Based upon refusal of the above named minor's parent or legal guardian to consent to the routine tr while in custody of the Department of Children's Services or because, after diligent efforts to locate, guardian cannot be located, the Department of Children's Services due to its rights and responsibilities authorized to consent to ordinary and/or necessary medical care and/or treatment.	he parent or legal
*** parent refused to sign paperwork at time of removal No parent available at time of removal DCS Staff Signature	

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



Medication Transfer

Name		OB			
Date					
The following medications are	being sent with this ch	ild/youth to a ne	ew placement:		
Medication and Dosage:	Instruction:		Count:	# Refills	
			 -		
					
			-		
Medications collected/counted					
Medication has been sealed by					
Signature #1	_	nature #2			
Medication has not been seale	ed 🔲				
By signing below you are ag	reeing that all medic	ations and cou	nts are accura	te as listed	
Signature of Person releasing	medications			 ate	
orginature of the resemble and	modications		5.		
Signature of Transport Person			Date		
Signature of Person or Parent	/Cuardian resolving me				
Signature of Person of Parent	Guardian receiving me	dication	Date		
Medication has been sealed	by medical staff and	is being releas	sed to parent/g	uardian. By signing	below
you are agreeing that you ar				, , ,	
Signature of parent/guardian re	eceiving sealed medica	ation	Da	ate	
Note: Some medication may n	not be in "child proof" co	ontainers. Pleas	e keep all medi	cations out of the read	ch of
children.					
Youth released from a <i>Youth I</i> sent directly from the pharmac	y via UPS. Please che	ck the medication	on you receive t		
medication and the dose is con	rrect. Report any errors	directly to the p	pharmacy.		
In case of questions, please co	ontact:				
Sending Staff/Facility/FSW			_ Pł	none	

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Authorization for Release of Information and HIPAA Protected Health Information <u>TO</u> 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											
Other Legal Names:											
Address					1						
City				State			Z	<mark>Zip Code</mark>			
SSN	DOB				☐ Fe	<mark>male</mark>					
Telephone Numbers: Co	ell ()	-		н	ome	() -		Work	() -		
This form's expiration da	This form's expiration date is: Date not to exceed one year from date of signature on this form. The expiration date should be 90 days from the date of signature if making a onetime request.										
Name of Provider/School/Entity Releasing Information TO DCS:											
Type of Information Req	uested (chec	k ONLY one) Yo	ou must hand	l write/ty	pe in s	pecific informa	ntion being re	equested:			
1.	_	•	「CAP, Specia	l Educatio	on						
2. Psychological/Psyc results. <i>Does not a</i> Specific Informa	pply to emplo	yees or voluntee		s, alcoho	l/drug	:/substance ak	ouse treatmo	ent records, a	and any associated test		
3. Medical records, in Specific Informa			atory tests, a	and pres	cribed	treatments. <i>L</i>	oes not appl	ly to employe	es or volunteers.		
4. Background/Crimii Specific Informa	-	_	Polygraph,	and Fing	erprin	t Results					
5. Employment Recor Specific Informa		ted:									
6. Personal Finance/0 Specific Informa	-		ords (as app	licable)							
7. Other Specific Informa	tion Reques	ted:									
Purpose of the Request Check all that apply: Other:	Arrange/A		CPS Inv	estigation.	on	☐ Juvenile Co	ourt Case				
Signature:							Date:				
OR											
Signature of Authorize *Authorized Representation	-						Date:_				

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A. AUTHORIZATION FOR RELEASE TO	DCS		
☐ I,	=	he information specified on page	
	artment of Children's Services bearing this		
	hereby direct you as an individual or agend with the full knowledge and understanding		
•	ailure to grant access to the requested info		
information.		-	
Lundovetand that there are laws and regu	ulations protesting the confidentiality of co	rtain written and eral informatio	on such as: Title 22 of
	ulations protecting the confidentiality of ce ealth Insurance Portability and Accountabil		
of Federal Regulations (CFR) Parts 160 and	d 164; and the federal Confidentiality of Alc	ohol and Substance Abuse Patien	t Records and its
	e indicates I have received a copy of this au		
	ified on page 2 of this release. I understand eady made in reliance on this authorization		
			J
HIPAA Authorization for Release of P			
	ure of my individually identifiable heal		
• • • • • • • • • • • • • • • • • • • •	thorization is voluntary. (2) If the pers ealth care provider the released inforn		
•	receive health care, eligibility for healt		-
	rm. (4) I may see and copy the informa		
_	(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 language in have read this section.		n was read to me	
Initial	OK This section	Initio	
	f the information requested is a Child l	_	
	se. <u>EXCEPTION:</u> Release of records under		_
· · · · · · · · · · · · · · · · · · ·	minor. Release of records under categ nted to the health care instead of the p	·	-
regulatess of age, it the youth conser	ted to the health care instead of the p	Jarene, guardian, or custodian	r consenting.
One signature required:			
Print Name	 Signature		Date
	<u> </u>		
OR			
		(A d	
Name of Authorized Representative (Pr	int) Signature o	f Authorized Representative	Date
Signer's Relationship to client and au	thority to release confidential	Self Parent Legal	Guardian*
information		Legal Custodian*	
Conservator*	Personal Representative for HIPAA		d d
rrooj oj authority to release informa	tion, such as a court order or Power of A	ttorney aocument, must be pro	videa.
Name of Witness (Print)	Signa	ature 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	egal Names:											
Address		•										
City						State			Zi	i <mark>p Code</mark>		
SSN			DOB			Male	□ Fe	male				
Telepho	ne Numbers: C	ell () -			H	lome	() -		Worl	k () -	
This forn	n's expiration d	<mark>ate is:</mark>					on dat	e should b			on this form. The ignature if making a	
Name of	Provider/School	l/Entity	Receivin	g Informati	on FROM DC	:S: <u>:</u>						
Type of I	nformation Req	uested	(check Of	NLY one) Y	ou must han	d write in	specif	ic informat	ion being request	<mark>ed</mark> :		
	ication records, pecific Informa				TCAP, Specia	l Educati	ion					
res	rchological/Psyc sults. <i>Does not a</i> pecific Informa	pply to	employees	or volunted		ds, alcoh	ol/druį	g/substanc	e abuse treatme	nt records,	and any associated test	
	dical records, ir pecific Informa				ratory tests,	and pres	cribed	treatmen	ts. Does not apply	y to employe	ees or volunteers.	
	kground/Crimi ecific Informa				g Polygraph,	and Fing	gerprin	t Results				
	ployment Reco		quested:									
	sonal Finance/o ecific Informa				ords (as app	olicable)						
7. 🗌 Otł Sp	ner oecific Informa	tion Re	quested:									
	e of the Reques all that apply: [her:				☐ CPS In	vestigati	on	☐ Juvenil	e Court Case			
<mark>Signatu</mark>	ıre:								<mark>Date</mark> :			
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 hereby authorize th	e Tennessee Department of Children's Services to	
release the information specified on page 1, to the person/entity		
I understand that there are laws and regulations protecting the confid the Tenn. Code Annotated; the federal Health Insurance Portability ar of Federal Regulations (CFR) Parts 160 and 164; and the federal Confid 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 reguentiality of Alcohol and Substance Abuse Patient copy of this authorization. I hereby request and a c. I understand I may revoke this authorization in	lations at 45 Code Records and its authorize the writing at any
HIPAA Authorization for Release of Protected Health Informat I hereby authorize the use or disclosure of my individually ide		ove. 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, eligibe 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 Initial If the individual who is the subject of the information request Legal Guardian Must Sign This Release. EXCEPTION: Release of	2) If the person or organization authorized to leased information may no longer be proted ility for health care, or the payment for my to the information described on this form if I dorization at any time by notifying the effect on actions taken before the revocation receiving revocation of the release shall not this section was read to me. Initial ed is a Child Under the Age of 18, the Child's records under category number 2 for a min	co receive the cted by federal health care will ask for it, and I on was received. It constitute a
older, requires the signature of that minor. Release of records regardless of age, if the youth consented to the health care in:		
One signature required:		g.
Print Name	Signature	Date
OR		
Name of Authorized Representative (Print)	Signature of Authorized Representative	Date
Signer's Relationship to client and authority to release confident		uardian*
information Conservator* Personal Representat	Legal Custodian* ive for HIPAA* Other*, specify:	
*Proof of authority to release information, such as a court order		ided.
Name of Witness (Print)	Signature of Witness	Date

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

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

Name: Last					First					<mark>Middle</mark>	
Other Le	gal Names:				I						,
Address											
City						State			Zi	<mark>p Code</mark>	
SSN			DOB			Male	F€	emale			1
	ne Numbers:	Cell () -	l			lome	() -		Work	() -
-	's expiration		Ĺ			1		ceed one year fro	m date of		this form. The
	expiration date should be 90 days from the date of signature if making a onetime request.										
Name of Provider/School/Entity Releasing Information TO DCS:											
Type of l	oformation Pe	auested	(check O	VI V one) V	ou must han	d write/tı	ma in s	specific information	n haina rac	vuostad:	
Type of it	normation Re	questeu	(CHECK O	VET OHE, 70	ou must man	u writerty	pe iii s	specific injoiniation	ii beilig req	juesteu.	
_	cation record		_	•	CAP, Specia	al Educati	on				
Sp	ecific Inform	ation Re	equestea	:							
	chological/Psy ults. <i>Does not</i>					ds, alcoho	ol/drug	g/substance abuse	e treatmei	nt records, aı	nd any associated test
Sp	ecific Inform	ation Re	equested	:							
	dical records, ecific Inform				atory tests,	and pres	cribed	l treatments. <i>Doe</i> s	s not apply	to employees	s or volunteers.
	kground/Crim		-	_	Polygraph,	and Fing	erprin	t Results			
	oloyment Rec		equested	:							
	sonal Finance ecific Inform				ords (as app	olicable)					
7.	er ecific Inform	ation Re	equested	:							
Check a	Purpose of the Requested Release/Disclosure: Check all that apply: Arrange/Access Services CPS Investigation Juvenile Court Case Other:										
<mark>Signatu</mark>	<mark>re</mark> :								Date:		
OR											
Signatu	re of Authoriz	ed Repr	esentative	;*:					Date:		
*Authoriz	ed Representa	tive mea	ns you hav	e legal proof	you can act	for this pe	erson.				

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A. AUTHORIZATION FOR RELEASE TO DCS		
any representative of the Tennessee Department of Children's Service information deemed to be confidential. I hereby direct you as an indiverpresentative. This release is executed with the full knowledge and a the 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 of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidence under the Tennessee of records or information as specified on page 2 of this release	vidual or agency to release this information upon requinderstanding that the information released is for the requested information may result in a court order for the reduction of certain written and oral information such accountability Act of 1996 (HIPAA) and its regulation entiality of Alcohol and Substance Abuse Patient Recopy of this authorization. I hereby request and auther. I understand I may revoke this authorization in wri	ling any luest of said le official use of the h as: Title 33 of ons at 45 Code ords and its orize the ting at any
HIPAA Authorization for Release of Protected Health Information I hereby authorize the use or disclosure of my individually idea understand the following: (1) This authorization is voluntary. (2) information is not a health plan or health care provider the reprivacy regulations. (3) My ability to receive health care, eligibe 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 of HIPAA or my confidentiality rights. I have read this section. OR	ion: ntifiable health information as described above 2) If the person or organization authorized to re leased information may no longer be protected ility for health care, or the payment for my hea y the information described on this form if I ask norization at any time by notifying the effect on actions taken before the revocation w	e. I eceive the I by federal alth care will c for it, and I
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 installed.	records under category number 2 for a minor a s under categories 2 and 3 should be signed by t	nge 16 or the youth,
One signature required:		
	Signature Date	2
Name of Authorized Representative (Print)	Signature of Authorized Representative	Date
Signer's Relationship to client and authority to release confide		dian*
information	Legal Custodian*	
Conservator* Personal Representation, such as a court order		<i>i</i> .
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

-	ininacion rejers ti	ie iii tiie iiiuiviuut	ii whose injormation is	s being relea	seu.				1
Name: Last			First				Mic	ldle	
Other L	egal Names:		·						
Address	s								
City				State			Zip Co	<mark>de</mark>	
SSN		DOB		☐ <mark>Male</mark>	☐ <mark>Fen</mark>	<mark>nale</mark>			
Telepho	<mark>one Numbers</mark> : C	ell () -		Н	ome () -		Work	() -
This for	m's expiration d	ate is:			n date		_		this form. The nature if making a
Name o	f Provider/Schoo	ol/Entity Receivin	g Information FROM	DCS: <u>:</u>					
Type of	Information Rec	<mark>juested (check O</mark>	NLY one) You must h	and write in	specific	information bei	ng requested:		
		, including transo	cripts, GED, TCAP, Spe :	cial Educatio	on				
re	sults. Does not a	chiatric/Mental H apply to employee ation Requested	s or volunteers.	ords, alcoho	l/drug/	substance abuse	e treatment ro	ecords, aı	nd any associated test
		ncluding examina ation Requested	ations, laboratory tes :	ts, and pres	cribed t	reatments. <i>Doe</i> s	s not apply to e	employees	s or volunteers.
		nal History Chec Ition Requested	ks, including Polygrap :	oh, and Finge	erprint	Results			
	nployment Reco pecific Informa	rds ition Requested	:						
		Credit History/In Ition Requested	surance Records (as a :	pplicable)					
7. 🗌 Ot S		ition Requested	:						
Check	all that apply: [ted Release/Disc		Investigatio	on [] Juvenile Cour	t Case		
Signat	<mark>ure</mark> :						Date:		
OR									
Signat	ure of Authorize	ed Representative	e*:		· · · · · · · · · · · · · · · · · · ·		Date:		
*Authori	ized Renresentati	ve means you hay	e legal proof you can a	ct for this ne	rson				

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B <u>AUTHORIZATION FOR DCS FROM F</u>	<u>LEASE</u>	
☐ I, release the information specified on	hereby authorize the Tennessee Department of Children's Services to age 1, to the person/entity specified on page 1B.	
I understand that there are laws and reg	ations protecting the confidentiality of certain written and oral information such as:	Title 33 of
the Tenn. Code Annotated; the federal He	olth Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at	45 Code
of Federal Regulations (CFR) Parts 160 and	164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records a	nd its
	indicates I have received a copy of this authorization. I hereby request and authorize	
	ied on page 2 of this release. I understand I may revoke this authorization in writing a	-
time, but it will not affect disclosures alro	ady made in reliance on this authorization. This release takes effect on the date I signe	ed it.
HIPAA Authorization for Release of P	otected Health Information:	
	re of my individually identifiable health information as described above. I	
	horization is voluntary. (2) If the person or organization authorized to receive	e the
9	alth care provider the released information may no longer be protected by fo	
privacy regulations. (3) My ability to	eceive health care, eligibility for health care, or the payment for my health c	are will
	m. (4) I may see and copy the information described on this form if I ask for i	it, and I
• .,	5) I may revoke this authorization at any time by notifying the	
	if I do it won't have any effect on actions taken before the revocation was re	
violation of HIPAA or my confidentia	is authorization prior to receiving revocation of the release shall not constitu	ute a
I have read this section.	OR This section was read to me	
Initial	Initial	
If the individual substitutes as the	the information represent is a Child Haderthe Ass of 10 the Child's Darent's	-\
	the information requested is a Child Under the Age of 18, the Child's Parent(s	
Legal Guardian Must Sign This Releas	e. <u>EXCEPTION:</u> Release of records under category number 2 for a minor age 16	6 or
Legal Guardian Must Sign This Releas older, requires the signature of that	· · · · · · · · · · · · · · · · · · ·	or outh,
Legal Guardian Must Sign This Releas older, requires the signature of that	e. <u>EXCEPTION:</u> Release of records under category number 2 for a minor age 16 ninor. Release of records under categories 2 and 3 should be signed by the year.	or outh,
Legal Guardian Must Sign This Releas older, requires the signature of that	e. <u>EXCEPTION:</u> Release of records under category number 2 for a minor age 16 ninor. Release of records under categories 2 and 3 should be signed by the year.	or outh,
Legal Guardian Must Sign This Releas older, requires the signature of that regardless of age, if the youth conse	e. <u>EXCEPTION:</u> Release of records under category number 2 for a minor age 16 ninor. Release of records under categories 2 and 3 should be signed by the year.	or outh,
Legal Guardian Must Sign This Releas older, requires the signature of that regardless of age, if the youth conse	e. <u>EXCEPTION:</u> Release of records under category number 2 for a minor age 16 ninor. Release of records under categories 2 and 3 should be signed by the year.	or outh,
Legal Guardian Must Sign This Releas older, requires the signature of that regardless of age, if the youth conse One signature required:	e. <u>EXCEPTION:</u> Release of records under category number 2 for a minor age 16 ninor. Release of records under categories 2 and 3 should be signed by the younge to the health care instead of the parent, guardian, or custodian consenti	or outh,
Legal Guardian Must Sign This Releas older, requires the signature of that regardless of age, if the youth conservation on the signature required: Print Name	e. <u>EXCEPTION:</u> Release of records under category number 2 for a minor age 16 ninor. Release of records under categories 2 and 3 should be signed by the younge to the health care instead of the parent, guardian, or custodian consenti	or outh,
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Legal Guardian Must Sign This Release older, requires the signature of that regardless of age, if the youth conservations of age, if the youth conservations of age, if the youth conservations of age, if the youth conservation of the youth conservation	E. EXCEPTION: Release of records under category number 2 for a minor age 16 ninor. Release of records under categories 2 and 3 should be signed by the year to the health care instead of the parent, guardian, or custodian consenting. Signature Signature Signature of Authorized Representative Date Date Signature of Authorized Representative Legal Guardian* Legal Custodian* Personal Representative for HIPAA* Other*, specify:	outh, ng.
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Authorization for Release of Information and HIPAA Protected Health Information <u>TO</u> the Department of Children's Services and Notification of Release

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

Name: Last					First					<mark>Middle</mark>	
Other Le	gal Names:				I						,
Address											
City						State			Zi	<mark>p Code</mark>	
SSN			DOB			Male	F€	emale			1
	ne Numbers:	Cell () -	l			lome	() -		Work	() -
-	's expiration		Ĺ			1		ceed one year fro	m date of		this form. The
	expiration date should be 90 days from the date of signature if making a onetime request.										
Name of Provider/School/Entity Releasing Information TO DCS:											
Type of l	oformation Pe	auested	(check O	VI V one) V	ou must han	d write/tı	ma in s	specific information	n haina rac	vuostad:	
Type of it	normation Re	questeu	(CHECK O	VET OHE, 70	ou must man	u writerty	pe iii s	specific injoiniation	ii beilig req	juesteu.	
_	cation record		_	•	CAP, Specia	al Educati	on				
Sp	ecific Inform	ation Re	equestea	:							
	chological/Psy ults. <i>Does not</i>					ds, alcoho	ol/drug	g/substance abuse	e treatmei	nt records, aı	nd any associated test
Sp	ecific Inform	ation Re	equested	:							
	dical records, ecific Inform				atory tests,	and pres	cribed	l treatments. <i>Doe</i> s	s not apply	to employees	s or volunteers.
	kground/Crim		-	_	Polygraph,	and Fing	erprin	t Results			
	oloyment Rec		equested	:							
	sonal Finance ecific Inform				ords (as app	olicable)					
7.	er ecific Inform	ation Re	equested	:							
Check a	Purpose of the Requested Release/Disclosure: Check all that apply: Arrange/Access Services CPS Investigation Juvenile Court Case Other:										
<mark>Signatu</mark>	<mark>re</mark> :								Date:		
OR											
Signatu	re of Authoriz	ed Repr	esentative	;*:					Date:		
*Authoriz	ed Representa	tive mea	ns you hav	e legal proof	you can act	for this pe	erson.				

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Distribution: Copies: Pages 1-3 - Client

Page 4 - Signed Client Acknowledgement - Case File



A. AUTHORIZATION FOR RELEASE TO DCS		
any representative of the Tennessee Department of Children's Services information deemed to be confidential. I hereby direct you as an indiverepresentative. This release is executed with the full knowledge and use the Department of Children's Services. Failure to grant access to the reinformation. I understand that there are laws and regulations protecting the confident 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 correlease of records or information as specified on page 2 of this release.	ridual or agency to release this information up inderstanding that the information released is equested information may result in a court or entiality of certain written and oral information d Accountability Act of 1996 (HIPAA) and its regentiality of Alcohol and Substance Abuse Patien opy of this authorization. I hereby request and	including any on request of said for the official use of der for the on such as: Title 33 of gulations at 45 Code at Records and its d authorize the in writing 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(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	on: atifiable health information as described a bif the person or organization authorized eased information may no longer be prot fility for health care, or the payment for m the information described on this form i orization at any time by notifying the effect on actions taken before the revocat	above. I I to receive the ected by federal y health care will f I ask for it, and I tion was received. 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 older, requires the signature of that minor. Release of records regardless of age, if the youth consented to the health care ins	records under category number 2 for a m under categories 2 and 3 should be signe	inor age 16 or d by the youth,
One signature required:		
Print Name	Signature	Date
OR		
Name of Authorized Representative (Print)	Signature of Authorized Representative	Date
Signer's Relationship to client and authority to release confident information Conservator* Personal Representati	Legal Custodian*	Guardian*
*Proof of authority to release information, such as a court order of		ovided.
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: Last						First				Middle				
Other Le	egal	Names:					•			•				
Address														
City							State		Z	ip Code				
SSN				DOB			Male	 				<u> </u>		
Telepho	ne l	Numbers: (:ell () -			Н	lome	() -	Wo	rk	() -		
=		expiration o		·			Date not to exceed one year from date of signature on this form. The expiration date should be 90 days from the date of signature if making a onetime request.							
Name of Provider/School/Entity Receiving Information FROM DCS:														
Type of I	Type of Information Requested (check ONLY one) You must hand write in specific information being requested:													
1. Education records, including transcripts, GED, TCAP, Special Education Specific Information Requested:														
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: 													
		al records, i fic Informa				atory tests,	and pres	cribed	treatments. Does not appl	y to emplo	yees	or volunteers.		
	_	ound/Crim		-	s, including	Polygraph,	and Fing	erprin	t Results					
		yment Reco		equested:										
		al Finance/ fic Informa			surance Reco	ords (as app	licable)							
7. 🗌 Otl		fic Informa	ation Re	equested:										
	all ti	the Reques hat apply: :	Arraı	nge/Acces		CPS In	vestigati	on	☐ Juvenile Court Case					
Signatu	ıre:								Date:					
OR														
Signatu	ire (of Authoriz	ed Repre	esentative	*:				Date:					

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

B AUTHORIZATION FOR DCS FROM RELEASE		
hereby authorize t	he Tennessee Department of Children's Services	s to
release the information specified on page 1, to the person/entity		
I understand that there are laws and regulations protecting the conf	identiality of certain written and oral informatio	on such as: Title 33 of
the Tenn. Code Annotated; the federal Health Insurance Portability a	-	=
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 releas		
time, but it will not affect disclosures already made in reliance on thi	is authorization. This release takes effect on the	date I signed it.
HIPAA Authorization for Release of Protected Health Informa	tion:	
I hereby authorize the use or disclosure of my individually ide		above. I
understand the following: (1) This authorization is voluntary.		
information is not a health plan or health care provider the r		-
privacy regulations. (3) My ability to receive health care, eliginot be affected if I do not sign this form. (4) I may see and con	· · ·	-
get a copy of this form after I sign it. (5) I may revoke this aut	•	i i ask for it, allu i
person/organization(s) in writing, but if I do it won't have any		tion was received.
(6) Any release made in reliance on this authorization prior to	receiving revocation of the release shall n	not constitute a
violation of HIPAA or my confidentiality rights.	-1.	
I have read this section OROR	This section was read to me	
muui ———————————————————————————————————		
If the individual who is the subject of the information request Legal Guardian Must Sign This Release. <u>EXCEPTION:</u> Release o older, requires the signature of that minor. Release of record	ted is a Child Under the Age of 18, the Child f records under category number 2 for a m ls under categories 2 and 3 should be signe	l's Parent(s) or inor age 16 or d by the youth,
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Authorization for Release of Information and HIPAA Protected Health Information <u>TO</u> 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											
Other Legal Names:											
Address											
City			<u>State</u>			<mark>Zip Code</mark>					
SSN	DOB		☐ <mark>Male</mark>	Female							
Telephone Numbers: Ce	II () -		н	ome ()	-	Work	() -				
This form's expiration da	te is:		expiration		one year from date ould be 90 days from						
Name of Provider/School/Entity Releasing Information TO DCS:											
Type of Information Requ	uested (check C	ONLY one) You must hand	<mark>d write/t</mark> y	pe in specif	ic information being r	equested:					
1.	_	•	ıl Educati	on							
2. Psychological/Psych results. <i>Does not ap</i> Specific Informat	ply to employed	es or volunteers.	ds, alcoho	l/drug/sub	stance abuse treatm	ent records, a	nd any associated test				
3. Medical records, inc Specific Informat			and pres	cribed trea	tments. Does not app	ly to employee	s or volunteers.				
4. Background/Crimin Specific Informat	-		and Fing	erprint Res	ults						
5. Employment Record Specific Informat		l :									
6. Personal Finance/C Specific Informat	_		olicable)								
7. Other Specific Informat	ion Requested	i:									
Purpose of the Request Check all that apply: Other:		ss Services 🔲 CPS In	vestigatio	on 🗌 Ju	ıvenile Court Case						
Signature:					Date:						
OR											
Signature of Authorized *Authorized Representative		e*:									

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Distribution: Copies: Pages 1-3 - Client



A. AUTHORIZATION FOR RELEASE TO DCS		
any representative of the Tennessee Department of Children's Services information deemed to be confidential. I hereby direct you as an indiverepresentative. This release is executed with the full knowledge and use the Department of Children's Services. Failure to grant access to the reinformation. I understand that there are laws and regulations protecting the confident 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 correlease of records or information as specified on page 2 of this release.	ridual or agency to release this information up inderstanding that the information released is equested information may result in a court or entiality of certain written and oral information d Accountability Act of 1996 (HIPAA) and its regentiality of Alcohol and Substance Abuse Patien opy of this authorization. I hereby request and	including any on request of said for the official use of der for the on such as: Title 33 of gulations at 45 Code at Records and its d authorize the in writing 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(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	on: atifiable health information as described a bif the person or organization authorized eased information may no longer be prot fility for health care, or the payment for m the information described on this form i orization at any time by notifying the effect on actions taken before the revocat	above. I I to receive the ected by federal y health care will f I ask for it, and I tion was received. 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 older, requires the signature of that minor. Release of records regardless of age, if the youth consented to the health care ins	records under category number 2 for a m under categories 2 and 3 should be signe	inor age 16 or d by the youth,
One signature required:		
Print Name	Signature	Date
OR		
Name of Authorized Representative (Print)	Signature of Authorized Representative	Date
Signer's Relationship to client and authority to release confident information Conservator* Personal Representati	Legal Custodian*	Guardian*
*Proof of authority to release information, such as a court order of		ovided.
Name of Witness (Print)	Signature of Witness	Date

 ${\it Check the "Forms" We bpage for the current version and disregard previous versions. This form may not be altered without prior approval.}$





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>					<mark>First</mark>					Middle		
Other Le	gal Names:											
Address		•										
City						State	e		Z	ip Code		
SSN			DOB			☐ <mark>Ma</mark>	ale	☐ <mark>Fe</mark>	male			
Telephor	n <mark>e Numbers</mark> : C	ell () -				Но	me	() -	Work	() -	
This form	ı's expiration d	ate is:					atio	n dat	ceed one year from date o e should be 90 days from t est.			a
Name of	Jame of Provider/School/Entity Receiving Information FROM DCS:: The provider School Entity Receiving Information FROM DCS:: The provider School Entitle Entity Receiving Information FROM DCS:: The provider School Entity Receiving Information FROM DCS:: The provider School Entity Receiving Information FROM DCS:: The provider School E											
Type of li	nformation Red	<mark>uested</mark>	(check Of	NLY one) Y	'ou must han	d write	in s	pecifi	ic information being reques	ted:		
	cation records ecific Informa		_	-	TCAP, Specia	al Educ	atio	n				
res	. ☐ Psychological/Psychiatric/Mental Health Treatment Records, alcohol/drug/substance abuse treatment records, and any associated test results. <i>Does not apply to employees or volunteers</i> . Specific Information Requested:											
	dical records, in ecific Informa				ratory tests,	and pi	resc	ribed	treatments. Does not appl	y to employee	es or volunteers.	
	kground/Crimi ecific Informa		-		g Polygraph,	and Fi	inge	rprin	t Results			
	oloyment Reco ecific Informa		quested:									
	sonal Finance/ ecific Informa				cords (as app	olicable	e)					
7. 🗌 Oth Sp	er ecific Informa	tion Re	quested:									
	e of the Reques Il that apply: [her:	Arrar	ige/Acces		CPS In	vestiga	atio	n	☐ Juvenile Court Case			_
<mark>Signatu</mark>	<mark>re</mark> :											
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 hereby authorize th	e Tennessee Department of Children's Services t	0						
release the information specified on page 1, to the person/entity								
I understand that there are laws and regulations protecting the confidence the Tenn. Code Annotated; the federal Health Insurance Portability are 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 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	nd Accountability Act of 1996 (HIPAA) and its regu entiality of Alcohol and Substance Abuse Patient copy of this authorization. I hereby request and a e. I understand I may revoke this authorization in	llations at 45 Code Records and its authorize the writing at any						
HIPAA Authorization for Release of Protected Health Informat I hereby authorize the use or disclosure of my individually ide		oove. I						
I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand the following: (1) This authorization is voluntary. (2) If the person or organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. (3) My ability to receive health care, eligibility for health care, or the payment for my health care will not be affected if I do not sign this form. (4) I may see and copy the information described on this form if I ask for it, and I get a copy of this form after I sign it. (5) I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do it won't have any effect on actions taken before the revocation was received. (6) Any release made in reliance on this authorization prior to receiving revocation of the release shall not constitute a violation of HIPAA or my confidentiality rights. I have read this section. OR This section was read to me. Initial In								
older, requires the signature of that minor. Release of records regardless of age, if the youth consented to the health care in:		-						
One signature required:	1 70	J						
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		Guardian*						
information Conservator* Personal Representat	Legal Custodian*							
Conservator* Personal Representat *Proof of authority to release information, such as a court order		rided.						
Name of Witness (Print)	Signature of Witness	<u>Date</u>						

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Authorization for Release of Information and HIPAA Protected Health Information <u>TO</u> 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											
Other Legal Names:											
Address											
City			<u>State</u>			<mark>Zip Code</mark>					
SSN	DOB		☐ <mark>Male</mark>	Female							
Telephone Numbers: Ce	II () -		н	ome ()	-	Work	() -				
This form's expiration da	te is:		expiration		one year from date ould be 90 days from						
Name of Provider/School/Entity Releasing Information TO DCS:											
Type of Information Requ	uested (check C	ONLY one) You must hand	<mark>d write/t</mark> y	pe in specif	ic information being r	equested:					
1.	_	•	ıl Educati	on							
2. Psychological/Psych results. <i>Does not ap</i> Specific Informat	ply to employed	es or volunteers.	ds, alcoho	l/drug/sub	stance abuse treatm	ent records, a	nd any associated test				
3. Medical records, inc Specific Informat			and pres	cribed trea	tments. Does not app	ly to employee	s or volunteers.				
4. Background/Crimin Specific Informat	-		and Fing	erprint Res	ults						
5. Employment Record Specific Informat		l :									
6. Personal Finance/C Specific Informat	_		olicable)								
7. Other Specific Informat	ion Requested	i:									
Purpose of the Request Check all that apply: Other:		ss Services 🔲 CPS In	vestigatio	on 🗌 Ju	ıvenile Court Case						
Signature:					Date:						
OR											
Signature of Authorized *Authorized Representative		e*:									

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A. AUTHORIZATION FOR RELEASE TO DCS		
any representative of the Tennessee Department of Children's Services beinformation deemed to be confidential. I hereby direct you as an individual representative. This release is executed with the full knowledge and under the Department of Children's Services. Failure to grant access to the requesinformation.	al or agency to release this information upon rec erstanding that the information released is for th	ling any Juest of said ne official use of
I understand that there are laws and regulations protecting the confidention the Tenn. Code Annotated; the federal Health Insurance Portability and Accomplete Federal Regulations (CFR) Parts 160 and 164; and the federal Confidential regulations at 42 CFR Part 2. My signature indicates I have received a copy release of records or information as specified on page 2 of this release. I untime, but it will not affect disclosures already made in reliance on this aution.	countability Act of 1996 (HIPAA) and its regulation wility of Alcohol and Substance Abuse Patient Rec of this authorization. I hereby request and auth Inderstand I may revoke this authorization in wri	ons at 45 Code ords and its orize the ting at any
HIPAA Authorization for Release of Protected Health Information:		
I hereby authorize the use or disclosure of my individually identification understand the following: (1) This authorization is voluntary. (2) If information is not a health plan or health care provider the releas privacy regulations. (3) My ability to receive health care, eligibility not be affected if I do not sign this form. (4) I may see and copy the get a copy of this form after I sign it. (5) I may revoke this authoriz person/organization(s) in writing, but if I do it won't have any effect (6) Any release made in reliance on this authorization prior to receiviolation of HIPAA or my confidentiality rights. I have read this section. OR The Initial If the individual who is the subject of the information requested is Legal Guardian Must Sign This Release. EXCEPTION: Release of records under the signature of that minor. Release of records under the signature of that minor.	the person or organization authorized to red information may no longer be protected for health care, or the payment for my health care, or the payment for my health care, or the payment for my health in the information described on this form if I ask ation at any time by notifying the ct on actions taken before the revocation veloving revocation of the release shall not consist section was read to me. Initial Sea Child Under the Age of 18, the Child's Paint and Control of the Child's Paint and Child of the Child of th	eceive the I by federal Alth care will I for it, and I I vas received. Institute a I rent(s) or I age 16 or I the youth,
regardless of age, if the youth consented to the health care instea One signature required:	d of the parent, guardian, or custodian con	senting.
Print Name Sign	pature Date	,
OR		
Name of Authorized Representative (Print) Si	ignature of Authorized Representative	Date
Signer's Relationship to client and authority to release confidentia information	Self Parent Legal Guar	dian*
☐ Conservator* ☐ Personal Representative f		
*Proof of authority to release information, such as a court order or Po	ower of Attorney document, must be provided	
Name of Witness (Print)	Signature of Witness	Date

 ${\it Check the "Forms" We bpage for the current version and disregard previous versions. This form may not be altered without prior approval.}$





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: Last					First					Mid	dle		
Other Le	egal Names:				•	•							
Address													
City						State				<mark>Zip Co</mark>	de		
SSN			DOB			☐ <mark>Male</mark>		<mark>Female</mark>					
Telepho	ne Numbers: (:ell () -			ı	Home	. ()	-		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.											l	
Name of Provider/School/Entity Receiving Information FROM DCS:													
Type of I	nformation Re	quested	(check O	NLY one)	You must hai	nd write ii	spec	ific inforn	nation being reque	<mark>sted</mark> :			
	ucation records pecific Informa				TCAP, Speci	al Educat	ion						
res	rchological/Psy sults. <i>Does not</i> o <mark>ecific Inform</mark>	apply to	employee:	s or volunte		ds, alcoh	ol/dr	ug/substa	ance abuse treatm	ent re	cords, ar	nd any associated	test
	dical records, i pecific Informa				ratory tests	, and pre	scrib	ed treatm	ents. <i>Does not app</i>	ly to e	mployees	or volunteers.	
	ckground/Crim pecific Information		-		g Polygraph	າ, and Fin _ໃ	gerpr	int Result	:s				
	ployment Reco pecific Informa		equested										
	rsonal Finance/ pecific Informa				cords (as ap	plicable)							
7. 🗌 Otl	ner Decific Informa	ation Re	equested										
	e of the Reque all that apply: her:	Arraı	nge/Acces			nvestigat	ion	☐ Juve	enile Court Case				
Signatu	ıre:								Date:_				
OR													
Signatu	ire of Authoriz	ed Repre	esentative	·*:					Date:_				

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B AUTHORIZATION FOR DCS FROM RELEASE		
	the Townson Demontroont of Children's Comisses t	
release the information specified on page 1, to the person/entity	he Tennessee Department of Children's Services to specified on page 1B.	:0
I understand that there are laws and regulations protecting the conf	-	
the Tenn. Code Annotated; the federal Health Insurance Portability a of Federal Regulations (CFR) Parts 160 and 164; and the federal Confi		
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 releas		
time, but it will not affect disclosures already made in reliance on th	is authorization. This release takes effect on the d	late I signed it.
HIPAA Authorization for Release of Protected Health Informa	tion:	
I hereby authorize the use or disclosure of my individually ide		bove. I
understand the following: (1) This authorization is voluntary.	(2) If the person or organization authorized	to receive the
information is not a health plan or health care provider the r		-
privacy regulations. (3) My ability to receive health care, eligi		
not be affected if I do not sign this form. (4) I may see and cop get a copy of this form after I sign it. (5) I may revoke this aut	· •	i ask for it, and i
person/organization(s) in writing, but if I do it won't have any		on was received.
(6) Any release made in reliance on this authorization prior to		
violation of HIPAA or my confidentiality rights.	_	
I have read this section OR	This section was read to me	
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<mark>Initial</mark>	<u>Initial</u>	
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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.

identify	<u>ing information</u>	i oi inaiviauai	<u>to whom this kele</u>	ase reitailis.										
Name:	Last			First						Midd	lle			
Address	3													
City					State					Zip Cod	le			
SSN		DOB		Place of Birth	h				☐ Male ☐	Female	:			
Telepho	one Numbers:	Home	() -		'	Work	() -		I	Cell	()	-	
This for	n is effective fr	om:	Date:		•	to)	Date:				•		
Date n	ot to exceed on	e year from be	gin date.											
Signatu	re:								D	ate:				
Witness *Authori	·	ive means you h	nave legal proof you	ı can act for thi	is persor	n. A rep	resen	tative sig	ns for an appli	Date: cant wh	o may or	may not	legally sig	n on his o
* *	*****	* * * * * * * * * * *	*********	******	****	****	***	*****	*****	***				
Unab	le to locate req	uested Inform	ation		Reques	ted inf	orma	tion cou	ld not be rele	ased				
Reason														
Informa	ition released b	у								Date				
DCS Cor	ntact Person							Telepho	ne Number					
DCS Off	ice Address													
DCS Sta	ff Requesting R	elease of Tenno	Care Eligibility Info): 							Da	te:		
DCS Sta	ff Who Accessed	d TennCare Elig	gibility Info:								Da	te:		

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identily	ing inioninati	un un mu	iiviaaai to	WINDIN CHIS IN	cicase i ci tailis.								
Name:	Last				First					Midd	lle		
Address	5												
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Telepho	ne Numbers:	Home		() -		1	Work () -			Cell		
This for	m is effective	from:		Date:			to	Date:		•			
Date n	ot to exceed o	ne year	from begir	n date.			I	1					
Signatu	re:								D	ate:			
Signatu	re of Authoriz	ed Repre	esentative ³	*: 									
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	•		,	0 ,	you can act for thi	is person	. A represe	ntative sigr	ns for an appl	icant wh	o may or n	may not legally sign on l	nis
her own. * *	. We may have	to get th	is proof fro	•	*****	****	*****	*****	*****	****			
Unab	ole to locate re	equested	Informati	on		Reques	ted inform	ation coul	d not be rele	ased			
Reason													
Informa	ation released	by								Date			
DCS Cor	ntact Person							Telepho	ne Number				
DCS Off	ice Address												
DCS Sta	ff Requesting	Release	of TennCai	re Eligibility II	nfo:						Dat	e:	
DCS Staff Who Accessed TennCare Eligibility Info: Date:											·e•		
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DCS Staf	ff Who	Accessed Ter	nnCare Eligil	bility Info:	Staff Who Accessed TennCare Eligibility Info: Date:											

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Reason												
Informa	tion released by								Date			
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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 Needs	3	
DART 2 DARTIES DESPONSIBLE ES	AD COMPLETING KING	IUD EVCEDTION D	FOLIECT			
PART 2PARTIES RESPONSIBLE FO	OR COMPLETING KINS	HIP EXCEPTION R	CPS		FSW	
Requesting Case Manager:					F3VV	
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:				Date	2:	
Other Information/Regional						
Protocol Requirements:						

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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

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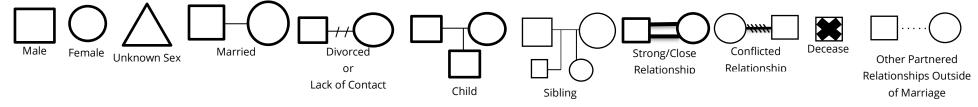
Community Support	Name/Agency	Phone	Address	Contacts/Important People to child/youth/family	Dates Attended/Services Delivered
Neighbors					
School Personnel					
School Personnel					
School Personnel					
School Personnel					

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



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

Genogram Drawing (Optional)



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







bluecare.bcbst.com

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 White Unavailable/Unknown American India Alaskan Native	
Is the child/applicant Hispanic/Latino?	☐ No
Date of Birth: Sex:	Male
County of Commitment:	County of Placement:
PART 3:	
For Case Management, please call 1-888-416-3025.	
PART 4: Provider and Other Insurance Information	<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.	S
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:	R	egion of Custody:	
This document verif the Tennessee Depar	ies that tment of Children's Service	S.	is in the legal cu	ustody of
Parent/Guardian				
ny permission to provide, Department. I understand numans to stimulate the b	, understand that the request and/or facilitate vaccination the meaning of vaccination to mea ody's immune response against an Idhood vaccinations. Routine childh	ns to my child wh in the act of intro infectious diseas	ile he/she is in the custody o ducing a substance intended e or pathogen. I give permis	f the for use in
 Hepatitis B Rotavirus Diphtheria, te Influenza Varicella Meningococca 	tanus, and acellular pertussis al disease	- Pneum - Inactiva	ohilus influenzae type b ococcal conjugate ted poliovirus s, mumps, rubella s A	
have also been informed authorize vaccination of th	that if I choose not to consent, the I e child.	Department of C	nildren's Services, may seek a	court order to
	Parent or Legal Guardian Signature		Date	
	Witness Signature		 Date	