Tennessee Department of Children's Services

Multi-Agency Collaboration Single Team Single Plan Approach Consent

NOTE: *Families served by the State of Tennessee may be unaware of the many resources that are available to them. Sometimes it is difficult to use these resources effectively because they are offered by multiple agencies. This program is meant to ensure that your family has full access to all of the programs, benefits, and services that the participating agencies provide.*

PARTICIPATION

What agencies are currently participating?

- Department of Children's Services
- Department of Health Care Finance and Administration, Division of TennCare
- Department of Education
- Department of Mental Health and Substance Abuse Services
- Department of Health
- Department of Human Services
- Department of Labor Workforce Development
- Department of Intellectual and Developmental Disabilities

PARTICIPANT INFORMATION

Adult Participant(s): _____

Date(s) of Birth: _____

Address: _____

Minors for which participant may consent: _____

Dates of Birth: _____

CONFIDENTIALITY

Information may be collected about:

- You, your household, or your child
- Any services your child receives
- Any community support available to your familiy
- Your child's school attendance
- Your family's experience in caring for your child
- Mental and physical health histories of you and your child
- Other:

AGREEMENT TO JOIN

Why Use This Approach? The Single Team/Single Plan Approach is designed to help you and your family get support you need by pulling together services from multiple providers. You will work with a services team to figure out which programs will be most helpful to your family. You and the team will work together to make a plan, set goals, and be successful.

How to Use This Approach? Any person who wants to use this Approach must show they agree to participate. You can agree by signing your name and writing the date on the lines at the bottom of this form. To use this Approach, you must also agree that team members can talk to each other about you and your family's needs. You can agree to let team members talk with each other by signing the other side of this form.

This approach brings you and your family together with these state programs you may need, such as:

- Food, Income, and Childcare Supports
- Job Search Services and Supports
- Health, Dental, Mental Health, and Addiction Services
- Care Coordination
- Disability Services and Supports
- Family Planning

What You Need To Do For This Approach To Work:

- Tell the truth about the help you and your family needs
- Ask the service team for help if you need it
- Participate in meetings with your services team. This will help you and your family get the help you need.
- Let your services team members share information about how you and your family are doing
- Do your best with the help that is given to your family

Right Not to Use this Approach: You and your family do not have to use this Approach. If you do not want to use this approach, do not sign this form. If you decide not to sign this form, it does not change you or your family's eligibility for services outside of this Approach.

Consent: If you want to use this Approach, sign your name and write the date on the line below. When you sign your name and write the date, you have joined the Approach until your case is complete or you no longer wish to continue to participate. You can end your participation in this Approach by telling us you no longer want to use this Approach.

Agree: I agree to join this Approach and give my permission for the services team to work with me and my child or children(ren).

_____ _____

Adult Participant Signature Date

If you are the parent or authorized representative or guardian of a child or children and you want them to join and get help from this Approach, write their names on the line below. If you are the authorized representative or guardian, you must have proof you can act for the child or children.

Write the child(ren)'s name(s) here: _____

How to discontinue your participation the Approach: If you decide to end your participation in this Approach, and do not want to verbally end your participation with your team, you can send a written letter or email to your local Department of Children's Services Worker:

The below information needs to be completed by DCS in order for this form to be valid.

Staff Name, Agency: _____

Address: _____

Email Address: _____

Telephone Number: _____

AUTHORIZATION TO SHARE AND RELEASE INFORMATION

Why a Release of Information is Helpful: By signing this Authorization, you allow the members of the Single Team/ Single Plan Approach Team to share with each other information about you, your children, or other people that you can legally act for in order to better meet your family's needs. You will not become ineligible for benefits solely because you refuse to sign this Authorization. However, you must fill out, sign, and date this Authorization if you want to participate in the Single Team/Single Plan Approach.

What Information May be Shared or Released? Single Team/Single Plan Approach team members may use these records to help you and your family get services that are needed. Here is a list of records that may be used for this Approach:

- Alcohol and Substance Abuse History and Treatment
- Mental Health Conditions and Treatment
- Sexually Transmitted Diseases (STDs)
- HIV/Auto Immune Deficiency Syndrome (AIDS)
- Educational and Developmental Information and Services
- Educational Services
- Public Health Services
- Child Care Services
- Any community support your family already uses
- Any services your child or family receives
- Financial Assistance Programs
- DCS Involvement
- Medical and Other Health Information, including HIPAA protected health information
- Disability Services
- Job Search and Employment Supports
- Other:

Who will be Sharing Information about You or Your Family? By signing this Authorization, you are allowing all members of the Single Team/Single Plan Approach Team to disclose your records and confidential information, including protected health information, to any other member of the Single Team/Single Plan Approach Team as necessary to the extent permissible under applicable law. The Single Team/Single Plan Approach Team includes the following entities:

- Department of Children's Services
- Department of Education
- Department of Health
- Department of Human Services
- Department of Labor and Workforce Development
- Department of Intellectual and Developmental Disabilities
- Department of Mental Health and Substance Abuse Services
- All contractors and partners of the parties listed above, including Managed Care Organizations and other entities
- Division of TennCare (Medicaid, CHOICES, Employment and Communities First CHOICES, CoverKids)

NOTE: Some of these State Agencies have partners that will provide you or your family with services through this Approach. These partners may share with each other or the State information about you or your family for this Single Team/Single Plan Approach. Some agencies and their partners may have different rules and policies and may ask you to sign another release before they share your information. This may include releases for your medical records.

Right Not to Sign: You do not have to participate in this Approach and may refuse to sign this Authorization. If you decide not to sign this Authorization, you will not be a participant in the Single Team/Single Plan Approach because this model requires the sharing of information with the other team members to get the services that will help your family. If you choose not to sign or participate, it will not change your eligibility for other State or Federal programs.

Can You Lose Your Private Information Protections? Yes. The Single Team/Single Plan Approach team members follow laws and regulations that protect private information. But not all organizations have to follow the same laws and regulations. When you sign this Authorization, you understand that your information may be shared with Single Team/Single Plan members or partners, and they may share it with others.

How to End this Release: This release is valid for 2 years from the date you sign this form. You can end this release at any time by writing to the below address and explaining that you would like to end your release. By ending this release, it will not change information that has already been shared. But we will not share any more information. If you wish to end this release, please write to:

The below information needs to be completed by DCS in order for this form to be valid.

Staff Name, Agency:_____

Address: _____

Email Address: _____

Telephone Number: _____

Agree to Release and Share Information: I have read and understand this Authorization. I agree to let the Single Team/Single Plan Approach team members share and give each other information about myself, my children, and other people that I can legally act for.

Name: _____ Date of Birth: _____

Address: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Signature: _____Date: _____

Relationship to Child/Children: _____

This Authorization permits the release of confidential information about a person receiving services (service recipient) governed and regulated by Title 33, Tennessee Code Annotated, including Mental

Health and Alcohol and Substance Abuse related records. Any information released under this Authorization shall be released in accordance with the following confidentiality laws and regulations: Title 33, Tennessee Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. The records released through this Authorization are protected by the above-named confidentiality laws and regulations. Federal rules restrict any use of alcohol and substance abuse information to criminally investigate or prosecute the person to whom the information pertains. Further disclosure of this information to parties other than those designated on this Authorization is expressly prohibited without the express written consent of the person to whom the information pertains.

Need free language help? / Necesita ayuda con el idioma gratuita? / هل تريد المساعدة اللغوية مجانا؟로 통역 도움이 필요하십니까? / Cần giúp đỡ miễn phí ngôn ngữ? / تو پنتڤي هاريکاريا زماني يا بئ به رامبه ر؟ / Ma u baahan tahay gargaar luqadda oo bilaash ah –
Call / llame / تصل / 请致电 / 전화 / Gọi / په يوه نديئ بکه / so wac **800-482-8292**

Have a disability and need free help or an auxiliary aid or service (Braille, large print)? / Tiene una discapacidad y necesita ayuda gratuita? /هل عندك عجز و تحتاج الى المساعدة مجانا؟
/ 您是否因残障而需要免费的帮助呢? / 장애가 있으신 분으로서 무료 도움이 필요하십니까? / Có khuyết tật và cần sự giúp đỡ miễn phí / تو يئ کئم ئه ندامي وپئتڤي هاريکاريا بئ به رامبه ري؟ / Ma leedahay naafo oo u baahan tahay gargaar bilaash ah
Call / llame / تصل / 请致电 / 전화 / Gọi / په يوه نديئ بکه / so wac **615-532-5552**

Free / gratis TRS **Call** / llame 711 **Ask** / pregunte **800-848-0299**