Release Signed______________

INTAKE FORM
GEAUGA COUNTY FAMILY FIRST COUNCIL
12480 RAVENWOOD DRIVE
CHARDON, OH 44024

FAMILY NAME:

DATE PRESENTED:_____/_____/_____ **PRESENTER:____________________**

LEAD CASE MANAGER:____

ALL HOUSEHOLD MEMBERS D.O.B. **D.O.B.**

1.________________(FATHER) ______ **4.________________________________**

2.________________(MOTHER) ______ **5.________________________________**

3.________________________________ **6.________________________________**

FAMILY ADDRESS:____________________ **FAMILY PHONE:____________________**

________________________________ **BEST TIME/DAY TO CONTACT:__________**

PRIMARY SOURCES OF FINANCIAL SUPPORT FOR FAMILY: **FOR PARENTS/GUARDIANS: IF EMPLOYED, PLEASE LIST THE FOLLOWING INFORMATION ABOUT EMPLOYER:**

__EMPLOYMENT **___UNEMPLOYMENT COMP.** **NAME:____________________________**

__SOCIAL SECURITY **___WORKMENS COMP.** **PHONE:___________________________**

__S.S.D. **___CHILD SUPPORT** **NAME:____________________________**

__S.S.I. **___ALIMONY** **PHONE:___________________________**

__OWF (ADC) **___PENSION**

__G.A.

INSURANCE INFORMATION (COMPLETE OR ATTACH COPY OF CARD)

MEDICAL INSURANCE:

NAME OF COMPANY:____________________ **MEDICAID NUMBER:____________________**

NAMES OF INSURED:____________________ **MEDICAID NUMBER:____________________**

POLICY NUMBER:____________________

POLICY EFFECTIVE DATE:________________

For office use only:
Case accepted for service coordination: YES/NO Referred to Council for funding ____/_____/______

REASON FOR REFERRAL: ______________________________

MEDICAL INFORMATION: ______________________________

DATE OF LAST PHYSICAL: ______________

EXISTING MEDICAL INFORMATION: ______________________________

CURRENT MEDICATION: ______________________________

MENTAL HEALTH DIAGNOSIS (if available): ______________________________

FAMILY HISTORY: ______________________________

FAMILY INTERACTION PATTERNS: ______________________________

EDUCATION INFORMATION OF CHILDREN IN HOME:

STUDENTS NAME	NAME OF SCHOOL	CITY/STATE	GRADE

FORMAL SUPPORTS

Agencies Involved (Please check all appropriate responses):

___Geauga County Board of MR/DD
___Geauga County Dept. Human Services
___Geauga County Health Dept.
___Geauga County Juvenile Court
___Catholic Charities
___Social Security Administration
___Geauga County Public Schools
___Geauga County After School Program
___Ohio Dept. of Youth Services
___BVR
___Ravenwood
___OTHER___________________________

Please fill in details below:

AGENCY	MOST RECENT CONTACT DATE	CONTACT PERSON	PHONE	MISC. INFO.

INFORMAL SUPPORTS

Relatives, Friends, 4-H Club, Church Affiliation, Scouts, Support Groups, Organizations:

ORGANIZA-TION NAME	NATURE OF RELATION-SHIP	MOST RECENT CONTACT PERSON	CONTACT PERSON	PHONE	MISC. INFO.

FAMILY PAGE
(As Stated by Family)

FAMILY STRENGTHS:____

FAMILY PRIORITIES &CONCERNS:____________________________________

FAMILY DREAMS/VISIONS/DESIRES:__________________________________

RELEASE OF INFORMATION FORM SIGNED? __YES __NO

PARENT SIGNATURE **PARENT SIGNATURE**

DATE **DATE**

GEAUGA COUNTY FAMILY FIRST COUNCIL
12480 Ravenwood Dr.
Chardon, OH 44024

RELEASE OF INFORMATION

The undersigned, having requested services from the Geauga County Family First Council, do hereby give our consent to the agencies listed below releasing information to the Council for use in preparing and implementing an individual family service plan.

The family members who are covered by this Release are:

1. ______________________ DOB: ______________________
2. ______________________ DOB: ______________________
3. ______________________ DOB: ______________________
4. ______________________ DOB: ______________________
5. ______________________ DOB: ______________________
6. ______________________ DOB: ______________________

The agencies that are authorized to release information are:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

______
INITIAL

I authorize the agencies and/or individuals specified above to disclose the information I have initialed below to the other treatment team members specified above. It is understood that the information is requested to assist staff of the program in planning services with me and/or in completing an assessment of me. (Initial information to be released.)

___Psycho-social History
___Medical Evaluation
___Education/Test Rec.
___Ind./Family Ser. Plan
___DHS Case Plan
___Psychological Evaluation
___Medications Prescribed
___Hospitalization Records
___Lab Rpts./X-rays
___Probation Reports
___Psychiatric Evaluation
___Discharge Summary
___Treatment Notes
___Family First Council Rpts.
___Other (specify__________

I fully understand that my records are protected under federal and state confidentiality regulations and cannot be released or disclosed without my written permission. I understand the reason(s) the information indicated above is being requested.

I fully understand that I may revoke this consent at any time. However, any information shared prior to such a revocation of consent falls within the bounds of this release.

GEAUGA COUNTY FAMILY COUNCIL
12480 Ravenwood Dr.
Chardon, OH 44024

RELEASE OF INFORMATION

Initial only one of the following:

_______ This consent, unless revoked earlier, expires on my formal termination from services or ninety (90) days after signing of the Release, whichever occurs first.

_______ I agree for this Release to be expanded to one hundred eighty (180) days or the end of my involvement with services, whichever occurs first.

Executed this _______ day of __________________________, 20____

Signatures:

Client: ____________________________ Parent/Guardian (Circle): ____________________________

Client: ____________________________ Parent/Guardian (Circle): ____________________________

Staff Person: ______________________ Guardian Relationship: ______________________________

Agency: __________________________

Witness: __________________________

NOTICE TO ALL DRUG AND ALCOHOL CLIENTS: This information has been disclosed to you from records protected by federal confidentiality rules (42CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.