

**AUTHORIZATION FOR RELEASE OF INFORMATION
TO THE ERIE COUNTY DEPARTMENT OF SOCIAL SERVICES**

I, _____, SS# _____,
date of birth _____ and address of _____
hereby authorize _____ to
release, use or disclose my individually identifiable health information to the Erie County Department of
Social Services _____.

The information to be released: _____
_____ during the time period from _____ to _____.

The purpose and use of this disclosure is _____.

This Authorization will expire: _____ on _____
_____ upon completion of the requested disclosure.
_____ upon the following event _____.

Alcohol and Drug Abuse Records

I understand that alcohol and drug abuse records are confidential and protected under federal regulations 42 CFR Part 2 and that redisclosure of these records to a party other than the one designated above is forbidden without my written authorization unless otherwise provided for in those regulations. I also understand that I may revoke this consent at any time except to the extent that action has already been taken.

If my protected health information contains confidential alcohol and drug abuse information I hereby authorize its release unless this box is checked. Do not disclose drug and alcohol information.

HIV Related Information

Under New York State law, confidential HIV related information can only be given to people I allow to have it by giving my written approval, or to people who need to know my HIV status in order to provide medical care and services, including medical care providers; persons involved with foster care or adoption; parents and guardians who consent to healthcare for minors; jail, prison, probation and parole employees, emergency response workers and other workers in hospitals, other regulated settings or medical offices, who are exposed to blood/body fluids in the course of their employment; and organizations that review services I receive. The law allows my HIV information to be released under limited circumstances; by special court order; to public health officials as required by law; and to insurers as necessary to pay for care and treatment.

Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

The law protects me from HIV-related discrimination in housing, healthcare or other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at 1-800-523-2437. This agency is responsible for protecting your rights.

If my protected health information contains confidential HIV- related information I hereby authorize its release unless this box is checked. Do not disclose confidential HIV-related information.

I understand that my payment, enrollment or eligibility for benefits from the Erie County Department of Social Services will not be affected if I refuse to sign this authorization.

I understand that I have a right to receive a copy of this authorization after I sign it.

I have been made aware of the Erie County Department of Social Services "Notice of Privacy Practice".

I understand the potential for information disclosed pursuant to this authorization to be re-disclosed by the Erie County Department of Social Services and that it may no longer be protected by federal health information laws.

I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information. The revocation will not be affective from the date written revocation is provided and will not apply retroactively.

A photocopy of this authorization will have the same effect as the original

Signature of individual or legal representative

Date

Print name of individual's legal representative

Relationship to the individual:

Signature of ECDSS Employee Witness

Printed Name of ECDSS Witness . Witness Telephone Number _____

Erie County Department of Social Services

**AUTHORIZATION FOR RELEASE OF INFORMATION FOR THE PURPOSE OF
DEVELOPING A FAMILY SUPPORT NETWORK**

(Case Name)

I hereby authorize Erie County Department of Social Services to contact the following relatives and family friends for purposes of developing a family support network:

_____	_____
_____	_____
_____	_____

I understand that I have the right to revoke this Authorization at any time. I may not revoke it to the extent that Erie County Department of Social Services has already relied upon it. I understand that if I revoke this Authorization, I must revoke it in writing to Erie County Department of Social Services.

I understand that if my child(ren) is placed in the custody of the Erie County Department of Social Services as per Federal Law (Fostering Connections), consent would no longer be necessary for Erie County Department of Social Services to contact relatives/kin for placement and family support. We would be required by law to contact all adult relatives within 30 days of removal.

I have read this Authorization, or had it explained to me, and I understand its contents.

(Print Full Name)

(Signature and Date)

(Print Full Name)

(Signature and Date)

(Caseworker's Name)

(Signature and Date)

ERIE COUNTY DEPARTMENT OF SOCIAL SERVICES
AUTHORIZATION FOR RELEASE OF PROTECTED PATIENT HEALTH INFORMATION

Client Name _____

DOB: _____

I hereby authorize the use or disclosure of my individually identifiable health information as described below to the Erie County Department of Social Services at 478 Main Street, Buffalo, New York 14202

I understand that:

1. This authorization is voluntary. I may revoke it at any time by notifying the DSS in writing except to the extent that action has been taken in reliance on it.
2. I understand that if the organization authorized to receive the information is not a health plan, health care provider or clearinghouse, the released information may no longer be protected by federal privacy regulations, except that an enrollee/patient may be prohibited from re-disclosing substance abuse information under the federal substance abuse confidentiality requirements.
3. State law governs the release of HIV/AIDS information and you may request a list of persons authorized to re-release HIV/AIDS information.
4. Authorizations for the release of HIV/AIDS data must comply with the requirements of Article 27-F of the Public Health Law.
5. Authorizations for the release of alcohol and substance abuse records must comply with the requirements of 42 C.F.R Part 2.

This information may be released to and used by the Erie County Commissioner of Social Services or designee(s), and re-released by DSS to the Court and other Service Providers **for purposes of the investigation of a report of suspected child abuse or maltreatment, arranging for the provision of services and/or monitoring the client's compliance with court ordered services**, but only in connection with their official duties. This information may include, but is not limited to: diagnosis, care and treatment of medical and/or mental health history and treatment, completion or termination of treatment; medications; progress, attendance and degree of participation in any service or treatment program or components thereof as well as Court Ordered Service Plan compliance as mandated by the Court, as necessary to monitor my court-ordered Service Plan, and allow for its re-disclosure on an "as needed" basis.

I willingly and voluntarily authorize the disclosure of the following information: **ALL RECORDS RELATED TO:**

(Check Appropriate Box(es))

Drug/alcohol treatment Medical/Health

Programs of the Erie County Health Department Court Ordered Services

Mental Health Treatment/Counseling DSS financial assistance programs

DSS CPS and Foster Care records Sexual Offender Treatment Parenting

Vital Statistics such as Birth Cert., Adoption Records, Military Discharge Employment Records

Probation/Parole Status Other (Describe): _____

[] School documentation including attendance and duality sharing of information as it relates to the best interest of the child. The sole purpose and need to disclose the above information is to allow the Department of Social Services, the Court and other Service Providers to monitor my **voluntary participation in services, or where there have been court proceedings**, my compliance with the conditions of my court mandate to engage in remedial services, as directed through the Court Ordered Service Plan, and my consent for release of such information is limited to these purposes.

This authorization shall continue in full force and effect until the later of one year from the date of my signature, or the closing of my case with DSS.

(Signature of client)

(Date)

Erie County Department of Social Services
Background for Department Recommendation on Custody
(1017 or Article 6)
478 Main Street
Buffalo, New York 14202

CONFIDENTIAL

*** Denotes questions that must be answered prior to placement or within 24 hours of placement**

Date of Placement: _____

*** Primary Caretaker:**

First Name: _____ Last Name: _____

Other Known Last Names: _____

D.O.B. _____ Race: _____

Address: (# Street, City/Town, County, State, Zip):

Day Telephone #: _____ Home Telephone #: _____

E-mail address _____

*** Secondary Caretaker:**

First Name: _____ Last Name: _____

Other Known Last Names: _____

D.O.B. _____ Race: _____

Address: (# Street, City/Town, County, State, Zip):

Day Telephone #: _____ Home Telephone #: _____

E-mail address _____

CHILD CHARACTERISTICS

1. Name of children to be potentially placed in home:

Child 1: _____

Sex: male female Age: _____

Child 2: _____

Sex: male female Age: _____

Child 3: _____

Sex: male female Age: _____

Child 4: _____

Sex: male female

Age: _____

2. Are you aware of any of the following special needs of the child(ren) you are considering caring for in your home?

- PHYSICAL: Mild Moderate Severe
MENTAL HEALTH: Mild Moderate Severe
DEVELOPMENTAL DISABILITY: Mild Moderate Severe
EMOTIONAL/BEHAVIORAL: Mild Moderate Severe
LEARNING: Mild Moderate Severe

3. The following special needs have been identified at this time:

4. Your reasons for wanting to care for this child in your home:

* 5. Your relationship to the child: (example: cousin, uncle, aunt, godparent, family friend)

6. Have you taken care of children other than your own in your own home?

yes no

If so, describe circumstances, including age and sex, length of time, from whom received, reason for their leaving:

7. Do you feel you are able to meet the ongoing needs of the child (eg. Behavioral, religious, cultural, developmental)?

yes no

CARETAKER INFORMATION

* **Please list below and complete the requested information about all others living in your home.**

<u>Name of children living in your home</u>	<u>Sex</u>	<u>DOB</u>

<u>Name of other people living in your home</u> (Indicate if related to caretaker and how related)	<u>Sex</u>	<u>DOB</u>
<u>Name of your children living outside your home</u>	<u>Sex</u>	<u>DOB</u>

EMPLOYMENT/SOURCE OF INCOME

Primary Caretaker:

Current Profession or trade: _____

Place of Employment (name, address, telephone):

Hours per week: _____

Yearly salary: _____

Length of current employment: _____

Alternative Source of Income (such as: SSI, SSD, Public Assistance, Alimony):

Secondary Caretaker:

Current Profession or trade: _____

Place of Employment (name, address, telephone):

Hours per week: _____

Yearly salary: _____

Length of current employment: _____

Alternative Source of Income (such as: SSI, SSD, Public Assistance, Alimony):

* **Child Care plan (if applicable)**

before school care needed

after school care needed

full time day care needed

part time day care needed

Resources:

All basic needs of the child(ren) will be met without assistance.

* **Challenges to providing care/resources needed:**

- Financial Assistance
- Transportation
- Car Seats
- Furniture
- Medical Insurance/Medicaid
- Clothing
- Food Stamps
- Other: _____

PERSONAL INFORMATION

1. How will the child's placement affect the parent/child/caregiver relationship?
- * 2. Will the alleged perpetrator of child abuse/neglect have access to the child in your home? If yes, how will you control access?
3. Is placement in your home close proximity to the child's parent(s) for reunification purposes and when possible close to the child's current school placement?
- * 4. Are there any other factors that may prevent you from being able to care for the child, such as, commitments outside the home and number of persons already dependent upon the caregiver?
 - a. Does your age, physical and mental health allow you to adequately care for the child?
 - b. Are you or any member of your household on any type of prescribed drugs?
 yes no
If YES, list patient's name, name of drug, reason prescribed: _____

 - c. Do you or any member of your household have any physical problems?
 yes no
If YES, list physical problem and patient's name:

 - d. Do you or any members of your household have any mental health problems and/or have ever attended counseling?
 yes no
If YES, please list dates and place of treatment, example which clinic or doctor

- * 5. Please list name, address, and telephone number of your family physician(s): _____

6. Have you or any member of your family ever received foster care services from any other social agency, public or private, within this area or out of state ?
 yes no

If YES, please explain:

- * 7. Have you, any member of your household, or anyone who may assist with child care, ever been the subject of an Indicated Child Abuse/Maltreatment Report?
 yes no

If YES, name State/Country and Date Indicated: _____

8. Have you ever applied to any other agency for an adoption/foster care home study?
 yes no

If so, which agency? _____

- * 9. Have you, any other member of your household, or anyone who may assist with child care, ever had a criminal conviction, have current charges pending and/or been placed on probation?
 yes no

If YES, please explain and identify family members:

If YES, do you understand you must provide our agency with a copy of the conviction record?

yes no

10. Do you have any adults that frequent the home who been the subject of an Indicated Child Abuse/Maltreatment Report or have criminal convictions or current charges pending?

yes no

11. How long have you lived at your current address? _____

12. Where else have you lived in the past 5 years? _____

- * 13. Are you willing to accept the county agency involvement and work cooperatively with the county agency? *

ASSESSMENT OF THE HOME

- * 1. At least one flush toilet, one sink and one bath or shower with hot and cold running water.

- * 2. An operable heating and electrical system?
- * 3. Food storage and cooking facilities?
- * 4. Adequate sleeping area (not a hallway, garage, closet, common area, etc.) and child has a clean, comfortable mattress with clean linens.
- 5. Caretaker(s) have appropriate, up to date car seats for children 8 years of age and under.
- 6. Does the home have smoke detectors and carbon monoxide detectors?

Additional Comments: _____

The facts set forth in this document are true and complete. I agree to cooperate with ECDSS in supplying or assisting in gathering any necessary materials as required to complete this document.

Signature of Primary Caretaker:

Date: _____

Signature of Secondary Caretaker:

Date: _____

NOTE: ALL INFORMATION ON THIS DOCUMENT IS ACCEPTED IN CONFIDENCE AND SHALL NOT BE USED FOR ANY PURPOSE OTHER THAN TO DETERMINE suitability for temporary custody of the child (ren). Should you decide to pursue foster care certification, this document may be used to help expedite that process.

(Rev. 5/16)

 Pre Certification (office use only, to be completed as information is obtained)

1. Date of Abuse/Neglect records check (if completed):
 Results:
2. Date of Criminal History Check (if completed):
 Convictions:
3. Outstanding home safety issues (i.e. fire extinguisher needed):
4. Outstanding medical issues that impact caregiving:

Background Release Form

Primary Caretaker:

____ I hereby give Erie County Department of Social Services permission to complete both State Child Abuse/Maltreatment Report background check. All background information obtained is confidential and will only be disclosed for judicial or administrative proceedings relating to the child(ren) placed in your home by the court.

Relative caregiver

Date

Secondary Caretaker:

____ I hereby give Erie County Department of Social Services permission to complete both State Child Abuse/Maltreatment Report background checks. All background information obtained is confidential and will only be disclosed for judicial or administrative proceedings relating to the child(ren) placed in your home by the court.

Relative caregiver

Date

Adult member of household or adult providing child care:

____ I hereby give Erie County Department of Social Services permission to complete both State Child Abuse/Maltreatment Report background check. All background information obtained is confidential and will only be disclosed for judicial or administrative proceedings relating to the child(ren) placed in your home by the court.

Relative caregiver

Date

Adult member of household or adult providing child care:

____ I hereby give Erie County Department of Social Services permission to complete both State Child Abuse/Maltreatment Report background check. All background information obtained is confidential and will only be disclosed for judicial or administrative proceedings relating to the child(ren) placed in your home by the court.

Relative caregiver

Date