Family & Adolescent PARTNERSHIP

Funding Request Form

DATE OF REQUEST: _____

Youth: _____ **DOB:** _____

Ethnicity _____ Gender Disability Status _____

Parent/Guardian: _____

Parent/ Guardian

Contact Information: _____ *(address)*

_____ *(city, state, zip)*

_____ ***(primary phone)***

_____ *(email address)*

Sibling Information

Name: _____ **DOB:** _____

Ethnicity _____ Gender: **Disability Status**_____

Name: _____ **DOB:** _____

Ethnicity _____ Gender: **Disability Status**_____

Name: _____ **DOB:** _____

Ethnicity _____ Gender: **Disability Status**_____

Name: _____ **DOB:** _____

Ethnicity _____ Gender: **Disability Status**_____

Name: _____ **DOB:** _____

Ethnicity _____ Gender: **Disability Status**_____

Please include additional sibling information on back.

****All requests must be accompanied by up-to-date, signed FAP Release of Information.**

Current Situation/Goal of Good or Service:_____

_____

_____

_____

_____

_____

Other funding sources tried: _____

_____

Plan for sustainability (how will the family pay for services once FAP has provided funding?)_____

_____

_____

_____

Does the youth have health insurance? Yes No Insurance Provider: _____

See next page

Requested Provider:_____ Amount Requested:_____

Email: _____

Contact Number:_____

Requested Service:_____

_____

**Please include information about length of service (i.e. # of hrs/wks, total # of weeks)

Referral Source Information

Name: _____ Phone/Cell #: _____

Organization:_____ Email:_____

Please complete all of the fields above.

Date of Staffing/Approval:_____ Amount Approved:_____

Funding Approval:

_____Ariel _____DHS

_____Probation _____CYDC

_____WIOA _____Mind Springs

_____DYC _____Hilltop

_____SD 51 _____Partners

_____MCHD _____Strive

Please return this **funding request** to the Family & Adolescent Partnership by one of the methods below:

Email to FAPreferrals@htop.org or Fax 970.244-0542

Questions? Concerns? Comments? Please call 970.244.0613 or email at FAPreferrals@htop.org

State of Colorado

Authorization — Consent to Release Information

Agency Requesting Information

Agency Name Family & Adolescent Partnership	Contact Name/Title Abby Leinbach / Coordinator		
Mailing Address 1129 Colorado Avenue			
City Grand Junction		State CO	ZIP 81501
Email abigaill@htop.org	Phone 244-0613	Fax	Date

Client Information

Last Name	First Name	MI
Physical Address		
City	State	ZIP
Permanent Address (if different than physical address)		
City	State	ZIP
Email	Phone	DOB
Type of Identifier: ☐ Other ☐ School ID ☐ DL ☐ State ID ☑ Child Welfare Case # ☐ Case Report # ☐ JD# ☐ Passport	Identifier #: Use only last four digits of SSN if used.	Role:

Consenter/Person Authorizing Consent (if person above is a minor)

Last Name	First Name	MI
Physical Address		
City	State	ZIP
Permanent Address (if different than physical address)		
City	State	ZIP
Email	Phone	DOB
Type of Identifier: ☐ Other ☐ School ID ☐ DL ☐ State ID ☐ Child Welfare Case # ☐ Case Report # ☐ JD# ☐ Passport	Identifier #: Use only last four digits of SSN if used.	Role:

Authorizes

☑ DHS/ Office: MCDHS
☑ DHS/ Office of Behavioral Health
☑ DHS/ Division of Youth Corrections
☑ Court (Juvenile, County, Municipal)
☑ Service Provider
☑ LEA
☑ School (Private or District)
☑ Probation (Juvenile, County, Municipal)
☑ Diversion
☐ Juvenile Assessment Ctr
☑ SB94
☑ DA

Other Mind Springs Health, Rocky Mountain Health Plans, Primary Care Partners, Partners, Public Health, Ariel, Hilltop, Workforce Center, Strive/MDS

To Release Information to

☑ DHS/ Office: MCDHS
☑ DHS/ Office of Behavioral Health
☑ DHS/ Division of Youth Corrections
☑ Court (Juvenile, County, Municipal)
☑ Service Provider
☑ LEA
☑ School (Private or District)
☑ Probation (Juvenile, County, Municipal)
☑ Diversion
☐ Juvenile Assessment Ctr
☑ SB94
☑ DA

Other Mind Springs Health, Rocky Mountain Health Plans, Primary Care Partners, Partners, Public Health, Ariel, Hilltop, Workforce Center, Strive/MDS

To Receive Information From

☑ DHS Office: MCDHS
☑ DHS/Office of Behavioral Health
☑ DHS/ Division of Youth Corrections
☑ Court (Juvenile, County, Municipal)
☑ Service Provider
☑ LEA
☑ School (Private or District)
☑ Probation (Juvenile, County, Municipal)
☑ Diversion
☐ Juvenile Assessment Ctr
☑ SB94
☑ DA

Other Mind Springs Health, Rocky Mountain Health Plans, Primary Care Partners, Partners, Public Health, Ariel, Hilltop, Workforce Center, Strive/MDS

For the Purpose of

☐ Adjudication
☑ Assessment
☑ Other Implementation and Funding of Services
☑ Coordination of Services
☐ Intake
☐ Insurance (Health/Life)
☑ Interdisciplinary Team Staffing
☐ Placement
☐ Pretrial
☐ Treatment

Type of Information Requested

Education
☑ School Grades/Test Scores
☑ School Attendance Records
☑ School Behavior Reports
☑ IEP's/504

Substance Abuse
☑ Treatment History
☐ Evaluations

Medical
☑ Current Prescriptions
☑ Medical History
☐ Immunizations

Mental Health
☐ MH Assessment
☑ MH Treatment History
☑ Diagnosis

Justice Agency
☑ Probation History
☐ Probation Records
☐ Police Reports/Records
☑ Other Court Records

Other Records
☐ Human Service Records
☐ Child Welfare History

Other (Please Specify) _____

Preparer's Initials _____ **Consenter's Initials** _____

Date Range of Youth Records:	From: Month: 01	Day: 01	Year: 2001	To: Month: 07	Day: 01	Year: 2024
Date Range of Authorization/Consent:	From: Month: 07	Day: 01	Year: 2023	To: Month: 07	Day: 01	Year: 2024

How is this information being released? ☑ Fax ☐ Email ☑ Telephone ☑ In Person ☑ Other FAP databases

Signature of person authorizing consent: Date: (MM/DD/YYYY)

Type or print name:

Signature of youth: Date: (MM/DD/YYYY)

Type or print name:

☑ By my signature, I consent to the release of information contained on this form for use by the requesting agency(cies). I understand that my records are protected under Federal and State regulations governing confidentiality, 42 part 2, HIPAA , and FERPA and cannot be released without my written consent unless otherwise provided for by the regulations. I understand that any agency or individual using the confidential information or records obtained will take all necessary steps to protect the confidentiality of the above named juvenile/child's identity. I acknowledge that I have been informed of my rights to refuse to sign this form, and any conditions related to my consent or refusal, and that I am entitled to receive a copy of the signed form.

☐ Consenter declined release of information. _____[staff initial] [Copy Provided to Client]
Date Declined: (MM/DD/YYYY)_____

General

Disclosure Notice to Receiving Agencies: This notice accompanies a disclosure of information concerning a client whose information is protected by HIPAA, 42 part 2, FERPA, or other Federal or State law. This information has been disclosed to you from records whose confidentiality is protected by Federal Law. 42 part 2 and FERPA prohibit you from making further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by 42 part 2 or FERPA. A general authorization for the the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of 42 part 2 information to criminally investigate or prosecute any alcohol or drug abuse patient.

HIPAA Redisclosures: Information released under a HIPAA authorization may be subject to redisclosures that do not fall under HIPAA.

Confidentiality Notice for Electronic Transmittal: This release, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential information. If you have received this communication in error, please immediately notify the sender. In addition, if you have received this in error, do not review, distribute, or copy the document or attachments.

Condition Statement: I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Consent Expiration: This authorization - consent expires on/no later than (specific date), or one year from the date signed, at end of event, completion of treatment, or if included as part of a Court Order or condition of probation, upon the terms specified, whichever is less. Length of time consent is valid can be specific by program or provider, or set by length of program/ referral, period of time that records are utilized for specified consent purpose. See specific agency rules for agency specific time frames for record retention.

Copies of Authorization/Consent Valid: A copy, photocopy, or facsimile transmission of this release will have the same authority as the original.

Parent must be informed of consent rights and right to revoke consent in native language: Under Section 300.9 of Title 34 of the Code of Federal Regulations, parental consent means all of the following: (a) The parent or guardian has been fully informed of all information relevant to the activity for which consent is sought, in his or her native language, or other mode of communication. (b) The parent or guardian understands and agrees in writing to the carrying out of the activity for which his or her consent is sought; and the consent describes that activity and lists the records, if any, that will be released and to whom. (c) The parent or guardian understands that the granting of consent is voluntary on the part of the parent or guardian and may be revoked at any time. If a parent or guardian revokes consent, that revocation is not retroactive to negate an action that has occurred after the consent was given and before the consent was revoked. A public agency is not required to amend the education records of a child to remove any reference to the child's receipt of special education and services if the child's parent or guardian submits a written revocation of consent after the initial provision of special education and related services to the child.

Authorization/Consent Revocation Limitation/Period: This release/authorization may be revoked at any time by written notice to AGENCY, except to the extent that action has already been taken to comply with it. Without such revocation, this release/ authorization will expire as explained. Consenter may revoke consent in writing by contacting the releasing agency. This revocation will be re-corded in the AGENCY record. HIPAA requires written revocation of an authorization to release HIPAA information (45 CFR §164.508(b)(5)). Both Part 2 and HIPAA allow the program to make a disclosure for services already rendered in reliance on a signed consent or authorization form. See 42 CFR §2.31(a) (8) and 45 CFR §164.508. If consent is for Substance Abuse Treatment –verbal consent is acceptable. Verbal consent may also be accepted in specific emergency situations. See agency specific policies for more details.

Child Welfare and Medicaid Records: Federal law requires states to exchange information electronically through the state's automated child welfare and Medicaid systems to the extent it is feasible (45 C.F.R. § 1355.53(b) (2) (2009)) and encourages automated data exchange between child welfare and the courts. (45 C.F.R. § 1355.53(d) (2009).

Questions: If you have questions concerning this release please call (PROVIDER AGENCY PHONE #) or Please Send Information to: (PROVIDER AGENCY NAME AND ADDRESS AND FAX) Under the State of Colorado and Federal Confidentiality Regulations, no information about a juvenile participation in treatment can be disclosed without written consent except in the case of medical emergency, child abuse or Court Order. If applicable, a minimum necessary determination has been applied to this release/ authorization.

Preparer's Initials _____ **Consenter's Initials** _____