Job Foundation Application

Personal Information

Full Name: _____
First Last M.I.

Address: _____
Street Address Apartment/Unit # City State Zip Code

Email(s) _____

Contact Phone number: _____ Date of Birth: _____

DDA Case Manager Name: _____

High School: _____ Teacher: _____

Emergency Contact Information

Full Name: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____
City State ZIP Code

Primary Phone: _____ Alternate Phone: _____

Relationship: _____

- I certify that the information provided is true to the best of my knowledge. I am also aware that the information I have provided is subject to review and verification and I may have to provide documentation to support this application. I allow release of this information for verification purposes and understand that it will be used to determine eligibility. Upon request, I will be provided information on equal opportunity and appeal rights and the Privacy Act of 1974.
- I consent the use of confidential information about me within the Department of Social and Health Services, Developmental Disabilities Administration and Division of Vocational Rehabilitation to plan, provide, and coordinate services related to the Job Foundation application. I further grant permission to DSHS to use my confidential information with the County and school / school district named above. This exchange is authorized for information relevant to eligibility determination and coordination of service delivery and all information will be kept confidential.to

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STUDENT'S SIGNATURE | DATE

Guardian: Signature is required below if other than student.

- I authorize the County to assist my student with Job Foundations supports and activities.
- I certify the exchange of information between DSHS the County and any school / school district as appropriate in which my student is or has been enrolled. This exchange is authorized for any information relevant to the success of my student's participation. I understand that it may include standardized test results, transcripts, attendance records, performance reports and information from counselors, teachers, and other staff.
- I grant permission for my student to fully participate in educational, training, and employment related counseling activities for Job Foundation supports provided or arranged by the County.

Signature **Date**

Guardian Signature (if applicable) **Date**

Please return this application to: Spokane County Community Services: DD
Attn: Leah Kaplan – Lkaplan@spokanecounty.org
1116 W. Broadway
Spokane, WA 99260

*Please fill out both consent forms.

Washington State Department of Social & Health Services
Transforming lives

Consent

NOTICE TO CLIENTS: The Department of Social and Health Services (DSHS) can help you better if we are able to work with other agencies and professionals that know you and your family. By signing this form, you are giving permission for DSHS and the agencies and individuals listed below to use and share confidential information about you. DSHS cannot refuse you benefits if you do not sign this form unless your consent is needed to determine your eligibility. If you do not sign this form, DSHS may still share information about you to the extent allowed by law. If you have questions about how DSHS shares client confidential information or your privacy rights, please consult the DSHS Notice of Privacy Practices or ask the person giving you this form.

CLIENT IDENTIFICATION:

NAME	DATE OF BIRTH	IDENTIFICATION NUMBER

ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBER (INCLUDE AREA CODE)	OTHER INFORMATION

CONSENT:

I consent to the use of confidential information about me within DSHS to plan, provide, and coordinate services, treatment, payments, and benefits for me or for other purposes authorized by law. I further grant permission to DSHS and the below listed agencies, providers, or persons to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer data transfer, mail, or hand delivery.

Please check all below who are included in this consent in addition to DSHS and identify them by name and address:

- ☐ Health care providers: _____
- ☐ Mental health care providers: _____
- ☐ Substance use disorder service providers: _____
- ☒ Other DSHS contracted providers: Developmental Disabilities Administration(DDA)
- ☐ Housing programs: _____
- ☐ School districts or colleges: _____
- ☐ Department of Corrections: _____
- ☐ Employment Security Department and its employment partners: _____
- ☐ Social Security Administration or other federal agency: _____
- ☐ See attached list
- ☒ Other: County Contract Employment Agencies & Division of Vocational Rehabilitation

I authorize and consent to sharing the following records and information (check all that apply):

- ☐ All my client records ☐ Records on attached list
- ☐ Only the following records
  - ☐ Family, social and employment history ☐ Health care information ☐ Treatment or care plans
  - ☐ Payment records ☐ Individual assessments ☐ School, education, and training
  - ☐ Other (list):

PLEASE NOTE: If your client records include any of the following information, you must also complete this section to include these records.

I give my permission to disclose the following records (check all that apply):

☐ Mental health ☐ HIV/AIDS and STD test results, diagnosis, or treatment ☐ Substance Use Disorder

- **This consent is valid for ☐ one year ☐ as long as DSHS needs records, or ☐ until _____ (date or event).**
- **I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.**
- **I understand that records shared under this consent may no longer be protected under the laws that apply to DSHS.**
- **A copy of this form is valid to give my permission to share records.**

SIGNATURE	DATE	WITNESS / NOTARY (SIGN AND PRINT NAME, IF APPLICABLE)	DATE

PARENT OR OTHER REPRESENTATIVE'S SIGNATURE (IF APPLICABLE)	TELEPHONE NUMBER (INCLUDE AREA CODE)	DATE

If I am not the subject of the records, I am authorized to sign because I am the: (attach proof of authority)

☐ Parent ☐ Legal Guardian (attach court order) ☐ Personal representative ☐ Other:

NOTICE TO RECIPIENTS OF INFORMATION: **If these records contain information about HIV, STDs, or AIDS, you may not further disclose that information without the client's specific permission.** If you have received information related to **drug or alcohol abuse** by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR 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 42 CFR part 2. A general authorization for the release of medial or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Client Identification			
NAME	DATE OF BIRTH	IDENTIFICATION NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER (INCLUDE AREA CODE)	OTHER INFORMATION		

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Consent

Notice to Clients: The Department of Social and Health Services (DSHS) can help you better if we are able to work with other agencies and professionals that know you and your family. By signing this form, you are giving permission for DSHS and the agencies and individuals listed below to use and share confidential information about you. DSHS cannot refuse you benefits if you do not sign this form unless your consent is needed to determine your eligibility. If you do not sign this form, DSHS may still share information about you to the extent allowed by law. If you have questions about how DSHS shares client confidential information or your privacy rights, please consult the DSHS Notice of Privacy Practices or ask the person giving you this form.

Consent

1. I consent to the use of confidential information about me within DSHS to plan, provide, and coordinate services, treatment, payments, and benefits for me or for other purposes authorized by law. I also grant permission to DSHS and the below listed agencies, providers, or persons to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or electronically, by mail, or hand delivery.

   Reason for Disclosure: This information is required before DSHS can share drug and alcohol or mental health records. If you do not fill in this field, DSHS will note the reason for disclosure as being at your request.

   Please check all below who are included in this consent in addition to DSHS and identify them by name and address:

   - ☐ Health care providers: _____
   - ☐ Mental health care providers: _____
   - ☐ Substance use disorder service providers: _____
   - ☒ Other DSHS contracted providers: **Division of Vocational Rehabilitation**
   - ☐ Housing programs: _____
   - ☐ School districts or colleges: _____
   - ☐ Department of Corrections: _____
   - ☐ Employment Security Department and its employment partners: _____
   - ☐ Social Security Administration or other federal agency: _____
   - ☐ See attached list
   - ☐ Other:

2. Reason for disclosure: ☐ Continuity of care ☐ Legal ☐ Personal ☒ Other: **DVR Eligibility**

3. I authorize and consent to sharing the following records and information (check all that apply):
   - ☒ All my client records ☐ Records on attached list
   - ☐ Only the following records
     - ☐ Family, social and employment history
     - ☐ Treatment or care plans
     - ☐ Payment records
     - ☐ Individual assessments
     - ☐ School, education, and training
     - ☐ Mental health care information (specify):
     - ☐ Health care information (specify):
     - ☐ Other (list):

Client Identification		
NAME	DATE OF BIRTH	IDENTIFICATION NUMBER

Please note: If your client records include any of the following information, you must also complete this section to include these records.

I give my permission to disclose the following records (check all that apply):

☒ Mental health ☒ HIV/AIDS and STD test results, diagnosis, or treatment ☒ Substance Use Disorder

- **This consent is valid for one-year or ☒ until DVR Close (date or event).**
- **I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.**
- **I understand that records shared under this consent may no longer be protected under the laws that apply to DSHS.**
- **A copy of this form is valid to give my permission to share records.**

SIGNATURE		DATE
WITNESS / NOTARY SIGNATURE, IF APPLICABLE	WITNESS / NOTARY PRINTED NAME	DATE
PARENT OR OTHER REPRESENTATIVE'S SIGNATURE (IF APPLICABLE)	TELEPHONE NUMBER (INCLUDE AREA CODE)	DATE

If I am not the subject of the records, I am authorized to sign because I am the: (attach proof of authority)

☐ Parent ☐ Legal Guardian (attach court order) ☐ Personal representative ☐ Other:

Notice to Recipients of Information: **If these records contain information about HIV, STDs, or AIDS, you may not further disclose that information without the client's specific permission.** If you have received information related to **drug or alcohol abuse** by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR 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 42 CFR 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Instructions for Completing the Consent Forms, DSHS 14-012

Use: Use this form when you need consent to use or share confidential information about a client on a continuing basis about a client within DSHS or to disclose that information to other agencies to coordinate services or for treatment, payment or agency operations or for other purposes recognized by law.

Fill out this form electronically if possible. You must complete **a separate form for each person, including children.** .

Parts of Form:

IDENTIFICATION:

- Name: Provide the name of only one client on each form. Include any former names that client may have used when receiving services.
- Date of Birth: Needed to identify client from persons with similar names.
- Identification Number: Provide a client identification number or other identifier such as a social security number (not required) to assist in identifying records and tracking history and services received.
- Other: Include in this box any additional information that may help to locate records, such as DSHS involved with services, names of family members, or other relevant information.

CONSENT (AUTHORIZATION):

- Reason for disclosure: This information is required before DSHS can share drug and alcohol or mental health records. If you do not fill in this field, DSHS will note the reason for disclosure as being at your request.
- Agencies or persons exchanging records: This completed form allows: (1) the use and disclosure of confidential information inside DSHS and with the agencies or persons listed; and (2) disclosure of confidential information to DSHS by the outside agencies or persons listed. You may also attach a list of agencies allowed to share information, which the client must also sign.
- Information included: Clients must indicate what records are covered by the consent. Clients may make all records available or may limit the included records by date, type or source of record. If a client does not sign a consent or does not specify a particular record, sharing of that record will still be allowed if permitted by law. You may attach a list of covered records that the client must also sign. If any records include information relating to mental health (RCW 71.05.620), HIV/AIDS or STD testing or treatment (RCW 70.02.220), or drug and alcohol services (42 CFR 2.31(a)(5)), the client must mark these areas specifically to give permission to share these records. This form is not valid to include psychotherapy notes under 45 CFR 164.508(b)(3)(ii); a separate form must be completed to include those records.
- Duration: Include an expiration date for the consent, if different than one year. The consent will expire in one year unless you identify a different date.
- Understanding: Be sure the client understands what permission is being granted and how and why information will be shared. If needed, use a translated form and interpreter or read the form aloud. If the client needs more information, provide an additional copy of the DSHS Notice of Privacy Practices or refer the client to the public disclosure officer for your unit.

SIGNATURES:

- Client: Have client or a child over age of consent (13 for mental health and drug and alcohol services; 14 for HIV/AIDS and other STDs; any age for birth control and abortions; 18 for health care and other records) sign this box and insert the date of signature. The client may substitute a mark in this box that you witness.
- Witness or Notary: A witness or notary may be needed to verify the client's identity if the client does not submit this form in person or if a program requests verification. This person should sign and print his or her name.
- Parent or Other Representative: If the client is a child under the age of consent, a parent or guardian must sign. If the child does not meet the age of consent for all records to be shared, both the child and the parent must sign. If the client has been declared legally incompetent, the court appointed guardian must sign and provide a copy of the order of appointment. If someone is signing in another capacity (including a person with a power of attorney or an estate representative), mark "other" and obtain a copy of the legal authority to act. The person signing must date the signature and give a telephone number or contact information.