KIDS CENTRAL, INC.
A COMMUNITY APPROACH TO THE WELFARE OF CHILDREN
*Building Better Lives*

Dear Independent Living Youth:

In response to your request for entry into the Extended Foster Care enclosed you will find a packet of documents you must complete and return to address listed below. We MUST receive all these completed documents before we can determine your eligibililty for the program.

Upon receipt of the completed documents, you will be contacted by an Independent Living staff member to confirm receipt. Within 10 business days of receipt of the required documents you will be provided written notice either approving or denying your application.

- ☐ Extended Foster Care Application
- ☐ Client's Rights and Responsibilities
- ☐ Authorization for Release of Information form and this must have a witness signature.
- ☐ Signed HIPPA Form/ Notice of Privacy Practices
- ☐ Documentation showing proof of your quallifying factor for Extended Foster Care. This would inclued 1 of the following:

1. Enrollment in secondary education or a program leading to an equivalent ( proof of enrollment in high school & GED). Along with your proof of attendance;
2. Employment for at least 80 hours per month;
3. Participating in a program or activity designed to promote or eliminate barries to employement.
4. Proof of a documented disablity. That would impair you to complete any of the items listed above.

**Please send this information to:**

**Kids Central, Inc.**
**C/O Carol Wilcoxon**
**901 Industrial Dr. Suite 200**
**Wildwood, FL 34785**

**or you may fax the information to my attention at 352-387-3558**

If you have any questions, please call me at 352-387-3531.

Sincerely,

Carol Wilcoxon
Independent Living Administrator

# APPLICATION FOR EXTENDED FOSTER CARE

**Name** _____ **Date of Birth** _____

**Address** **City** **State** **Zip**

**Phone** _____ **Email** _____

**County where court was held when you were last in foster care: _____**

**Date application submitted: _____**

I want to re-enter Extended Foster Care on _____ (date). I realize that I must meet the activity requirements for this program, which are outlined below.

☐ I am already doing the activity/activities checked below, **OR**
☐ I need help from a case manager in beginning the activity/activities checked below, **OR**
☐ I am not able to do, or am limited in doing any of the activities below because I have a physical, intellectual, emotional, or psychiatric condition that that impairs my ability to perform one or more life activities and that limits my participation. ***Note:*** *If you check this box, please complete Section B, below:*

**A. Activity Requirements for Extended Foster Care:**

☐ Completing high school or a program leading to an equivalent credential, e.g., GED Program;
☐ Enrolled in an institution that provides postsecondary or vocational education;
☐ Participating in a program or activity designed to promote or eliminate barriers to employment;
☐ Employed for at least 80 hours per month.

**B. Condition that prevents me from full participation:**

Please describe your physical, intellectual, emotional or psychiatric condition that limits your ability to participate fully in any of the activities listed in section A, above. Please identify the condition; describe how it keeps you from participating; describe who, when and what a professional or other person told you about your not being able to participate fully in all of the activities listed above. Please include any other information you want us to know about this. If you have any documents from a doctor, a school or anyone else that describes this situation, please attach or let the case manager or designated staff know how they can get those documents. [Feel free to add additional pages.]

_____
_____
_____
_____

**C. My current living situation.**

Please describe where you are currently living (apartment or house alone, apartment or house with a roommate, dormitory, shelter, staying with a friend temporarily, etc.) If you have a lease, please attach a copy if you have it, or describe the term of the lease if it is on a set term rather than month-to-month. If you are currently homeless, please check the line at the end of this section.

_____

_____

_____

_____ I am currently homeless

**D. Is there a former foster parent with whom you would like to live?** Yes_____ No_____

If yes, please identify who that is and whether you have been in contact with that person.

_____

_____

**E. Are you willing and able to live in the following type of housing?**

Family Foster Home Yes_____ No_____
If no, why not? _____

_____

Licensed Group Home Yes_____ No_____
If no, why not? _____

_____

Shared Housing arranged by the Community-Based Care agency Yes_____ No_____
If no, why not? _____

_____

**F. Please give any other information that will help your case manager chose an approved living arrangement if you are accepted into Extended Foster Care.**

_____

_____

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## NOTICE OF WHAT HAPPENS NEXT

A decision must be made within 10 business days of the date you submit this application to the Case Manager or designated staff. If you start this application, but don't submit it, or don't get a decision within 30 days after you first spoke with a case manager, it will be considered to be denied. If that happens, you can submit a new application at any time, or you can appeal the denial. If your application is denied, you will be given information on how to challenge, or appeal, the denial.

If the decision is to admit you into Extended Foster Care, your case manager will contact you to begin writing your transition plan and case plan, and to get you started on your chosen qualifying activity if you are not already doing what you want to do to be eligible for this program.. You and the case manager will together decide where you will be living.

**Young Adult:**

_____ _____

Signature Date

_____ _____

Phone Email

**Case Manager/Designated Staff:**

I acknowledge that I have received this application. I will give _____ a written decision within 10 business days.

_____ _____ _____

Name (Print) Signature Date

_____ _____

Phone Email

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## Client Rights & Responsibilities

Kids Central Inc. is committed to providing the highest quality service to the children and families in Citrus, Hernando, Lake, Marion and Sumter Counties in Florida. As the lead agency for community-based care in Circuit 5, Kids Central provides independent living services directly throughout the circuit. Whenever youth are actively receiving services the following is expected:

- That each person served will be treated with dignity and respect regardless of age, sex, religion, race, ethnic or cultural background, sexual preference, or disability.
- That each person will receive the right to be heard to include being provided the opportunity to participate in the decision making process and service plan.
- That the transition plan developed will be provided in writing in a language that you can understand.
- That appropriate services will be provided to you in your community and delivered by qualified staff in a professional manner.
- That your rights to privacy and confidentiality will be guaranteed in accordance with applicable law.
- That the Independent Living Staff will provide you with a Clients Rights and Responsibilities Information Fact Sheet and Due Process Rights. If you are dissatisfied with the services they provide, you can file a grievance.
- **First, if dissatisfied with the response from specialist, please contact the Independent Living Supervisor, Lindsey Tew at 352 - 387-3511 (office)**
- Then if you fail to receive a timely response to any grievance filed or you are dissatisfied with the response, you can seek assistance from the Kids Central Clients Rights/Ombudsman by calling (352) 873-6332.
- That you will be open and honest with Kids Central, Inc. staff.
- That to the best of your ability you cooperate with service plans, service providers, the court system and others who are working to assure that your child's best interest is served.

Youth Signature: _____

Date: _____

Please keep one copy for your record and return the signed and dated copy.

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***VERY IMPORTANT DOCUMENT***

# AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ SS#_____ Birth date:_____

Address:_____ City: _____ State:_____ Zip Code:_____

Telephone Number: (_____) _____

I hereby request and authorize, Kids Central Inc. Independent Living Staff / Department of Children & Families

to obtain from or release to _____
(School)

The following information from my records (initial or check to authorize release)

X Educational Information _____Other (must specify): _____

For the purpose of school verification required as proof of eligibility for the Independent Living program.

This Information will be used solely for the purpose of educational consultation, advocacy and monitoring for:

Form in which information may be released: ____X Written _____X Verbal _____X Electronic

REQUIRED- PLEASE CALL YOUR INDEPENDENT LIVING FACILITATOR IF YOU HAVE QUESTIONS

Valid Authorization Dates: (_____) - (_____) (Valid one year from date of signature)
(Today's date) (1 year from todays date)

All information I authorize to be obtained from this agency will be strictly confidential and cannot be released by the recipient without my express written consent.
You may refuse to sign this authorization. We will not condition treatment or payment on your providing this authorization (subject to exceptions).
I understand that if the person or organization that receives this information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.
I understand that unless otherwise limited by state or federal regulations and except to the extent that action has been taken based on my prior authorization, I may revoke this authorization at any time.

_____ _____
Clients signature Date

_____ _____
Print Clients name Legal Representative Signature

_____ _____
Witness Signature Date

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure without specific written consent of the person, to whom it pertains, or as otherwise permitted, by such regulations. A general authorization for release of medical or other information is not sufficient for this purpose.

"No person shall, on the basis of race, color, religion, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to unlawful discrimination under any program or activity receiving or benefiting from federal financial assistance".

# Florida Department of Children and Families
# Notice of Privacy Practices

*HIPAA Privacy Officer*
*1317 Winewood Blvd., Bldg. 1, Room 110*
*Tallahassee, FL 32399-0700*
*Phone: (850) 487-1901 FAX: (850) 921-8470*
*Website: www.myflfamilies.com/hipaa*

## Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

### Your Rights

**You have the right to:**

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

### Your Choices

**You have some choices in the way that we use and share information as we:**

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

### Our Uses and Disclosures

**We may use and share your information as we:**

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*



_____

(Client Signature)