CHILDREN'S REHABILITATION SERVICE
CLIENT/FAMILY INFORMATION

STATE OF ALABAMA
DEPARTMENT OF REHABILITATION SERVICES

CLIENT INFORMATION

Last name: _____ First: _____ Middle:_____Suffix: _____

Sex: - Primary Race -_____Secondary Race: -_____

Primary Language: - Secondary language: -

Hispanic origin: ◯Yes ◯No Country of Hispanic origin: -_____

Street Address:_____City:_____

State:_____ZIP code:_____County of residence:_____ Home phone: (____)____-_____

Mailing address:_____City:_____State:_____ZIP:_____

E-mail address: _____

If student, name of school:_____

Is client married:◯Yes ◯No Receives Supplemental Security Income (SSI):◯Yes ◯No ◯Applied

FAMILY INFORMATION (Parents, Spouse, Guardian)

1. Last name: _____First:_____ MI:_____ Suffix:_____

Relationship to client:_____Email:_____

Is this the person financially responsible for the client: ◯Yes ◯No

Work phone: (____)_____-_____Cell phone: (____)_____-_____Birthdate:____/____/_____

Address and home phone number same as client: ◯Yes ◯No If no, please provide below:

Street:_____City:_____

State:_____ZIP code:_____Home phone: (____)_____-_____

2. Last name: _____First:_____ MI:_____ Suffix:_____

Relationship to client:_____Email:_____

Is this the person financially responsible for the client: ◯Yes ◯No

Work phone: (____)_____-_____Cell phone: (____)_____-_____Birthdate:____/____/_____

Address and home phone number same as client: ◯Yes ◯No If no, please provide below:

Street:_____City:_____

State:_____ZIP code:_____Home phone: (____)_____-_____

3. Neighbor/Relative:_____Relationship:_____Phone: (____)_____-_____

4. Neighbor/Relative:_____Relationship:_____Phone: (____)_____-_____

CHILDREN'S REHABILITATION SERVICE
MEDICAL HISTORY INFORMATION FORM

STATE OF ALABAMA
DEPARTMENT OF REHABILITATION SERVICES

CLIENT INFORMATION

Last Name: _____ First: _____ Middle: _____ Suffix: _____

Referring Diagnosis: _____

Referred by: _____ Phone number: (___)_____-_____

Address: _____

Presenting Problem: _____

Previous Treatment/History: _____

_____

_____

_____

Current Medications and Dosage: _____

BIRTH HISTORY

Length of pregnancy: _____ Birthweight: _____

Complications:

-during pregnancy _____

-during labor/delivery _____

-after birth _____

Place of delivery: _____

Length of stay in nursery: _____

My child has/had:

☐ measles	☐ herpes	☐ heart problems	☐ learning problems
☐ mumps	☐ asthma	☐ ear infections	☐ sleeping problems
☐ chicken pox	☐ CMV	☐ hearing problems	☐ others _____
☐ scarlet fever	☐ sickle cell	☐ vision problems	_____
☐ diabetes	☐ genetic testing	☐ eating problems	_____

Allergies

☐ None known

List allergies (including medications): _____

Pertinent Family Health History (Mother's and father's family, if known)

_____

_____

_____

Other family members known to CRS: _____

_____

The above information is true to the best of my knowledge. I understand that I will be required to submit financial and insurance information each year that my child receives treatment through Children's Rehabilitation Service.

Date: _____ Signature: _____

CHILDREN'S REHABILITATION SERVICE
MEDICAL/DENTAL PROVIDER INFORMATION FORM

STATE OF ALABAMA
DEPARTMENT OF REHABILITATION SERVICES

Last name: ______________________________ First: ____________________ Middle: ________________ Suffix: _____

CLIENT'S PRIMARY PEDIATRICIAN/DOCTOR INFORMATION*

Last name: ______________________________ First: ______________________________

Name of clinic or practice: ______________________________

Street: ______________________________ City: ______________________________

State: ______________________ ZIP code: ________-_________ Office phone: (_____) _________-___________

CLIENT'S DENTAL CARE PROVIDER INFORMATION*

Last name: ______________________________ First: ______________________________

Name of clinic or practice: ______________________________

Street: ______________________________ City: ______________________________

State: ______________________ ZIP code: ________-_________ Office phone: (_____) _________-___________

CLIENT'S SPECIALTY CARE PROVIDER INFORMATION*

Provider's specialty: ______________________________

Last name: ______________________________ First: ______________________________

Name of clinic or practice: ______________________________

Street: ______________________________ City: ______________________________

State: ______________________ ZIP code: ________-_________ Office phone: (_____) _________-___________

CLIENT'S SPECIALTY CARE PROVIDER INFORMATION*

Provider's specialty: ______________________________

Last name: ______________________________ First: ______________________________

Name of clinic or practice: ______________________________

Street: ______________________________ City: ______________________________

State: ______________________ ZIP code: ________-_________ Office phone: (_____) _________-___________

CLIENT'S SPECIALTY CARE PROVIDER INFORMATION*

Provider's specialty: ______________________________

Last name: ______________________________ First: ______________________________

Name of clinic or practice: ______________________________

Street: ______________________________ City: ______________________________

State: ______________________ ZIP code: ________-_________ Office phone: (_____) _________-___________

***Please complete a Release of Information (page 7) for each provider.**

CHILDREN'S REHABILITATION SERVICE CONSENT FORM

STATE OF ALABAMA
DEPARTMENT OF REHABILITATION SERVICES

RE: _____ County:_____Last 4 SSN:_____
(Client)

I. CONSENT FOR MEDICAL CARE: I hereby give my permission and consent to the Children's Rehabilitation Service Staff, both medical and paramedical, to conduct a thorough physical examination, evaluation, and/or observation of the above-named individual, and also to request or secure any medical information and/or tests. Furthermore, I authorize the Children's Rehabilitation Service staff to provide such treatment as it shall deem is indicated by the aforementioned physical examination, evaluation, and/or observation and which is consistent with that provided by this State Agency.

II. LITIGATION SETTLEMENT: For and in consideration of Children's Rehabilitation Service examining and/or providing medical treatment or other treatment and/or services to the above-named individual, I hereby agree that the Children's Rehabilitation Service is entitled to full and complete recovery of any and all expenses and costs of services provided to the above-named individual from any and all monies received by or on behalf of the above- named individual, derived from any judgement, settlement, or any other source, the monies being received as a result of the above-named individual's injury. I hereby agree that the Children's Rehabilitation Service is entitled to a full recovery regardless of whether the above-named individual recovers the full amount of his/her loss which is caused by his/her injury. The Children's Rehabilitation Service and I hereby agree that the above will govern the rights of the parties as they relate to the recovery of monies by the above-named individual and the payment of services provided by Children's Rehabilitation Service.

III. ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and request that all insurance benefits be paid directly to Children's Rehabilitation Service for services and items provided to the above-named individual by Children's Rehabilitation Service. I completely release the insurance company to the extent of the payment made by and to the Children's Rehabilitation Service.

IV. CIVIL RIGHTS: I have received a written statement specifying the provision of Title VI of the Civil Rights Act of 1964 (Public Law 88-352) and my right to appeal.

V. PHOTOCOPY: I agree that photocopy of this document shall be considered as effective and valid as the original.

VI. CONFIDENTIALITY: I understand that the Children's Rehabilitation Service will not disclose or release information created or received about the above-named individual except for purposes of (1) appropriate medical treatment and/or development/assessment; (2) release to insurance companies for the purpose of payment; (3) other health care operations such as review for staff monitoring and/or evaluation and for purposes of Quality Assurance monitoring. For certain other instances, I understand that I must sign an authorization permitting the disclosure or release of information.

VII. PRIVACY: I have received a written statement specifying the ADRS Notice of Privacy Practices. The Notice describes how health information about me may be used and disclosed, how I can get access to this information, and how information may be shared with me.

I certify that I understand the above statements and by signing, give consent to the above. I also understand that this consent shall remain in effect until and unless CRS is otherwise notified in writing.

_____ _____

Date Signature of Client/Parent/Guardian

DECLARATION OF CITIZENSHIP AND LAWFUL PRESENCE OF AN ALIEN FOR PUBLIC BENEFITS

Title IV of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 8 U.S.C. § 1621, provides that, with certain exceptions, only United States citizens, United States non-citizen nationals, non-exempt "qualified aliens" (and sometimes only particular categories of qualified aliens), nonimmigrants, and certain aliens paroled into the United States are eligible to receive state or local public benefits.

With certain exceptions, Alabama Act 2011-535 prohibits aliens unlawfully present in the U.S. from receiving state or local benefits. Every U.S. Citizen applying for a state or local public benefit must sign a declaration of Citizenship, and the lawful presence of an alien in the U.S. must be verified by the Federal Government.

Directions: All applicants must complete and submit this form. Applicant is the child or youth applying to receive services.

SECTION 1 --- APPLICANT INFORMATION

Last name: _____ First: _____ Middle:_____Suffix: _____

Current Address:_____City:_____

State:_____ZIP code:_____County of residence:_____

SECTION II --- CITIZENSHIP DECLARATION

Are you a citizen or national of the United States? (check one) ◯ Yes ◯ No

If "No," please proceed to Section III. If "Yes," proceed to signature/date.

SECTION III --- LAWFUL PRESENCE DECLARATION

Only complete this section if you answered "No" to the question above in Section II.

Are you an alien lawfully present in the United States? (check one) ◯ Yes ◯ No

SECTION IV --- DECLARATION

I declare under penalty of perjury under the laws of the State of Alabama that the answers I gave and the information I provided are true and correct to the best of my knowledge.

_____ _____

PARENT/GUARDIAN/APPLICANT'S SIGNATURE DATE

CHILDREN'S REHABILITATION SERVICE
BILLING INFORMATION FORM CLIENT

STATE OF ALABAMA
DEPARTMENT OF REHABILITATION SERVICES

Last name: _____ First: _____ Middle: _____ Suffix: _____

SSN:_____-_____-_____ Date of Birth:_____/_____/_____

Medicaid number: ☐☐☐☐☐☐☐☐☐☐☐☐☐ EPSDT provider: _____

Name as it appears on the Medicaid card: _____

HEALTH INSURANCE INFORMATION

Change in health insurance within the last 12 months: ◉ Yes ○ No

Insurance company name: _____ Code: _____

Policy contract number: _____ Policy group number: _____

Effective date: From: _____ To: _____

Pharmacy benefits? ○ Yes ○ No Check if: ☐ Point of sale or ☐ Drug co-pay Dental coverage? ○ Yes ○ No

Policyholder SSN: _____-_____-_____ Insured's relationship to client: _____

Last name: _____ First: _____ MI: ____ Suffix: _____

Birthdate: _____/_____/_____ Policy holder's employer: _____

Street: _____ City: _____

State: _____ ZIP code: _____-_____ Phone: (_____) _____-_____

SECONDARY HEALTH INSURANCE

Change in health insurance within the last 12 months: ○ Yes ○ No

Insurance company name: _____ Code: _____

Policy contract number: _____ Policy group number: _____

Effective date: From: _____ To: _____

Pharmacy benefits? ○ Yes ○ No Check if: ☐ Point of sale or ☐ Drug co-pay Dental coverage? ○ Yes ○ No

Policyholder SSN: _____-_____-_____ Insured's relationship to client: _____

Last name: _____ First: _____ MI: ____ Suffix: _____

Birthdate: _____/_____/_____ Policy holder's employer: _____

Street: _____ City: _____

State: _____ ZIP code: _____-_____ Phone: (_____) _____-_____

FAMILY FINANCIAL PARTICIPATION INFORMATION

Number of persons living in household: _____

Taxable annual household income as reported on last tax return(s): _____

NOTE: Taxable annual household income should include wages of all persons in the home who support the child.

Retirement, survivor, and disability benefits may be reported in lieu of wages.

The above information is true to the best of my knowledge. I understand that I will be required to submit financial and insurance information each year that my child receives treatment through Children's Rehabilitation Service.

Date: _____ Signature: _____

CHILDREN'S REHABILITATION SERVICE
Authorization for Use, Disclosure, and/or Release of Information

STATE OF ALABAMA
DEPARTMENT OF REHABILITATION SERVICES

Child/Client Name: _____

Child/Client Address: _____

Date of Birth: _____

I give my permission to obtain and release the following protected health information about my child and/or family and communication between the individuals listed below for the purpose of treatment, medical follow up, and/or care coordination. I can revoke this permission at any time by notifying **Children's Rehabilitation Service** in writing.

I understand that a revocation is not effective to the extent that the parties named below have already relied on the authorization for use/disclosure of the protected health information.

I understand that this information may include medically sensitive material and I authorize its release for the purpose stated.

I understand that information used or disclosed related to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. **CRS will not condition treatment, payment or enrollment or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.**

Name: _____ **Name:** _____

Address: _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax** _____ **Phone:** _____ **Fax** _____

The following written, verbal, and audio/video information may be:

□ Obtained

□ Released

For Dates of Service: _____

□ Birth records
□ Developmental Testing/Report
□ Discharge Summary
□ Enrollment Information
□ Health/Medical Records
□ Hearing Reports
□ Progress Reports
□ Psychological Testing/Reports
□ Social/Developmental History
□ Staffing Reports (IFSP/IEP)
□ Therapy/Testing Reports
□ Vision Reports
□ X-rays/Labs
□ Other: _____

This information will be used to determine eligibility and services within Children's Rehabilitation Service.

The above information is not to be released to any other individuals or agency except the one listed.

Photocopies of this Release of Information form will be considered as an original.

I understand that I have the right to refuse to sign this Release of Information.

This signed release of information form is effective from date of signature until revoked in writing by the authorized individual/s.

Parent/Guardian Name (Please Print): _____

Client/Parent/Guardian Signature: _____ **Relationship:** _____ **Date Signed:** _____

Alabama Department of REHABILITATION SERVICES

ADRS NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING HEALTH INFORMATION

This notice applies to all personal health information about you created and maintained by the Alabama Department of Rehabilitation Services (ADRS). We understand that medical information about your health is personal. We are committed to protecting your personal health information (PHI). We create and maintain a record of services provided to you by the department and services provided to you by others on behalf of the department. This record is to provide you with quality services. This notice will tell you about the ways we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information. If ADRS privacy practices change, a new privacy notice will be posted to the ADRS web site and in all ADRS offices.

USE, SHARING AND PROTECTION OF HEALTH INFORMATION

ADRS staff will only use your personal health information when doing their jobs. When health information is shared with other agencies or organizations, ADRS requires the other agencies and organizations to safeguard your health information. The purposes of the use and sharing of health information are:

Operating the ADRS Program for:

Eligibility- Some ADRS programs require health information to determine eligibility for the program.

Treatment - ADRS will use and share your health information to approve treatment and to determine if your medical treatment is appropriate. For example, ADRS professionals may review your treatment plan with your health care provider to determine medical necessity.

Payment - ADRS may use and share your health information to request reimbursement from Medicaid and Insurance companies. For example, ADRS may bill Medicaid for services provided in the Children's Rehabilitation Service, the SAIL Medicaid Waiver, or the Early Intervention Programs.

Other uses, sharing of health information or disclosures of health information required or allowed by law:

Information purposes - ADRS may mail, text or email you helpful information such as brochures related to various programs administered by ADRS and/or appointment reminders.

Other Government Agencies or organizations providing benefits, services, or disaster relief - ADRS may share information with other government agencies or organizations that are providing benefits or services when the information is necessary for you to receive those benefits or services. Information may also be shared between divisions within ADRS (Early Intervention, Children's Rehabilitation Service, Vocational Rehabilitation, State of Alabama Independent Living) to determine your eligibility for other benefits or services provided by the department.

Public Health - ADRS may disclose health information to the appropriate agencies for public health activities for disease control and prevention, problems with medical products or medications and victims of abuse, neglect or domestic violence as required by law.

Health Oversight Activities - ADRS may disclose specific health information to authorized health oversight agencies responsible for the Medicaid program, Maternal and Child Health Bureau, the Department of Health and Human Services, and the Office of Civil Rights.

Judicial and Administrative Hearings - ADRS may disclose specific health information in judicial and administrative proceedings as required by law.

Law Enforcement Purposes - ADRS may disclose specific health information for law enforcement purposes as required by law.

Coroners and Medical Examiners - ADRS may disclose specific health information to coroners and medical examiners to carry out their jobs, as required by law.

Organ Donation and Disease Registries - ADRS may disclose specific health information to authorized entities involved where you have consented to organ donation and transplantation, communicable disease registries, and cancer registries.

Research Purposes - ADRS may disclose specific health information to entities authorized to conduct a research project. When information is disclosed for research purposes, information that identifies you will not be disclosed.

To avert a serious threat to health, safety, or emergency situation - ADRS may disclose specific health information to prevent a serious threat to a person's or the public's health or safety.

Specialized government functions - ADRS may disclose health information for national security and intelligence and for protection of the President and others, as required by law. Also, ADRS may disclose health information to the appropriate military authorities if you are or have been a member of the armed services.

Correctional Institutions - ADRS may disclose health information to correctional facilities or law enforcement officials to maintain the health, safety, and security of the corrections system.

Workers' Compensation - ADRS may disclose health information to workers' compensation programs that provide benefits for work-related injuries or illness without regard to fault.

YOUR RIGHTS TO PRIVACY

Your health information will not be shared without your authorization except as described in this notice or as required by law. You may authorize other disclosures by completing an ADRS Authorization Form, and you may revoke such authorization in writing at any time. ADRS has procedures to assist you with your rights to your health information and you may ask your counselor, case manager, care coordinator or service coordinator for a paper copy of this notice at any time. An electronic copy of this notice is available on the ADRS web site, http://www.rehab.alabama.gov

You have the Right to:

Request Restriction - You may request in writing that ADRS limit the use or disclosure of your health information except for treatment, payment, and health care operations purposes. ADRS is not required by law to agree to your request.

Request Confidential Communications - You may request in writing that ADRS communicate with you in a different way or to a different location. For example, a different mailing address or calling you at a different phone number.

Inspect and Copy - You may, upon written request and during normal business hours, review all the records maintained by ADRS relating to the grant, denial, or provision of services. A Department staff member shall be present during any review. ADRS will make all information in the case record available except: (a) when ADRS believes medical, psychological, or other information may be harmful to the individual, the information shall be provided to the client's authorized representative, a physician, or licensed or certified psychologist; and (b) information obtained from another organization or agency may be released only under the conditions established by the outside agency, organization, or provider.

You may request a copy of your record. ADRS may charge a reasonable fee for any copies of records reproduced, but not to exceed $.50 per page. State and federal agencies, other health care providers, and families (first copy only) are exempt from this charge.

Amend - You may request, in writing along with the reason, to change or add information to your health record. However, original documentation maintained by ADRS may not be erased. ADRS is not required by law to agree to your request.

Accounting of Disclosures - You may request an accounting of disclosures of your health information except for purposes of treatment, payment, health care operations and disclosures required by law for purposes of national security or law enforcement.

For more information or to report an incident where you feel that your privacy has been compromised by an ADRS staff person, you may contact the individuals listed below or the Secretary of Health and Human Services, 200 Independence Ave. S.W., Washington, D.C. 20201. No individual will be retaliated against for filing a complaint.

Send complaints to: Complianceofficer@rehab.alabama.gov

Or, you can also mail a complaint to:
The Commissioner
Alabama Department of Rehabilitation Services
602 S. Lawrence Street
Montgomery, Alabama 36104

ALABAMA DEPARTMENT OF REHABILITATION SERVICES

Jane Elizabeth Burdeshaw, Commissioner

602 South Lawrence St. Post
Office Box 4280
Montgomery, Alabama 36103-4280

To persons receiving services or applicants for services from the Alabama Department of Rehabilitation Services.

COMPLIANCE WITH CIVIL RIGHTS ACTS:

TITLE VI of the Civil Rights Act, Title IX of the Education Amendments and Title V of the Rehabilitation Act provides that no person in the United States shall on the grounds of race, color, national origin, age, sex or disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

These acts further provide that all individuals, agencies, institutions, and political subdivisions which provide services to persons with disabilities under the program comply with the provisions of the acts. ADRS has prepared a statement of compliance as required by the acts and regulations.

If a person has knowledge that the agency is being operated otherwise, a written and signed complaint describing the nature of the alleged discrimination and the time place, and other pertinent facts may be filed with the ADRS Commissioner, 602 South Lawrence St., PO Box 4280, Montgomery, Alabama 36103 or with the Office for Civil Rights, 101 Marietta Towers, Atlanta, Georgia 30323.

CHILDREN'S
Rehabilitation Service

CHILDREN'S REHABILITATION SERVICE
CLIENT AND FAMILY RIGHTS

Children's Rehabilitation Service (CRS), Alabama Department of Rehabilitation Services follows established procedures to ensure client/family rights to services. The following is an explanation of those rights and the due process procedures available to ensure clients/families understand their rights under the law. If you would like further explanations of any other rights, contact:

_____

(Local district office contact information)

Or, Children's Rehabilitation Service, P.O. Box 4280, Montgomery, Alabama 36103-4280 [street address: 602 South Lawrence Street, Montgomery, Alabama 36104], telephone (334) 638-5900 or 1-800-846-3697.

1. Clients and families have the right to receive a written notice of the services to be provided by CRS and a written notice when services or eligibility is denied. This is referred to as a "Notice of Action".

2. Applicants/Clients and families may request an Informal Administrative Review (optional) in an effort to resolve a complaint. A request for an Informal Administrative Review must be in writing, be directed to the appropriate CRS District Supervisor, and be filed within ten (10) calendar days of the receipt of Notice of Action. Within ten (10) days of the receipt of the request for an Information Administrative Review, you will be notified by mail of the time and place for the review to take place. Following the review, you will receive a written decision from the review team within fifteen (15) days of the completion of the review.

3. Applicant/Clients and families have the right to request a Formal Hearing if they are dissatisfied with the decision of an Informal Administrative Review Team or if they choose not to request an Informal Administrative Review. The request for a Formal Hearing must specify the reason(s) for requesting the hearing, specify what is being asked for, be received by the Commissioner of the Alabama Department of Rehabilitation Services within fourteen (14) calendar days of the date of the Notice of Action or within fourteen (14) calendar days of the receipt of an Informal Administrative decision when one has been requested.

4. Clients/families have the right to continue receiving services without reduction or suspension of those services while a request for an Informal Administrative Review or hearing, Formal Hearing or other judicial proceeding is in progress.

5. All applicant and client information acquired by CRS remains the property of CRS. This information is used and released only for purposes directly related to the

administration of programs within the Department of Rehabilitation Services. Clients/Applicants/Parents or legal guardians may, upon reasonable notice received in writing and at a reasonable time during normal business hours, review all of the applicant's/client's records maintained by the Department related to the provision or denial of services.

6. Release of information is by written consent of the applicant/client or the applicant's/client's authorized representative. However, the Department may disclose information pertaining to an applicant or client without consent to its employees, agents and providers who have a need for access to the information. Except as authorized above, employees of the Department will not make public the contents of any records to any person, or testify in court or in a hearing, nor release records without the consent of the individual unless served with an appropriate subpoena or process and ordered to do so by a judge, hearing officer or other lawful authority.

7. Applicants/Clients or their authorized representative may request a copy of their record without charge (first copy only).

8. Applicants/Clients or their legal guardian must give written consent before evaluation, assessment or services are provided. The granting of consent is strictly voluntary and may be revoked by the applicant/client or legal guardian at any time.

My signature below verifies that the above information was explained to me in a manner that I could understand. I have also been provided with a copy of these rights.

_____ _____

Client/Parent/Guardian Signature Date