



Lower Columbia College Head Start/EHS/ECEAP
Parent/Guardian Permission to
Reveal or Obtain Confidential Information

Please complete this form with ALL information.

Child's Name: _____

DOB: _____

Address: _____

Phone: _____

City/State: _____

I hereby authorize the exchange of information orally, in writing or electronically between the Head Start/EHS/ECEAP Program and the Agencies/Persons listed below for the purpose of meeting performance standard requirements and to provide ongoing care.

Name of Individual/Agency: CASCADE EYE CARE

Address: 950 - 11TH AVENUE

Phone: 360-577-1500

City/State/Zip: LONGVIEW, WA 98632

Fax/Email: 360-425-0735

Check all that apply:

- Health/Medical Information
Dental
Educational/IEP/IFSP
Screening/Assessment
Mental Health (initials)
AIDS or HIV (initials)
Other:
All of the Above

PARENT AUTHORIZATION

I understand that I may withdraw this authorization, in writing or at any time and it will not affect my enrollment. Information received through this request will not be re-disclosed to any other persons/clinics/agencies without an additional parent signed release. The information will be released in accordance with state and federal laws/FERPA and Head Start/EHS/ECEAP policies and procedures.

I give my specific authorization for these records to be released, excluding any State and/or Federally protected information.

Parent Name (please print): _____

Signature: _____

Date: _____

(authorized parent, legal guardian or authorized representative)

This authorization will expire after 18 months of signature date.

Lower Columbia College Head Start/EHS/ECEAP
PO Box 3010
Longview, WA 98632
360-442-2800 FAX: 360-442-2819
Email: headstart.info@lowercolumbia.edu



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Name of Individual/Agency: CASTLE ROCK SCHOOL DISTRICT

Address: 700 HUNTINGTON AVENUE

Phone: 360-501-2910

City/State/Zip: CASTLE ROCK, WA 98611

Fax/Email: 360-501-3140

Check all that apply:

- Health/Medical Information
Dental
Educational/IEP/IFSP
Screening/Assessment
Mental Health (initials)
AIDS or HIV (initials)
Other:
All of the Above

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Name of Individual/Agency: CHILD & ADOLESCENT CLINIC

Address: 971 – 11TH AVENUE

Phone: 360-577-1771

City/State/Zip: LONGVIEW, WA 98632

Fax/Email: 360-423-9537

Check all that apply:

- Health/Medical Information
- Dental
- Educational/IEP/IFSP
- Screening/Assessment
- Mental Health (_____ initials)
- AIDS or HIV (_____ initials)
- Other: _____
- All of the Above

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Signature: _____

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Name of Individual/Agency: COLUMBIA WELLNESS

Address: 921 - 14TH AVENUE

Phone: 360-423-0203

City/State/Zip: LONGVIEW, WA 98632

Fax/Email: 360-577-0249

Check all that apply:

- Health/Medical Information
- Dental
- Educational/IEP/IFSP
- Screening/Assessment
- Mental Health (_____ initials)
- AIDS or HIV (_____ initials)
- Other: _____
- All of the Above

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City/State: _____

I hereby authorize the exchange of information orally, in writing or electronically between the Head Start/EHS/ECEAP Program and the Agencies/Persons listed below for the purpose of meeting performance standard requirements and to provide ongoing care.

Name of Individual/Agency: FAMILY HEALTH CENTER - KELSO

Address: 300 OAK STREET, SUITE B

Phone: 360-353-5511

City/State/Zip: KELSO, WA 98626

Fax/Email: 360-353-5502

Check all that apply:

- Health/Medical Information
- Dental
- Educational/IEP/IFSP
- Screening/Assessment
- Mental Health (_____ initials)
- AIDS or HIV (_____ initials)
- Other: _____
- All of the Above

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Signature: _____

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Name of Individual/Agency: FAMILY HEALTH CENTER - LONGVIEW

Address: 784 - 14TH AVENUE

Phone: 360-703-6400

City/State/Zip: LONGVIEW, WA 98632

Fax/Email: 360-414-1342

Check all that apply:

- Health/Medical Information
Dental
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AIDS or HIV (initials)
Other:
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Name of Individual/Agency: _____

Address: _____

Phone: _____

City/State/Zip: _____

Fax/Email: _____

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Name of Individual/Agency: HAPPY KIDS DENTISTRY

Address: 1717 OLYMPIA WAY, SUITE 101

Phone: 360-636-1900

City/State/Zip: LONGVIEW, WA 98632

Fax/Email: 360-636-7317

Check all that apply:

- Health/Medical Information
- Dental
- Educational/IEP/IFSP
- Screening/Assessment
- Mental Health (_____ initials)
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Name of Individual/Agency: HARBOR KIDS DENTAL AND ORTHODONTICS

Address: 900 OCEAN BEACH HIGHWAY, SUITE A

Phone: 360-501-5437

City/State/Zip: LONGVIEW, WA 98632

Fax/Email: 1-360-208-8505

Check all that apply:

- Health/Medical Information
- Dental
- Educational/IEP/IFSP
- Screening/Assessment
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Name of Individual/Agency: HILANDER DENTAL

Address: 510 ALLEN STREET

Phone: 360-636-5170

City/State/Zip: KELSO, WA 98626

Fax/Email: 360-636-0052

Check all that apply:

- Health/Medical Information
- Dental
- Educational/IEP/IFSP
- Screening/Assessment
- Mental Health (_____ initials)
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(*Kaiser Permanente regions are listed on reverse side of this form)

See reverse side for instructions to fill out this form. Failure to follow instructions may result in processing delay.

Authorization for use or disclosure of patient health information

Note: Fees may apply to certain requests

1. PATIENT INFORMATION

PRINT Patient Name: _____
Birth Date (mm/dd/yyyy): _____
Medical Record Number: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____
Email: _____

2. KAISER PERMANENTE MAY RELEASE THIS INFORMATION TO:

Check if the same as 1 above

Organization or person: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Email: _____

DELIVERY METHOD FOR RECORDS: Secure Email Fax Patient account at kp.org/wa (patients only)

3. PURPOSE OF RELEASE:

Doctor Legal Insurance Medical Leave Personal / Other

4. INFORMATION TO BE RELEASED: FROM DATE ____/____/____ TO DATE ____/____/____

- Medical records
- Radiology reports: _____
- Immunizations
- Radiology images (on CD): _____
- Billing records
- FMLA documentation
- Other (provider, department, specialty): _____

5. PATIENT AUTHORIZATION: I understand that:

- ✓ Records released may include information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental health and for patients below age 18, information regarding reproductive care. By signing this form, I give my specific authorization for this information to be released.
- ✓ Generally, Kaiser Foundation Health Plan of Washington and any other entity covered by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. If this authorization is for purposes of determining enrollment, eligibility, underwriting or risk rating prior to enrollment, not signing or revoking this authorization may impact enrollment or benefit determinations by Kaiser Foundation Health Plan of Washington.
- ✓ I may revoke this authorization in writing. If I revoke my authorization, it will not affect any actions already taken based upon this authorization.
- ✓ Once disclosed, health care information may be subject to redisclosure by the recipient and may no longer be protected under health information privacy laws.

6. SIGNATURE: _____ DATE: _____

If personal representative*, print name and relationship: _____

*Documentation may be required to prove authority to sign on behalf of the patient.

7. MINOR SIGNATURE: _____ DATE: _____

Signature of minor is required for certain information, see number 7 on instruction page.

8. This authorization expires one year from the date signed OR on the date or event indicated here:

Business Office/Clinic Staff: Has this request been processed?

WWA YES, already processed: send to Scanning at RCS	EWA YES, already processed: send to Scanning at ACN-AC3
WWA NO, needs processing: fax to ROI at 206-630-6849	EWA NO, needs processing: fax to ROI at 509-232-3127

Please visit kp.org for contact information for the following Kaiser Permanente regions:

- California
- Colorado
- Georgia
- Hawaii
- Mid-Atlantic States (Maryland, Virginia & Washington DC)
- Northwest (Oregon, Longview & Vancouver, Washington)
- Washington

INSTRUCTIONS:

1. **PATIENT INFORMATION:** Print name of patient, birth date, medical record number (if known), address, phone number and email.
2. **RECIPIENT INFORMATION:** Print name, address, phone number, fax number and email address.
Delivery method: Please PRINT the email address clearly
KP.ORG/WA – records remain available for 30 days after they are released to your secure member account
3. **PURPOSE:** Check the box that applies to the reason the records are being requested.
4. **INFORMATION TO BE RELEASED:** Indicate date(s) that are authorized to be released.
 - Medical records – a maximum of 10 years of records
 - Billing records – premium payments not included
 - Radiology images – please specify images and/or dates needed
 - Other – use this field to indicate specific information needed. Only that specific information will be released.
5. Read the **PATIENT AUTHORIZATION section**.
6. **SIGNATURE:** Sign and date. Electronic signatures must meet federal and state requirements. Personal representative should print name and indicate relationship to the patient. Documentation may be required to prove authority to sign on behalf of the patient.
7. **MINOR SIGNATURE:** Minor patients have the right to control certain types of healthcare information. They may be required to sign an authorization to release this information.
 - Sexually transmitted diseases including HIV (ages 14-17)
 - Mental health and addiction recovery services (ages 13-17)
 - Reproductive care (all minors)
8. **EXPIRATION:** If no date or event is given, authorization will expire one year from date signed.

To submit your request, please send your completed form to the appropriate locations listed below. Fax submission is preferred. Please visit our website www.kp.org/wa for additional copies of this form or for more information.

Western Washington

Kaiser Foundation Health Plan of Washington
Release of Information
MAILSTOP: RCG-D1N-02
PO Box 9812
Renton, WA 98057-9054

Phone: 206-630-6848 or toll-free 1-866-656-4184
Hours: 8 a.m. to 5 p.m.
Email: KPWA-ROI@kp.org
Fax: 877-848-6896

Eastern Washington

Kaiser Foundation Health Plan of Washington
Release of Information
MAILSTOP: ACN-AC3
PO Box 204
Spokane, WA 99210-9809

Phone: 509-241-7824
Hours: 8 a.m. to 5 p.m.
Email: KPWA-ROI@kp.org
Fax: 509-232-3127

To request Radiology Images ONLY (x-rays, MRI's, CT's, mammograms etc.), please send requests to:

Kaiser Foundation Health Plan of Washington
Central Imaging Center
201 16th Ave E
Seattle, WA 98112

Phone: 206-326-3715
Email: KPWA-RadROI@kp.org
Fax: 855-524-2256



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Name of Individual/Agency: KELSO SCHOOL DISTRICT

Address: 601 CRAWFORD STREET

Phone: 360-501-1900

City/State/Zip: KELSO, WA 98626

Fax/Email: 360-501-1965

Check all that apply:

- Health/Medical Information
Dental
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Screening/Assessment
Mental Health (initials)
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Parent Name (please print): _____

Signature: _____

(authorized parent, legal guardian or authorized representative)

Date: _____

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Longview, WA 98632
360-442-2800 FAX: 360-442-2819
Email: headstart.info@lowercolumbia.edu



AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

The information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law.

Refusal to sign this authorization will not affect the patient's ability to obtain health care services or reimbursement for services unless authorization is required to bill the patient's insurance company.

Patient Last Name	Patient First Name	Middle Name
Nickname/Maiden Name	Birth Date	Telephone: Okay to leave detailed message? Yes No
Patient's Mailing Address		

Healthcare Provider to Release Information:			Person or Agency to Receive Information:		
Name			Name Lower Columbia College HS/EHS/ECEAP		
Address			Address PO Box 3010		
City	State	Zip	City	State	Zip
			Longview	WA	98632
Phone	Fax		Phone	Fax	
			360-442-2800	360-442-2819	

Purpose of release: for school entry requirement and ongoing support

If such information exists, I authorize the disclosure of the entire medical record **or** the following specific documents, dates of service, and/or information about the following injury/illness/disease:

The following items **must be initialed** to be released:

- HIV-positive test results and HIV diagnosis
- Mental health information and/or records (Oregon only)
- Genetic testing information and/or records (Oregon only)
- Other sexually transmitted diseases (Washington only)
- Drug/alcohol diagnosis, treatment or referral information. Per Federal regulations, describe how much and what kind of information is to be disclosed: _____

Federal or state law may restrict redisclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, specially protected mental health information, genetic testing information, and drug/alcohol diagnosis treatment or referral information.

The only circumstance when refusal to sign means the patient will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described in this authorization. Unless revoked earlier, this authorization will expire in one year from the date of signing or on _____, whichever is later.

I am requesting the following records in electronic format:

- Discharge Instructions Available Electronic Medical Record

Signature of Patient or Patient's Legal Representative

Date

Print Name (If other than the patient, proof of authority is required.)

Relationship to Patient





AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

The information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law.

Refusal to sign this authorization will not affect the patient's ability to obtain health care services or reimbursement for services unless authorization is required to bill the patient's insurance company.

Patient Last Name	Patient First Name	Middle Name
Nickname/Maiden Name	Birth Date	Telephone: Okay to leave detailed message? Yes No
Patient's Mailing Address		

Healthcare Provider to Release Information:			Person or Agency to Receive Information:		
Name Randall Children's Hospital			Name Lower Columbia College HS/EHS/ECEAP		
Address 2801 N. Gantebein			Address PO Box 3010		
City Portland	State OR	Zip 97227	City Longview	State WA	Zip 98632
Phone 503-276-6500	Fax 855-892-7124		Phone 360-442-2800	Fax 360-442-2819	

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Signature of Patient or Patient's Legal Representative

Date

Print Name (If other than the patient, proof of authority is required.)

Relationship to Patient





AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

The information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law.

Refusal to sign this authorization will not affect the patient's ability to obtain health care services or reimbursement for services unless authorization is required to bill the patient's insurance company.

Patient Last Name	Patient First Name	Middle Name
Nickname/Maiden Name	Birth Date	Telephone: Okay to leave detailed message? Yes No
Patient's Mailing Address		

Healthcare Provider to Release Information:

Name Legacy Salmon Creek		
Address 2121 NE 139th St		
City Vancouver	State WA	Zip 98686
Phone 503-413-2762	Fax 855-892-7124	

Person or Agency to Receive Information:

Name Lower Columbia College HS/EHS/ECEAP		
Address PO Box 3010		
City Longview	State WA	Zip 98632
Phone 360-442-2800	Fax 360-442-2819	

Purpose of release: for school entry requirement and ongoing support

If such information exists, I authorize the disclosure of the entire medical record **or** the following specific documents, dates of service, and/or information about the following injury/illness/disease:

The following items **must be initialed** to be released:

- HIV-positive test results and HIV diagnosis
- Mental health information and/or records (Oregon only)
- Genetic testing information and/or records (Oregon only)
- Other sexually transmitted diseases (Washington only)
- Drug/alcohol diagnosis, treatment or referral information. Per Federal regulations, describe how much and what kind of information is to be disclosed: _____

Federal or state law may restrict redisclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, specially protected mental health information, genetic testing information, and drug/alcohol diagnosis treatment or referral information.

The only circumstance when refusal to sign means the patient will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described in this authorization. Unless revoked earlier, this authorization will expire in one year from the date of signing or on _____, whichever is later.

I am requesting the following records in electronic format:

- Discharge Instructions Available Electronic Medical Record

Signature of Patient or Patient's Legal Representative

Date

Print Name (If other than the patient, proof of authority is required.)

Relationship to Patient





**Lower Columbia College Head Start/EHS/ECEAP
Parent/Guardian Permission to
Reveal or Obtain Confidential Information**

Please complete this form with **ALL** information.

Child's Name: _____

DOB: _____

Address: _____

Phone: _____

City/State: _____

I hereby authorize the exchange of information orally, in writing or electronically between the Head Start/EHS/ECEAP Program and the Agencies/Persons listed below for the purpose of meeting performance standard requirements and to provide ongoing care.

Name of Individual/Agency: LONGVIEW SCHOOL DISTRICT

Address: 2715 LILAC STREET

Phone: 360-575-7164

City/State/Zip: LONGVIEW, WA 98632

Fax/Email: 360-575-7174

Check all that apply:

- Health/Medical Information
- Dental
- Educational/IEP/IFSP
- Screening/Assessment
- Mental Health (_____ initials)
- AIDS or HIV (_____ initials)
- Other: _____
- All of the Above

PARENT AUTHORIZATION

I understand that I may withdraw this authorization, in writing or at any time and it will not affect my enrollment. Information received through this request will not be re-disclosed to any other persons/clinics/agencies without an additional parent signed release. The information will be released in accordance with state and federal laws/FERPA and Head Start/EHS/ECEAP policies and procedures.

I give my specific authorization for these records to be released, excluding any State and/or Federally protected information.

Parent Name *(please print)*: _____

Signature: _____

(authorized parent, legal guardian or authorized representative)

Date: _____

This authorization will expire after 18 months of signature date.

Lower Columbia College Head Start/EHS/ECEAP
PO Box 3010
Longview, WA 98632
360-442-2800 FAX: 360-442-2819
Email: headstart.info@lowercolumbia.edu



**Oregon Health & Science University
Hospitals and Clinics
Health Information Services /
Medical Correspondence**
3181 SW Sam Jackson Park Rd,
Mail Code: OP17A
Portland, OR 97239-3098
(503) 494-8521, Fax (503) 494-6970

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
ALL SECTIONS OF THIS FORM **MUST** BE COMPLETED OR THE AUTHORIZATION WILL NOT BE ACCEPTED.

I authorize: OHSU
(Name of person / entity/ facility disclosing information)
3181 SW Sam Jackson Park Road Mail Code OP17A Portland OR 97239
(Address of person / entity) (City) (State) (Zip Code)

to use and disclose an electronic copy of the specific health information described below; unless you check here for a paper copy. This release is regarding:

(Name of individual)
consisting of: (see back side for definitions) Physician reports X-rays (please see the back side of this form for complete instructions) Labs ED Billing
 Other, specify _____
 If outpatient practice/clinic records are needed, please specify the practice(s)/clinic(s) (see back side for practice/clinic list) _____

to: Lower Columbia College - LCC Head Start/EHS/ECEAP
(Name of recipient)
1600 Maple St. / PO Box 3010 Longview WA 98632
(Address of recipient) (City) (State) (Zip Code)

for the purpose of: (Describe each purpose of disclosure) Continued Care Legal Disability
 School Entry Other, specify Providing Support and Assistance to Child & Family

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my **initials** in the applicable space next to the type of information.

_____ HIV/AIDS information _____ Genetic testing information
_____ Mental health information _____ Drug/alcohol diagnosis, treatment, or referral information

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign will mean you will not receive health services is if the health services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any uses or disclosures already made with your permission cannot be undone.

To revoke this authorization, please send a written statement to Medical Correspondence, Health Information Services, OP17A, OHSU 3181 SW Sam Jackson Park Rd. Portland, OR 97239-3098, and state that you are revoking this authorization

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

I have read this authorization and I understand it.

This authorization expires one year from the date of signing unless revoked or otherwise specified below:

(enter alternative expiration date or event) _____

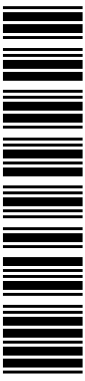
By: _____ Date: _____
(Signature of individual or personal representative)

Description of personal representative's authority: _____

ONLINE 6/12 (Supersedes 5/04)

MR-1470

*** I authorize future records sent to LCC Head Start/EHS/ECEAP up until said date _____ signature: _____



MR1470



**Oregon Health & Science University
Hospitals and Clinics
Health Information Services /
Medical Correspondence**
3181 SW Sam Jackson Park Rd,
Mail Code: OP17A
Portland, OR 97239-3098
(503) 494-8521, Fax (503) 494-6970

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Continued from page 1

Patient Identification

DEFINITION OF REPORTS:

- Physician reports include Discharge Summary, Discharge instructions, History & Physical exam, any procedures or operations
- X-rays include X-ray reports, Ultra sound, MRI, and special Imaging reports (If you are requesting for an actual image please make sure to fill out the Authorization Form MR-4775) The form may be accessed at the following web site: <http://ozone.ohsu.edu/healthsystem/HIS/mr4775.pdf>
- Labs – all laboratory test results
- ED – Emergency Department reports by physician
- Billing – Hospital and / or clinic billing information
- Immunizations – all immunization records
- Other – Specify information not listed

OHSU OUTPATIENT PRACTICES/CLINICS:

- | | |
|---|---|
| Adult Psychiatry | Infectious Disease |
| Allergy & Immunology | Intercultural Psychiatry Program |
| Anticoagulation | Internal Medicine |
| Audiology | Knight Cancer Center/Community Hematology
Oncology |
| Bone & Mineral | Lipids |
| Bone Marrow Transplant / Leukemia | Liver Transplant |
| Cardiology | Marquam Hill Internists |
| Casey Eye Institute | Nephrology & Hypertension |
| CDRC Eugene | Neurology |
| Center for Women's Health | Neurosurgery |
| Child and Adolescent Psychiatry | Oral & Maxillofacial Surgery |
| Childhood Development and Rehabilitation
(CDRC) | Orthopaedics |
| Comprehensive Pain Center | Otolaryngology |
| Dermatology | Pediatric Hematology / Oncology |
| Dermatology Surgery | Pediatric Specialties |
| Diabetes | Perinatal |
| Digestive Health | Plastic Surgery |
| Doernbecher Pediatrics - Westside | Pulmonary |
| Employee Health | Radiation Oncology |
| Endocrinology | Renal Transplant |
| Executive Health | Rheumatology |
| Family Medicine at South Waterfront
Gabriel Park | Richmond |
| Gastroenterology | Riverplace |
| General Pediatrics | Scappoose |
| General Surgery | Sleep Medicine |
| GI / Hepatology | Surgical Oncology |
| Health Promotion and Sports Medicine | Urology |
| Hematology / Oncology | Vascular Surgery |



**Lower Columbia College Head Start/EHS/ECEAP
Parent/Guardian Permission to
Reveal or Obtain Confidential Information**

Please complete this form with **ALL** information.

Child's Name: _____

DOB: _____

Address: _____

Phone: _____

City/State: _____

I hereby authorize the exchange of information orally, in writing or electronically between the Head Start/EHS/ECEAP Program and the Agencies/Persons listed below for the purpose of meeting performance standard requirements and to provide ongoing care.

Name of Individual/Agency: PeaceHealth-Health Information Management, Release of Information Dept.

Address: 1115 SE 164TH Avenue, Dept. 336

Phone: 360-729-1300

City/State/Zip: Vancouver, WA 98663

Fax/Email: 360-527-9383

Check all that apply:

- Health/Medical Information
- Dental
- Educational/IEP/IFSP
- Screening/Assessment
- Mental Health (_____ initials)
- AIDS or HIV (_____ initials)
- Other: _____
- All of the Above

PARENT AUTHORIZATION

I understand that I may withdraw this authorization, in writing or at any time and it will not affect my enrollment. Information received through this request will not be re-disclosed to any other persons/clinics/agencies without an additional parent signed release. The information will be released in accordance with state and federal laws/FERPA and Head Start/EHS/ECEAP policies and procedures.

I give my specific authorization for these records to be released, excluding any State and/or Federally protected information.

Parent Name *(please print)*: _____

Signature: _____

(authorized parent, legal guardian or authorized representative)

Date: _____

This authorization will expire after 18 months of signature date.

Lower Columbia College Head Start/EHS/ECEAP
PO Box 3010
Longview, WA 98632
360-442-2800 FAX: 360-442-2819



**Lower Columbia College Head Start/EHS/ECEAP
Parent/Guardian Permission to
Reveal or Obtain Confidential Information**

Please complete this form with **ALL** information.

Child's Name: _____

DOB: _____

Address: _____

Phone: _____

City/State: _____

I hereby authorize the exchange of information orally, in writing or electronically between the Head Start/EHS/ECEAP Program and the Agencies/Persons listed below for the purpose of meeting performance standard requirements and to provide ongoing care.

Name of Individual/Agency: PROGRESS CENTER

Address: 600 - 3RD AVENUE

Phone: 360-425-9810

City/State/Zip: LONGVIEW, WA 98632

Fax/Email: 360-425-1053

Check all that apply:

- Health/Medical Information
- Dental
- Educational/IEP/IFSP
- Screening/Assessment
- Mental Health (_____ initials)
- AIDS or HIV (_____ initials)
- Other: _____
- All of the Above

PARENT AUTHORIZATION

I understand that I may withdraw this authorization, in writing or at any time and it will not affect my enrollment. Information received through this request will not be re-disclosed to any other persons/clinics/agencies without an additional parent signed release. The information will be released in accordance with state and federal laws/FERPA and Head Start/EHS/ECEAP policies and procedures.

I give my specific authorization for these records to be released, excluding any State and/or Federally protected information.

Parent Name (*please print*): _____

Signature: _____

Date: _____

(authorized parent, legal guardian or authorized representative)

This authorization will expire after 18 months of signature date.

Lower Columbia College Head Start/EHS/ECEAP
PO Box 3010
Longview, WA 98632
360-442-2800 FAX: 360-442-2819
Email: headstart.info@lowercolumbia.edu



Lower Columbia College Head Start/EHS/ECEAP
Autorización de los Padres/Tutores para
Revelar u Obtener Información Confidencial

Por favor, complete esta forma con **TODA** la información.

Nombre del niño: _____ Fecha de Nacimiento: _____
 Domicilio: _____ Número de teléfono: _____
 Ciudad/Estado: _____

Por la presente autorizo el intercambio de información entre el programa Head Start/EHS/ECEAP y las agencias o personas mencionadas a continuación de forma oral, por escrito o a través de medios electrónicos con el propósito de satisfacer requisitos de las normas de operación de operación y proporcionar atención continua.

Nombre de la persona/agencia: _____
 Domicilio: _____ Teléfono: _____
 Ciudad/Estado/C. Postal: _____ Fax/Email: _____

Marque todos los que correspondan:

- Información médica/de salud
- Dental
- Educacional/de IEP o IFSP
- Evaluaciones
- Salud mental (_____ iniciales)
- SIDA o VIH (_____ iniciales)
- Otro: _____
- Todos los mencionados

AUTORIZACIÓN DE PADRE

Comprendo que puedo cancelar esta autorización, por escrito y en cualquier momento, y no afectará mi inscripción. La información recibida con esta autorización no será compartida con ninguna otra persona, clínica o agencia sin una autorización adicional firmada por los padres. La información será compartida de acuerdo con las leyes estatales y federales, y las políticas y procedimientos de Head Start/EHS/ECEAP.

Autorizo específicamente la comunicación de esta información, con excepción de información protegida por leyes estatales o federales.

Nombre del padre (*imprimir por favor*): _____

Firma: _____ Fecha: _____
(padre autorizado, tutor legal o representante autorizado)

Esta autorización tendrá una vigencia de 18 meses a partir de la fecha de su firma.

Lower Columbia College Head Start/EHS/ECEAP
 PO Box 3010
 Longview, WA 98632
 360-442-2800 FAX: 360-442-2819
 Email: headstart.info@lowercolumbia.edu



Lower Columbia College Head Start/EHS/ECEAP
Parent/Guardian Permission to
Reveal or Obtain Confidential Information

Please complete this form with ALL information.

Child's Name: _____

DOB: _____

Address: _____

Phone: _____

City/State: _____

I hereby authorize the exchange of information orally, in writing or electronically between the Head Start/EHS/ECEAP Program and the Agencies/Persons listed below for the purpose of meeting performance standard requirements and to provide ongoing care.

Name of Individual/Agency: FAMILY HEALTH CENTER - WIC

Address: 1717 OLYMPIA WAY, SUITE 206

Phone: 360-423-7740

City/State/Zip: LONGVIEW, WA 98632

Fax/Email: 360-423-7894

Check all that apply:

- Health/Medical Information
Dental
Educational/IEP/IFSP
Screening/Assessment
Mental Health (initials)
AIDS or HIV (initials)
Other:
All of the Above

PARENT AUTHORIZATION

I understand that I may withdraw this authorization, in writing or at any time and it will not affect my enrollment. Information received through this request will not be re-disclosed to any other persons/clinics/agencies without an additional parent signed release. The information will be released in accordance with state and federal laws/FERPA and Head Start/EHS/ECEAP policies and procedures.

I give my specific authorization for these records to be released, excluding any State and/or Federally protected information.

Parent Name (please print): _____

Signature: _____

(authorized parent, legal guardian or authorized representative)

Date: _____

This authorization will expire after 18 months of signature date.

Lower Columbia College Head Start/EHS/ECEAP
PO Box 3010
Longview, WA 98632
360-442-2800 FAX: 360-442-2819
Email: headstart.info@lowercolumbia.edu

Lower Columbia College Head Start/EHS/ECEAP

CHANGE OF STATUS

(to be completed by staff)

Child's Name: _____

LOC ID # _____ Birthdate: _____

Child's Name: _____

LOC ID # _____ Birthdate: _____

Parent's Name: _____

Staff Name: _____ Date: _____

FAMILY ADDRESS/PHONE

WITHDRAW

Address: _____

Withdraw Date: _____

City: _____

Reason for Withdrawal: _____

(Please Circle: ADD or DELETE or CHANGE)

Put Back on Wait List? _____ Yes _____ No

Phone: Home / Cell / Work (please circle)

If Yes, Model or Site Requested: _____ AM / PM

Email Address _____

STUDENT EMERGENCY CONTACT

LEGAL NAME CHANGE

(Please Circle: ADD or DELETE or CHANGE)

Child Parent Documents Attached

1. Name: _____

Changed From: _____

Relation to Child: _____

Changed To: _____

Address: _____

Phone: Home / Cell / Work (please circle)

COURT ORDERS/OTHER INFORMATION

(Please Circle: ADD or DELETE or CHANGE)

Parenting Plan

2. Name: _____

Restraining Order

Relation to Child: _____

Kinship/Guardianship

Address: _____

Protection Order

Phone: Home / Cell / Work (please circle)

Criminal Order

(Please Circle: ADD or DELETE or CHANGE)

Birth Certificate

3. Name: _____

Request for Transfer to Transitional Kindergarten (MSYS 7q)

Relation to Child: _____

Request for Change of Classroom (MSYS 7p)

Address: _____

Child/Family File Transfer or Withdraw Checklist (ERSEA 2d)

Phone: Home / Cell / Work (please circle)

New family member added:
Name: _____
Date of Birth: _____

Guardian Ad Litem

Protected Address From

Other Information: _____

Parent/Guardian Signature _____ Date _____

*Is the Parent a Policy Council Representative/ Alternative/Officer? Yes / No (circle one)

*Does the student ride a bus? Yes / No (circle one)
(If "yes", provide copy to bus driver for phone, address, or emergency contact changes)



**Lower Columbia College Head Start/EHS/ECEAP
Adult/Pregnant Individual Permission
to Reveal or Obtain Confidential Information**

ERSEA 1f
LOC ID _____

Please complete this form with **ALL** information.

Adult Name: _____ DOB: _____
Address: _____ Phone: _____
City/State: _____

I hereby authorize the exchange of information orally, in writing or electronically between the Head Start/EHS/ECEAP Program and the Agencies/Persons listed below for the purpose of meeting performance standard requirements and to provide ongoing care.

Name of Individual/Agency: _____
Address: _____ Phone: _____
City/State/Zip: _____ Fax/Email: _____

Check all that apply:

- Health/Medical Information
- Prenatal Records
- Dental
- Educational/IEP/IFSP
- Screening/Assessment
- Mental Health (_____ initials)
- AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)
- Other: _____
- All of the Above

ADULT AUTHORIZATION

I understand that I may withdraw this authorization, in writing or at any time and it will not affect my enrollment. Information received through this request will not be re-disclosed to any other persons/clinics/agencies without an additional parent signed release. The information will be released in accordance with state and federal laws/FERPA and Head Start/EHS/ECEAP policies and procedures.

I give my specific authorization for these records to be released, excluding any State and/or Federally protected information.

Signature: _____ Date: _____
(authorized parent, legal guardian or authorized representative)

This authorization will expire after 18 months of signature date.

Lower Columbia College Head Start/EHS/ECEAP
PO Box 3010
Longview, WA 98632
360-442-2800 FAX: 360-442-2819
Email: headstart.info@lowercolumbia.edu

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



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: Lower Columbia College Head Start/EHS/ECEAP
- 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: Eligibility Ver

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
<p>Please note: If your client records include any of the following information, you must also complete this section to include these records.</p> <p>I give my permission to disclose the following records (check all that apply):</p> <p><input type="checkbox"/> Mental health <input type="checkbox"/> HIV/AIDS and STD test results, diagnosis, or treatment <input type="checkbox"/> Substance Use Disorder</p> <ul style="list-style-type: none"> • This consent is valid for one-year or <input type="checkbox"/> 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 SIGNATURE, IF APPLICABLE	WITNESS / NOTARY PRINTED NAME	DATE
PARENT OR OTHER REPRESENTATIVE'S SIGNATURE (IF APPLICABLE)	TELEPHONE NUMBER (INCLUDE AREA CODE)	DATE
<p>If I am not the subject of the records, I am authorized to sign because I am the: (attach proof of authority)</p> <p><input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian (attach court order) <input type="checkbox"/> Personal representative <input type="checkbox"/> Other:</p>		

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.

LOWER COLUMBIA COLLEGE EARLY HEAD START
LEHSP File Transfer or Withdraw Checklist

Child's Name: _____ Date: _____

Parent's Name: _____

From: LOC ID # _____ To: LOC ID # _____ or Withdrawal
 Place back on waitlist

All Items must be completed prior to returning file to office.

File must be returned no longer than 3 days for a transfer and 5 days for a withdrawal.

Site File

Initials

- ___ Emergency Notebook Information
- Parent Agreement Contract
 - Medication Forms
 - Individual Care Plan
 - Medical Action Plans
- (Please highlight those that apply)*
- ___ Classroom Sign-In/Out Forms *(Teen Program/PAL)*
- ___ Medication *(see medication HLTH 5a)*
- ___ List Dietary Restrictions *(highlight):* _____
-
- ___ Pictures
- ___ Confidential Notebook Contents *(placed in sealed envelope – marked with “confidential contents” and child’s name)*
- ___ Change of Status *(place on top of file)*
- ___ Email the following:
- Computer Specialist for TS Gold Changes
 - Program Coordinator for notification that a child is going to be transferred or withdrawn and cc: EHS Area Manager
- ___ Follow ChildPlus close-out procedure. Include:
- Reason for transfer or withdrawal
 - Summary of family services *(Family Goal)*
 - Education summary *(progress on education goals)*
 - ***If a child is withdrawing***, complete PIR for family services, the family services information tab in cp.net. Complete paper PIR End of Year Enrollment Questionnaire *(MSYS 7r)* and send to office.
- ___ Transportation Request
- ___ Enter all outstanding TSG observations and/or checkpoints
- ___ Refer to Site File Policy and Procedure *(MSYS 7b)* for further instructions regarding return of site files if needed.
- ___ Other _____

EHS Area Manager Signature

Date

(C: 12/12; R: 02/21)

LOWER COLUMBIA COLLEGE EARLY HEAD START
Home-Based Child/Family File Transfer or Withdraw Checklist

Child's Name: _____ Date: _____

Parent's Name: _____

From: LOC ID # _____ To: LOC ID # _____ or Withdrawal
 Place back on waitlist

All Items must be completed prior to returning file to office.

File must be returned no longer than 3 days for a transfer and 5 days for a withdrawal.

Site File

Initials

- ___ Confidential Notebook Contents (*placed in sealed envelope – marked with “confidential contents” and child’s name*)
- ___ Change of Status (*place on top of file*)
- ___ Current Picture of Child
- ___ Diaper Offer Form
- ___ Formula Offer Form

Additional Information

Initials

- ___ Emergency Notebook Information
 - Parent Agreement Contract
 - Medication Forms
 - Individual Care Plan
 - Medical Action Plans*(Please highlight those that apply)*
- ___ Pictures
- ___ Email the following:
 - Computer Specialist for TS Gold Changes
 - Program Coordinator for notification that a child is going to be transferred or withdrawn and cc: EHS Area Manager
- ___ Follow ChildPlus close-out procedure. Include:
 - Reason for transfer or withdrawal
 - Summary of family services (*Family Goal*)
 - Education summary (*progress on education goals*)
 - **If a child is withdrawing**, complete PIR for family services, the family services information tab in cp.net. Complete paper PIR End of Year Enrollment Questionnaire (*MSYS 7r*) and send to office.
- ___ Enter all outstanding TSG observations and/or checkpoints
- ___ Refer to Site File Policy and Procedure (*MSYS 7b*) for further instructions regarding return of site files if needed.
- ___ Other _____

 EHS Area Manager Signature

 Date

(C: 08/17; R: 02/21)

**LOWER COLUMBIA COLLEGE HEAD START/ECEAP
Child/Family File Transfer or Withdraw Checklist**

Child's Name: _____ Date: _____

Parent's Name: _____

From: LOC ID # _____ To: LOC ID # _____ or Withdrawal
 Place back on waitlist

All items must be completed prior to returning file to office.

File must be returned no longer than 3 days for a transfer and 5 days for a withdrawal.

If a child is transferring between Head Start and ECEAP, the records will be transferred. Please allow 72 hours for this process to take place once transfer is initiated. Please inform the family that if transferring for the next school year, family will need to provide most recent income verification.

Site File

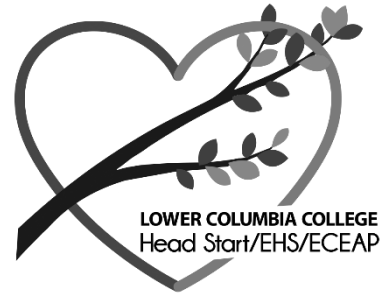
Initials

- _____ Emergency Notebook Information
 - Parent Agreement Contract (*copy shredded*)
 - Medication Forms
 - Individual Care Plan
 - Medical Action Plans
 (*Please highlight those that apply.*)
- _____ Classroom Sign-In/Out Forms
- _____ Medication (*see medication HLTH 5a*)
- _____ List Dietary Restriction (*highlight*) _____

- _____ Pictures
- _____ Confidential Notebook Contents (*placed in sealed envelope – marked with “confidential contents” and child’s name*)
- _____ Change of Status (*place on top of file*)
- _____ Email the following:
 - Computer Specialist for TS Gold changes
 - Program Coordinator for notification that a child is going to be transferred or withdrawn and cc: Area Manager
- _____ Follow the appropriate close-out procedure. Include:
 - Reason for transfer or withdraw
 - Complete paper PIR End of Year Enrollment Questionnaire (*MSYS 7r*) and send to office.
 - ***If child is withdrawing from a Head Start classroom,***
 - Follow ChildPlus close-out procedure.
 - Complete Family Services PIR questions under Family Services tab.
 - Summary of family services (*Family Goal*), include reason for transfer or withdraw.
 - Education summary (*progress on education goals*)
 - ***If child is withdrawing from an ECEAP classroom,***
 - Follow ELMS close-out procedures.
 - Complete end-of-year ELMS questions.
 - Summary of family services (*Family Goal*), include reason for transfer or withdraw.
 - Education summary (*progress on education goals*)
- _____ Transportation Request
- _____ Enter all outstanding TSG observation and/or checkpoints
- _____ Refer to Site File Policy and Procedure (*MSYS 7b*) for further instructions regarding return of site files if needed
- _____ Other _____

Area Manager Signature

Date



Date: _____

Dear _____:

We are writing to check in on _____ and offer support. They have missed _____ days of school so far this year.

We are wondering how we can support your child’s attendance to meet the attendance policy for the LCC Head Start/EHS/ECEAP Program.

Going to school is an opportunity for your child to:

- Build routines that help reduce stress
- Connect to their friends and teachers
- Engage in learning

When children attend school regularly, they are much more likely to read proficiently by the third grade, do well in middle school, and graduate high school

We would like to partner with you to improve _____’s attendance, so we can keep them engaged and learning.

Please call us at _____ by _____ to discuss the Attendance Family Partnership Agreement and to continue enrollment.

Sincerely,

Teacher / EHS Staff

Family Advocate

Area Manager, Contact Information

**Lower Columbia College Head Start/EHS/ECEAP
Eligibility Verification**

Child's Name: _____

Child's Age: _____

Child's date of birth: _____

Family Size: _____

Immunization Status: _____

IEP: _____

Income Verification

- | | |
|--|---|
| <input type="checkbox"/> Foster care grant for this child
<i>(choose family size of 1)</i> <ul style="list-style-type: none"> <input type="radio"/> Case Number _____ <input type="radio"/> Monthly Grant _____ <input type="checkbox"/> McKinney Vento Statement attached and signed
<input type="checkbox"/> Family Income Statement attached and signed | <input type="checkbox"/> Living with a guardian who receives SNAP/TANF Grant <ul style="list-style-type: none"> <input type="radio"/> Client ID _____ <input type="radio"/> Number of children on grant <i>(use this for family size)</i> _____ <input type="radio"/> Monthly grant amount _____ <input type="checkbox"/> Kinship Care |
|--|---|

If one of the grants above is checked, skip other income verification and sign on bottom of the page.

Name of person(s) receiving income	Document Verified	Weekly Amount	# of Weeks Received	Monthly Amount	# of Months Received	Annual Amount	Verified ✓
	W-2					\$	
	W-2					\$	
	Tax Return (1040) or IRS transcript					\$	
	Tax Return (1040) or IRS transcript					\$	
	Pay stubs for 12 months					\$	
	Pay stubs for 12 months					\$	
	Child support received, if required by a child support order						
	Disability income, including SSI (HS Eligible)			\$		\$	
	Military Leave & Earnings Statement (LES). Count all pay and allowances except BAH, BAS, FSH, and HFP/IDP.					\$	
	Self-employment net income			\$		\$	
	SSI (HS eligible)						
	SNAP Food Assistance						
	TANF cash assistance						
	Child-only TANF or foster care grant for non-ECEAP child			\$		\$	

Name of person(s) receiving income	Document Verified	Weekly Amount	# of Weeks Received	Monthly Amount	# of Months Received	Annual Amount	Verified ✓
	Unemployment	\$					
	Worker's Compensation (L & I)	\$				\$	
	Tribal Income (taxable)					\$	
	Other cash income not above			\$		\$	
	Other cash income not above			\$		\$	
						\$	Subtotal
Subtract	Child support paid to another household, per legal order			\$		-\$	
						\$	TOTAL
						Head Start/EHS FPL%	
						ECEAP SMI%	

HEAD START

- Income Eligible Between 100<130% FPL (no more than 35% enrollment)
 Exceeds FPL Eligibility (no more than 10% enrollment allowed)

ECEAP

- Income Eligible Between 37%-50% SMI (no more than 13% w/o IEP)
 Exceeds SMI Eligibility (no more than designated number of slots w/o IEP)

I have carefully reviewed the documents and information that has been provided to me by the applicant, and, by signing this form, certify to the best of my knowledge and belief that all information regarding eligibility provided to me is true and accurate.

Staff Name: _____ Date of Verification: _____

Staff Signature: _____ Title: _____

INCOME CALCULATION GUIDE Monthly Income Calculation Table: How to Translate Income into a Monthly Figure

Pay Period	Formula
Hourly	Hourly wage x 40 hours per week x 4.33
Monthly, same gross pay each month	Use gross salary
Paid same gross amount exactly 2 times per month (e.g. 1 st and 15 th of month)	Gross salary x 2
Paid same gross amount every 2 weeks (e.g. every other Friday)	Gross salary x 2 x 4.33
Weekly	Gross salary x 4.33

**Lower Columbia College Head Start/EHS/ECEAP
Head Start and Early Head Start Selection Criteria Score Sheet**

INCOME	Points	Criteria Met
≤ 50% of Federal Poverty Level (FPL)	300	<input type="checkbox"/>
51-100% FPL	250	<input type="checkbox"/>
Categorical Income Eligibility: Public Assistance (TANF, SNAP, SSI)		<input type="checkbox"/>
Categorical Income Eligibility: Homeless Status		<input type="checkbox"/>
Categorical Income Eligibility: Foster Care Status		<input type="checkbox"/>
101-130% FPL	100	<input type="checkbox"/>
131-150% FPL	50	<input type="checkbox"/>
151-179% FPL	30	<input type="checkbox"/>
Above 180% does not receive income prioritization points		

CHILD WELFARE SYSTEM OR MCKINNEY-VENTO	Points	Criteria Met
Foster Care	100	<input type="checkbox"/>
Kinship Care (with a relative or suitable other, with or without a grant)	100	<input type="checkbox"/>
Adopted after Foster/Kinship Care	100	<input type="checkbox"/>
Reunited with parents after Foster or Kinship Care in past 12 months	50	<input type="checkbox"/>
Family Actively Involved in and/or receiving support from CPS/FAR or law enforcement/court system	100	<input type="checkbox"/>
Previously involved in CPS/FAR or law enforcement/court system	50	<input type="checkbox"/>
Homeless currently per McKinney-Vento Act	100	<input type="checkbox"/>
Homeless in past 12 months	50	<input type="checkbox"/>

I.D.E.A./IEP	Points	Criteria Met
Developmental delay or disability with Individualized Education Program (IEP)	15	<input type="checkbox"/>
Developmental delay or disability – diagnosed with no IEP, or developmental screening clearly recommending referral for evaluation	10	<input type="checkbox"/>

Previous Early Learning Enrollment	Points	Criteria Met
Previous EHS or ESIT or Early ECEAP	15	<input type="checkbox"/>

ADDITIONAL POINTS	Points	Criteria Met
4 years old by August 31	50	<input type="checkbox"/>
Received Professional Referral for child/family	10	<input type="checkbox"/>
Teen parent – below age 18 at <u>this</u> child's birth	10	<input type="checkbox"/>
Single parent	10	<input type="checkbox"/>

EHS AGE	Points	Criteria Met
Prenatal – 12 months	100	<input type="checkbox"/>
13 months – 24 months	75	<input type="checkbox"/>
25 months – 30 months	25	<input type="checkbox"/>
31 months – 36 months	0	<input type="checkbox"/>

Date: _____

Total Points: _____

Name of Child: _____

DOB: _____

Staff Completing Score Sheet: _____

Lower Columbia College Head Start/EHS/ECEAP
Applicant/Intake Information

Application Date: Location:

Child: Birthdate:

Parent/Guardian: Phone:

Application Notes:

Four horizontal lines for notes.

- Eligible, Not Eligible, Need Immunizations, Need Further Information

Does the Family need an interpreter? Yes No If yes, what language?

Appointment Date: Time:

Medical Provider/WCE Date:

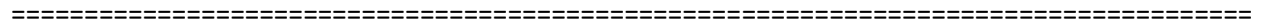
Dental Provider/Exam Date:

Specialist Information/Dates:

WIC: Yes No

Parent to bring in (reminder given):

- Birth Certificate



INTAKE FORMS CHECKLIST

- ChildPlus Contact Information #1520, Birth Certificate, Application (Pre/Eligibility) Information/Eligibility Verification Reviewed and Uploaded, Medical Release, Dental Release, Specialists Release, Mental Health Release, WIC Release, School Districts Release, Other Releases, Upload Attachments in ChildPlus, Health Data Entries in ChildPlus, Immunization Entry in ChildPlus, Enrollment Entry Child Plus, Update Application Information in ChildPlus, Diaper Form, Records Request have been Faxed, Sex Offender Verification of Parents/ Emergency Contacts

HANDOUTS:

- Lead Screening, Other:

Signature:

Date:

LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
EHS Applicant/Intake Information

Application Date: Loc ID:

Child: Birthdate:

Parent/Guardian: Phone:

Application Notes:

Blank lines for application notes.

- Eligible, Not Eligible, Need Immunizations, Need Further Information

Does the Family need an interpreter? Yes No If yes, what language?

Appointment Date: Time:

Medical Provider/WCE Date:

Dental Provider/Exam Date:

Specialist Information/Dates:

WIC: Yes No

Parent to bring in (reminder given):

- Birth Certificate

Separator line

INTAKE FORMS CHECKLIST

- ChildPlus Contact Information #1520, Birth Certificate, Application (Pre/Eligibility) Information/Eligibility Verification Reviewed and Uploaded, Medical Release, Dental Release, Birth Hospital - OAE (for infants only, i.e. PeaceHealth/St. John & Legacy Salmon Creek Medical Centers), Specialists Release, Mental Health Release, Progress Center Release, WIC Release, Other Releases, Immunization Form, Health History/Nutrition Intake, Intake Event Entry on ChildPlus, Upload Attachments in ChildPlus, Health Data Entries in ChildPlus, Immunization Entry in ChildPlus, Enrollment Entry Child Plus, Update Application Information in ChildPlus, Formula Offer Form (infant), Diaper Form, Records Request have been Faxed, Sex Offender Verification of Parents/ Emergency Contacts

HANDOUTS:

- List Items Given:

Signature:

Date:

LOWER COLUMBIA COLLEGE HEAD START/EHS/ECEAP
Early Head Start – Prenatal Applicant/Intake Information

Application Date: _____ Loc ID: _____

Pregnant Individual: _____ Birthdate: _____

Due Date of Baby: _____ Phone: _____

Application Notes: _____

Eligible Not Eligible Need Immunizations Need Further Information

Does the Family need an interpreter? Yes No If yes, what language? _____

Appointment Date: _____ Time: _____

Medical Provider/Exam Date: _____

Dental Provider/Exam Date: _____

Specialist Information/Dates: _____

First Steps: Yes No

=====

INTAKE FORMS CHECKLIST

- ChildPlus Contact Information #1520
- Birth Certificate
- Application (Pre/Eligibility) Information/Eligibility Verification Reviewed and Uploaded
- Medical Release
- Dental Release
- Specialists Release
- First Steps Release
- Other Releases _____
- Prenatal Health History/Dental/Nutrition Intake

- Intake Event Entry on ChildPlus
- Upload Attachments in ChildPlus
- Health Data Entries in ChildPlus
- Enrollment Entry Child Plus
- Update Application Information in ChildPlus
- Records Request have been Faxed
- Sex Offender Verification of Parents/ Emergency Contacts

HANDOUTS:

List Items Given: _____

Signature: _____

Date: _____