

WELCOME TO NEIGHBORHOOD PLACE

DATE:

PLEASE PRINT

Name: _____		Date of Birth: _____	
Complete Home Address: _____		Complete Mailing Address: _____	
Number in Household: _____		Social Security Number: _____	
Phone: <input type="checkbox"/> Home	Reason for Visit: <input type="checkbox"/> New Applicant	<input type="checkbox"/> Cell	<input type="checkbox"/> Return Visitor
<input type="checkbox"/> Alternate	<input type="checkbox"/> Follow up appt. with		

APPLICATION INSTRUCTIONS

Neighborhood Place offers a variety of services. Complete the check boxes that best describe the services needed:

SERVICES NEEDED

Social Services		Medicaid Services	
Child Care Assistance Program (CCAP)	<input type="checkbox"/>	Aging & Elderly Services (OAS)	<input type="checkbox"/>
Child Support Services (SES)	<input type="checkbox"/>	Disabled Adults-Disability Medicaid (DM)	<input type="checkbox"/>
Family Independence Temporary Assistance Program (FITAP) – cash assistance	<input type="checkbox"/>	LaMOMS (no cost Medicaid for pregnant women)	<input type="checkbox"/>
Food Stamp Program (FSP)	<input type="checkbox"/>	Louisiana Children’s Health Insurance Program (LaCHIP)	<input type="checkbox"/>
Kinship Care Subsidy Program (KCSP)	<input type="checkbox"/>	Medicare Purchase Plan (MPP)	<input type="checkbox"/>
LA Combined Application Project (LACAP)	<input type="checkbox"/>	Medically Needy Program (MNP)	<input type="checkbox"/>
Strategies to Empower People Program (STEP)	<input type="checkbox"/>	Medicare Savings Program (MSP)	<input type="checkbox"/>
Alternative Response	<input type="checkbox"/>	TAKE CHARGE (TC) – no cost Medicaid family planning services	<input type="checkbox"/>
Housing Services			
Emergency Shelter	<input type="checkbox"/>	Health Services	
Energy Assistance	<input type="checkbox"/>	Children’s Special Health Services (CSHS)	<input type="checkbox"/>
Homeless	<input type="checkbox"/>	Family Planning	<input type="checkbox"/>
Rental Assistance	<input type="checkbox"/>	Head Lice Check	<input type="checkbox"/>
Section 8	<input type="checkbox"/>	HIV Testing	<input type="checkbox"/>
Subsidized Housing	<input type="checkbox"/>	Immunizations	<input type="checkbox"/>
Utility Assistance	<input type="checkbox"/>	Infant or toddler car seat	<input type="checkbox"/>
Weatherization	<input type="checkbox"/>	Lead Test	<input type="checkbox"/>
		Pregnancy Test	<input type="checkbox"/>
Behavioral Health Services		Sexually Transmitted Disease (STD)	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	TB Test	<input type="checkbox"/>
Child abuse or neglect	<input type="checkbox"/>	Women, Infants & Children (WIC)	<input type="checkbox"/>
Child behavior	<input type="checkbox"/>	General Physician, Eye Care, Dentist, Mental and Behavioral Health	<input type="checkbox"/>
Depression – Feeling sad, hopeless, fearful	<input type="checkbox"/>	Pre-natal – 3 yrs Case management, Parenting Classes, WIC, Referral	<input type="checkbox"/>
Drugs	<input type="checkbox"/>		

Behavioral Health Services cont.		Employment Services	
School attendance	<input type="checkbox"/>	Initial Intake	<input type="checkbox"/>
Attention Deficit Disorder (ADHD)	<input type="checkbox"/>	Career Assessment	<input type="checkbox"/>
		Career Counseling	<input type="checkbox"/>
		Job Search	<input type="checkbox"/>
Developmental Disabilities Services		Work Readiness Seminars	<input type="checkbox"/>
Cash Subsidy Program	<input type="checkbox"/>	Earned Income Tax Credit (EIC)	<input type="checkbox"/>
Early Steps Program referral	<input type="checkbox"/>	Help with resume (job application)	<input type="checkbox"/>
Home and Community-Based Waiver Services	<input type="checkbox"/>		
Individual & Family Support Program	<input type="checkbox"/>		
Rehabilitation Services		Education Services	
Blind Services	<input type="checkbox"/>	Adult Literacy - GED	<input type="checkbox"/>
Deaf Services	<input type="checkbox"/>	Even Start (family services for adult learners)	<input type="checkbox"/>
Independent Living Services	<input type="checkbox"/>	Behavioral Concerns	<input type="checkbox"/>
Vocational Rehabilitation Services	<input type="checkbox"/>	School Dropout Concerns	<input type="checkbox"/>
Traumatic Head & Spinal Cord Injury	<input type="checkbox"/>	Academic Concerns	<input type="checkbox"/>
		School Health Concerns	<input type="checkbox"/>
Other		Attendance Concerns	<input type="checkbox"/>
Community Diversion Programs	<input type="checkbox"/>	Truancy Concerns	<input type="checkbox"/>
Juvenile Court Services	<input type="checkbox"/>	Computer Lab	<input type="checkbox"/>
Transportation Assistance	<input type="checkbox"/>	Technology Classes	<input type="checkbox"/>
Tribal Services	<input type="checkbox"/>	Universal Pre-K Enrollment	<input type="checkbox"/>
Library - Multimedia	<input type="checkbox"/>	Family Literacy	<input type="checkbox"/>
Music/Drama/Dance, Practice Rooms	<input type="checkbox"/>	Early Head Start	<input type="checkbox"/>
Government Access – Voter Registration	<input type="checkbox"/>	Head Start	<input type="checkbox"/>
Youth Outreach	<input type="checkbox"/>	LA4 (Pre-K)	<input type="checkbox"/>
Referrals	<input type="checkbox"/>	Kindergarten	<input type="checkbox"/>
In-home Family Services	<input type="checkbox"/>	English Second Language	<input type="checkbox"/>
Parenting – Teen Parenting	<input type="checkbox"/>		
De-Stress Center – exercise, cooking, nutrition, stress reduction activities	<input type="checkbox"/>	Service Needed but not Listed	
		Write in here:	<input type="checkbox"/>
		Write in here:	<input type="checkbox"/>
		Write in here:	<input type="checkbox"/>



RELEASE OF INFORMATION CONSENT FORM

I, _____, am seeking services from Neighborhood Place for ___myself, ___my family, ___my child (check all that apply). By signing this form, I am giving Neighborhood Place staff permission to communicate regarding services offered to me and/or my family. I understand that all records and information regarding services will be protected by regulations that govern the exchange of confidential information. I further understand that services may include an assessment of our needs and the development of a service plan to meet those needs.

It is understood that by authorizing the release of such information, it will be used for the sole purpose of providing and enhancing services to me, my family and/or my child and to avoid duplication between the agencies. The disclosure of information will be limited to staff at Neighborhood Place and within these organizations and will not be released to anyone else without my consent.

The agencies below have my written consent to share information of a confidential nature to the extent allowed by federal and state law and regulations unless I have indicated otherwise by putting my initials next to those agencies I want excluded.

Government, City, Private Non-profit Providers

Please initial those agencies you want excluded. Write in additional agencies you want to add.

- _____ Louisiana Department of Health & Hospitals
_____ Louisiana Public School System
_____ Parish School System
_____ Louisiana Workforce Commission
_____ Louisiana Department of Social Services
_____ Boys Town Louisiana
_____ Louisiana Office of Juvenile Justice
_____ Job 1
_____ Louisiana Department of Education
_____ Recovery School District
_____ Louisiana City/Parish Government
_____ Total Community Action
_____ Early Childhood & Family Learning Foundation
_____ New Orleans Health Department
_____ Healthy Start
_____ Central City Renaissance Alliance

Please initial the information you wish to have excluded from this authorization. Write in information you want to add to this authorization.

- ___ The full name and other identification of myself my family or my child
___ Treatment, services or education plans
___ Records pertaining to juvenile justice proceedings, including arrests/adjudication
___ Recommendations to other providers
___ Social and educational history and observations
___ Medical records and information pertaining to medical history, physical condition, services rendered and treatments given
___ Records pertaining to child in need of care/certification for adoption proceedings in juvenile court
___ Medical records and information and information pertaining to mental health

Other Records: _____

I have read and understand the contents of this form; I have a copy and I agree to its provisions with the exception of any items I initialed above.

This authorization to receive services from the above agencies and to exchange confidential information shall remain in effect for a period of twelve (12) months. I understand that this release may be revoked by me at any time if requested in writing, but understand my records may have been released and re-released to others before I request that this consent be revoked.

Signature of self or children Date Witness signature Date

* Parent/Guardian (please list children's names) _____

THIS DOCUMENT DOES NOT AUTHORIZE THE RELEASE OF INFORMATION RELATIVE TO HISTORY OF DRUG/ALCOHOL TREATMENT, SEXUALLY TRANSMITTED DISEASES, AND/OR HIV STATUS. PURSUANT TO FEDERAL LAW, PROTECTED HEALTH INFORMATION MAY BE RELEASED WITHOUT YOUR AUTHORIZATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. AUTHORIZATION IS NOT REQUIRED TO COMPLY WITH LAWS REGARDING MANDATORY REPORTING OF SUSPECTED ABUSE OR NEGLECT OR ASSESSMENT THAT THERE IS A DANGER OF SERIOUS HARM TO SELF OR OTHERS.