LOVE146
INTAKE/REFERRAL FORM

YOUTH'S NAME: _____ **DATE OF INITIAL REFERRAL:** _____

REFERRING AGENCY

Name of referring agency: _____

Name, email, and phone of referring individual: _____

LEGAL GUARDIAN

☐ Biological parent(s) ☐ Kin ☐ Self (adult/emancipated ☐ Other
☐ Adoptive parent(s) ☐ Child welfare ☐ Unknown _____

Name and contact information of legal guardian: _____

SERVICE PROVIDER INFORMATION

Child welfare involvement (at the time of intake): ☐ Yes ☐ No
Juvenile justice involvement (at the time of intake): ☐ Yes ☐ No
If yes, is the juvenile justice involvement judicial? ☐ Yes ☐ No
Law enforcement involvement (at the time of intake): ☐ Yes ☐ No

Notifications:

If the youth has a public defender, have they been notified of the referral to Love146? ☐ Yes ☐ No
If law enforcement is involved, have they been notified of the referral to Love146? ☐ Yes ☐ No

***Public defenders and law enforcement must be notified and forensic interviews must be conducted before services can be provided. If a forensic interview is scheduled please put the date here: _____**

Name and contact information of providers:

	Name	Phone Number	Email
DCF Worker			
DCF Supervisor			
Probation/Parole Officer			
Youth's Attorney			
Law Enforcement			

Name and contact information of other providers involved in the case:

_____
_____
_____

*** Please make sure all placements and providers are listed on the release of information that accompanies this referral**

DEMOGRAPHICS

Date of Birth: _____ **Gender:** ☐ Male ☐ Female ☐ Transgender

RACE *(check all that apply):*

☐ African American/Black ☐ Caucasian/White Non-Hispanic ☐ American Indian/Alaskan Native
☐ Hispanic/Latina ☐ Asian/Pacific Islander ☐ Other_____

HISTORY *(check all that apply):*

☐ Child welfare involvement (prior to current incident)
☐ Juvenile justice involvement (prior to current incident)
☐ Sexual abuse
☐ Sexual abuse images (i.e., child pornography)
☐ Physical abuse
☐ Psychological abuse
☐ Physical neglect
☐ Emotional neglect
☐ Mental illness
☐ Suicidal ideation
☐ Self-injurious behavior
☐ Mentally ill/suicidal household/family members
☐ Running away/AWOL
☐ Personal substance use
☐ Familial substance abuse
☐ Gang involvement
☐ Dating violence
☐ Domestic violence at home
☐ Incarcerated household member
☐ Separated/divorced parents
☐ Deceased family member (immediate)
☐ Pregnancy or parenting

LOVE146

Youth's history (additional information): _____

_____

_____

_____

SCHOOLING

Name of current school: _____

Grade level: _____

Attendance: ☐ Regularly attending ☐ Irregularly attending ☐ Not attending

Special education (IEP/504): ☐ Yes ☐ No

CURRENT PLACEMENT

☐ Biological parent(s)
☐ Adoptive parent(s)
☐ Kin
☐ Foster family
☐ Shelter/Emergency Placement
☐ Out of home placement facility
☐ Juvenile Justice Facility
☐ In need of housing
☐ Unknown
☐ Other _____

Current placement (name, address, phone number and other contact information):

_____

_____

CASE INFORMATION

Human trafficking/commercial sexual exploitation designation:

☐ Confirmed ☐ High-Risk/Suspected ☐ Low-risk

If confirmed or suspected:

Is there a confirmed/suspected third-party trafficker (e.g., a pimp)? ☐ Yes ☐ No ☐ Unknown

If yes, who is/was the trafficker?

☐ Family member
☐ "Romantic" partner
☐ Gang affiliate
☐ Unknown
☐ Other _____

Name (if known): _____

How old was the youth believed to be the first time they were trafficked? _____

What was the setting of the trafficking (select all that apply)

☐ Bar
☐ Brothel
☐ Casino
☐ Hotel/Motel
☐ Massage Parlor
☐ Mobile Trailer/Trailer Park
☐ Parking lot
☐ Residential Private Home/Apartment
☐ Residential Group Home
☐ Street
☐ Strip/Exotic Dance/ Gentleman's Club
☐ Trap House
☐ Truck Stops

Was the internet used for any of the following (check all that apply)?

☐ Recruitment/Grooming
☐ Advertising of commercial activities
☐ Exploitation (e.g., pornography distribution)
☐ The internet was not used

Does the youth acknowledge exploitation/trafficking? ☐ Yes ☐ No ☐ Unknown

Reason youth was identified as high-risk/confirmed and additional information:

_____

_____

_____

_____

LOVE146

PARTICIPATION CONSENT AND PERMISSION FORM

The professional staff of Love146 are committed to fully explaining the nature and scope of the services we offer. By signing this form, you acknowledge that you understand and consent to these services as they have been explained. Our Notice of Privacy Practices and Nondiscrimination is available online at https://love146.org/clientnotice. If you have any questions at any time, we encourage you to contact us for any additional information or clarification of services.

I, _____ (parent/legal guardian) give my informed consent and permission for _____ (youth) to participate in the Love146 programs and related activities.

I hereby acknowledge that the minor will be transported by Love146 staff while participating in the Love146 programs and related activities, and that such transportation is voluntary and at his/her own risk.

I agree that if any injury or emergency should occur while the minor is participating in a Love146 program, Love146 staff is authorized to take whatever steps are reasonably necessary in their judgment to attend to the minor's medical needs. I agree to be responsible for any hospital expenses, doctor bills, or other expenses that may be incurred to attend to the minor's medical needs.

I also understand that Love146 staff are required by law to disclose confidential information of any suspected child abuse (physical, emotional, sexual) or neglect, or serious threats of harm to self or others.

Because successful work with adolescents requires a confidential safe relationship with their worker, I agree to waive my right to receive copies of session casenotes regarding the above named youth.

I further understand that any de-identified information disclosed or personal testimonials submitted may be used collectively or individually to further Love146's overall mission statement.

I release Love146 and their trustees, officers, agents, employees, representatives, volunteers, students and assigns (collectively referred to as "Love146 Parties') of all liability of injury, death, or other damages that may result from the minor's participation in the program, including but not limited to transportation, and hold harmless Love146 Parties, both collectively and individually, of any injury, physical or emotional, other than where gross negligence has been determined. I understand that I and the minor are releasing Love146 Parties from liability to the full extent of the law. I understand that THIS RELEASE OF LIABILITY IS INTENDED TO BE AS BROAD AS LEGALLY POSSIBLE.

_____ _____

Signature of Parent/Guardian Date

LOVE 146
END CHILD TRAFFICKING AND EXPLOITATION

Authorization to Share Information

READ FIRST: Love146 has an obligation to keep your personal information, identifying information, and records confidential. If you decide you want Love146 to release some of your confidential information, you can use this form to choose what, how, with whom, and for how long it is shared.

I, _____, the parent/guardian of _____ (youth) authorize the mutual exchange of information between **Love146** and the following

Agency/Organization: _____

Location of agency (if known): _____

Description of Information to be Disclosed: Due to the broad nature of services involved in many clients' lives, we request authorization for the release of the complete client record. Please select one of the following options below:

- □ **Option 1:** I authorize the release of my child's complete record (including but not limited to: records related to health/mental health, education, substance abuse treatment and Love146 service provision). In addition,

  _____(initial here) I specifically consent to the disclosure of information concerning drug/alcohol treatment records

  _____(initial here) I specifically consent to the disclosure of information concerning HIV/AIDS status

- □ **Option 2:** I authorize the release of my child's complete record with the exception of the following information:
  - □ Mental health records
  - □ Health records
  - □ Education records
  - □ Drug/alcohol abuse treatment
  - □ HIV/AIDS status
  - □ Other (please specify): _____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, to share information relevant to treatment, and, when appropriate, to coordinate treatment services. If the purpose is different from that specified above, please provide details: _____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Marketing and Sale of Information

Love146 does not disclose client information for marketing, sale of information, or other related purposes.

Research

- □ If the purpose of this disclosure is for research purposes, please check this box and identify the current and future research studies as well as whether each research study is conditioned upon execution of this authorization and individual's ability to opt into each study._____

Conditions

By signing this document, I understand:

- Disclosure of personal health information is voluntary and I can refuse to sign this authorization.
- Refusal to sign this authorization will not affect my ability to obtain services from Love146.
- This authorization will expire one year from the date signed, unless another date or event is indicated here: _____
- I have the right to revoke/withdraw this authorization, in writing, at any time, and that revocation/withdrawal will be effective except to the extent that action has already occurred in reliance upon my authorization. That written revocation/withdrawal should be addressed to: Love146 P.O. Box 8266 New Haven, CT 06530.
- Information disclosed as a result of this authorization is protected by federal privacy laws, but any disclosure carries the potential for re-disclosure where the information may no longer be protected by law.

Contact Love146 at survivorcare@love146.org if you would like a copy of this authorization for your records.

_____ _____

Signature of Client (if emancipated or over 18 years old), Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.)._____

Statutory Notes:

The recipient of the requested information is prohibited by federal law (Code of Federal Regulations 42, Part 2) from making any further disclosure of it without the client's written permission.

The confidentiality of this record is required under Chapter 899, PL 93-079 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written authorization as provided in the aforementioned statutes.

Drug and Alcohol Abuse Records: In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Regulations: This information has been disclosed from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any 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.

Confidential HIV Related Information: In the event that information to be released would disclose a person's HIV status: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by said law. A general authorization of medical or other information is not sufficient for this purpose (Connecticut General Statutes, 19a-581 through 19a-593)

LOVE146
END CHILD TRAFFICKING AND EXPLOITATION

Notice of Privacy Practices

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and state laws. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. We are required by contract to provide PHI to DCF, our funding source, to document services provided.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As an agency dedicated to your well-being, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with our ethical mandates and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious

threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Verbal Permission. We may also use or disclose your information to individuals that are directly involved in your treatment with your verbal permission. In such a case, a note will be made in your client file that you provided verbal permission for disclosure of PHI to specific individuals.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Sarah Spear, at sarah@love146.org:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require specification of an alternative address or

other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Sarah Spear, at sarah@love146.org or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2017.

Notice of Nondiscrimination

THIS NOTICE DESCRIBES THE LOVE146 POLICY OF NONDSCRIMINATION IN SERVICES AND HOW YOU CAN FILE A COMPLAINT ALLEGING DISCRIMINATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

This Notice of Nondiscrimination describes our policy of nondiscrimination in accordance with applicable law including Title IX of the Education Amendments of 1972 which prohibits discrimination on the basis of sex. It also describes your rights regarding how you may file a complaint of discrimination.

We are required by law to not discriminate in our service provision and to provide you with notice of our legal duties and policy of nondiscrimination. We are required to abide by the terms of this Notice of Nondiscrimination. We reserve the right to change the terms of our Notice of Nondiscrimination at any time. We will provide you with a copy of the revised Notice of Nondiscrimination by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

POLICY OF NONDISCRIMINATION IN SERVICES

Love146 provides services regardless of and does not discriminate on the basis of race, ethnicity, national origin, religion, political preference, sex, gender, sexial orientation, disability, and age. The Program Director acts as the designee to coordinate the program's compliance with prohibitions against discrimination on the basis of any protected class.

Specific Prohibitions. These include:

- Treat one person differently from another in determining whether such person satisfies any requirement or condition for the provision of such aid, benefit, or service;

- Provide different aid, benefits, or services or provide aid, benefits, or services in a different manner;
- Deny any person any such aid, benefit, or service;
- Subject any person to separate or different rules of behavior, sanctions, or other treatment;
- Apply any rule concerning the domicile or residence of a student or applicant;
- Aid or perpetuate discrimination against any person by providing significant assistance to any agency, organization, or person that discriminates on the basis of sex in providing any aid, benefit, or service to students or employees;
- Otherwise limit any person in the enjoyment of any right, privilege, advantage, or opportunity.

COMPLAINTS

If you believe we have violated your right to nondiscrimination in your service provision, you have the right to file a complaint in writing with our Title IX Coordinator, Sarah Spear, at sarah@love146.org or with the Centralized Case Management Operations, U.S. Department of Health and Human Services at 200 Independence Avenue, S.W. Room 509F HHH Bldg, Washington, D.C. 20201 or by emailing OCRComplaint@hhs.gov. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2017.

LOVE 146
END CHILD TRAFFICKING AND EXPLOITATION

Notice of Privacy Practices and Nondiscrimination
Receipt and Acknowledgment of Notice

Client Name: _____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Love 146's Notice of Privacy Practices and Nondiscrimination. I understand that if I have any questions regarding the Notice or my privacy or nondiscrimination rights, I can contact Love146's Privacy Officer, Jermika Cost, at jermika@love146.org or 203.772.4420.

_____ _____

Signature of Client (if emancipated or over 18 years old), Parent, Guardian or Personal Representative Date

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Client Refuses to Acknowledge Receipt**:

_____ _____

Signature of Staff Member Date