St. Johns County Board of County Commissioners
Health and Human Services | Social Services Division

St. Johns County Social Services Application

Date: Clients Name:

Other names known by:

Gender:

Phone #: Social Security #: Birthdate:

Address:

Mailing Address:

Email Address:

Who are the members of your household? (adults/children/ages)

Marital Status: Single Married Divorced Annulled Separated Widowed Partnered/Living Together

Race: White Asian Black/African American Native Hawaiian/Pacific Islander
Native American Other Refused

Ethnicity: Hispanic/Latino Not Hispanic/Latino Refused

Where did you stay last night?

Do you feel safe in your situation? Yes No

Is there a veteran in your household? Yes No

Next of Kin: Contact #:

Are you at risk of homelessness? Y N Are you homeless? Y N

How were you referred to our office?

Please tell us what we can do to help you today:

Amount of Financial Assistance Requested:
_____Rent _____Deposit(s) _____ Utility _____ Utility Deposit
_____Application Fee

Medical Assistance:
___ Voucher for specialty physician or medical testing ___ Inpatient Hospital Stay

Navigational Services:
___ Assistance applying for Medicaid/Food stamps ___ Housing
___ Food Assistance ___ Community Referrals
___ Resource Center ___ Tokens
___ Cremation ___ Birth Certificates/ID's

200 San Sebastian View, Suite 2300
St. Augustine, FL 32084
P: 904-209-6140 F: 904-209-6141
www.sjcfl.us

Have you applied for SSDI and/or SSI? Yes No
If so, were you approved or denied?_____

Are you a U.S. Citizen? Yes No

If No, you must provide a copy of your Permanent Resident Alien Card.
Date admitted to United States _____
Are you sponsored? If so, by whom _____

Asset Assessment Sheet

Do you own your home, or are you renting? _____

Amount of rent or mortgage_____

Do you own or are you buying any other property? (house, land, etc.) Yes No

Value $_____ Date Purchased: _____Balance Owed $_____

Location and Description_____

Have you sold any property in the last 2 years? Yes No
If yes, were there any proceeds from sale? _____

Description	Current Value	Year, Make & Model	Amount Owed
1) Car/Truck/Motorcycle	$_____	_____	$_____
2) Car/Truck/Motorcycle	$_____	_____	$_____
3) Boat/other vehicle	$_____	_____	$_____
4) Other vehicles	$_____	_____	$_____

Do you or any household member have any of the following:

	Bank Name	City/State	Balance
Checking Account(s)			
Checking Account(s)			
Checking Account(s)			
Savings Account(s)			
Savings Account(s)			
Trust, IRA, CD, Stocks			
Money market, bonds			

Have you or any household member closed any accounts in the past year? Yes No
If yes, explain when and why? _____

Please provide the following information <u>on all members of your household</u> including yourself:

Household Information **MUST BE COMPLETED IN FULL**

Name	Relationship	DOB	Social Security Number	Employer/School	Date employed	Gross Monthly Income
					Total Earned Income	$

If unemployed state reason:_____

Date Last Employed:_____ Last Place of Employment:_____

Expenses:

Auto Insurance	
Cable	
Car	
Childcare	
Child Support	
Credit Cards	
Electric	
Food	
Furniture	
Gas- Auto	

Gas - Heating	
Health Insurance	
Home Insurance	
Life Insurance	
Medical Bills	
Medication	
Mortgage	
Phone	
Rent	
Water	
Total Expenses	

Income:

Unearned Income	
Child Support	
Unemployment	
Workers Compensation	
Alimony	
Social Security (SSI/SSDI)	
Food Stamps	
Other:_____	
Earned Income Total	
Total Income	

APPLICANT'S STATEMENT
AUTHORIZATION FOR RELEASE OF INFORMATION AGREEMENT

Chapter 837.06

"Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty shall be guilty of a misdemeanor of the second degree, punishable by imprisonment according to Florida Statute 775.082"

I hereby certify that residence is established in St. Johns County and declare intentions of remaining in St. Johns County. By signing this form, I am saying that the answers are true and complete to the best of my knowledge. I know that if wrong information is given or if information is withheld on purpose, I am breaking the State Law and are subject to the penalties provided by Law, including the penalty for perjury.

Permission is hereby granted and authorized for any insurance company, employer, utility company, or financial institution to disclose to the Board of County Commissioners and/or its designee, full information regarding my past, present, or future assets, earnings, and financial status. Privacy rights under State or Federal Law concerning my income, assets, liabilities or assistance received from such agencies are hereby waived, and I further consent and request that any State or Federal agency having information concerning me to disclose same to the Board of County Commissioners of St. Johns County, Florida or its agents.

I give my permission the release of any medical and/or psychiatric or psychological information to the St Johns County Social Services Department (SJCSS). I also authorize SJCSS to forward any information as necessary to hospitals, physicians and/or providers involved in providing my medical care.

I request public assistance since I am unable to pay the usual cost of medical care. I hereby agree that all hospital insurance, voluntary contributions and part payments will be assigned to the hospital for services. I hereby authorize the insurance companies to make available to the hospital and/or SJCSS any requested information concerning medical insurance and financial records related to my medical care.

I do not own any real estate and/or personal property except as written on page 4 of this application.
_____, do swear or affirm that I am resident(s) of
(Applicant's Name)
St. Johns County, Florida, and the information given on this application are true and complete. I have read, or it has been read to me/us, the above statements and I understand the above statements and releases.

Signature of Applicant:_____

200 San Sebastian View, Suite 2300
St. Augustine, FL 32084
P: 904-209-6140 F: 904-209-6141
www.sjcfl.us

CLIENT RIGHTS

There are fundamental rights granted to all clients while receiving any service within the St. Johns County Health and Human Services Department. Client rights will vary depending on the program. In each case, the client will be explained these rights and will be given the particulars for that program. In addition, there are general responsibilities:

- To have access to services regardless of race, religion, sex, ethnicity, age or handicap.
- To have personal dignity recognized and respected without abuse or neglect.
- To continue to have legal rights, to which all citizens are entitled, except as provided by law.
- To be informed of agency or department procedures used and the organizational rules for client conduct.
- To initiate a complaint or grievance related to issues that arise in the provision of care and services.
- To be informed of rights in a language that the client can understand.

CLIENT RESPONSIBILITIES

Just as clients have certain rights, it should be recognized that clients also have certain responsibilities while working with HHS. Client responsibilities will vary depending on the program. In each case, the client will be explained these responsibilities and will be given the particulars for that program. In addition, there are general responsibilities:

- To actively participate in achieving goals outlined in the service planning.
- To adhere to St. Johns County Health and Human Services Department's policy of a drug and alcohol free environment.
- Staying in touch with your case manager, case specialist, or other assigned staff member.
- To respect the privacy, confidentiality, dignity, and safety of other clients, staff, and self. This includes avoiding the use of profanity, refraining from aggressive acts (verbal and physical) and bringing weapons of any kind into the agency. .
- To abide by all agency and program rules.
- Providing your case manager or case specialist with current contact information. This includes home information, work information, and an alternate contact source, if possible.
- You are responsible for being honest with all the information you share with your case manager or case specialist.
- You are responsible for asking questions if you do not understand something.
- You are responsible for the safety of yourself.

NOTICE OF PRIVACY PRACTICE AND CLIENT RIGHTS & RESPONSIBILITIES

The Social Services Notice of Privacy Practice and Client Rights & Responsibilities have been provided to me. I understand that the Notice of Privacy Practice speaks about my protected health information (PHI). Should I have any questions regarding either of these documents, I understand I can ask for clarification.

_____

Client Signature Date

_____

Case Specialist Signature Date

200 San Sebastian View, Suite 2300
St. Augustine, FL 32084
P: 904-209-6140 F: 904-209-6141
www.sjcfl.us

SOCIAL SERVICES- NOTICE OF PRIVACY PRACTICES

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

I. We have a legal duty to safeguard your protected health information (PHI).

We are legally required to protect the privacy of your health information. We call this information "protected health information", or "PHI" for short. It includes information that identifies you and that has been created or received by us about (1) your past, present, or future health or condition(s); (2) the provision of health care to you; or (3) the payment for this health care.

We are providing you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure.

We are legally required to follow the privacy practices that are described in this notice. However, we reserve the right to change the terms of this notice and our privacy policy at any time. Any changes will apply to the PHI we already have. If we make an important change to our policies, we will promptly change this notice, post a new notice in the main lobby area of the program, and have copies available for distribution.

You can request a copy of this notice from the Social Services Division at any time.

Note to parents/guardians: If you reading this notice as your child's personal representative, this notices describes our privacy practices with respect to your child. Please let us know if you have any questions.

II. How we may use and disclose your PHI.

We use and disclose PHI for many different reasons. For some of these uses or disclosures, we need your specific authorization, while for others, we do not. Below, we describe the different categories of our uses and disclosures.

A. We may use and disclose PHI for the following reasons without a written authorization.

1. **For treatment, payment, or health care operations.**

a. **For treatment.** We may disclose your PHI to physicians, nurses, mental health professionals, and other health care personnel who provide you with health care services or are involved in your care. For example, we may disclose your PHI to your primary care physician for treatment purposes.

b. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and service provided to you. For example, if a service we provide is billable to a third party insurance company or to Medicaid, we may submit the information to them that is necessary for payment.

c. **For health care operations.** We may disclose your PHI in order to operate our program. For example, we use your PHI to evaluate the quality of the healthcare services you received.

2. **When a disclosure is required by law.** For example, we are required to make disclosures about victims of abuse, neglect, or domestic violence to the appropriate agency.

3. **For public health activities.** For example, we are required to report information pertaining to certain diseases to local health authorities.

4. **For health oversight activities.** For example, we will provide the necessary information to assist a government agency conducting an investigation or inspection of our health care activities.

5. **To avert a serious threat to health or safety.** For example, we may disclose PHI if in good faith we believe it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

6. **For specific government purposes.** For example, we may disclose PHI if we believe it is a matter of national security.

B. Other uses and disclosures of your PHI not listed above, and permitted by the laws that apply us, will be made only with your written authorization. If you choose to sign an authorization to disclose your PHI, you may revoke (i.e., take back) it in writing at any time, except to the extent that we have already taken action based on the original authorization.

III. You have the following rights with respect to your PHI:

a. The right to request limits on uses and disclosures of your PHI. We are not required, however, to agree or comply with your request.

b. The right to choose how we send PHI to you. You have the right to ask that we send information to you to an alternate address (e.g., your work address rather than your home address) or by alternate means (e.g., email instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.

c. The right to see your PHI. In most cases you also have the right to look at or get copies of your PHI that we have, but your request must be made in writing. If we don't have your PHI, but know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain cases, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that in advance.

d. The right to correct or update your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. If we approve your request, we will make the change to your PHI, tell you that we have done so, and tell others that need to know about the change. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement. If you don't file a written statement of disagreement, you may alternatively ask that your original request and our denial be attached to all future disclosures of your PHI.

e. The right to receive notification if and when your PHI is breached. A breach is when there is an unauthorized acquisition, access, use or disclosure of PHI which compromises the security or privacy of this information.

f. The right to get a list of the disclosures we have made. You have the right to get a list of those instances in which we have disclosed your PHI. The list will not include uses or disclosures made to you; those related to treatment, payment, or health care operations; those that were authorized by you; those made for national security purposes; or in certain circumstances, those made to correctional institutions or for other law enforcement custodial situations.

g. Your request must be made in writing and you must specify the time period for which you want to receive a list of disclosures. This time period may not be longer than six years and may not include dates prior to July 1, 2003. We will respond within 60 days of receiving your request. The list we will give you will include the date of the disclosure, to whom the PHI was disclosed (including the address if known), a brief description of the PHI disclosed, and a brief statement of the reason for the disclosure.

h. The right to get this notice by email. You have the right to get a copy of this notice by email. Even if you have agreed to receive the notice via email, you also have the right to request a paper copy of this notice.

IV. How to express concerns about our privacy practices.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section V below. You also may send a written complaint to the Secretary of the Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

V. Contact information about this notice.

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact our offices at (904) 209-6080 or by traditional mail at 200 San Sebastian View, Ste. 2300, Saint Augustine, FL 32084. An administrative employee will assist you in this matter.

VI. Effective date of this notice

This notice is effective as of July 1, 2003. It was last updated May 6, 2016

ACCESS - Partner View System Release

Customer's Name:_____ ACCESS Case/S.S.#_____

I,_____, understand that by my signature I am authorizing the Department of Children and Family (DCF) to release limited case information to_____ in their role as a DCF Community Partner and shall be used solely to fulfill obligation in assisting me with the application filed with DCF on_____. Information to be released is limited to:

- Verifying my eligibility information (approved, denied, enrolled or pending)
- Reason for closure or denial
- Assisting me with information on scheduled interview dates and time
- Assisting me with understanding what information is needed to complete my case and dates the information is due
- Assisting me with printing a temporary Medicaid card for eligible members in my household
- Assisting me with opening an account through My ACCESS Account

No additional information shall be provided to the Community Partner without my specific written consent. This authorization expires no more than ninety (90) days from the date signed.

Dated: _____day of _____, 20_____ Signature:_____

Printed Name:_____ Date of Birth:_____

Community Partner Staff Signature:_____

ACCESS - Liberación del Sistema de Visualización de Socios

Nombre del cliente:_____ ACCESS Caso/S.S.#_____

Yo,_____ , entiendo que con mi firma autorizo al Departamento de Niños y Familias (DCF) a divulgar información limitada del caso a_____ en su papel como Socio Comunitario de DCF y se utilizará únicamente para cumplir con la obligación de ayudarme con la solicitud presentada ante DCF el dia_____. La información que se divulgará se limita a:

- Verificar mi información de elegibilidad (aprobado, denegado, inscrito o pendiente)
- Motivo del cierre o negación
- Ayudarme con información sobre fechas y horas de entrevistas programadas
- Ayudarme a comprender qué información se necesita para completar mi caso y fechas de vencimiento
- Ayudarme a imprimir una tarjeta de Medicaid temporal para miembros elegibles en mi hogar
- Ayudarme a abrir una cuenta a través de Mi Cuenta ACCESS

No se proporcionará información adicional al Socio Comunitario sin mi consentimiento específico por escrito. Esta autorización vence no más de noventa (90) días a partir de la fecha firmada.

Fecha: Día_____ de_____ , 20_____ Firma:_____

Imprimir Nombre:_____ Fecha de Nacimiento:_____

Firma del personal del Socio Comunitario:_____

Authorization for Release of General and/or Confidential Information For FPL Payment Assistance Qualification

(Revised 10-2-2018)

Note: The Applicant must sign this form in order for the agency to use the Florida Power & Light (FPL) ASSIST process in qualifying the FPL account for payment assistance. Refusal to sign this form may lead to disqualification. The Applicant may appeal this requirement by speaking to the agency Director/Manager, as the agency deems appropriate. The agency Director/Manager may opt to contact FPL to discuss any confidentiality concerns the Applicant may have regarding the application/qualification process.

FPL ACCOUNT HOLDER (CUSTOMER NAME): _____

SERVICE ADDRESS FOR FPL (INCL. CITY/ST/ZIP): _____

FPL ACCOUNT NUMBER: _ _ _ _ _-_ _ _ _ _ **PHONE FOR FPL ACCOUNT:** _____

SECTION A: APPLICANT READS AND COMPLETES THIS SECTION ONLY IF HE/SHE **IS THE ACCOUNT HOLDER**

I hereby authorize FPL and this agency to disclose pertinent information to related community agencies. I understand that the need or purpose of this disclosure is solely to facilitate the assistance qualification process.

All information is accurate to the best of my knowledge. The agency may verify information contained in the payment assistance application, including the FPL account for which I am seeking assistance.

ACCOUNT HOLDER'S SIGNATURE: _____ **DATE:** _____

SECTION B: APPLICANT READS AND COMPLETES THIS SECTION ONLY IF HE/SHE **IS NOT THE ACCOUNT HOLDER**

As applicant for payment assistance for the above-referenced FPL account, I hereby confirm that I am not the Account Holder with FPL, but I am authorized by the Account Holder to initiate this assistance application on his/her behalf. This may be confirmed at the agency's discretion, by contacting the Account Holder.

All information is accurate to the best of my knowledge. The agency may verify my personal information contained in this authorization, including the FPL bill account for which I am seeking assistance.

APPLICANT'S NAME (NOT ACCOUNT HOLDER): _____

APPLICANT'S PHONE NUMBER: _____

APPLICANT'S SIGNATURE: _____ **DATE:** _____

SECTION C: FOR AGENCY USE ONLY

Agency must maintain this form in the applicant's file and make it available to FPL upon request, for accounting and auditing purposes.

AGENCY NAME : _____ **PHONE:** _____

AGENCY CASEWORKER'S NAME (*PLEASE PRINT*): _____

AGENCY CASEWORKER'S SIGNATURE: _____ **DATE:** _____

Care Connect Information Network
ServicePoint Consent
Release of Information (ROI)

Purpose of this form: St Johns County Social Services is a participating provider of vital services **("Participant")** who is an active project of the Care Connect Information Network (CCIN) hosted by St. Johns Care Connect, Inc. CCIN participating agencies work together to provide services to persons and families in need. When you request or receive services, we may collect data about you and your household such as:

- Your name, date of birth, Social Security Number, gender, ethnicity, race, veteran status, prior residence and program status.
- Your service needs, income, benefits, education, employment, destination, disability, general health, as well as pregnancy, HIV/AIDS, behavioral health, legal, and domestic violence status, destination.

How will my data be used? The ways in which the Agency may use or disclose your information are discussed in our Notice of Privacy Practices, which is posted in our reception area; we can direct you to the Notice at your convenience.

How will my data be protected? We enter your data in a computer program that is protected by passwords and encryption technology. Each Participant and CCIN user must sign an agreement to maintain the security and confidentiality of the information. Any person or Participant that violates the agreement may lose their access rights and be subject to further penalties.

How do I benefit by providing the requested information and sharing it with other agencies? By sharing your information with other agencies, you may be able to avoid being screened again, get services faster, and minimize how many times you have to tell your "story." You also help agencies document the need for services and demonstrate that funding is needed.

PLEASE PRINT NAME OF INDIVIDUAL *AFFECTED BY THIS ROI*: _____

IF HOUSEHOLD SITUATION, PLEASE INCLUED HOUSEHOLD MEMBERS AFFECTED BY THIS ROI:

1.	2.	3.	4.
5.	6.	7.	8.

Client Informed Consent/Authorization for Release of Information - By signing this form, I agree that the Agency may disclose and other participating agencies in the SERVICEPOINT may use the following information for lawful purposes of the agencies that participate in the SERVICEPOINT and their employees and agents: (**please initial & check the applicable boxes if appropriate**)

____1) I agree to share ***all of my information and household member's information*** with other CCIN participating agencies.

____2) I agree to share all of my information with other CCIN participating agencies, ***WITH THE EXCEPTION OF***:
(Check All That Apply)

- □ HIV/AIDS Information, such as status, diagnostic test results, mode of transmission, sexuality
- □ Domestic Violence Information, such as abuse history, abuser information, trauma information
- □ Behavioral Health Information, such as substance and alcohol abuse and mental illness information

____3) I **DO NOT agree** to share any of my information with other CCIN participating agencies.

I UNDERSTAND THAT:

- I am not required to sign this consent and that if I refuse to sign this consent my treatment, payment, or eligibility for benefits will not be affected. I may also request a copy of this consent after I sign it.
- This consent form expires in seven (7) years. I have the right to revoke this consent at any time by writing to the Agency, except to the extent that the agency has acted in reliance on it. Past information I previously consented to release will not be retrieved from agencies that received that information. I understand that my revocation must be in writing.
- The Agency has posted a Notice of Privacy Practices, and I may request a paper copy of the Notice from the Agency. I acknowledge that I have been given an opportunity to read and/or request a copy of the Notice and that I have read the Notice. The Notice describes ways in which my personal information may be used and disclosed within and outside of the Agency. Its terms may change and I may obtain a copy of the Notice by writing to: CCIN SERVICEPOINT c/o St. Johns Care Connect, 400 Health park, Blvd. St. Augustine, FL 32086.
- I understand that neither the Agency, nor the CCIN, can control how another Participant will use or disclose my information that it receives under this consent. It is possible that the other agency will disclose my information to others, and that the disclosed information may no longer be protected by federal privacy regulations.

_____	_____	_____	_____
Signature of Individual or Guardian	Date	Signature of Witness	Date