GUIDELINES FOR ADOPTION APPLICANTS

1. _______ Complete the 5 page "Adoption Application."
2. _______ Sign the "DCF Release of Information Form."
3. _______ Complete and sign the "Central Abuse Hotline Record Search."
4. _______ Ages 12-17, "Request for FDLE Criminal History Information."
5. _______ 18 & over, Live Scan Information Form – call 352-2546 for fingerprint appt.
   Include your driver's license number on the form.
6. _______ Sign Palm Beach County Sheriff's Department release (per person 18 & over).
7. _______ Sign the "Local Law Enforcement Check" release (per person age 18 & over).
8. _______ Reference Contact Information.
10._______ Physical Exam & Health Certificate (completed by a health professional).
11._______ Financial Security Determination. – and 2 years W-2s (or tax returns)
12._______ Not U.S. born, documentation: Passport/Green Card/Citizenship Papers
13._______ Provide a copy - Marriage Certificate & divorce verification (if applicable).
14._______ Read "A Guide to Complaint & Grievance Reporting Procedures."
   Sign the "Complaint Investigation Procedures" receipt.
15._______ Sign the "DCF Confidentiality Agreement" (Keep one copy).
16._______ Sign the "Acknowledgement of Firearms Safety Requirements."
17._______ CHS 1018 Consent to Services and Release of Liability for Transportation
18._______ Read "Consumer Handbook" and sign receipt

Children's Home Society of Florida * 3333 Forest Hill Blvd., West Palm Beach, FL 33406
(561) 868-4300 * Fax (561) 868-4496

Amy Garvin-Liddell, LCSW
Adoption Manager
Abigail Buteau, MSW
Post Adoption Specialist
Tynashkee Chapman, MSW
Adoption Specialist

Eileen Kreitzman, BS
Adoption Specialist
Richard Miller, BS
Adoption Specialist
Nicole Redford, BA
Adoption Recruiter

Briana Calzada, BSW
Adoption Specialist
Elizabeth Phelps, BS
Adoption Specialist
Jessica Murphy, BA
Adoption Specialist

Jill Ortiz BA
Wendy's Wonderful
Harriet Zeikowitz, MS, LMHC
Adoption Specialist
ADOPTIVE HOME APPLICATION

I. CURRENT SITUATION

A. RESIDENCE: Address: ___________________________________________________________
   (Number and Street) (City) (County) (State) (Zip Code)
   Telephone Number(s): _______________ _______________ _______________ E-mail: _______________
   (Home Number) (Work Number) (Cell Number)
   How long at this address: ___________ Number of Rooms: ___________
   Check One: [] House Check One: [] Own Monthly Payment: $________
   [ ] Apartment [ ] Rent Mortgage Balance: $_______
   If less than 3 years at above address, list former addresses for 5 years.

B. PRESENT MARRIAGE: Date of Present Marriage: ____________________________ (If applicable)
   Attach copy of marriage certificate.
   Describe briefly any separations, including dates and duration. [ ] Copy attached

List children of Present Marriage
   Child's Name: ___________________________________________________________
   __________________________ __________________________ __________________________
   __________________________ __________________________ __________________________
   __________________________ __________________________ __________________________
   __________________________ __________________________ __________________________

C. Name of Others in Home
   __________________________ __________________________ __________________________
   __________________________ __________________________ __________________________
   __________________________ __________________________ __________________________

D. Prospective Parent 1
   Religious Affiliation: ___________________________________________________
   Prospective Parent 2
   Religious Affiliation: ___________________________________________________
E. INTERESTS:  

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<tr>
<th>Community (clubs, lodges, etc.)</th>
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<tr>
<th>Hobbies or Special Interests</th>
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F. HEALTH: Attach completed physician's reports for both adults, if a physical is necessary.  

G. EMPLOYMENT: If current employment is less than 3 years, list former employment for 10 years.

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<th>Current Employment</th>
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<tr>
<th>Prior Employment (if applicable)</th>
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H. FINANCIAL STATUS – ASSETS:

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<th>Gross Yearly Salary</th>
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<th>Interest or Dividends</th>
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<th>Rental Income</th>
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<th>Other</th>
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<th>Real Estate at Market Value</th>
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<th>Savings</th>
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<tr>
<th>Other Investments (list on separate sheet and attach to this application)</th>
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<th>Life</th>
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<th>Accident</th>
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<th>Hospitalization</th>
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<th>Other (specify)</th>
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FINANCIAL STATUS – LIABILITIES: Itemize on separate sheet and indicate payment plan. Attach sheet to this application.

<table>
<thead>
<tr>
<th>Debts Totaled</th>
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<th>Other Obligations</th>
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</table>
II. LIFE HISTORY

A. Prospective Parent 1 Birthday: ________________ Prospective Parent 1 Birthplace: ____________________
   Prospective Parent 2 Birthday: ________________ Prospective Parent 2 Birthplace: ____________________

B. RACE/ETHNICITY:
   Prospective Parent 1: [ ] White [ ] Black or Hawaiian or Hispanic [ ] Asian [ ] American Indian or Other
   African American [ ] Pacific Islander [ ] Hispanic [ ] Asian [ ] American Indian or Alaskan Native [ ] Other
   Prospective Parent 2: [ ] White [ ] Black or Hawaiian or Hispanic [ ] Asian [ ] American Indian or Other
   African American [ ] Pacific Islander [ ] Hispanic [ ] Asian [ ] American Indian or Alaskan Native [ ] Other

C. EDUCATION: Last Grade Completed or Degree Special Training, if any
   Prospective Parent 1
   Prospective Parent 2

D. MEDICAL HISTORY — PHYSICAL and PSYCHIATRIC — MAJOR MEDICAL CONDITIONS
<table>
<thead>
<tr>
<th>Condition Treated for</th>
<th>Date Treated</th>
<th>Inpatient or Outpatient</th>
<th>Place Treated</th>
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E. PREVIOUS MARRIAGES: Attach documentation of death or divorce.
<table>
<thead>
<tr>
<th>Previous Spouse’s Name</th>
<th>Date and Place Married</th>
<th>Date and Place Marriage Terminated</th>
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<tbody>
<tr>
<td>Prospective Parent 1</td>
<td></td>
<td></td>
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<tr>
<td>Prospective Parent 2</td>
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</table>

Children of Previous Marriage:
<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Age</th>
<th>Whereabouts</th>
<th>Support Payments</th>
<th>Describe continuing contact if out of home</th>
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<td>Prospective Parent 1</td>
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<tr>
<td>Prospective Parent 2</td>
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</table>
F. ARREST RECORD: (violations of law other than minor traffic violations)

If either prospective parent has an arrest record, provide details below:

<table>
<thead>
<tr>
<th>Prospective Parent’s Name</th>
<th>Where Arrested</th>
<th>Date Arrested</th>
<th>Nature of Charge</th>
<th>Disposition</th>
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III. REFERENCES (two must be non-relatives)

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Telephone Number</th>
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IV. ADOPTION

Do you know anyone well who is adopted? ☐ Yes ☐ No If yes, who? __________________________ Have you ever applied to adopt a child from another source? ☐ Yes ☐ No If yes, when? ________________ 
What source? ____________________________

What children would you like us to consider for your family (age, sex, siblings, disabilities, etc.)?

What children would you not like us to consider for your family (age, sex, siblings, disabilities, etc.)?

I understand the importance of providing complete information and attest that the information provided above is accurate to the best of my knowledge. I understand, in accordance with Section 837.06, Florida Statutes, that making false statements in writing with the intent to mislead a public servant in the performance of his official duty is a misdemeanor of the second degree, punishable as provided in Sections 775.082, 775.083, or 775.084, Florida Statutes.
ADOPTIVE HOME APPLICATION
(All information herein is strictly confidential.)

Date: ______________________

I, We

Prospective Parent 1 First Name    Middle Name    Last Name

Prospective Parent 2 First Name    Middle Name    Last Name

Residing at ________________________________

County: ________________________________

Have read and understand the following:

IMPORTANT NOTE: Pursuant to the Multi-Ethnic Placement Act of 1994 and the Small Business Job Protection Act of 1996, Section 1808, "Removal of Barriers to Interethnic Adoption," race, culture or ethnicity may not be used as the basis for any denial of placement, nor may such factors be used as a reason to delay a foster or adoptive placement. Discrimination is not to be tolerated, whether it is directed toward adults who wish to serve as foster or adoptive parents, toward children who need safe and appropriate homes, or toward communities or populations that may previously have been under-utilized as a resource for placing children.

Prospective Parent 1 Signature

Prospective Parent 2 Signature
RELEASE OF INFORMATION

I (we) hereby authorize the release of any information requested by the Department of Children and Families to be utilized in determining my (our) suitability to become

☐ a licensed out-of-home caregiver, or ☐ an adoptive parent.

I (we) hereby grant permission to the Department of Children and Families to obtain information from local, state, or federal law enforcement agencies to help determine my (our) suitability to serve as a foster parent or as an adoptive parent. I (we) understand, however, that a history of arrest reported by any of these agencies will not necessarily prohibit my (our) participation in

☐ the licensed out-of-home care program, or ☐ the adoption program.

Pursuant to Florida Statute 39.202(2)(a)5., I (we) hereby authorize the Department of Children and Families to make inquiry of the central abuse registry and tracking system in regard to the existence of any confirmed report of abuse, neglect, or exploitation and the results of any investigation pursuant hereto.

______________________________________________________________________________  _______________________________________________________________________
Applicant                                                                                   Date

______________________________________________________________________________  _______________________________________________________________________
Applicant                                                                                   Date

______________________________________________________________________________  _______________________________________________________________________
Adult Household Member                                                                       Date

______________________________________________________________________________  _______________________________________________________________________
Adult Household Member                                                                       Date

NOTE: All adult members (age 18 and over) of the household will be responsible for granting consent to these record checks.
Central Abuse Hotline Record Search

I / We_________ ___________________________ and

(please print – first, middle, last name) (please print – spouse first, middle, last name, if applicable)

as an applicant for adoption, an applicant for licensing/registration, or a DCF employee, authorize a search for reports of abuse, neglect or abandonment investigated pursuant to Chapter 39, Florida Statutes in which my name appears and there were "some indication" or "verified indicators" of maltreatment of a child(ren). I understand I will be given the opportunity to discuss the findings of the report(s). I further understand that the central abuse hotline search is only one part of the preliminary report to the court for adoption, one of the requirements reviewed by an agency with the authority to license or approve homes for the care of develop-mentally disabled persons and children, including family child care homes and facilities, or for DCF employment. This consent is valid solely for the requesting agency/facility listed below on this form.

Applicant Signature: __________________________________________ Date: ________________

Spouse Signature: __________________________________________ Date: ________________ Phone: ____________________

Applicant: SSN: __________ DOB __________ Sex: _______ Prior Name(s) __________

Applicant: SSN: __________ DOB __________ Race: _______ Sex: _______ Prior Name(s) __________

Current Address: Address __________________ City __________ County __________ ST __________ Zip __________ Dates at Address __________

Previous Address: Address __________________ City __________ County __________ ST __________ Zip __________ Dates at Address __________

Previous Address: Address __________________ City __________ County __________ ST __________ Zip __________ Dates at Address __________

Reason for Record Search: ☒ Adoption Applicant (Chapter 63) ☐ DCF Employee (Chapter 39)

☐ Licensing/Registration Applicant (Chapters 39, 415, 402 or 409)

(NOTE: Searches of the Central Abuse Hotline may not be used for any employee except those working for DCF.)

Family child care, foster/shelter/group home or adoption applicants must list all child and adult household members on page two of this form. Do not include any foster care children.

TO BE COMPLETED BY REQUESTING AGENCY

☒ Child Care Center ☐ Family Child Care Home ☐ Foster / Shelter / Small Group Home ☒ Adoption

☒ Child-Caring Agency ☐ Child-Placing Agency ☐ DD Foster / Small Group Home

OCA and/or Facility ID: 50313933406

Facility / Agency Name: Children’s Home Society of Florida Phone: 561-868-4300

Address: 3333 Forest Hill Blvd. West Palm Beach, FL 33406

Mailing Address __________ City __________ Zip Code __________

I understand it is a misdemeanor of the first degree for any agency to use or release abuse, neglect or abandonment information to others. The information is CONFIDENTIAL and may be used only for the purpose for which it was obtained.

Signature of Requesting Facility / Agency Representative ______________________________________ Date ________________
Central Abuse Hotline Record Search

APPLICANTS FOR FAMILY CHILD CARE, FOSTER/GROUP HOME OR ADOPTIONS PLEASE ENTER INFORMATION FOR ALL CHILD AND ADULT HOUSEHOLD MEMBERS EXCEPT FOSTER CHILDREN.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>DOB</th>
<th>Race</th>
<th>Sex</th>
<th>SSN</th>
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RESULTS (Department or Agency Conducting Search Use Only)

☐ No records found with verified findings where the applicant was the caretaker responsible in the final role or, for licensing, in any role in three reports within a five year period.

☐ Records found for review are listed below:

<table>
<thead>
<tr>
<th>Report Number</th>
<th>Report Date</th>
<th>County</th>
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Date of Search: ____________

Employee Conducting Search: ___________________________  Phone: ___________________________  Signature: ___________________________
REQUEST FOR FDLE CRIMINAL HISTORY INFORMATION

DATE: _______________

TO: Applicant Section
    User Service Bureau
    FDLE
    Post Office Box 1489
    Tallahassee, FL 32302
    Attn: Caretaker Program

FACILITY NUMBER: 503139

From: ________________________________
    Name of Requester / Children's Home Society of FL
    3333 Forest Hill Boulevard
    (Mailing Address)
    West Palm Beach, Florida 33406
    Telephone: (561) 868-4300

The more complete this information is, the better the search and associated results will be.

PLEASE TYPE OR PRINT CLEARLY

Applicant Name: ________________________________
    Last Name    First Name    Middle

Other names applicant has used (include maiden names & nicknames)

AKA: ________________________________

Race: (circle one) Black    White    Asian    American Indian
    Alaskan Native    Unknown

Sex: (circle one) Male    Female    Date of Birth: __________

Social Security Number: ________________________________

Address: ________________________________
    Street    City    State    Zip Code

******************************************************************************
I certify that the person listed above is a volunteer or a caretaker employee requiring a five-year rescreening. I understand that the Legislature has established a reduced payment of $8.00 for the criminal history checks of these persons.

(Signature of Owner or On-Site Director) ________________  (Date) ________________
REQUEST FOR FDLE CRIMINAL HISTORY INFORMATION

DATE: __________________

TO: Applicant Section
    User Service Bureau
    FDLE
    Post Office Box 1489
    Tallahassee, FL 32302
    Attn: Caretaker Program

FACILITY NUMBER: 503139

From: ________________________________

    Name of Requester / Children’s Home Society of FL

    3333 Forest Hill Boulevard
    (Mailing Address)

    West Palm Beach, Florida 33406

    Telephone: (561) 868-4300

The more complete this information is, the better the search and associated results will be.

PLEASE TYPE OR PRINT CLEARLY

Leave this space blank

Applicant Name: __________________________
    Last Name     First Name     Middle

Other names applicant has used (include maiden names & nicknames)

AKA: _________________________________

Race: (circle one) Black     White     Asian     American Indian

    Alaskan Native     Unknown

Sex: (circle one) Male     Female     Date of Birth: ___________

Social Security Number: ________________________________

Address: ____________________________________________

    Street    City    State    Zip Code

**********************************************************************************************************

I certify that the person listed above is a volunteer or a caretaker employee requiring a five-year rescreening. I understand that the Legislature has established a reduced payment of $8.00 for the criminal history checks of these persons.

(Signature of Owner or On-Site Director) ___________________________ (Date) ___________
Live Scan Information Form

Client MUST bring completed form & photo ID with him/her and call in advance to make an appointment (we do not take walk-ins) 561-352-2546

Fax To: 561-352-2544

NAME: ________________________________
Maiden/aliases: ___________________________ Type of ID presented: ___________________________
SS#: ________________________________ FL DL ____________
DOB: ________________________________
COUNTRY/STATE OF BIRTH: ____________________________
COUNTRY OF CITIZENSHIP: ____________________________
HOME ADDRESS: ____________________________
City, State, ZIP: ____________________________
County ____________________________
Telephone# ____________________________

GENDER (CIRCLE ONE): M or F

RACE (CIRCLE ONE): A – Asian  I – Native American  B – Black  W – Caucasian/Latino

EYE COLOR: ____________________________ HEIGHT: ______________
HAIR COLOR: ____________________________ WEIGHT: ______________

DEPARTMENTAL USE BELOW LINE

OCA #: 09503139Z REQUESTED BY (Name):
AGENCY NAME: Childrens Home Society TELEPHONE #:

Date 1st Prints Taken: ____________________________ Prints Taken by: ____________________________
Date Transmitted: ____________________________ Transmit # (TCN): ____________________________
Date 1st Results Received: ____________________________ Rejected? (Circle): YES or No
Rejected TCR #: ____________________________ Prints Taken by: ____________________________
Date Retransmitted: ____________________________
Date 2nd Results Received: ____________________________

Check One ORI #:
[ ] RELATIVE/ NON RELATIVE PLACEMENT (FL921833Z)
X [ ] ADOPTION SCREENING (FL921833Z)
[ ] FOSTERING SCREENING (EDCFGN10Z)
Please keep your ID handy (we will make a copy)
Live Scan Information Form

Client MUST bring completed form & photo ID with him/her and call in advance to make an appointment (we do not take walk-ins) 561-352-2546

Fax To: 561-352-2544

NAME: ________________________________
Maiden/aliases: ________________________ Type of ID presented: ________
SS#: ________________________________ FL DL __________
DOB: ________________________________
COUNTRY/STATE OF BIRTH: ________________________________
COUNTRY OF CITIZENSHIP: ________________________________
HOME ADDRESS: ________________________________________
City, State, ZIP: ________________________________
County ________________________________
Telephone#____________________________________

GENDER (CIRCLE ONE): M or F

RACE (CIRCLE ONE): A – Asian I – Native American B – Black W – Caucasian/Latino

EYE COLOR: ___________________________ HEIGHT: ______________________
HAIR COLOR: _________________________ WEIGHT: ______________________

DEPARTMENTAL USE BELOW LINE

OCA #: 09503139Z
AGENCY NAME: Childrens Home Society

REQUESTED BY (Name):
TELEPHONE #:

Date 1st Prints Taken: ________________________ Prints Taken by: ________________________
Date Transmitted: ________________________ Transmit # (TCN): ________________________
Date 1st Results Received: ________________________ Rejected? (Circle): YES or No
Rejected TCR #: ________________________ Prints Taken by: ________________________
Date Retransmitted: ________________________
Date 2nd Results Received: ________________________

Check One ORI #:
☐ RELATIVE/ NON RELATIVE PLACEMENT (FL921833Z)
☒ ADOPTION SCREENING (FL921833Z)
☐ FOSTERING SCREENING (EDCFGN10Z)
CHILDREN'S HOME SOCIETY OF FLORIDA
Request for Local Law Enforcement Check for Adoption Applicant

Date _____/_____/_____

Local Law Enforcement Check

Pursuant to Chapter 85-54, F.S., Children's Home Society of Florida requests a local records check on the applicant listed below, as well as notification of any and all contacts your department has had with this applicant.

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MIDDLE</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>MAIDEN</th>
<th>OR</th>
<th>A.K.A</th>
</tr>
</thead>
</table>

/_____/   RACE   SEX   SOCIAL SECURITY #

Please document the findings on this check and return the information to:
Children's Home Society of Florida - South Coastal Division
3333 Forest Hill Blvd., West Palm Beach, FL 33406

Sincerely,

Children's Home Society of Florida

The Children's Home Society currently has a contract with the Department of Children & Families to complete home studies for the Department's adoptive applicants. We are requesting that you process the background screenings without charging a fee.

I hereby authorize PALM BEACH COUNTY SHERIFF'S OFFICE to check any and all records pertaining to the criminal arrests and convictions, and for any law enforcement agency to release to Children's Home Society of Florida information regarding arrests and convictions and any and all contacts the applicant has had with said agency, under Florida statutes or statutes of any other jurisdiction.

Date _____/_____/_____

___________________________________________
APPLICANT FOR ADOPTION SIGNATURE
CHILDREN'S HOME SOCIETY OF FLORIDA
Request for Local Law Enforcement Check for Adoption Applicant

Date______/_______/_______

Local Law Enforcement Check

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</tbody>
</table>

<table>
<thead>
<tr>
<th>DOB</th>
<th>RACE</th>
<th>SEX</th>
<th>SOCIAL SECURITY #</th>
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<td></td>
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Date______/_______/_______

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CHILDREN'S HOME SOCIETY OF FLORIDA
Request for Local Law Enforcement Check for Adoption Applicant

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LAST NAME                      FIRST NAME                      MIDDLE

MAIDEN                          OR                               A.K.A

/    /    RACE                  SEX                  SOCIAL SECURITY #

DOB

Please document the findings on this check and return the information to:
Children's Home Society of Florida - South Coastal Division
3333 Forest Hill Blvd., West Palm Beach, FL 33406

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The Children's Home Society currently has a contract with the Department of Children & Families to complete home studies for the Department's adoptive applicants. We are requesting that you process the background screenings without charging a fee.

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Date _____/ _____/ ______

APPLICANT FOR ADOPTION SIGNATURE
CHILDREN'S HOME SOCIETY OF FLORIDA
Request for Local Law Enforcement Check for Adoption Applicant

Date_____/_______/_______

Local Law Enforcement Check

Pursuant to Chapter 85-54, F.S., Children's Home Society of Florida requests a local records check on the applicant listed below, as well as notification of any and all contacts your department has had with this applicant.

LAST NAME  FIRST NAME  MIDDLE

MAIDEN  OR  A.K.A

___/_____/___  RACE  SEX  SOCIAL SECURITY #

Please document the findings on this check and return the information to:
Children's Home Society of Florida - South Coastal Division
3333 Forest Hill Blvd., West Palm Beach, FL 33406

Sincerely,

Children's Home Society of Florida

The Children's Home Society currently has a contract with the Department of Children & Families to complete home studies for the Department's adoptive applicants. We are requesting that you process the background screenings without charging a fee.

*****************************************************************************

I hereby authorize________________________________________ to check any and all records pertaining to the criminal arrests and convictions, and for any law enforcement agency to release to Children's Home Society of Florida information regarding arrests and convictions and any and all contacts the applicant has had with said agency, under Florida statutes or statutes of any other jurisdiction.

Date_____/_______/_______  APPLICANT FOR ADOPTION SIGNATURE
REFERENCE CONTACT INFORMATION

Family Name: ____________________________________________________________

1. Relative -

Name: ___________________________________________ E-Mails: ______________

Phone #: ____________________  City/State/Zip: ____________________________

Street: ____________________________ City/State/Zip: _______________________

2. Personal -

Name: ___________________________________________ E-Mails: ______________

Phone #: ____________________  City/State/Zip: ____________________________

Street: ____________________________ City/State/Zip: _______________________

3. Personal -

Name: ___________________________________________ E-Mails: ______________

Phone #: ____________________  City/State/Zip: ____________________________

Street: ____________________________ City/State/Zip: _______________________

4. Personal -

Name: ___________________________________________ E-Mails: ______________

Phone #: ____________________  City/State/Zip: ____________________________

Street: ____________________________ City/State/Zip: _______________________

5. Employer (Parent 1)-

Company Name: ____________________________ Name of Supervisor: __________

Phone #: ____________________  E-Mails: ________________________________

Street: ____________________________ City/State/Zip: _______________________ 

6. Employer (Parent 2)-

Company Name: ____________________________ Name of Supervisor: __________

Phone #: ____________________  E-Mails: ________________________________

Street: ____________________________ City/State/Zip: _______________________ 

ADULT CHILDREN NOT RESIDING IN THE HOME

Family Name: ____________________________________________

Child 1
Name: ____________________________________________ DOB: __________________
Phone #: __________________ E-Mails: __________________
Street: __________________________ City/State/Zip: __________________

Child 2
Name: ____________________________________________ DOB: __________________
Phone #: __________________ E-Mails: __________________
Street: __________________________ City/State/Zip: __________________

Child 3
Name: ____________________________________________ DOB: __________________
Phone #: __________________ E-Mails: __________________
Street: __________________________ City/State/Zip: __________________

Child 4
Name: ____________________________________________ DOB: __________________
Phone #: __________________ E-Mails: __________________
Street: __________________________ City/State/Zip: __________________

Child 5
Name: ____________________________________________ DOB: __________________
Phone #: __________________ E-Mails: __________________
Street: __________________________ City/State/Zip: __________________

Child 6
Name: ____________________________________________ DOB: __________________
Phone #: __________________ E-Mails: __________________
Street: __________________________ City/State/Zip: __________________
ADOPTIVE APPLICANT PHYSICAL EXAMINATION

To Examining Physician: In evaluating the applicant, this agency must be guided by your medical findings as reported on this form. Please print or type all information. Note "N/A" or "None" if applicable. Thank you for your assistance. Please do not leave any blanks.

Applicant's Name: ___________________________ DOB: ________

Address: ____________________________________________

1. MEDICAL HISTORY: Has the patient ever had:

<table>
<thead>
<tr>
<th>Disease</th>
<th>No</th>
<th>Yes</th>
<th>Year</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tumor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
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<tr>
<td>Liver Disease</td>
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<tr>
<td>Neuropathy</td>
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<tr>
<td>Mental Illness</td>
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<tr>
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<tr>
<td>Alcoholism</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Substance Abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any Genetic Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any Operations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Type(s) and date(s) __________________________________________

II. PHYSICAL EXAMINATION

Date of Exam: ________ Height: ________ Weight: ________ Blood Pressure: ________

Vision: ___________________________ Hearing: ___________________________

Heart: ___________________________ Liver: ___________________________

Lymph: ___________________________ Thyroid: ___________________________

Nervous System: ___________________________

How long has this person been under your care? ___________________________

What is your assessment of the patient's overall health? ___________________________

Is the patient taking any medications? ________ No ________ Yes ________ If yes, list type of medications taken, dosage and purpose: ___________________________

Do you know of any physical or mental conditions that will affect the applicant's ability to parent? ___________________________

Please explain: ___________________________

Are you aware of any reason why this patient should not adopt a child? ___________________________

Physician's Signature: ___________________________ Date: ________

M.D. License No: ___________________________ Phone Number: ___________________________

Physician's Name (please print clearly): ___________________________

Address: ___________________________
CHILDRen's HOME SOCIETY
3333 Forest Hill Blvd., West Palm Beach, FL 33406
Phone: 561-866-4334 * Fax: 561-866-4496

HEALTH CERTIFICATE

Applicant's Name: ___________________________ DOB: ________

Address: ____________________________________________

The above individual has applied with the Florida Department of Children & Families to be considered as an adoptive parent. The information you provide will help us in considering the applicant through the assessment process. Please feel free to make additional comments.

How long has this person been under your care? ____________________________

Date of last visit? ____________________________________________

What is the patient's general health and physical condition? ____________________________________________

Does the individual have any history or evidence of organic or functional disorder? ____________________________

What is the diagnosis? ____________________________ Prognosis? ____________________________

Current medication/dosage/purpose (condition/illness that medications prescribed should be listed under diagnosis)
_________ ____________

______________

How would you describe this person's emotional stability? ____________________________

Is this person free from contagious or communicable diseases? ____________________________

Is this person physically and emotionally capable of performing parental responsibilities? ____________________________

Are you aware of any past or current issues of substance abuse, mental health, physiological or surgical services? ______

If so, please describe: ____________________________

Additional comments: ____________________________

Physician's Signature: ____________________________ Date: ________

M.D. License No: ____________________________ Phone Number: ____________________________

Physician's Name (please print clearly): ____________________________
ADOPTIVE APPLICANT PHYSICAL EXAMINATION

To Examining Physician: In evaluating the applicant, this agency must be guided by your medical findings as reported on this form. Please print or type all information. Note "N/A" or "None" if applicable. Thank you for your assistance. Please do not leave any blanks.

Applicant's Name: _______________________________ DOB: __________

Address: ________________________________________

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<td>Any Genetic Disease</td>
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<tr>
<td>Any Operations</td>
</tr>
</tbody>
</table>

Type(s) and date(s): ________________________________________

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<tr>
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</thead>
<tbody>
<tr>
<td>Date of Exam: ______________________________</td>
</tr>
<tr>
<td>Height: ____________________ Weight: ________</td>
</tr>
<tr>
<td>Blood Pressure: ____________________________</td>
</tr>
<tr>
<td>Vision: ____________________</td>
</tr>
<tr>
<td>Heart: ____________________ Liver: ________</td>
</tr>
<tr>
<td>Lung: ________</td>
</tr>
<tr>
<td>Lymph: ____________________ Thyroid: ________</td>
</tr>
<tr>
<td>Nervous System: ____________________________</td>
</tr>
</tbody>
</table>

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Is the patient taking any medications? ______ No ______ Yes

If yes, list type of medications taken, dosage and purpose:____________________

Do you know of any physical or mental conditions that will affect the applicant's ability to parent?______________________________

Please explain: ____________________________________________________________

Are you aware of any reason why this patient should not adopt a child?________

Physician’s Signature: __________________________ Date: ________________

M.D. License No: ____________________________ Phone Number: ____________

Physician’s Name (please print clearly): _________________________________

Address: ____________________________________________________________
CHILDS HOME SOCIETY  
3333 Forest Hill Blvd., West Palm Beach, FL 33406  
Phone: 561-868-4334 * Fax: 561-868-4496  

HEALTH CERTIFICATE  

Applicant’s Name: ___________________________  DOB: _________  

Address: ______________________________________  

The above individual has applied with the Florida Department of Children & Families to be considered as an adoptive parent. The information you provide will help us in considering the applicant through the assessment process. Please feel free to make additional comments.  

How long has this person been under your care? ________________________________________________  

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What is the patient’s general health and physical condition? ___________________________________________  

________________________________________________  

Does the individual have any history or evidence of organic or functional disorder? ________________________________  

________________________________________________  

What is the diagnosis? ___________________ Prognosis? ___________________  

Current medication/dosage/purpose (condition/illness that medications prescribed should be listed under diagnosis)  

________________________________________________  

________________________________________________  

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Additional comments: ________________________________________________  

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M.D. License No: __________________________ Phone Number: __________________________  

Physician’s Name (please print clearly): ________________________________________________
## FINANCIAL SECURITY DETERMINATION

<table>
<thead>
<tr>
<th></th>
<th>Caregiver 1</th>
<th>Caregiver 2</th>
<th>Household</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
<td></td>
<td>Combined Monthly Income</td>
</tr>
<tr>
<td>Current Employer</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Employer's Address</td>
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<td></td>
<td>$</td>
</tr>
<tr>
<td>Length of Current Employment</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Hours &amp; Shifts Worked</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Gross Yearly Salary</td>
<td>$</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Net Take Home</td>
<td>$ weekly $</td>
<td>$ weekly $</td>
<td>$</td>
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<td></td>
<td>biweekly</td>
<td>biweekly</td>
<td>$</td>
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<tr>
<td></td>
<td>OR $ monthly</td>
<td>OR $ monthly</td>
<td>$</td>
</tr>
<tr>
<td>Medicaid Eligible</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Additional Support or Income</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>* Social Security Benefits</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>* Retirement Benefits</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>* Wages (Temp. Case Assistance)</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>* Disability Benefits</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>* Others (list)</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td>TOTAL MONTHLY EXPENSES $</td>
</tr>
</tbody>
</table>

Will child care or after-school care be needed? ( ) Yes ( ) No How will it be provided?

What new expenses are anticipated for the child(ren) to be placed in the home?

Health Insurance Coverage? ( ) Yes ( ) No Name of Insurance Company

$ of Workman's Compensation Insurance Caregiver 1 $ Caregiver 2$ Name of Companies None ( )

Amount of Life Insurance Caregiver 1 $ Caregiver 1$ Name of Companies None ( ) None ( )

Please describe any debt or bills that are causing a problem for you at this time.

How would you handle a financial situation if the subsidy check failed to arrive when expected.

Caregiver 1 Signature Caregiver 2 Signature Date
A GUIDE TO COMPLAINT & GRIEVANCE REPORTING PROCEDURES

For Consumers of the Department of Children & Families
Licensed Adoption Agencies & Child Placing Agencies

Which Child Placing Agencies Must be Licensed by the Dept of Children & Families in District 9?

* All agencies placing children in foster homes or residential child caring facilities.
* All adoption agencies located in Palm Beach County.
* Not attorneys that provide adoption legal services.
* Not doctors that provide adoption services.
* Not adoption referral services that recommend adoption resources.

How to Report your Complaint to the Department of Children & Families

We accept your complaints reported by phone. Call 561-837-5078
Or you may address your complaints in writing to:
Department of Children & Families - Client Relations Coordinator
1111 South Sapodilla Ave., West Palm Beach, FL 33401

Complaint Investigation Procedures

1. Licensing staff of the department may make scheduled or unannounced visits to a licensed home, facility or agency at any reasonable time to investigate compliance with the licensing requirements. All agencies shall be inspected at least annually.
2. The department shall investigate complaints to determine if the agency is meeting the licensure requirements.
3. The department shall advise the owner and operator with authority over the licensed agency that there is a licensing complaint when initiating an investigation and shall advise the agency of the results when the investigation is concluded.
4. Whenever the department receives a report questioning the certification status or compliance of a child placing agency with requirements of the state adoption law or alleging violation of this chapter by the agency, the department shall investigate the allegation within 20 working days to determine whether the complaint is substantiated.
5. The department shall notify the complainant and the agency in writing of the results of the complaint investigation within 15 working days after the report of the department's investigation has been finalized.
6. The agency shall fully cooperate with the department whenever such complaint investigations are conducted.

District 9, Dimick Building, Family Safety & Preservation
111 South Sapodilla Avenue, West Palm Beach, Florida 33401
(561) 837-5120

Working in partnership with local communities to help people be self-sufficient and live in stable families and communities.
COMPLAINT INVESTIGATION PROCEDURES

By my signature below, I verify that I have received and reviewed “A Guide To Complaint and Grievance Reporting Procedures” for consumers of Florida Department of Children & Families Licensed Adoption Agencies and Child Placing Agencies.

______________________________  ______________________
Signature                                    Date

______________________________  ______________________
Signature                                    Date

Note: The original of this page must be kept on file at the agency.

District 9, Dimick Building, Family Safety & Preservation
111 South Sapodilla Avenue, West Palm Beach, Florida 33401
(561) 837-5120

Working in partnership with local communities to help people be self-sufficient and live in stable families and communities.
CONFIDENTIALITY AGREEMENT

I understand and agree that all information as it relates to child abuse records and clientele are to be held confidential in compliance with the Child Abuse Statute, Florida Statute 39.205 which states “any person who willfully or knowingly makes public or discloses any information contained in the child abuse registry or the records of any child abuse case except as provided in this section is guilty of a misdemeanor of the second degree.”

I further agree to treat any such information on clients that should come to my attention and knowledge as privileged and confidential, and that I will not disclose such information to anyone other than authorized persons.

_________________________________________  __________________________
Date                                             Signature

_________________________________________  __________________________
Witness                                          Signature

This will acknowledge that I have received a copy of this document.

_________________________________________  __________________________
Date                                             Signature

_________________________________________  __________________________
Date                                             Signature
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________________________________________________________
Date                                                 Signature

________________________________________________________
Witness                                               Signature

This will acknowledge that I have received a copy of this document.

________________________________________________________
Date                                                 Signature

________________________________________________________
Date                                                 Signature

CF-FSP 5067, PDF 03/2007
ACKNOWLEDGEMENT OF FIREARMS SAFETY REQUIREMENTS

Florida Statute 790.174 (Safe storage of firearms required) states:

(1) A person who stores or leaves, on a premise under his or her control, a loaded firearm, as defined in s. 790.001, and who knows or reasonably should know that a minor is likely to gain access to the firearm without the lawful permission of the minor’s parent or the person having charge of the minor, or without the supervision required by law, shall keep the firearm in a securely locked box or container or in a location which a reasonable person would believe to be secure or shall secure it with a trigger lock, except when the person is carrying the firearm on his or her body or within such close proximity thereto that he or she can retrieve and use it as easily and quickly as if he or she carried it on his or her body.

(2) It is a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083, if a person violates subsection (1) by failing to store or leave a firearm in the required manner and as a result thereof a minor gains access to the firearm, without the lawful permission of the minor’s parent or the person having charge of the minor, and possesses or exhibits it, without the supervision required by law:
   (a) In a public place; or
   (b) In a rude, careless, angry, or threatening manner in violation of s. 790.10.
This subsection does not apply if the minor obtains the firearm as a result of an unlawful entry by any person.

(3) As used in this act, the term “minor” means any person under the age of 16.

I/We, ____________________________________________,
acknowledge that I/we have read and understand this document.

__________________________________________  Caregiver/Adoptive Parent Signature

Date

__________________________________________  Caregiver/Adoptive Parent Signature

NOTE: This acknowledgement must be executed by all foster and adoptive parents during the home study process.
CONSENT TO SERVICES AND RELEASE OF LIABILITY FOR TRANSPORTATION

I ___________________________ date of birth ___________ agree to participate in services
(Print name of client/parent/guardian)

provided by The Children’s Home Society of Florida ("CHS") in their

__ADOPTIONS ___________________________ Program on behalf of ☐ myself and/or
(Enter name of CHS Program)

Family
member
(Print name) ___________________________ (Relationship) ___________________________
(Date of birth) _________________________

The program/services have been explained to me and I voluntarily consent to the program/services.

I agree to work collaboratively, to take an active part in the development and ongoing review of my/our/their service plan, and to work toward my/our/their goals by completing the tasks outlined in the service plan in order to accomplish my/our/their stated objectives.

I understand that I may be requested to sign a separate Authorization to Release Confidential Information in order that The Children’s Home Society of Florida may receive or release information to referring organizations or others as specified in the authorization.

The services provided may include face-to-face meetings, telephone conversations, and technology-based interactions including video conferencing, email, or text exchanges. I understand that audio or video recording of services may occur for purposes of training and supervision only with my advance written authorization (CHS1018 Form H Consent and Agreement to Be Audio/Videotaped), however, common areas of some CHS facilities are continuously recorded for security purposes.

In the event it is needed, I authorize The Children's Home Society of Florida and its employees to transport me, my child(ren) or ward, or other member of my family to and from destinations necessary for proper care of my family. I hereby forever release and discharge The Children’s Home Society of Florida and its employees from any and all liability for any and all loss or damage on account of injury or death to the person or property while being transported, whether caused by the negligent acts or omissions of The Children’s Home Society of Florida or its employees or otherwise.

I acknowledge that some services may require payment from me, in which case I will be advised of the costs in advance and given the opportunity to choose whether to receive the service.

This consent shall be effective the date of signature and shall expire one (1) year from the date of signature or may be revoked at any time, provided I notify the program in writing to this effect. Revocation has no effect on action previously taken. I authorize that a photocopy/electronic copy of this consent may be considered as valid as the original.

SIGN SECTIONS THAT APPLY

Signature of Parent or Guardian of minor child ___________________________ Date ___________

Signature of Adult Client ___________________________ Date ___________

Signature of Minor Client ___________________________ Date ___________

Signature of Witness ___________________________ Date ___________

Printed Name of Witness ___________________________

If the consumer has difficulty understanding or reading this document, please print the name of the person who read this document or explained it to the consumer ___________________________.

CHS1018 Form A Consent to Services
Effective Date: 01/21/2013 Revision Date: 06/29/2016

Page 1 of 1 Review Date: August 2021
ACKNOWLEDGEMENT OF RECEIPT
OF THE
CHS CONSUMER HANDBOOK

Consumer Name: __________________________

Client Provider/Medicaid Number: __________________________

I have received the Children's Home Society of Florida Consumer Handbook. I was given time to ask questions and I understand the answers that were given to me.

The Children's Home Society of Florida Consumer Handbook has information on the following subjects:

- Children's Home Society's Mission, Vision, and Values
- Definitions
- How to Help Yourself
- Consumer Rights and Responsibilities
- Children's Home Society's Rights and Responsibilities
- Confidentiality (Privacy) and How Information Is Shared
- Consent for Photos and Video/Voice Taping
- Notice of CHS Privacy Practices
- Consumer Grievance Procedures
- How to Plan and Receive Services
- Contact Information
- Acknowledgement of Receipt

Printed Name of Client or Guardian of Minor Child

Signature of Client or Guardian of Minor Child

CHS Employee Witness Signature

Date

Date

Revised
9-29-16
Consumer Handbook

Children’s Home Society of Florida recognizes, respects, promotes and celebrates the value of cultural diversity. Your ethnic or cultural customs, practices and beliefs, sexual orientation, gender, gender identity, gender expression, disability and community differences will be respected by agency staff.

Last updated: September 28, 2016

Review Date: September 2021
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MISSION:
Building bridges to success for children.

VISION:
A world where children realize their potential.

VALUES:

Caring: We show kindness and compassion.

Integrity: We are honest, ethical, and reliable.

Respect: We treat people with dignity, valuing their ideas and contributions.

Commitment: We work passionately and diligently.

Leadership: We set a positive example as we serve others.

Excellence: We never settle for less than our collective best.

Definitions

Consumer: YOU – the person receiving services.

Appointment: A time that Children’s Home Society of Florida has set aside to provide services to you.

Confidential Information: Health, drug, alcohol and/or mental health information about you.

Confidentiality: Things that need to be kept private, not discussed or shared with others in any way.

Informed Consent: You or your legal guardian know exactly what you are agreeing to do.

Services/Treatment Plan: The activities and tasks that you, your family and the Children’s Home Society of Florida caseworker agree must be done to reach your goals.
HOW TO HELP YOURSELF

Children's Home Society of Florida has committed staff and resources to help you achieve the goals that you set for you and/or your family. This handbook is designed to help you get the most out of your experience with our agency.

It is suggested that you actively participate in program services and treatment activities as scheduled. Arrive at your appointments on time. If you cannot come to an appointment, call your caseworker to reschedule.

Your desire to reach the goals you have set is the key to success. Be honest about what you want to do and the things that prevent success. This is a time to fully use the helpful Children’s Home Society of Florida services to make changes in your life.

It is important to avoid actions that are not good for your health or the health of others. Things like drugs, alcohol and violence are not good for your health or those around you. At Children’s Home Society of Florida, we care about you, other people getting services, our staff and our visitors’ well-being.

CONSUMER RIGHTS AND RESPONSIBILITIES

At Children’s Home Society of Florida, you are protected by certain rights and have responsibilities that support the services you receive.

You have the right:

- To be treated with courtesy, dignity and respect without regard to race, gender, gender identity (or expression), sexual orientation, religion, age, national origin or disability.
- To be free from harassment or bullying from others.
- To understand the availability of services you need, what services you will be using, and Children's Home Society of Florida expectations and rules for using those services.
- To receive quality services, provided by a qualified staff member in a professional and timely manner.
- To expect that employees working on behalf of Children’s Home Society of Florida will comply with all laws that protect you from abuse, neglect or being taken advantage of.
- To be informed in writing, to know and to agree to any fees charged to you or billed to your insurance for services before you receive service.
- To have your rights to confidentiality and privacy respected and upheld within the limits of the law, and to obtain your agreement before information is given to another agency or person outside Children’s Home Society of Florida.
- To know that your record may be reviewed for quality and compliance and that persons from accrediting organizations, program staff and funder staff also may review your record.
- To participate in setting up and reviewing your services plan.
- To understand rules and conditions related to Children’s Home Society of Florida stopping services.
- To refuse services, unless law or court order has limited your rights, and to be informed of what will happen if you refuse services.
- To file a grievance and to receive a copy of the Children’s Home Society of Florida consumer grievance procedure.
You have the responsibility:

- To be honest in giving information requested by Children’s Home Society of Florida in order to be accepted for service and to set up a service plan.
- To comply with all Children’s Home Society of Florida rules, policies and procedures.
- To work toward service plan goals.
- To respect the privacy and confidentiality of others receiving services.
- To not behave in any way that threatens or endangers another person and to understand that such activity could cause Children’s Home Society of Florida to stop services.
- To promptly pay agreed-upon fees or other charges.
- Caregivers, have the responsibility to inform Children’s Home Society of Florida of any incident or accident involving a child or elder in your care.

Please read and discuss these Consumer Rights and Responsibilities with a Children’s Home Society of Florida caseworker and take this time to ask questions. When you are satisfied that you understand your rights and responsibilities, please sign the receipt form provided by the Children’s Home Society of Florida caseworker to indicate that you have reviewed the Children’s Home Society of Florida Consumer Handbook.

CHILDREN’S HOME SOCIETY OF FLORIDA RIGHTS AND RESPONSIBILITIES

Children’s Home Society of Florida has the right to serve you according to staff and program availability and to set up a waiting list when more people need services than we are able to immediately provide. Children’s Home Society of Florida may also provide you with information about other agencies that provide similar services if our programs are full.

Children’s Home Society of Florida has the right to deny services, whether short- or long-term, to anyone who threatens the health or well-being of others or who does not meet his/her obligations to Children’s Home Society of Florida.

Children’s Home Society of Florida will offer high-quality services and schedule appointments and activities that are helpful to you. Our services will be as easy to get to and as convenient as possible.

Children’s Home Society of Florida is responsible for obtaining your ideas and help in setting up and carrying out your service/treatment plan.

Children’s Home Society of Florida is responsible for hiring qualified staff.

Children’s Home Society of Florida services are provided in safe and clean buildings.

Children’s Home Society of Florida staff is required by law to report suspicion of child abuse or elder abuse.

If Children’s Home Society of Florida staff considers someone as being an immediate danger to himself/herself or others, the staff member will act to protect all involved including notifying the consumer’s family, mental health professionals, law enforcement or others as appropriate.
CONFIDENTIALITY (PRIVACY) AND HOW INFORMATION IS SHARED

Children's Home Society of Florida follows laws and regulations regarding privacy and protection of information.

If Children's Home Society of Florida needs confidential information from another agency or provider, a Children's Home Society of Florida staff member will:

- Review with your and/or your legal guardian what information is needed and why.
- Ask you or your legal guardian to sign the "Authorization to Release Confidential Information form" indicating that you agree to have the necessary information released.
- If you are unable to give your informed consent or if the lack of information might result in harm to you, then the release of confidential information may be authorized by two Children's Home Society of Florida supervisory staff.

Children's Home Society of Florida cannot obtain confidential information about you without an "Authorization to Release Confidential Information," which includes the:

- Name of the source being requested for information;
- The information that is being requested;
- Listing of Children's Home Society of Florida as the agency requesting the information;
- Date the request form is valid; and
- Date of signature.

CONSENT FOR PHOTOS AND VIDEO/VOICE TAPEING

To protect your privacy, you will only be photographed, video/audio taped, or viewed through a one-way mirror with your written approval. If you agree, you will:

- Receive a written description of the request and the reasons for it;
- Not be encouraged or given payment or other incentives to agree to the request; and
- Be asked to sign a form giving your informed consent.

Group Care / Residential / Shelter Services

Within CHS residential, group care, and shelter facilities, CHS utilizes a behavior support plan to maintain a safe environment and prevent the need for restrictive behavior management interventions. However, in a situation where a child/youth exhibits behavior that is a physical threat to him/herself or others, a manual restraint may be used by trained staff for a limited time while the child regains control of their behavior. Such occurrences will be documented and parents will be notified.
NOTICE OF CHILDREN'S HOME SOCIETY OF FLORIDA PRIVACY PRACTICES

Effective September 23, 2013

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

This information may be about services or health care given to you or payment for that care. It may be about your past, present, or future medical condition or services. Children's Home Society of Florida is required by law to give you this "Notice of Privacy Practices" explaining our legal duties about your medical information in the way that Children's Home Society of Florida describes in this Notice. Children's Home Society of Florida is required to abide by the terms of this Notice that are currently in effect.

If Children's Home Society of Florida changes this Notice, we will post a new notice in our waiting areas and provide copies to you at your request. Contact your caseworker if you have questions or need any of the forms listed in this information. To protect your privacy, if you are asked to be photographed, video/audio taped, or to be viewed through a one-way mirror, you must first be told of this and you must agree to it. If you do not agree, the activity cannot be carried out. If you agree, you will:

• Receive a written description of the request and the reasons for it;
• Not be encouraged, given payment or other incentives to agree to the request; and
• Be asked to sign a form giving your informed consent.

CHILDREN'S HOME SOCIETY OF FLORIDA MAY USE AND SHARE YOUR MEDICAL INFORMATION IN A FEW SITUATIONS:

1. Treatment: To provide or coordinate your health care and related services by talking with other health care givers.

2. Payment: To obtain payment from your insurers, collection agencies and consumer reporting agencies either for services that you received or before you receive certain services to know whether the insurance plan will pay for a service.

3. Business Operations:
   • To evaluate the skills and performance of those taking care of you.
   • To develop training programs for student caregivers.
   • To cooperate with licensing authorities and government agencies.
   • To review the quality of your care.
   • To manage the care of people who have similar problems.
   • To plan for Children's Home Society of Florida future operations.
   • To resolve grievances.
   • To review Children's Home Society of Florida performance.
   • To work with this notice and other laws.

4. Persons Involved in Your Care: Children's Home Society of Florida may share your medical information with a relative, close personal friend or a person you identify if that
person is involved in your care and the information is about your care. If the consumer is a minor, Children’s Home Society of Florida may share medical information about the minor to a parent, guardian or other person responsible for the minor except in some situations.

5. **Required by Law**: To report known or suspected child abuse or neglect to the Department of Children and Families.

6. **National Priority Uses and Sharing**: When permitted by law, Children’s Home Society of Florida may use or share your medical information without your permission for various activities that are recognized as “national priorities” such as:
   - When required by law - Statute, regulation or court order.
   - Threat to health or safety - If Children’s Home Society of Florida believes it is necessary to prevent or lessen a serious threat to your health or safety and/or the health and safety of others.
   - Public health activities - For public health activities such as disease or vital statistics.
   - Abuse, neglect or domestic violence - If Children’s Home Society of Florida believes you or others may be a victim of abuse, neglect or domestic violence.
   - Health oversight activities - A review by a health oversight agency.
   - Court proceedings - A review by a court or an officer of the court (such as an attorney) if a judge orders us to do so.
   - Law enforcement - A review by a law enforcement official for specific law enforcement purposes such as criminal investigations.
   - Coroners and others - A review by a coroner, medical examiner, funeral director or to an organ donor or transplant agency.
   - Workers’ compensation - To comply with workers’ compensation laws.
   - Research organizations - To research organizations after they satisfy conditions about protecting the privacy of medical information.
   - Certain government functions - For certain government functions, including but not limited to military and veterans’ activities, national security and intelligence activities, and correctional institutions in some situations.
Authorization: Other than the uses and sharing listed above, Children's Home Society of Florida will not use or share your medical information without your/your parent/guardian's signed permission. You may later cancel your permission form by writing us a letter canceling your permission. **Certain programs may have more legally required restrictions on disclosure of your medical information.**

**YOU HAVE RIGHTS WHEN IT COMES TO YOUR MEDICAL INFORMATION**

1. You have the right to have a paper copy of your "Notice of Children's Home Society of Florida Privacy Practices" at any time.

2. You have the right to see and have a copy of your medical information that is kept in certain groups of records. To see or receive a copy of your medical information, you must make a written request or fill out the "Client Request to Inspect, Copy or Amend Records" (CHS1019 form A). We will respond to your request within a reasonable amount of time. Requests for older records may take longer to retrieve from storage. Children's Home Society of Florida may deny your request in certain situations but will explain why in writing and let you know if you have the right to have our decision reviewed by another person.

3. You have the right to have us amend your medical information that Children's Home Society of Florida keeps if you believe that Children's Home Society of Florida has information that is not correct or not complete. Children's Home Society of Florida may amend the information to indicate the problem and notify others who have copies of the incorrect information. If you would like us to amend information, you must make a request in writing and explain why you would like us to amend the information. You may either write us a letter or fill out the "Client Request to Inspect, Copy or Amend Records" (CHS1019 form A). Children's Home Society of Florida may deny your request in certain situations. If Children's Home Society of Florida denies your request, Children's Home Society of Florida will explain why in writing. You will have the opportunity to send us a letter explaining why you disagree with our decision, and Children's Home Society of Florida will share your statement whenever Children's Home Society of Florida shares your information in the future.

4. You have the right to have a list of who Children's Home Society of Florida has shared your information with for the previous six years. If you would like to have a list, you may send us a letter requesting a list or fill out the "Client Request to Inspect, Copy or Amend Records" (CHS1019 form A). The list will not include some types of shared information, including sharing for treatment, payment or health care operations. If you request a list more than once every twelve months, Children's Home Society of Florida may charge you a fee to cover the cost of preparing the list.

5. You have the right to request that Children's Home Society of Florida limit the use and sharing of your medical information for treatment, payment and health care operations. Children's Home Society of Florida is not required to agree to your request except as indicated below. If Children's Home Society of Florida does agree to your request, Children's Home Society of Florida must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restriction at any
time in which case Children's Home Society of Florida will notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

6. Children's Home Society of Florida is not required to agree to requests to restrict the use and sharing of your medical information as described above, unless the Disclosure is to a health plan for purposes of Payment or Healthcare Operations and the medical information pertains to a health care item or service for which the provider has been paid in full by either the individual or person, other than the health plan, on behalf of the individual.

7. You have the right to request to be contacted at a different location or by a different method such as your work address instead of home address. If you would like to request a different method of contact, you must make a written request by letter to update your record.

8. You have the right to be notified following a breach of your unsecured protected health information.

9. Most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information require authorization and in addition other uses and disclosures not specifically described in this Notice of Privacy Practices will be made only with your authorization.

Notice of Federal Confidentiality Requirements for Alcohol and Drug Program Participants

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser UNLESS:

(1) The patient consents in writing; or

(2) The disclosure is allowed by a court order; or

(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

(See 421 U.S.C. 290dd-3 and 42 U.S. C. 290ee-3 for Federal laws and 42CFR part 2 for Federal regulations.)
YOU MAY FILE A COMPLAINT ABOUT CHILDREN'S HOME SOCIETY OF FLORIDA PRIVACY PRACTICES

If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy practices, you may file a complaint either with us or with the federal government. Children's Home Society of Florida will not take any action against you or change our treatment of you if you file a complaint.

To file a written or verbal complaint with the Children's Home Society of Florida, you may bring your complaint to a Children's Home Society of Florida office or you may mail it to the following address:

Privacy Officer
1485 S. Semoran Blvd., Ste. 1448
Winter Park, Florida 32792

To file a complaint with the federal government, you may send your complaint to either of the following addresses:

United States Department of Health and Human Services
Attention: Office for Civil Rights
Atlanta Federal Center, Ste. 3B70, 61 Forsyth Street, SW
Atlanta, GA 30303-8909
Telephone: (404) 562-7886
Fax: (404) 562-7881
TDD: (404) 331-2867

United States Department of Health and Human Services
Attention: Office for Civil Rights
200 Independence Avenue, SW Room 509F; HHH Building
Washington, D.C. 20201
Telephone: (202) 619-0257
Toll free: 1-877-696-6775

More information is available about complaints at the government's website, http://www.hhs.gov/hipaa/index.html

For more information on the privacy of minors' information, or to obtain forms or general information, contact our Privacy Officer at 321-397-3000.

CONSUMER GRIEVANCE PROCEDURES

Children's Home Society of Florida wants to work with you to find solutions to challenges when they happen. We seek solutions that both you and the organization find satisfactory. You or your representative are welcome to provide additional input into the process at any time.

You, your family, your guardian and your primary caretaker or legal representative has the right to voice dissatisfaction with the services or decisions made by a Children's Home Society of Florida caseworker. The caseworker will make every effort to resolve your concern. In the event that a solution is not found, you or your representative may file a written grievance. The written grievance should contain the following information:

- Name of the caseworker, if applicable
- Date of the grievance
- Nature of the grievance, dispute or dissatisfaction
- Desired outcome
The written grievance should be given to the caseworker’s supervisor. The supervisor will try to find a solution that is acceptable to you.

If a solution is not found, the supervisor will send the grievance to the division’s Executive Director. If the Executive Director cannot resolve the concern, the grievance will be forwarded to the Chief Program Officer.

The decision of the Chief Program Officer is final and shall be given to you or your representative in writing.

If the services you receive are being paid by a government contract, the funder will be notified of the filing of a grievance. The funder will also be notified of the outcome.

The Board of Directors of Children’s Home Society of Florida will be informed when issues that arise from the grievance may affect organization policy and/or community relations.

This procedure does not prevent Children’s Home Society of Florida from taking any necessary action to protect an individual from physical or mental harm, neglect or abuse.

**HOW TO PLAN AND RECEIVE SERVICES**

**Access to Services (Americans with Disabilities Act):**

You are eligible for services based on your needs. You **may** receive services from the organization based on availability.

Children’s Home Society of Florida recognizes that some consumers may have particular communication needs. We will make available auxiliary aids, sign language interpreter, and foreign language interpreters at no charge to you or your companions in order to meet these needs. To request such assistance, please contact your Children’s Home Society of Florida caseworker/counselor at least 48 hours prior to the date the assistance is needed.

Children’s Home Society of Florida will seek staff to match your needs. If you stop receiving services and later return, we will try to assign the same staff to your case.

You may bring allegations of an Americans with Disabilities Act violation to one of the Children’s Home Society of Florida coordinators or state or federal agencies listed in the attachment to this handbook for prompt investigation.

**Services/Treatment Plan:**

Children’s Home Society of Florida will go over any changes in your service/treatment plan with you and/or your parent or guardian. If you or your parent/guardian are not able to participate in service/treatment planning, you will be told in advance about the benefits, risks and alternatives to planned services or treatment to be administered by Children’s Home Society of Florida.

**Right to Refuse Medication:**

If your treatment includes the use of medication, you have the right to say no to the medication. Staff will inform you what will happen if you do not take the medication. You may be able to
continue to receive services. However, services are not guaranteed if you are not following your doctor's orders.

Signed Written Agreement for Voluntary Out-of-Home Placement:

You and/or your parent or guardian and Children's Home Society of Florida will establish an agreement for voluntary out-of-home care and other voluntary services that are requested. This does not include in-patient hospitalization and/or court ordered placement.

Access to Information:

You have the right to review the information collected during your service/treatment time with Children's Home Society of Florida and can do so by making a written request to Children's Home Society of Florida staff.

ACKNOWLEDGEMENT OF RECEIPT

You will be asked to sign a form which will be filed in your record and contains the following statement: “I have received the Children’s Home Society of Florida Consumer Handbook. I was given time to ask questions and I understand the answers that were given to me.”
Children’s Home Society of Florida  
Consumer Handbook Attachment--Contact Information

Allegations of an ADA violation should be taken to one of the following Children’s Home Society of Florida coordinators for prompt investigation:

Executive Director, Brevard Division  
328 Croton Rd  
Melbourne, FL 32935  
Ph: 321-752-3170, Fax: 321-752-3179

Executive Director, Buckner Division  
3027 San Diego Road  
P.O. Box 5616  
Jacksonville, FL 32207  
Ph: 904-493-7744, Fax: 904-348-2818

Executive Director, Central Florida Division  
1485 South Semoran Blvd., Suite 1402  
Winter Park, FL 32792  
Ph: 321-397-3000, Fax: 321-397-0398

Executive Director, Emerald Coast Division  
914 Harrison Avenue  
Panama City, FL 32401  
Ph: 850-747-5411, Fax: 850-747-5662

Executive Director, Greater Lakeland Division  
1010 E. Rose Street  
Lakeland, FL 33801  
Ph: (863) 413-3126, Fax: (863) 413-3146

Executive Director, Gulf Coast Division  
1515 Michelin Court  
Lutz, FL 33549  
Ph: (813) 949-8946, Fax: (813) 948-15

Executive Director, Intercoastal Division  
401 N.E. 4th Street  
Ft. Lauderdale, FL 33301  
Ph: (954) 453-6402, Fax: (954) 764-6458

Executive Director, Mid-Florida Division  
711 NW First St  
Gainesville, FL 32601  
Ph: 352-334-0955, Fax: 352-334-0957

Executive Director, North Central Division  
1801 Miccosukee Commons Drive  
Tallahassee, FL 32308  
Ph: 850-921-0772, Fax: 850-921-0726

Executive Director, North Coastal Division  
2400 S. Ridgewood Avenue, Suite 32  
South Daytona, FL 32119  
Ph: 386-304-7600, Fax: 386-304-7620

Executive Director, Palm Beach Division  
3333 Forest Hill Blvd.  
West Palm Beach, FL 33406  
Ph: 561-868-4300, Fax: 561-868-4499

Executive Director, Southeastern Division  
800 NW 15th Street  
Miami, FL 33136  
Ph: 305-755-6500, Fax: 305-326-7561

Executive Director, Southwest Division  
1940 Maravilla Ave.  
Ft. Myers, FL 33901  
Ph: 239-334-0222, Fax: 239-334-0244

Executive Director, Treasure Coast Division  
650 10th Street  
Vero Beach, FL 32960  
Ph: 772-344-4020, Fax: 772-344-4038

Executive Director, Western Division  
1300 N. Palafox Street, Suite 103  
Pensacola, FL 32501  
Ph: 850-266-2700, Fax: 850-595-0181
To file a complaint with the Department of Children and Families, you may send your complaint to the following address:

Secretary Florida Dept. of Children and Families
1317 Winewood Boulevard
Building 1, Room 202
Tallahassee, FL 32399-0700
Telephone number: 850-487-1111
Fax number: 850-922-2993
Website: http://www.myfamilies.com/

Contact Information by Region

Central Region (Brevard, Citrus, Hardee, Hernando, Highlands, Lake, Marion, Orange, Osceola, Polk, Seminole, Sumter)
Regional Director
400 W. Robinson St. Suite 1129
Orlando, Florida 32801
(407) 317-7000

Regional Managing Director
5920 Arlington Expressway
Jacksonville, Florida 32211
(904) 723-2000

Northwest Region (Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Okaloosa, Santa Rosa, Wakulla, Walton, Washington)
Regional Managing Director
2383 Phillips Road
Tallahassee, Florida 32301
(850) 778-4061

Southeast Region (Broward, Indian River, Martin, Okeechobee, Palm Beach, St. Lucie)
Regional Managing Director
111 S. Sapodilla Avenue
West Palm Beach, Florida 33401
(561) 837-5078

Southern Region (Dade, Monroe)
Managing Director
401 NW 2nd Avenue N1007
Miami, Florida 33128
(305) 377-5055

SunCoast Region (Charlotte, Collier, Desoto, Glades, Hendry, Hillsborough, Lee, Manatee, Pasco, Pinellas, Sarasota)
Regional Director
9393 North Florida Avenue
Tampa, Florida 33612
(813) 558-5500
To file a complaint with the Department of Juvenile Justice, you may send your complaint to the following address:

Secretary, Florida Dept. of Juvenile Justice
Knight Building
2737 Centerview Drive
Tallahassee, Florida 32399-3100
Telephone number: 850-488-1850
Fax number: 850-922-2992

To file a complaint with the Florida Office of Civil Rights, you may send your complaint to the following address:

Office of Attorney General
The Capital PL-01
Tallahassee, FL 32399-1050
Telephone number: 850-414-3990
Fax number: 850-410-1630
Website:
http://www.myfloridalegal.com/pages.nsf/Main/E3EB45228E9229DD85257B05006E32EC

To file a complaint with the United States Department of Health and Human Services, Office of Civil Rights, you may send your complaint to the following address:

Timothy Noonan, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7557
Email: ocrmail@hhs.gov
or visit their website: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

To file an Americans with Disabilities Act complaint with the U.S. Department of Justice, you may send your complaint to the following address:

US Department of Justice
950 Pennsylvania Avenue, NW
Civil Rights Division
Disability Rights Section – 1425 NYAV
Washington, D.C. 20530
Fax number: (202) 307-1197
email: ADA_compliant@usdoj.gov
Electronic Complaint Form: https://www.ada.gov/complaint/

Additional Contacts:

Florida Abuse Hotline: 1-800-962-2873

Disability Rights Florida: 1-800-342-0823