Fairfield County Perinatal Cluster
Consent for Release of Information

Client Name:_____Date of Birth:_____Phone:_____

Client Address:_____City_____State_____Zip_____

Client Email Address: _____

I authorize the following agencies and/or organizations the right to exchange information regarding case history, psychological and education assessments, treatment, and progress updates in order to develop comprehensive service coordination goals that meet the needs of this client and/or family. Information released under this authorization may be subject to re-disclosure by the recipient of the information.

The agencies/organizations listed below have my permission to exchange/share information while assisting me with services through the Perinatal Services Council. If there are exclusions, please indicate.

Fairfield County ADAMH Board

Fairfield County Board of Developmental Disabilities

Fairfield County Department of Health

Fairfield County Department of Job and Family Services (specify if there are exclusions)
- Child Protective Services
- Child Support Enforcement
- Community Services

Lancaster-Fairfield Community Action Agency
- Early Childhood Programs
- Housing Assistance and Supports for Youth
- Social Services

Fairfield County Family and Children First Council

Fairfield County Help Me Grow

Fairfield Medical Center

New Horizons Mental Health Services

Pickerington Area Counseling Office

The Recovery Center

Ohio Guidestone

School (specify)_____

Other Hospital (specify)_____

Other Agency/Organization
(specify) PDHC (Pregnancy Decisions Health Care)_____

Integrated Services Behavioral Health

Mid-Ohio Psychological Services

I understand that I may revoke my consent to release information at any time. This consent form is valid for one year from the date the release is signed or as otherwise stated.

_____/_____
(Client Signature) (Date)

Sign below only if you wish to revoke your consent.
Revocation of consent: I hereby revoke the above consent for release of information.
Upon revocations of consent, further release of specified information shall cease immediately.

_____/_____
(Client Signature) (Date)

7/9/2024

Fairfield County Family & Children First Council
Perinatal Cluster Enrollment Packet

Client Name _____ Referral Date _____

Email _____ Date of Birth _____

Address _____

City _____ Zip Code _____

Phone _____ Texting Permitted? ☐ **Yes** ☐ **No**

Race _____ Gender _____ Primary Language _____

Referring Person/Agency _____

Possible Services Requested _____

Family

- Mother's Partner _____ Male ☐ Female ☐

  Address (☐same) _____ Phone _____

  May information be shared with them? ☐ **Yes** ☐ **No**

- **Is there another adult living in the home?** (i.e. friend/relative) ☐ **Yes** ☐ **No**

  Name _____ Relationship _____ Phone _____

  Name _____ Relationship _____ Phone _____

  May information be shared with them? ☐ **Yes** ☐ **No**

- **Child/Children (Please list all children)**

  Son/Daughter Name _____ Age _____ Date of Birth _____
  Currently resides with _____
  Father of child _____

  Son/Daughter Name _____ Age _____ Date of Birth _____
  Currently resides with _____
  Father of child _____

  Son/Daughter Name _____ Age _____ Date of Birth _____
  Currently resides with _____
  Father of child _____

  Son/Daughter Name _____ Age _____ Date of Birth _____
  Currently resides with _____
  Father of child _____

Is client and family in a stable living environment? ☐ **Yes** ☐ **No**

If "**no**", please explain your housing situation.

_____

Agency Involvement (check all that apply)

_____Child Protective Services: *Caseworker* _____

_____Job & Family Services: *Services* _____

_____Court Program: Probation Officer _____

_____Mental Health Providers: *Agency/Clinician* _____

Agency/Clinician _____

Agency/Clinician _____

_____WIC: In what county? _____

_____Early Childhood Programs (pre-school or home visiting) _____

Home Visitor's Name _____

_____Community Action: *Services* _____

_____Other: Agency _____

Mother's Health

Is Mother currently pregnant? ☐ **Yes** *Due Date* ____/____/____ ☐ **No**

Is Mother currently receiving OB/GYN Care? ☐ **Yes** ☐ **No** Physician _____

What is the name of your planned birthing facility? _____

Is mother currently using any substances legal or illegal? ☐ **Yes** ☐ **No**

Do you have a Plan of Safe Care (PoSC)? ☐ **Yes** ☐ **No**

If "**yes**" what substance(s)? _____

Current Medications _____

Diagnoses _____

Insurance Information

_____Medicaid ☐ UHC ☐ Aetna ☐ CareSource ☐ Molina ☐ Buckeye Healthcare ☐ Anthem BC/BS

_____Private Insurance Provider _____

Financial Information

Annual gross income from Mother _____ Employer _____

Annual gross income from Father _____Employer _____

Do you receive SNAP (Supplemental Nutrition Assistance Program)? ☐ **Yes** ☐ **No** Amount per month?_____

Other income (i.e. child support, retirement, social security etc.) _____

_____

Please write a summary of the client's needs and services requested from Fairfield County Perinatal Services Cluster.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Mother's Objectives/Goals **(please complete one but not more than three)**

1)_____

Outcome: _____ Completed Date _____

2)_____

Outcome: _____ Completed Date _____

3)_____

Outcome: _____ Completed Date _____

All referrals should be sent to:

Laurie Clark, Perinatal Cluster Coordinator
Fairfield County Family and Children First Council
831 College Ave., Suite C Lancaster Ohio 43130
740-652-7285 (Phone) 740-681-5540 (Fax)
laurie.clark@fairfieldcountyohio.gov

Referrals will be presented and reviewed at the monthly Fairfield County Perinatal Services Cluster meetings.