COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

AUTHORIZATION FOR RELEASE OF INFORMATION

CASE IDENTIFICATION	
COUNTY	PELICAN RECORD NUMBER

NAME

ADDRESS ZIP CODE

I hereby authorize and request the disclosure to the Early Learning Resource Center (ELRC) to contact reliable sources for knowledge of Information pertinent to verification of: identity; residence; employment; education and training activities; family size and composition; care and control of child(ren) residing with a grandparent, aunt or uncle; income; and any additional information pertinent to eligibility for the Subsidized Child Care Program for myself and/or those individuals on whose behalf subsidy benefits are paid. I understand that the information obtained will be used only for purposes directly related to the determination of eligibility for the Subsidized Child Care Program.

PARENT/CARETAKER SIGNATURE DATE

PARENT/CARETAKER SIGNATURE DATE

ELRC REPRESENTATIVE SIGNATURE DATE

PLEASE SEE REVERSE SIDE FOR ADDITIONAL INSTRUCTIONS TO THE ELRC AGENCY ONLY

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

AUTHORIZATION FOR RELEASE OF INFORMATION

PARENT NAME

DO NOT COPY THIS SECTION - FOR ELRC OFFICE USE ONLY

In the event I cannot be reached, I give the ELRC permission to contact the person(s) identified below:

The ELRC has permission to contact or speak to the following people on my behalf.

Name:	Telephone Number:	Relationship:

PARENT/CARETAKER SIGNATURE

DATE

NOTICE OF PRIVACY PRACTICES

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

This notice contains important information about the privacy of your medical information. If you need this notice in another language or someone to interpret, please contact your local County Assistance Office. Language assistance will be provided free of charge.

The Department of Public Welfare (DPW) provides and pays for many types of health and social services. We also determine persons' eligibility to receive those services. When we do these things, we collect personal and health information about you and/or your family. The information we collect about you and/or your family is private. We call this information "protected health information." DPW does not use or disclose protected health information unless permitted or required by law. DPW must follow new laws protecting the privacy of your protected health information. These new laws are known as the Health Insurance Portability and Accountability Act (HIPAA) privacy rules. When we do use or disclose protected health information, we will make every reasonable effort to limit its use or disclosure to the minimum necessary to accomplish the intended purpose. This notice explains your right to privacy of your protected health information and how we may use and disclose that information. For more information on DPW privacy practices, or to receive another copy of this notice, please contact us. For information on how to contact us, see the "Questions or Complaints" section on page four of this notice. We are required by law to follow the terms of this notice. We reserve the right to change this notice. If we make an important change in our privacy policies or procedures, we will provide you with a new privacy notice either by mail or in person.

What Is Protected Health Information?

Protected health information is information about you that relates to a past, present or future physical or mental health condition, or treatment or payment for the treatment, that can be used to identify you. This information includes any information, whether verbal or recorded in any form, that is created or received by DPW or persons or organizations that contract with DPW. This includes electronic information and information in any other form or medium that could identify you, for example: Your Name (or names of your children), Telephone Number, Address, DPW Case Number, Date of Birth, Social Security Number, Admission/Discharge Date , Medical Procedure Code, Diagnostic Code

Who Sees and Shares My Health Information?

DPW professionals (such as caseworkers and other county assistance office and program staff) and people outside of DPW (such as employment and training contractors, health maintenance organization (HMO) staff, nurses, doctors, therapists, social workers and administrators) may see and use your health information to determine your eligibility for benefits, direct treatment or for other permitted reasons. Sharing your health information may relate to services and benefits you had before, receive now, or may receive later.

Why is My Protected Health Information used and Disclosed by DPW?

There are different reasons why we may use or disclose your protected health information. The law says that we may use or disclose information without your consent or authorization for the reasons described below.

For Treatment: We may use or disclose information so that you can receive medical treatment or services. For example, we may disclose information your doctor, hospital or therapist needs to know to give you quality care and to coordinate your treatment with others helping with your care. For Payment: We may use or disclose information to pay for your treatment and other services. For example, we may exchange information about you with your doctor, hospital, nursing home, or another government agency to pay the bills for your treatment and services. For Operating Our Programs: We may use or disclose information in the course of our ordinary business as we manage our various programs. For example, we may use your health information to contact you to provide information about appointments, health-related information and benefits and services. We may also review information we receive from your doctor, hospital, nursing home and other health care providers to review how our programs are working or to review the need for and quality of health care services provided to you and/or your family. For Public Health Activities: We report public health information to other government agencies concerning such things as contagious diseases, immunization information, and the tracking of some diseases such as cancer. For Law Enforcement Purposes and As Required by Legal Proceedings: We will disclose information to the police or other law enforcement authorities as required by court order. For Government Programs: We may disclose information to a provider, government agency or other organization that needs to know if you are enrolled in one of our programs or receiving benefits under other programs such as the Workers' Compensation Program. For National Security: We may disclose information requested by the federal government when they are investigating something important to protect our country. For Public Health and Safety: We may disclose information to prevent serious threats to health or safety of a person or the public. For Research: We may disclose information for permitted research purposes and to develop reports. These reports do not identify specific people. For Coroners, Funeral Directors and Organ Donation: We may disclose information to a coroner or medical examiner for identification purposes, cause of death determinations, organ donation and related reasons. We may also disclose information to funeral directors to carry out funeral-related duties. For Reasons Otherwise Required By Law: DPW may use or disclose your protected health information to the extent that the use or disclosure is otherwise required by law. The use or disclosure is made in compliance with the law and is limited to the requirements of the law.

Do Other Laws Also Protect Certain Health Information About Me?

DPW also follows other federal and state laws that provide additional privacy protections for the use and disclosure of information about you. For example, if we have HIV or substance abuse information, we may not release it without special, signed written permission that complies with the law. In some situations, the law also requires us to obtain written permission before we use or release medical or mental health/mental retardation and certain other information.

Can I Ask DPW to Use or Disclose My Health Information?
Sometimes, you may need or want to have your protected health information sent to someone or somewhere outside of DPW for reasons other than treatment, payment or operating our programs. If so, you may be asked to sign an authorization form, allowing us to send your health care information somewhere other than for treatment or payment purposes, or for operating our programs. The authorization form tells us what, where and to whom the information will be sent. You may cancel or limit the amount of information sent at any time by letting us know in writing. If you are younger than 18 years old and, by law, you are able to consent for your own health care, then you will have control of that health information. You may ask to have your health information sent to any person who is helping you with your health care. What Are My Rights Regarding My Health Information? As a DPW client, you have the following rights regarding your protected health information that we use and disclose: Right to See and Copy Your Health Information: You have the right to see most of your protected health information and to receive a copy of it. If you want copies of information you have a right to see, you may be charged a small fee. However, you may not see or receive a copy of: (1) psychotherapy notes; or (2) information that may not be released to you under federal law. If we deny your request for protected health information, we will provide you a written explanation for the denial and your rights regarding the denial. DPW does not receive or keep a file of all of your protected health information. Doctors, hospitals, nursing homes and other health care providers (including an HMO, if you are enrolled in one) may also have your protected health information. You also have a right to your health information through your doctor or other provider who has these records. Right to Correct or Add Information: If you think some of the protected health information we have is wrong, you may ask us in writing to correct or add new information. You may ask us to send the corrected or new information to others who have received your health information from us. In certain cases, we may deny your request to correct or add information. If we deny your request, we will provide you a written explanation of why we denied your request. We will also explain what you can do if you disagree with our decision. Right to Receive a List of Disclosures: You have the right to receive a list of where your protected health information has been sent, unless it was sent for purposes relating to treatment, payment, operating our programs, or if the law says we are not required to add the disclosure to the list.
For example, the law does not require us to add to the list any disclosures we may have made to you, to family or persons involved in your care, to others you have authorized us to disclose to, or for information disclosed before April 14, 2003.
Right to Request Restrictions on Use and Disclosure: You have the right to ask us to restrict the use and disclosure of your protected health information. We may not be able to agree to your request. In fact, in some situations, we are not permitted to restrict the use or disclosure of the information. If we cannot comply with your request, we will tell you why. Except as otherwise required by law, we must grant your request to restrict disclosure to a health plan if the purpose of disclosure is not for treatment and the medical services to which the request applies have been paid out-of-pocket in full.
Right to Request Confidential Communication: You may ask us to communicate with you in a certain way or at a certain location. For example, you may ask us to contact you only by mail.

You can contact the DPW HIPAA helpline, toll-free at 800-692-7462 to discuss your rights or to ask questions about this notice. You can also contact your caseworker or health care provider or write to DPW's Privacy Officer, 3rd Floor West, Health and Welfare Building, 7th and Forster Streets, Harrisburg, PA 17120. You can receive important information or updates to this notice by visiting DPW's Web site at www.dpw.state.pa.us. You may contact either office listed below if you want to file a complaint about how DPW has used or disclosed information about you. There is no penalty for filing a complaint. Your benefits will not be affected or changed if you file a complaint. DPW and its employees and contractors cannot and will not retaliate against you for filing a complaint.

PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE
DEPARTMENT OF PUBLIC WELFARE PRIVACY OFFICER
3RD FLOOR WEST, HEALTH AND WELFARE BUILDING
7TH AND FORSTER STREETS
HARRISBURG, PA 17120

REGION III
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS
150 S. INDEPENDENCE MALL
WEST-SUITE 372
PHILADELPHIA, PA 19106-9111

I _____ certify that I have received and read the Notice of Privacy Practices provided to me by the Early Learning Resource Center.

Parent Signature: _____ Date: _____/_____/_____

ELRC Staff Signature: _____ Date:_____/_____/_____

Parent/Caretaker Name:	ELRC Record #:

9 Rights and Responsibilities: You have the right to be treated fairly and with respect.

Your rights and responsibilities will be reviewed and discussed with you in detail by a person from the ELRC.

I understand that:

- The information in this form will be kept confidential.
- I may pick any **eligible** child care provider for my children. An eligible provider meets the requirements of the Subsidized Child Care Program and agrees to follow the Department of Human Services rules.
- I may need to pick another provider if my provider is not eligible to participate in the Subsidized Child Care Program.
- I will be told in writing when a change causes my family to lose help in paying for child care and that I may ask for hearing if I disagree with a decision that the ELRC has made.
- I must give the ELRC true and complete information and proof of information as requested.
- I must contact the ELRC **within ten days** following the date:
  - My family's gross monthly income exceeds income limits based on the flyer the ELRC provided me for reference;
  - The child no longer has a need for care or is no longer residing in the household.
  - A parent or caretaker in my family becomes an owner or director of a child care facility;
  - My family's assets are over $1 million; or
  - I adopt my foster child.
- It is important that I contact the ELRC **immediately** if there is a change to:
  - My address;
  - My telephone number;
  - Who is providing child care for my child(ren); or
  - The number of days and hours my child needs care.

After the ELRC has determined you eligible for child care and funds are available to enroll your child(ren) in care, you need to know the following:

1. **You must pay a copayment to your provider every week.** The copayment is due to the provider on the first day of the week that your child(ren) attend(s). It is important that you pay your copayment on time. If you do not pay your copayment on time, you may lose the ELRC's help in paying for your child care.

2. Unless your child is ill, your child must attend the child care program on all the days that you told the ELRC he/she needed child care. If you need to make a change due to your work, education or training schedule, you must call the ELRC. You must report to the ELRC if your child will be absent for more than five days in a row. You could lose the ELRC's help in paying for your child care costs if your child has excessive, unexplained absences.

3. If your child is absent for more than 40 enrollment days between July 1 and June 30, you will be responsible to pay the provider the daily rate for each day of absence beginning with the 41st absence. **You must pay the provider's daily rate in addition to your weekly copayment.** For example, if your copayment is $20/week and the daily rate is $20, you must pay $40 for the week that includes your child's 41st day of absence.

4. The ELRC will pay a child care center, family child care home or a group child care home **for up to 15 days when the facility is not open to care for your child.** The ELRC is unable to pay an alternate child care provider during these 15 days when your provider is not open to care for your child.

5. If the ELRC sends you a Notice of Adverse Action, it means there may be a change in your eligibility for subsidized child care. **If you do not understand what is written in the notice, you should contact the ELRC immediately.** If you disagree with a decision that the ELRC has made, you may ask for a hearing to review the decision. You must inform the ELRC that you do not agree with the decision by doing one of the following: (1) Fill out the bottom part of your notice or write a letter and then mail, fax or take the information to the ELRC; and (2) Call the ELRC to discuss the reason you do not agree with the decision and follow-up by putting your concerns in writing within seven days following the date of your telephone call with the ELRC. If you want the ELRC to continue to help pay for your child care during this process, you must mail, fax or take the bottom part of your notice or the letter that you wrote to the ELRC or call the ELRC on or before the date on the Notice of Adverse Action.

6. You may choose a new provider at any time. However, you must tell the ELRC and the ELRC must issue a new authorization before your child can begin child care with the new provider. The ELRC will authorize the transfer and continue to help pay for your child care after the transfer if: your family copayments are up-to-date **AND** you continue to be eligible for the ELRC's help in paying for your child care **AND** the new provider that you choose meets the requirements of the Subsidized Child Care Program. The new provider must also agree to follow the Department of Human Services rules. **If the ELRC does not authorize the transfer, you will be responsible for paying the total cost of child care at the new provider.**

Date discussed with parent/caretaker: _____ **Initials of worker:** _____

My signature below confirms that my Rights and Responsibilities were explained to me and that I have received a copy for my records:

Parent/Caretaker Signature: _____ **Date:** _____

CURRENT PROVIDER INFORMATION

Parent Name: _____ Date of Birth____/____/____

Current Phone: _____-_____

Please fill out the information below to identify the provider(s) that is caring for your children.

Provider #1

Provider's Name: _____

Provider's Address: _____

_____

Provider's Telephone Number: _____
(Area Code) Phone Number

Child's Name	Days M T W H F Sa Su	Time	1st Day Attended	Relation to Child
	☐ ☐ ☐ ☐ ☐ ☐ ☐			
	☐ ☐ ☐ ☐ ☐ ☐ ☐			
	☐ ☐ ☐ ☐ ☐ ☐ ☐			
	☐ ☐ ☐ ☐ ☐ ☐ ☐			

Provider #2

Provider's Name: _____

Provider's Address: _____

_____

Provider's Telephone Number: _____
(Area Code) Phone Number

Child's Name	Days M T W H F Sa Su	Time	1st Day Attended	Relation to Child
	☐ ☐ ☐ ☐ ☐ ☐ ☐			
	☐ ☐ ☐ ☐ ☐ ☐ ☐			
	☐ ☐ ☐ ☐ ☐ ☐ ☐			
	☐ ☐ ☐ ☐ ☐ ☐ ☐			

Provider Selection Information for Regulated Providers and Relative Provider Process

You can search https://find.alleghenychildcare.org/families to locate eligible providers in your area based on your requirements.

* Please note: Your child must be enrolled with an eligible provider within 30 days from the date ELRC tells you Funds Are Available for your family.

RELATIVE Provider Information

1. Must be your child's grandparent, great grandparent, aunt, uncle, or sibling (must be 18 years of age or older).

2. Must sign an Attestation form with you as verification of their relationship to your child. This legally binding statement holds you and the relative provider liable; it explains the requirement to repay the full cost of subsidized childcare received for which you and/or the relative provider was not eligible.

3. Must have a working phone and proof of residence. (May not live with you)

4. Must give the ELRC written notice no later than 72 hours after the provider's or anyone in the household's arrest, conviction, or notification of being listed as a perpetrator of child abuse in the Statewide Central Register.

5. Must have FBI fingerprinting completed. To pre-register, the provider needs to go online at

   https://www.identogo.com/locations to find a location (fee is charged & subject to change).

   Call *1-844-321-2101* to pre-register for fingerprinting CODE 1KG74S

6. Must complete Mandated Reporter training by logging on to www.ReportAbusePa.Pitt.edu.

7. Must pass criminal and child abuse background checks (Acts 33 & 34 Clearances). A $35 fee will be deducted from their first subsidy payment.

8. Must complete National Sex Offender Registry Verification. To complete NSOR, the provider may access the KeepKidsSafe website at http://keepkidssafe.pa.gov/resources/clearances/index.htm to print the application.

9. Must complete an orientation and sign an ELRC agreement.

Main Phone: 412.350.3577 Fax: 412.350.3575 Email: elrc5@alleghenycounty.us

County Record #_____

Appendix D

PARENT/CARETAKER AND RELATED PROVIDER ATTESTATION OF RELATIONSHIP TO CHILD

Parent's First Name:_____ **Last Name**:_____

Telephone Number:_____ **County Where You Live:**_____

The information contained in this form is a true statement of the relationship between my child(ren) and the provider.

List your child's name	Relationship to provider

ATTESTATION BY PARENT

I hereby swear/affirm that (**Provider Name):**_____ is related to my child(ren) as indicated below. This information is true, correct and complete to the best of my ability, knowledge and belief. I understand that information may be shared with other Department of Human Services programs and the Office of the Inspector General. Further, I understand that the penalty for false swearing (affirming false information to mislead a public servant) is a misdemeanor of the third degree pursuant to Section 4903(b) of the Criminal Code and that I can be penalized by fine, imprisonment, subsidized child care ineligibility, or a combination of these three for making any false statements. I understand that if I receive subsidized child care for which I was not eligible, I will be required to pay back the child care funds paid on my behalf during the period of time when I was ineligible.

Relationship to the child (including by marriage, court decree or blood relationship):

- ☐ Grandmother
- ☐ Grandfather
- ☐ Great Grandmother
- ☐ Great Grandfather
- ☐ Aunt
- ☐ Uncle
- ☐ Sibling 18 years of age or older and not living in the child's home

Print Parent's Name | Parent's Signature | Date

ATTESTATION BY RELATED PROVIDER

I hereby swear/affirm that I am related to (**Child(ren)'s Names**): _____ as indicated above. This information is true, correct and complete to the best of my ability, knowledge and belief. I understand that information may be shared with other Department of Human Services programs and the Office of the Inspector General. Further, I understand that the penalty for false swearing (affirming false information to mislead a public servant) is a misdemeanor of the third degree pursuant to Section 4903(b) of the Criminal Code and that I can be penalized by fine, imprisonment, or a combination of these for making any false statements. I understand that if I receive subsidized child care payments for which I was not eligible, I will be required to pay back the child care funds I received during the period of time when I was ineligible to be a child care provider for the subsidized child care program. If I am I not related to the child(ren) in one of the manners indicated above, I understand that I must be licensed in order to care for this child or other unrelated children in order to receive subsidized child care funds.

Print Provider's Name | Provider's Signature | Date

ELRC Region 5
Personal Interview Checklist

Name (Print): **Phone Number:**

Address: **Zip Code:**

- ☐ Application Processed
- ☐ Application Reviewed (Client signs and dates, FS signs and dates)
- ☐ I have read and signed the Parent Rights and Responsibilities
  - *Report any changes within 10 days to the Family Specialist
  - *Report if your child begins a Head Start/Pre-K Counts/Kindergarten Program or if you begin receiving Cash Assistance from the County Assistance Office.
  - *Report all income including wages, child support, alimony, SSI, etc. to the ELRC
- ☐ Authorization for Release of Information completed and signed
- ☐ Photo ID copied and signature verified by ELRC employee
- ☐ Identified my provider and completed the Provider Information Sheet
  - *Parent must provide current and accurate provider information
  - *The ELRC will contact my provider
  - *I understand a provider change must be reported/identified before the change occurs
- ☐ I understand I am responsible for paying provider additional charges
  - *Meals, transportation, difference between private rate and DPW reimbursement rate
- ☐ Stay in compliance with all regulations and complete Annual Redeterminations
  - *Working an average of 20 hours per week (or 10 hours of work and 10 hours of training)
  - *Include spouse (or live-in companion of parent of child needing care)
- ☐ Subsidy available to a child from birth until the redetermination after the child's 13th birthday (exception: documented developmental/physical/behavioral disability)
- ☐ HIPPA reviewed and signed
- ☐ I understand I have the right to appeal and the appeal procedures
- ☐ I understand that I cannot live in the same household as my child care provider
- ☐ I understand that my child care provider must be 18 years of age or older
- ☐ I understand I am required to pay my copay on the first day of the service week.

Parent/Caretaker Statement

I acknowledge that the Parent's Handbook and Rights and Responsibilities were explained to me and that I have received a copy. I understand that I may jeopardize my subsidized child care if I fail to report changes to the ELRC. I understand that information submitted to determine my status for subsidized child care funding may be shared with the Department of Public Welfare, the Domestic Relations Section of the Courts, and the Office of the Inspector General. I understand I can be penalized by fine or imprisonment, monetary restitution, and/or subsidized child care ineligibility by making false statements. I understand that if I received child care for which I was not eligible, regardless of the circumstances, I will be required to pay back the cost of the child care I received in error.

_____ _____

Parent/Caretaker Signature *Date*

_____ _____

Parent/Caretaker Signature *Date*

_____ _____

Family Specialist Signature *Date*