

OUR MOTHER'S HOUSE
P.O. Box 2240
Venice, FL 34285
(941)485-6264 FAX (941)488-2289

Please Read Carefully:

Check all that apply:

- I am under the age of 18
- I have more than two children in my custody
- My child(ren) is over the age of three (four years old and older)

If you checked any of the above items, you are not eligible for residency at Our Mother's House. If you have any questions about eligibility, please call the office: (941) 485-6264

Application Packet Checklist:

- Complete Program Application (5 pages) and return to Our Mother's House
- Sign** "Authorization to Obtain and/or Release Information", providing Outside Community Agency Information such as Department of Children and Families, Coastal Behavioral, Healthy Start, Healthy Families, etc. Return signed form to Our Mother's House
- Sign** "Client Rights and Responsibilities/Consent for Services" form (top portion pertaining to Clients of Catholic Charities) and return to Our Mother's House
- Read** "Catholic Charities, Diocese of Venice, Inc. Notice of Privacy Practices" and keep the notice for your records.
- Sign** "Notice of Privacy Practices" form and return to Our Mother's House

Mail completed Application and signed release forms to:

Our Mother's House
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Dear Applicant:

Thank you for your interest in Our Mother's House. We are pleased to begin the application process to determine if our program is suitable to your needs. This program challenges participants to continue learning as a parent, academically, and on a personal level as you take part in on-site programming, schooling in the community and employment.

We are including the program brochure and application forms. Please review this information and thoroughly complete all of the forms. You need to review and **keep** the **Notice of Privacy Practices** and return to us all other documents that you have completed and/or signed.

After you have returned the application to us, the Case Managers and the Program Director will review your information to determine if we meet your needs. If determination is made that you will benefit from our program, you will be contacted for an interview. If there are no vacancies at the time of your acceptance to the program your name will be placed on a waiting list depending on availability of apartments.

Please contact our office at (941) 485-6264 with any questions you might have concerning this packet. We are here Monday-Friday between 9-5 p.m.

We look forward to hearing from you.

Sincerely,

Our Mother's House

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Our Mother's House Program Application

Our Mother's House is a program of Catholic Charities, Diocese of Venice. Applications are considered without regard to race or religion. Applicants may be admitted as residents dependent upon:

- Available space
- Appropriateness of service to meet the applicant's needs

Acceptance is based upon a demonstrated commitment to self-development and the ability to participate in the program.

Admission Criteria:

- Single mother age 18 or over
- No more than two children under three years of age
- Required attendance at program sponsored Life Skills Training classes
- Expressed intention for further schooling and/or employment
- Drug and Alcohol free (all residents shall agree to periodic & random drug testing)
- Non-threatening relationship (If an applicant has been in an abusive relationship, OMH needs to know the details in order to protect the personal safety of residents)

Our Mother's House provides shelter and case management for single mothers and their child(ren). Residents have their own apartments and have access to on-site laundry facilities. A case management team is on duty during the day to provide guidance and assistance to mothers who have chosen to accept the responsibility of raising their children on their own. Volunteers assist with childcare while the mothers are in school or working.

Mothers work toward self-sufficiency during residency by:

- **Attending Life Skills Classes including but not limited to parenting, self-esteem, nutrition and budgeting**
- **Participating in individual and group counseling**
- **Enrolling and attending school/job training for a specific goal and/or seeking and maintaining full/part-time employment**
- **Abiding by House Rules and Regulations**
- **Attending House Meetings**
- **Accepting communal responsibilities of everyday living i.e. picking up and cleaning of common areas**
- **Paying their individual rent and utilities**

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PROGRAM APPLICATION

Complete the forms and return to the address above.

Incomplete applications will not be considered.

The following documents are required and must be submitted with your application, if applicable.

1. Your medical history
2. Your child's medical history
3. Copies of any psychological/mental health evaluations you have had
4. An authorized copy of your most recent school records and certificates, if applicable
5. Legal documents regarding custody status, if applicable
6. Your child's birth certificate
7. Your marriage/divorce certificate(s), if applicable

Name: _____ Phone: _____
Last First M.I. Maiden

Address: _____
Number Street City State Zip County

SS#: _____ DOB: _____ Are you a U.S. Citizen?: YES / NO

Driver's License #: _____ Vehicle Year Make & License: _____

Child's Name: _____ Age: _____ DOB: _____ SS#: _____

Do you have other children not residing with you? _____

Pediatrician: _____
Name Address Phone

List any prescription medications your child is taking: _____

Your Physician: _____
Name Address Phone

Medications you are taking: _____ Due date: _____
If applicable

Child's Father: _____
Name SS# DOB

His Current Address: _____

Father's relationship with you and your child:

Your Parents:

Mother

Father

Address & Phone:

Your relationship w/parents:

Name of a relative or friend to contact in case of emergency:

Name

Relationship

Address

Phone

Do you now, or have you ever had a threatening relationship with anyone? YES/NO

If yes, please provide details (who, when, circumstances):

Have you ever been the victim of abuse? YES/NO

If YES, was it PHYSICAL / SEXUAL / EMOTIONAL / OTHER

Have you ever appeared in court? YES/NO If YES, when and why:

Have you ever been arrested? YES/NO If YES, when and why:

Have you ever been charged with a misdemeanor YES/NO Felony? YES/NO

If YES to either, please explain:

Date: _____ Location--State & County: _____

Charge: _____ What happened? _____

Were you convicted?: YES/NO Are you on probation?: YES/NO

If YES, parole officer's name and phone #:

What agencies are you currently involved with?

Dates Agency/Program Contact Person Phone #

Have you ever received counseling? YES/NO If YES, when:

With Whom:

Are you willing to receive counseling?

Highest grade of schooling completed? _____ High School diploma? YES/NO
GED? YES/NO

Date received: _____ In process? YES/NO Where? _____

Are you currently in school? YES/NO If YES, where? _____

Course of study? _____ Graduation date: _____

Are you currently employed? YES/NO If YES, where:

Past work experience (type of employment):

What is your monthly income? _____ Other financial resources? _____

SSI: _____ Medicaid: _____ WAGES: _____

SSDI: _____ Food Stamps: _____ Other: _____

Who referred you to Our Mother's House? _____

Phone # _____

Why are you applying to Our Mother's House?

Describe your ability to live in a group home, care of your child(ren), participate in the program, and be responsible for your actions:

I understand that completion of this form does not guarantee acceptance for residence at Our Mother's House and falsifying information on this application can result in disqualification.

Signature: _____ Date: _____

PROGRAM GOALS

What are your short term goals, including steps to achieve them?

What are your long term goals, including steps to achieve them?

What do you hope to achieve during the program term and what do you hope to have accomplished when you exit the program?



Client Rights & Responsibilities/Consent for Services Catholic Charities, Diocese of Venice in Florida

Clients of Catholic Charities:

I have received a copy of the Client Rights & Responsibilities brochure, and I understand my rights and responsibilities. I consent and authorize Catholic Charities, Diocese of Venice in Florida to provide services, care and treatment as applicable to my needs.

Printed Name of Client: _____

Signature of Client: _____ **Date:** _____

Printed Name of Parent/Guardian: _____

Mother Father Guardian

Signature of Parent/Guardian: _____ **Date:** _____

Signature of Caseworker/Counselor: _____ **Date:** _____

Clients receiving professional counseling services to read and sign this portion also:

My therapist has provided me with a copy of the Catholic Charities Family Counseling Center Information brochure, which documents more specific detail relating to my rights and responsibilities as a client receiving professional counseling services. I understand my rights and responsibilities.

Printed Name of Counseling Client: _____

Signature of Counseling Client: _____ **Date:** _____

Printed Name of Parent/Guardian: _____

Check one: Mother Father Guardian

Signature of Parent/Guardian: _____ **Date:** _____

Signature of Therapist:

_____ **Date:** _____

Client name: _____ **D.O.B. or ID #:** _____

Catholic Charities, Diocese of Venice, Inc.

Notice of Privacy Practices

(Retain this for your records)

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.

Notice Requirements

Catholic Charities, Diocese of Venice, Inc. is required by federal and state laws to maintain the privacy of your health care information. The law also requires us to give you a Notice of your health care information. The law also requires us to give you a Notice telling you about the law, your rights, and our privacy practices. This notice represents all direct services of this Agency, where personal data is collected and maintained in an Agency file.

This Notice will go into effect April 14, 2003 and last until we replace it. If our Privacy Practices change, this Notice will change. You will find it, or any future notices posted at all service locations throughout the Diocese of Venice. If you would like additional copies or to learn more, please contact us at Catholic Charities, Diocese of Venice, Inc., 1000 Pinebrook Road, Venice, Florida 34285.

Use and Disclosure of Your Protected Health Care Information

As a part of our counseling, social and education services, Catholic Charities, Diocese of Venice, Inc., may need to create, receive, or keep medical information about you. To provide treatment, to handle billing and payment activities, and to manage our services, we may use and disclose (share) your protected health care information without first getting you written approval. Examples of how we might use or disclose your information include the following activities:

- ♦ **Treatment.** Catholic Charities might discuss your medical condition with doctors, nurses, technicians or hospital staff to arrange or provide medical treatment. We might request copies of medical records to arrange for treatment based on eligibility for treatment in our counseling programs.
- ♦ **Payment.** Catholic Charities may use or disclose information to discuss your condition, any treatments given to you, or to review the cost for services in order to arrange for payment. We may use or disclose this information with an insurance company. We may contact others to pay or bill for services.
- ♦ **Health Care Operations.** Catholic Charities counselors, case managers, or our business partners might discuss or review your condition to assure you receive quality care, to verify you are actually receiving the services that are being billed, or to develop better ways to provide care. We may use your information to manage or purchase services. It may be used to evaluate our providers and contractors. Health information may be used or disclosed for legal purposes or for internal management purposes.

♦ **Other Uses or Disclosures.**

Catholic Charities may contact you to:

- ♦ Arrange appointments or eligibility interviews.
- ♦ Provide you with information about new services that are available.
- ♦ Market services or raise funds for Catholic Charities.

Catholic Charities may provide information to government officials who:

- ♦ Are responsible for Public Health and Disease Reporting.

- ◆ Provide Health Oversight (Professional Licensing, FDA, HHS, Audits, Investigations).
 - ◆ Respond to Judicial Related Requests (Subpoenas, Trials, Court Hearings).
 - ◆ Provide Law Enforcement Services.
 - ◆ Report and Investigate Deaths (Medical Examiner).
 - ◆ Conduct Lawful Military or Intelligence Activities.
 - ◆ Are Military personnel
 - ◆ Are authorized by worker's compensation laws.
 - ◆ Respond to threats to public safety from unsafe products, unsafe drinking water, or disease.
 - ◆ Protect against abuse, neglect, domestic violence and other crimes.
- Catholic Charities may provide information to:
- ◆ Licensed researchers or care groups, who are under strict rules regarding how they use and disclose protected health care information. Those researchers or medical review members may use the information about individuals with your condition for a study to improve ways to treat or manage like diseases.
 - ◆ Hearing and Appeals groups to resolve disputes, render opinions, provide independent reviews.
 - ◆ Other involved in your care.
 - ◆ Responders to Emergency Situations.
 - ◆ Funeral Directors.
 - ◆ Others as required by law.
 - ◆ **OTHER USES OF PROTECTED HEALTH INFORMATION.**

Other uses and disclosures of protected health information not covered by this notice or the laws that apply to us will be made only with your written permission (authorization). If you give permission to use or disclose protected health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission.

◆ **YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION.**

You have the following rights regarding the protected health information we maintain about you:

1. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to Catholic Charities, Diocese of Venice, Inc., 1000 Pinebrook Road, Venice, Florida 34285. In your request tell us: 1.) what information you want to limit; 2.) whether you want to limit our use, disclosure or both; and 3.) to whom you want the limits to apply, for example, disclosures to your spouse.

2. **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain location. For example, you can ask that we only contact you at home or only by mail.

To request confidential communications, you must make your request in writing to Catholic Charities, Diocese of Venice, Inc., 1000 Pinebrook Road, Venice, Florida 34285. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

3. **Right to Inspect and Copy.** You have the right to inspect and obtain a copy of protected health information that may be used to make decisions about your care. This includes case records, but does not include psychotherapy notes.

To inspect and copy protected health information, you must submit your request in writing to Catholic Charities, Diocese of Venice, Inc., 1000 Pinebrook Road, Venice, Florida 34285. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other costs associated with your request.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to protected health information, you may request a review of that denial.

4. **Right to Amend.** If you believe that protected health information we have asked about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is key by Catholic Charities.

To request an amendment, your request must be made in writing and submitted to Catholic Charities, Diocese of Venice, 1000 Pinebrook Road, Venice, Florida 34285. In addition, you must provide a reason for your request.

We may deny your request for an amendment if it is not in writing. We may also deny your request if it does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

Is not part of the protected health information kept by Catholic Charities;

Is not part of the information which you would be permitted to inspect or copy; or Is accurate and complete.

5. **Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures of your protected health information made by Catholic Charities.

To request an accounting of disclosures, you must submit your request in writing to Catholic Charities, Diocese of Venice, Inc., 1000 Pinebrook Road, Venice, Florida 34285. Your request must state a time period not longer than six (6) years, and the time period cannot extend to dates before April 14, 2003. The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you for the costs of providing the list.

6. **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice, and you may ask us to give you a copy of this notice at any time.

WE ARE REQUIRED BY LAW TO:

maintain the privacy of protected health information about you;

Give you this notice of our legal duties and privacy practices regarding protected health information about you; and

Abide by the terms of the notice that is currently in effect.

Questions and Complaints

If you have any questions or complaints about the way Catholic Charities, Diocese of Venice, Inc. handles your protected health information or if you believe your privacy rights have been violated, you may complain by contacting the Catholic Charities, Diocese of Venice Administrative Office at 941-488-5581. You may also contact the Secretary of the U.S. Department of Health and Human Services. Please note that there will be no retaliation against you for filing a complaint or for making requests regarding your protected health care information or if you disagree with Catholic Charities related decisions about your protected health care information.

Notice Updates

Catholic Charities, Diocese of Venice, Inc. may need to change its privacy practices from time to time. Before making such changes however, Catholic Charities will modify this Notice and begin distributing it to individuals when they receive services by Catholic Charities. These new practices will then apply to all information held by Catholic Charities. At any time, you have a right to get a paper copy of the latest version of this Notice by contacting the Catholic Charities Administrative Office at 941-488-5581.

The effective date of this Notice is April 14, 2003.

You have the right to:

- Timely and appropriate services
- Be treated with dignity and respect
- Make choices regarding services (including refusing or discontinuing)
- Participate in the development of your service plan
- Confidentiality regarding your personal information
- Make a complaint without fear of reprisal
- Be free of abuse, disrespectful and/or restrictive interventions
- Access your record

You are responsible for:

- Participating in the development of your services plan
- Cooperating in the delivery of services
- Treating your service provider with respect
- Following applicable rules and regulations
- Keeping appointments or providing notice if you must cancel
- Paying for services in accordance with your agreement



Catholic Charities, Diocese of Venice, Inc.

I _____ certify that the “**Notice of Privacy Practices**”, that describes how confidential information about me may be used and disclosed and how I can get access to this information, has been clearly explained by Our Mother’s House/ Rita Millner or Elizabeth Gibbons, and I have reviewed it carefully. (Provider)

I further understand that I may obtain additional copies by requesting them from my provider.

(Signature of Client/Legal Guardian)

(Date)



**Catholic Charities
Diocese of Venice, Inc.**

Authorization to Obtain and/or Release Information

AGENCY INFORMATION:

Catholic Charities Program/Service: Our Mother's House
Address of Program/Service: 221 Harbor Drive North, Venice, FL 34285
Telephone Number: (941) 485-6264 Fax Number: (941) 488-2289
Name of staff member releasing and/or obtaining information: Rita Millner/Elizabeth Gibbons

CLIENT INFORMATION:

Client Name: _____ Date of Birth: ____/____/____

I, _____, hereby authorize Catholic Charities, Diocese of Venice, Inc. to obtain and/or release information from the agencies/persons listed from my clinical/case record, pertaining to myself, or my child, _____, date of birth ____/____/____

NATURE OF INFORMATION TO BE RELEASED OR OBTAINED:

Progress notes and any information to assist with program acceptance

OUTSIDE COMMUNITY AGENCY INFORMATION:

This information is: To be released to: To be obtained from:

Name of outside agency person releasing or obtaining information:

The purpose of obtaining/releasing this information is to assist in the case management and/or treatment of the above named individual, and to facilitate coordination of services. I understand that I have the right to refuse to sign this authorization. I further understand that if information other than that listed above is requested, such information will not be released or obtained without my written consent.

This authorization is for a single, or continuing disclosure, valid for one year following the date of my signature as it appears below, or until my case with Catholic Charities is terminated, whichever comes first. This authorization may be revoked at any time upon written notification by the client or legal guardian, but revocation has no effect on action previously taken.

Expires: ____/____/____

Signature of Client: _____ **Date:** ____/____/____

Signature of Parent: _____ **Date:** ____/____/____

Signature of Legal Guardian: _____ **Date:** ____/____/____

Signature of Witness: _____ **Date:** ____/____/____

Copy to client Original in client file