Douglas County Collaborative Management Program (DCCMP)-
Family Assistance Flex Fund Program
Referral Reference Guide and Instructions

Important Information:

- The DCCMP Family Assistance Flex Fund program is available for children and youth ages **0-21 years old** who are residents of Douglas County.
- Any signing member of the DCCMP Interagency Oversight Group (IOG) can refer to the program.
- Assistance of up to $2000.00 per family per fiscal year can be approved at the discretion of the CMP Team without DCCMP Executive Committee approval.
- Any request over $2000.00 requires explicit approval from the DCCMP Executive Committee.
- **Please use discretion** when referring to the Family Assistance Flex Fund program. The use of Flex Funds should be time limited and cost-efficient. Flex Funds should be used as a **"Payer of Last Resort"-** all other revenues should be attempted prior (Medicaid, Emergency Assistance, community partners, etc.).
- Flex Funds cannot be paid directly to youth or families nor can they be used to reimburse families for expenses already incurred. Flex funds must be paid to a third party/vendor.

Instructions:

Step 1: Identify the child, youth or family that would benefit from the DCCMP Family Assistance Flex Fund program.

Step 2: Staff your Family Assistance Flex Fund request with the DCCMP Liaison (by phone or in person), if you have questions.

Step 3: Submit your Family Assistance Flex Fund request to the DCCMP Liaison by email- dccmp@adv4children.org. If you are submitting an emergency request, please put "Emergency Flex Fund Request" in your subject line.
*****ALL FLEX FUND REQUEST SENT VIA EMAIL MUST BE ENCRYPTED TO ENSURE PROTECTION OF PERSONAL HEALTH INFORMATION. PLEASE SUBMIT A TYPED REQUEST*****

Step 4: Routine requests will be reviewed within five (5) business days of receipt. Emergency requests will be reviewed within 48 business hours (please see above for how to specify if a request is an emergency request).

Step 5: The DCCMP Liaison will send notification of payment approval or denial via email to the requester.

Step 6: Once your request is approved, it is the responsibility of the requester to facilitate necessary communication between the provider, the family and the DCCMP Liaison, unless otherwise informed.

Step 7: DCCMP will provide payment to the provider directly, either through a check or Purchase Card. Receipt of purchase is required for all Family Assistance Flex Fund requests.

Step 8: The DCCMP Manager may reach out to the requester following services or goods rendered to follow-up with service engagement or outcomes. The requesting party may be asked to submit service outcome information at any time within the fiscal year.

For direct questions contact the Youth and Family Engagement Liaison, Elise Cordle, at Elise_Cordle@adv4children.org or by phone at 303-328-2353

Douglas County Collaborative Management Program (DCCMP)

Family Assistance Flex Fund Request Form

Please complete the form and submit to the Youth and Family Engagement Liaison,
Elise Cordle at elise_cordle@adv4children.org and dccmp@adv4children.org

Child/Youth/Family Information:

Name: DOB: Age: Gender: ☐ Male ☐ Female

Ethnicity: ☐ White/Caucasian ☐ Black/African American ☐ Asian/Pacific Islander

☐ Hispanic/Latinx ☐ Multi-Racial ☐ Native/American Indian **Siblings:** ☐ **Yes** ☐ **No** ☐ **Unsure**

Caregiver(s) Information:

Name(s): Relationship to child/youth:

Zip Code: Phone: Email:

Requestor Information:

Requestor Name: Requestor Organization:

Requestor relationship to child/youthfamily:

Requestor Phone: Requestor Email:

Request Information:

Date of Request: Date Funds Needed by:

Emergency Request: Yes ☐ No ☐ If yes, brief explanation:

Item/Service Request:

Item/Service Quantity: Funding Amount:

Length of Time Funding is Approved:

Provider Name: Provider Phone/Email:

Provider Address:

Additional concerns, please list or state "none":

What will the flex funds be used for? Why? (i.e. what services or goods and reason)

Provide an explanation of what family, community, systems and provider resources have been explored as funding options prior to making this request. Does the family have Medicaid? If yes, has a request for Member Giving Program been submitted?

State of Colorado

Authorization — Consent to Release Information

Agency Requesting Information

Agency Name Douglas County CMP	Contact Name/Title Elise Cordle Youth and Family Engagment Lias		
Mailing Address 16965 Pine lane suite 120			
City Parker		State CO	ZIP 80134
Email Elise Cordle@adv4children.org	Phone 303-328-2353	Fax	Date

Client Information

Last Name	First Name	MI
Physical Address		
City	State	ZIP
Permanent Address (if different than physical address)		
City	State	ZIP
Email	Phone	DOB
Type of Identifier: ☐ Other ☐ School ID ☐ DL ☐ State ID ☐ Child Welfare Case # ☐ Case Report # ☐ JD# ☐ Passport	Identifier #: Use only last four digits of SSN if used.	Role:

Consenter/Person Authorizing Consent (if person above is a minor)

Last Name	First Name	MI
Physical Address		
City	State	ZIP
Permanent Address (if different than physical address)		
City	State	ZIP
Email	Phone	DOB
Type of Identifier: ☐ Other ☐ School ID ☐ DL ☐ State ID ☐ Child Welfare Case # ☐ Case Report # ☐ JD# ☐ Passport	Identifier #: Use only last four digits of SSN if used.	Role:

Authorizes

☐ DHS/ Office:_____
☐ DHS/ Office of Behavioral Health
☐ DHS/ Division of Youth Corrections
☐ Court (Juvenile, County, Municipal)
☐ Service Provider
☐ LEA
☐ School (Private or District)
☐ Probation (Juvenile, County, Municipal)
☐ Diversion
☐ Juvenile Assessment Ctr
☐ SB94
☐ DA

Other CMP

To Release Information to

☐ DHS/ Office:_____
☐ DHS/ Office of Behavioral Health
☐ DHS/ Division of Youth Corrections
☐ Court (Juvenile, County, Municipal)
☐ Service Provider
☐ LEA
☐ School (Private or District)
☐ Probation (Juvenile, County, Municipal)
☐ Diversion
☐ Juvenile Assessment Ctr
☐ SB94
☐ DA

Other CDHS for data tracking

To Receive Information From

☐ DHS Office:_____
☐ DHS/Office of Behavioral Health
☐ DHS/ Division of Youth Corrections
☐ Court (Juvenile, County, Municipal)
☐ Service Provider
☐ LEA
☐ School (Private or District)
☐ Probation (Juvenile, County, Municipal)
☐ Diversion
☐ Juvenile Assessment Ctr
☐ SB94
☐ DA

Other

For the Purpose of

☐ Adjudication
☐ Assessment
☐ Coordination of Services
☐ Intake
☐ Insurance (Health/Life)
☐ Interdisciplinary Team Staffing
☐ Placement
☐ Pretrial
☐ Treatment
☑ Other Data tracking

Type of Information Requested

Education
☐ School Grades/Test Scores
☐ School Attendance Records
☐ School Behavior Reports
☐ IEP's/504

Substance Abuse
☐ Treatment History
☐ Evaluations

Medical
☐ Current Prescriptions
☐ Medical History
☐ Immunizations

Mental Health
☐ MH Assessment
☐ MH Treatment History
☐ Diagnosis

Justice Agency
☐ Probation History
☐ Probation Records
☐ Police Reports/Records
☐ Other Court Records

Other Records
☐ Human Service Records
☐ Child Welfare History

Other (Please Specify) _____

Preparer's Initials	EC	Consenter's Initials	

Date Range of Youth Records:	From: Month: Choose Mon Day: Choose Day Year: Choose Year	To: Month: Choose Mont Day: Choose Day Year: Choose Year
Date Range of Authorization/Consent:	From: Month: Choose Mon Day: Choose Day Year: Choose Year	To: Month: Choose Mont Day: Choose Day Year: Choose Year
How is this information being released?	☐ Fax ☐ Email ☐ Telephone ☐ In Person ☐ Other_____	

Signature of person authorizing consent: Date: (MM/DD/YYYY)

Type or print name:

Signature of youth: Date: (MM/DD/YYYY)

Type or print name:

☐ By my signature, I consent to the release of information contained on this form for use by the requesting agency(cies). I understand that my records are protected under Federal and State regulations governing confidentiality, 42 part 2, HIPAA , and FERPA and cannot be released without my written consent unless otherwise provided for by the regulations. I understand that any agency or individual using the confidential information or records obtained will take all necessary steps to protect the confidentiality of the above named juvenile/child's identity. I acknowledge that I have been informed of my rights to refuse to sign this form, and any conditions related to my consent or refusal, and that I am entitled to receive a copy of the signed form.

☐ Consenter declined release of information. _____[staff initial] [Copy Provided to Client]
Date Declined: (MM/DD/YYYY)_____

General

Disclosure Notice to Receiving Agencies: This notice accompanies a disclosure of information concerning a client whose information is protected by HIPAA, 42 part 2, FERPA, or other Federal or State law. This information has been disclosed to you from records whose confidentiality is protected by Federal Law. 42 part 2 and FERPA prohibit you from making further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by 42 part 2 or FERPA. A general authorization for the the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of 42 part 2 information to criminally investigate or prosecute any alcohol or drug abuse patient.

HIPAA Redisclosures: Information released under a HIPAA authorization may be subject to redisclosures that do not fall under HIPAA.

Confidentiality Notice for Electronic Transmittal: This release, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential information. If you have received this communication in error, please immediately notify the sender. In addition, if you have received this in error, do not review, distribute, or copy the document or attachments.

Condition Statement: I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Consent Expiration: This authorization - consent expires on/no later than (specific date), or one year from the date signed, at end of event, completion of treatment, or if included as part of a Court Order or condition of probation, upon the terms specified, whichever is less. Length of time consent is valid can be specific by program or provider, or set by length of program/ referral, period of time that records are utilized for specified consent purpose. See specific agency rules for agency specific time frames for record retention.

Copies of Authorization/Consent Valid: A copy, photocopy, or facsimile transmission of this release will have the same authority as the original.

Parent must be informed of consent rights and right to revoke consent in native language: Under Section 300.9 of Title 34 of the Code of Federal Regulations, parental consent means all of the following: (a) The parent or guardian has been fully informed of all information relevant to the activity for which consent is sought, in his or her native language, or other mode of communication. (b) The parent or guardian understands and agrees in writing to the carrying out of the activity for which his or her consent is sought; and the consent describes that activity and lists the records, if any, that will be released and to whom. (c) The parent or guardian understands that the granting of consent is voluntary on the part of the parent or guardian and may be revoked at any time. If a parent or guardian revokes consent, that revocation is not retroactive to negate an action that has occurred after the consent was given and before the consent was revoked. A public agency is not required to amend the education records of a child to remove any reference to the child's receipt of special education and services if the child's parent or guardian submits a written revocation of consent after the initial provision of special education and related services to the child.

Authorization/Consent Revocation Limitation/Period: This release/authorization may be revoked at any time by written notice to AGENCY, except to the extent that action has already been taken to comply with it. Without such revocation, this release/ authorization will expire as explained. Consenter may revoke consent in writing by contacting the releasing agency. This revocation will be re-corded in the AGENCY record. HIPAA requires written revocation of an authorization to release HIPAA information (45 CFR §164.508(b)(5)). Both Part 2 and HIPAA allow the program to make a disclosure for services already rendered in reliance on a signed consent or authorization form. See 42 CFR §2.31(a) (8) and 45 CFR §164.508. If consent is for Substance Abuse Treatment –verbal consent is acceptable. Verbal consent may also be accepted in specific emergency situations. See agency specific policies for more details.

Child Welfare and Medicaid Records: Federal law requires states to exchange information electronically through the state's automated child welfare and Medicaid systems to the extent it is feasible (45 C.F.R. § 1355.53(b) (2) (2009)) and encourages automated data exchange between child welfare and the courts. (45 C.F.R. § 1355.53(d) (2009).

Questions: If you have questions concerning this release please call (PROVIDER AGENCY PHONE #) or Please Send Information to: (PROVIDER AGENCY NAME AND ADDRESS AND FAX) Under the State of Colorado and Federal Confidentiality Regulations, no information about a juvenile participation in treatment can be disclosed without written consent except in the case of medical emergency, child abuse or Court Order. If applicable, a minimum necessary determination has been applied to this release/ authorization.

Preparer's Initials	EC	**Consenter's Initials**	