Welcome to the CITC Child Care Assistance Program

The CITC Child Care Assistance Program provides financial assistance to help pay for child care expenses for families with Alaska Native or Native American children living within the Cook Inlet Region service area.

COOK INLET TRIBAL COUNCIL
People. Partnership. Potential.

To be eligible for our program:

- **You or your children must be Alaska Native or Native American.**
- **You must have a demonstrated need for child care.**
- **You must live, work, or go to school in the Anchorage area.**
- **You must meet income requirements.** Income limits and copays are based on gross income and household size.
- **You must take part in an eligible activity at least 20 hours each week.** For our program, eligible activities include: work, attending school, or treatment/prevention services on a case-by-case basis.

Application process

Submit a completed application, along with supporting documents, to our office in person, via email or by fax. Complete applications will be processed within ten business days. Applications will NOT be processed until all required items have been submitted. If an incomplete application is submitted you will be notified within ten business days of any additional items needed. If requested items are not submitted by the due date, the application will be denied.

Office hours are Mon-Fri 8a-5p. Contact us by phone at 793-3300 or email at childcare@citci.org.
Documents may be submitted via email to childcare@citci.org, or by fax to 793-3296.

Application Checklist: *Additional documents may be requested on a case-by-case basis.*

- ☐ Fully completed child care application
- ☐ Participant Code of Conduct
- ☐ Verification of ALL income received, both earned and unearned, by all members of the household in the past 30 days.
- ☐ Chosen child care provider. If you have not already chosen a provider, please visit www.threadalaska.org.
- ☐ Year-to-Date Verification of Native Corporation Dividends for each shareholder in the household
- ☐ **Employed Parents:** Employment Verification Form(s). *This form is only required to verify new employment, when paystubs have not yet been issued. For those self-employed, additional documents are required.*
- ☐ Verification of application for child support.
- ☐ **University/College Students:** Class Schedule, Verification of Financial Aid, and Student Bill.
- ☐ **GED or Vocational Training Students:** Enrollment Verification, Training Schedule (with days and hours listed, start and end dates of training), and Verification of Financial Aid/Funding

The following items are not required if an up-to-date version is currently on file.

- ☐ Picture ID for each adult in the household
- ☐ BIA or verification of Indian Blood (parent or child)
- ☐ Birth Certificates for child(ren) needing care
- ☐ Authorization to Obtain Personal Information
- ☐ Authorization to Release Personal Information

CITC Intake Form

Date of Intake: _____

Participant Name: Last: _____ First: _____ Middle: _____ Suffix: _____

Maiden Name: _____ Other Names: _____

Birth Date: _____ ☐ Estimated

Social Security Number: _____

Gender: _____

Home Address: _____

Home Address: _____

City: _____

State: _____

Zip: _____ ☐ Mailing Address Same

☐ Rent
☐ Own
☐ Staying w/ Relatives or Friends

If not provided, due to homelessness? ☐ No ☐ Yes

Have you moved to Anchorage in the past 3 years? ☐ Yes ☐ No

If Yes, From Where? _____

Mailing Address: _____

Mailing Address: _____

City: _____

State: _____

Zip: _____

Home Number: _____

Cell Number: _____

Work Number: _____

Email Address: _____ ☐ Home ☐ Work

Registered for Selective Service: ☐ (Males between 18 & 25 according to federal guidelines)

Veteran: ☐

CITC Intake Form

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

Race (Check all that apply):

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Other Race Specify:

Other: _____

Hispanic, Latino or Spanish Origin:

- ☐ No, not of Hispanic, Latino or Spanish origin
- ☐ Yes, Mexican, Mexican Am. Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino or Spanish origin

Specify: _____

Alaska Native Ethnicity:

- ☐ Aleut
- ☐ Alutiiq
- ☐ Athabascan
- ☐ Eyak
- ☐ Haida
- ☐ Inupiat
- ☐ Siberian Yup'ik
- ☐ Tlingit
- ☐ TSimshian
- ☐ Yup'ik / Cup'ik
- ☐ Don't Know

Regional Corporation Affiliation:

S - Shareholder
F - Family Member
D - Descendant of

	Affiliation		Affiliation
☐ Ahtna		☐ Doyon	
☐ Aleut		☐ Koniag	
☐ ASRC		☐ NANA	
☐ Bering Straits		☐ Sealaska	
☐ Bristol Bay		☐ 13th Region	
☐ Calista		☐ None	
☐ Chugach			
☐ CIRI			

CITC Intake Form

Employment Status:

Currently Working:

- ☐ Yes
- ☐ No

- ☐ Part-Time
- ☐ Full-Time

- ☐ Architecture & Engineering
- ☐ Arts, Design, Entertainment, Sports & Media
- ☐ Building & Grounds Cleaning & Maintenance
- ☐ Business & Financial Operations
- ☐ Community & Social Services
- ☐ Computer & Mathematical
- ☐ Construction & Extraction
- ☐ Education, Training & Library
- ☐ Farming, Fishing & Forestry
- ☐ Food Preparation & Serving Related
- ☐ Healthcare Practitioners & Technical
- ☐ Healthcare Support
- ☐ Other:
- ☐ Installation, Maintenance & Repair
- ☐ Legal
- ☐ Life, Physical & Social Science
- ☐ Management
- ☐ Military Specific
- ☐ Office & Administrative Support
- ☐ Personal Care & Service
- ☐ Production
- ☐ Protective Service
- ☐ Sales & Related
- ☐ Student
- ☐ Transportation & Material Moving

Other: _____

If Unemployed, Last Date of Employment: _____

- ☐ Estimated
- ☐ Never Worked

Last Grade Level Completed:

- ☐ Pre-K / Headstart
- ☐ Kindergarten
- ☐ 1st Grade
- ☐ 2nd Grade
- ☐ 3rd Grade
- ☐ 4th Grade
- ☐ 5th Grade
- ☐ 6th Grade
- ☐ 7th Grade
- ☐ 8th Grade
- ☐ 9th Grade
- ☐ 10th Grade
- ☐ 11th Grade
- ☐ 12th Grade
- ☐ Voc. / Tech. College
- ☐ Some College
- ☐ Associate's Degree
- ☐ Bachelor's Degree
- ☐ Master's Degree and/or above

Certificate/Degree Title: _____ **Completion Year:** _____

Emergency Contact Information:

Emergency Contact Name: **Last:** _____ **First:** _____

Middle: _____

Emergency Cont. Home Number: _____

Emergency Cont. Cell Number: _____

CITC Intake Form

Emergency Cont. Work Number: _____

Emergency Cont. Email Address: _____ ☐ Home ☐ Work

Initial Program/Service Requested:

- ☐ Employment and Training
- ☐ Child and Family Services
- ☐ Educational Services
- ☐ Recovery Services
- ☐ Chanlyut
- ☐ Two Spirits Gallery

I understand that the information that I have provided CITC on this Intake form will be used to assist CITC in providing me an offering of appropriate services. I consent to receive services from CITC and understand that I can accept or decline any of the services or programs that CITC offers to me.

Participant Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

For Internal Use Only

Form of ID Provided:

- ☐ Drivers License
- ☐ State ID
- ☐ Student ID
- ☐ Military ID
- ☐ Social Security Card
- ☐ Birth Certificate
- ☐ CIB
- ☐ Passport / Work or Student Visa
- ☐ Permanent Residence Card
- ☐ Tribal Enrollment Card

Additional Household Members - Please complete these questions for each family member in Participant's home.

First Name	MI	Last Name	Birth Date	Sex	SSN - Last 4	Relation to You

COOK INLET TRIBAL COUNCIL
People. Partnership. Potential.

CITC Child Care Assistance Program Supplemental Application

Please complete all sections which are applicable to you.

As with all CITC programs, the Child Care Assistance Program is dependent on grant funding. We reserve the right to deny any applications on the grounds of available funding.

EMPLOYMENT or EDUCATION/TRAINING ACTIVITY

Applicant:

Employer/Training Institution

Job Title/Course of Study

Start Date End Date

Work/Training Schedule (ex: Mon-Fri, 8-5pm)

Name of Supervisor/School Advisor Phone Number

Pay Rate: _____

Pay Days: ☐ Bi-Weekly ☐ Semi-Monthly ☐ Other: _____

Co-Applicant:

Employer/Training Institution

Job Title/Course of Study

Start Date End Date

Work/Training Schedule (ex: Mon-Fri, 8-5pm)

Name of Supervisor/School Advisor Phone Number

Pay Rate: _____

Pay Days: ☐ Bi-Weekly ☐ Semi-Monthly ☐ Other: _____

CO-APPLICANT CONTACT INFORMATION Phone: _____ Email: _____

MODE OF TRANSPORTATION *1/2 hour of travel time to and from child care is permitted.*

☐ People Mover Bus ☐ Own Transportation ☐ Other: _____

INCOME SOURCES

Please check, list amount, and provide verification for each item received within the past 30 days by any member of your household.

☐ Employment	$_____/mo	☐ Child Support Payments	$_____/mo
☐ Unemployment Benefits	$_____/mo	☐ TANF	$_____/mo
☐ Education Financial Aid	$_____/mo	☐ Social Security	$_____/mo
☐ Support by others	$_____/mo	☐ Native Corp. Dividend	$_____/yr
☐ Other (describe):	$_____/mo	☐ I have had no income in the past 30 days.	

DEDUCTIONS *If not deducted from wages, you will need to provide proof of payment in order to receive the deduction.*

Does anyone in your household pay child support ☐ Yes ☐ No

Does anyone in your household pay Health Insurance Premiums (Medical, Vision, Dental only) ☐ Yes ☐ No

ALASKA NATIVE REGION & VILLAGE CORPORATION

The first $2000 per household member, per calendar year, is excluded from countable household income. Attach Year-To-Date Verification for each family member, from each corporation.

Corporation(s) Name(s) and Number of shares

Corporation(s) Name(s) and Number of shares

FAMILY & PROVIDER INFORMATION

Please complete these questions for each additional person living in the Participant's home.

First Name	MI	Last Name	Birth Date	Sex	SSN-last 4	Relationship

CUSTODY SCHEDULE **Do you have shared custody?** ☐ Yes ☐ No

You must have physical custody at least 50% of the time to be eligible for this program. This may be by court order or informal agreement with the other parent. You may be asked to complete a custody calendar and/or supply verification of custody.

Name of Child(ren)	Custody Schedule	Court Ordered
		□ Yes □ No
		□ Yes □ No

SPECIAL NEEDS *If yes, additional documents and a separate application will be required.*

Do any of the children in your household have special needs requiring additional services while in child care? ☐ Yes ☐ No

CHOSEN DAYCARE PROVIDER(S)

List all children within your household for whom you are requesting child care assistance and have legal custody. Child care may ONLY be used while parents are in their approved activities. Providers must be Licensed or Approved and registered with this program before an authorization and payment can be issued. Please make sure your provider will accept CITC Child Care Assistance before enrolling your child(ren).

Name of Child	Name of Child Care/Daycare Provider	Expected Start Date
☐ Needs child care ☐ Attends ASD	Need Registration Fee? ☐ No ☐ Yes	
☐ Needs child care ☐ Attends ASD	Need Registration Fee? ☐ No ☐ Yes	
☐ Needs child care ☐ Attends ASD	Need Registration Fee? ☐ No ☐ Yes	
☐ Needs child care ☐ Attends ASD	Need Registration Fee? ☐ No ☐ Yes	
☐ Needs child care ☐ Attends ASD	Need Registration Fee? ☐ No ☐ Yes	

In the past 30 days, have you received child care assistance from TANF Child Care? ☐ No ☐ Yes

REPORTING CHANGES

You must notify the Child Care Assistance Program of any changes within five business days; including any changes in eligible activity, household size, contact information, child care, or any other factors that may affect your eligibility for the program. No specific form is required to report changes, and additional documentation may be requested.

APPLICANT CERTIFICATION

I certify I am the parent, legal guardian, or foster parent of the child(ren) for which I am requesting child care assistance. I hereby certify that all information made on or in connection with this application is true and complete. I understand that information may be obtained on my behalf from outside parties which are listed on Authorization to Obtain Personal Information form. I understand that if I deliberately enter false information on this form, I may receive a $10,000 fine, imprisonment for not more than two years, or both. I also understand that any misrepresentation or concealment of material fact will be sufficient grounds for rejection of my application or suspension from any CITC program and/or services. I certify that I have read and understand my rights and responsibilities under the CITC Child Care Assistance Program.

Applicant Signature _____ Date _____

Co-Applicant Signature _____ Date _____

PARENT RESPONSIBILITIES

You must respond timely to program requests.

All documentation necessary to verify eligibility must be submitted. Requests for additional documentation must be responded to in a timely manner for efficient processing of your application.

You must notify the Child Care Assistance Program of any changes within five business days; to include:

- **Eligible activity** – starting or stopping your activity, schedule changes
- **Household size** – marital status, pregnancy, adding or removing any member from the household
- **Changes in earned or unearned income** – you must report any changes in the amount of money available to your household monthly.
- **Contact information** – addresses, phone numbers, or email address
- **Child care** – changing providers, school break care needs, absent more than 5 days, or no longer in need of child care services
  - If changing providers, you must comply with your provider's notice policy.
- **Please report any other factors you think may affect your case or eligibility for the program**.

While you are receiving child care assistance through CITC's Child Care Assistance Program, you may not receive child care assistance from any other program at the same time. If you transfer to another program you must immediately inform CITC.

You must maintain eligibility for our program in order to continue receiving assistance, this includes:

- Participate in an eligible activity at least 20 hours each week; report to our program if hours drop below 20 hours.
- Eligible activities are; work, job search, or attending school
- Treatment/prevention services, on a case-by-case basis
- Care is only authorized when you are in your approved activity.
- In two parent households, both parents must be in their approved activity to use care.

You must comply with all billing procedures.

- You must pay your copay to your provider each month. Copays are determined by household size and income.
- You must sign your billing report monthly, as requested by your child care provider, to verify your child's attendance.
- It is your responsibility to pay any costs incurred exceeding the authorized amount or the monthly maximum state rate.
- It is your responsibility to pay for unauthorized child care.

You must remember to renew.

It is your responsibility to renew your Child Care Authorization prior to expiration. The renewal period begins 45 days before the end of the eligibility term.

PARENT RIGHTS

You may request an income reevaluation at any time, as long as it has been at least 30 days since your last evaluation.

You may request a copy of the Child Care Assistance Program Policies & Procedures at any time. You have the right to discuss any action taken on your case with your case manager or their supervisor.

CITC Client Grievance

If you disagree with decisions made on your case, or are unhappy with your treatment, you may file a grievance. First, contact the staff with whom you have a complaint and attempt to resolve the disputed action. If this does not resolve the dispute, you may then meet with their supervisor, who will work with you to resolve the complaint.

If your grievance remains unresolved, you may then submit a written complaint to the CITC CRP Officer at 3600 San Jeronimo Dr., Anchorage, AK 99508. The CRP Officer will work with you until a solution is reached.

FRAUD WARNING

You may be prosecuted or debarred if you knowingly give false, incorrect, or incomplete information to get or try to get benefits you are not eligible for, or help someone else get benefits they are not eligible for. The debarment process may be utilized if you fail to pay child care costs, fail to submit documents as requested, or fail to comply with the Child Care Policies & Procedures.

Applicant Signature _____ Date _____

Co-Applicant Signature _____ Date _____

Cook Inlet Tribal Council, Inc.
3600 San Jeronimo Drive, Anchorage, AK 99508
Phone (907) 793-3307; Fax (907) 793-3296

Authorization to Obtain Personal Information

Participant's Name: Firstname Lastname DOB: 01/01/80 Last four digits of SSN: 1234

I (FL **Participant** _____ **Parent** _____ **Legal Guardian)** hereby authorize Cook Inlet Tribal Council (CITC) to:

☒ FL **Obtain protected health and other information as indicated below.**

The Participant's signature below authorizes CITC to obtain protected health information and personal information from the following organization(s).

Name: Past and present employers; Child care providers; Dept. of Health and Social Services; Div of Public Assistance; Dept. of Labor; Child Support Services Division, Selective Service System
(Facility, Organization, or Individual Name)

Address: _____ Phone/Fax: _____

PURPOSE OF INFORMATION:
At the request of the participant for the purpose of treatment or services. I understand that although this ROI provides CITC with the authority to obtain my information, CITC policies require that only the minimum necessary information be obtained for the provision of services.
Other specifications, if any:

_____

_____

Psychotherapy Notes CANNOT be released with this Authorization – see Psychotherapy Authorization to obtain those records

WRITTEN **(W)**, ELECTRONIC **(E)** AND/OR VERBAL **(V)** INFORMATION RELEASED:
(circle and initial all that apply)

(W / E / V) FL	Application for Services	(W / E / V) FL	Income and Wages
W / E / V ____	Admission Summary	W / E / V ____	Health History/Physical Records
W / E / V ____	Psychosocial History	W / E / V ____	Lab Reports (OCS and PO)
W / E / V ____	Treatment Plan (clinical)	W / E / V ____	Medication Records
W / E / V ____	Discharge Status	W / E / V ____	Career Development Assessment
W / E / V ____	Psychological Evaluation	W / E / V ____	Psychiatric Evaluation
(W / E / V) FL	Attendance/ Progress Report	W / E / V ____	Education assessments*
W / E / V ____	Immunization Records	W / E / V ____	FAS/FASD Assessments
(W / E / V) FL	Billing Information	W / E / V ____	Legal History
(W / E / V) FL	Service Plan (non-clinical)	W / E / V ____	Ho
W / E / V ____	Other (specify)_____		

***I give permission for the exchange of any and all information required for these purposes, including but no nited t des, personal information, attendance, test scores, date and place of birth, schools attended, tribal affiliation, educational barriers, appr munity agencies and other information through Zangle and other resources between CITC and ASD, and within CITC. Th exchange is p sible until this release expires, even if I am no longer a student of ASD or participant of CITC. I understand that I may request a c of the records g rele t any time. _____ (initials)**

1. I understand that: (1) I can refuse to authorize the release of any pers ealt rmat (PHI); (2) I am not required to release PHI in order to ensure health care treatment, payment, enrollment, or eligibility for h care b fits; (may t or copy the information to be used or disclosed, as provided in CFR 164.524; (4) the information released include in nation Psychiatric Treatment (except psychotherapy notes), Substance Abuse Treatment/Rehabilitation, Medica ment, HIV st . I give s ic authorization for these records to be used and disclosed. If I have questions about disclosure of my health tion, I the CITC Privacy Officer at 907-793-3403.
2. I understand that; (1) I have a right to revoke this authorizati time; (2 revoke this authorization I must do so in writing and present my written revocation to CITC for PHI records, and by ne for s and buse tr ent records; (3) the revocation will not apply to information that has already been released in response to this au (4) t evoc will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this autho n will expire the fol ng date : _____
If this space is left blank, this authori be presu to expire two (2) years after the signature date below.

3. I understand that y alcohol /or dr tment ords (if any) are protected under the Health Insurance Portability Accountability Act of 1996 (HIPAA), a acting regu ons pending on the nature of the record and treatment involved, my records may also be protected under the Fede Regulations govern dentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2. I understand that only health information covered 42 CFR Part 2 (alco and drug abuse records), will continue to be protected by law from redisclosure once it leaves CITC. However, if the informati by H AA, it is subject to redisclosure by the recipient and may no longer be protected. I understand that my records cannot be disclose by CITC be d w is permitted under this authorization without my written consent, unless provided for by the regulations.

☐ _____ **Check if inf tion being disclosed is subject to 42 CFR part 2 (alcohol and substance abuse treatment).**
NOTICE TO R – PROHIBITION ON REDISCLOSURE IF BOX IS CHECKED: This information has been disclosed to you from records that may be protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from further disclosing this information unless such disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

By my signature below, I indicate that I have read this document or have had it read to me, that I fully understand its meaning, and that I consent to its terms knowingly and voluntarily.

Firstname Lastname — Signature — 09 / 01 / 14 — Date

_____ — Signature of Guardian/Parent/Authorized Person — _____ — Relationship to Participant — _____/_____/_____ — Date

Firstname Lastname — Printed Name — 09 / 01 / 14 — Date

Signed copy received by participant: ☐ _____ **Yes** ☒ FL **No, participant declined copy**

Revised on 6-7-12

A COPY WILL SERVE AS ORIGINAL

*****THIS FORM NOT TO BE SENT OUTSIDE OF CITC*****

Cook Inlet Tribal Council, Inc.
3600 San Jeronimo Drive, Anchorage, AK 99508
Phone (907) 793-3307; Fax (907) 793-3296

Authorization to Release Personal Information Within CITC

Participant's Name: _____ DOB: _____ Last four digits of SSN: _____
I (_____ **Participant** _____ **Parent** _____ **Legal Guardian)** hereby authorize Cook Inlet Tribal Council (CITC) to:
☐ _____ **Release protected health and other information within and among CITC departments as indicated below.**
Please mark any records to be shared within CITC.

PURPOSE OF INFORMATION:
At the request of the participant for the purpose of treatment or services. I understand that although this ROI provides CITC with the authority to release my information within CITC departments, CITC policies require that only the minimum necessary information be released for the provision of services.
Other specifications, if any:

_____

_____

_____

Psychotherapy Notes CANNOT be released with this Authorization – see Psychotherapy Authorization to obtain those records

WRITTEN **(W)**, ELECTRONIC **(E)** AND/OR VERBAL **(V)** INFORMATION RELEASED:
(circle and initial all that apply)

W / E / V ____ Application for Services	W / E / V ____ Income and Wages
W / E / V ____ Admission Summary	W / E / V ____ Health History/Physical Records
W / E / V ____ Psychosocial History	W / E / V ____ Lab Reports (OCS and PO)
W / E / V ____ Treatment Plan (clinical)	W / E / V ____ Medication Records
W / E / V ____ Discharge Status	W / E / V ____ Career Development Assessment
W / E / V ____ Psychological Evaluation	W / E / V ____ Psychiatric Evaluation
W / E / V ____ Attendance/ Progress Report	W / E / V ____ Education assessments*
W / E / V ____ Immunization Records	W / E / V ____ FAS/FASD Assessments
W / E / V ____ Billing Information	W / E / V ____ Legal History
W / E / V ____ Service Plan (non-clinical)	W / E / V ____ Housing
W / E / V ____ Other (specify)_____	

***I give permission for the exchange of any and all information required for these purposes, including but not limited to grades, personal information, attendance, test scores, date and place of birth, schools attended, tribal affiliation, educational barriers, applicable community agencies and other information through Zangle and other resources between CITC and ASD, and within CITC. This exchange is permissible until this release expires, even if I am no longer a student of ASD or participant of CITC. I understand that I may request a copy of the records being released at any time. _____ (initials)**

1. I understand that: (1) I can refuse to authorize the release of any personal health information (PHI); (2)I am not required to release PHI in order to ensure health care treatment, payment, enrollment, or eligibility for health care benefits; (3) I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524; (4) the information released may include information regarding Psychiatric Treatment (except psychotherapy notes), Substance Abuse Treatment/Rehabilitation, Medical Treatment, and HIV status. I give specific authorization for these records to be used and disclosed. If I have questions about disclosure of my health information, I can contact the CITC Privacy Officer at 907-793-3403.
2. I understand that: (1) I have a right to revoke this authorization at any time; (2) if I revoke this authorization I must do so in writing and present my written revocation to CITC for PHI records, and by telephone for substance abuse treatment records; (3) the revocation will not apply to information that has already been released in response to this authorization; (4) the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
   Unless otherwise revoked, this authorization will expire on the following date : _____
   If this space is left blank, this authorization will be presumed to expire two (2) years after the signature date below.
3. I understand that my alcohol and/or drug treatment records (if any) are protected under the Health Insurance Portability Accountability Act of 1996 (HIPAA) and its enacting regulations, and that, depending on the nature of the record and treatment involved, my records may also be protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2. I understand that only health information covered by 42 CFR Part 2 (alcohol and drug abuse records), will continue to be protected by law from redisclosure. However, if the information is covered only by HIPAA, it is subject to redisclosure by the recipient and may no longer be protected. I understand that my records cannot be disclosed by CITC beyond what is permitted under this authorization without my written consent, unless provided for by the regulations.

☐ _____ **Check if information being disclosed is subject to 42 CFR part 2 (alcohol and substance abuse treatment).**
NOTICE TO RECIPIENT – PROHIBITION ON REDISCLOSURE IF BOX IS CHECKED: This information has been disclosed to you from records that may be protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from further disclosing this information unless such disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

By my signature below, I indicate that I have read this document or have had it read to me, that I fully understand its meaning, and that I consent to its terms knowingly and voluntarily.

_____ _____/_____/_____
Signature Date

_____ _____ _____/_____/_____
Signature of Guardian/Parent/Authorized Person Relationship to Participant Date

_____ _____/_____/_____
Printed Name Date

Signed copy received by participant: ☐ _____ Yes ☐ _____ No, participant declined copy

Continued from Page One - Billing Entities potentially receiving information: AETNA; Affiliated Computer Services, Inc (Medicaid); AK Pipe Trade Local 367 Health and Security; AK Electrical Health and Welfare Fund; AK HERE Health and Welfare Trust; AK Rural Employee Benefit Trust; Alaska Labors; Alaska U.C.F.W.Trust; Ameriben/IEC Group; ASEA/AFSCME Local 52 Health Benefits Trust; Blue Cross Blue Shield; Chanlyut; First Choice Health PPO Plan; Great West Health Care; Health and Welfare Benefits System; Healthcomp; Meritain Health; ODS Select Network Group; PGBA/Tricare; Principal Financial Group; Providence Health Plan; PS5 Health Plan Solutions; Risk Benefits Management Services; Salvation Army; SO AK Carpenters Health & Security Plan; SOA Office of Children's Services; American Postal Workers Union Health Plan; Zenith Administrators

Family Educational Rights and Privacy Act (FERPA): This Authorization to Release Personal Information within CITC is governed by The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99), which protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education, including the Anchorage School District.

Revised on 6-7-12 Page 1 of 1 PHOTOCOPY WILL SERVE AS ORIGINAL

Cook Inlet Tribal Council, Inc.
3600 San Jeronimo Drive, Anchorage, AK 99508
Phone (907) 793-3307; Fax (907) 793-3296

Authorization to Obtain Personal Information

Participant's Name: _____ DOB: _____ Last four digits of SSN: _____

I (_____ **Participant** _____ **Parent** _____ **Legal Guardian)** hereby authorize Cook Inlet Tribal Council (CITC) to:

☐ _____ **Obtain protected health and other information as indicated below.**

The Participant's signature below authorizes CITC to obtain protected health information and personal information from the following organization(s).

Name: Past and present employers; Child care providers; Dept. of Health and Social Services; Div of Public Assistance; Dept. of Labor; Child Support Services Division, Selective Service System, Housing/Landlords
(Facility, Organization, or Individual Name)

Address: _____ Phone/Fax: _____

PURPOSE OF INFORMATION:
At the request of the participant for the purpose of treatment or services. I understand that although this ROI provides CITC with the authority to obtain my information, CITC policies require that only the minimum necessary information be obtained for the provision of services.
Other specifications, if any:

_____

_____

Psychotherapy Notes CANNOT be released with this Authorization – see Psychotherapy Authorization to obtain those records

WRITTEN **(W)**, ELECTRONIC **(E)** AND/OR VERBAL **(V)** INFORMATION RELEASED:
(circle and initial all that apply)

W / E / V ____ Application for Services	W / E / V ____ Income and Wages
W / E / V ____ Admission Summary	W / E / V ____ Health History/Physical Records
W / E / V ____ Psychosocial History	W / E / V ____ Lab Reports (OCS and PO)
W / E / V ____ Treatment Plan (clinical)	W / E / V ____ Medication Records
W / E / V ____ Discharge Status	W / E / V ____ Career Development Assessment
W / E / V ____ Psychological Evaluation	W / E / V ____ Psychiatric Evaluation
W / E / V ____ Attendance/ Progress Report	W / E / V ____ Education assessments*
W / E / V ____ Immunization Records	W / E / V ____ FAS/FASD Assessments
W / E / V ____ Billing Information	W / E / V ____ Legal History
W / E / V ____ Service Plan (non-clinical)	W / E / V ____ Housing
W / E / V ____ Other (specify)_____	

***I give permission for the exchange of any and all information required for these purposes, including but not limited to grades, personal information, attendance, test scores, date and place of birth, schools attended, tribal affiliation, educational barriers, applicable community agencies and other information through Zangle and other resources between CITC and ASD, and within CITC. This exchange is permissible until this release expires, even if I am no longer a student of ASD or participant of CITC. I understand that I may request a copy of the records being released at any time. _____ (initials)**

1. I understand that: (1) I can refuse to authorize the release of any personal health information (PHI); (2) I am not required to release PHI in order to ensure health care treatment, payment, enrollment, or eligibility for health care benefits; (3) I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524; (4) the information released may include information regarding Psychiatric Treatment (except psychotherapy notes), Substance Abuse Treatment/Rehabilitation, Medical Treatment, and HIV status. I give specific authorization for these records to be used and disclosed. If I have questions about disclosure of my health information, I can contact the CITC Privacy Officer at 907-793-3403.

2. I understand that; (1) I have a right to revoke this authorization at any time; (2) if I revoke this authorization I must do so in writing and present my written revocation to CITC for PHI records, and by telephone for substance abuse treatment records; (3) the revocation will not apply to information that has already been released in response to this authorization; (4) the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date : _____
If this space is left blank, this authorization will be presumed to expire two (2) years after the signature date below.

3. I understand that my alcohol and/or drug treatment records (if any) are protected under the Health Insurance Portability Accountability Act of 1996 (HIPAA), and its enacting regulations, and that, depending on the nature of the record and treatment involved, my records may also be protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2. I understand that only health information covered by 42 CFR Part 2 (alcohol and drug abuse records), will continue to be protected by law from redisclosure once it leaves CITC. However, if the information is covered only by HIPAA, it is subject to redisclosure by the recipient and may no longer be protected. I understand that my records cannot be disclosed by CITC beyond what is permitted under this authorization without my written consent, unless provided for by the regulations.

   ☐ _____ **Check if information being disclosed is subject to 42 CFR part 2 (alcohol and substance abuse treatment).**
   NOTICE TO RECIPIENT – PROHIBITION ON REDISCLOSURE IF BOX IS CHECKED: This information has been disclosed to you from records that may be protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from further disclosing this information unless such disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

By my signature below, I indicate that I have read this document or have had it read to me, that I fully understand its meaning, and that I consent to its terms knowingly and voluntarily.

_____ _____/_____/_____
Signature Date

_____ _____ _____/_____/_____
Signature of Guardian/Parent/Authorized Person Relationship to Participant Date

_____ _____/_____/_____
Printed Name Date

Signed copy received by participant: ☐ _____ **Yes** ☐ _____ **No, participant declined copy**