



## The Children's Home Lower School

2011-2012

Rebecca Davis  
Administrative Asst.  
272-1725 ext. 3237  
[bdavis@thechildrenshomecinti.org](mailto:bdavis@thechildrenshomecinti.org)  
527-7345 Fax

Liz Fenimore  
Vice Principal  
272-1725 ext. 3435  
[lfenimore@thechildrenshomecinti.org](mailto:lfenimore@thechildrenshomecinti.org)

Mike McKinley  
Principal  
272-1725 ext. 3437  
[mmckinley@thechildrenshomecinti.org](mailto:mmckinley@thechildrenshomecinti.org)

Thank you for considering The Children's Home Lower School as your student's Educational provider. In ensure enrollment for your student please complete this Intake Packet and return with required documentation.

Please make sure that all forms in the Intake Packet are completed. If you have any questions please feel free to give Ms. Davis a call at 513-272-1725 ext. 3237 and she will help assist you with all paperwork.

Here is the list of documents needed. Most documents will come from the current school your child attends.

- Birth Certificate
- Immunization Record (updated)
- Court Paper (showing guardianship/foster placement)
- Current ETR also known as MFE.
- Current IEP (that should reflect "separate facility, and curb to curb transportation")

We look forward to becoming a team player in your child's education!

Sincerely,

The Children's Home Lower School Staff



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Date: \_\_\_\_\_

Returning Student:   
K-8  7-12  PH

**Student Information:**

Student's Name: \_\_\_\_\_  
First Middle Last

Student's Date of Birth: \_\_\_\_\_

Student's Gender: Male  Female  Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Primary Language Spoken in Home: \_\_\_\_\_

**Racial/Ethnic Group:**

- Asian (Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent)
- Black or African – American (Persons having origins in any Black racial groups in Africa)
- Caucasian (Persons having origins in any of the original peoples of Europe, North America, or the Middle East)
- Hispanic/Latino (Persons having origins of Hispanic or Latino peoples)
- Multi-Racial (Persons having origins in more than one racial group)
- Native American (Persons who maintain tribal affiliations or community attachment to the original peoples of North, South and Central America)
- Native Hawaiian or Pacific Islander (Persons having origins in any of the original people of Hawaii, Guam, or other Pacific Islands)
- Other (Other race not list above) \_\_\_\_\_

**Student's Residence:**

Street Address: \_\_\_\_\_ Apartment #: \_\_\_\_\_ P.O. Box #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

*\* Transportation is based on this address\**

( ) \_\_\_\_\_ ( ) \_\_\_\_\_ E-mail \_\_\_\_\_  
Home Number Cell Number

Grade Level: \_\_\_\_\_ Home School District: \_\_\_\_\_  
Entering this School Year

School Previously Attended: \_\_\_\_\_  
School Attended City, State



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**Student Lives With:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

**Parent/Guardian Information:**

Parent/Guardian Name: \_\_\_\_\_  
First MI Last

Parent/Guardian Residence:

Street Address: \_\_\_\_\_ Apartment #: \_\_\_\_\_ P.O. Box #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Home Number Cell Number E-mail

Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Step Mother (if applicable): \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Name Cell Number Work Number

Step Father (if applicable): \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Name Cell Number Work Number

**Is there a custody agreement related to this student: Yes No**

**If foster/guardian, in which district did the natural parents reside at the time of placement? \_\_\_\_\_**

**Are you interested in more information regarding Mental Health services: Yes No**

I, the undersigned, do hereby state and declare under penalty of falsification (\*) that I am the parent or legal guardian of the student named on this form and that this registration information is true and correct.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(\*) Falsification under Ohio Revised Code section 2921:13 is a misdemeanor of the first degree punishable by a maximum of six months imprisonment of a fine of \$1,000 or both.



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**Emergency Contacts:**

List below the names, relationship to the child and phone numbers of people we can call in the event of an emergency, whether health related or behavioral. Please list contacts in the order you would like them to be called. If we are unable to reach someone when an emergency arises, our School Resource Officer (SRO) will either take your student to Children Hospital Medical Center or Juvenile Detention Center (20/20). **Please be aware that if your student becomes ill or is injured and must leave the program, he or she may be released to anyone on the list below.**

**Student's Name:** \_\_\_\_\_

Contact:

(\* A Minimum of Three Contacts Must Be Listed\*)

1.	_____	_____	_____
	Name		Relationship
	_____	_____	_____
	Home Telephone	Work Telephone Number	Cell Phone Number
	_____		
	E-Mail Address		
2.	_____	_____	_____
	Name		Relationship
	_____	_____	_____
	Home Telephone	Work Telephone Number	Cell Phone Number
	_____		
	E-Mail Address		
3.	_____	_____	_____
	Name		Relationship
	_____	_____	_____
	Home Telephone	Work Telephone Number	Cell Phone Number
	_____		
	E-Mail Address		
4.	_____	_____	_____
	Name		Relationship
	_____	_____	_____
	Home Telephone	Work Telephone Number	Cell Phone Number
	_____		
	E-Mail Address		



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**Professional Contacts:**

List below the names and contact information for all professional providers including JFS Worker, Therapist, Case Managers, Probation Officers and Other Providers.

**Student's Name:** \_\_\_\_\_

**Contact:**

(\* All External Providers Must Be Listed\*)

1.	_____	_____	_____
	Name		Relationship
	_____	_____	_____
	Home Telephone Number	Work Telephone Number	Cell Phone Number
	_____	_____	_____
	E-Mail Address		Agency
2.	_____	_____	_____
	Name		Relationship
	_____	_____	_____
	Home Telephone Number	Work Telephone Number	Cell Phone Number
	_____	_____	_____
	E-Mail Address		Agency
3.	_____	_____	_____
	Name		Relationship
	_____	_____	_____
	Home Telephone Number	Work Telephone Number	Cell Phone Number
	_____	_____	_____
	E-Mail Address		Agency
4.	_____	_____	_____
	Name		Relationship
	_____	_____	_____
	Home Telephone Number	Work Telephone Number	Cell Phone Number
	_____	_____	_____
	E-Mail Address		Agency



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**Notification and Consent for Follow-Up Survey:**

I agree to be contacted after services have ended for the purposes of gathering transitional information. This information will be gathered by telephone with either you or your school district representative at 30 days, 180 days, and one year following discharge from Early Childhood Programs and Education Programs. The purpose of this information is to begin to develop some benchmarks for measuring the effectiveness of Early Childhood and Education Programs.

By signing below, I acknowledge the above information has been discussed with me and I understand the process. I also understand that I may choose at any time, not to participate in these surveys.

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Client Signature (when applicable)

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Program Enrolled



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**Authorization for Release of Information:**

I, \_\_\_\_\_ authorize the release of the records of:

Parent/Legal Guardian

\_\_\_\_\_  
Student's Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Birth

From the Following School/Institution: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

This document authorizes release of any and all treatment including, but not limited to:

- |  |   |
|--|---|
| <input type="checkbox"/> Current IEP                                     | <input type="checkbox"/> Psychiatric/ Psychological Records |
| <input type="checkbox"/> Current ETR                                     | <input type="checkbox"/> Individual Client Plans            |
| <input type="checkbox"/> Birth Certificate                               | <input type="checkbox"/> Current Medications                |
| <input type="checkbox"/> Immunization Records                            | <input type="checkbox"/> Treatment Progress Notes           |
| <input type="checkbox"/> Social History                                  | <input type="checkbox"/> Educational Records                |
| <input type="checkbox"/> Court Documents to show<br>Custody/Guardianship |   |

The records may be released and faxed or mailed to:

**Becky Davis**  
**Administrative Assistant**  
**The Children's Home Lower School**  
**5050 Madison Road**  
**Cincinnati, Ohio 45227**  
**513-272-2800 ext. 3237**  
**513-527-7345 Fax**

This Authorization for Release of Information may be revoked at any time, except to the extent that action has already been taken in reliance thereon, further, this Authorization will automatically expire ninety (90) days after the date signed, unless a longer period is specified below. Should authorization expire or be revoked, further release of information shall only be permitted upon the execution of a new Authorization.



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This consent is expected that services shall continue beyond ninety (90) days, this authorization will expire at the end of the current school year.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Date

**Emergency Medical Authorization:**

**Purpose** - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

In the event reasonable attempts to contact me at \_\_\_\_\_(phone number) or \_\_\_\_\_(other parent/guardian) at \_\_\_\_\_(phone number), have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. \_\_\_\_\_, (preferred physician) or Dr. \_\_\_\_\_(preferred dentist), or in the event the designated preferred practitioner is not available by another licensed physician or dentist and (2) the transfer of the child to \_\_\_\_\_(preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Please list all medical conditions including diagnosis/disabilities and all allergies:

\_\_\_\_\_  
\_\_\_\_\_

**Any medical problems listed will be shared with the staff involved with your child's program. If you do not want this information shared, you are required to state this in writing and submit your statement to the school. Please remember that no medication prescribed or over-the-counter will be administered to your child without the written consent of the Parent/Guardian and Physician.**

Please check below all that apply:

- |                     |                          |  |                            |                          |
|---------------------|--------------------------|--|----------------------------|--------------------------|
| Alcohol Abuse       | <input type="checkbox"/> | <del>Allergies</del> Problems & Mental | Miscarriages, stillbirths, |                          |
| Anemia              | <input type="checkbox"/> | Illness                                | neonatal deaths            | <input type="checkbox"/> |
| Arthritis           | <input type="checkbox"/> | Encephalitis                           | Paralysis                  | <input type="checkbox"/> |
| Asthma              | <input type="checkbox"/> | Epilepsy/Seizures                      | Rheumatic Fever            | <input type="checkbox"/> |
| Birth Defects       | <input type="checkbox"/> | Heart Trouble                          | Sight, hearing, speech     |                          |
| Bowel Problems      | <input type="checkbox"/> | High Blood Pressure                    | impairment                 | <input type="checkbox"/> |
| Cancer              | <input type="checkbox"/> | Hormonal Disorder                      | Tuberculosis               | <input type="checkbox"/> |
| Cystic Fibrosis     | <input type="checkbox"/> | Kidney Problems                        | Ulcers/Stomach Issues      | <input type="checkbox"/> |
| Dental Problems     | <input type="checkbox"/> | Learning Disability                    | Other: _____               |                          |
| Developmental Delay | <input type="checkbox"/> | Leukemia                               | _____                      |                          |
| Diabetes            | <input type="checkbox"/> | Liver Disorders                        |                            |                          |
| Drug Abuse          | <input type="checkbox"/> | Meningitis                             |                            |                          |

Food Allergies: Dairy  Pork  Sea Food  Red Dye  Other \_\_\_\_\_

Our kitchen staff will do their best to accommodate the special dietary needs for your child. Please remember



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that you may always pack your child a lunch for the days that we have a food that your child may be allergic to or will not eat for religious purposes.

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Date

**PARENTAL/GUARDIAN CONSENT FOR PHYSICAL RESTRAINT**

It is the policy of The Children's Home of Cincinnati, Ohio to utilize Special Treatment and Safety Measures in accordance with the regulations and requirements of all accrediting organizations and in full compliance with the standards and rules as stipulated by the Ohio Department of Mental Health.

The only Special Treatment and Safety Measures authorized for use at The Children's Home of Cincinnati, Ohio are Physical Restraints.

The philosophy of The Children's Home of Cincinnati in the use of Special Treatment and Safety Measures includes:

- Ensuring a physically and psychologically safe environment, which serves as the basic foundation and requirement for effective mental health treatment and education?
- Creating calm surroundings and establishing positive, trusting relationships, which are essential to facilitating a child's treatment and education.
- The goal of minimizing the use of physical restraint.
- Recognition that physical restraint is a very intrusive technique. Physical restraint shall only be utilized by trained, qualified staff as a last resort in order to prevent imminent harm to self or others.
- Early assessment, involving the parent or guardian, of a person's history, experiences and preferences and the effectiveness or ineffectiveness of past exposure to physical interventions. The identification of contraindications to physical restraint.
- This is a teaching environment where children are learning new behaviors. Our goal is to teach and support children in learning appropriate behaviors and interactions with other.

The program is committed to consistently monitoring the utilization of any Special Treatment and Safety Measures and continuously reviewing these via Quality Improvement processes.

I/We, \_\_\_\_\_ authorize The Children's Home of Cincinnati to provide for the day-to-day safety and security of \_\_\_\_\_ inclusive of the use of physical restraint and time-out per Ohio Department of Mental Health regulations and standards and The Children's Home of Cincinnati's policies and procedures. The Children's Home of Cincinnati will notify me on each instance of physical restraint involving my child. I understand that I can be involved in an initial behavioral assessment of my child and can request an update of that assessment following each instance of physical restraint or at any other time that I feel the need. In signing this form I am also acknowledging that I have received a copy of The Children's Home of Cincinnati's Restraint Policy, Rules and Procedure.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Relationship to Child)

\_\_\_\_\_  
Date





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\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date



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Date: \_\_\_\_\_

**Authorization to Administer Medication:**

The policy of The Children's Home of Cincinnati requires consent from the parent/legal guardian and an order from the physician before **ANY** medication can be given to a child by our nursing staff. The following information is necessary to comply with this policy.

**ALL ITEMS MUST BE COMPLETED IN FULL.**

**MEDICATIONS MUST BE BROUGHT IN BY GUARDIAN. NO STUDENT MAY BRING THEM IN.**

CHILD'S NAME: \_\_\_\_\_ D.O.B: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

\*\*\*\*\*

**TO BE COMPLETED BY PHYSICIAN ONLY:**

The above child is under my care for (diagnosis \_\_\_\_\_, and should receive  
\_\_\_\_\_ at the following times: \_\_\_\_\_.  
*Medication* *Dosage and Route*

Specific instructions for administration: \_\_\_\_\_  
\_\_\_\_\_

Possible Side Effects: \_\_\_\_\_  
\_\_\_\_\_

Effective Date: \_\_\_\_\_ Expiration Date of this Request: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Number



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**Consent for Photographic, Cinematic and/or Voice Reproduction:**

This release is based on the following conditions:

- Materials produced become the property of The Children's Home of Cincinnati
- Release is given without promise of compensation
- Release is effective until terminated by a written retraction from the person granting this authorization
- The parent or legal guardian and child/client release to The Children's Home of Cincinnati any right, title, and/or interest of any kind they may have in the records produced.

**Release for Photographic, Cinematic, and/or Voice Reproduction for publicity purposes:**

I hereby grant The Children's Home of Cincinnati the right and authority to photograph, film, and/or vocally record:

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(Please print) Child/Client Name

Age

The materials produced may be used for promotional or publicity purposes, and may be used in mass media publications, on the organization's websites and social media sites, televised, or used in film presentations. Media resources include, but are not limited to, newsletters, annual reports, brochures, professional publications, and special event/promotional materials. Actual names of clients and families will not be used. This release is effective until revoked in writing by the undersigned. Such revocation shall only be effective to prevent further use of recorded materials.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Witness (for authorization by phone)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date





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**Handbook(s) Acceptance Forms:**

**Parent/Guardian Handbook Acceptance Form**

I, \_\_\_\_\_, Parent/Guardian of \_\_\_\_\_

Have read and agree to abide by the information within the school handbook. I have read and understand these Client's Rights and Grievance Procedures as outlined in the school handbook.

\_\_\_\_\_  
**Student Name**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

**Student Handbook Acceptance Form**

I, \_\_\_\_\_, have read and agree to abide by the information within the school handbook.

\_\_\_\_\_  
**Student Name**

\_\_\_\_\_  
**Date**



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Date: \_\_\_\_\_

**Notice of Privacy Practices and Acknowledgement:**

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.

If you have any questions, please contact our Privacy Officer, whose name and number are at the bottom of this notice.

**Who will follow this notice?**

The Children's Home of Cincinnati provides health care to our clients in partnership with physicians and other professionals and organizations. The information privacy practices in this notice will be followed by:

- Any health care, mental health or social service professional who provides services to you at any of our locations.
- All departments and units of our organization, including: the Mental Health Services Department, Adoption Services Department, and Every Child Succeeds Program and all locations of these departments and programs.
- All employed associates, staff or volunteers of the Mental Health Services Department, Adoption Services Department and the Every Child Succeeds Program of the Early Childhood Services Department.
- Any business associate or partner of The Children's Home of Cincinnati with whom we share health information.

**Our pledge to you.**

We understand that health care information about you is personal. We are committed to protecting health care information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether created by facility staff or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office. We are required by law to:

- keep health care information about you private.
  - give you this notice of our legal duties and privacy practices with respect to health care information about you.
- follow the terms of the notice that is currently in effect.

**Changes to this Notice.**

We may change our policies at any time. Changes will apply to health care information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies,



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we will change our notice and post the new notice in waiting areas, exam rooms, and on our Web site at [www.thechildrenshomecinti.org](http://www.thechildrenshomecinti.org)

You can receive a copy of the current notice at any time. The effective date is listed just below the title. You will be offered a copy of the current notice each time you register at our facility for treatment. You will also be asked to acknowledge in writing your receipt of this notice.

**How we may use and disclose health care information about you.**

- We may use and disclose health care information about you for **treatment** (such as sending health care information about you to a specialist as part of a referral); **to obtain payment for treatment** (such as sending billing information to your insurance company or Medicaid); and **to support our health care operations** (such as comparing client data to improve treatment methods.)
- We may use or disclose health care information about you **without** your prior authorization for several other reasons. Subject to certain requirements, we may give out health care information about you without prior authorization for **public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements and organ donation, workers' compensation purposes, and emergencies**. We also disclose health care information **when required by law**, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders.
- We also may contact you for **appointment reminders**, or to tell you about or recommend **possible treatment options, alternatives, health-related benefits or services** that may be of interest to you, or to support **fundraising efforts**.
- If admitted as a client, unless you tell us otherwise, we will list **in the client directory** your name, service area and program enrollment, your general condition and your religious affiliation, and will release all but your religious affiliation to anyone who asks about you by name. Your religious affiliation may be disclosed only to a clergy member, and even if they do not ask for you by name.
- We may disclose health care information about you to a **friend or family member who is involved in your medical care**, or to disaster relief authorities so that your family can be notified of your location and condition.

**Other uses of health care information**

- In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing health care information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

**Your rights regarding health care information about you.**

- In most cases, **you have the right to look at or get a copy of health care information** that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.
- If you believe that information in your record is incorrect or if important information is missing, **you have the right to request that we correct the records**, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us; if it is not part of the health care information maintained by us; or if we determine that record is accurate. You may appeal, in writing, a decision by us not to amend a record.
- **You have the right to a list of those instances where we have disclosed health care information about you**, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written request. The request must state the



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time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003. You may receive the list in paper or electronic form. The first disclosure list request in a 12-month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the cost before you incur any costs.

- If this notice was sent to you electronically, **you have the right to a paper copy of this notice.**
- **You have the right to request that health care information about you be communicated to you in a confidential manner**, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.
- **You may request, in writing, that we not use or disclose health care information about you** for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request **but we are not legally required to accept it.** We will inform you of our decision on your request.

All written requests or appeals should be submitted to our Privacy Officer contact listed at the bottom of this notice.

### **Complaints**

- If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Officer (listed below). You may also contact our Client Rights Officer-Carol Smith at 272-2800.
- Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Officer can provide you the address.
- Under no circumstance will you be penalized or retaliated against for filing a complaint.

**I have read and understood these Privacy Practices and Acknowledgement:**

Privacy Officer:  
Heather Ellison  
5050 Madison Road  
513-272-2800  
hellsion@thechildrenshomecinti.org

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**Student Name**

---

**Parent/Guardian Signature**

---

**Date**



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Dear Parent/Guardian:

Children need healthy meals to learn.

**1. Do I need to fill out an application for each child?** No. Complete the application to apply for free or reduced price meals. Use one Free and Reduced Price School Meals Application for all students in your household. We cannot approve an application that is not complete, so be sure to fill out all required information. **Return the completed application with your enrollment packet.**

**2. Who can get free meals?** Children in households receiving benefits through the **Supplemental Nutrition Assistance Program (SNAP, formerly the Food Stamp Program)**, or Ohio Works First (OWF) benefits and most foster children can get free meals regardless of your income. Also, your children can get free meals if your household's gross income is within the free limits on the Federal Income Guidelines.

**3. Can homeless, runaway and migrant children get free meals?** If you have not been told your children will get free meals, please call or email to see if they qualify.

**4. Who can get reduced price meals?** Your children can get low cost meals if your household income is within the reduced price limits on the Federal Income Chart.

**5. Should I fill out an application if I received a letter this school year saying my children are approved for free meals?** Please read the letter you got carefully and follow the instructions. Call the school at **[phone number]** if you have questions.

**6. My Child's application was approved last year. Do I need to fill out another one?** Yes. Your child's application is only good for that school year and for the first few days of this school year. You must send in a new application unless the school told you that your child is eligible for the new school year.

**7. I get WIC. Can my child(ren) get free meals?** Children in households participating in WIC may be eligible for free or reduced price meals. Please fill out an application.

**8. Will the information I give be checked?** Yes, we may ask you to send written proof.

**9. If I don't qualify now, may I apply later?** Yes. You may apply at any time during the school year.

**10. What if I disagree with the school's decision about my application?** You should talk to school officials. You also may ask for a hearing by calling or writing to: **Clients Rights Officer at 513-272-2800.**

**11. May I apply if someone in my household is not a U.S. citizen?** Yes. You or your child(ren) do not have to be a U.S. citizen to qualify for free or reduced price meals.



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**12. Who should I include as members of my household?** You must include all people living in your household, related or not (such as grandparents, other relatives, or friends). You must include yourself and all children who live with you.

**13. What if my income is not always the same?** List the amount that you normally receive. For example, if you normally make \$1000 each month, but you missed some work last month and only made \$900, put down that you made \$1000 per month. If you normally get overtime, include it, but do not include it if you only work overtime sometimes.

**14. We are in the military, do we include our housing allowance as income?** If you get an off-base housing allowance, it must be included as income. However, if your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income.

**15. My Spouse is deployed to a combat zone. Is her combat pay counted as income?** No, if the combat pay is received in addition to her basic pay because of her deployment and it wasn't received before she was deployed, combat pay is not counted as income. Contact your school for more information.

**16. Why am I being asked about giving my consent for an instructional fee waiver?** Ohio public schools are required to waive the school instructional fees for children who qualify for free meal benefits. School Food Service personnel must have parent consent to share student meal application if your child(ren) qualify for a fee waiver. If you agree to allow your child(ren)'s meal application to be shared with school officials to see if he/she/they qualifies for a fee waiver then check "yes" in part 5. If you do not wish for that information to be shared, then check "no" in part 5. Answering no to this question will mean your child will not be able to be considered for a fee waiver. Answering this question either way will not change whether your child(ren) will get free or reduced price meals.

**17. My Family needs more help. Are there other programs we might apply for?** To find out how to apply for Ohio SNAP or other assistance benefits, contact your local assistance office or call 877-852-0010.

If you have other questions or need help, call **513-272-2800**.

Sincerely,

The Children's Home of Cincinnati



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**INSTRUCTIONS FOR APPLYING**

***A HOUSEHOLD MEMBER IS ANY CHILD OR ADULT LIVING WITH YOU***

**IF YOUR HOUSEHOLD RECEIVES BENEFITS FROM THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP, FORMERLY THE FOOD STAMP PROGRAM), OR OHIO WORKS FIRST (OWF), FOLLOW THESE INSTRUCTIONS:**

- Part 1:** List all household members, the school name for each child, and the **10 digit** SNAP (Food Stamp) or OWF case number for any household member (including adults). Ohio Direction Card Numbers **are not** acceptable (these are 16 digits in length). Attach another sheet of paper if you need to.
- Part 2:** Skip this part.
- Part 3:** Skip this part.
- Part 4:** Skip this part.
- Part 5:** Answer yes or no if you would like the application to be checked by school official to determine if the child(ren) qualifies for a school instructional fee waiver
- Part 6:** Sign and date the form. A Social Security Number is not necessary.
- Part 7:** Answer this question if you choose to.

**IF NO ONE IN YOUR HOUSEHOLD GETS SNAP OR OWF BENEFITS AND IF ANY CHILD IN YOUR HOUSEHOLD IS HOMELESS, A MIGRANT OR RUNAWAY, FOLLOW THESE INSTRUCTIONS:**

- Part 1:** List all household members, the school name for each child.
- Part 2:** Check the appropriate box.
- Part 3:** Skip this part.
- Part 4:** Complete only if a child in your household isn't eligible under Part 2. See Instruction for All Other Households.
- Part 5:** Answer yes or no if you would like the application to be checked by school official to determine if the child(ren) qualifies for a school instructional fee waiver



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**Part 6:** Sign and date the form. A Social Security Number is not necessary if you didn't need to fill in part 4.

**Part 7:** Answer this question if you choose to.

**IF YOU ARE APPLYING FOR A FOSTER CHILD, FOLLOW THESE INSTRUCTIONS:**

**Part 1:** Use a separate application for each foster child. List the child's name, school, and, if the child has no income, check the box "no income".

**Part 2:** Skip this part.

**Part 3:** Check the box and list the child's personal use monthly income, if any. This does not include any funds the Foster Parent(s) receives from the courts for acting as a Foster Parent. This is only the child's personal income (stipend, part-time job, etc.)

**Part 4:** Skip this part.

**Part 5:** Answer yes or no and sign if you would like the application to be shared with school officials if the child(ren) qualifies for a school instructional fee waiver

**Part 6:** Sign and date the form. A Social Security Number is not necessary.

**Part 7:** Answer this question if you choose to.

**ALL OTHER HOUSEHOLDS, INCLUDING WIC HOUSEHOLDS, FOLLOW THESE INSTRUCTIONS:**

**Part 1:** List all household members and the school name for each child. For any person, including children, with no income, you must check the "No Income Box". Attach another sheet of paper if you need to.

**Part 2:** Check the appropriate box, if any.

**Part 3:** Skip this part.

**Part 4:** Follow these instructions to report total household income from this month or last month.

**Column 1-Name:** List all household members with income. Attach another sheet of paper if you need to.

**Column 2-Gross income last month and how often it was received.** For each household member list each type of income received for the month. You must tell us how often it was received – weekly, every other week, twice a month or monthly. For earnings, be sure to list the gross income, not the take-home pay. **Gross income is the amount earned before taxes and other deductions.** You should be able to find it on your pay stub or your boss can tell you. For other income, list the amount each person got for the month from welfare, child support, alimony, pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, and ALL OTHER INCOME SOURCES. Under *All Other Income*, list Worker's Compensation, unemployment or strike benefits, regular contributions from people who do not live in your household, and ANY OTHER INCOME. For ONLY the self-employed, under *Earnings From Work*, report income after expenses. This is for your business, farm, or rental property. If you are in the Military Housing Privatization Initiative or get combat pay, do not include these allowances as income.

**Part 5:** Answer yes or no if you would like the application to be shared with school officials if the child(ren) qualifies for a school instructional fee waiver.

**Part 6:** An adult household member must sign the form and list his or her Social Security Number (or mark the box if s/he doesn't have one). Include today's date.

**Part 7:** Answer this question if you choose to.

**2011-2012 FREE AND REDUCED PRICE SCHOOL MEALS FAMILY APPLICATION**

**Part 1. ALL HOUSEHOLD MEMBERS (USE A SEPARATE APPLICATION FOR EACH FOSTER CHILD)**

Names of household members (First, Middle Initial, Last)	School Name for Each Child	10-digit Supplemental Nutrition Assistance Program* (SNAP, Food Stamp) or Ohio Works First (OWF) case # for any member of the household. <b>Skip to Part 5 if you list a SNAP* or OWF case #</b>										Check if No Incom e
												<input type="checkbox"/>
												<input type="checkbox"/>
												<input type="checkbox"/>
												<input type="checkbox"/>
												<input type="checkbox"/>
												<input type="checkbox"/>
												<input type="checkbox"/>

**Part 2. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call Jasmine Madison, homeless liaison, migrant coordinator at phone 513-272-2800.** Homeless  Migrant  Runaway

**Part 3. FOSTER CHILD** If this application is for a child who is the legal responsibility of a welfare agency or court, check this box  and then list the amount of the child's personal use monthly income: \$\_\_\_\_\_. Skip to Part 5.

**Part 4. TOTAL HOUSEHOLD GROSS INCOME—You must tell us how much and how often**

1. NAME (List all household members with income)	2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED			
	Earnings from work before deductions	Welfare, child support, alimony	Pensions, retirement, Social Security	All Other Income
(Example) Jane Smith	\$200/weekly	\$150/every other week	\$100/monthly	\$_____/_____
	\$_____/_____	\$_____/_____	\$_____/_____	\$_____/_____
	\$_____/_____	\$_____/_____	\$_____/_____	\$_____/_____
	\$_____/_____	\$_____/_____	\$_____/_____	\$_____/_____
	\$_____/_____	\$_____/_____	\$_____/_____	\$_____/_____

**Part 5. SCHOOL INSTRUCTIONAL FEE WAIVER ADULT CONSENT:** Your child(ren) may qualify for a waiver of their school instructional fees. We must have your permission to share your meal application information with school officials if your child(ren) qualifies for a fee waiver. Answering this question will not change whether your children will get free or reduced price meals.

Please check a box: ( ) Yes I agree to have my meal application used to determine if my child(ren) qualify for a fee waiver  
( ) No, I do not agree to have my meal application used to determine if my child(ren) qualify for a fee waiver

Signature of Parent/Guardian for the Instructional Fee Waiver Question  
: \_\_\_\_\_ Date: \_\_\_\_\_

**Part 6. SIGNATURE AND SOCIAL SECURITY NUMBER (ADULT MUST SIGN)**

An adult household member must sign the application. **If Part 4 is completed, the adult signing the form must also list his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this page.)

*I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will get Federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.*

Sign here: X \_\_\_\_\_ Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone \_\_\_\_\_

Number: \_\_\_\_\_

Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_  I do not have a Social Security Number

**Part 7. Children's ethnic and racial identities (optional)**

Choose one ethnicity:

- Hispanic/Latino
- Not Hispanic/Latino

Choose one or more (regardless of ethnicity):

- Asian
- White
- Black or African American
- American Indian or Alaska Native
- Native Hawaiian or other Pacific Islander

**Don't fill out this part. This is for school use only.**

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24 Monthly x 12

Total Income: \_\_\_\_\_ Per:  Week,  Every 2 Weeks,  Twice A Month,  Month,  Year Household size: \_\_\_\_\_

Categorical Eligibility: \_\_\_\_ Date Withdrawn: \_\_\_\_\_ Eligibility: Free \_\_\_\_ Reduced \_\_\_\_ Denied \_\_\_\_ Reason: \_\_\_\_\_

Temporary: Free \_\_\_\_ Reduced \_\_\_\_ Time Period: \_\_\_\_\_ (expires after \_\_\_\_ days)

Determining/Approval Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Confirming Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Follow-up Official's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If selected for Verification, Date Verification Notice Sent: \_\_\_\_\_ Response Date: \_\_\_\_\_ 2<sup>nd</sup> Notice Sent: \_\_\_\_\_

Results Sent: \_\_\_\_\_

Verification Result: No Change \_\_\_\_ Free to Reduced Price \_\_\_\_ Free to Paid \_\_\_\_ Reduced Price to Free \_\_\_\_

Reduced Price to Paid \_\_\_\_\_

**Privacy Act Statement: This explains how we will use the information you give us.**

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a **Supplemental Nutrition Assistance Program (SNAP, former Food Stamp Program)**, Ohio Works First (OWF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

**Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.** "In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer."



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**SHARING INFORMATION WITH MEDICAID/*Healthy Start, Healthy Families***

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Dear Parent/Guardian:

If your children get free or reduced price school meals, they may also be able to get free or low-cost health insurance through Medicaid or the State of Ohio Healthy Start, Healthy Families Program. Children with health insurance are more likely to get regular health care and are less likely to miss school because of sickness.

Because health insurance is so important to children's well-being, **the law allows us to tell Medicaid and *Healthy Start, Healthy Families* that your children are eligible for free or reduced price meals, unless you tell us not to.** Medicaid and *Healthy Start, Healthy Families* only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children. Filling out the Free and Reduced Price School Meals Application does not automatically enroll your children in health insurance.

If you do not want us to share your information with Medicaid or *Healthy Start, Healthy Families*, fill out the form below and send in (Sending in this form will not change whether your children get free or reduced price meals).

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**No! I DO NOT** want information from my Free and Reduced Price School Meals Application shared with Medicaid or the *Healthy Start, Healthy Families*.

**If you checked no, fill out the form below.**

Child's Name: \_\_\_\_\_ School: \_\_\_\_\_

Child's Name: \_\_\_\_\_ School: \_\_\_\_\_

Child's Name: \_\_\_\_\_ School: \_\_\_\_\_

Child's Name: \_\_\_\_\_ School: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Address: \_\_\_\_\_

For more information, you may call **Jasmine Madison** at **513-272-2800**.



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CLIENT RIGHTS

We place high value on you, as a client of The Children's Home, and pledge to respect your rights as listed below.

<b>Rights</b>	<b>Description</b>
1. The right to be treated with consideration and respect for personal dignity, autonomy and privacy.	1. <i>You have the right to be free from physical abuse, sexual abuse, and emotional abuse. If you are not sure if it is abuse, ask your CLIENT RIGHTS OFFICER or someone you trust.</i>
2. The right to service in a humane setting which is the least restrictive feasible, as defined in the treatment plan.	2. <i>You can't be committed to a hospital or put in a quiet room unless there is no other treatment to help you to be safe to yourself and others. As soon as it is safe, you must be given more freedom.</i>
3. The right to be informed of one's own condition, of proposed or current services, treatments or therapies and the alternatives.	3. <i>Ask questions. You have the right to answers and the right to know what's going on.</i>
4. The right to consent to or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent to or refuse any service, treatment or therapy on behalf of the child.	4. <i>Say yes when you mean yes and no when you mean no. A parent or guardian may do this on behalf of a child.</i>
5. The right to a current, written individualized service plan that addresses one's own mental health, physical health, social and economic needs, and that specifies the provision of appropriate and adequate services, as available, either directly or by referral.	5. <i>You must have a plan which meets your needs. It is your road map to getting on with life.</i>
6. The right to active and informed participation in the establishment, periodic review and reassessment of the service plan.	6. <i>You or a parent or guardian must be permitted to help create or change your plan.</i>
7. The right to freedom from unnecessary or excessive medication.	7. <i>Taking meds is your choice. If you refuse some or all of your meds, you don't lose other rights or services.</i>
9. The right to participate in any appropriate and available agency service, regardless of refusal of one or more other services, treatments, or therapies, or regardless of relapse from earlier treatment in that or another service, unless there is a valid and specific necessity which precludes and/or requires the client's participation in other services. This necessity will be explained to the client and written in the case record.	9. <i>Services are like a submarine sandwich made especially for you. If you (or your parent/guardian) do not want the onions, you can still have the rest of the sandwich.</i>
10. The right to be informed of and refuse any unusual or hazardous treatment procedures.	10. <i>You (or your parent/guardian) must be told of special or risky treatments and make a decision not to have them.</i>
11. The right to be advised of and refuse observation by	11. <i>Nobody can take your picture or record you in</i>



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techniques such as one-way vision mirrors, tape recorders, movies or photographs.	<i>a mental health setting without your (or your parent/guardian's) permission.</i>
12. The right to have the opportunity to consult with independent treatment specialists or legal counsel at one's own expense.	<i>12. You can have your own doctor, counselor or lawyer, but usually you must pay for it.</i>
13. The right to confidentiality of communications and of all identifying information within the limitations and requirements for disclosure of various funding and/or certifying sources, state or federal statutes, unless release of information is specifically authorized by the client, parent or legal guardian of the child.	<i>13. There are rules about who may see your records. These rules protect you from having people tell private information without your permission (or the permission of your parent/guardian).</i>
14. The right to have access to one's own records, unless restricted by adoption statutes or there are clear treatment reasons for denying access. When access is denied to specific information, the treatment plan indicates what information is restricted and the reasons for the restriction. "Acceptable reason for restriction" means that severe emotional damage will be done to the client, such that dangerous or self-injurious behavior is an eminent risk. The client or others authorized to have the information are informed about the restriction and the specific reasons for it. The restriction is valid for up to one year and thereafter must be re-issued with appropriate procedures followed. Any person authorized in writing by the client and professionally qualified to do so has unrestricted access to all information.	<i>14. You (or your parent/guardian) may see or get a copy of your own records in most cases. If you are denied the right to see your records, check with a Client Rights Officer to see if the denial is valid.</i>
15. The right to be informed in advance of the reason(s) for discontinuance of service provision, and to be involved in planning for the consequences of discontinuance.	<i>15. You cannot just be kicked out of a program or service. You must be told why and helped to find other service.</i>
16. The right to receive an explanation of reasons for denial of service	<i>16. You must know why an agency will not serve you.</i>
17. The right not to be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, lifestyle, physical or mental handicap, developmental disability or ability to pay.	<i>17. Everyone is welcome. If you have special needs, they will be provided for.</i>
18. The right to know the cost of services	<i>18. You or your parent/guardian must be told what, if anything, a service will cost. A parent/guardian will be asked to sign a fee agreement.</i>
19. The right to be fully informed of all rights.	<i>19. Your rights will be explained and you will be given a copy. If you lose it you may have another.</i>



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	<i>If you like, your rights will be read to you.</i>
20. The right to exercise any and all rights without reprisal in any form including continued and uncompromised access to service.	<i>20. If you have a complaint, you can speak up without losing services.</i>
21. The right to file a grievance.	<i>21. If you are not satisfied with the outcome when you make a complaint, you may make your complaint formal by contacting the Client Rights Officer.</i>
22. The right to have oral and written instructions for filing a grievance.	<i>22. You will be helped if you want it in making this complaint formal.</i>
23. The right to accessible written and oral communication tools when clients have difficulty understanding or reading the primary language used in the practice setting.	<i>23. Basic program information is available in your language or a translator is used so that you can fully participate in planning.</i>

If you feel one or more of your rights has been infringed upon, you have a right to file a grievance with our Client Rights Officer:

**Heather Ellison**  
**Client Rights Officer**  
**The Children's Home of Cincinnati, Ohio**  
**5050 Madison Road**  
**Cincinnati, Ohio 45227**  
**(513) 272-2800**

The Client Rights Officer is available to receive your grievance during regular business hours 7:30 a.m. to 3:00 p.m. Monday through Friday. If the Client Rights Officer is unavailable, you may contact Tom Eigel, at The Children's Home of Cincinnati.

If you have any questions, please ask any staff member. He/She will explain any aspect of our Client Rights or our grievance policy and procedure.

You may also contact one or more of the following boards or government agencies:

Hamilton County Mental health Board  
 2350 Auburn Ave.  
 Cincinnati, OH 45219  
 (513) 946-8635

State Board of Psychology  
 77 S. High Street, 17<sup>th</sup> Floor  
 Columbus, OH 43266-0321  
 (614) 466-8808  
 (614) 728-7081 (fax)  
[www.state.oh.us/phy/](http://www.state.oh.us/phy/)

U.S. Department of Health & Human Services  
 Office for Civil Rights – Region V  
 105 West Adams Street

Nursing Education & Nurse Registration Board  
 77 S. High Street, 17<sup>th</sup> Floor  
 Columbus, OH 43266-0316



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Chicago, IL 60603  
(312) 886-5078

(614) 466-3947  
[www.state.oh.us/nur](http://www.state.oh.us/nur)

Ohio Department of Mental Health  
Client Advocacy Coordinator  
30 E. Broad Street, 8<sup>th</sup> Floor  
Columbus, OH 43215-3430  
(614) 466-2333  
(614) 466-1571 (fax)  
[www.mh.state.oh.us](http://www.mh.state.oh.us)

State of Ohio Counselor and Social Work Board  
77 S. High Street, 16<sup>th</sup> Floor  
Columbus, OH 43266-0340  
(614) 466-0912

Ohio Legal Rights Service  
8 E. Long Street, 5<sup>th</sup> Floor  
Columbus, OH 43266-0523  
(800) 282-9181  
(614) 644-1888 (fax)  
[www.olrs.state.oh.us](http://www.olrs.state.oh.us)

State Medical Board  
77 S. High Street, 17<sup>th</sup> Floor  
Columbus, OH 43266-03115  
(614) 466-3934  
(614) 728-5946 (fax)  
[www.state.oh.us/med](http://www.state.oh.us/med)

ADA – Ohio  
700 Morse Rd., Suite 101  
Columbus, OH 43214  
800-949-4232 (voice)  
800-232-2321 – (TTY)  
(614) 844-5410 – (local)  
[www.ada-ohio.org](http://www.ada-ohio.org)

Attorney General's Office  
Health Care Fraud Unit  
101 E. Town St., 5<sup>th</sup> Floor  
Columbus, OH 43215  
(614) 466-0722  
(614) 644-9973 (fax)  
[www.ag.state.oh.us](http://www.ag.state.oh.us)

Client Assistance Program  
(For Vocational Rehabilitation)  
c/o Ohio Legal Rights Service  
8 East Long Street  
(614) 466-7546  
(800) 282-9181  
(614) 644-1888 (fax)  
[www.olrs.state.oh.us](http://www.olrs.state.oh.us)

Counselor & Social Work Board  
77 S. High Street, 16<sup>th</sup> Floor  
Columbus, OH 43566-0340  
(614) 466 0912  
(614) 728-7790 (fax)  
[www.state.oh.us/csw](http://www.state.oh.us/csw)

Equal Employment Opportunity  
Cleveland Office  
Skylight Office Tower  
1660 W. 2<sup>nd</sup> St., Suite 850  
Cleveland, OH 44113  
(216) 522-2001 or (216) 522-2002  
(800) 669-4000

U.S. Equal Employment Opportunity Commission  
1801 L. Street, NW, Room 9024  
Washing, DC 20507  
(202) 663-4900  
(800) 669-4000  
[www.eeoc.gov](http://www.eeoc.gov)



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U.S. Department of Medicare  
6401 Security Blvd.  
Baltimore, MD 21235-6401  
(800) 633-4227  
[www.medicare.gov](http://www.medicare.gov)

Office of the American with Disabilities Act  
Civil Rights Division  
U.S. Department of Justice  
Box 66118  
Washington, DC 20035-6118  
ADA info line (800) 514-1301  
(800) 514-0383  
[www.usdoj.gov/crt/ada/adahom1](http://www.usdoj.gov/crt/ada/adahom1)

Ohio Department of Jobs & Family Services  
30 E. Broad St., 32<sup>nd</sup> Floor  
Columbus, OH 43266-0423  
(614) 466-6282  
(614) 466-2815  
[www.state.oh.us/odjfs](http://www.state.oh.us/odjfs)

U.S. Department of Social Security  
Office of Public Inquiries  
6401 Security Blvd.  
Room 4-C-5 Annex  
Baltimore, MD 21235-6401  
(800) 772-1213  
(800) 325-0778 (TTY)

Ohio Governor's Council on People with  
Disabilities  
400 E. Campus View Blvd.  
Columbus, OH 43235  
(800) 282-4536 Ext. 1391 or  
(614) 438-1391 (both voice & tty)  
[www.state.oh.us/gcpd](http://www.state.oh.us/gcpd)

President's Committee on Employment of People  
with Disabilities  
1331 F Street, NW, Suite 300  
Washington, DC 20004  
(202) 376-6200  
(202) 376-6205 (TTY)  
[www.pcepd.gov](http://www.pcepd.gov)

Ohio Psychiatric Association  
1350 W. 5<sup>th</sup> Ave., Ste. 218  
Columbus, OH 43212-2907  
(614) 481-7555  
(614) 481-7559 (fax)

Ohio Resource Center on Deafness  
500 Morse Road  
Columbus, OH 43214  
(614) 781-6670  
(614) 781-9960 (TTY)  
(614) 781-9959 (fax)  
(877) 781-6670 (toll free)  
[ORCD@osd.ode.state.oh.us](mailto:ORCD@osd.ode.state.oh.us)



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I have read and understood these Client Rights:

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Date**

Revised 2/12/10

\_\_\_\_\_  
**Date**