Virginia HEALS

Caring Collaboration, Empowering Families

REFERRAL AND RESPONSE PROTOCOL

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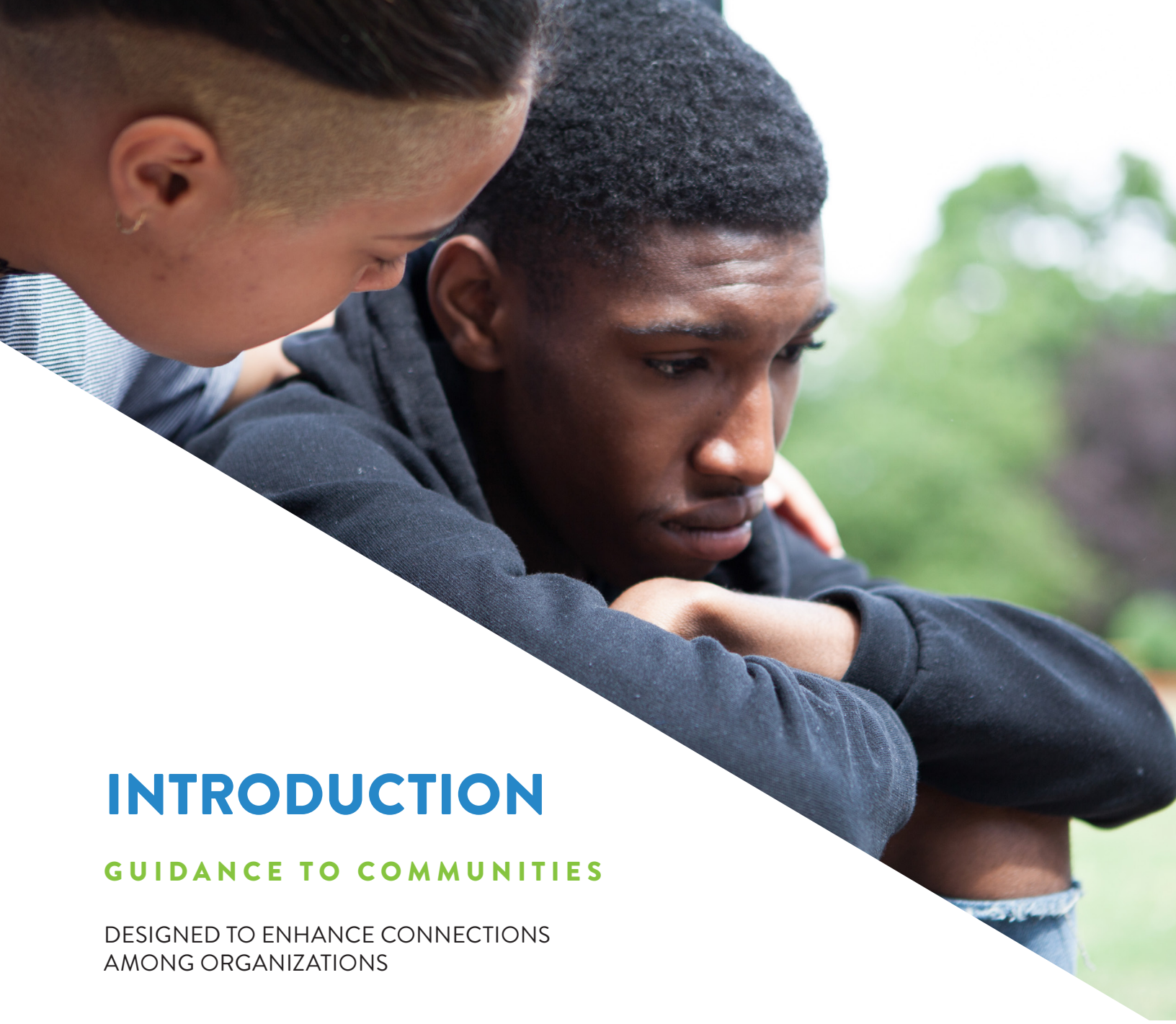


INTRODUCTION

GUIDANCE TO COMMUNITIES

DESIGNED TO ENHANCE CONNECTIONS AMONG ORGANIZATIONS

The Referral and Response Protocol (Protocol) provides guidance to communities as they encounter children, youth, and families that have experienced trauma. It is designed to enhance connections among diverse organizations and systems including, but not limited to: child welfare, behavioral health, public health, juvenile justice, education, early childhood development, housing, and victim advocacy, as well as community based, culturally specific programs or faith communities. The Protocol will also help familiarize community leaders with promising practices and program models to provide trauma-informed services and support to children, youth, and families that have been impacted by victimization/trauma, improving the experiences for those receiving services.

While children and youth are the specific focus of the Protocol, support of parents/kin/caregivers is inextricably linked to the wellbeing of the children and youth in their lives and much of the Protocol is relevant for both youth and adults. Additionally, in order for a local referral and response process to address the needs of those disproportionately impacted by victimization and trauma, specific attention must be given to making these components and processes both relevant and accessible to marginalized and oppressed communities, i.e. Black/African American youth, Latinx youth, Immigrant/Refugee youth, LGBTQ+ youth, those experiencing poverty and/or homelessness, living in foster care, and with diverse abilities.

INTENDED AUDIENCE

COMPONENTS AND ELEMENTS

AGENCY/ORGANIZATIONAL LEADERSHIP AND FRONT LINE STAFF

Section 1: **Program and Community Components** is for agency/organizational leadership and multi-disciplinary teams (MDTs) (e.g. Trauma Informed Community Networks or Community Policy and Management Teams). Section 1 provides guidance on specific components that support successful referrals and referral responses. Some of the components are relevant across organizations/systems and some are more specific to particular organizations/systems.

Section 2: **Elements of Referral and Response** is for front line staff providing direct services to children, youth, and families. Section 2 outlines a distinct process for linking children, youth, and families to needed services and support. Section 2 helps answer the question, "What do I do once I find out about the victimization/trauma that this child, youth, or family has experienced?"

SECTION 1

PROGRAM AND COMMUNITY COMPONENTS

Section 1 is divided into seven components that support successful referrals and referral responses occurring across organizations/systems that may be adopted by an organization or by an entire locality. Where specific resources are mentioned, links are provided which connect to the Virginia HEALS website. The components include:

1. Resource Mapping
2. Resource Directory
3. Memorandums of Understanding
4. Routine Engagement Across Systems/Organizations
5. Training
6. Accountability
7. Promising Practices/Program Models

COMPONENT 1

RESOURCE MAPPING

Developing a broad understanding of the resources available in the community for children, youth, and families that have been impacted by victimization/trauma and identifying gaps in services is one of the first steps for any MDT in developing a successful referral/response process.

Resource mapping allows MDTs to: 1) identify resources in the community 2) learn about gaps between resources and community needs 3) promote collaboration. A resource mapping process can be facilitated in a number of different ways and can form the basis for a local service provider directory (Component 2). When identifying resources within the mapping process, participants should think about support and resources very broadly. The list may include local non-profit organizations, faith communities, informal or non-traditional sources of support, or government agencies. The process should result in as many diverse agencies and organizations being identified as possible.

MDTs should plan to re-visit the resource mapping exercise periodically to ensure that the information remains up-to-date and that as new resources are developed they are incorporated. Resource mapping is not just an exercise to engage in at the beginning of a process of strengthening a community's referral and response processes; it should be an ongoing practice.

COMPONENT 2

RESOURCE DIRECTORY

A resource directory can help service providers

- make targeted referrals based on individual identity and need;
- engage families in creating collaborative and comprehensive plans for the future; and
- collaborate with agencies/organizations to leverage resources and funding to serve young victims and their families better.

A resource directory should include readily available information, as well as lesser-known programs and services that may be available in the community. Some steps to consider in the development of local resource directory include:

Ask partners and other allied agencies and organizations to share lists or directories that have already been created for internal use.

Conduct a community resource mapping exercise (Component 1).

Conduct interviews and/or focus groups and ask families where they turn for information and/or support and care (incentives should be provided to community members for participation/input).

Encourage identified resource agencies/ organizations to join Unite Virginia, a coordinated care network of health and social care providers.

A current directory with detailed service information (e.g. cost, accessibility, required identification/documentation) allows service providers to make targeted referrals that meet the specific needs of children, youth, and families.

COMPONENT 3

MEMORANDUMS OF UNDERSTANDING (MOU)

Written agreements between organizations, departments, and systems that serve children, youth, and families is another critical element in establishing coordinated referral and response processes. MOUs are intended to express a common vision and represent a commitment among or between service providers and other relevant agencies, to adhere to specific principles and shared responsibilities for the cross-organization engagement and referral and response success.

When developing MOUs, stakeholders must define the roles and responsibilities of each involved party, as well as the areas of shared responsibility. Detailing these roles and responsibilities will allow community partners to engage in a process of mutual and self-accountability (Component 6). MOUs should be developed with the understanding that it is a living document and subject to changes, as needed.

An MOU of this type is not a legally binding contract; it is a document of good faith and a way to avoid misunderstandings by clearly delineating expectations, roles, and responsibilities. Key elements of an MOU include the following (Appendix D):

- Introduction of Key Partners
- Shared Mission and Vision
- History of Involvement
- Roles and Responsibilities
- Information Sharing Parameters (Appendix E)
- Commitment to Partnership
- Financial Responsibilities
- Time Period
- Contact Information/Signatures

COMPONENT 4

ROUTINE ENGAGEMENT ACROSS SYSTEMS/ORGANIZATIONS

Engaging with other agencies and organizations on a routine basis provides opportunities for organizational relationship building, cross training, and on-going opportunities to revisit, update, and clarify the inter-agency agreements listed above. Additionally, routine engagement helps community partners identify and articulate common values related to working with children, youth, and families that have been impacted by victimization and trauma.

The methods utilized to create a culture of regular engagement and communication should be unique to each community and make every effort not to present additional burdens to staff. Things to consider when exploring engagement options:

- Current landscape of cross-systems/multidisciplinary team meetings
- Information sharing parameters of the various MDT meetings
- Reducing MDT member burnout by integrating the work of referral and response into existing MDT meetings
- Opportunities to include additional voices that are not represented on your teams
- Strategies for building relationships with communities that are not represented without placing additional burdens on those communities
- Leveraging technology to make MDT meetings or trainings more accessible
- Clarity about the purpose and function of meetings
- Methods to incorporate the experiences and voices of children, youth, and families in ongoing engagement processes
- Process for engaging or re-engaging with an agency or organization that is not attending MDT meetings (outline accountability processes in MOU's [Component 3])
- Opportunities to incorporate regular cross training into engagement methods (Component 5)
- Processes for making meetings linguistically accessible (interpreters, translated documents, etc.)

The methods utilized to create a culture of regular engagement and communication should be unique to each community and make every effort not to present additional burdens to staff.

COMPONENT 5

TRAINING

Training and professional development opportunities for individuals that support children, youth, and families in communities are essential to an effective referral and response process. MDTs should consider the development of a comprehensive training plan for staff, including needs assessments, learning objectives, and evaluations. In addition to trainings that address professional continuing education, consider additional trainings on diverse, relevant topics offered by local or statewide community-based, culturally specific organizations.

Training topics addressing the service needs of diverse children, youth, and families that have been impacted by trauma include, but are not limited to, the following:

- Addiction and recovery
- Child/youth engagement
- Child/youth development
- Critical thinking
- Cultural humility
- Culturally specific topics (information/resources specifically related to LGBTQ+ communities, immigrant/refugee communities, disability communities, communities of color, etc.)
- Family engagement
- Historical trauma
- Information sharing across organizations/systems
- Mandatory reporting complexities
- Time management
- Secondary trauma
- Trauma-informed practices
- Trauma-informed screening for victimization/trauma
- Trauma-informed supervision
- Understanding common definitions/terminology across organizations/systems

Consider additional trainings on diverse, relevant topics offered by local or statewide community-based, culturally specific organizations.

COMPONENT 6

ACCOUNTABILITY

A referral and response process should also include the development of feedback practices to help organizations and systems ensure that services reflect good practice as it relates to providing support, care, and interventions to children, youth, and families that have been impacted by trauma. These processes must provide opportunities for youth, families, and caregivers, as well as service providers, to provide feedback to organizations and systems that are participating in making referrals and responding to children, youth, and families.

Accountability processes can be both separate practices and/or integrated with other program components of a successful referral and response protocol that have been discussed previously. For example, processes for accountability can be incorporated into written agreements (Component 3) and into routine engagement strategies (Component 4) used by child, youth, and family-serving organizations.

ADDITIONAL ACCOUNTABILITY CONSIDERATIONS INCLUDE:

- **Engage children and youth in the development of accountability processes in a way that does not burden them;**
- **Use follow-up surveys/reviews/focus groups and adjust programming based on feedback;**
- **Compensate community members for their time and input (e.g. incentives, meals, per diem, travel reimbursement);**
- **Collect and analyze community data;**
- **Produce and disseminate regular reports of a qualitative and quantitative nature for community to demonstrate transparency and accessibility.**

COMPONENT 7

PROMISING PRACTICE/PROGRAM MODELS

Active collaboration supports the practice of successful referrals and referral responses. Decreasing silo's and increasing agency connections is an ongoing process that takes effort, but will significantly benefit the children, youth, and families that have been impacted by victimization and trauma in Virginia.

A number of promising practices and program models exist regarding referral and response processes. Themes related to successful processes in communities across systems and organizations are listed below.

- Staff, leadership, and volunteers reflect the racial, ethnic, linguistic, cultural, sexual orientation, and gender identities of those that they serve
- Organizations provide consistent, in-person assistance in navigating systems
- Care coordinators, parent support partners, community navigators specifically advocate for the community members' interests
- Peer support providers (individuals with lived experience) are employed/involved in the work
- Drop in model (voluntary, optional services)
- Co-location of resources (e.g. Family Justice Centers)
- Programming that supports the family as a whole without fragmenting/separating them
- Community has multiple opportunities for round table approach (FAPT meeting; rapid response team) where multiple systems come together on behalf of the youth

SECTION 2

ELEMENTS OF REFERRAL AND RESPONSE

ESTABLISH RAPPORT

In order to establish trust and understanding with children, youth, and their families, it is important to establish rapport.

A number of techniques may be used to establish rapport, varying, as appropriate, across systems. Motivational interviewing, reflective listening, and the Wiekart Model are strategies often used by behavioral health professionals to build rapport. Age and developmental level are important considerations when determining effective rapport building techniques.

A child's concept of their sexual orientation can begin to form as early as age six, and their gender identity can form as early as age three.

Assess for Racial/ethnic, cultural/linguistic, sexual orientation/gender identity, and diverse ability considerations during the rapport building process, as having this information is critical to building relationships and making an appropriate and person-centered referral. The best way to make this assessment is by asking questions verbally and directly (e.g. "How do you identify your ethnicity?", "How do you identify your sexual orientation?", "Which pronouns do you use?")

Ask the child, youth, who they consider their family. Utilize an expanded definition of family that includes all forms (kin, extended family members, and supportive people in a child's life) to help identify connections, recognizing that some people who play the most supportive roles and serve as protective factors in a child's life may not be related.

An important component of establishing rapport is being direct and transparent about any reporting mandates to which you may be subject (e.g. child abuse or neglect, disclosures of harm to self or others, etc.). If you do not make these disclosures early, it could diminish trust and may result in the person not seeking help from you or other service providers in the future.

ELEMENTS OF REFERRAL AND RESPONSE

SCREEN FOR TRAUMA AND/OR VICTIMIZATION

Screening tools can identify the presence of victimization or other traumatic life experiences. In order to identify victimization and/or trauma, an evidence-informed screening tool should be used.

Consider identity when selecting a screening tool. (e.g. Is the tool available in multiple languages? Is the terminology on the tool gendered?)

Screening is NOT re-traumatizing when conducted in a trauma-informed manner.

Participate in training on the screening tool that you select to ensure that you have the skills to appropriately and properly administer it.

When screening a child or youth, obtaining consent from a parent or legal guardian is required with a few exceptions (e.g. youth 13 and older seeking mental or reproductive health services).

When offering options for referrals, consider organizations and individuals that you know promote trauma-informed practice.

It should also be standard practice to obtain permission from the child or youth. During this process, the purpose of the screening and the right to skip or choose not to answer any questions, or stop the screening at any time, is explained to the child or youth to better ensure that they understand they have a voice in what happens in their lives.

Screening should be conducted in a private and, if applicable and possible, child-friendly and developmentally appropriate space. If using an office, however, make sure that the child, youth, and/or family member is comfortable with having the door closed.

ELEMENTS OF REFERRAL AND RESPONSE

DETERMINE IMMEDIACY AND PRIORITY OF NEED

Information should be solicited from the child, youth, and/or family members and from the screening tool to determine the immediacy and priority of need for interventions and/or referrals.

It is important to solicit input from the child, youth, and/or family about their perception as to immediacy and priority of need, as they are the experts in not only their safety but also in what are the most critical things to address and in which order.

Screening tools typically provide some information about risk factors and immediacy of need for interventions and/or referrals. Indications of acts and/or thoughts of harm to self or others typically set a crisis plan in motion. Other risk factors that may be indicated on a screening tool include whether a parent or caregiver perpetrated an abuse on a child or youth and how recently a crime or other traumatic event has occurred.

ELEMENTS OF REFERRAL AND RESPONSE

DISCUSS AND DETERMINE APPROPRIATE REFERRAL

When determining appropriate referrals, provide multiple opportunities to engage children, youth, and their families in discussions about their needs, expectations, goals and aspirations, as well as capacity of your agency or others to respond to them.

Ask the child, youth, and family for input about where they have sought help and/or services before. Previous experiences with different resources/systems will likely determine what options are viable and effective for them and/or influence their decision as to whether they will follow through.

Intentionally consider and fully utilize extended community, informal, and non-traditional sources of support (e.g. faith-based, culturally specific services). Sustainability and investment increase with non-systems support.

When determining which agencies/organizations/programs might be possible referral options, keep racial/ethnic, cultural/linguistic, sexual orientation/gender identity and diverse ability considerations at the forefront. (e.g. are there bilingual, bicultural staff? Are there LGBTQ+ identities represented on staff? Is the space wheelchair accessible?) If there is not a culturally specific resource available locally, look to see whether it is available in a neighboring locality, regionally, or statewide.

Consider logistics:

- Transportation — Does the person have a driver's license and a vehicle? If not, is the agency to which the referral is being made accessible by public transportation? Is assistance with bus vouchers available?
- School/work hours — Considering school and/or work schedules, are the services available during times when they can be accessed by children, youth, and their caretakers?
- Child care — Is child care offered on site while services are being provided? Is there a fee?
- Cost — Is there a fee for services? Is there a sliding scale? Are there resources available to provide financial assistance?
- Age/Relationship — Does the resource provide services to the entire family or just children/youth?

When making referrals, consider the least restrictive resource (e.g. in-home rather than residential treatment).

Be transparent.

- Provide possible pros and cons of different referral options; provide possible scenarios of what might happen.
- Note the limitations of your own particular agency/organization and other referral options.
- Communicate information about waiting lists.
- Address what can be done with/without parent or legal guardian participation and consent. (Can services be accessed without permission at the referral destination?)
- Be specific about who will provide which services (paid staff or volunteers, clinicians or interns, etc.).
- Be clear about the potential limitations of continuing particular services if they are no longer paid for by a third party.

Determine what interventions or services will be provided by your agency/organization and what will be provided by others. Acknowledge and communicate that your services will remain an available resource, regardless of follow-through on the referrals offered or made.

ELEMENTS OF REFERRAL AND RESPONSE

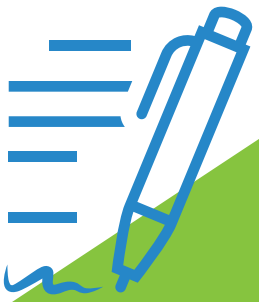
OBTAIN AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

In order to legally share or exchange information about a child, youth, or family across organizations/systems, one must obtain an authorization to release information that is specific to the organizations or systems that are involved in the referral and response.

When requesting that an authorization for release of information be signed, be transparent:

- Explain exactly what your information you are requesting to share, with whom, when the release expires, and whether it will it be shared with an individual or with a team of people
- Explain the benefits and the risks of sharing the information

Consider a Limited Referral Release of Information Form (Appendix E), which would allow the individual agency/organization to which the referral was made to communicate back as to whether the child, youth, and/or family followed through with the referral. For exchange of further information, or for exchange of information with other service providers, additional release forms may be required that meet system-specific requirements (Appendix F).



ELEMENTS OF REFERRAL AND RESPONSE

MAKE REFERRAL

Referring a child, youth, or family to another organization or system is a person-centered process that should continue to engage children, youth, and their families until they access the referral.

Contact the referral agency/organization to inform them that the referral is being made. Discuss and determine whether there is capacity to accept the referral, particularly if it is a systems-based referral and there are consequences if the services are not provided within a particular timeframe.

Consider whether accompaniment is possible, given your time constraints, confidentiality, appropriateness, etc. Be transparent about your capacity to support children, youth, and their families through the process of accessing the referral.

A warm handoff, also referred to as a warm referral, describes a referral practice wherein the service provider directly introduces the child, youth, and family to the person to whom they are being referred.

Ask the child, youth, and family about how they would like the referral to be made, given what is possible.

- Accompany them to the referral agency
- Call the referral agency together (warm handoff)
- Call the referral agency on their behalf (without them present)
- Provide the contact information for the referral agency and ask them to confirm that they reached someone

Establish next steps:

- Amount/extent of contact
- Best ways to contact (times, in person or by phone, etc.). Consider implementing standard timeframes for doing this follow up
- Emphasize open-door ("no shame") policy and that your agency is an available resource for the child, youth, and family whether they follow through with referral offered or not

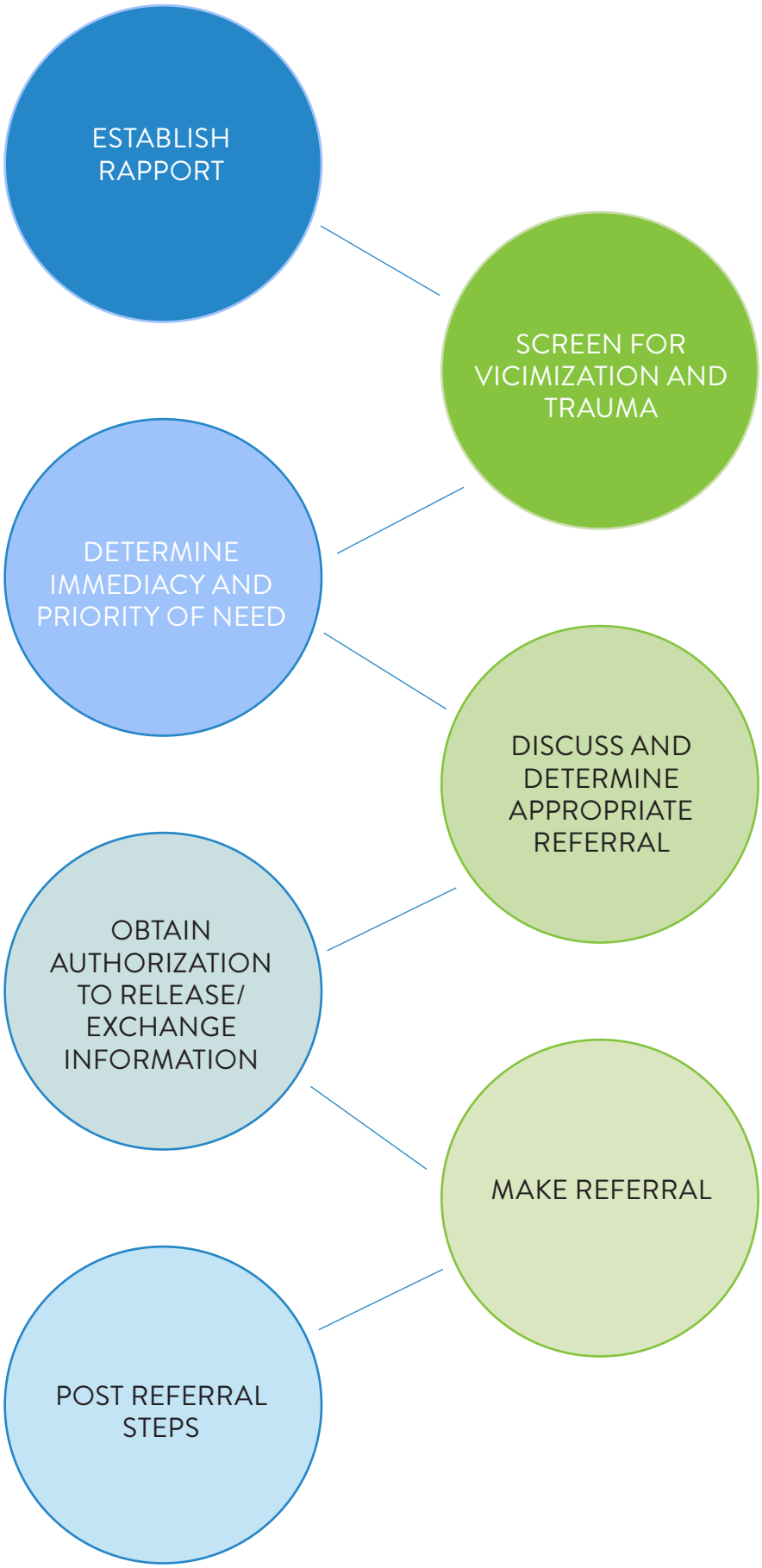
POST REFERRAL STEPS

A comprehensive referral and response process includes efforts on the part of both the agency/organization that made the referral and the agency/organization that received the referral.

1. The agency to which the referral has been made will engage with the child, youth, and family within previously agreed upon time frames (in a Memorandum of Understanding or other written agreement.)
2. If consent has been given, the referral agency will confirm contact with the referring agency within the specified time frame.
3. The referring agency will contact the child, youth, and family to find out whether their needs have been met or if further services are needed based on the previously established follow up plan.
4. If written consent has been given, the referring and referral agencies will communicate and coordinate the additional services and support needed.

If a referral is not a good fit for the child, youth, and family, both referring and referral agencies should make every effort to find a resource that meets their needs.

ELEMENTS OF REFERRAL AND RESPONSE



APPENDIX A

BACKGROUND ON VIRGINIA HEALS PROJECT

Virginia was one of four states funded by the United States Department of Justice, Office of Justice Programs, Office for Victims of Crime as a Linking Systems of Care (LSC) for Children and Youth demonstration project now referred to as Virginia HEALS. The goal of the project is to identify children and youth who have had crimes committed against them and to address the potential serious and long-lasting consequences of exposure to crime. The project gave Virginia an opportunity to collaboratively create, strengthen, and improve the coordination of services provided by the many child and youth-serving systems to ensure that:

1. children are screened for victimization;
2. children, youth, and families are provided comprehensive and coordinated services to fully address their needs; and
3. policies and practices are established to sustain this approach long-term

Guiding Principles and Values

The Guiding Principles and Values for Virginia HEALS are designed to guide efforts to develop and better align all of the systems of care that respond to the needs of children, youth, and families who have experienced victimization or trauma.

Principle I: Healing Individuals, Families, and Communities

Principle II: Linked Systems of Care

Principle III: Informed Decision Making

The following values inform the work of linked systems of care:

- Communicate effectively
- Share information
- Implement trauma-informed efforts (including recognizing various forms of trauma and avoiding re-traumatization)
- Adopt strength-based and resiliency-focused policies, practices, and interventions
- Embrace a client-centered perspective to service provision
- Empower children, youth, and families to have a voice in the decision-making process

APPENDIX B

TERMS/DEFINITIONS

Accessibility: is the design of services, environments, and/or resources for people with diverse abilities, including physical, emotional, or cognitive challenges. Accessibility can be viewed as the "ability to access" and benefit from some system or entity. The concept focuses on enabling access for people with diverse abilities or enabling access through the use of assistive technology; however, research and development in accessibility brings benefits to everyone.

Accountability: a system that serves to prompt and encourage organizations, systems, and people to keep their promises to each other and starts with a broad based effort to set and measure performance standards across an organization's or system's functions.

Cultural Humility: the process of maintaining a willingness to suspend what you know, or what you think you know, about a person based on generalizations about their culture. Rather, what you learn about an individuals' culture stems from being open to what they themselves have determined is their personal expression of their heritage and culture.

Disproportionately Impacted: when the percentage of persons impacted from a particular racial, ethnic, gender, age, or disability group is significantly different from the representation of that group in the general population.

Diverse Abilities: ability is the resources to perform well at something, while disability is the limits or challenges a person faces, including physical, emotional, or cognitive challenges. Having a variety of talents and limits is called diverse abilities.

Family [legal and chosen]/parents/kin/caregivers: broadly used, this term includes extended family members and all supportive people in a child's life who have been in an -emotionally ¬significant ¬relationship with the child, youth, or family.

Latinx: relating to people of Latin American origin or descent (used as a gender-neutral or non-binary alternative to Latino or Latina).

Homelessness: people who are living in a place not meant for human habitation, in emergency shelter, in transitional housing, or are exiting an institution where they temporarily resided for up to 90 days, and were in shelter or a place not meant for human habitation immediately prior to entering that institution.

Immigrant: a person who makes a conscious decision to leave his or her home and move to a foreign country with the intention of settling there. There are distinctions between an immigrant, an asylum seeker, a migrant, and a refugee (see below).

- **Asylum seeker**: a person who is also seeking international protection from dangers in his or her home country, but whose claim for refugee status has not been determined legally.
- **Migrant**: a person who is moving from place to place (within his or her country or across borders), usually for economic reasons such as seasonal work.
- **Refugee**: a person who has been forced to flee his or her home because of war, violence, or persecution, often without warning.

Language Justice: best practices for creating inclusive multilingual spaces where all languages are valued equally and speakers of different languages benefit from listening to and sharing with one other.

LGBTQ: (L)esbian, (G)ay, (B)isexual, (T)ransgender, (Q)ueer and (Q)uestioning.

- **Lesbian**: a term used by some female-identified people who are primarily or exclusively attracted to other female-identified people.

APPENDIX B *CONTINUED*

TERMS/DEFINITIONS

- **Gay**: a term most commonly used by male-identified people who are primarily or exclusively attracted to other male-identified people. This term can also be used by women and is sometimes used to describe the LGBTQ+ community, as a whole.
- **Bisexual**: a term used to indicate a potential attraction to more than one gender.
- **Transgender**: a term for people whose gender identity is different from the sex they were assigned at birth.
- **Queer**: a broad term that some LGBTQ people have reclaimed, while others still consider it derogatory, this term can refer to either to gender identity or sexual orientation, or both, and can be used by any gender.
- **Questioning**: a term that refers to either an identity or a process of introspection whereby one learns about/explores their sexual orientation and/or gender identity. Questioning can happen at any age and/or at multiple times throughout one's lifetime.

Poverty: a social condition that is characterized by the lack of resources necessary for basic survival or necessary to meet a certain minimum level of living standards expected for the place where one lives. The income level that determines poverty is different from place to place, so it is best defined by conditions of existence, like lack of access to food, clothing, and shelter. People in poverty typically experience persistent hunger and inadequate or absent employment, education, and health care.

Referral Agency: the agency, organization, or system that is receiving the referral.

Referring Agency: the agency, organization, or system from which a referral is being made.

Trauma: results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

Trauma-informed program, organization, or system is one that:

1. realizes the widespread impact of trauma and understands potential paths for recovery;
2. recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. responds by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. seeks to actively resist re-traumatization.

Historical Trauma: multigenerational trauma experienced by a specific racial, ethnic, cultural, or marginalized group. Historical trauma can be experienced by anyone living in families at one time marked by severe levels of trauma, poverty, dislocation, war, etc., and who are still suffering as a result.

Vicarious Trauma (also referred to as secondary trauma): the exposure to the trauma experiences of others and is an occupational challenge for those who have experienced violence and/or trauma. Working with victims of violence and trauma changes the worldview of responders and puts individuals and organizations at risk for a range of negative consequences. A vicarious trauma-informed agency or system recognizes these challenges and proactively addresses the impact of vicarious trauma through policies, procedures, practices, and programs.

APPENDIX C

INITIAL REFERRAL: LIMITED RELEASE OF INFORMATION FORM

READ FIRST: You have the right to keep information about you private. The only time your personal information should be shared is when you choose to for specific services or if we are compelled by law or court order.

- By signing this form, you are giving permission for **[Agency Name]** to confirm that you have accessed services to which you were referred.
- You never have to agree to share your information. We will still help you and provide our services.
- You can change your mind about sharing your information at any time.

These are my instructions for [Agency Name] to share my information:

_____

_____

I want this information about me shared:

- My name and whether I have contacted [Agency Name]
- Whether or not services are being provided

I want the information shared with this person or agency: [Agency Name]

I want the information shared:

- ○ in person
- ○ by phone
- ○ by fax
- ○ by mail
- ○ by e-mail
- ○ by text
- ○ by other method: _____

I want [Agency Name] to stop sharing the information above on _____ **(date)**.

I know that I can change my mind and tell [Agency Name] to stop sharing sooner than the date above. **(initial)**

Parent/Guardian signature (if required):

Signed: _____ ***Signed:*** _____

Printed Name: _____ ***Printed Name:*** _____

Date: _____ ***Date:*** _____

EXTENDING THE RELEASE

For exchange of further information, or for exchange of information with other service providers, an additional release form is required.

APPENDIX D

MEMORANDUM OF UNDERSTANDING (MOU) SAMPLE/TEMPLATE

MEMORANDUM OF UNDERSTANDING

Between

(Partner)

and

(Partner)

This Memorandum of Understanding (MOU) sets for the terms and understanding between the (partner) and the (partner) to (insert activity).

Shared Mission and Vision
Each participating agency or system will bring its own values, philosophical foundations, and knowledge to the collaboration. Many collaborations have found it helpful to include in an MOU the intersections of the participating agency or system's missions and how they combine to create a collective vision.

History of Involvement
This section can be included to briefly describe previous work that the participating agencies or systems have engaged in together if they have worked together in the past on projects.

Roles and Responsibilities
This section should be detailed and specific about the roles and responsibilities of each party. Include specific timeframes that referral/response actions are to occur within and details related to participation in routine engagement across systems/organizations.

Information Sharing Parameters
This section should detail the legal requirements of each MOU partner related to exchanging information about a community member where a referral was made between agencies/systems. If possible, attach release of information forms from each participating agency (Appendix D).

Commitment to Partnership
This section describes each participating agency or system's commitment to the partnership and may include a detailed allocation of personnel, space, time, and other resources to support the collaborative.

Financial Responsibilities
Specify that this MOU is not a commitment of funds.

Time Period
This MOU is at-will and may be modified by mutual consent of authorized officials from (list partners). This MOU shall become effective upon signature by the authorized officials from the (list partners) and will remain in effect until modified or terminated by any one of the partners by mutual consent. In the absence of mutual agreement by the authorized officials from (list partners) this MOU shall end on (end date of partnership).

APPENDIX D *CONTINUED*

MEMORANDUM OF UNDERSTANDING (MOU) SAMPLE/TEMPLATE

Contact Information

Partner name _____

Partner representative _____

Position _____

Address _____

Telephone _____

Fax _____

E-mail _____

Partner name _____

Partner representative _____

Position _____

Address _____

Telephone _____

Fax _____

E-mail _____

Date: _____

(Partner signature) _____

(Partner name, organization, position) _____

Date: _____

(Partner signature) _____

(Partner name, organization, position) _____

APPENDIX E

QUICK REFERENCE GRID ON INFORMATION SHARING LAWS IN VIRGINIA

SHARING INFORMATION REGARDING SERVICES TO CHILDREN AND FAMILIES

This grid was created with technical assistance from a federal grant program (Project AWARE) in order to share information between youth-serving organizations surrounding mental wellness and mental health, professionals who's interactions with youth and families are covered under federal FERPA, HIPAA and VAWA, as well as the Code of Virginia. Project AWARE (Advancing Wellness and Resilience in Education) is a five-year grant that was awarded to the Virginia Department of Education in October of 2014 from the Substance Abuse and Mental Health Services Administration (SAMHSA; #1H79SM061897). The project's ultimate purpose is to advance wellness and resilience in education for youth and families by improving access to mental health prevention supports, connecting children and youth with behavioral health issues to needed services, and increasing mental health literacy through training and promotion.

Notes to Grid:

- This grid highlights the most relevant provisions of applicable confidentiality law when agencies are sharing information related to service provision to youth. The descriptions are brief.
- Agencies and providers should reference the cited law for more information on how to implement the specific exception.
- This grid **does not reference every information-sharing provision and exception in each law.** Rather, key provisions were selected based on the information sharing goals of this project. The grid therefore should be understood in that context and not assumed to include everything.
- Where an authorization to release information is required, often the applicable law requires the release form include certain information and/ or elements to be valid. The law also will define who may or must sign the release. It is important to reference the applicable law for this information.
- Often there are limits that restrict the recipient of information from re-disclosing information. It is important to understand how these work.
- Many confidentiality laws include exceptions that allow release of information for research or data analysis. These exceptions are not referenced in this chart.
- Where health information is housed in another agency's file (for example, in social services files), there may be applicable health confidentiality laws to consider as well as the laws that control release of information in the agency file.

Note: Column headers below and on the reverse indicate the "Recipients of Information."

Local School Division[1, 29]	Substance Abuse Provider	Mental Health Providers	Department of Social Services/ Child Welfare	CASA Worker	Law Enforcement	Department of Juvenile Justice

APPENDIX E *CONTINUED*

INFORMATION SHARING GRID
SAMPLE AUTHORIZATIONS TO RELEASE INFORMATION

QUICK REFERENCE GRID ON INFORMATION SHARING LAWS IN VIRGINIA **January 2019**

• GIVER OF INFORMATION • GIVER OF INFORMATION • GIVER OF INFORMATION • GIVER OF INFORMATION •

	Recipient of Information						
	Local School Division[1, 29]	**Substance Abuse Provider**	**Mental Health Providers**	**Department of Social Services/ Child Welfare**	**CASA Worker**	**Law Enforcement**	**Department of Juvenile Justice**
School Official[1]	School staff on same campus may access information in education record[2] of students if they have "legitimate educational interests" in information.[3]			May share information necessary in order to satisfy mandated child abuse reporting duty.[4] May share any information with agency caseworker when agency is legally responsible for care and protection of student (with restrictions on re-disclosure).[5]	Shall permit CASA to inspect and copy records relating to the child after CASA shows appointment order and specific court order regarding records access.[6]		
	See next row	*See next row*	*See next row*	*See next row*	*See next row*	*See next row*	*See next row*
	• May share information obtained through personal knowledge or observation.[7] • May share directory information.[8] • May share pursuant to FERPA compliant release of information form dated and signed by parent, guardian or adult student.[9] • May share pursuant to health and safety emergency exception.[10] • May share if required by court order or lawful subpoena.[11] • May share de-identified information (personally identifiable information removed) in certain circumstances.[12]						
Substance Abuse Providers[13]				May share information necessary in order to satisfy mandated child abuse reporting duty.[14]			
	See next row	*See next row*	*See next row*	*See next row*	*See next row*	*See next row*	*See next row*
	• May share pursuant to 42 CFR Part 2 compliant release of information form.[15] • May share pursuant to 42 CFR Part 2 compliant court order.16 Must share if there are both subpoena and a court order.[17] • May share in medical emergency with medical personnel who need the information to treat emergency situation.[18]						
Mental Health Providers - Licensed, Funded, Operated by Dept. of Behavioral Health[19]		May share with another provider information required to give services to the minor.[20]	May share with another provider information required to give services to the minor.[21]	May share information necessary in order to satisfy mandated child abuse reporting duty.[22]	Shall permit CASA to inspect and copy records relating to the child after CASA shows appointment order and specific court order regarding records access.[23]	Pursuant to a search warrant or a grand jury subpoena.[24]	
	See next row	*See next row*	*See next row*	*See next row*	*See next row*	*See next row*	*See next row*
	• May share pursuant to a HIPAA and state law compliant authorization to release information.[25] • May disclose in an emergency to any person who needs the information to prevent injury or death of an individual or another person. Shall not disclose information not needed for this purpose.[26] • May disclose facts necessary to alleviate potential threat if person receiving services makes a specific threat to cause serious bodily injury or death to an identified or readily identifiable person and provider reasonably believes individual has intent and ability to carry out threat immediately.[27] • May disclose if another state law or regulation requires or permits disclosure.[28]						

	Local School Division[1, 29]	Substance Abuse Provider	Mental Health Providers	Department of Social Services/ Child Welfare	CASA Worker	Law Enforcement	Department of Juvenile Justice
Mental Health Inpatient Facilities - Licensed, Funded or Operated by Department of Behavioral Health[30]		Health providers shall disclose to one another health records and information where necessary to provide care and treatment to the minor and to monitor that care and treatment.[31]	Health providers[32] shall disclose to one another health records and information where necessary to provide care and treatment to the minor and to monitor that care and treatment.[33] Shall disclose information necessary and appropriate to community services board or its designee performing the evaluation, preadmission screening, or monitoring duties.[33]	May share information necessary in order to satisfy mandated child abuse reporting duty.[34]	Shall permit CASA to inspect and copy records relating to the child after CASA shows appointment order and specific court order regarding records access.[35]	Upon request, shall disclose to law enforcement officer information from minor's record necessary to protect the officer, the minor or the public from physical injury or to address the health care needs of the minor. Information shall not be used for any other purpose, disclosed to others or retained.[36]	
	See next row	*See next row*	*See next row*	*See next row*	*See next row*	*See next row*	*See next row*
	• May share pursuant to a HIPAA and state law compliant authorization to release information.[37] • May disclose in an emergency to any person who needs the information to prevent injury or death of an individual or another person. Shall not disclose information not needed for this purpose.[38] • May disclose facts necessary to alleviate potential threat if person receiving services makes a specific threat to cause serious bodily injury or death to an identified or readily identifiable person and provider reasonably believes individual has intent and ability to carry out threat immediately.[39] • May disclose if another state law or regulation requires or permits disclosure.[40]						
Department of Social Services/ Child Welfare	Local department shall notify the Superintendent of Public Instruction when an individual holding a Board of Education license is the subject of a founded complaint of child abuse or neglect and shall transmit identifying information regarding such individual in certain situations.[41]			May see social services records.[42]	Shall permit CASA to inspect and copy records relating to the child after CASA shows appointment order and specific court order regarding records access.[43]	Local department shall notify local law enforcement regarding specified complaints of child abuse or neglect.[44]	
	See next row	*See next row*	*See next row*	*See next row*	*See next row*	*See next row*	*See next row*
	• May be disclosed to any person having a "legitimate interest"45 as that is defined by state law.[46] • May be disclosed to hospital and community based multidisciplinary teams, as defined in 63.2-1503(J) and (K), for the purposes set out in those code sections, including coordinating medical, social, and legal services for the children and their families.[47]						
CASA Worker				May share in order to satisfy mandated child abuse reporting duty.[48]			
	See next row	*See next row*	*See next row*	*See next row*	*See next row*	*See next row*	*See next row*
	• Shall not disclose the contents of any document or record to which he becomes privy, which is otherwise confidential pursuant to the provisions of this Code, except upon order of a court of competent jurisdiction						

	Local School Division[1, 29]	Substance Abuse Provider	Mental Health Providers	Department of Social Services/ Child Welfare	CASA Worker	Law Enforcement	Department of Juvenile Justice
Law Enforcement	May share with school principal that a student is a suspect in certain violent crimes.[49]			May share in order to satisfy mandated child abuse reporting duty.[50]	Shall permit CASA to inspect and copy records relating to the child after CASA shows appointment order and specific court order regarding records access.[51]	May share youth records among law enforcement agencies for criminal investigative or intelligence information.[52]	May allow inspection by agencies to which minor is currently committed and those responsible for supervision after release.[53]
	See next row	*See next row*	*See next row*	*See next row*	*See next row*	*See next row*	*See next row*
	• May share if court order and has legitimate interest in the case or work of law enforcement.[54]						
Department of Juvenile Justice		Pursuant to written authorization for the release/ inspection of records to the individual treating or responsible for the treatment of youth.[55]	Pursuant to written authorization for the release/inspection of records to the individual treating or responsible for the treatment of youth.[56]	May share in order to satisfy mandated child abuse reporting duty.[57] The Department may request and shall receive from the records of all departments, boards, bureaus or other agencies of this Commonwealth … information as is necessary for the purpose of carrying out the provisions and programs of this title, and the same are authorized to provide such information; provided that, a written statement from the requesting party stating the reason for seeking such record is submitted and filed with the record sought.[58]	Shall permit CASA to inspect and copy records relating to the child after CASA shows appointment order and specific court order regarding records access.[59]		
	See next row	*See next row*	*See next row*	*See next row*	*See next row*	*See next row*	*See next row*
	• Shall be open to any agency or institution having legitimate interest in the youth, with order of court[60] • Shall be open to any person who is treating or providing services to youth pursuant to a contract with the Department of Juvenile Justice or the Virginia Juvenile Community Crime Control Act.[61] • To any person having a legitimate interest when (i) release of information is for provision of treatment or rehabilitation services for the juvenile, OR (ii) requesting party has custody or is providing supervision for juvenile and release is in interest of security, OR (iii) release is for consideration of admission to any group home, residential facility, or post-dispositional facility.[62]						
Domestic Violence Programs[63]				May share in order to satisfy mandated child abuse reporting duty.[64]		May share information necessary for law enforcement and prosecution purposes.[65]	
	See next row	*See next row*	*See next row*	*See next row*	*See next row*	*See next row*	*See next row*
	• May disclose pursuant to compliant release of information[66] • May disclose pursuant to court order but must make reasonable attempts to provide notice to victims affecting disclosure[67] • May disclose non-personally identifying data in the aggregate in order to comply with evaluation or data collection requirements[68]						

Please refer to source law for details and ask legal counsel for information on implementation.

APPENDIX E *FOOTNOTES*

[1] Employees of educational agencies that receive federal funds under programs administered by the U.S. Secretary of Education and thus are subject to the Family Educational Rights and Privacy Act. (FERPA). 20 U.S.C. § 1232g, 99 C.F.R. § 99.1(a).

[2] 20 U.S.C. § 1232g(a)(4)(A), 34 C.F.R. § 99.3 (defining"education record").

[3] 20 U.S.C. § 1232g(b)(1), 34 C.F.R. § 99.7(a)(3)(iii) ("Legitimate Educational Interests" exception).

[4] U.S. Dep't of Educ. Family Compliance Policy Office, Letter to University of New Mexico re: Applicability of FERPA to Health and Other State Reporting Requirements, Nov. 29, 2004; Va. Code Ann. 63.2-1509(A) summarizes the professionals who must make a child abuse report when they suspect that a child is abused or neglected.

[5] 20 USC § 1232g(b)(1)(L)("an agency caseworker or other representative of a State or local child welfare agency, or tribal organization (as defined in section 5304 of title 25), who has the right to access a student's case plan, as defined and determined by the State or tribal organization, when such agency or organization is legally responsible, in accordance with State or tribal law, for the care and protection of the student, provided that the education records, or the personally identifiable information contained in such records, of the student will not be disclosed by such agency or organization, except to an individual or entity engaged in addressing the student's education needs and authorized by such agency or organization to receive such disclosure and such disclosure is consistent with the State or tribal laws applicable to protecting the confidentiality of a student's education records. Nothing in subparagraph (E) of this paragraph shall prevent a State from further limiting the number or type of State or local officials who will continue to have access thereunder.").

[6] Va Code Ann. § 9.1-156(CASA); 20 U.S.C. § 1232g(b)(1), 34 C.F.R. § 99.31(a)(10), 34 C.F.R. § 99.36 (authorizing release pursuant to court order).

[7] 20 U.S.C. § 1232g(a)(4)(A), 34 C.F.R. § 99.3 (defining what is and is not an "education record" protected by FERPA). See "FERPA General Guidance for Students" available at https://www2.ed.gov/policy/gen/guid/fpco/ferpa/students.html

[8] 34 C.F.R. § 99.31(a)(11), § 99.37 (directory information exception).

[9] 20 U.S.C. § 1232g(b)(2), 34 C.F.R. § 99.30.

[10] 20 U.S.C. § 1232g(b)(1), 34 C.F.R. § 99.31(a)(10), 34 C.F.R. §99.36 ("An educational agency or institution may disclose personally identifiable information from an education record to appropriate parties, including parents of an eligible student, in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the student or other individuals.").

[11] 34 C.F.R. § 99.31(a)(9)(i) (court order exception).

[12] 34 C.F.R. § 99.31(b) (de-identified data exception).

[13] 12 Va. Admin Code § 35-115-80 (those that provide substance abuse services and are licensed, funded, or operated by Department of Behavioral Health also must comply with 42 CFR Part 2.).

[14] See Va Code Ann. § 63.2-1509(mandated reporting duty and professionals who are mandated reporters); 42 C.F.R. § 2.12.

[15] 42 CFR §§ 2.31, 2.33.

[16] 42 CFR § 2.61-2.67.

[17] 42 C.F.R. § 2.61.

[18] 42 C.F.R. § 2.51.

[19] Providers licensed, funded or operated by Department of Behavioral Health and Develpmental Services 12 Va. Admin Code § 35-115-10(B) defines precisely who is subject to these regulations.

[20] Va. Code Ann. § 32.1-127.1:03; 12 Va Admin. Code § 35-115-80(B)(8)(b).

[21] 12 Va Admin. Code § 35-115-80(B)(8)(b).

[22] See Va Code Ann. § 63.2-1509(mandated reporting duty and professionals who are mandated reporters).

[23] Va Code Ann. § 9.1-156.

[24] Va. Code Ann. § 32.1-127.1:03(D); 12 Va. Admin. Code § 35-115-80(B)(8)(n).

[25] See Va. Code Ann. § 32.1-127.1:03(D); 12 Va. Admin. Code § 35-115-80(A), (B)(2).

[26] Va. Code Ann. § 32.1-127.1:03(D); 12 Va. Admin Code § 35-115-80(B)(8)(a).

[27] Va. Code Ann. § 32.1-127.1:03(D); Va. Code Ann. 54.1-2400.1; 12 Va. Admin. Code § 35-115-80(B)(8)(j).

[28] Va. Code Ann. § 32.1-127.1:03(D); 12 Va. Admin Code § 35-115-80(A), (B)(8)(o).

[29] Employees of educational agencies that receive federal funds under programs administered by the U.S. Secretary of Education and thus are subject to the Family Educational Rights and Privacy Act. (FERPA). 20 U.S.C. § 1232g, 99 C.F.R. § 99.1(a).

[30] Va. Code Ann § 16.1-336("'Inpatient Treatment' means placement for observation, diagnosis, or treatment of mental illness in a psychiatric hospital or in any other type of mental health facility determined by the Department of Behavioral Health and Developmental Services to be substantially similar to a psychiatric hospital with respect to restrictions on freedom and therapeutic intrusiveness.").

[31] Va. Code Ann. § 16.1-337(B)(Psychiatric Treatment of Minors Act – "Inpatient treatment of minors").

[32] Va Code Ann. § 16.1-337(citing 32.1-127.1:03), Va. Code

APPENDIX E *FOOTNOTES CONTINUED*

Ann. 32.1-127.1:03(defining health care provider)("Health care provider" means those entities listed in the definition of "health care provider" in § 8.01-581.1, except that state-operated facilities shall also be considered health care providers for the purposes of this section. Health care provider shall also include all persons who are licensed, certified, registered or permitted or who hold a multistate licensure privilege issued by any of the health regulatory boards within the Department of Health Professions, except persons regulated by the Board of Funeral Directors and Embalmers or the Board of Veterinary Medicine.) Va. Code Ann. 8.01-581.1(""Health care provider" means (i) a person, corporation, facility or institution licensed by this Commonwealth to provide health care or professional services as a physician or hospital, dentist, pharmacist, registered nurse or licensed practical nurse or a person who holds a multistate privilege to practice such nursing under the Nurse Licensure Compact, nurse practitioner, optometrist, podiatrist, physician assistant, chiropractor, physical therapist, physical therapy assistant, clinical psychologist, clinical social worker, professional counselor, licensed marriage and family therapist, licensed dental hygienist, health maintenance organization, or emergency medical care attendant or technician who provides services on a fee basis; (ii) a professional corporation, all of whose shareholders or members are so licensed; (iii) a partnership, all of whose partners are so licensed; (iv) a nursing home as defined in § 54.1-3100 except those nursing institutions conducted by and for those who rely upon treatment by spiritual means alone through prayer in accordance with a recognized church or religious denomination; (v) a professional limited liability company comprised of members as described in subdivision A 2 of § 13.1-1102; (vi) a corporation, partnership, limited liability company or any other entity, except a state-operated facility, which employs or engages a licensed health care provider and which primarily renders health care services; or (vii) a director, officer, employee, independent contractor, or agent of the persons or entities referenced herein, acting within the course and scope of his employment or engagement as related to health care or professional services.").

[33] Va. Code Ann. § 16.1-337(B)(Psychiatric Treatment of Minors Act – "Inpatient treatment of minors")("Any health care provider, as defined in § 32.1-127.1:03, or other provider rendering services to a minor who is the subject of proceedings under this article, upon request, shall disclose to a magistrate, the juvenile intake officer, the court, the minor's attorney, the minor's guardian ad litem, the qualified evaluator performing the evaluation required under §§ 16.1- 338, 16.1-339, and 16.1-342, the community services board or its designee performing the evaluation, preadmission screening, or monitoring duties under this article, or a law- enforcement officer any and all information that is necessary and appropriate to enable each of them to perform his duties under this article. These health care providers and other service providers shall disclose to one another health records and information where necessary to provide care and treatment to the person and to monitor that care and treatment. Health records disclosed to a law-enforcement officer shall be limited to information necessary to protect the officer, the minor, or the public from physical injury or
to address the health care needs of the minor. Information disclosed to a law-enforcement officer shall not be used for any other purpose, disclosed to others, or retained.
Any health care provider providing services to a minor who is the subject of proceedings under this article shall make a reasonable attempt to notify the minor's parent of information that is directly relevant to such individual's involvement with the minor's health care, which may include the minor's location and general condition, in accordance with subdivision D 34 of § 32.1-127.1:03, unless the provider has actual knowledge that the parent is currently prohibited by court order from contacting the minor. No health care provider shall be required to notify a person's family member or personal representative
pursuant to this section if the health care provider has actual knowledge that such notice has been provided. Any health care provider disclosing records pursuant to this section shall be immune from civil liability for any harm resulting from the disclosure, including any liability under the federal Health Insurance Portability and Accountability Act (42
U.S.C. § 1320d et seq.), as amended, unless the person or provider disclosing such records intended the harm or acted in bad faith.")

[34] See Va Code Ann. § 63.2-1509(mandated reporting duty and professionals who are mandated reporters).

[35] Va. Code Ann. § 9.1-156.

[36] Va. Code Ann. § 16.1-337(B)(Psychiatric Treatment of Minors Act -"Inpatient treatment of minors")("Any health care provider, as defined in 32.1-127.1:03, or other provider rendering services to a minor who is the subject of proceedings under this article, upon request, shall disclose to...law-enforcement officer...information necessary to protect the officer, the minor, or the public from physical injury or to address the health care needs of the minor.").

[37] See 12 Va. Admin. Code § 35-115-80(A), (B)(2).

[38] 12 Va. Admin Code § 35-115-80(B)(8)(a).

[39] 12 Va. Admin. Code § 35-115-80(B)(8)(j).

[40] 12 Va. Admin Code § 35-115-80(A), (B)(8)(o).

[41] Va. Code Ann. § 63.2-1503(P).

[42] Va. Code Ann. § 63.2-104.

[43] Va Code Ann. § 9.1-156.

APPENDIX E *FOOTNOTES CONTINUED*

[44] Va Code Ann. § 36.2-1503(D).

[45] Va. Code Ann. § 63.2-104, 63.2-105(A)(Legitimate interest if " in the judgment of the local department such disclosure is in the best interest of the child who is the subject of the records. Persons having a legitimate interest in child- protective services records of local departments include, but are not limited to, (i) any person who is responsible for investigating a report of known ro suspected abuse or neglect or for providing services to a child or family that is the subject of a report, including multid. isciplinary teams and family assessment and planning teams referenced in subsections J and K of 63.2-1503, law-enforcement agencies and attorneys for the Commonwealth; (ii) child welfare or human services agencies of the Commonwealth or its political subdivisions when those agencies request information to determine the compliance of any person with a child-protective services plan or an order of any court; (iii) personnel of the school or child day program as defined in 63.2-100 attended by the child so that the local department can receive information from such personnel on an ongoing basis concerning the child's health and behavior, and the activities of the child's custodian…").

[46] Va. Code Ann. § 63.2-104(A).

[47] Va Code Ann. § 63.2-1503(J)("The local department shall foster, when practicable, the creation, maintenance and coordination of hospital and community-based multidisciplinary teams that shall include where possible, but not be limited to, members of the medical, mental health, social work, nursing, education, legal and law- enforcement professions. Such teams shall assist the local departments in identifying abused and neglected children; coordinating medical, social, and legal services for the children and their families; developing innovative programs for detection and prevention of child abuse; promoting community concern and action in the area of child abuse and neglect; and disseminating information to the general public with respect to the problem of child abuse and neglect and the facilities and prevention and treatment methods available to combat child abuse and neglect.

These teams may be the family assessment and planning teams established pursuant to § 2.2-5207. Multidisciplinary teams may develop agreements regarding the exchange of information among the parties for the purposes of the investigation and disposition of complaints of child abuse and neglect, delivery of services and child protection. Any information exchanged in accordance with the agreement shall not be considered to be a violation of the provisions of § 63.2-102, 63.2-104, or 63.2-105."); Va Code Ann. § 63.2-1503 (K)(" The local department may develop multidisciplinary teams to provide consultation to the local department during the investigation of selected cases involving child abuse or neglect, and to make recommendations regarding the prosecution of such cases. These teams may include, but are not limited to, members of the medical, mental health, legal and law-enforcement professions, including the attorney for the Commonwealth or his designee; a local child-protective services representative; and the guardian ad litem or other court-appointed advocate for the child. Any information exchanged for the purpose of such consultation shall not be considered a violation of § 63.2- 102, 63.2-104, or 63.2-105.").

[48] See Va Code Ann. § 63.2-1509(mandated reporting duty and professionals who are mandated reporters).

[49] Va Code Ann. § 16.1-301(B).

[50] See Va Code Ann. § 63.2-1509(mandated reporting duty and professionals who are mandated reporters).

[51] Va Code Ann. § 9.1-156.

[52] Va Code § 16.1-310(C)(4),(F).

[53] Va Code Ann. § 16.1-301(C)(2).

[54] Va Code Ann. § 16.1-301(C)(4).

[55] Va Code Ann. § 16.1-300(A)(13).

[56] Va Code Ann. § 16.1-300(A)(13).

[57] See Va Code Ann. § 63.2-1509(mandated reporting duty and professionals who are mandated reporters)

[58] Va. Code Ann. § 63.2-101.

[59] Va Code Ann. § 9.1-156.

[60] Va Code Ann. § 16.1-300(A)(6).

[61] Va Code Ann. § 16.1-300(A)(2).

[62] Va Code Ann. § 16.1-300(A)(7).

[63] Program shall include public and not-for-profit agencies the primary mission of which is to provide services to victims of domestic violence, dating violence, sexual assault, or stalking, or victims of certain crimes. (Va Code Ann. § 63.2- 104.1(D)).

[64] See Va Code Ann. § 63.2-1509(mandated reporting duty and professionals who are mandated reporters)

[65] Va. Code Ann. § 63.2-104.1(D)(3).

[66] Va. Code Ann. § 63.2-104.1; 42 U.S.C. § 13925(b)(2)(B)(ii) (Violence Against Women Act (VAWA) consent for programs subject to VAWA).

[67] Va. Code Ann. § 63.2-104.1; 42 U.S.C. § 13925(b)(2)(C) (programs subject to VAWA).

[68] Va. Code Ann. § 63.2-104.1; 42 U.S.C. § 13925(b)(2)(D)(i) (programs subject to VAWA).

APPENDIX F

HIPAA RELEASE FORM

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

SECTION I

I, _____ , give my permission for _____ to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

SECTION II – HEALTH INFORMATION

I would like to give the above healthcare organization permission to:

Tick as appropriate

- ☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

- ☐ Disclose my complete health record except for the following information
- ☐ Mental health records
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Alcohol/drug abuse treatment records
- ☐ Genetic information
- ☐ Other (Specify)_____

_____

_____

Form of Disclosure:

- ☐ Electronic copy or access via a web-based portal
- ☐ Hard copy

SECTION III – REASON FOR DISCLOSURE

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____

_____

SECTION IV – WHO CAN RECEIVE MY HEALTH INFORMATION

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name:_____

Organization:_____

Address:_____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

APPENDIX F *CONTINUED*

HIPAA RELEASE FORM

SECTION V – DURATION OF AUTHORIZATION

This authorization to share my health information is valid:
Tick as appropriate
☐ a) From _____ to _____
Or
☐ b) All past, present, and future periods
Or
☐ c) The date of the signature in section VI until the following event:

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:
Name: _____

Organization: _____

Address: _____

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

SECTION VI – SIGNATURE

Signature: _____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form:

APPENDIX G

VIOLENCE AGAINST WOMEN ACT (VAWA) COMPLIANT TEMPLATE: LIMITED RELEASE OF INFORMATION FORM

READ FIRST: [Program] must keep information about you private. The only time your personal information should be shared is when you want us to for specific services or if we are compelled by law or court order.

- You never have to agree to share your information. We will still help you and provide our services.
- If you do want [Program/Agency Name] to share some information about you, use this form to give instructions about what you do and don't want shared, and with whom you want it shared.
- Before you sign this, someone at [Program/Agency Name] will discuss your goals/needs, your choices for how to meet those, and the pros and cons of having us share the information for you.
- You can change your mind about what you want shared at any time, and we will update this form to reflect your decision.

These are my instructions for [Program/Agency Name] to share my information:

I want this information about me shared:

_____

_____

(Be as specific as possible. A few examples include: my name, dates I got help, documents about me)

I want the information shared with this person or agency: _____

I want the information shared:

- ○ in person
- ○ by phone
- ○ by fax
- ○ by mail
- ○ by e-mail
- ○ by text
- ○ by other method: _____

Sharing this information helps me because: _____

I know that once the information is shared by [Program/Agency Name]:

- Others will know that I have worked with [Program/Agency Name],
- Others might try to get more information about me from [Program/Agency Name], and
- The person/agency receiving my information might share it without asking me first.

_____ **(initial)**

Non-abusive parent/guardian signature (if required):

Signed: _____ **Signed:** _____

Printed Name: _____ **Printed Name:** _____

Date: _____ **Date:** _____

EXTENDING THE RELEASE

To help meet my goals, I want [Program/Agency Name] to keep sharing the information above for longer.

I want them to stop sharing on _____ **(new date).**

Signed: _____ **Date:** _____

Non-abusive parent/guardian signature (if required) **Signed:** _____ **Date:** _____

Virginia HEALS

Caring Collaboration, Empowering Families

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