Application for Child Care Financial Assistance

If English is not your primary language and you need help understanding this information, tell your local office.
إذا لم تكن اللغة الإنجليزية لغتك الأولى وتحتاج إلي الحصول على المساعدة قم بإبلاغ المكتب الفرعي القريب منك.
Ako engleski jezik nije Vaš primarni jezik i ako Vam je potrebna pomoć da razumijete ovu informaciju, obavijestite svoj lokalni ured.
အကယ်၍ အင်္ဂလိပ်စကားသည် သင့်မိခင်ဘာသာစကား မဟုတ်သဖြင့် ဤသတင်းအချက်အလက်ကို နားလည်ရန်အတွက် အကူအညီလိုပါက သင့်ဒေသခံရုံးကို အကြောင်းကြားပါ။
Si vous n'êtes pas anglais de langue maternelle et que vous avez besoin d'aide pour comprendre ces informations, dites-le à votre bureau local.
Mugihe icongereza atari ururimi rw'awe rw'amavukiro ukaba ushaka impfashanyo y'ugusobanukirwa iy'inkenuzo, egera ibiro vyaho uba.
यदि अङ्ग्रेजी तपाईको प्रथम भाषा हो र तपाईलाई यो जानकारी बुझ्न मद्दत चाहिन्छ भने, तपाईको स्थानीय कार्यालयमा सम्पर्क गर्नुहोस।
Haddii luuqada Ingiriisiga aysan ahayn luuqadaada asaasiga ah aadna u baahan tahay caawimaad ah fahanka macluumaadka, u sheeg xafiiska deegaankaaga.
Si su idioma materno no es el inglés y necesita ayuda para comprender esta información, infórmelo a su oficina local.
Ikiwa Kiingereza sio lugha yako ya msingi na unahitaji msaada wa kufahamu maelezo haya, waeleze ofisi yako ya mtaa.
Nếu tiếng Anh không phải là ngôn ngữ chánh của quý vị và quý vị cần trợ giúp để hiểu thông tin này, hãy cho văn phòng tại địa phương quý vị biết.

Section One: Applicant Information

Complete all fields. Incomplete applications will be returned.

Last Name _____ First _____ Middle _____ Suffix (Jr, Sr, II) _____

Other Names, such as Maiden Name or Alias _____

Home/Physical Address (required) _____

Town/City _____ State _____ Zip Code _____

Mailing Address (if different from address above) _____

Town/City _____ State _____ Zip Code _____

Email Address _____ Vermont Resident: ❑Yes ❑No

Social Security Number* _____ Date of Birth (mm/dd/yyyy) _____

U.S. Citizen: ❑Yes ❑No If no, please indicate status: ❑Refugee ❑Immigrant ❑Asylee ❑Permanent Resident

❑Other (please explain) _____

Marital Status: ❑Married ❑Civil Union ❑Legally Separated ❑Separated ❑Divorced ❑Single ❑Single w/ Domestic Partner ❑Widowed

Gender: ❑Female ❑Male Single-Parent Household: ❑Yes ❑No Primary Language: _____

Race (check all that apply): ❑American Indian/Alaskan Native ❑Asian ❑Black/African American ❑Native Hawaiian/Pacific Islander ❑White

Ethnicity: ❑Hispanic ❑Non-Hispanic

** You are not required to list your social security number on this application. Please note if you choose not to disclose your social security number, it may delay your application processing.*

Do you contribute money into a qualified child education savings account, such as the Vermont Higher Education Investment Plan. Y____N____

Is your family homeless: ❑Yes ❑No

Does the applicant have one million dollars or more in assets? ❑Yes ❑No

Is a parent currently active duty in the U.S. Military, a member of a National Guard Unit or a Military Reserve Unit: ❑Yes ❑No

If Yes, ❑Active Military ❑National Guard/Military Reserve

All phone numbers (check your preference):

❑Home _____ ❑Work _____ ❑Cell _____

Section Two: Need for Care

❑ Employment
❑ Self-Employment
❑ Seeking Employment
❑ Training/Education
❑ Special Health Need - Parent
❑ Reach Up Case Worker: _____

See page 7 for required documentation.

Reason services are needed. (check all that apply)

❑ Special Health Need - Child
❑ Family Support - Requires Additional Application (i.e., extreme stress your family is experiencing in areas such as shelter, safety, emotional stability, substance abuse, and children's behaviors)

VERMONT
DEPARTMENT FOR CHILDREN AND FAMILIES
CHILD DEVELOPMENT DIVISION

Section Three: Other Household Members

List second parent/guardian and all children living in the household. (use additional page if needed)

Last Name ____ First Name ____ Middle Name ____ Suffix (Jr, Sr, II) ____

Date of Birth (mm/dd/yyyy) ____ Social Security Number * ____ Primary Language ____ Relationship to Applicant ____

Gender: ❑ Female ❑ Male Ethnicity: ❑ Hispanic ❑ Non-Hispanic

U.S. Citizen: ❑ Yes ❑ No If no, please indicate status: ❑ Refugee ❑ Immigrant ❑ Asylee ❑ Permanent Resident

Race: ❑American Indian or Alaskan Native ❑Asian ❑Black or African American ❑Native Hawaiian or Pacific Islander ❑White

Is this a special needs child under age 19 requiring child care? (Special Needs Documentation is Required) ❑ Yes ❑ No

---

Last Name ____ First Name ____ Middle Name ____ Suffix (Jr, Sr, II) ____

Date of Birth (mm/dd/yyyy) ____ Social Security Number * ____ Primary Language ____ Relationship to Applicant ____

Gender: ❑ Female ❑ Male Ethnicity: ❑ Hispanic ❑ Non-Hispanic

U.S. Citizen: ❑ Yes ❑ No If no, please indicate status: ❑ Refugee ❑ Immigrant ❑ Asylee ❑ Permanent Resident

Race: ❑American Indian or Alaskan Native ❑Asian ❑Black or African American ❑Native Hawaiian or Pacific Islander ❑White

Is this a special needs child under age 19 requiring child care? (Special Needs Documentation is Required) ❑ Yes ❑ No

---

Last Name ____ First Name ____ Middle Name ____ Suffix (Jr, Sr, II) ____

Date of Birth (mm/dd/yyyy) ____ Social Security Number * ____ Primary Language ____ Relationship to Applicant ____

Gender: ❑ Female ❑ Male Ethnicity: ❑ Hispanic ❑ Non-Hispanic

U.S. Citizen: ❑ Yes ❑ No If no, please indicate status: ❑ Refugee ❑ Immigrant ❑ Asylee ❑ Permanent Resident

Race: ❑American Indian or Alaskan Native ❑Asian ❑Black or African American ❑Native Hawaiian or Pacific Islander ❑White

Is this a special needs child under age 19 requiring child care? (Special Needs Documentation is Required) ❑ Yes ❑ No

---

Last Name ____ First Name ____ Middle Name ____ Suffix (Jr, Sr, II) ____

Date of Birth (mm/dd/yyyy) ____ Social Security Number * ____ Primary Language ____ Relationship to Applicant ____

Gender: ❑ Female ❑ Male Ethnicity: ❑ Hispanic ❑ Non-Hispanic

U.S. Citizen: ❑ Yes ❑ No If no, please indicate status: ❑ Refugee ❑ Immigrant ❑ Asylee ❑ Permanent Resident

Race: ❑American Indian or Alaskan Native ❑Asian ❑Black or African American ❑Native Hawaiian or Pacific Islander ❑White

Is this a special needs child under age 19 requiring child care? (Special Needs Documentation is Required) ❑ Yes ❑ No

* *You are not required to list your social security number on this application.*
Please note if you choose not to disclose your social security number, it may delay your application processing.

Section Four: Applicant's Need for Care

Complete this section about yourself.

❑ Employed at _____ Flexible schedule? ❑ Yes ❑ No Scheduled work hours per week _____

Employer's Address _____ Telephone Number _____

City _____ State _____ Zip Code _____

Do you have a Bachelor's Degree? ❑ Yes ❑ No Does your employer contribute money towards child care? ❑ Yes ❑ No

Indicate your work hours, circle AM or PM:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm
End	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm

❑ In school or training at _____ Flexible schedule? ❑ Yes ❑ No Scheduled hours per week _____

Indicate your school/training hours, circle AM or PM:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm
End	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm

Section Five: Second-Parent's Need for Care

Complete this section for a second parent in the household. If there is none, go to Section 6.

❑ Employed at _____ Flexible schedule? ❑ Yes ❑ No Scheduled work hours per week _____

Employer's Address _____ Telephone Number _____

City _____ State _____ Zip Code _____

Do you have a Bachelor's Degree? ❑ Yes ❑ No Does your employer contribute money towards child care? ❑ Yes ❑ No

Indicate your work hours, circle AM or PM:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm
End	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm

❑ In school or training at _____ Flexible schedule? ❑ Yes ❑ No Scheduled hours per week _____

Indicate your school/training hours, circle AM or PM:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm
End	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm	_____ am / pm

Section Six: Requested Child Care Provider

Your provider must be registered, licensed, or certified by the Child Development Division to receive payment.

Child's Name _____

Child Care Provider's Name _____

Child Care Provider's Location _____

City _____

Telephone Number _____

Child Care Provider Relationship to Child _____

Child Care Start Date _____

Indicate hours needed, circle AM or PM:

Sunday _____ am / pm to _____ am / pm

Monday _____ am / pm to _____ am / pm

Tuesday _____ am / pm to _____ am / pm

Wednesday _____ am / pm to _____ am / pm

Thursday _____ am / pm to _____ am / pm

Friday _____ am / pm to _____ am / pm

Saturday _____ am / pm to _____ am / pm

Section Six: Requested Child Care Provider Continued

Child's Name _____

Child Care Provider's Name _____

Child Care Provider's Location _____

City _____

Telephone Number _____

Child Care Provider Relationship to Child _____

Child Care Start Date _____

Indicate hours needed, circle AM or PM:

Sunday ____ am / pm to ____ am / pm
Monday ____ am / pm to ____ am / pm
Tuesday ____ am / pm to ____ am / pm
Wednesday ____ am / pm to ____ am / pm
Thursday ____ am / pm to ____ am / pm
Friday ____ am / pm to ____ am / pm
Saturday ____ am / pm to ____ am / pm

Child's Name _____

Child Care Provider's Name _____

Child Care Provider's Location _____

City _____

Telephone Number _____

Child Care Provider Relationship to Child _____

Child Care Start Date _____

Indicate hours needed, circle AM or PM:

Sunday ____ am / pm to ____ am / pm
Monday ____ am / pm to ____ am / pm
Tuesday ____ am / pm to ____ am / pm
Wednesday ____ am / pm to ____ am / pm
Thursday ____ am / pm to ____ am / pm
Friday ____ am / pm to ____ am / pm
Saturday ____ am / pm to ____ am / pm

Section Seven: Child Support Information

If you are receiving court ordered child support please complete the boxes below. *See page 7 for required documentation.*

Amount received	Were you or are you still legally married to the person paying child support?	Names of children for whom support is received	Name of absent person paying child support
$ per	❑ Yes ❑ No		
$ per	❑ Yes ❑ No		
$ per	❑ Yes ❑ No		

If you are not receiving court ordered child support please provide a an explanation why below. Include the absent parent's name, physical address and indicate whether you were or still are married to the absent parent. Please indicate how much he/she contributes monthly. If the contribution is in the form of goods (diapers, wipes, clothing), mortgage payments, rent payments, etc... please indicate a monthly value in dollars.

_____

_____

_____

_____

_____

Does anyone in your household pay regular court ordered child support? ❑ Yes ❑ No If yes, please provide verification.

Name of Person Paying _____ Amount _____

Frequency _____

Section Eight: Household Income

Indicate household income by recipient and type of income.

For each type of income you claim you must supply written evidence. Examples of documentation include two current consecutive pay stubs, a copy of last year's income tax return for self-employment, a statement from your employer confirming wages for new employment, or a copy of your court order for child support.

Family Member _____

Type of Income (select all that apply):

	Amount	Frequency
❑ AmeriCorps Stipend		
❑ Child Support Received		
❑ Dividend Income		
❑ 3SquaresVT (formerly food stamps)		
❑ Housing Assistance		
❑ Interest Income		
❑ Medicaid		
❑ Military Pay-Active Duty		
❑ Military Pay-Reserve		
❑ Other		
❑ PSE Stipend		
❑ Reach Up		
❑ Reach Up Child Only		
❑ Rental Income		
❑ Self-employment Income		
❑ Social Security Benefit		
❑ Spousal Maintenance Received		
❑ Supplemental Security Income		
❑ Tips, etc.		
❑ Trust Fund		
❑ Unemployment Compensation		
❑ Veterans Benefits		
❑ Vista Stipend		
❑ Wages		
❑ Worker's Compensation		

Family Member _____

Type of Income (select all that apply):

	Amount	Frequency
❑ AmeriCorps Stipend		
❑ Child Support Received		
❑ Dividend Income		
❑ 3SquaresVT (formerly food stamps)		
❑ Housing Assistance		
❑ Interest Income		
❑ Medicaid		
❑ Military Pay-Active Duty		
❑ Military Pay-Reserve		
❑ Other		
❑ PSE Stipend		
❑ Reach Up		
❑ Reach Up Child Only		
❑ Rental Income		
❑ Self-employment Income		
❑ Social Security Benefit		
❑ Spousal Maintenance Received		
❑ Supplemental Security Income		
❑ Tips, etc.		
❑ Trust Fund		
❑ Unemployment Compensation		
❑ Veterans Benefits		
❑ Vista Stipend		
❑ Wages		
❑ Worker's Compensation		

Section Nine: Consent to Exchange Information

Complete this section about yourself.

Last Name _____ First _____ Middle _____ Suffix (Jr, Sr, II) _____

I give my permission for the eligibility specialists to exchange information required to determine my/our eligibility for Child Care Financial Assistance with, please check the boxes below that apply:
(For any boxes not checked I understand I am responsible for documentation needed to determine my eligibility. Failure to provide documentation may delay my application.)

- ❑ Department for Children and Families, Office of Child Support
- ❑ Department for Children and Families, Economic Services Division
- ❑ Department of Labor, formerly the Department of Employment & Training
- ❑ Department for Children and Families, Family Services Division
- ❑ Vocational Rehabilitation
- ❑ Child Care Provider _____ (provider's name)
- ❑ Employer _____ (employer's name)
- ❑ Family Support Team
- ❑ Essential Early Education (EEE)
- ❑ Visiting Nurses Association (VNA)
- ❑ Children's Integrated Services (CIS)
- ❑ Other _____

Relationship to child(ren) covered by this consent form:

❑ Mother ❑ Father ❑ Legal guardian ❑ Other _____

❑ I do not give consent to share my information with the agencies listed above.

Section Ten: Verification and Signature

You must sign and date your application in ink.

- I understand that the Child Development Division will notify me in writing about its decision on my application.
- I certify that the information given on this form is true and correct to the best of my knowledge.
- I understand that I must report any changes that may affect my eligibility within 10 business days (e.g., changes in my household size; marital status; unemployment, employment, or training status; address, and income).
- I understand that I could be subjected to prosecution for fraud if I do not report changes within 10 business days of the change, or provide incorrect or misleading information.
- If I am eligible, I understand that I must pay the difference between the child care financial assistance I receive and what my provider charges.
- I understand that I must pay for any child care costs I incur while I am not eligible for child care financial assistance.
- I understand failure to provide required documentation may result in denial of this application.

_____ Signature of Applicant

_____ Date

Instructions and Required Documentation

If your application is not completely filled out, it will be returned. Required forms may be obtained either by contacting your eligibility specialist or by downloading them from **http://dcf.vermont.gov/cdd**
If you are found eligible, your child care financial assistance will begin on the date your completed application is received.

Eligibility is determined based on your family's need for child care, total gross household income, and family size. Each parent/legal guardian must have one of the following service needs (reason for child care):

- **Employment:** Please submit two consecutive pay stubs from the last 30 days for each job you have. If you have a new job and have not yet received paystubs, please request an employment verification form. If your employer does not withhold taxes for you and you will pay those taxes yourself at the end of the year, follow the instructions for self employment.
- **Self-Employment:** Complete a Self-Employment Business Plan form. If you have been self-employed for more than one year, enclose a complete copy of your most recent tax return. If you have been self-employed for less than one year, a profit and loss form will be required.
- **In School or Training:** Complete a Training Plan Form, along with your course schedule including days and hours attending. If study time is needed, it may be granted at the rate of one hour per hour of class time. Upon completion of your classes, you will need to provide documentation of successfully completed coursework.
  If you have a Bachelor's Degree, you are ineligible for financial assistance under this service need.
- **Reach Up:** If you are eligible for Reach Up, ask your Reach Up case manager to submit an authorization for child care to your child care eligibility specialist.
- **Seeking Employment:** If you are looking for work and receiving TANF, contact your Reach Up case manager. If you are looking for employment and NOT on TANF, submit a Work Search Plan Form.
- **Special Health Need (Adult):** If you are medically incapacitated complete this application and submit a Special Health Need Adult form signed by an physician (MD), Nurse Practitioner (NP), Physician Assistant (PA) or state Licensed Psychologist.

Children's Integrated Services (CIS) Service Needs:

- ❑ **Protective Services:** Please discuss your need for child care with your Family Services social worker. Your social worker will let you know what information is required.
- ❑ **Family Support:** If your family is experiencing extreme short term stress in areas such as shelter, safety, emotional stability, substance abuse, and children's behaviors. Please contact the CIS Child Care Coordinator at your local agency.
- ❑ **Special Health Need (Child):** Request from the CIS Child Care Coordinator a Special Health Need Supplemental Documentation form.

Additional Required Documentation:

- ❑ **Adoption:** If you are a parent with an adoption assistance agreement through the State of Vermont, you must enclose a copy of your adoption subsidy agreement with your application. You will need to verify your service need for child care, but *your income may be waived if you have an adoption agreement with the State of Vermont.*
- ❑ **Household Income:** Include verification of all other household income such as SSI, Social Security, Veteran's Benefits, unemployment benefits, Worker's Compensation, interest income, stocks and bonds, and rental income. Include a copy of your check or a letter from the agency from which you receive compensation.
- ❑ **Child Support Verification:** For each child, include a court order, or a 6-12 month payment history from the Office of Child Support.

Community Child Care Support Agencies

If you have any questions regarding what information to send with this application or need help completing this application, please call your local community agency listed below.

Return your completed application along with all required supporting documentation to your local community agency.

The Family Center Of NW VT **60 Lake Street, Suite 100** **St. Albans, VT 05478** **(802) 524-6554**	**Child Care Resource** **181 Commerce Street** **Williston, VT 05495** **(802) 863-3367**
Kingdom Child Care Connection **1222 Main Street Suite 301** **St. Johnsbury, VT 05819** **(802) 748-1992**	**Windham Child Care Association** **130 Birge Street** **Brattleboro, VT 05301** **(802) 254-5332**
NEKCA Parent Child Center **70 Main Street** **PO Box 346** **Newport, VT 05855** **(802) 334-7316**	**Child Care Support Services** **VT Achievement Center** **88 Park Street** **Rutland, VT 05701** **(802) 773-4365**
Bennington Child Care **238 Union Street** **PO Box 929** **Bennington, VT 05201** **(802) 447-6936**	**Lamoille Family Center** **480 Cadys Fall Road** **Morrisville, VT 05661** **(802) 888-5229**
The Family Place **319 Us Route 5 South** **Norwich, VT 05055** **(800) 639-0039**	**Springfield Area Parent Child Center** **6 Main Street** **North Springfield, VT 05150** **(802) 886-5242**
Mary Johnson Child Care Services **81 Water Street** **Middlebury, VT 05753-0591** **(802) 388-4304**	**Family Center Of Washington County** **383 Sherwood Drive** **Montpelier, VT 05602** **(802) 262-3292**

Lamoille Family Center

480 Cady's Falls Road · Morrisville, VT 05661 · www.lamoillefamilycenter.org

Consent and Agreement to the use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I understand that as part of my service plan, The Lamoille Family Center (LFC) originates and maintains records that may describe my health history, symptoms, test results, diagnoses, treatment, and any plans for future service treatment. I understand that this information serves as:

- **A basis for my service and treatment plan.**
- **A possible means of communications among the professionals who contribute to my service and treatment plan.**
- **A source of information of billing purposes for the services I receive.**
- **A means by which an eligible third-party can verify the services billed were actually provided.**
- **A tool for routine healthcare operations such as assessing quality and reviewing the competence of staff and the quality of services that are offered.**

I have been provided with a *Notice of Privacy* that provides a more complete description of information uses and disclosures (release of or access to your information). I understand that I have the right to review the notice prior to signing this consent. I understand that the Lamoille Family Center reserves the right to change their notice and practices. However, prior to a material change taking effect, The Lamoille Family Center will publish an announcement of the change. I understand that a new Notice will be distributed to me.

I understand that my records are subject to confidentiality imposed by state and federal regulations. I also understand that alcohol and drug abuse client records are protected by 42 CFR part2, and that records may not be released or disclosed without my written consent unless otherwise provided for in the regulations.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand that the organization is not required to agree to the restrictions requested, however if The Lamoille Family Center agrees to the requested restrictions, it is bound by our agreement.

By signing this form, I consent to The Lamoille Family Center's use and disclosure of protected health information about me for services, treatment, payment, and healthcare operations. I understand that I may revoke this consent in writing, except to the extent that The Lamoille Family Center has already taken action based upon prior consent.

.....

Name of Individual receiving Services (please print)

Signature of Individual Receiving Services
Or Legal Representative

Witness

Date

Notice Effective Date or Version

Your rights regarding health information about you.

In most cases, **you have the right to see or obtain a copy of health information** that we use to make decisions about your service plan when you submit a written request. If you request more than one copy, we make charge a fee for the cost of copying, mailing or related supplies. If we should deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

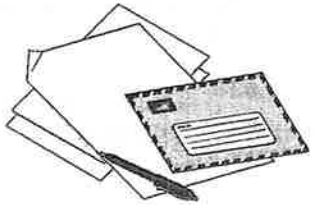
If you believe that information in your record is incorrect or if important information is missing, **you have the right to request that we correct the records**, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us, if it is not part of the health information maintained by us, or if we determine that the record is accurate. You may appeal, in writing, a decision by us not to amend a record.

When you submit a written request, **you have the right to a list of those instances where we have disclosed health information about you,** other than for treatment, payment, health care operations or where you specifically authorized a disclosure. Your request must state the time period desired for the accounting, 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 information about you be communicated to you in a confidential manner,** such as sending mail to an address other than your home, or 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 information about you for treatment, payment or health care 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 regarding your request. All written requests or appeals should be submitted to our Privacy Officer listed under "Complaints" section below.

Due to the nature of community based human service practices, LFC representatives may possess individually identifiable information beyond the physical security of LFC. In these cases, LFC representatives will ensure security and confidentiality of the information in a manner that meets LFC policy, State and Federal Law.



Complaints.

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we make about access to your records, you may contact our Privacy Officer at the Lamoille Family Center, 480 Cady's Falls Rd., Morrisville, VT 05661 (802-888-5229). Finally, you may also send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Officer can provide you with the address.

Under no circumstances will you be penalized or retaliated against for filing a complaint. We will ask you to sign an acknowledgement that you have received a copy of this Notice.

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

The Lamoille Family Center is a not-for-profit organization working to serve and strengthen families throughout Lamoille County, Craftsbury, Greensboro, Hardwick, Stannard and Woodbury.

Most of our services are free, and most services are available to anyone.

Lamoille Family Center

480 Cady's Falls Rd.
Morrisville, VT 05661
Phone: 802-888-5229
Fax: 802-888-5392

Lamoille Family Center
Notice of Privacy Practices

This notice describes how health 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 at the Lamoille Family Center, 480 Cady's Falls Rd., Morrisville, VT 05661.

Who will follow these practices?

The Lamoille Family Center (LFC) provides health care information and care to its clients in partnership with physicians, and other professionals and organizations. The information privacy practices in this notice will be followed by:

- All employed associates, staff or volunteers of our organization, including staff at LFC with whom we may share information,
- All departments and units of our organization,
- Any business associate or partner of LFC with whom we share health information .

Our pledge to you.

We understand that health information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality service and to comply with legal requirements. This notice applies to all of your records that we maintain, whether created by staff members or associates. We are required by law to:

- Keep health information about you private.
- Give you this notice of our legal duties and privacy practices with respect to health information about you .

How we may use and disclose health information about you.

We may use and disclose health information about you for the following reasons:

- **treatment** (such as sending medical 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 Medicare), and
- to support our **health care operations** (such as comparing client data to improve treatment methods).

Other uses of health information.

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

We may use or disclose health information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out health information about you without prior authorization for:

- **public health purposes,**
- **abuse or neglect reporting,**
- **health oversight audits or inspection,**
- **research studies,**
- **workers' compensation purposes and emergencies.**

We also disclose health information **when required by law**, or in response to valid judicial or administrative orders.

We may disclose health information about you to a **friend of family member who may get involved in your medical care**, or to disaster relief authorities so that your family can be notified of your location and condition.

We may also 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.**

Changes to this notice:

If we need to change our current information we will publicly post the new policies. You can receive a copy of the current policy at any time. The effective date is listed just below the title.

You will be offered a copy of the current policy whenever you enroll in an LFC service. You will also be asked to acknowledge in writing your receipt of this policy.