Client Name_____ Date_____

Address_____
City State Zip

Employer_____T-shirt Size_____

Home/Cell Phone_____ Work Phone _____

Other Number (Someone who is always able to reach you) _____

E-mail Address_____

Probation/Parole/Case Worker: _____Phone #:_____

Child/Children's Name(s)	Age	Date of Birth
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____

Contact with Children: Yes☐ No☐ Custody☐ Visitation☐ Phone☐

Current monthly child support payment $_____

Marital Status:

☐ Married ☐ Engaged ☐ Single

☐ Divorced ☐ Widowed

Ethnicity:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Islander
- ☐ White

MISSOURI DEPARTMENT OF SOCIAL SERVICES

CONSUMER'S AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I, _____ authorize and request
(NAME OF CONSUMER, PARENT, GUARDIAN/LEGAL REPRESENTATIVE)

Check all that apply:

- ☑ Department of Social Services (DSS)
- ☐ Division of Youth Services (DYS)
- ☐ MO HealthNet Division (MHD)
- ☐ Division of Finance & Administrative Services (DFAS)
- ☐ Missouri Medicaid Audit and Compliance (MMAC)
- ☑ Family Support Division (FSD)
- ☐ Children's Division (CD)
- ☐ Division of Legal Services (DLS)
- ☐ Other _____
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

to **disclose/release** the below specified information of:

NAME	PHONE NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER

ADDRESS	EMAIL ADDRESS
City State Zip	

to **(check all that apply)**

- ☐ Attorney: _____
- ☐ Employer: _____
- ☐ Legislator: _____
- ☐ Governor's Staff: _____
- ☑ Other Good Dads/Jennifer Baker (and staff)
(NAME OF FACILITY, AGENCY, PERSON)

205 W. Walnut Street, Ste. 10, Springfield, MO 65806
(ADDRESS, CITY, STATE, ZIP)

THE PURPOSE OF THIS DISCLOSURE IS (CHECK ALL THAT APPLY)

- ☐ Eligibility Determination
- ☐ Legal Consultation/Representation
- ☐ Legal Proceedings
- ☐ Employment
- ☐ Compliant/Investigation/Resolution
- ☐ Treatment Planning
- ☐ Continuity of Services/Care
- ☐ Background Investigation
- ☐ At Consumer's Request
- ☐ To share or refer my information to other Missouri state agencies (such as DMH, DHSS, DSS, DESE, etc.) to obtain services consistent with the **Good Dads** program (please complete the name of the program in which you want to participate)
- ☐ Other (specify) _____

THE SPECIFIC INFORMATION TO BE DISCLOSED IS (CHECK ALL THAT APPLY)

- ☑ Entire File
- ☐ Hotline Investigations
- ☐ Eligibility Determinations
- ☐ Licensure Information
- ☐ Home Studies
- ☐ Substance Abuse Treatment
- ☐ Medical/Psychiatric Evaluation/Treatment Records
- ☐ Client Employment Records (NOTE: THIS DOES NOT INCLUDE THE RELEASE OF EMPLOYMENT RECORDS FOR DSS EMPLOYEES)
- ☑ Benefits Received
- ☑ Other Child support records that FSD may release to the parent from his/her own case file.

1. **READ CAREFULLY:** I understand that my information and records with the Department of Social Services are confidential by law. I understand that by signing this authorization, I am allowing the release of any and all of my information and records which I am authorized to receive as specified on this document whether past, present or created in the future up to the expiration or revocation date of this authorization, unless otherwise indicated. The protected information in my records may include medical treatment and/or evaluation information, mental/behavioral health information, information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable or environmental diseases and conditions, application for and/or receipt of public assistance benefits, alcohol/drug abuse information, and/or information concerning child abuse and neglect.
2. This authorization includes both information presently compiled and information to be compiled during your association or dealings with the Department of Social Services, during the specified time frame.
3. Unless otherwise indicated, this authorization becomes effective on the date of signature below and will expire one year from that date.
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so **IN WRITING** and present my written revocation to the Privacy Officer of the Department of Social Services at P.O. Box 1527, Jefferson City, MO 65102. I further understand that actions already taken based on this authorization, prior to revocation, will **NOT** be affected.
5. I understand that I have the right to receive a copy of this authorization. **A photographic copy of this authorization is as valid as the original.**
6. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive services from the Department of Social Services. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with it the potential for redisclosure by the party receiving it and that the information may no longer be protected by law once it is in possession of the receiving party. If I have questions about disclosure of my information, I can contact the Privacy Officer of the Department of Social Services, my caseworker or designee.
7. By signing this disclosure on paper or electronically, I am giving the Family Support Division (FSD) permission to deliver, or cause to be delivered, phone calls or text messages to me regarding my case from an automated dialing system at my primary number. The FSD does not use an encryption system when sending text messages. Such unencrypted systems are not secure and carry some level of risk that text messages could be read by a third party. By signing, I am affirming that I nevertheless prefer to receive text messages from FSD and understand I do not have to consent to this as part of my application and can opt out of getting these calls or text messages by checking "No" in the "Accept Text Messages" box below.

My signature below acknowledges that I have read and understood the text aove, and authorize the release of my confidential information.

SIGNATURE OF CONSUMER	DATE
WITNESS	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE (IF APPLICABLE)	
ACCEPT TEXT MESSAGES YES ☐ NO ☐	

(Please include a Description of Authority to Act on Consumer's Behalf and attach a copy of the Document Granting Authority, where applicable.)

SURVEYS

Family Support Division would like to know what services enrolled participants are seeking from our programs. In an effort to capture this data, Family Support Division is administering a survey through Survey Monkey. Please select the preferred method of survey delivery:

☐ Email
☐ Address
☐ Online

If you would like to take the survey online visit: https://www.surveymonkey.com/r/C95SDWX

Healthy Marriage and Responsible Fatherhood Assessment Worksheet

Vendor Name: Good Dads

Participant Information	
Name:	
Date of Birth:	
Social Security Number :	
Eligibility Information	
Missouri Resident:	☐ Yes ☐ No
Child under 18 years old:	☐ Yes ☐ No
Financially eligible according to the appropriate income / resources standards:	☐ Yes ☐ No
Financial Assessment (Documents Provided)	
Driver's License	☐ Yes ☐ No
Utility Bill	☐ Yes ☐ No
Pay Stub	☐ Yes ☐ No
Written Employer Statement	☐ Yes ☐ No
Social Security Benefits Statement	☐ Yes ☐ No
Self-Attestation of No Employment or Income	☐ Yes ☐ No
Unemployment Compensation	☐ Yes ☐ No
Other:	☐ Yes ☐ No
Poverty Level Percentage Determination (using the provided tool):	
Gross Monthly Household Income	$
Number of Family Members in Household	
Percentage of FPL	0.00%

COMPLETED BY STATE AGENCY

Approved for Services: ☐ Yes ☐ No

State Agency review date:

To take this survey online, scan the QR Code or follow this link:

https://www.surveymonkey.com/r/C95SDWX

Healthy Marriage and Responsible Fatherhood

Introductory Survey

Please let us know what you hope to experience in your program. Your opinion is valued greatly.

(Optional) Please enter your date of birth _____ Fatherhood Program: **Good Dads**

Why are you here? (Check all that apply)

☐ I want to become a more responsible father.

☐ I was referred. (ex. From Probation and Parole, Department of Corrections, Family Support Division, Prosecuting Attorney) I was court ordered.

☐ I want to address my child support concerns.

☐ Other (please specify) _____

How did you hear about this program? (Check all that apply)

☐ Word of Mouth ☐ From a Past Participant ☐ Family Support Division ☐ Prosecuting Attorney

☐ Marketing (flyers, brochure, social media, etc.) ☐ The Organization Itself ☐ Other: _____

What do you expect to gain from this program? (Check all that apply)

☐ Employment Opportunities ☐ Assistance with Alcohol/Drug Abuse ☐ Increased Emphasis on Parenting Skills

☐ Resume Building Skills ☐ Free Legal Services ☐ Access to Mentors/Resources Outside of the Program

☐ Assistance w/ Criminal History ☐ Assistance w/ Overcoming Homelessness ☐ Assistance with Visitation/Custody

☐ Assistance w/ Credit Repair ☐ Maintaining Hope for the Future ☐ Increased Understanding of Child Support Issues

☐ Help Obtaining Information About Health/Wellness.

☐ Other (Please Specify):

_____

_____

_____

_____

Individualized Service Plan

Good Dads

Participant Name

Client Number	**Review Dates**

Service Areas:

x Parenting skill development

x Effective co-parenting with the child's guardian

x Employment and education

x Child Support

☐ **Domestic violence**

Service identified by the participant**:**

Goal:

Objectives	Strategies to Achieve Objective	Person Responsible	Timelines	Measure of Success
Parenting Skills Development	Completion of the Good Dads 2.0 Curriculum	Self	3 Months	Pre-Post Assessment
Managing Stress and Anger	Completion of the Stress and Anger Management Module in Good Dads 2.0	Self	3 Months	Pre-Post Assessment
Objectives	Strategies to Achieve Objective	Person Responsible	Timelines	Measure of Success
Custody/Visitation				
Education and or Employment				
Housing / Transportation				
Child Support Action Goal (Leave Blank)				
Objectives	Strategies to Achieve Objective	Person Responsible	Timelines	Measure of Success
Child Support Awareness and Information	Child Support Education from FSD and Evaluation by Child Support staff from MO DSS/FSD	NPGD staff and MO FSD staff	1 Month	Child Support Review from Missouri FSD Information about Payments and Modification
Effective Co-Parenting	Relationship Education to Improve Personal Relationships and Interactions with Mother(s) of Children	NPGD staff	3-6 Months	Completion of WMR/WOR Curriculum
Father to Father Mentoring	Find and develop a relationship with a good Dad	Self and NPGD staff	1-2 Months	Having a mentor

Participant Signature: _____ **Date:**_____

Case Manager Signature:_____ **Date:**_____

MULTI-MEDIA RELEASE FORM

Good Dads has my permission to use my photograph, videos, or written or spoken statements publicly to promote the Good Dads Organization. I understand that the images and statements may be used in print publications, online publications, presentations, websites, and social media. I also understand that no royalty, fee or other compensation shall become payable to me by reason of such use.

Printed Name: _____

Signature: _____ Date: _____

Phone Number: _____ Email: _____