North Los Angeles County Regional Center

9200 Oakdale Avenue, Suite 100, Chatsworth, CA 91311 - (818) 778-1900
25360 Magic Mountain Parkway, Suite 150, Santa Clarita, CA 91355 - (661) 775-8450
43850 10th Street West, Lancaster, CA 93534 - (661) 945-6761

Intake Application

for Children Over 3 Years of Age and Adults

Applicant's Information:

First Name | **Middle Name** | **Last Name**

Birth Date | **Age** | **Birth Place**

Gender (Sex assigned at birth) ☐Male ☐Female | **Preferred Gender** | **Marital Status**

Preferred Language for Communication with Regional Center | **Other Languages Spoken**

Ethnicity

If the Applicant's name has been changed, please list previous name below.

Applicant's Address:

Who does the applicant live with? _____

Street

City | State | Zip

Primary Phone Number | Alternate Phone Number | E-mail Address

Who is the primary responsible party that can be contacted regarding this application?

First Name | Last Name | Relationship

Primary Phone Number | Alternate Phone Number | E-mail Address

Please provide information regarding the individual, agency or office that made referral.

Name of Agency / Contact Person | Primary Phone Number | E-mail Address

Has the applicant previously received assessment or services from North Los Angeles County Regional Center or another Regional Center? ☐Yes ☐No

If "Yes," please name the Regional Center:

Please complete and fax entire form to Intake Department (818) 756-6357 or submit electronically to intake@nlacrc.org

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Parent 1 Information:

Relationship to applicant:_____

First Name	Middle Name	Last Name

Birth Date	Birth Place	Language

Street

City	State	Zip

Phone Number

Employer's Name	Job Title

Disabled ◯ Yes ◯ No **Deceased** ◯ Yes ◯ No

Marital Status ◯ Married ◯ Divorced ◯ Separated ◯ Single ◯ Widower

Parent 2 Information:

Relationship to applicant:_____

First Name	Middle Name	Last Name

Birth Date	Birth Place	Language

Street

City	State	Zip

Phone Number

Employer's Name	Job Title

Disabled ◯ Yes ◯ No **Deceased** ◯ Yes ◯ No

Marital Status ◯ Married ◯ Divorced ◯ Separated ◯ Single ◯ Widower

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Developmental Disability: Please indicate the developmental disability that is suspected or diagnosed. You may indicate more than one area of developmental disability. NLACRC will perform assessment to determine if the applicant meets the definition of developmental disability per California law and regulation. Children ages 3-4 who are not found to have a developmental disability may be considered for the Provisional Eligibility Program.

☐ Intellectual Disability ☐ Autism Spectrum Disorder ☐ Cerebral Palsy
☐ Epilepsy ☐ Conditions Similar to Intellectual Disability

Please describe why the applicant is applying for Regional Center services:

1. Intellectual Disability

Has the applicant been diagnosed by a health care professional with an Intellectual Disability? _____

Professional Name:_____ Age diagnosed?_____

Please describe concerns about the applicant's ability to learn:

Please describe concerns about the applicant's ability to perform age appropriate skills independently:

2. Autism Spectrum Disorder

Has the applicant been diagnosed by a health care professional with Autism Spectrum Disorder? _____

Professional Name:_____ Age diagnosed?_____

At what age did concerns about the applicant's development begin? _____

Describe concerns regarding the applicant's language:

Describe concerns regarding the applicant's social interaction and behaviors:

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3. Cerebral Palsy

Has the applicant been diagnosed by a health care professional with Cerebral Palsy?_____

Physician Name:_____ Age diagnosed?_____

Describe the impact on the applicant's physical functioning and list any adaptive equipment used:

4. Epilepsy

Has the applicant been diagnosed by a physician or neurologist with Epilepsy?_____

Physician Name:_____ Age diagnosed?_____

Please list the medication(s) used for Epilepsy (Seizures):

Describe the type of seizures, how often they occur, and the impact on the applicant's daily functioning:

5. Other

Please describe any other concerns that have not been addressed:

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Medical History

Please describe any medical diagnosis or chronic health conditions:

Physician name:_____

Please list any medications that the applicant is currently taking for any medical conditions:

Mental Health History

Please describe any current mental health (psychiatric) diagnosis:

Mental health provider name:_____

Please list any medications that the applicant is currently taking for any mental health (psychiatric) conditions:

School History

Is the applicant currently or previously been in a special education program or had an IEP (Individual Education Plan)? ☐ Yes ☐ No

Insurance Information:

Medi-Cal ☐

Insurance Name	Insurance Policy Number

IMPORTANT: Please submit a copy of the applicant's insurance card with your application.

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Clinician / Educational Contact Information For Record Request

Please indicate the name and contact information, as applicable, for the current physician, any medical specialist, psychologist or mental health provider, and last school attended and then please sign the corresponding consents to obtain current records from these providers.

A. Current Physician:

Name

Street

City | State | Zip

Phone Number

B. Other Current Physician, Medical Specialist, Hospital, Psychologist, or Mental Health Specialist:

Name

Street

City | State | Zip

Phone Number | Specialty

C. Current School or last school attended:

Name

Street

City | State | Zip

Phone Number

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Consent for Intake and Assessment Services

By signing this form, I hereby consent to the assessment of the individual named on this form for the purpose of determining eligibility for Regional Center services as per the Lanterman Developmental Disability Services Act. I understand that assessment may include collection and review of available historical diagnostic information, provision or procurement of necessary tests and evaluations and summarization of developmental levels and service needs. I understand that the North Los Angeles County Regional Center may consider evaluations and tests, including, but not limited to, intelligence tests, adaptive functioning tests, neurological and neuropsychological tests, diagnostic tests performed by a physician, psychiatric tests, and other tests and evaluations that have been performed by, and are available from, other sources. (California Welfare and Institutions code Section 4642, 4653)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that all information and records obtained by the North Los Angeles County Regional Center in the course of providing intake and assessment services are confidential.

Please review the enclosed **Notice of Privacy Practices.** By signing this form, I acknowledge that I was provided a copy of the *Notice of Privacy Practices* of the North Los Angeles County Regional Center. I acknowledge that I have read (or had the opportunity to read) and understood the Notice. I understand that I can request a paper copy of the Notice at any time.

Applicant Name	**Signature**	**Date**

If Applicant is a minor or unable to sign:

Name of Parent or Authorized Representative	**Signature**	**Date**

Relationship to Applicant

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AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEDICAL AND/OR OTHER INFORMATION

To: _____ Attention: _____

_____

_____

I hereby authorize the above named school, medical practitioner, hospital, clinic, mental health facility and/or designated employees to release school or medical information as indicated below.

Please release medical records and/or other information regarding:

Name: _____ Birth Date: _____

Release medical information to: NORTH LOS ANGELES COUNTY REGIONAL CENTER (NLACRC)

DURATION

This authorization shall become effective immediately and shall remain in effect until _____(enter date) or for one year from the date of signature if no date is entered.

REVOCATION

This authorization may be revoked by the undersigned at any time. The revocation must be in writing, signed by the undersigned, and delivered to NLACRC at the address above. Written revocation will be effective upon receipt, but will not be effective to the extent that the requester or others have acted in reliance upon this authorization.

REDISCLOSURE

NLACRC may not re-disclose the information obtained under this authorization unless additional authorization is obtained or disclosure is specifically required or permitted by law.

SPECIFY RECORDS

Check the box and initial the type of information to disclose:

☐ **Medical Information:** Birth Records, Office visits, physical examinations, developmental assessments, hospital admission and discharge summaries.

☐ **Psychiatric/Psychological Information:** Evaluations, medication and treatment records, hospital admission and discharge summaries, and diagnostic impressions including testing score sheets.

☐ **School/College and Psychological Services or Vocational/Rehabilitation records:** AB3632 assessment, case studies, psychological, hearing, speech and language evaluations, most recent IEP transcript and/or cumulative records.

☐ **HIV, AIDS, Substance Abuse Treatment.**

☐ **Other** (specify) _____

I request that the health information released pursuant to this authorization be used for the following purposes only:
These records will be used by the NLACRC to evaluate and make decisions regarding eligibility and appropriate services for this individual.

I understand that this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I have a right to receive a copy of this authorization for my records. A copy of this authorization is valid as an original.

_____ _____
Signature of Consumer or Consumer's Legal Representative Date

_____ _____
Printed Name Relationship, if signed by someone other than consumer

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Please Keep For Your Records.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The North Los Angeles County Regional Center (NLACRC) is mandated by law to maintain the privacy of your Protected Health Information (PHI). PHI is information that identifies you in any form (electronic, written, oral, etc.) collected, created, maintained, or received by NLACRC relating to your past, present or future physical/ mental health or condition. We are required by law to provide you, a NLACRC consumer, with this "Notice of Privacy Practices" explaining our legal duties and privacy practices concerning your PHI. We are also required to abide by the terms of the current version of this Notice. In this Notice, the terms "NLACRC", "we", "us", and "our" refer to the North Los Angeles County Regional Center.

WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU WITHOUT YOUR WRITTEN PERMISSION IN THE FOLLOWING SITUATIONS:

Treatment: We may use and disclose your PHI for the provision, coordination and/or management of health care and related services. For example, we may disclose your PHI to case managers, doctors, health care providers, vendors, business associates, caregivers, family and other persons who are involved in taking care of you, both within and outside of NLACRC.
Health Care Operations: We may use and disclose your PHI for our Operations. For example, activities involving, but not limited to, case management, quality assessment and improvement, risk mitigation, oversight by state and federal agencies, audit, training, and advocacy. This may include sharing your information with the California Department of Developmental Services (DDS), and other California regional centers when required.
Payment: We may use your PHI to, for example, determine our responsibility to pay for, or to permit us to bill and collect payment for the treatment and health-related services that you receive.
Appointment Reminders and Notification: We may contact you about appointments or provide you with information that may be of your interest.
Public Health Activities: We may share your PHI for Public Health Activities, for example, when related to prevention of disease, injury or disability; for tracking and monitoring of certain medical products.
Judicial Proceedings: We may use or disclose your PHI for Judicial Proceedings, for example, as part of an administrative hearing, in response to an order of a court, or a subpoena.
Law Enforcement: We may share your PHI with Law Enforcement Agencies, for example, to respond to a search warrant or to report a crime.
Research: We may use or share your PHI for research approved by NLACRC and an Institutional Review Board, a committee that is responsible, under law, for reviewing and approving research to protect the safety of the participants and the confidentiality of PHI. Participation in any such research may also require your specific authorization.
Serious Threat to Health or Safety or Disaster Relief: We may use or share your PHI to prevent serious/ imminent threat to your or another person's health and safety.
National Security: We may share PHI with authorized federal officials for intelligence, and other national security activities authorized by Law.
Coroners, Medical Examiners, Funeral Directors and Organ Donation: We may share your PHI with these agencies, as applicable by law, to allow these individuals to perform their official duties; for example, to identify a deceased person.
Correctional Institutions: If you are under law enforcement custody, we may share your PHI with correctional institutions or law enforcement, as needed, for your health care.
As Mandated by Law: We will share your PHI when otherwise required by law.

OTHER USES OF PROTECTED HEALTH INFORMATION
Other uses and disclosures of Protected Health Information not covered by this notice or the laws that apply to us will be made only with your written permission. The permission you provide us to use or disclose your PHI may be revoked in writing at any time. If you revoke your permission, this will stop any further use or disclosure of your PHI for the purposes covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you. There are stricter requirements for the use and disclosure of certain types of PHI, for example, records about HIV/AIDS, mental health, drug and alcohol treatment. This type of information can only be released in accordance with those stricter laws.

Please Keep For Your Records.

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YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION (PHI) INCLUDE:

Right to Inspect and Copy your Records You have the right to request in writing to inspect and copy your PHI in designated record sets. If we deny a request, we will do so in writing giving our reasons and you have the right to have that decision reviewed.

Right to Request Amendments to your Records If you feel that your PHI is incorrect or incomplete, you have the right to ask in writing that we amend it, stating why we should make the correction or addition. If we deny your request, we will do so in writing giving our reasons, and you may file a written statement of disagreement.

Right to Request Restrictions You have the right to request in writing a restriction or limitation of our use or disclosure of your PHI. You may request that your PHI not be shared with others, like a family member or friend. However, by law, we do not have to agree to your request.

Right to Request Confidential Communications You have the right to request in writing that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. When we can reasonably or lawfully agree to your request, we will.

Right to an Accounting of Disclosures You have the right to request in writing an accounting of our disclosures of your PHI for up to 6 years before your request, but not for disclosures made before April 14, 2003. An accounting does not include disclosures to carry out Treatment, Health Care Operations, Payment, General Notification, Law Enforcement, National Security, and to Correctional Institutions as well as otherwise Mandated by Law. Additionally, an accounting does not include disclosures for which NLACRC had a signed authorization, disclosures to you, your care giver, or persons acting on your behalf.

Right to a Paper Copy of this Notice You have the right to receive a paper copy of this Notice upon request at any time. Copies can be downloaded from **www.nlacrc.org**, provided by reception at any of our offices, or through your case manager.

CHANGES TO THIS NOTICE We reserve the right to change this Notice and our privacy practices at any time, as long as the change is consistent with state and federal law. Any revised Notice will apply both to the PHI we already have about you at the time of the change, and any PHI created or received after the change takes effect. A copy of the current Notice will be posted at all NLACRC offices in a clear and prominent location. If we change our Notice, you may obtain a copy of the revised Notice from the NLACRC web site, reception, or your case manager.

QUESTIONS/COMPLAINTS If you have questions regarding this Notice or our privacy practices, or if you are writing about your PHI, including requests for restrictions on its use or disclosure, or to make a complaint about our privacy practices, please write to NLACRC, Attn: HIPAA Privacy Officer, 9200 Oakdale Ave. Suite 100, Chatsworth, CA 91311 or call 818-778-1900. If you believe your privacy rights have been violated, you may also notify the Secretary of the Department of Health and Human Services (HHS). You will not be penalized for filing a complaint.

Welfare and Institutions Code, Section 4731
Consumer Rights Complaint Process

Consumers and their families have a legal right to file a complaint if they feel their rights have been violated or unreasonably denied. If you need more information on filing a complaint, please call the NLACRC contract administrator at (818) 778-1900.
Please review the enclosed Consumer Rights Complaint Process online:
https://www.nlacrc.org/consumers-families/complaint-process

If you are not registered to vote where you live now, would you like to apply to register to vote here today?
(Check One)

☐ Already registered. I am registered to vote at my current residence address.

☐ Yes. I would like to register to vote. (Please fill out the attached voter registration form.)

☐ No. I do not want to register to vote.

NOTE: IF YOU DO NOT CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME. YOU MAY TAKE THE ATTACHED VOTER REGISTRATION FORM TO REGISTER AT YOUR CONVENIENCE.

_____

Applicant Name Date

Important Notices

1. Applying to register or declining to register to vote will **not** affect the amount of assistance that you will be provided by this agency.

2. If you would like help in filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.

3. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party preference or other political preference, you may file a complaint with the Secretary of State by calling toll-free (800) 345-VOTE (8683) or you may write to: Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814. For more information on elections and voting, please visit the Secretary of State's website at www.sos.ca.gov.