Preschool (3-5 Year Olds) Registration Packet

(parents have 1 week to complete Registration packet or childcare services will be denied)

ALL HIGHLIGHTED ITEMS MUST BE HANDED IN BY PARENT

_____ Birth Certificate

_____ Class Schedule Mom___ Dad___

_____ Immunizations

_____ Tribal Enrollment

_____ UTTC ID Card (s) Mom___ Dad___

All papers listed below must be filled out by the parent

____ Authorization to Disclose Information

____ Billing Contract for Services

____ Child Information Sheet

____ Child Food Program Enrollment Form (with case number)

____ Contract for Childcare Services

____ Handbook Review

____ Registration

____ Statement of Health of Child

____Parent Questionnaire

____ Allocation Form

Child's NAME:_____

Child's DOB: _____

Parent/Guardian Name: _____

Parent/Guardian Name: _____

Parent Phone #:_____

Parent Email:_____

Add Date:_____

Drop Date:_____

Billing Office

_____ Authorization to Disclose Information

_____ Billing Contract

____ UTTC Card(s) ____mom____dad

____ Childcare Assistance Application

____ Allocation Form

UNITED TRIBES TECHNICAL COLLEGE

UTTC/Child Development Center Registration Form

Person Completing Child Registration Form

_____ _____
Printed Name of Person Completing Form Relationship to Child

_____ _____
Signature of Person Completing Form Date

Child Information

Last Name_____ First _____ Middle_____
Preferred Name (if different than above) _____
Home Phone _____ Gender ☐ Male ☐ Female
Date of Birth _____
Ethnicity (circle one): American Indian Caucasian African American
Hispanic Asian Pacific Islander
Is this child an enrolled member of federally recognized tribe? ☐ Yes ☐ No
Tribal Enrollment Number: _____

Address Information

Child Mailing Address_____ City _____ State _____ Zip _____
Street Address (if different) _____ City _____ State _____ Zip _____

Parent/Guardian Information

Father's Name _____ Home Phone _____ Cell Phone _____

Mother's Name _____ Home Phone _____ Cell Phone _____

Guardian's Name _____ Home Phone _____ Cell Phone _____

Living Arrangements

(Circle one)

Does this child live in a single-parent household? Yes No

Child currently lives with: Both Parents Mother Only

Father Only Other _____

(OVER – please fill out back side of form)

Emergency Information

(Indicate local contact persons other than parent – must live in Bismarck/Mandan/Lincoln)

Contact 1 _____ Relationship _____
Daytime Phone _____ Type of Phone: Home Work Cell

Contact 2 _____ Relationship _____
Daytime Phone _____ __ Type of Phone: Home Work Cell

Medical Information

Doctor _____ Phone _____
Dentist _____ Phone _____
Allergies (list) _____
Medications (list type and purpose) _____
Health Conditions: (circle and describe any that apply)

Glasses	Diabetes	Seizures	Frequent Ear Infections
Hearing Aids	Ear Tubes	Asthma	Other

Describe: _____

Has any health condition resulted in an emergency? ☐ Yes ☐ No
Describe: _____

I give permission for the center to apply bug spray/sun screen to my child: ☐ Yes ☐ No

Photo/Video Release Authorization

I give the Child Development Center Staff permission to take pictures/video of my child:

_____
(Child's Name) ☐ Yes ☐ No

Closed Facebook Page

I give the Child Development Center Staff permission to take photos/share information on the closed facebook page:

_____
(Child's Name) ☐ Yes ☐ No

Emergency Transportation

I give the Child Development Center Staff permission to transport my child in case of an emergency to a relocation site when it is unsafe to remain at the child care facility.

_____
(Child's Name) ☐ Yes ☐ No

This Section should be completed By Child's Legal Decision Maker

Has your child ever received service(s) for a disability? ☐ Yes ☐ No
If "yes" indicate which service(s) _____
Where were services provided? _____

In case of a medical emergency, and I cannot be reached, I give my child's doctor or any attending physician permission to administer medical treatment. ☐ Yes ☐ No

Beginning Date _____ your child will attending UTTC/Child Development Center.

(Print Name) (Signature) (Date)

UNITED TRIBES TECHNICAL COLLEGE

UTTC Child Care Billing Contract

3315 University Drive
Bismarck, ND 58504
Phone: (701) 255-3285 ext. 1388
http://www.uttc.edu/cdc/

This contract is made between UTTC and: (Please Print)

Student's Name: _____ ID#:_____

Local Address: _____City: _____State/Zip: _____

Home Phone: _____Cell Phone:_____Email:_____

Child(ren) Information: (only those needing care)

Child's Name:_____ Date of Birth:____/____/_____ Sex: Male / Female

Child's Name:_____ Date of Birth:____/____/_____ Sex: Male / Female

Child's Name:_____ Date of Birth:____/____/_____ Sex: Male / Female

Parent(s)/Guardian(s) Name: _____ and _____

Permanent Address:_____City:_____State/Zip:_____

Parent(s)/Guardian(s) Social Security Number:_____ and _____

The following documents must be provided prior to services being rendered:

- ☐ Provide 2 copies of my Student Identification Card.
- ☐ Provide 2 copies of my current class schedule. If changes are made to my schedule, it is my responsibility to provide 2 revised/final copies within 5 days of the changes.
- ☐ Complete the Child Care Assistance Application (SFN 598). You have the option of completing the online application or print a manual application and return it to a human service zone office (county social service office) just go to https://www.nd.gov/dhs/services/financialhelp/childcare.html find "FAMILIES - How to apply and submit an application" and select the option you choose. You may also turn in the manual application in to the CDC Billing Technician.
- ☐ Submit any additional documentation required by the human services zone office (Social Services) within 5 days of their request. If there are circumstances that will prevent the information from being submitted within the allotted time, notify the CDC Billing Technician immediately.

UTTC Child Care Billing Office responsibility:

- Assist student/guardian with questions related to child care bills or child care reimbursement.
- Prepare monthly bills that must be signed by the parent to certify the child care charges.
- If a signed statement has not been received by the stated deadlines, it will not be submitted to child care assistance agencies for reimbursement.
- **Notification of an unsigned billing statement or nonpayment will be sent to the Center Directors on the 9th of each month** or the previous Friday, if the 9th falls on a weekend.
- Submit child care bills through the ND.Gov Child Care Assistance Program portal.

Parent/Guardian's responsibility:

- Sign child in and out every day services are provided.
- Review and sign the final billing statement by the **5th of each month at the Jack Barden Center**. If the 5th falls on a Saturday or Sunday, I have until 4:00 pm on Monday to submit my signed statement.
    - If I do not sign my billing statement by the 5th of each month, the CDC Billing office will attempt up to a maximum of 2 times to contact me (via telephone, mail, email, final bill, and/or notice from daycare center) for a final signature.
    - CDC will **suspend child care services on the 10th of the month** until my bill is signed and/or paid.
- **Payment for child care services is *my responsibility***. I will be responsible for any and all amounts not covered by the Child Care Assistance Program or other available funds.
- I understand my child care must be at a **zero balance each semester** in order to utilize the child care facilities at the start of the next term; if it is not, I understand I will be denied services until it is paid.
- In the event that I do not complete all of the necessary requirements for the ND.Gov Child Care Assistance Program for reimbursement consideration or I am denied, it is my responsibility to pay all outstanding charges by the 10th of each month.
- If I have questions or concerns regarding my billing statement, I will need to contact the CDC Billing Office within ten (10) days of receipt of the bill.
- To abide by the terms and conditions as stated in this contract. This authorization expires twelve (12) months after the signed date below.
- Child care fee is $4.50 per hour for the 1st child, $2.00 per hour for each additional child.

By signing below, as the parent/guardian of the above stated child, I agree to the terms and conditions herein:

Parent's/Guardian Signature:_____Date:_____

Parent's/Guardian Signature:_____Date:_____

Witness by:

CDC Staff Signature:_____Date:_____

UNITED TRIBES TECHNICAL COLLEGE	**Contract for Childcare Services** UTTC Child Development Center Thanks for choosing CDC to provide your childcare needs!	***Regular Hours:*** Monday-Friday 7:30am-5:30pm *Friday pick up right after last class ***After Hours:*** *Monday-Friday 4:00pm-5:00pm ***Evening Care Hours:*** *Monday-Thursday 4:00pm-5:30pm ***Summer Session:*** *Monday-Friday 7:30am-5:30pm

Beginning_____childcare services will be provided at UTTC CDC for_____.
(Date) (Child's Name)

Child Development Center General Terms & Conditions:

- To use the CDC childcare services, the parent/guardian **must** be a current UTTC student/staff.
- An official class schedule must be turned into the center in order to receive childcare services.
- A registration packet is needed for all children to attend daycare at UTTC. The registration packet needs to be current to stay in compliance with Burleigh Country Social Services. At the time of enrollment, parents/guardians may not be able to produce all the needed information to the CDC. Therefore, parents/guardians are given two (2) weeks from the first day their child starts daycare to provide the necessary information. If this information is still missing from your child's registration packet after the (2) weeks, services will be denied until all information/documentation is received.
- The CDC is not a sick daycare facility. For the well-being of other children, sick children cannot attend.
- Behavior Guidance: Each staff person and child at CDC is special and will be treated with respect at all times. Any type of behavior intended to, or which in reckless disregard does, physically or emotionally hurt someone will not be tolerated at the Center. Violation of this policy may result in a referral to the Student Code of Conduct.
- Parents/guardians picking up their children after the center closes will be subject to the following in order of occurrence:
    - First Warning - Verbal
    - Second Warning - Written
    - Third Warning - Written
    - Fourth Warning - Referral to Social Services Agency

I understand and agree to abide by the policies and procedures as stated in the Parent Handbook and the above Contract for Childcare Services. I also understand that, from time to time, the Center Director/CDC Administrator may implement or change policies as needed. I understand that I will be notified of these changes.

Parent's/Guardian Signature: _____ Date: _____

Director's Signature: _____ Date: _____

Revised 8/2021

Child Information Form

Enrollment Date:

Child's Name:_____ Birth Date:_____

Local Address:_____

_____

_____

Please indicate if phone #'s are H- home C- cell W- work

Mother/Guardian:_____ Primary Phone: _____H C W

Secondary Phone:_____ H C W Other Phone: _____H C W

Address (If different from child): _____

_____ Lives with Child: Yes No Shared Custody

Father/ Guardian:_____ Primary Phone: _____H C W

Secondary Phone:_____ H C W Other Phone: _____H C W

Address (If different from child): _____

_____ Lives with Child: Yes No Shared Custody

Other people living in the home with child: (Indicate relationship next to name i.e. sister)

_____

_____

Child will generally be picked up and dropped off by:_____

Other people authorized for pick-up and transportation:_____

Please list any persons who are **UNATHORIZED** to pick up child:_____

_____

Allergies:_____

Other Health Concerns:_____

Changes/Events/Issues (i.e. death in the family, new baby, etc.)_____

_____

Prior Group Experiences:_____

Please share any other information you feel is important for us to know about your child. ☺

_____

_____

_____

_____

_____

CHILD INFORMATION SHEET

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
CHILDREN AND FAMILY SERVICES
SFN 845 (2-2020)

Every Early Childhood Program is required to have certain information on file. These requirements are set forth in the rules and regulations for Early Childhood Services as adopted by the North Dakota Department of Human Services. All information requested herein is required and shall be kept confidential.

Child's Name	Date Child Enrolled	Preferred or Nickname of Child	Date of Birth
Parent's Name	Home Telephone Number	Cell Phone Number	Work Telephone Number
Home Address			
Place of Employment			Hours of Work
Parent's Name	Home Telephone Number	Cell Phone Number	Work Telephone Number
Home Address			
Place of Employment			Hours of Work

EMERGENCY AUTHORIZATION

In case of an emergency and parents cannot be reached, who should be contacted?

Name	Relationship to Child	Work Telephone Number	Home Telephone Number
Name	Relationship to Child	Work Telephone Number	Home Telephone Number
Physician to Call in an Emergency			Clinic Telephone Number
Dentist to Call in an Emergency			Clinic Telephone Number

I hereby authorize the Early Childhood Program to secure emergency medical treatment for my child under the following conditions:

1. An emergency or unanticipated condition necessitates immediate action for the preservation of the life or health of the child, and
2. Reasonable attempts to contact me have failed.

Parent Signature	Date	Parent Signature	Date

AUTHORIZATION TO RELEASE CHILD

Unless otherwise authorized by you in writing, only the parent or legal guardian may pick up your child(ren) from the Early Childhood Program. List below any others you wish to authorize for this purpose.

Name	Relationship to Child	Telephone Number
Name	Relationship to Child	Telephone Number
Name	Relationship to Child	Telephone Number

These people are <u>NOT</u> allowed to pick up my child.

Name	Relationship to Child
Name	Relationship to Child

For Operator Use Only:

The identification of this child has been verified. As proof of identification, the child's parent has produced: ☐ Copy of Child's Birth Certificate ☐ Child's Passport ☐ Other _____
Signature of Operator

PARENT'S STATEMENT ON HEALTH OF CHILD

ND DEPARTMENT OF HUMAN SERVICES/CFS

SFN 847 (Rev. 11-2008)

INSTRUCTIONS: This form must be completed annually for any child enrolled in a licensed early childhood facility. This form is completed by a parent or guardian of the child.

Full Legal Name of Child:	Birth Date:	Enrollment Date:	Please check one: ☐ FT ☐ PT ☐ Dropin ☐ B/A School
Full Legal Name(s) of Parent or Guardian:			Relationship:
Address:	City:	State:	ZIP Code:
Home Telephone Number:	Work Telephone Number:	Family Dentist:	
Family Physician:	Clinic:	Telephone Number:	
Hospital:			Telephone Number:
Last Visit to Doctor:	Child's Height:	Child's Weight:	

Does The Child Have Any food, medication or environmental allergies: ☐ Yes ☐ No

If Yes, List Allergies:	Describe Allergy Reaction:	Usual Treatment:

Please Check If Any Of The Following Conditions Exist:

☐ Asthma ☐ Heart Condition ☐ Hearing Impairment ☐ Behavioral Issues

☐ Diabetes ☐ Seizure Disorder ☐ Frequent Earaches ☐ Other Conditions (please specify): _____

☐ Vision Impairment

Please Explain All Checked Items:

Is The Child Under Current Medical Treatment? ☐ Yes ☐ No If yes, please list:

Are There Any Medications That The Child Takes Daily? ☐ Yes ☐ No If yes, please list:

Describe Any Limitation Your Child May Have For Participation In An Early Childhood Program:

Is there a health care plan for your child? ☐ Yes ☐ No If yes, please attach

INSURANCE:

Liability insurance is not a requirement for a license to provide family or group child care. Please review with your child care provider the liability coverage that is presently in place.

CERTIFICATION:

I certify that the above information is true to the best of my knowledge.

Parent or Guardian's Signature:	Date

United Tribes Technical College

3315 University Drive
Bismarck, North Dakota 58504
701.255.3285 | www.uttc.edu

AUTHORIZATION OF FEDERAL STUDENT AID FUNDS AND/OR OTHER STUDENT AID PAYMENTS ALLOCATION FORM

Initials

_____ I am authorizing United Tribes Technical College to apply any credit balance of Agency funding and/or scholarships to pay for childcare charges.

_____ _____
Please print name ID#

_____ _____
Student Signature Date

NORTH DAKOTA DEPARTMENT OF PUBLIC INSTRUCTION

CACFP Enrollment Form / Free and Reduced-Price Income Application (Child Care)

Complete one application per household. Please use a pen (not a pencil).

Center Name

STEP 1 REQUIRED The parent / guardian must complete Parts 1 and 4. List ALL Children who attend day care

CHILD's Last Name, First Name	Date of Birth	Time of Care		Regular Days of Care							Meals Served During Care					
		Arrival Time	Leave Time	M	T	W	T	F	S	S	B	AM	L	PM	D	EV
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Check all that apply

Foster Child	Migrant	Head Start
☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐

PARENTS OF INFANTS

My Choice of CACFP Infant Participation is:

Your child care center must offer at least one brand of formula if your child is on formula. You have the option of declining that brand and supplying your own formula. Children must be served breast milk or iron-fortified infant formula until they are one year of age. All other food items must be provided by your center when age-appropriate, consistent with CACFP guidelines.

- ☐ I choose to supply expressed breast milk to my child care provider to serve at meal time.
- ☐ I choose to accept the iron-fortified infant formula (brand:_____) that my child care center has offered.
- ☐ My child care center has offered the following brand,_____. I have chosen to decline this brand and provide the formula for my infant.

STEP 2 Optional Do any household members (including you) currently participate in one or more of the following assistance programs: ☐ SNAP ☐ TANF, or ☐ FDPIR?

IF NO > Go to STEP 3 **IF YES** > Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER: Write only one case number in this space.

STEP 3 Optional Parent / guardian should fill out household income to determine the amount of CACFP funds the center will be eligible to receive. This form will be placed in our confidential files.

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The **"Sources of Income for Children"** chart will help you with the Child Income section.

The **"Sources of Income for Adults"** chart will help you with All Adult Household Members section.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child Income $ _____ How often? Weekly ☐ Bi-Weekly ☐ Monthly ☐ Bi-Monthly ☐

B. All Other Household Members (Including yourself)

List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Household Members not listed in Step 1 (Last Name, First Name)	Earnings from Work	How often? Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2xMonth ☐	Welfare/Child Support/Alimony	How often? Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2xMonth ☐	Pensions/Retirement/ Social Security/SSI/ VA Benefits	How often? Weekly ☐ Bi-Weekly ☐ Monthly ☐ 2xMonth ☐
	$		$		$	
	$		$		$	
	$		$		$	
	$		$		$	
	$		$		$	

Total Household Members (Children and Adults) _____

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member X X X X X _____ ☐ (Mark if No Social Security Number)

STEP 4 REQUIRED Sign and date the application. The form must be signed by the parent or guardian.

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form _____ Signature of Adult _____ Today's Date _____

Address _____ City _____ State _____ Zip _____ Phone/Email _____

Source of Income for Children	
Sources of Child Income	**Examples**
Earnings from work	• A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	• A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	• A friend or extended family member reguarly gives a child spending money
Income from any other source	• A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• Social Security (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household

OPTIONAL Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (202) 690-7442; or
EMAIL: program.intake@usda.gov.

This institution is an equal opportunity provider.

***Only use this address if you are filing a complaint of discrimination.**

DO NOT FILL OUT For official use only

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

Total Income

How often? Weekly ○ Bi-Weekly ○ Monthly ○ 2xMonth ○

Household size

Categorial Eligibility ☐

Eligibility: Free ○ Reduced ○ Denied ○

Determining Official's Signature | Date | Confirming Official's Signature | Date | Follow-up Official's Signature | Date

UNITED TRIBES
TECHNICAL COLLEGE

Parent Handbook Orientation

Hello Families,

Welcome to the UTTC Child Development Centers! For your information, the Parent Handbook can be found at www.uttc.edu

Use the following steps to access the handbook.

1. Go to www.uttc.edu
2. Find STUDENT Life (middle of the page) drop down menu click on Student Resources then click Childcare
3. Childcare Documents (middle of page) click on Parent Handbook

Your signature below indicates that you have received this information regarding the CDC Parent Handbook and it is my responsibility to read the Parent Handbook.

- -

My signature indicates that I have received the information to obtain the CDC Parent Handbook at www.uttc.edu

_____

_

Parent/Guardian Signature Date

AUTHORIZATION TO DISCLOSE INFORMATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
LEGAL SERVICES
SFN 1059 (9-2019)

Clear Fields

PRIVACY STATEMENT: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose a social security number will not affect the disclosure of other information. The Department will not condition treatment on your agreement to authorize disclosure of your health information. The Department may, however, require that you authorize disclosure of your health information if needed to make a determination about your eligibility for benefits or enrollment in a Department health plan.

Name of Client (Last, First, Middle Initial)	Social Security Number		Date of Birth
Previous Names Used			
Street Address	City	State	ZIP Code

CLIENT RELEASE AND SIGNATURE

1. I Hereby Authorize:

Name of Person/Agency	Email Address (complete ONLY if email delivery is requested)		
CDC Billing Technician	jstewart@uttc.edu		
Street Address	City	State	ZIP Code
3315 University Dr	Bismarck,	ND	58504

2. Permission To: ☒ Disclose To ☒ Obtain From ☒ Mutually Exchange With

Name of Person/Agency	Email Address (complete ONLY if email delivery is requested)		
Burleigh County Social Services	burleighea@nd.gov		
Street Address	City	State	ZIP Code
415 E Rosser Ave, Suite 113	Bismarck	ND	58501

3. Provide a detailed description of the information to be disclosed, including how much and what kind of information. (See instructions)

Any information needed in regards to child care assistancee such as eligibility, payment, approval and denial status of child care based services. Any information requested will only be used and pertain towards child care billing.

4. The information identified above will be used for: (Select all that apply)

☐ Coordination of Care/Treatment/Discharge Planning ☐ Legal ☒ At the Request of the Individual
☒ Billing/Payment ☒ Eligibility Determination ☐ Collateral
☐ Other (must specify to be valid): _____

5. Authorization remains in effect for one year from date signed unless a different expiration date is entered here (MM/DD/YYYY):

CLIENT CONSENT

This authorization is voluntary and remains in effect until the expiration date unless specifically revoked. This authorization may be revoked by written notice, at any time except to the extent that action has been taken in reliance on it. Refer to the Department's Notice of Privacy Practices for further description of revocation rights. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including verbal, written or electronic transmission. A photo copy of this authorization is as effective as the original.

Except for information protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, there is a potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected by state or federal privacy laws.

SUBSTANCE USE DISORDER INFORMATION is protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without written consent unless otherwise provided for in the regulations. In accordance with North Dakota law, the signature of a minor 14 years of age or older is required to disclose substance use disorder information. Both the signature of a minor 13 years of age or younger and the signature of the minor's legal representative is required to authorize the disclosure of substance use disorder information.

Signature of Client		Date
Signature of Parent/Guardian or Custodian (if needed)	Relationship	Date
Signature of Witness (if needed)		Date

☐ **CHECK IF APPLICABLE - NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING SUBSTANCE USE DISORDER PATIENT RECORDS:** 42 CFR Part 2 prohibits unauthorized disclosure of these records.

DISTRIBUTION: ☐ To agency/person from whom information is sought ☐ Client ☐ Other
☐ Requesting Agency ☐ Client refused copy

AUTHORIZATION TO DISCLOSE INFORMATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
LEGAL SERVICES
SFN 1059 (9-2019)

Clear Fields

PRIVACY STATEMENT: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose a social security number will not affect the disclosure of other information. The Department will not condition treatment on your agreement to authorize disclosure of your health information. The Department may, however, require that you authorize disclosure of your health information if needed to make a determination about your eligibility for benefits or enrollment in a Department health plan.

Name of Client (Last, First, Middle Initial)	Social Security Number		Date of Birth
Previous Names Used			
Street Address	City	State	ZIP Code

CLIENT RELEASE AND SIGNATURE

1. I Hereby Authorize:

Name of Person/Agency	Email Address (complete ONLY if email delivery is requested)		
CDC Billing Technician	jstewart@uttc.edu		
Street Address	City	State	ZIP Code
3315 University Dr	Bismarck,	ND	58504

2. Permission To: ☒ Disclose To ☒ Obtain From ☒ Mutually Exchange With

Name of Person/Agency	Email Address (complete ONLY if email delivery is requested)		
Morton County Social Services	mortonsso@nd.gov		
Street Address	City	State	ZIP Code
200 2nd Ave NW	Mandan	ND	58554

3. Provide a detailed description of the information to be disclosed, including how much and what kind of information. (See instructions)

Any information needed in regards to child care assistancee such as eligibility, payment, approval and denial status of child care based services. Any information requested will only be used and pertain towards child care billing.

4. The information identified above will be used for: (Select all that apply)

☐ Coordination of Care/Treatment/Discharge Planning ☐ Legal ☒ At the Request of the Individual
☒ Billing/Payment ☒ Eligibility Determination ☐ Collateral
☐ Other (must specify to be valid): _____

5. Authorization remains in effect for one year from date signed unless a different expiration date is entered here (MM/DD/YYYY):

CLIENT CONSENT

This authorization is voluntary and remains in effect until the expiration date unless specifically revoked. This authorization may be revoked by written notice, at any time except to the extent that action has been taken in reliance on it. Refer to the Department's Notice of Privacy Practices for further description of revocation rights. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including verbal, written or electronic transmission. A photo copy of this authorization is as effective as the original.

Except for information protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, there is a potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected by state or federal privacy laws.

SUBSTANCE USE DISORDER INFORMATION is protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without written consent unless otherwise provided for in the regulations. In accordance with North Dakota law, the signature of a minor 14 years of age or older is required to disclose substance use disorder information. Both the signature of a minor 13 years of age or younger and the signature of the minor's legal representative is required to authorize the disclosure of substance use disorder information.

Signature of Client		Date
Signature of Parent/Guardian or Custodian (if needed)	Relationship	Date
Signature of Witness (if needed)		Date

☐ **CHECK IF APPLICABLE - NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING SUBSTANCE USE DISORDER PATIENT RECORDS:** 42 CFR Part 2 prohibits unauthorized disclosure of these records.

DISTRIBUTION: ☐ To agency/person from whom information is sought ☐ Client ☐ Other
☐ Requesting Agency ☐ Client refused copy