Summit County
Family & Children First
Council

Summit County Family & Children First Council
Multi-System Youth Referral Guide

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County FCFC offers the following services and supports to youth involved in multiple systems:

1) **Wraparound Service Coordination**
2) **Case Consultation**
3) **Funding for short term, community based resources/services**

Eligibility for all FCFC Services:

The child/youth must meet all of the following criteria:

- Summit County Resident
- Child/Youth must be age 0-21
- Youth at risk of destabilization and/or out of home placement
- Multi-systemic issues/needs
- Current involvement (or within the past 30 days) in at least two of the below systems:
  - Summit County Children Services
  - Summit County Juvenile Court
  - Summit County Behavioral Health (mental health and/or substance abuse)
  - Summit County Board of Developmental Disabilities
  - Summit County School District AND Special Education (IEP) or 504 Plan
  - Ohio Dept. of Youth Services/Dept. of Corrections

PROGRAM DESCRIPTIONS:

1. WRAPAROUND SERVICE COORDINATION

When youth and their families are working with multiple agencies at the same time it can sometimes be overwhelming. FCFC Service Coordination/WrapAround is a service planning and coordination process that brings everyone to the same planning table and where families are full partners.

FCFC Service Coordination/Wraparound is not meant to take the place of traditional case management or service coordination offered by community agencies. FCFC Service Coordination/WrapAround offers a **neutrally positioned facilitator** that brings together service providers and natural family supports working with the child/family to form a **Family Team.** The Family Team meets on a regular basis and utilizes a team approach to planning to ensure services are aligned, streamlined and coordinated.

Who Can Apply

Anyone can make a referral, including a parent and young adult self-referral

How to Make a Referral

a. Agency staff must first obtain approval from their SRC representative to make a referral
b. Parents or young adults self-referring can contact FCFC with any questions or assistance with form completion. Self-referrals are not required to complete the Releases of Information in order to make a referral. Contact **Stacey Garske**, FCFC Program Coordinator at **330-926-5741** with any questions
c. Complete a referral packet (i.e. Referral Form, Risk Screen, FCFC Release of Information and SEI Release of Information (as applicable) and Attachment A
d. Submit completed packet to **Stacey Garske,** FCFC Program Coordinator at agarske@schd.org or fax to **330-923-6370.**

2. CASE CONSULTATION

Staff from any agency may request a case consultation with the FCFC Service Review Committee (SRC) to discuss challenging issues and brainstorm solutions from a cross-system perspective.

Examples of issues may include, but is not limited to:

- Challenges in meeting the needs of an individual youth/family
- Difficultly in determining the appropriate level of care
- System barriers/conflicts
- Service gaps
- Other

Who Can Apply
Staff from any agency working with an eligible, multi-system youth

How to Make a Referral

a. Agency staff must first obtain approval from their SRC representative to make a referral
b. Complete a referral packet (i.e. Referral Form, Risk Screen, FCFC Release of Information and Attachment B)
c. Submit completed packet to **Janice Houchins**, FCFC Director at jhouchins@schd.org or fax to 330-923-6370. Contact Janice Houchins at 330-926-5671 with any questions

Consultation requests will be added to an upcoming weekly SRC meeting agenda. SRC meets on Wednesday afternoons. All requests received before Noon on Tuesday will be considered for that week's SRC meeting. Requests received after Noon on Tuesday will be placed on the following week's agenda.

The requester(s) should be prepared to verbally provide a brief (approximately 5 minute) case history and summary of key issues.

3. FUNDING FOR COMMUNITY BASED RESOURCES/SERVICES

This funding stream provides **short-term** funding for **community-based** services or resources when **no other funding source is available**. It is designed to:

- Provide staff with resources to develop creative and innovative ways to meet the needs of youth at significant risk for out of home placement; and
- Support goals outlined in the youth/family Plan of Care

Please note that this cannot be an ongoing funding source; all requests must include strategies for meeting child/youth family need(s) beyond the funding request. Additionally, funds cannot be paid directly to youth or their family and they cannot be used to retroactively pay for a service and/or resource.

Who Can Apply
Staff from any agency working with an eligible, multi-system youth

How to Make a Referral

a. Agency staff must first obtain approval from their SRC representative to make a referral
b. Complete a referral packet (i.e. Referral Form, Risk Screen, FCFC Release of Information and Attachment C)
c. Submit completed packet to **Janice Houchins**, FCFC Director at jhouchins@schd.org or fax to 330-923-6370. Contact Janice Houchins at 330-926-5671 with any questions

d. Referrals received before Noon on Tuesday will be considered for that week's SRC meeting. Referrals received after Noon on Tuesday will be placed on the following week's agenda.

Post-Referral Process

a. After review, FCFC either approves the request, requests additional information before making a decision or denies the request. Notification is sent to the referring person, along with a copy of the decision and committee signatures.

b. If approved, the following must occur:

- Referral source/Requester makes all necessary arrangements for the service or resource. This includes informing the service provider of the funding parameters (i.e. total cost, # of units, timeframe, etc. approved by committee).

- FCFC Director works with requester on purchase and payment arrangements. Options include credit card, agency reimbursement or provider billing.

- Any invoices requesting payment from FCFC must be submitted to FCFC Director at jhouchins@email.sparcc.org in order to receive payment: All invoices must include:
    - Youth name and dates of service provision

      NOTE: Services provided outside the timeframe or cost parameters will not be reimbursed. It is the responsibility of the requester, parent and provider to stay within the parameters of the requested time frame and dollar amount

    - Provider W-9 and PEDACKN (if not already on file)

Summit County Family & Children First Council

Summit County Family & Children First Council

Multi-System Youth Referral Form

Youth Name:

Type of Multi-System Youth Referral

(Please check appropriate boxes and include REQUIRED Attachments:

☐ WRAPAROUND SERVICE COORDINATION (3-18 month service for families)

☐ The services and supports youth is receiving and/or will receive need coordinated and aligned. A **Family Team** (comprised of service providers and natural family supports) is needed to develop, implement and monitor a coordinated Plan of Care.

OR

☐ The services and supports youth is receiving are coordinated and aligned, but complex needs remain unmet. A **Family Team** (comprised of service providers and natural family supports) is needed to take a different approach as they develop, implement and monitor a coordinated Plan of Care.

AND/OR

☐ Youth is at risk of out-of-home placement.

REQUIRED ATTACHMENTS:

1) **Referral Form**
2) **Attachment A (only)**
3) **Signed Release of Information**
4) **Completed Risk Screen**

☐ CASE CONSULTATION (one time meeting for Professionals only)

Consultation with a diverse team of managers is needed to brainstorm next steps and/or solutions from a cross-system perspective, because:

☐ Staff is encountering system barriers to service provision

AND/OR

☐ The complex needs of a youth/family remains challenging and youth may be at risk for out of home placement.

REQUIRED ATTACHMENTS:

1) **Referral Form**
2) **Attachment B (only)**
3) **Signed Release of Information**
4) **Completed Risk Screen**

☐ FLEXIBLE, SHORT TERM FUNDING FOR COMMUNITY BASED RESOURCES (for youth)

Short term funding for a specific service/resource is needed to stabilize a multi-system youth/prevent out of home placement AND no other funding source is available.

REQUIRED ATTACHMENTS:

1) **Referral Form**
2) **Attachment C (only)**
3) **Signed Release of Information**
4) **Completed Risk Screen**

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Summit County Family & Children First Council
Multi-System Youth Referral Form

		Date of Referral:
Youth Information		
Last Name:	First Name:	Middle Initial:
Gender: ☐ Male ☐ Female ☐ transgender	Race: (circle) ☐ Declined to Specify ☐ Native American Indian/Alaskan ☐ Asia ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander	☐ Other ☐ Unknown ☐ White ☐ Mixed Race ☐ Hispanic or Latino
Date of Birth:	Age:	SSN:
Current Street Address:	City:	State and Zip Code:
Phone Number:	Medical Insurance Provider: Medicaid #:	Primary Care Physician:
School District of Residence:	School District **&** School Attending:	Grade:
Referral Source Information		
Name:	Agency Affiliation, if any	Contact Information: Phone: Email:
Parent/Guardian Consent Signed (required) ☐ Yes – see attached ☐ No		
Parent / Guardian Information		
Caregiver 1 Name:	Primary Caregiver? ☐ Yes ☐ No	Legal Custodian? ☐ Yes ☐ No
Relationship to Youth: ☐ Adoptive Parent ☐ Birth Parent ☐ Foster Parent ☐ Live In Partner/Parent ☐ Other Family (Grandparent, Aunt/Uncle, Cousin, Sibling) ☐ Other (specify):	Address: (street, city, state, zip)	Phone #:
Caregiver 2 Name:	Primary Caregiver? ☐ Yes ☐ No	Legal Custodian? ☐ Yes ☐ No
Relationship to Youth: ☐ Adoptive Parent ☐ Birth Parent ☐ Foster Parent ☐ Live In Partner/Parent ☐ Other Family (Grandparent, Aunt/Uncle, Cousin, Sibling) ☐ Other (specify):	Address: (street, city, state, zip)	Phone #:

Summit County Family & Children First Council

Summit County Family & Children First Council
Multi-System Youth Referral Form

YOUTH NAME:

Current System Involvement (within the last 30 days). Check all that apply:

☐ **Juvenile Court** ☐ Family Resource Center ☐ Intake ☐ Detention ☐ Probation/Parole Name of staff & contact info:	☐ **Special Education (IEP) or 504 Plan** ☐ Alternative School ☐ Specialized Classroom ☐ **Out of District Placement** Name of school, staff & contact info:	☐ **Alcohol/Drug Tx** ☐ **C**ounseling ☐ **Detox** ☐ **I**n-patient treatment Name of provider & staff contact info:
☐ **Children Services** ☐ Referrals ☐ Voluntary Plan ☐ Protective Supervision ☐ Custody ☐ PASSS (adoption subsidy) Name of staff & contact info:	☐ **DD (Developmental Disabilities)** Name of staff & contact info:	☐ **Early Intervention or Home Visiting** (Birth – 3 years old) Name of Provider and staff contact info:
☐ **Mental Health Svs.** ☐ case management ☐ counseling ☐ psychiatry/medication ☐ psych hospitalization **(**identify facility & dates of admission): _____ _____ ☐ in-patient residential tx: **(**identify facility & dates of admission): _____ _____ Names of Community Mental Health Providers & Staff Contact info:	☐ **Other:** Name of provider, staff & contact info:	☐ **Other:** Name of provider, staff & contact info:
List Current Mental Health Diagnosis:	What services and supports have been utilized to date? ☐ Intensive Home Based Treatment ☐ Case management ☐ Counseling ☐ Medication ☐ Respite ☐ Partial Hospitalization ☐ In-patient treatment ☐ After School Programs ☐ Parenting Classes ☐ Mentoring ☐ Other (please identify): ☐ Other (please identify):	

Summit County Family & Children First Council

Summit County Family & Children First Council

ATTACHMENT A (for Wraparound Service Coordination Referral)

YOUTH NAME:
Briefly describe case history, current concerns, interventions already tried and its level of success:
Describe how the requested service will address the needs of the youth and/or family. What are the expected outcomes/changes resulting from this service/resource:
Please identify strengths of the child and family:

Signature of Person Completing this Form: _____ Date:_____

FCFC's SRC Rep Signature (if applicable)_____ Date:_____

Summit County Family & Children First Council

Summit County Family & Children First Council

ATTACHMENT B (for Case Consultation Referral)

YOUTH NAME:

Name and Contact Information of Staff Presenting the Case:

Name:	Email:	Phone:
Name:	Email:	Phone:
Name:	Email:	Phone:

Briefly describe case history, current concerns, interventions already tried and its level of success:

What is the nature/scope of your request (e.g. what you hope to gain from the consultation)?

Please identify strengths of the child and family:

Signature of Person Completing this Form: _____ Date:_____

FCFC's SRC Rep Signature (if applicable)_____ Date:_____

Summit County Family & Children First Council

Summit County Family & Children First Council

ATTACHMENT C (for Community Based Resource Funding Referral)

YOUTH NAME:
TYPE OF SERVICE/RESOURCE BEING REQUESTED:
VENDOR NAME, ADDRESS, PHONE: (e.g. provider with whom you will you set up the service):
PROPOSED START/END DATE OF SERVICE AND FREQUENCY OF SERVICE (e.g. 1 hour session each week for 12 weeks, starting in July):
UNIT RATE AND TOTAL COSTS: (Please confirm costs with vendor prior to making the referral. Also, please include information about the product, such as a brochure, product print out off Internet, etc. Finally, show the breakdown of the cost, for example $25/hr x 12 sessions = $300 or 1 lock box at $180. **Total Cost: $** _____ **Breakdown of Costs:**
OTHER FUNDING SOURCES EXPLORED/USED (other available funding must first be used)**:**
Briefly describe case history, current concerns, interventions already tried and its level of success:
Describe how the requested service will address the needs of the youth and/or family. What are the expected outcomes/changes resulting from this service/resource:
Please identify strengths of the child and family:

Signature of Person Completing this Form: _____ Date:_____

FCFC's SRC Rep Signature (if applicable)_____ Date:_____

Summit County Family & Children First Council

Summit County Family & Children First Council
Risks & Strengths Assessment – Page 1 of 2

Youth Name:	DOB:		
Known Youth Risk Factors:			
Trauma (Adverse Childhood Experiences)	☐ Current (3)	☐ History (2)	
Suicidal Ideation and/or Gestures	☐ Current (3)	☐ History (2)	
Suicidal Attempts (life threatening and with clear intent)	☐ Current (3)	☐ History (2)	
Self-Injurious Behavior (cutting, head banging, etc.)	☐ Current (2)	☐ History (1)	
Verbal or Written Threats to Others	☐ Current (2)	☐ History (1)	
Violent/Aggressive (towards others, animals, property)	☐ Current (3)	☐ History (2)	
Homicidal Ideation, Gestures, Attempts	☐ Current (3)	☐ History (2)	
Known/Suspected Criminal Activity	☐ Current (2)	☐ History (1)	
Easy Access to Weapons	☐ Current (2)	☐ History (1)	
Hears Voices or Sees Things (psychotic hallucinations)	☐ Current (2)	☐ History (1)	
Anxiety	☐ Current (2)	☐ History (1)	
Depression	☐ Current (2)	☐ History (1)	
Fire Setting	☐ Current (2)	☐ History (1)	
Bedwetting	☐ Current (1)	☐ History (0)	
Sleep Disturbance	☐ Current (1)	☐ History (0)	
Runaway	☐ Current (2)	☐ History (1)	
Sexual Offending Behavior	☐ Current (3)	☐ History (2)	
Sexual Acting Out/Impulsivity	☐ Current (2)	☐ History (1)	
Suspended, Expelled or Dropped Out from School	☐ Current (2)	☐ History (1)	
Truancy/Irregular or Poor Attendance	☐ Current (1)	☐ History (0)	
Held Back/Behind in Grade	☐ Current (1)	☐ History (0)	
Educational/Emotional Disabilities	☐ Current (1)	☐ History (0)	
Limited Developmental Capacity to Maintain Personal Safety	☐ Current (2)	☐ History (1)	
Medical Illness or Chronic Medical Illness	☐ Current (1)	☐ History (0)	
Impulsive Behavior	☐ Current (1)	☐ History (0)	
Limited Ability to Control Anger	☐ Current (2)	☐ History (1)	
Eating Disorder	☐ Current (1)	☐ History (0)	
Victimization: Physical, Emotional, Sexual Abuse or Neglect	☐ Current (3)	☐ History (2)	
Social Isolation or Impairment	☐ Current (1)	☐ History (0)	
Alcohol and/or Drug Use	☐ Current (3)	☐ History (2)	
Negative Peer Involvement and/or Gang Activity	☐ Current (2)	☐ History (1)	
Prejudicial Thinking/Ideation	☐ Current (1)	☐ History (0)	
Unrestricted Internet/Media Access	☐ Current (1)	☐ History (0)	
Pregnant or Parenting Youth	☐ Current (2)	☐ History (1)	
Resides in a High Crime Neighborhood	☐ Current (1)	☐ History (0)	
Poverty and/or Lack of a Stable Residence/Homeless	☐ Current (2)	☐ History (1)	
Out of Home Placement	☐ Current (3)	☐ History (2)	
Lack of Caregiver Monitoring and/or Supervision	☐ Current (1)	☐ History (0)	
Severe Family Conflict /Violence in the Home	☐ Current (2)	☐ History (1)	
Acute Family Crisis	☐ Current (2)	☐ History (1)	
TOTAL SCORES (ADD each column)**:**			

Summit County Family & Children First Council

Summit County Family & Children First Council
Risks & Strengths Assessment – Page 2 of 2

Youth Name:

Known Youth Strengths			
Supportive Family Member (at least one)	☐ Strength		
Interpersonal (how a child or youth thinks of themselves)	☐ Strength		
Optimism (hope for the future)	☐ Strength		
Educational (likes school and/or is a good student)	☐ Strength		
Vocational (has a job or employment plan)	☐ Strength		
Talents/Interests (engages in pro-social activities)	☐ Strength		
Community Life (connected to a pro-social network)	☐ Strength		
Relationship Permanence (has stable, significant relationships)	☐ Strength		
Resiliency (ability to identify and use internal strengths in managing life)	☐ Strength		
Other(s): - *please identify:*	☐ Strength(s)		

Known Caregivers Risks and Strengths			
Ability to Provide Adequate Supervision	☐ Strength/No Concern	☐ Current Concern (1)	☐ History of Concern (0)
Involvement with Youth's Care	☐ Strength/No Concern	☐ Current Concern (3)	☐ History of Concern (2)
Appropriate Parenting Knowledge	☐ Strength/No Concern	☐ Current Concern (2)	☐ History of Concern (1)
Organization	☐ Strength/No Concern	☐ Current Concern (2)	☐ History of Concern (1)
Social Resources	☐ Strength/No Concern	☐ Current Concern (2)	☐ History of Concern (1)
Residential Safety and Stability	☐ Strength/No Concern	☐ Current Concern (3)	☐ History of Concern (1)
Mental Health	☐ Strength/No Concern	☐ Current Concern (2)	☐ History of Concern (1)
Substance Use or Abuse	☐ Strength/No Concern	☐ Current Concern (2)	☐ History of Concern (1)
Developmental Delay or Disability	☐ Strength/No Concern	☐ Current Concern (2)	☐ History of Concern (0)
Prejudicial Thinking/Ideation	☐ Strength/No Concern	☐ Current Concern (1)	☐ History of Concern (0)
Suspected/Substantiated Child Abuse/Neglect Perpetrator	☐ Strength/No Concern	☐ Current Concern (3)	☐ History of Concern (2)
Severe Chronic Illness	☐ Strength/No Concern	☐ Current Concern (3)	☐ History of Concern (1)
Criminal Involvement	☐ Strength/No Concern	☐ Current Concern (3)	☐ History of Concern (2)
TOTAL SCORES (ADD each column)**:**			

Any Other Significant Risks? If yes, please list below:

Completed By (individual's name)**:**	**Source** (agency affiliation, if applicable)**:**	**Date:**

Summit County
Family & Children First
Council

CONSENT TO EXCHANGE CONFIDENTIAL INFORMATION

CLIENT'S NAME: _____ **DATE OF BIRTH:** _____

I, _____ (relationship to client) _____ , **authorize:**

SUMMIT COUNTY FCFC SERVICE COORDINATION AGENCIES

Akron Public Schools	County of Summit Developmental Disabilities Board
Summit County Juvenile Court	Summit County Alcohol, Drug Addiction and Mental Health Services Board *
Summit Educational Service Center	Summit County Children Services
Summit County General Health District	Akron Children's Hospital
Summit County Family & Children First Council	Portage Path and/or Community Support Services (as appropriate)

OTHER AGENCIES/PERSONS:

1. Medicaid Managed Care Organization (MCO) – (if applicable, please provide MCO name): _____
2. _____
3. _____
4. _____

TO DO THE FOLLOWING:

- Share identifying information across child-serving agencies and systems for the benefit of service coordination and service delivery for the child and family. Identifying information: name, birth date, sex, address, telephone numbers, social security number.
- Share General Medical: Medical records (except for HIV, AIDS) disability, type of services being received and name of agency providing services.
- Share Social History: Treatment/service history, psychological evaluations and other personal information regarding the individual named above.
- Share Educational Information as FERPA Release: grades, attendance records, test scores, disciplinary records, IEP (individual education plan), ETR/MFE (multi-factored evaluation), IFSP (individualized family service plan), Section 504 plan, COEDI (children's Ohio eligibility determination instrument), OEDI (Ohio eligibility determination instrument – adult), transition plans and vocational assessments regarding the individual named above.
- Share Financial Information: public assistance or other financial eligibility and payment information.
- Measure Outcomes.
- **Share Alcohol/Drug Abuse Services:** you may limit the release to the following as desired: **Check** information that you wish to release.

_____ Diagnostic Information	_____ Psychosocial History
_____ Evaluation/Assessments	_____ Outcome of Treatment
_____ Treatment Plan	_____ Recommendations
_____ Ongoing Communication to Facilitate Services	_____ Other:

Summit County
Family & Children First
Council

NOTICE

PROHIBITION ON REDISCLOSURE OR INFORMATION CONCERNING CLIENTS IN ALCOHOL OR DRUG ABUSE TREATMENT

*This information has been disclosed to you from records protected by federal confidentiality rules The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Drug abuse patient records are also protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. parts 160 and 164. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.) The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**I understand and acknowledge that this Authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC5122.31), alcohol/drug use and/or abuse, (42 CFR Part 2), and/or Human Immunodeficiency Virus (HIV/Acquired Immune Deficiency Syndrome AIDS) test results or diagnoses (ORC3701 24.3).

I understand that knowledge so obtained will be treated in a confidential manner. A photostatic copy of this authorization shall be considered valid. **This consent (unless expressly revoked earlier) expires when the case is terminated.**

By signing this form, you are consenting to allow personal health information to be entered into an Electronic Protected Health Information (EPHI) medical file, FidelityEHR. FidelityEHR follows all requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to ensure the confidentiality, integrity, and availability of EPHI, and to mitigate any reasonable risks or hazards to EPHI. Further, FidelityEHR protects against all unauthorized disclosures and manages compliance for all employees, contractors and vendors. Ohio Family and Children First (OFCF) houses the **Fidelity EHR** system for the Summit County Children and Families First Council. Your personal information will not be collected by OFCF. Only demographic and non-personal identifying information will be collected by OFCF for data analysis.

This form has been fully explained to me and I certify that I understand its contents.

Signature: _____ Date: _____
Parent/Guardian or Person Authorized to Consent

Signature: _____ Date: _____
CHILD Authorization (to release AoD information and/or if 18+ years old)

Witness: _____ Date: _____

If choosing to REVOKE, complete the following section:

Written Revocation: I wish to cancel this Release effective: (give date) _____
Date

_____ _____
Parent/Guardian or Person Authorized to revoke consent Date

_____ _____
Witness Date

COMPLETE FOR APS STUDENTS ONLY

Parent/Guardian Consent Form – Release of Student Records

Summit FCFC is partnering with the Akron Public Schools and Summit Education Initiative to promote the success and academic achievement of students in Summit County. Summit Education Initiative (SEI) is a nonprofit organization located in Akron, Ohio, dedicated to increasing educational attainment in Summit County, Ohio. In this work, SEI provides secure data access between Akron Public Schools and Summit FCFC.

The Family Education Rights and Privacy Act (FERPA) protects students and parents by prohibiting most third parties from accessing student records, information, or data without clear permission from a parent or guardian if the student is under 18.

This form requests your consent to allow Summit FCFC to share the name, grade level, date of birth, student ID number and school of your child with SEI. Additionally, you are consenting to allow SEI to provide Summit FCFC access to your child's Akron Public Schools data, including test scores, grades, attendance records, and results of student surveys. Your consent allows data to be shared in two directions: from Summit FCFC to Akron Public Schools; and from Akron Public Schools to Summit FCFC. SEI is acting on behalf of both parties to match the information provided by Summit FCFC with your child's school information, and to conduct research to determine the effectiveness of programs on student success and achievement.

Accessing or sharing records, information, or data will be done to promote and support your student's academic success and achievement, and to evaluate services being offered. **No records, information, or data will be used for any other purpose, and will not be shared with any party other than those listed in this release.**

PARENT/GUARDIAN CONSENT

_____ (INITIAL HERE) I give consent for Summit Education Initiative to provide secure sharing of my child's personally-identifiable information between Summit FCFC and the Akron Public Schools. I understand the following information will be shared:

- **Student Name, grade level and date of birth, student ID number**
- **School district name and school building name**
- **Course grades and Grade Point Average**
- **National and state test results**
- **Attendance records (classroom and school absence totals, both excused and unexcused)**
- **Results of surveys administered at the building and/or district level**

I understand that my child's information will only be shared between Summit Education Initiative, Summit FCFC and the Akron Public Schools, and that this consent may be terminated at any time by my written request as the parent/guardian listed below. It is also my understanding that this consent will last until my child is 18 years old, unless it is revoked by me in writing, or unless my child is no longer affiliated with Summit FCFC or registered as a student in Akron Public Schools. As a parent or guardian, I have the right to revoke consent at any time. I also have the right to obtain copies of any information about my child that is shared because of this form.

_____ _____
Parent/Guardian Name (print) Date of Consent

_____
Parent/Guardian Signature

_____ _____
Child's Name Child's School District

_____ _____
Date of Birth (MM/DD/YYYY) Child's School Building

_____
Child's School Student Number