NVFS Arlington Dental Link Program Intake

Date _____Worker _____ Carry over _____ New _____

Referred By _____ Phone _____ English Speaking _____

Name _____ Contact _____

Address _____

Phone _____ (W) _____

DOB _____Ethnicity _____ Sex _____ Marital Status _____

Native Language _____

Yearly Income _____

Number in Household _____

Occupation _____

Receives: TANF____ FS _____ SSDI _____ GR _____ SS_____ WIC _____

Other: _____

Presenting Problem:

Best Time for appointment _____ Transportation _____

Permission granted to disclose information to Dental Care Providers _____Yes _____ No

Northern Virginia Family Service

Northern Virginia
Family Service

Arlington Dental Link

Please list the name, gender, and date of birth of all members of your household, and return with the release of information and authorization form.

Thank you!

Por favor llene este formulario con los nombres, sexo, fecha de nacimiento y relación de los miembros de su familia inmediata que viven con Ud. Y devuélvalo juntamente con el formulario de autorización para proveer información.

Gracias!

Name Nombre	Gender (circle) Sexo (circule)	Relation Relación	Date of Birth Fecha de Nacimiento
	Male/Hombre Female/Mujer		
	Male/Hombre Female/Mujer		
	Male/Hombre Female/Mujer		
	Male/Hombre Female/Mujer		
	Male/Hombre Female/Mujer		
	Male/Hombre Female/Mujer		
	Male/Hombre Female/Mujer		
	Male/Hombre Female/Mujer		
	Male/Hombre Female/Mujer		
	Male/Hombre Female/Mujer		
	Male/Hombre Female/Mujer		

Northern Virginia Family Service

Arlington Dental Link

Client Authorization to Release Information

(x) I hereby authorize Northern Virginia Family Service to exchange information in my record with representatives of the agencies listed below. I understand that this consent is valid for 1 one year from the date signed and is to be used solely for the purpose of service planning and delivery.

Partner Agencies: check all that apply

Arlington Dental Link ADL
Arlington Health Department
Arlington Department of Family Services
Arlington Department of Human Services
Dental Provider:

Other:

Northern Virginia Dental Clinic

Client Name _____

Signature _____ Date _____

Case Manager _____

Signature _____ Date _____

Northern Virginia Family Service

Arlington Dental Link

Client Authorization to Release Information

(x) Autorizo a Northern Virginia Family Service a intercambiar información de mis datos con representantes de las agencies de la siguiente lista. Entiendo que este consentimiento es válido por un año desde la fecha que fue firmado y será usado solo para el propósito de planificar y ejecutar el servicio dental.

Partner Agencies: check all that apply

Arlington Dental Link ADL
Arlington Health Department
Arlington Department of Family Services
Arlington Department of Human Services
Dental Provider:

Other:

Northern Virginia Dental Clinic

Client Name _____

Signature _____ Date _____

Case Manager _____

Signature _____ Date _____

Northern Virginia Family Service

Arlington Dental Link Guidelines and Requirements

Client agrees to:

1. Sign this contract and return it to an Arlington Dental Link (ADL) Case Manager.
2. Submit income and residency verification to an ADL Case Manager.
3. Notify Dental provider and an ADL Case Manager at least 48 business hours in advance if appointment needs to be reschedule or cancelled.
   ** **Failure to provide 48 business hour notifications will result in termination from ADL and a 25.00** no show fee.
4. Payments are due upon service is rendered in cash or credit card. Checks are not accepted.
5. Notify ADL Case Manager of any changes with family status, such as income, address/phone number, addition to family, etc.
6. Arrange for childcare. No children are allowed to attend the appointments with you.
7. Arrange for translator to attend the appointments with you, if you do not understand or speak English.
8. Turn off, or silence your cellular phone at Dental Office.

Case Managers agree to:

- Notify you whether you have been accepted into Arlington Dental Link.
- Arrange timely appointments for you with a Dental Provider.
- Schedule the first appointments for you with an estimate of how much the service will cost.
- Refer you to other social service/health care resources, as necessary.

By signing this form I am indicating that I agree to comply with all ADL guidelines and requirements. My signature also provides ADL case managers consent to share my eligibility information with Dental providers as well as internal NVFS departments, as necessary. I understand that I may revoke this consent at any time, by writing to an ADL case manager, except when action has already been taken to obtain information. Please print name, address, phone, number, and best days/times for appointments.

Name: _____

Address: _____

Home Phone Number: _____Other Number _____

Best Days/Times for Appointments: _____

Please Date and Sign:

Date _____ Signature _____

*** This client rights and responsibilities contract expires one year from signature date.

Northern Virginia Family Service

NORTHERN VIRGINIA FAMILY SERVICE
CLIENT RIGHTS, RESPONSIBILITIES AND PROCEDURES

All Clients have the Right:

1. To be treated fairly and without discrimination.
2. To be treated in a professional, respectful and non-coercive manner.
3. To confidentiality and privacy, unless NVFS staff are required by law under the following circumstance to share confidential information; a) you are in imminent danger of harming yourself or others; b) suspicion of child or elder abuse or neglect; c) court order.
4. To make informed choices and decide for themselves the services they want.
5. To be a part of decisions about the services provided.
6. To review their own record of service provision, have a copy sent to qualified professionals (at their own expense), and to insert a statement in their record.

When a Client is Enrolled in a Program or Service, he or she may expect to receive:

1. Information about the rules, expectations, and requirements to participate in the specific program or service.
2. Notification of what behaviors or factors that may result in the withdrawal of services or termination from the program.
3. Information about the days and times when services and staff are available.
4. Information about how to make a complaint or to appeal a service decision, and to expect no retaliatory actions in response to their complaint.

All Clients have the Responsibility:

1. Let the staff know if they don't understand their rights and responsibilities, or any program requirements.
2. To notify staff if they are unable to keep an appointment or scheduled meeting.
3. To actively participate in the services offered.
4. To let staff know if they are dissatisfied with the service(s) and give staff a chance to correct the problem(s).
5. To let staff know if they need alternate forms of communication, including the use of translators, sign-language signers, TTD machines, and other communication tools.

CLIENT GRIEVANCE PROCESS

To access the grievance procedure when you, the client, feel that your rights have been violated:

1. First, discuss your concerns with your assigned direct service worker or case manager. If you do not feel that you can discuss your concerns with them, contact the direct supervisor.
2. If you feel the supervisor has not addressed your concerns, contact the Program Management Team (program manager and/or Program VP). At that time a case review will be conducted to review your concern and assure that all agency and legal guidelines have been followed.
3. If you are not satisfied with the Management Team response, you may file a written grievance with the Senior Vice President of Programs. This written notification should include your complaint and all steps that have been taken to resolve this concern.
4. The Senior VP of Programs will review the case and respond in writing to you within ten (10) business days of receipt of the grievance.

5. If you are not satisfied you may request in writing that the President/ CEO review the grievance. The President CEO will respond in writing to you within ten (10) business days. This decision is final.

I have reviewed and received a copy of these rights, responsibilities, and procedures.

_____

_____

Printed Name Date Signature

Guia y Requisitos de la Conexion Dental de Arlington ADL

Cliente accede a:

1. Firmar este contrato y devolverlo al administrador de casos de ADL
2. Proveer documentos de verificación de residencia e ingresos a ADL.
3. Hacer saber a ADL y a la oficina Dental por lo menos con 48 horas de anticipación si necesita cancelar o cambiar su cita.
4. Se paga en el día que se proporciona el servicio dental o en pagos anticipados, en caso de tener un plan de pago.
5. Notificar a ADL de algún cambio en su familia como ingresos, teléfono, dirección, familiar adicional, etc.
6. No se permiten niños en las citas dentales. Consiga alguien que les cuide a sus niños.
7. Si no sabe Ingles, por favor vaya acompañado de traductor.
8. Apagar o silenciar celulares en el consultorio dental.

Administrador de Casos accede a:

- Notificar si ha sido aceptado en ADL.
- Coordinar las citas entre Ud. y la oficina dental.
- Sacar la primera cita y un estimado del costo del servicio.
- Referirlo a otros servicios sociales o ayuda de salud.

Firmando este formulario acepto seguir los requisitos y guías de la Conexión Dental de Arlington. Mi firma da permiso al administrador de ADL para compartir información de mi elegibilidad, estado de salud dental con los proveedores dentales y departamentos internos de NVFS en caso necesario. Entiendo que puedo cancelar este permiso en cualquier momento, por escrito al encargado de casos de ADL, con excepción de alguna medida que haya sido tomada con anterioridad, para obtener información.

Escribir con letra Imprenta:

Nombre y Apellido:

_____

Dirección: _____

Numero de Teléfono:_____ Otro Numero:_____

Días/Hora para Cita_____

Firme y ponga fecha:

Firma_____ Fecha _____

****** Responsabilidades y derechos del cliente terminan al ano del dia que Firma.**

Mandar este Formulario y los datos requeridos a:

Northern Virginia Family Service Cecilia Revilla Phone: (703) 769-4619

Attn: Arlington Dental Link Fax: (703) 892-0895
3401 Columbia Pike, Suite 300
Arlington,VA 22204

Northern Virginia Family Service

Clients Rights, Responsibilities and Procedures

Todos los Clientes tienen el Derecho de:

1. Ser tratados justamente y Ser sin discriminación.
2. Ser tratados de manera profesional, respetuosa y no coactive.
3. Confidencialidad y privacidad, a menos que la ley requiera que el personal de NVFS comparta información confidencial.
4. Tomar decisiones educadas y decidir por ellos mismos los servicios que desean.
5. Ser parte de las decisiones sobre los servicios proporcionados.
6. Revisar su propio record de tratamiento de servicio, que una copia sea enviada a profesionales calificados (al costo de ellos), e insertar una declaración en su expediente.

When a Client is Enrolled in a Program or Service, he or she may expect to receive:

1. Información sobre las reglas, expectativas y requisitos para participar en el programa especifico o servicio.
2. Notificación de que comportamiento o factores pueden resultar en suspensión de servicios o la terminación del programa.
3. Información sobre los días y horario cuando los servicios y el personal están disponibles.
4. Información sobre como hacer una queja o apelar una decisión del servicio, y no esperar ninguna acción de represalia en respuesta a su queja.

T**odos los Clientes tienen la Responsabilidad de:**

1. Dejar saber al personal si ellos no entienden sus derechos y responsabilidades, o cualquier requisito del programa.
2. Notificar al personal, si no puede mantener una cita o reunión programada.
3. Participar activamente en los servicios ofrecidos.
4. Dejar saber al personal si están descontentos con el/los servicios(s) y dar al personal una oportunidad de corregir el/los problemas(s).

He revisado y recibido una copia del formulario de los derechos, responsabilidades y procedimientos.

_____ _____

Nombre en Letra Imprenta Fecha Firma