NC InCK
NC INTEGRATED CARE FOR KIDS

NC InCK Care Team Consent

Child/Patient Name:

_____

Child Date of Birth: / /

Parent/Legal Guardian ("Guardian") Name:

_____

Guardian Primary Language:

Does the Patient or the Guardian require an interpreter? ☐ Yes ☐ No

North Carolina Integrated Care for Kids (NC InCK) is a model to advance the well-being of children insured by the Medicaid and CHIP health insurance programs in five counties – Alamance, Durham, Granville, Orange and Vance. NC InCK aims to support and bridge health, social and education services for children from birth through age 20.

I, [Patient / Guardian name] _____ agree that Duke University Health System, Inc., and Duke University, including their physicians, employees, trainees, students, and contractor affiliates (collectively, "NC InCK") may access, receive, or share health, social and educational ***information related to the Child/Patient*** to strengthen integrated care coordination for the Child with the Care Team, who include the Child's health providers, care managers, schools and education supports, child welfare offices, social service providers and other persons supporting the Child.

This Authorization is to:

1) Allow the Care Team to communicate and support health, social and educational needs of the Child;
2) Share the Child's Information with the Care Team;
3) Grant access to the Child's profile on InCK's VirtualHealth platform for the Care Team; and
4) Share the Child's InCK Shared Action Plan with the Care Team (if one is created).

How does sharing benefit a Child?

NC InCK designed this authorization to help your Child's Care Team more easily identify and discuss your Child's care needs and coordinate their care.

How will the information be shared?

The information could be shared in conversations between the past, current and future Care Team, through messaging or online health platforms, verbal and written communication. The information could be shared through the Child's profile on the InCK VirtualHealth platform (see more details below) including any document uploaded by NC InCK, the Care Team or the family.

Who will have access to the information?

Any of the Care Team listed below will be able to share information about the Child's care needs, access to the Child's Shared Action Plan and InCK VirtualHealth profile.

What will be shared?

- Child's information, including name, date of birth, address, and county of residence.
- Guardian contact information, including name, address, county of residence, telephone and email.
- Medicaid information, including the Child's current Medicaid plan, the primary care provider's name, email, telephone number.
- Care management information including the organization responsible for providing care management for the Child, care needs and service needs identified for the Child, information on levels of support for the Child, and the name and contact information of care manager(s).
- Shared Action Plan is a brief, family-centered tool that includes contact information for Care Team members, Child's strengths, prioritized goals for the Child and family, and plans to achieve those goals. Some children and youth in the InCK model complete a Shared Action Plan to enable a Care Team and family to work together to support the Child.
- Child's ongoing care and service needs, including the Guardian's requests for services for the Guardian and the Child to help with meeting their goals for the Child.
- Provider and/or Care Management notes, including sensitive medical conditions, trauma-related conditions or psychiatric related services.

This information will be collectively referred to as "Child's Information" for purposes of this Authorization.

Information shared without Authorization	HIPAA allows sharing of the Child's Information to permit providers to treat the Child and to receive payment.
Can I cancel this Authorization?	Yes, you can cancel this authorization at any time by emailing ncinckconsent@duke.edu. Please read below for more information on cancelling your authorization. For further information or assistance, you can reach out to NC InCK at the same email address.

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Specifying the Care Team: The Care Team includes current and future organizations and individuals coordinating to meet the health, social and educational needs of the Child. Guardians must specify the "Entity" (practice, school, organization or agency) here for the authorization to enable Care Team information sharing. Guardians may also specify a "preferred contact" at each Care Team; however, the Care Team may share information with others within the Care Team entity to coordinate the Child's care.

Physical and mental health service providers for the Child (for example: Pediatrician, Primary Care practice, specialists, or therapists):

Practice Name	Preferred Contact (Name and Role)	Phone	Email

Schools and Education Supports (for example: The Child's school, Child Care Center)

School or Center	Preferred Contact (Name and Role)	Phone	Email

Child Welfare Offices (Social Worker) or Juvenile Justice Offices (Court Counselor)

Office Name	Preferred Contact (Name and Role)	Phone	Email

Food/nutrition support or housing services for the Child (for example: WIC Program Coordinator):

Organization/Agency	Preferred Contact (Name and Role)	Phone	Email

Others supporting the Child (for example: Neighbors, Coaches, Other Family or anyone else):

Organization/Agency *(if applicable)*	Preferred Contact (Name and Role)	Phone	Email

I understand that I may **cancel this Authorization** in writing **at any time** by submitting my written cancellation request (the "Cancellation Request") to: ncinckconsent@duke.edu. I understand that my cancellation will not apply to any information already released as permitted by this Authorization. I understand that for the information shared by NC InCK or the Care Team with third parties for the purposes described in this Authorization, NC InCK may not retain control over the further use or disclosure of such information by those third parties or other future recipients, and may no longer be protected by federal privacy laws.

I understand that **signing this Authorization is my choice** and **I may refuse** to sign this Authorization. If I do not sign this Authorization, certain Care Team members, the Child and their family will not have access to VirtualHealth, and some of the integrated planning features it offers. The Care Team will continue to provide care to the Child, and I will receive bills associated with the Child's medical care.

This Authorization will expire upon the earlier of: (i) the fifth (5th) business day following the date the Child is no longer enrolled in the InCK model; or (ii) the fifth (5th) business day following the date on which NC InCK receives a Cancellation Request at ncinckconsent@duke.edu.

Patient/Parent/Legal Guardian Signature: _____

Print Name: _____

Relationship to Patient: _____

Date: _____

Please submit this completed consent to personalhealthadvocate@unchealth.unc.edu