The Arc of Delaware County

Delaware County Down Syndrome Group (DSIG) Education Advocacy Program

740 S. Chester Road, Swarthmore, PA 19081 Phone 610-544-6600 FAX 610-544-8916

EDUCATIONAL ADVOCACY AGREEMENT/RELEASE OF INFORMATION

Consumer Name: _____ Diagnosis_____ DOB _____

Parent/Guardian Name:_____

Parent/Guardian Address:_____

Parent/Guardian Phone:_____ Mobile Phone:_____ E-mail:_____

I/We have requested **THE ARC OF DELAWARE COUNTY** to serve as an advocate for the purpose of supporting (name of consumer)_____ with issues that are important to my family and me. This includes, but is not limited to: referrals for supports and services, conflict resolution, consumer rights/freedom from abuse concerns, medical/emotional supports, or future planning needs. I/We authorize the release of any and all confidential information, including, but not limited to medical/psychological/therapeutic assessments and evaluations, educational history, provider service history (including nature and length of services provided along with outcomes) relating to _____ to **THE ARC OF DELAWARE COUNTY**. I/We further authorize **THE ARC OF DELAWARE COUNTY** to use this information solely for the purposes stated above; this Release ***does not*** permit **THE ARC OF DELAWARE COUNTY** to release this material to third parties without my/our specific consent. This authorization shall remain in effect for one year from the date of the agreement unless revoked earlier by me/us and I understand this Release can be revoked at any time by me notifying me/our advocate in writing. I/We agree that the Delaware County Down Syndrome Group (DSIG) has provided to The Arc a grant to cover the initial six (6) hours of time that my case is expected to take and that this program is being offered to me with a waiver of a membership to The Arc. I understand that The Arc will communicate back to The DSIG that I have registered with them for this program. I agree to pay **THE ARC OF DELAWARE COUNTY** the Advocacy Program Fee of $50 per hour for advocacy services for any hours over the initial six(6) hours agreed to and that this fee will be billed directly to me and not the DSIG. The initial six hours of service is assumed to include The Arc's standard Education Advocacy Program and includes an Intake, Parent Meeting, Research and Planning, and the IEP or similar meeting where The Arc will provide a qualified and experienced Education Advocate to assist me/my child. I understand that The Arc does not assume that there will be any additional fees associated with this program and will communicate to me in advance if The Arc believes there will be based on unusual circumstances. I understand that time spent on the case after the initial IEP or similar meeting will be billed at a rate of $50 per hour ($75 per hour for households above $100,000 in household income), billable in 15 minute intervals, and that continuing with The Arc after this meeting is voluntary and I may cease their services at any time. The Arc offers a Financial Assistance Program to families from Delaware County who qualify. Please ask for more information if interested.

This will authorize _____ to release confidential information to **THE ARC OF DELAWARE COUNTY, 740 S. Chester Road, Swarthmore, PA 19081.**

Parent/Guardian Signature: _____ Witness: _____