

Budget

Provide your best estimate of your present living expenses in the first column of each item. Your counselor will suggest changes in the second column. Use monthly averages for expenses such as utilities and auto insurance. Bring all relevant bills with you to the counseling session.

<table border="0" style="width: 100%;"> <tr><td>Total Client Income</td><td>_____</td><td>_____</td></tr> <tr><td>Rent/First mortgage</td><td>_____</td><td>_____</td></tr> <tr><td>Second mortgage</td><td>_____</td><td>_____</td></tr> <tr><td>Property tax</td><td>_____</td><td>_____</td></tr> <tr><td>Home/Renter insurance</td><td>_____</td><td>_____</td></tr> <tr><td>Association dues</td><td>_____</td><td>_____</td></tr> <tr><td>Electric</td><td>_____</td><td>_____</td></tr> <tr><td>Gas</td><td>_____</td><td>_____</td></tr> <tr><td>Water/Sewer</td><td>_____</td><td>_____</td></tr> <tr><td>Garbage/Recycling</td><td>_____</td><td>_____</td></tr> <tr><td>Pest control/Lawn care</td><td>_____</td><td>_____</td></tr> <tr><td>Security system</td><td>_____</td><td>_____</td></tr> <tr><td>Other home maintenance</td><td>_____</td><td>_____</td></tr> <tr><td>Telephone</td><td>_____</td><td>_____</td></tr> <tr><td>Cell phone</td><td>_____</td><td>_____</td></tr> 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CCCS Use Only

Surplus for debts	\$ _____
Total debt from Section D	\$ _____
Current mo. debt payment	\$ _____
Proposed DMP payment	\$ _____

Updated 06/28/2016

Debts

Please provide a listing of all of your accounts. If you have more accounts than will fit in the space provided, copy this page or add them on a plain sheet of paper. IMPORTANT: Be sure to bring recent copies of all your creditor statements to the session.

1. Creditor/Bank Name _____

Acct. No. _____

Current Balance \$ _____ Int. Rate % _____

Months Past Due ____ Monthly Pymt \$ _____

Account Owner(s) _____

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2. Creditor/Bank Name _____

Acct. No. _____

Current Balance \$ _____ Int. Rate % _____

Months Past Due ____ Monthly Pymt \$ _____

Account Owner(s) _____

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3. Creditor/Bank Name _____

Acct. No. _____

Current Balance \$ _____ Int. Rate % _____

Months Past Due ____ Monthly Pymt \$ _____

Account Owner(s) _____

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4. Creditor/Bank Name _____

Acct. No. _____

Current Balance \$ _____ Int. Rate % _____

Months Past Due ____ Monthly Pymt \$ _____

Account Owner(s) _____

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5. Creditor/Bank Name _____

Acct. No. _____

Current Balance \$ _____ Int. Rate % _____

Months Past Due ____ Monthly Pymt \$ _____

Account Owner(s) _____

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6. Creditor/Bank Name _____

Acct. No. _____

Current Balance \$ _____ Int. Rate % _____

Months Past Due ____ Monthly Pymt \$ _____

Account Owner(s) _____

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7. Creditor/Bank Name _____

Acct. No. _____

Current Balance \$ _____ Int. Rate % _____

Months Past Due ____ Monthly Pymt \$ _____

Account Owner(s) _____

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8. Creditor/Bank Name _____

Acct. No. _____

Current Balance \$ _____ Int. Rate % _____

Months Past Due ____ Monthly Pymt \$ _____

Account Owner(s) _____

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9. Creditor/Bank Name _____

Acct. No. _____

Current Balance \$ _____ Int. Rate % _____

Months Past Due ____ Monthly Pymt \$ _____

Account Owner(s) _____

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10. Creditor/Bank Name _____

Acct. No. _____

Current Balance \$ _____ Int. Rate % _____

Months Past Due ____ Monthly Pymt \$ _____

Account Owner(s) _____

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Statement of Counseling Rights

INITIAL and SIGN

Please read the following statements carefully. They outline the Triangle Family Services (referred to as Agency) counseling procedure. **INITIAL** the line next to each statement to indicate that you understand that provision. *Be sure to INITIAL all 13 paragraphs and SIGN BEFORE you meet with your counselor.*

Basic Description of Services Provided

____ I understand that the Agency will provide a comprehensive personal money management interview. I understand that the interview will be conducted by a certified consumer credit counselor or qualified professional counselor.

____ I understand that the Agency is approved or certified to conduct sessions on budgeting, credit issues, credit report review, homebuyer counseling, homeowner mortgage delinquency counseling, and related financial topics.

____ The Agency will provide me with a written summary of my counseling session, known as the *client action plan*. This written assessment outlines suggested actions for me to follow.

____ I will be referred to the other services of the organization or another agency or agencies as appropriate that may be able to assist with particular problems that have been identified.

Legal Considerations

____ During a client financial session a counselor may not give legal advice. If I want legal advice, I will seek my own legal counsel and will be referred for appropriate assistance.

____ A client financial session may include a discussion about bankruptcy. During the session a counselor may answer general questions about bankruptcy, but not give legal advice. While an attorney can make a recommendation to file bankruptcy, it is a personal choice based on individual circumstances.

____ I hold the Agency, its employees, agents and volunteers harmless from any claim, suit, action or demand of my creditors, myself or any other person resulting from advice or counseling.

Supplemental Handouts

____ I have received a copy of, read, and understand the Agency Statement of Clients' Rights, which includes my right to confidentiality.

____ I have received a copy of, read, and understand the agency Client Bill of Rights, the agency Complaint Resolution Process (which I may utilize if I am dissatisfied with the counseling process), the agency Non-Discrimination Policy, and Additional Disclosures.

____ I have received a copy of, read, and understand the Agency Privacy Notice, which explains how my privacy is protected and under what conditions information about me may be shared.

____ I have received a copy of, read, and understand the Agency Privacy Notice for Protected Health Information, which protects medical information privacy under HIPAA.

Special Program for Debt Management

____ If I qualify, the Agency may offer to enroll me in the Agency's debt management plan (DMP). Under the DMP, the Agency serves as a neutral third party in negotiating with creditors to liquidate financial obligations. I understand the Agency has no responsibility or obligation for any past, present, or future credit rating I receive. If the counselor suggests a DMP, I will receive complete details of the operations, requirements, responsibilities, and an estimate of the length of time it will take to complete the DMP.

Authorization to Pull Credit Reports

____ I authorize the Agency to contact the major credit bureaus on my behalf in order to obtain information about my credit rating. I understand that this inquiry will not be reported on my credit. I understand that the Agency's agreement with the major credit bureaus prohibits the Agency from giving me a copy of my credit report. The information obtained will be used to assist the Agency in providing me with credit and/or housing counseling services **only**. This authorization will be in effect for 36 months from the date this application is signed.

Applicant _____

Co-Applicant _____

Counselor _____ Date _____

Consent for Release/Exchange of Client Info (Housing Clients Only)

I authorize the Agency to release/exchange information from my client record in order to assist me in one of the following:

- Purchasing a home
- Resolving or preventing mortgage delinquency
- Reverse mortgage or help with home maintenance and homeowner finances
- Locating, securing, or maintaining residence in rental housing
- Seeking shelter or services for the homeless

This information will be released only to those institutions, companies, agencies, or other facilities that the Agency believes can provide assistance in the above checked area. Examples of such entities include mortgage or home equity lenders, landlords, creditors, collection agents, and public agencies. If necessary, information on file from a facility may also be released to the Agency. The information release/exchange will be restricted to specific financial data such as income, budget, and debt details provided by the client on the Application Form or in financial information on file with the contacted facility.

I understand that the provision of services at this agency is not contingent upon my decision concerning the release/exchange of this information.

The doctrine of informed consent has been explained to me and I understand the contents to be released/exchanged, the need for the information and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken. This consent shall expire sixty (60) days from the date shown below. I also acknowledge that a copy of this form is as valid as the original.

Applicant _____

Co-Applicant _____

Counselor _____ Date _____

Triangle Family Services - Statement of Clients' Rights

Triangle Family Services provides services to all clients without regard to race, color, religion, national origin, gender, sexual orientation, age, disability, veteran status, or any other discriminatory factor recognized by law.

When you receive services from Triangle Family Services, you also have certain rights. Listed below is a summary of those rights. If you would like more detailed information about these rights, please ask your primary service provider. At Triangle Family Services, we strive to provide the highest quality of services possible while striving to protect and enhance the rights and quality of life of all of our clients.

You have the right to know the basic expectations for use of the organization's services. The main offices of Triangle Family Services are located at 3937 Western Blvd in Raleigh and are open Monday through Thursday from 8:00 a.m. to 6:00 p.m., and on Friday from 8:00 a.m. to 1:30 p.m. You will be given written information explaining the various services that we offer, the specific locations and hours of operation for each service, and the expectations required to receive those services. You will also be notified in writing of any rules, behavioral expectations, and other factors that could result in discharge or termination of services. Termination of services may result if you violate one or more of the conditions as specified in your individual service agreement.

You have the right to a treatment plan or a plan for your services. You have the right to participate in the development of your plan. A written plan of services or treatment, based on your individual needs, must be implemented within 30 days of admission to services. For Medicaid recipients of mental health services, a treatment plan will be developed upon admission to services.

You have the right to refuse services or treatment. You have the right to consent to treatment or services and may withdraw your consent at any time. If you refuse a recommended service, treatment, or medication, the organization will attempt to inform you of the consequences for such refusal. The only time that you can be treated without your consent is in an emergency situation, when it has been court-ordered, or if you are a minor and your parent or guardian has given consent.

You have the right to confidentiality. Unless the law requires it, your records and other information about you will not be released without your written permission (or if you are a minor, the written permission of your parent or legal guardian). Circumstances under which we may be required by law to share information with others about the services you receive include:

- If you give written permission we may share information with any person or agency you name.
- If we believe that you are an imminent danger to yourself or to others, or if we believe you are likely to commit a crime, we may share information with law enforcement and with threatened individuals.
- To report a crime committed by you on Triangle Family Services premises or against Triangle Family Services personnel.
- The court may order us to release your records without your permission.
- If we suspect that you have neglected or abused a child or dependent adult, or you are being investigated for child abuse or neglect, we are required by law to share information with county protective services officials.
- If you are HIV positive and we are aware that you are not following proper control measures, we are required to report this to agents charged with the protection of public health.
- To medical personnel in a medical emergency.
- Our attorney may need to see your file because of legal proceedings.

You have the right to be informed of policies that you are expected to follow. You also have the right to be informed of the possible consequences for not following the policies.

You have the right to know the costs of the services that you receive. You should be informed of the costs of your services before the provision of the services. It is your responsibility to arrange for payment of costs, and your services can be terminated for failure to pay for agreed costs.

You have the right to privacy. You have the right to be free from any unwarranted search of your person or property.

You have the right to be treated with dignity. In our programs we do not administer any potentially painful procedures or stimuli to reduce the frequency or intensity of a behavior. Employees must protect clients from harm and report any form of abuse, neglect, or exploitation.

If you are a client in Individual and Family Counseling program, you have the right to be informed about medication that is prescribed to you.

You have the right to have medication prescribed in accordance with accepted medical standards and upon the order of a physician. When medication is needed, you have the right to receive it in the lowest therapeutic dose. You cannot be treated with experimental drugs or procedures without being informed of the risks, benefits, and alternatives. You may refuse to take medication. However, you will be informed of the risks of doing this. Minors have the right to agree to some treatments without the consent of a parent or guardian:

- For treatment of venereal diseases
- For pregnancy
- For abuse of controlled substances or alcohol
- For emotional disturbances

You have the right to make a complaint or file a grievance. If you are dissatisfied with the services delivered by Triangle Family Services, you have the right to state a complaint or file a grievance at any time. Before starting a written grievance or complaint, we urge you to first discuss the matter with the staff of the program providing you with services to allow them an opportunity to resolve your complaint. If this is unsuccessful, your complaint should then go to that program's director. If the issue is then not resolved, you may obtain a Grievance Form from any staff member and submit that to the President and CEO. The President and CEO will involve appropriate staff to investigate and attempt to resolve the matter in a timely fashion. You also have the right to contact the Governor's Advocacy Council for Persons with Disabilities (GACPD), the statewide agency designated under federal and state law to protect and advocate for the rights of persons with disabilities.

As a client at Triangle Family Services you are encouraged to participate on Wake's Consumer and Family Advisory Committee. This committee acts in an advisory capacity to the Local Management Entity (LME).

Client Bill of Rights

We pledge that our clients have the right

- To prompt counseling services for managing money based on their financial situation;
- To treatment with dignity and respect;
- To be actively involved in a comprehensive assessment of their financial situation including an appropriate action plan;
- To express dissatisfaction through a Complaint Resolution Process;
- To discontinue their relationship with our Agency at any time;
- To ask questions and to have concerns addressed.

Complaint Resolution Process

We are committed to providing you with high quality professional services. However, if you are not satisfied with the services provided or if you want to make a complaint, we ask that you follow these guidelines:

- **Step One:** Try to resolve the issue with the staff member involved giving him or her specific information about your complaint.
- **Step Two:** If Step One is not possible or the issue is not resolved to your satisfaction, you may request a grievance form by mailing the request to Triangle Family Services at 3937 Western Blvd. Raleigh, NC 27606 or by e-mailing the Financial Stability Manager at cccs@tfsnc.org.
- **Step Three:** Agency may request a meeting with you (phone or face-to-face) or seek more information from a staff person.

Non-Discrimination Policy

Our Agency serves all members of the community. We do not engage in the practices of discrimination in the selection and participation of clients in our programs or services with respect to race, religion, color, gender, national origin, or disability, sexual orientation, veteran status, or any other discriminatory factor recognized by law.

Additional Disclosures

I may be referred to other services of the organization or another agency or agencies as appropriate that may be able to assist with particular concerns that have been identified. I understand that I am not obligated to use any of the services offered to me.

Privacy Notice

Privacy Policy: Our Agency is committed to assuring the privacy of individuals and/or families who have contacted us for assistance. We assure you that all information shared both orally and in writing will be managed within legal and ethical considerations. Your "personal financial information", such as your total debt information, income, living expenses, and personal information concerning your financial circumstances, will be provided to creditors and, possibly others with your specific authorization. We may also use aggregated case file information for the purpose of evaluating our services, gathering valuable research information, and designing future programs. Your anonymity will be maintained through the use of your client number or by using aggregate data in all circumstances.

In all other situations, your information may be released to appropriate individuals or agencies ONLY UPON YOUR WRITTEN REQUEST or when our staff has been served by a valid subpoena.

The following PRIVACY PRACTICES detail circumstances under which we will release your information to a third party:

1. We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law.
2. We may compile data and aggregate information that you give to us, but this information may not be disclosed in a manner that would personally identify you in any way.
3. We may disclose some or all of the information that we collect to creditors, or third parties that you have authorized who need this information in order for us to assist you during and after a counseling session.
4. We restrict access to non-public personal information about you to those employees who need to know that information to provide services to you. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your non-public personal information.
5. We collect non-public personal information about you from the following sources:
 - a. Information we received from you on our applications or other forms you provide;
 - b. Information about your transactions with us, your creditors, or others; and
 - c. Information we receive from a credit-reporting agency.
6. We may disclose all of the information that we collect, as described below, to creditors and related financial institutions that need this information in order to put you on a debt management plan (DMP.)
7. We may disclose the following kinds of non-public personal information about you:
 - a. Information we receive from you on applications or other forms, such as your name, address, social security number, assets, and income;
 - b. Information about your transactions with us, your creditors, or others such as your account balance, payment history, parties to transactions and credit card usage; and
 - c. Information we receive from a credit-reporting agency, such as your credit history.
8. My information may be used for confidential research and/or a neutral third party may contact me to request an evaluation of the Agency's services.

RELEASE: I hereby authorize Consumer Credit Counseling Service, a division of Triangle Family Services and Consumer Credit Counseling of Denver to release all non-public information it obtains about me to (1) my creditors and (2) any third parties necessary to resolve the matter(s) discussed during my counseling session. I further release and authorize all of my creditors to provide non-public information about me to Consumer Credit Counseling Service, a division of Triangle Family Services and Consumer Credit Counseling Service of Denver.

HIPAA Privacy Notice

THE FOLLOWING NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION (PHI) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE OF YOUR RIGHTS AS DEFINED IN THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA).

Protected health information (PHI) is individually identifiable health information that relates to the covered person's past, current, or future health status, the provision of health services, or payment for the provision of health care services to covered persons.

- Triangle Family Services is legally required to maintain the privacy of PHI and to abide by the terms of this notice and the Health Insurance Portability and Accountability Act (HIPAA).
- Triangle Family Services will typically ask for your written authorization to share or obtain information from others. However, we may use and disclose information about you without your authorization in the following circumstances:
 - To coordinate treatment within the agency. For example, your therapist may share information with another therapist or with your physician to coordinate services
 - Payment: We may use and disclose necessary information about you to obtain payment for our services. For example, this information could include information that your health insurance plan may require before it approves or pays for treatment services.
 - Health Care Operations: We may need to use or disclose information for our agency activities which might include assessment of the quality of our services, clinical supervision of staff, education and training of students and other professionals, and compliance activities required to ensure that we are following policies, procedures, laws, regulations, and professional standards.
- PHI may be released without your consent to the insurance company, third party administrators, and to providers for the purposes of claims payment, treatment and health care operations.
- PHI may be released without your consent if required by state or federal law.
- We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition. We may leave a message on your answering machine or on voicemail as a means of communication. We may mail you a written notice as a means of communication. We may e-mail you as a means of communication. Unless otherwise instructed in writing, these methods of communication will be used.
- PHI may not be released for any purposes other than those identified in this notice. Other disclosures and uses will be made only with your written authorization or consent and you may revoke such authorization/consent at any time.
- The plan reserves the right to make changes to this notice and to continue to maintain the confidentiality of all healthcare information. You will receive notice of any changes within 60 days of making a change.
- You have the right to inspect and copy your PHI.
- You have the right to request that your PHI be amended when you believe that it is inaccurate or incomplete. If your care provider does not agree to amend it, you may add an explanation to your record.
- You have the right to request restrictions on the use or disclosure of your PHI, even though the agency is not required to agree to the requested restrictions.
- You have the right to obtain an accounting of instances in which the plan has disclosed PHI for purposes other than treatment, payment, or health care operations, except for disclosures made at your request.
- You have the right to receive written notice of the policy regarding privacy and access to PHI. You can also obtain a copy of this Privacy Notice upon request.
- You have the right to complain to Triangle Family Services if you believe your privacy rights have been violated. You can mail your complaint to Privacy Officer, Triangle Family Services, PO Box 33393, Raleigh, NC 27636-3393. You may also make a written complaint to the U.S. Department of Health and Human Services. This complaint must be filed within 180 days of the time you became or should have become aware of the problem. You will not be retaliated against for filing a complaint.
- If you have any concerns regarding your case, please discuss it with your care provider.
- For further information about this Privacy Notice, please contact Nellie Mejia, (919) 821-0790 ext. 333.
- This notice is effective as of April 14, 2003.