# FOSTER CARE ASSESSMENT PROGRAM (FCAP)
# KEY PERSON STAFFING

## PARTICIPANT AGREEMENT
## OF NON DISCLOSURE

I understand that the information shared during the FCAP is for the sole purpose of assisting in the implementation of an appropriate case and service plan pertaining to_____.

I agree, as a participant in the Key Person Staffing, that the information shared in this meeting will be kept confidential and will not be discussed or disseminated beyond the confines of the meeting.

As a treatment professional or other mandatory reporter pursuant to RCW 26.44.030(9) I may not disseminate or release any information which is shared at the Key Person Staffing except as authorized by state or federal statute. I also understand that violation of this law is a misdemeanor.

Signature of Participant: Place Date