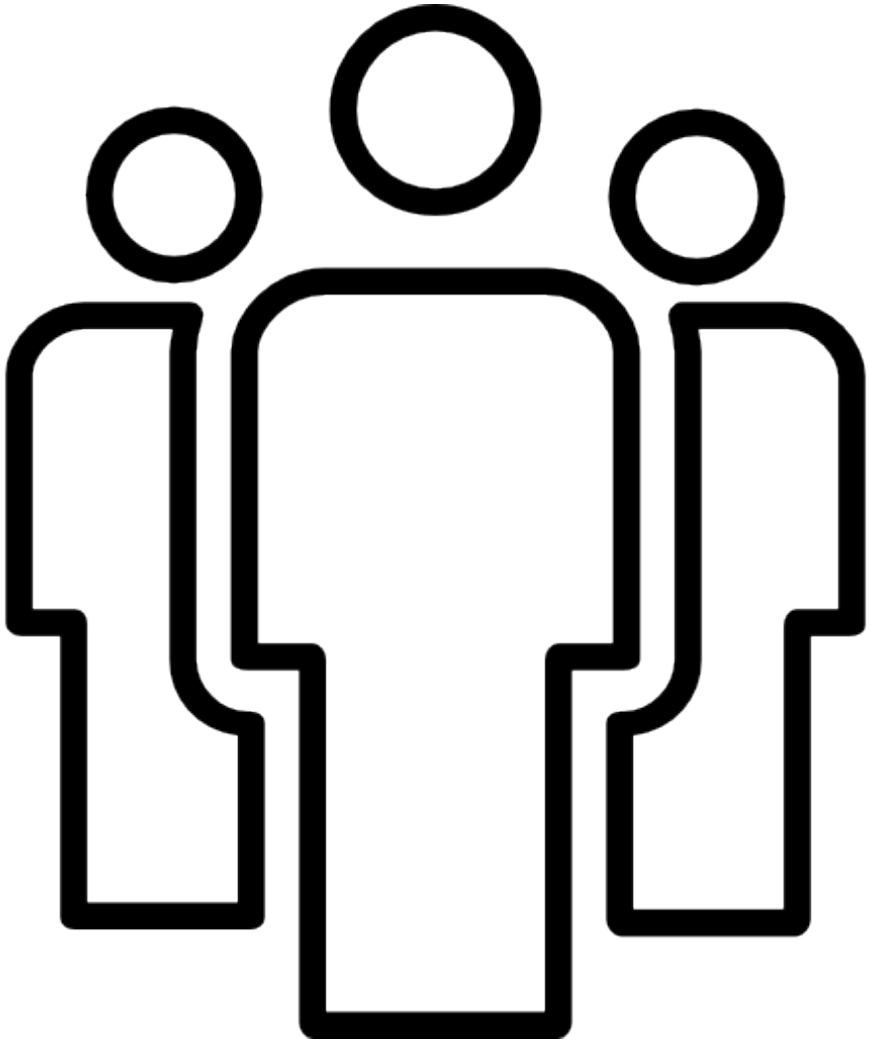
Office of Youth Alternatives

Group Intake Packet



INTAKE QUESTIONNAIRE

Please provide the following information so we continue to provide the necessary services to you and your family. Services are funded through the City of Cheyenne, Laramie County, School District Number One, and various grants. Certain information is necessary to continue to provide these services free of charge. This information is confidential and will remain part of your confidential file. Thank you for your assistance.

Today's Date: _____ PROGRAM/GROUP: _____

CLIENT'S NAME: _____ DOB: _____

ADDRESS: _____ CITY: _____ ZIP: _____

REFERRED BY: _____ AGE: _____ SEX: _____

SCHOOL: _____ GRADE: _____

PRIMARY PHONE NUMBER: _____

ALTERNATE PHONE NUMBER: _____

Does your child live with:

_____1. A Single Biological Parent
_____2. Two Biological Parents
_____3. A Biological and a Step Parent
_____4. Grandparents
_____5. Extended Family or Guardian
_____6. Other (please specify) _____

The child's PRIMARY ethnicity:

_____1. African American
_____2. Hispanic American
_____3. Caucasian
_____4. Asian American
_____5. Native American
_____6. Other (please specify)_____

Household Income Average is:

_____1. $16,900 or less _____2. $16,901 to $20,000 _____3. $20,001 to $25,000
_____4. $25,001 to $30,000 _____5. $30,001 to $35,000 _____6. $35,001 to $40,000
_____7. $40,001 to $45,000 _____8. $45,001 to $51,000 _____9. $51,001 or higher

Child's Insurance:

Policy Holder: _____Provider: _____ Policy Number: _____

NUMBER OF PEOPLE LIVING IN THE HOME: _____

Father's Name: _____
Employer: _____
Occupation: _____
Call at Work? Yes No Work #:_____

Mother's Name: _____
Employer: _____
Occupation: _____
Call at Work? Yes No Work #:_____

OTHERS IN HOUSEHOLD

Name	**Relationship to Client**	**Age**	**DOB**	**Education**

Does your child have _____ an IEP? or _____ a 504?

Does your child receive a free or reduced lunch at school? _____Yes _____ No
Does your child have any kind of emotional, physical or mental disability? _____Yes _____ No
Is he/she receiving special services at school because of his/her disability? _____Yes _____No

OFFICE OF YOUTH ALTERNATIVES

City of Cheyenne

RELEASE OF INFORMATION

WE CARE

NAME OF CLIENT: _____

PARENTS/GUARDIANS: _____

TO WHOM IT MAY CONCERN:

This release is to authorize and direct any physician or staff member of a private, federal, state, county or city agency, institution, or school to give to _____ and/or the staff of the Office of Youth Alternatives, medical, psychological, psychiatric, legal, or academic information regarding the above-named client which may have been acquired in any professional capacity. A faxed or emailed copy of this authorization shall serve in its stead.

_____
Initial

This release is to authorize _____and/or the staff of the Office of Youth Alternatives, to utilize and incorporate such materials for professional consideration while acting on what is in the best interest of the child involved.

_____
Initial

This release is to further authorize the staff of the Office of Youth Alternatives to release information to any physician or staff member of a private, federal, state, county or city agency, institution, or school regarding the nature of my/our child's involvement with the Office of Youth Alternatives.

_____
Initial

The I/we, the undersigned, have read and fully understand the conditions of this release.

SIGNED:

Name _____ Relationship _____

Name _____ Relationship _____

WITNESSED: _____

DATE: _____

OFFICE OF YOUTH ALTERNATIVES
City of Cheyenne

WE CARE

Release/Authorization for Emergency Medical Care
Medical History Information

I give my child permission to attend the following Youth Alternatives activity/trip: _____

_____

I hereby release the City of Cheyenne and the Office of Youth Alternatives from all claims of any kind arising out of my child attending the stated outing. I also release the said parties from claims arising from transportation to and from this event.

I hereby authorize the release of My or My Child's medical information to the staff of Youth Alternatives, any physical or staff member of a private, federal, state, county or city agency or institution. I further authorize the staff members or representatives of Youth Alternatives to give consent for any and all necessary emergency medical care for myself or my child while participating in a Youth Alternatives activity or group.

NAME OF CLIENT: _____

NAME OF PARENTS/GUARDIANS: _____

ADDRESS: _____ City: _____ St: _____ Zip: _____

EMERGENCY PHONE: Home: _____ Work: _____ Cell: _____

ALTERNATE EMERGENCY CONTACT: _____

ALTERNATE EMERGENCY CONTACT PHONE NUMBER: _____

HEALTH/MEDICAL INFORMATION

DOES THE CLIENT HAVE ANY ALLERGIES/SPECIAL HEALTH CONSIDERATIONS?

Yes___ No___ If yes, please list: _____

PLEASE LIST ANY MEDICATIONS THE CLIENT IS CURRENTLY TAKING (and dosage if known): _____

_____

HOSPITAL/CLINIC PREFERENCE (if none, leave blank): _____

MEDICAL INSURANCE PROVIDER: _____

POLICY NUMBER: _____

CLIENT SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

WITNESSED BY: _____ DATE: _____

OFFICE OF YOUTH ALTERNATIVES
INFORMED CONSENT FOR COUNSELING SERVICES

Please read this Informed Consent Statement before meeting with your counselor. When you meet with the counselor, you can discuss any questions or concerns you have before signing the document. If you would like a copy, please request one from your counselor.

Eligibility and Service Limits
Youth Alternatives provides short-term counseling to Cheyenne and Laramie County families. The service you receive are based upon a determination of your needs and goals, and our resources. If Youth Alternatives is unable to help you meet your goals, referral resources will be identified for you.

Benefits and Risks
There are benefits and risks that may occur in counseling. The benefits from counseling may include:
(1) improved ability to handle school, family and home situations, (2) enhanced personal development and (3) improved interpersonal relationships. Counseling may also involve the risk of remembering or dealing with unpleasant events that could arouse strong feelings.

Emergencies
Counselors are available Monday through Friday from 8:00 a.m. to 6:00 p.m. For after hour emergencies, you may call our regular office number (307- 637-6480) to reach the after-hours answering service, who will connect you with the on-call counselor.

Appointments
If you are unable to keep a counseling appointment, call the receptionist to cancel AS SOON AS POSSIBLE and at least 24 hours in advance. If your counselor cannot keep an appointment with you, the receptionist will attempt to contact you at the earliest opportunity.

Consent to Counseling
I have read the above conditions of counseling. I accept these conditions and give my consent for my children and myself to receive counseling at Youth Alternatives. I have had the opportunity to discuss this information with my counselor.

_____ _____

Printed Name Date

_____

Signature

OFFICE OF YOUTH ALTERNATIVES

NOTICE OF PRIVACY PRACTICES

Effective Date of Notice: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU FOR SERVICES DELIVERED AT YOUTH ALTERNATIVES MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Responsibility to our Clients:

Youth Alternatives is obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what right you have regarding it. We will abide by the terms of this notice. We will not use or disclose your health information without your authorization, **except** as descried in this notice.

Youth Alternatives reserves the right to change this Notice and to make the revised or changed notice effective for heath information it already has about you as well as any information received in the future. If you have questions about your privacy rights as described in this Notice and/or about our responsibilities as to your health information, please contact the Director of Youth Alternatives at the following address and/or phone number.

Director
Youth Alternatives
1328 Talbot Court
Cheyenne, WY 82001
(307) 637-6480

WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:

1. In Disclosures To Others: This may include making disclosures of health information about you to your family members, your personal representative, or other persons identified by you who are involved in your health care. With your written consent, or a court order, this information may be shared with the school, court, Guardian Ad Litum, Department of Family Services , or the District Attorney's office.

2. In Our Health Care Operations: Our health care operations include the following functions: Quality assessment, reviewing the qualifications and performance of health care providers; accreditation; and licensing.

3. In Our Client Surveys: You will receive a client satisfaction survey upon completion of the provided services at Youth Alternatives requesting your evaluation of the care and other services provided to you.

USES AND DISCLOSURES OF HEALTH INFORMATION FOR OTHER REASONS WITHOUT YOUR PERMISSION:

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply and some ay never come up at our agency. Some examples of such uses or disclosures are:

a. for public health purposes, such as a contagious disease reporting.
b. to a social service or law enforcement agency authorized by law to receive reports of abuse, neglect or domestic violence.
c. disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.
d. to law enforcement officials as required by law or in response to a valid court order.
e. disclosures of a "limited data set" for research, public health or health care operations.

OTHER USES AND DISCLOSURES:

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form". We may initiate the form, or you may initiate the use of the form. If we initiate the form, you do not have to sign it. If you do not sign the authorization, we cannot make the disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing.

YOUR RIGHTS REGARDINGYOUR HEALTH INFORMATION:

Although your health record is the physical property of Youth Alternatives, the information belongs to you. You have the right to:

1. Request a restriction on certain uses and disclosures of your health information. Although the Client has the right to make such a request, please note that we are not required to agree to a requested restriction.
2. By written request, you may inspect and obtain a copy of your health record, except for psychotherapy notes, and information complied in reasonable anticipation of or for use in, a civil, criminal or administrative proceeding.
3. Request amendment of your health information record. If you feel that health information in your record is incorrect, or incomplete, you may ask that the information be amended. You have this right as long as the information is maintained by Youth Alternatives. Your request must be in writing with the reason(s) supporting your request. Your request to amend your health record may be denied if:
   - it is not in writing;
   - does not include a reason to support the request;
   - the information was not created by a provider while you were a client at Youth Alternatives;
   - the information is not part of the health record;
   - the information is not part of the record which you would be permitted to inspect or copy;
   - the information is accurate and compete.
4. Request confidential communications. You have the right to request that we contact you about health matters in a certain way or at a certain location.
5. Obtain a paper copy of this notice upon request.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with the Director of Youth Alternative or with the Secretary of the Department of Health and Human Services – Civil Rights Division. All complaints must be submitted in writing, describe how you believe your privacy rights were violated and be delivered to the Director of Youth Alternatives.

By signing this notice, I acknowledge that I have read this notice and understand how my personal health information may be used and disclosed and how I can get access to this information.

_____ _____

Parent/Guardian Date

OFFICE OF YOUTH ALTERNATIVES
DISCLOSURE STATEMENT
Client Rights and Information

Welcome to Youth Alternatives. As a client you have the right to:

- Impartial access to treatment, regardless of race, religion, sex, age, handicap, or ethnicity.
- Recognition and respect of your personal dignity and privacy in the provision of all care and treatment.
- Confidentiality of all written communication between clients and all staff. Client information is released **only** with a client's informed written consent, except in case of imminent life threatening physical danger to the client or others, or when court ordered (see below). Staff members from Youth Alternatives are required by law to report cases of suspected child abuse, neglect or exploitation to the Department of Family Services.

As of March 1, 1999 Wyoming has implemented a privileged communication statute. This law states that, when involved in legal proceedings (civil, criminal, or juvenile) clients retain the right to privacy , unless these specific circumstances exist:

- abuse or harmful neglect of children, the elderly or disabled or incompetent individuals is known or reasonably suspected
- the validity of a will of a former client is contested
- information related to counseling is necessary to defend against a malpractice action brought by a client
- an immediate threat of physical violence against a readily identifiable victim is disclosed to the counselor
- in the context of civil commitment proceedings, where an immediate threat of self-inflicted harm is disclosed to the counselor
- the client alleges mental or emotional damages in civil litigation or his/her mental or emotional state becomes an issue in any court proceeding concerning child custody or visitation
- the patient or client is examined pursuant to a court order
- in the context of investigations and hearings brought by the client and conducted by the board, where violations of this act are at issue

***** Resolve questions or problems regarding your services through first discussing the matter with your counselor. If this doesn't resolve your concerns, you may request to meet with the counselor's supervisor.

We strive to maintain the highest quality of service. All staff members are expected to adhere to the agency Code of Ethics and to the Code of Ethics of the profession to which they belong.

Licensed Marriage and Family Therapists adhere to the American Association for Marriage and Family Therapy Code of Ethics.

Licensed Professional Counselors and Certified Mental Health Workers adhere to the American Counseling Association Code of Ethics.

Licensed Clinical Social Workers and Certified Social Workers Adhere to the National Association of Social Workers Code of Ethics.

Areas of Specialization: Staff members specialize in individual, group, and family counseling with special emphasis on children and adolescents.

Sexual intimacy between a counselor and a client is never appropriate.

This Disclosure Statement is required by law, administered by the Wyoming Mental Health Professions Licensing Board, 1800 Carey Ave, Cheyenne, WY 82001 - (307) 777-7788.

Credentials for each staff member are listed on the back of this Disclosure Statement.

I have read and understand the information in this Disclosure Statement:

_____ _____

Parent / Guardian Date

OFFICE of YOUTH ALTERNATIVES

1328 Talbot Ct., Cheyenne, WY 82001
(307) 637-6480

STAFF CREDENTIALS AND LICENSE INFORMATION

Sullivan, Jay, B.S., Director
B.S., Administration of Justice;
'92, University of Wyoming, WY
A.A., Psychology;
'92, University of Wyoming, WY
Certified Mental Health Worker; WY: # 053A

Broyles, Georgia LCSW, C-SSWS
M.S.W., Social Work
'95, Colorado State University, CO
B.A., Elementary Education
'90, University of Northern Colorado, CO
A.A., Christian Ministries
'86, The Salvation Army School for Officers Training, CA
A.A., Psychology
'84, Laramie County Community College, WY
A.A., Early Childhood Education
'84, Laramie County Community College, WY
Licensed Clinical Social Worker WY LCSW-232
Certified-School Social Worker Specialist, NASW

Carter, Alice, A.A.
Practical Experience
14 Yrs., Temporary & Permanent Guardianships, Custody Arrangements & Kinship Care
Multiple National Training Certificates
Works with all Wyoming County Agencies
A.A., Business Administration
'73, Laramie County Community College, WY

Cotton, Brooks, B.S.
B.S., Business Administration;
'04, Presentation College, SD
A.A., Sport/Wellness and Communication;
'02, Presentation College, SD

Duffet, Paige, B.S.
B.S., Psychology (Forensic Psychology),
Minor in Criminal Justice;
'20, Arizona State University, AR

Patterson, Eric, M.S.
M.S., Marriage and Family Therapy
'15, Colorado State University, CO
B.S., Human Development and Family Studies
'10, Colorado State University, CO
Licensed Marriage and Family Therapist WY: # 232
Supervision provided by Georgia Broyles LCSW, C-SSWS

Schmucker, Brenda, M.S.W.
M.S.W., Social Work
'18 Edinboro University, PA
B.S., Psychology
'14, Colorado Christian University, CO
Licensed Clinical Social Worker LCSW-1338
Supervision provided by Georgia Broyles LCSW, C-SSWS