DeKalb County Youth Service Bureau

Alternative to Suspension Program - Referral Packet

Academic School Year – 2016-2017

330 Grove Street
DeKalb, IL 60115

Phone: 815-748-2010
Fax: 815-748-2019
Website: www.dcysb.com
Program Coordinator: Renee Burger

Alternative to Suspension Program (ASP)
Procedures for School Personnel

1. When a youth is suspended, the school will decide length of suspension. Some schools will cut the suspension time in half for completion of ASP (i.e. 10 day suspension for possession of alcohol cut down to 5 days if youth completes ASP successfully)
2. School **MUST** contact YSB to check availability prior to referring a suspended youth. Our limit is 5 students in the program at one time or at the coordinator's discretion.
3. School will contact parents and inform them of the suspension and ASP information as listed below (*a-d).
4. A referral form or suspension report must be faxed to YSB from the school. Our fax number is 815-748-2019. It is important for us to know exactly what days to expect the youth to be in attendance of ASP! Please complete the **front page highlighted sections** of the "YSB Intake / Referral" form in this packet and return to YSB as well.
5. School **MUST** provide homework or supplemental material (i.e. a book to read) that the youth can complete during the assigned homework time.
6. If issues arise during the time the youth is in ASP, a staff member will contact the school and parent as needed.
7. Following the completion of ASP, YSB will fax to the school a brief completion form.
8. Students are allowed to attend ASP only once per semester (or at the discretion of YSB supervisors/ASP coordinator).
9. For any questions, please contact Renee at YSB at 815-748-2010 or at rburger@dcysb.com.

*Information for School to Give to Parent / Guardian:

a. Parent/guardian **MUST** come to YSB the morning of the suspension to sign consent forms and paper work. If they cannot come that morning they can call YSB to set up a time the day or evening **before** the suspension to fill out paperwork. A parent/guardian **MUST** also be available for an exit interview (aprox. 30 min to 1 hr) during the last day of suspension.
b. **Youth must arrive at YSB at 9 am.** ASP **ends at 1:00 pm**. If a student arrives earlier than 9am, YSB cannot guarantee a staff member will have the office open – the student is allowed to wait outside until staff does arrive. Staff does not assume responsibility of the student before 9am or after 1:00pm.
c. **Youth must bring a sack lunch**. YSB does NOT provide food or transportation for lunch to youth involved in ASP.
d. Students must have homework, or other structured activities to engage in during homework time. If they do not have homework or such items, they will be provided things to do by YSB staff.

☐ Entered in CarePaths
☐ Entered in Therapist Helper

DeKalb County Youth Service Bureau
Intake/Referral Form

Person Taking Intake Information: **Staff Name:_____ Date/Time of Intake:_____**

Client Information:

Who is providing the information for this intake?(ie: caller)_____

Name: _____ D.O.B._____ Age:_____ Sex:_____ Race:_____

Address: _____ City: _____ Zip:_____

Primary Contact Person: _____ Primary Phone: _____

Alternate Contact Person/Phone: _____
(relationship to client)

Email Address:_____

"We utilize email to send initial paperwork, quality surveys, and information about programming."

Do we have permission to:
- ☐ Call you
- ☐ Leave a message
- ☐ Send mail
- ☐ Send email

Is the youth covered by Medicaid? ☐ Yes ☐ No
- If yes, inform them of referral to BGC.

Referral Source: (Include Agency Contact Info)

- ☐ **JCS**_____
- ☐ **JCS/Diversion**_____
- ☐ **School**_____
- ☐ **Police**_____
- ☐ **City Court**_____
- ☐ **DCFS**_____
- ☐ **Family**_____
- ☐ **State's Attny**_____
- ☐ **Other Agency**_____
- ☐ **Other**_____

Reason for Referral: (brief narrative of caller's report)

_____

_____

_____

_____

(Check all that apply)

1. Intrapersonal	2. School	3. Family	4. Legal	5. Substance	6. Peer Relations
☐ Self-Esteem	☐ Truancy	☐ Divorce/Separation	☐ Runaway/Curfew	☐ Youth	☐ Gang
☐ Suicide	☐ Grades	☐ Abuse	☐ Probation	☐ Parent/Family	☐ Peer conflict
☐ Self-Injury	☐ Attendance	☐ Family Conflict/Violence	☐ Diversion	Please ID substance:	☐ Peer violence
☐ Homicidal	☐ Suspension	☐ Parenting Related Issues	☐ Stealing	_____	
☐ Death/Loss	☐ Behavioral	☐ Behavioral Issues		_____	
☐ Sexual Issues		☐ Custody Issues		_____	
☐ Mental Health		☐ Poverty/Homeless		_____	

School Info:

School:_____ Grade:_____

Previous Counseling Experience: (Can you tell me about any other services your child has received or is currently receiving?)

Previous counseling:	
☐ YSB:_____	☐ Other:_____

Annual Income and Fees:

Counseling Fees	Special Services:	Fee
1. Do you have health insurance that covers mental health? ☐ Yes ☐ No Carrier _____ **2.** "*Our standard rate is $75 per hour-long session for counseling. However, we can offer a sliding fee scale for families who qualify based on income levels as well as certain life circumstances.* *In order to qualify for a reduced rate, we will need you to bring in last year's tax returns* to determine your rate. Your first session will be free of charge as long as you bring in the required documentation.* *Your financial information will be given to our finance manager who will determine your rate and call you to discuss prior to the 2nd session. Please make sure to arrive 10-15 minutes early for paperwork."* ***** *If unable to produce tax returns, ok to bring 3 recent check stubs.* **3.** Approximate annual household income? **$**_____	☐ Counseling Assessment* 3 sessions – Payment due before 3rd session ☐ Drug & Alcohol Assessment* 1 to 2 session assessment & 8 week group ☐ META* 1 session assessment plus 10 week group ☐ Girls Empowerment* 1 session assessment plus 10 week group ☐ Active Parenting of Teens* Orientation, book, & 6 week group ☐ Urine Screen * ☐ Alternative to Suspension ☐ Juvenile Diversion ☐ VolunTEEN ☐ Crisis (runaway/lockout) *Payment due at time of service.	$75 ↓ $20 No Charge ↓

☐ Availability? **(Mon)**:_____ **(Tue):**_____

(Wed):_____ **(Thur):**_____**(Fri):**_____

☐ Illinois Law dictates that minors in treatment must have both parents' consent. YSB needs consent from **both** parents for **all** cases. If there is an exception to this, such as divorce, court documentation must be provided.

☐ Explain next steps: "This is all the information we need at this point. We will identify the appropriate program and you should hear from the counselor within 2 business days. If you need anything in the meantime, please feel free to call."

Program(s) Referred To: (indicate date of referral for each program)

Programs:	Program 1	Program 2	Program 3	Program 4
Alternative to Suspension (ASP)				
Active Parenting (APoT)				
Crisis (CCBYS)				
Diversion (DIV)				
Early Intervention (EIP)				
VolunTEEN (VT)				
Youth & Family Counseling (YFC)				
Counseling Assessment				
Youth Project/META				
Youth Project/GEG				
Therapeutic Art-Making Group (TAG)				

Office Use Only:

1.

☐ ***Program Coordinator:*** (Assign counselor, inform them immediately and give them this original)
Counselor Assigned:_____ Date Assigned:_____

☐ ***Therapist:*** **(you MUST contact family within 2 business days of the intake date/time!)**
Time/Date of Follow up Contact:_____ Time/Date of 1st Session_____

☐ Clients Refused Services (check box if client refused services prior to first session)

2. ***Intake Input:***

□ CD entered into CarePaths. □PC Recvied □ OM opened in CarePaths and Therapist Helper.

Informed Consent

Alternative to Suspension Program

Part 1: General Information

1. The DeKalb County Youth Service Bureau Inc. (YSB) provides individual and family counseling services to DeKalb County youth ages 8-18 and their families. Our mission at YSB is to assist DeKalb County youth to build healthy lives and responsible relationships with family, friends, and the community. Our goal is to provide caring and professional services for our clients.
2. The DeKalb County Youth Service Bureau Inc. (YSB) Alternative to Suspension Program (ASP) provides students, who are suspended from school, a safe supervised environment, decision making strategies, social/emotional skills development, physical activity, and exposure to community/civic duty (through participation in community service activities).
3. The DeKalb County Youth Service Bureau employs professionally trained counselors with graduate degrees in psychology, counseling, or marriage and family therapy. In addition, Master's level candidates completing their practical experience requirements are also on staff at YSB, and may be involved with, or serving as, your counselor. These interns are highly competent and will be working under the direct supervision of a clinical supervisor as well as a team of experienced youth and family counselors.
4. In case of a mental health/physical emergency reasonable efforts will be made to contact youth's guardian. If contact is unable to be made, then the alternate contact will be attempted. YSB staff will contact an ambulance in situations in which the youth may be at immediate risk of harm.

Part 2: Your Rights as a Client

1. **Confidentiality:** Within the limits of the law, information revealed by you during counseling will be kept strictly confidential and will not be revealed to any other person or agency unaffiliated with YSB without your written permission. We routinely staff our cases during clinical supervision and team consultation to assist counselors in improving skills and in planning for future sessions. These meetings will be kept strictly confidential.
2. Illinois law and ethical practice requires us to notify appropriate state agencies **without** your permission if **(a)** we suspect or know of a child or elder abuse/neglect situation, **(b)** you threaten bodily harm or death to another person or yourself, or **(c)** a judge issues a court order requesting relevant information. If you have concerns about any of the above stated conditions regarding confidentiality, please discuss them with your counselor.
3. Verbal and written information regarding the youth's participation, behavior, and attendance in the Alternative to Suspension Program will be exchanged with their school.

Part 3: Program Rules and Guidelines

1. Participating students are required to attend individual and group activities that will involve school work, decision making strategies, social/emotional skills development, physical activity, and exposure to community/civic duty (through participation in community service activities).
2. Parent/Guardian of participating students is required to sign a contract agreeing to comply with program requirements and to complete an exit interview with the program coordinator.
3. General Program Guidelines:
    a. **The program runs 9:00 am to 1:00 pm, Tuesday, Wednesday, Thursday during the school year.** YSB follows the DeKalb School District calendar for Holidays, early dismissals, etc. When you arrive in the morning, please sit in the hallway until a YSB staff member attends to you. Please remember that while you are at YSB or out in the community, you are expected to behave and dress and in an appropriate manner that represents YSB well.
4. Participation:
    a. Successful completion of the program is based on attendance and participation in all individual as well as group activities.
    b. Breaks will be provided at the discretion of the ASP coordinator or supervisor.
    c. Students will meet with a therapist on staff within 48 hours of beginning ASP for a general counseling and mental health screening. Parents are strongly urged to participate in this screening and follow all professional recommendations.
5. Conduct:
    a. **Students must follow the school's codes for conduct and dress while in ASP.** All participants must wear clothing that is appropriate for outdoor work and cleaning.

b. No inappropriate behavior or language will be tolerated in the ASP program. Consequences will be given for negative behaviors, including dismissal from the program. If dismissal is required, the youth's parents and school will be notified immediately.
c. In the event that the youth chooses to leave the premises of YSB or other locations during community service without permission, YSB will contact the parent/guardian immediately.
d. **The use of cell phones, MP3 players, hand-held video games, and other electronic devices are prohibited during ASP hours**. These items may be taken from the youth and returned at the end of the day. If phone usage is necessary there are phones that may be used at YSB.

6. Policy:
a. Attendance Policy – In order to be excused from the ASP program a phone call and message is required **prior to 9:00 am** from a parent or guardian. An appropriate reason must be given for any absences. Failure to comply with this could result in early dismissal from the ASP program.
b. **All participants are required to bring ALL school assignments (homework, books, etc.)** Failure to bring school assignments or materials needed to complete assignments will result in alternative work being provided by the ASP coordinator.
c. **Participants are required to provide their own sack lunch each day.**

Part 4: Consent for Activity and Transportation

1. I/we represent that we are the parent(s)/guardian(s) of _____, a minor, and have full authority to grant consent and release on behalf of said minor.
2. I/we grant our consent for the above named youth, a minor, to participate in the social skill/recreational activities offered through the DeKalb County Youth Service Bureau and to be transported by YSB staff as necessary for participation in programming or in case of emergency.
3. I grant this permission with the understanding of the risks involved and knowing that the DeKalb County Youth Services Bureau, Inc. is assuming no liability or responsibility in connection with such transportation or social skill/recreational activities except to the extent required by law. Further, on behalf of myself and the minor child, I/we hereby expressly release (to the extent permitted by law) DeKalb County Youth Services Bureau, Inc. from any and all liability which may otherwise accrue by reason of the provision of transportation assistance for this minor. I/we further warrant that I/we have full authority to grant this permission and execute this release on behalf of the minor child named above.
4. **I/we consent to the following transportation plan for arrival and dismissal to determine how and by whom the youth will be transported (ex: picked up by mom/dad, walk, drive themselves, etc.)**

_____

Failure to follow any of the Alternative to Suspension Program (ASP) rules or guidelines may result in dismissal from the Alternative to Suspension Program (ASP) and the school will be notified immediately.

I certify that I have read this form or had it read to me and that I understand its contents. If I have any questions or concerns now or in the future, I understand that I should consult with my counselor or the Executive Director of YSB (815-748-2010). I certify that I have legal authority to give consent for the treatment of all minor children that are included in counseling.
Signed:

_____ _____
Parent/Guardian Date

_____ _____
Child (age 12 and above) Date

_____ _____
Witness Date

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. OUR RESPONSIBILITIES:
We reserve the right to change this Notice of Privacy Practices and to make any new Notice of Privacy Practices effective for all protected health information that we maintain. Any new Notice of Privacy Practices adopted will be posted at our website and can be made available at your next appointment.

II. WHAT IS "PROTECTED HEALTH INFORMATION" (PHI)?
Protected health information ("PHI") is demographic and individually identifiable health information that will or may identify the patient and relates to the patient's past, present or future physical or mental health or condition and related health care services.

IV. HOW IS PHI USED?
We use a cloud-based electronic medical record certified by ONC-ACB with certification criteria adopted by the Secretary of the US Department of Health and Human Services, as a way of recording client information, planning care and treatment, tracking clinical progress and for billing insurance, as applicable. Your insurance company may request information such as diagnosis information that we are required to submit in order to bill for treatment we provide. Other health care providers or health plans reviewing your records must follow the same confidentiality laws and rules required of us.

USES AND DISCLOSURES OF INFORMATION: Under federal law, we are permitted to use and disclose personal health information without authorization for certain treatment, payment and health care operations.

V. HOW MEDICAL INFORMATION MAY BE USED FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS:
Treatment: We will use medical information to establish a treatment plan.
Payment: We may use or disclose your PHI in determining your insurance coverage and in processing claims, if applicable.
Health Care Operations: From time to time, we may use your PHI to remind you of an appointment with us. We may use the emergency contact information you provided if yours is no longer accurate.
Authorization: You may give us written authorization to use your PHI or to disclose it to another person and for the purpose you designate. If you give us an authorization, you may withdraw it in writing at any time. Your withdrawal will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice. We will make disclosures of any psychotherapy notes we may have only if you provide us with a specific written authorization or when disclosure is required by law.

VI. WHY DO I HAVE TO SIGN A CONSENT FORM AND A SEPARATE AUTHORIZATION FORM?
When you, as the client or guardian of a client, sign a consent form, you are giving us permission to use and disclose PHI for the purposes of treatment, payment and health care operations. This permission does not include psychotherapy notes, psychosocial information, alcoholism and drug abuse treatment records and other privileged categories which require a separate authorization. You will need to sign a separate authorization to have PHI released that clearly explains how the information is to be used and disclosed.

VII. WHAT ARE PSYCHOTHERAPY NOTES AND PSYCHOSOCIAL INFORMATION?
Psychotherapy notes are notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session that are separated from the rest of the patient's medical record. Psychosocial information is information provided regarding your social history and counseling or psychiatric services you have received in the past.

X. CAN I CHANGE MY MIND AND REVOKE AN AUTHORIZATION?
You may change your mind and revoke an authorization, except to the extent that we have relied on the authorization up to that point. All requests to revoke an authorization should be in writing.

XI. SHARING INFORMATION WITH BUSINESS ASSOCIATES

There are some services provided through contracts with business associates. Examples include billing services and transcription services. When these services are contracted, we may disclose your health information to the business associate so that they can perform the job we have contracted them to do. We maintain cyber insurance and work with agencies that have certification for secure data transfers.

XII. WHEN IS MY AUTHORIZATION / CONSENT NOT REQUIRED?

The law requires that some information may be disclosed without authorization:

- When required by law for law enforcement purposes
- To report suspected child abuse or neglect or abuse/neglect to the elderly or to other disabled persons
- In connection with judicial or administrative proceedings
- In the event of a serious threat to health or safety

XIII. YOUR PRIVACY RIGHTS

The following is a statement of rights in regards to your PHI and a description of how you may exercise them.

1. You have the right to inspect and copy your health information.
2. You have the right to request a restriction of your health information.

This means you may ask us to restrict/limit the information we use or disclose for the purposes of treatment, payment or healthcare operations.

3. Your have the right to request to receive confidential communications by alternative means or at alternative locations.
4. You have the right to request amendments to your health information.

This means you may request an amendment of PHI. If we deny your request, you have the right to file a statement of disagreement in writing.

5. You have the right to receive an accounting of disclosures of your health information.

The request must be made in writing and specify the time period sought for the accounting.

6. You have the right to receive a paper copy of this Notice of Privacy Practices.

XIV. WHAT IF I HAVE A QUESTION / COMPLAINT?

If you have questions regarding your privacy rights, please contact your therapist or the executive director. If you believe your privacy rights have been violated, you may file a complaint by contacting the executive director, or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint. The address for the Secretary of the Department of Health and Human Services is:

Office of Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth St., S.W.
Atlanta, GA 30303-8909
(404) 562-7886 (phone) (404) 562-7881 (fax)
(404) 331-2867 (TDD) www.hhs.gov/ocr/hipaa

_____ _____

Parent/Guardian Date Parent/Guardian Date

_____ _____

Child (age 12 and above) Date Witness Date

Alternative to Suspension Program Rules

Conduct:

- Students must follow the school's codes for conduct and dress while in the ASP program. All participants must wear clothing that is appropriate for outdoor work and cleaning. Participants must follow the same dress code during ASP that they would if they were in their school.
- No inappropriate behavior or language will be tolerated in the ASP program. Consequences will be given for negative behaviors.
- The use of cell phones, MP3 players, hand-held video games, and other electronic devices are prohibited during ASP hours. These items may be taken from the youth and returned at the end of the day. If phone usage is necessary there are phones that may be used at YSB.

Policy:

- Attendance Policy – In order to be excused from the ASP program a phone call and message is required prior to 8 am from a parent or guardian. An appropriate reason must be given for any absences. Failure to comply with this could result in early dismissal from the ASP program.
- All participants are required to bring ALL school assignments. Failure to bring school assignments or materials needed to complete assignments will result in alternative work being provided by the ASP coordinator.
- Participants are **required** to provide their own sack lunch each day; we do have a refrigerator to provide.

Participation:

- When ASP participant enters the Youth Service Bureau they are to sit in the hallway and wait for a staff member to greet them and follow up with further directions.
- All ASP participants are required to attend individual as well as group activities that involve school work, social and emotional skill development, involvement in community or civic duties, physical activity, and career exploration, skill training, creative exploration and art making.
- Breaks will be provided at the discretion of the ASP coordinator or supervisor.
- Students will meet with a therapist on staff within 48 hours of beginning ASP for a general counseling screening. Parents are strongly urged to participate in this screening.

I understand that failure to meet the above expectations may result in additional requirements. Failure to meet any additional requirements/expectations may result in unsuccessful completion of ASP. Any youth that chooses not to meet expectations will be subject to their original school suspension requirements. School personnel will be informed immediately.

Signature of Youth: _____ Date: _____

Signature of Parent: _____ Date: _____

Witness: _____Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name_____ Date of Birth_____

I HEREBY AUTHORIZE the **DeKalb County Youth Service Bureau, Inc.** to exchange information with the following agency for the purpose of comprehensive case planning:

_____ Family Service Agency
14 Health Services Dr., DeKalb, IL. 60115
_____ Ben Gordon Community Mental Health Center, Inc.
12 Health Services Dr., DeKalb, IL. 60115
_____ The Illinois Department of Children and Family Services (D.C.F.S.)
P.O. Box 308 Sycamore, Illinois 60178
_____ DeKalb County Juvenile Court Services (J.C.S.)
133 W. State Street, Sycamore, IL. 60178
__X_ School District_____
_____ DeKalb County Public Defender's Office
313 E. State St., Sycamore, IL 60178
_____ DeKalb County State's Attorney's Office
133 W. State St, Sycamore, IL 60178
_____ Other_____

I further consent to have the following pertinent professional information disclosed as part of the information to be exchanged:

__X___Social History	___X__Anecdotal Records
__X___Medical Evaluations/Records	___X__Disciplinary Information
__X___Psychological/Psychiatric Evaluations	___X__Special Education Reports
__X___ Educational Testing	(Including staffings)
__X___ Academic Information/Attendance	___X__ Assessment & Recommendations
__X___ Urninalysis Results	___X__ Treatment Plan
__X___ Discharge Summary	___X__ Non-educational Agency Case Records

_____ Other _____

I understand that this authorization to exchange information becomes effective when I sign this release. This authorization expires on the following date of expiration: Date_____. I understand that I may revoke this authorization at any time. In order to do this, I must give written notice to the agency listed below as the "Witnessing Agency", that I wish to revoke this authorization. I further understand that I have the right:

1. To inspect and copy such records and information to be disclosed
2. To challenge the contents of such records.
3. To limit any such consent to designated records or designated portions of information within the records.

Client Signature _____Date_____

Signature _____Date_____
Relationship
Signature _____Date_____
Relationship
Witnessed _____Date_____
Position
Witnessing Agency: DeKalb County Youth Service Bureau