☐ Entered in CarePaths

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)______________________
Are they Guardian? ☐ Yes ☐ No If no, they cannot be Primary Contact until a Release of Info is signed

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.

Does youth go to center for Family Health on Plank Rd? ☐ Yes ☐ No
- If yes, inform them that Youth Counseling is provided at Elgin location.

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)

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____

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

☐ 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)