

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: _____ Gender: _____ Race: _____	
Preferred Name: _____	Primary Contact Person: _____ <small>(relationship to client)</small>
Primary Phone: _____	Email Address: _____
Address: _____ City: _____ Zip: _____	
Alternate Contact Person/Phone: _____ <small>(relationship to client)</small>	Do we have permission to: <input type="checkbox"/> Call you <input type="checkbox"/> Leave a message <input type="checkbox"/> Send mail <input type="checkbox"/> Send email
"We utilize email to send initial paperwork, quality surveys, and information about programming." Is the youth covered by Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No Does youth go to center for Family Health on Plank Rd? <input type="checkbox"/> YES <input type="checkbox"/> NO - If yes, inform them of referral to BGC. - If yes, inform them that Youth Counseling is provided at Elgin location.	

Referral Source: (Include Agency Contact Info)

<input type="checkbox"/> JCS _____	<input type="checkbox"/> DCFS _____
<input type="checkbox"/> JCS/Diversion _____	<input type="checkbox"/> Family _____
<input type="checkbox"/> School _____	<input type="checkbox"/> State's Attny _____
<input type="checkbox"/> Police _____	<input type="checkbox"/> Other Agency _____
<input type="checkbox"/> City Court _____	<input type="checkbox"/> 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
<input type="checkbox"/> Self-Esteem	<input type="checkbox"/> Truancy	<input type="checkbox"/> Divorce/Separation	<input type="checkbox"/> Runaway/Curfew	<input type="checkbox"/> Youth	<input type="checkbox"/> Gang
<input type="checkbox"/> Suicide	<input type="checkbox"/> Grades	<input type="checkbox"/> Abuse	<input type="checkbox"/> Probation	<input type="checkbox"/> Parent/Family	<input type="checkbox"/> Peer conflict
<input type="checkbox"/> Self-Injury	<input type="checkbox"/> Attendance	<input type="checkbox"/> Family Conflict/Violence	<input type="checkbox"/> Diversion	Please ID substance:	<input type="checkbox"/> Peer violence
<input type="checkbox"/> Homicidal	<input type="checkbox"/> Suspension	<input type="checkbox"/> Parenting Related Issues	<input type="checkbox"/> Stealing	_____	
<input type="checkbox"/> Death/Loss	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Behavioral Issues		_____	
<input type="checkbox"/> Sexual Issues		<input type="checkbox"/> Custody Issues		_____	
<input type="checkbox"/> Mental Health		<input type="checkbox"/> 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: <input type="checkbox"/> YSB: _____	<input type="checkbox"/> Other: _____
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Annual Income and Fees:

Counseling Fees	Special Services:	Fee
<p>1. Do you have health insurance that covers mental health? <input type="checkbox"/> Yes <input type="checkbox"/> No Carrier _____</p> <p>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. <i>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.</i> <i>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."</i> <i>* If unable to produce tax returns, ok to bring 3 recent check stubs.</i></p> <p>3. Approximate annual household income? \$ _____</p>	<p><input type="checkbox"/> Counseling Assessment* 3 sessions – Payment due before 3rd session</p> <p><input type="checkbox"/> Drug & Alcohol Assessment* 1 to 2 session assessment & 8 week group</p> <p><input type="checkbox"/> META* 1 session assessment plus 10 week group</p> <p><input type="checkbox"/> Girls Empowerment* 1 session assessment plus 10 week group</p> <p><input type="checkbox"/> Active Parenting of Teens* Orientation, book, & 6 week group</p> <p><input type="checkbox"/> Urine Screen *</p> <p><input type="checkbox"/> Alternative to Suspension</p> <p><input type="checkbox"/> Juvenile Diversion</p> <p><input type="checkbox"/> VolunTEEN</p> <p><input type="checkbox"/> Crisis (runaway/lockout)</p> <p>*Payment due at time of service.</p>	<p>\$75</p> <p style="text-align: center;">↓</p> <p>\$20</p> <p style="text-align: center;">↓</p> <p>No Charge</p> <p style="text-align: center;">↓</p>

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:

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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)