



WELCOME TO YOUTH ALTERNATIVES

1328 Talbot Court Cheyenne, WY 82001
Phone (307) 637-6480

Please complete the attached information and either email it to OYA@cheyennecity.org
or print and return it to us at the above listed address.

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: _____
 EMAIL ADDRESS: _____ AGE: _____ SEX: _____
 REFERRED BY: _____ SCHOOL: _____
 PRIMARY PHONE NUMBER: _____ GRADE: _____ IEP _____ 504 _____
 ALTERNATE PHONE NUMBER: _____

PLEASE LIST **ONLY** THOSE WHO WILL BE ATTENDING COUNSELING

Name	Relationship	Age	Birthdate	Sex	School	IEP	504

Father's Name: _____ **Employer:** _____
Work #: _____

Mother's Name: _____ **Employer:** _____
Work #: _____

Insurance:
Policy Holder: _____ **Provider:** _____ **Policy Number:** _____

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

Your child lives 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

Counseling Information

1. Please check any of the following agencies or counselors who are currently involved with your family in some way:

- 1. Peak Wellness Center
- 2. Wyoming Behavioral Institute (WBI)
- 3. Youth Crisis Center
- 4. Private Therapy

- 6. Court
- 7. Department of Family Services
- 8. Division of Vocational Rehabilitation
- 9. School Counselor

Clinic/Doctor: _____

10. Other: _____

- 5. Chemical Health Services

Name: _____

(Pathfinder, Drug Testing Center, Foundations)

2. Why did you choose to come to Youth Alternatives?

- a. How did you learn about our program?
- b. What have you heard about this program?
- c. What type of counseling do you expect to receive here?
- d. Given what you know about your family and our program, what do you think will be most difficult for your family in counseling?
- e. How long do you expect to be in counseling here?

3. Have you or any member of your family been in counseling before? If yes, answer the following:

- a. Who was involved in counseling?
- b. Where and when?
- c. Regarding the most recent time, for how long?
- d. What changes occurred?
- e. What did you like about it?
- f. What didn't you like about it?
- g. What were the reasons for leaving counseling?
- h. Who was most helpful?

4. Please list any medication your child takes:

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
City of Cheyenne
RELEASE OF INFORMATION



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 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 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: _____

Pre-Intake Questionnaire

Parents, this questionnaire is part of the initial intake process. Please complete the questions below to the best of your knowledge. We appreciate your cooperation in this matter. Please be advised that this information is confidential and will only be used in a professional capacity to assist in the services provided to your child.

Childs Name: _____ Date of Birth: _____ Sex: ____ Date: _____

- | | Yes | No |
|--|--------------------------|--------------------------|
| ▪ Has your child suffered any loss in life, like a death of a relative or divorce? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Is your child being bullied at school? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Is your child experiencing domestic violence in the home? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Has there been any trauma or abuse (physical/sexual/mental) in your child’s life? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Is your child involved in pornography or violent/sexual entertainment, including video games, movies or music? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Has your child ever been caught “peeping” on a neighbor, mother, or sister? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Are there any signs of suicide or depression? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Is your child using drugs or alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Is your child prescribed any medications? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Is it possible that your child is involved in gang activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Is your child fascinated with deadly weapons (guns, knives, bombs, swords)? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Are there weapons in the home? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Are the weapons secured? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Is there a history of suicide in the family? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Is your child showing any warning signs of suicide, like threats or giving away prized possessions? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Have you ever seen anything violent or troubling in your child’s schoolwork, artwork, or their journal? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Does your child wet the bed? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Is your child fascinated with fire and setting fires? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Has your child ever tortured or harmed animals? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Has your child ever made a threat or statement about killing anyone, including family? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Does your child have a journal? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Does your child have a presence on the web, including a website, blog, Facebook and/or other social media? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Has your child ever showed any interest in violence, serial killers, or school shootings? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Does your child collect any books that may be filled with violent or hate-filled philosophies, including the Necronomicon, Satanic Bible, Anarchist Cookbook, or the Mein Kompf? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Has your child ever committed petty crimes, like vandalism, arson, or running away? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Has your child’s appearance changed, including clothes and hair? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Has your child ever partaken in self-abuse activities? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Is it possible your child is dating an older person? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Do your child’s friends project pro-social attitudes and behaviors? | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Does your child spend any time away from the home, out of your supervision besides school? | <input type="checkbox"/> | <input type="checkbox"/> |

Parent/Guardian Signature

Date

Client History

CLIENT NAME: _____ DATE: _____

1. Did you have a normal pregnancy with this child? If not, please describe:

2. Were there any complications during your child's birth? If yes, please describe:

3. Did your child have any illnesses during the first few years of life, such as colic, ear infections, etc.? If yes, list illnesses and age:

4. Was your child hospitalized for illness or surgery from infancy through five years of age? If yes, reason for hospitalization and age:

5. Were you separated from your child during infancy to three years of age for longer than five days at a time? If yes, reason for separation and age:

6. Did you experience depression during your child's infancy to three years of age? If yes, reason for and length of depression, age of child:

7. How old was your child when he/she began walking?

8. How old was your child when he/she was toilet trained? Did he/she ever have a problem with bed wetting or controlling bowel movements after being toilet trained?

9. Was you child cuddly as an infant?

10. Up to age five, did your child get along and play with other children easily? If not, explain:

11. Has your child ever had a period in his/her life when he/she had frequent nightmares? If yes, age of child, content of nightmares, description of effect on child:

12. Have you ever had trouble with your child playing with matches or starting fires? If yes, age and consequences:

13. Did your child display any unusual or peculiar behaviors during the elementary school years? If yes, please explain:

14. Did your child often get into trouble during the elementary school years? If so, please describe:

15. Did your child make friends easily and keep those friendships for some time during the elementary school years?

16. As a teenager, has your child been in trouble at school? If so, for what kinds of things, and what kind of consequences did he/she receive?

17. Has your child ever been in trouble with the law? If yes, please list age, offense, and consequences:

18. Does your child currently have any disabilities, medical problems, or other special needs? If yes, please explain:

19. To your knowledge, has your child ever used drugs or alcohol? If yes, please list substances used, frequency and effects:

20. As a teenager, does your child get along well with other kids who are his/her age?

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 described in this notice.

Youth Alternatives reserves the right to change this Notice and to make the revised or changed notice effective for health 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 Litem, 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 may 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 REGARDING YOUR 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 compiled 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 complete.
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

Berry, Dick, Psy.D., Clinical Supervisor

Psy.D., Counseling Psychology,
'85, University of Northern Colorado, CO
M.A., Counseling
'76, Denver Seminary, CO
B.A., Psychology,
'73, University of Wyoming, WY
Licensed Marriage & Family Therapist WY: # 179
Licensed Psychologist WY: # 231

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

Cox, Leslie, B.S.

B.S., Psychology: Crisis Counseling
'14, Liberty University, VA

Givhan, Johnny, M.H.R.

M.H.R., Human Relations;
'03, University of Oklahoma, OK
B.A., Criminal Justice;
'97, University of Nebraska at Omaha, NE
A.A., Security Administration,
'98 Community College of the Air Force

Goertz, Melissa, M.A.

M.A., Marriage and Family Therapy
'19, Liberty University, VA
M.A. Human Services
'11, Liberty University, VA
B.S., General Studies
'10, Minot State University, ND
Provisionally Licensed Marriage and Family Therapist
Supervision provided by Dick Berry, Psy.D.

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
Provisionally Licensed Marriage and Family Therapist
Supervision provided by Dick Berry, Psy.D.

Schmucker, Brenda, M.S.W.

M.S.W., Social Work
'18 Edinboro University, PA
B.S., Psychology
'14, Colorado Christian University, CO
Provisionally Licensed Clinical Social Worker
Supervision provided by Dick Berry, Psy.D.