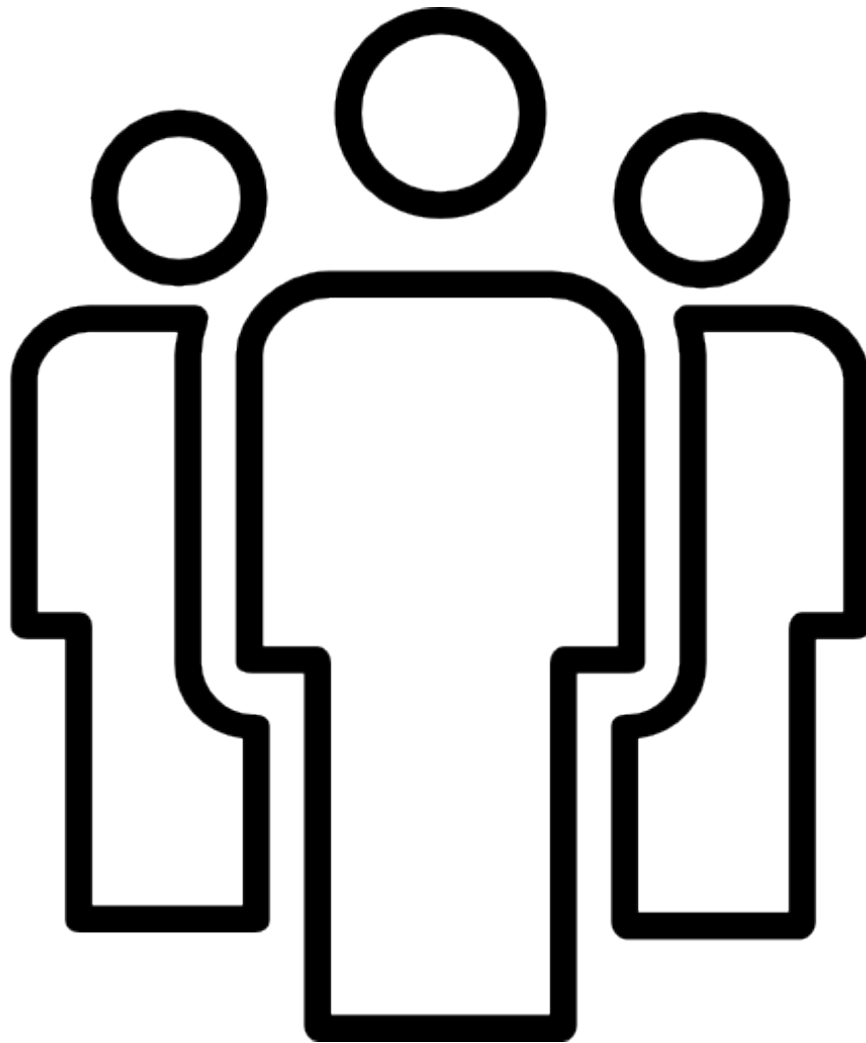


# Office of Youth Alternatives

## 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: \_\_\_\_\_  
 EMAIL ADDRESS: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_  
 REFERRED BY: \_\_\_\_\_ SCHOOL: \_\_\_\_\_  
 PRIMARY PHONE NUMBER: \_\_\_\_\_ GRADE: \_\_\_\_\_ IEP \_\_\_\_\_ 504 \_\_\_\_\_  
 ALTERNATE PHONE NUMBER: \_\_\_\_\_

**PLEASE LIST ALL INDIVIDUALS LIVING IN THE HOME**

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  
 Is English your child's second language? \_\_\_\_\_ 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



**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

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



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.

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Printed Name

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Date

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Signature

# OFFICE OF YOUTH ALTERNATIVES

## NOTICE OF PRIVACY PRACTICES

Effective Date of Notice: April 14, 2003

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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.

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### **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 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 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.

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Parent/Guardian

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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

### **Cotton, Brooks, B.S.**

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

### **Welch, Margaret M., MSW, LCSW, VAWC**

M.S.W., Master of Social Work & Certificate in Violence  
Against Women and Children  
'17, Rutgers University, NJ  
B.A., Criminal Justice/Juvenile Specific  
'13, University of Wyoming, WY  
A.A., General Studies  
'13, Laramie County Community College, WY  
A.S., General Studies  
'08, Clackamas Community College, OR  
Licensed Clinical Social Worker, WY LCSW #999

### **Patterson, Eric, M.S., LMFT**

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

### **Sink, Mikayle, MSW, PCSW**

M.S.W., Master of Social Work  
'23, Troy University, AL  
B.A., Psychology  
Minor in Women and Gender Studies  
'17, Valdosta State University, GA  
A.A., Psychology  
'15, Georgia Military Collage, GA  
Provisional Clinical Social Worker, WY PCSW-1144

### **Burrill, David, PPC**

M.A.E.- Clinical Mental Health Counseling  
'23, Chadron State College  
License # PPC-1441  
Wyoming Licensed Educator/Coach  
1978 to present  
B.A., History  
1975, Colorado State University

### **Giacchino, Kassie, B.A.**

B.A., Criminal Justice  
Minor in Psychology  
Minor in Sociology  
'20, University of Wyoming, WY

### **Runion, Chantelle, B.A.**

B. A., Psychology  
Minor in Women's Studies  
'18, University of Wyoming

### **Roybal, Fredrick, M.A.**

M.A. Education and Technology  
'04, Walden University, MN  
B.A. English and Secondary Education  
'92, University of Wyoming, WY