CATHEDRAL HOME FOR CHILDREN
APPLICATION CHECK LIST

Please utilize this list to aid you in the completion of the necessary application materials.

Packet materials

_____ Cathedral Home Application Form

_____ Medical Intake Form

Authorizations

_____ Medical authorization

_____ Consent to treatment

_____ Release of information (x 3)

_____ Publicity clearance

_____ Wilderness experience

_____ School record release (x 3)

Other materials needed

_____ School records (including IEP if applicable)

_____ Psychological testing (within last 6 months)

_____ Social summary/Predispositional reports (including an outline of child's developmental background as well as current and past information on family functioning)

_____ Social security card (photocopy)

_____ Birth certificate (photocopy)

_____ Immunization records

_____ Insurance information (Title XIX coupon/# or private insurance card (copy) or other information regarding health insurance coverage)

_____ Court records (adjudication, disposition) - including school district of origin and court order for placement at CHC

_____ Physical examination record (within last month)

_____ Reports from other agencies having had contact with child (treatment programs, therapists, probation officer, etc.)

CATHEDRAL HOME FOR CHILDREN
APPLICATION

Date of Application: ____________________

1. *Identifying information on child*:

Name ____________________________ Sex ________ DOB _________ Age _________

Address: __________________________________ City_________________State_______

Weight ________ Height ________ Hair _____________ Eyes ___________

Build ______________

Adjudication ________________________ SS# ______________________

Religion ______________ Ethnic origin _____________________________

Identifying features ____

Relevant cultural variables ____

2. *Referring agency information*

Referring Agency ____

Social worker/referring individual ___________________ Phone ________________________

Address ____

3. *What problems has the child been having?* (Please include problems at home, school or in the community and indicate when problems began)

____

____

____

4. *Has the child been treated by a private psychiatrist, psychologist, social worker, or mental health agency, including out of home placements?*

<u>Therapist/Agency</u> <u>Date</u>

____

____

____

____

5. *Cathedral Home provides parent education material that describes aspects of our program in general, and certain specific educational materials about components of the treatment program. Please provide the names and addresses of the parents who would like to receive this material:*

Name Address

____

____

____

6. *Family information*

A. Father

Name ____ DOB __________________

Address ____

Occupation________________________ Employer __________________________

Telephone (home) _____________________ (work) _________________________

B. Mother

Name ____ DOB __________________

Address ____

Occupation________________________ Employer __________________________

Telephone (home) _____________________ (work) _________________________

C. Siblings

Name__________________________________(Bio, step, 1/2)______Age________

Name__________________________________(Bio, step, 1/2)______Age________

Name__________________________________(Bio, step, 1/2)______Age________

Name__________________________________(Bio, step, 1/2)______Age________

D. Step/Adoptive Parents

Name ____ DOB __________________

Address ____

Occupation_________________________ Employer ___________________________

Telephone (home) ______________________ (work) __________________________

Name ____ DOB __________________

Address ____

Occupation_________________________ Employer ___________________________

Telephone (home) ______________________ (work) __________________________

7. *Restricted contacts (Please list persons whom child may not have contact with)*

____

8. *How did you find out about Cathedral Home?*

____

Please feel free to call the cottage supervisor (307) 745-8997, if you have any questions about the application process. Thank you.

CATHEDRAL HOME FOR CHILDREN
MEDICAL INTAKE FORM

Name ________________________ DOB _________________ Age ____ Date: __________

1. *Medical insurance information***

Title XIX _____ Private Insurance _____ Other insurance _____

Title XIX # _________________ Private Insurance carrier #__________(attach copy of card)

Other insurance information:

____

Financially Responsible Person/Agency:

Name: ____

Address:____

****Information regarding medical insurance coverage is mandatory.
Lack of information may jeopardize placment.***

2. *Family Medical History*

A. *Biological Father*

Name ____Age: __________

Occupation____

Please circle (yes) or (no) as it applies to the biological father:

Diabetes	Yes	No	Hypertension	Yes	No
Heart Disease	Yes	No	Mental Illness	Yes	No
Stroke	Yes	No	Alcoholism	Yes	No
Cancer	Yes	No	Drug Use/Abuse	Yes	No
Chronic Illness	Yes	No	Seizures/Epilepsy	Yes	No
Hearing Loss/Deafness	Yes	No	Hepatitis	Yes	No
HIV/AIDS	Yes	No	Asthma/Hay Fever	Yes	No
Other	Yes	No			

Please explain any of the above items circled "yes":

____

____

____

B. Biological Mother

Name ____Age: __________

Occupation____

Please circle (yes) or (no) as it applies to the biological father:

Diabetes	Yes	No	Hypertension	Yes	No
Heart Disease	Yes	No	Mental Illness	Yes	No
Stroke	Yes	No	Alcoholism	Yes	No
Cancer	Yes	No	Drug Use/Abuse	Yes	No
Chronic Illness	Yes	No	Seizures/Epilepsy	Yes	No
Hearing Loss/Deafness	Yes	No	Hepatitis	Yes	No
HIV/AIDS	Yes	No	Asthma/Hay Fever	Yes	No
Other	Yes	No			

Please explain any of the above items circled "yes":

____

____

____

C. Biological Siblings (Brothers and Sisters)

Name____Age________

Name____Age________

Name____Age________

Please circle (yes) or (no) as it applies to the siblings:

Diabetes	Yes	No	Hypertension	Yes	No
Heart Disease	Yes	No	Mental Illness	Yes	No
Stroke	Yes	No	Alcoholism	Yes	No
Cancer	Yes	No	Drug Use/Abuse	Yes	No
Chronic Illness	Yes	No	Seizures/Epilepsy	Yes	No
Hearing Loss/Deafness	Yes	No	Hepatitis	Yes	No
HIV/AIDS	Yes	No	Asthma/Hay Fever	Yes	No
Other	Yes	No			

Please explain any of the above items circled "yes":

____

____

____

D. Medical background of significant others (Please explain any medical, emotional, or physical difficulties and include what relationship the person(s) has to the child)

____

____

____

3. *Medical history of applicant (child)*

Does the child have any allergies to medications, foods, or other antigens (e.g. dogs, grass, pollen)?

____

____

Please indicate if the child has had the following illnesses:

Diabetes	Yes	No	Hypertension	Yes	No
Heart Disease	Yes	No	Mental Illness	Yes	No
Stroke	Yes	No	Alcoholism	Yes	No
Cancer	Yes	No	Drug Use/Abuse	Yes	No
Chronic Illness	Yes	No	Seizures/Epilepsy	Yes	No
Hearing Loss/Deafness	Yes	No	Hepatitis	Yes	No
HIV/AIDS	Yes	No	Asthma/Hay Fever	Yes	No
Other	Yes	No			

Please explain above items circled yes and include age/date:

____

____

Please circle (yes) or (no) as it applies to the child:

Head injuries	Yes	No	Surgery	Yes	No
Concussion	Yes	No	Headaches	Yes	No
Accidents	Yes	No	Stomach Pain	Yes	No
Cancer	Yes	No	Rectal bleeding	Yes	No
Hay fever	Yes	No	Heart palpitation	Yes	No
Allergies	Yes	No	Heart Murmur	Yes	No
Earaches	Yes	No	Hearing Loss/Deafness	Yes	No
Drug reactions	Yes	No	Hearing difficulty	Yes	No
Hospitalizations	Yes	No	Sore throats	Yes	No

Ulcers	Yes	No	Eating disorders	Yes	No
Frequent colds	Yes	No	Seizures	Yes	No
Tonsil infections	Yes	No	Moles	Yes	No
Pneumonia	Yes	No	Scars	Yes	No
Persistent Cough	Yes	No	Acne	Yes	No
Rash/skin infections	Yes	No	Heart problems	Yes	No
Asthma	Yes	No	Bone/joint pain	Yes	No
Enuresis (bed wetting)	Yes	No	Back problems	Yes	No
Encopresis (soiling)	Yes	No	Broken bones	Yes	No
Urinary problems	Yes	No	Speech problems	Yes	No
Fainting/dizziness	Yes	No	Sleep difficulties	Yes	No
STD's	Yes	No	Musculoskeletal braces	Yes	No
Diarrhea	Yes	No	Cold Sores	Yes	No
Constipation	Yes	No	Hepatitis	Yes	No
Vomiting	Yes	No	HIV/AIDS	Yes	No
Physical Disabilities	Yes	No	OTHER	Yes	No

Please list age/date, or further explain, any of the above items circled (yes):

____

____

____

If yes to deafness/hearing loss:

Age when first discovered _______ By whom? ______________________________

Age when first acquired language _____ Type of language acquired _____________

Child's preferred language ______________Parent's preferred language __________

If either parent or child uses SIGN, what method?

____

Other methods of communication used by child

____

Family history of deafness/hearing loss? Yes No

If yes, explain____

Is child comfortable with use of interpreter? Yes No

6. *Optometric history of child*

Date of last ophthalmologic (eye) or optometric exam: ________________________

Name/address of physician:____

Wears glasses	Yes	No		
All the time	Yes	No		
Close work only	Yes	No		
Wears contacts	Yes	No	If yes, are they: Soft _____	Hard ____

Other eye problems (if any):

____

____

7. *Please circle (yes) or (no) as it applies to the child's hearing*:

Wears hearing aids	Yes	No
All the time	Yes	No
Bilateral	Yes	No
Other _______________		

If yes, please explain type of device: _______________________________________

Date of last audiogram: _____________ Date of last fitting: ____________________

Name of audiologist: ____

Address: ____

8. *Please circle (yes) or (no) as it applies to child's dental condition*:

Gum problems	Yes	No	Pain	Yes	No
Braces	Yes	No	Cavities	Yes	No
Dental work needed	Yes	No	Other	Yes	No
Wisdom teeth removed	Yes	No			

Please explain the above items circled (yes): _________________________________

____

Date of last dental exam: ______________

Name/address of dentist:____

____

9. Please *circle (yes) or (no) as it applies to child's current or past substance use:*

Tobacco use	Yes	No	Narcotics use	Yes	No
Alcohol use	Yes	No	Cocaine use	Yes	No
Marijuana use	Yes	No	Inhalants use	Yes	No
Amphetamine use	Yes	No	Other substances	Yes	No

Please explain the above items circled yes (include age at which use began, degree of use, specific substances used):

____

____

10. *Is the child taking any kind of prescription medication:* Yes No If yes:

(1)
Name of medication ______________________Dosage (strength):_________________

How often:________________________For treatment of: _______________________

Prescribed by Dr. ____
Address: ____

(2)
Name of medication ______________________Dosage (strength):_________________

How often:________________________For treatment of: _______________________

Prescribed by Dr. ____
Address: ____

(3)
Name of medication ______________________Dosage (strength):_________________

How often:________________________For treatment of: _______________________

Prescribed by Dr. ____
Address: ____

(4)
Name of medication ______________________Dosage (strength):_________________

How often:________________________For treatment of: _______________________

Prescribed by Dr. ____
Address: ____

11. *Has the child been seen by a psychologist or psychiatrist*: Yes No

Date of last session: _________________________

Name and address: ____

Reason for treatment: ____

____

12. *Primary physician's name*: ____

Address: ____

13. Special medical problems, medical instructions, or any other relevant information not already provided:

____

____

____

____

14. *The Cathedral Home for Children is fortunate to be able to provide quality medical care for your child on site with the services of both a psychiatrist and a family nurse practitioner. In the event that your child needs to be seen by another health care provider, is there any **in the Laramie area** whom you would like to designate as your child's preferred medical provider?*

YES NO

If yes: Name of designated physician:__________________________________

Address:______________________________Phone: _______________________

Name of designated dentist: ____

Address:______________________________Phone: _______________________

Name of designated eye care provider:__________________________________

Address:______________________________Phone: _______________________

Name of designated audiologist: ______________________________________

Address:______________________________Phone: _______________________

Are there specialty medical providers who your child needs to be seen by?

YES NO

Name: ____

Specialty: ______________________

Address:_____________________________Phone: _______________________

If this specialist(s) is outside of the Laramie area, would you be willing to help transport your child to and from the specialist(s)? YES NO

CATHEDRAL HOME FOR CHILDREN
MEDICAL AUTHORIZATION

I hereby authorize Cathedral Home for Children to obtain emergency medical treatment for ____. I can be reached at (phone) ______________________________ and I understand that I will be notified should such treatment be necessary.

____
Signature of Parent or Guardian

____
Relationship to Minor Child

____
Date

Cathedral Home for Children
P.O. Box 520
Laramie, Wyoming 82073
(307) 745-8997

CATHEDRAL HOME FOR CHILDREN
CONSENT FOR TREATMENT

I, ____ grant my permission for
(Name of parent or guardian)
designated personnel of Cathedral Home for Children to provide the necessary treatment services for my child, _____________________________________.

____
Signature of Parent or Guardian

____
Relationship to Minor Child

____
Date

Cathedral Home for Children
P.O. Box 520
Laramie, Wyoming 82073
(307) 745-8997

CATHEDRAL HOME FOR CHILDREN
RELEASE OF EDUCATION RECORDS AND INFORMATION

Student Name ______________________________________ DOB ___________________

I do hereby consent and request:

____
(Name of Educational Program)

____
(Address)

____
(City, State, Zip Code)

to release the following records:

________ Special education records (IEP objectives, handicapping condition, MDAT report, permission for placement, etc)
________ Enrollment and withdrawal dates, with current grade placement
________ Immunization and health records
________ Psychological testing results/Achievement testing results
________ Grades and/or transcripts
________ Progress reports

to:

Cathedral Home for Children
Director of Education
P.O. Box 520
Laramie, Wyoming 82073-0520

I authorize the release of the above requested information:

Signature of legal guardian: ____

Address: ____

Date ______________________

NOTE: Please fill out a separate release form for each school or educational program the student has attended.

CATHEDRAL HOME FOR CHILDREN
WILDERNESS PROGRAM AUTHORIZATION
FOR PARTICIPATION - RISK RELEASE

Resident's Name: ______________________________________

Cathedral Home periodically conducts wilderness trips in a variety of areas of the western United States. While staff and residents will be traveling in a wilderness environment, each trip is very carefully structured to ensure safety.

We would like permission for the above resident to participate in the CHC Wilderness Program and to travel on these trips, both in and out of state.

During a CHC wilderness course your son/daughter may be exposed to activities and risk which are different from those encountered during day to day school activities. Some activities that the students may be involved with include camping, carrying backpacks, initiatives, climbing, orienteering, swimming, canoeing and river rafting. Each of these involve some risks. Our staff work to control these risks through instructions, proper equipment and supervision. Despite our preparation and training, we cannot guarantee absolute safety against these risks and unforeseen accidents. It is vital that each student also share in the responsibility for a safe program.

Your signature signifies that you have read the above, and have determined that your child is able to participate in the program. If you have any specific questions about the CHC Wilderness Program, please feel to contact Dann Harvey, CHC Boys' Cottage Director at (307) 745-8997.

____
Signature of parent or legal guardian

Date ______________________________________

PHOTOGRAPH, VIDEO, ARTWORK, AND WRITINGS (OF RESIDENT) PUBLICITY CLEARANCE/USE CONSENT FORM

I, _____________________ , the parent or legal guardian of ________________ , (hereafter "Resident"), grant to Cathedral Home for Children, Laramie, Wyoming, its successors and assigns, the right to use and publish for advertising, promotional and fundraising purposes, photographic portraits or any photographic likeness or picture of Resident. Resident may be included in the portraits, any photographic likeness or pictures in whole or in part, in composite or other form, in color or otherwise, make and published through any medium, including but limited to print, video and the Internet.

I waive on behalf of Resident any right to inspect or approve the finished product or the copy that may be used in connection therewith or the use to which it may be applied.

I release and discharge on behalf of such Resident such photographers, videographers or Internet "page designers" and Cathedral Home for Children, their successors and assigns, and all persons acting under their permission or authority from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form whether intentional or otherwise, that may occur or be produced in the taking of the pictures or videos, or in any processing tending toward the completion of the finished product.

In addition to the rights granted herein, I further grant to Cathedral Home for Children the non-exclusive right to reproduce or publish original works of authorship (graphic and/or text) of Resident, for the exclusive purposes of advertising, promotion and fundraising purposes, PROVIDED, HOWEVER, this grant shall not be considered an assignment of copyrights whatsoever in said original works of authorship.

Additionally, I and the resident have been made aware that Resident has the right to request cessation of recording/filming at any point in time of recording/filming and has the right to rescind consent for use of the film, photographs, likenesses, artwork, etc. up to 30 days before actual use.

DATED THIS _____________day of ______________ 20__.

______________________________ ______________________________
Signature of Resident Signature of Parent/Guardian

____
Signature of Cathedral Home for Children Representative

If you have any questions regarding this form or the video, please contact:
Marketing Department
Cathedral Home for Children
P.O. Box 520
Laramie, WY 82073
Phone (307) 745-8997
info@cathedralhome.org

AUTHORIZATION TO RELEASE TREATMENT INFORMATION
FROM CATHEDRAL HOME

Cathedral Home for Children
P.O. Box 520
Laramie, WY 82073

Resident Name: ___________________________
Social Security # __________________________
Date of Birth: _________ Phone: ___________
Address: _________________________________
City/State/Zip: ___________________________

****

Please obtain information from the following:___________**Cathedral Home for Children**_________
Please send my treatment information **to**: ____

Name of Practitioner:____

Name of person requesting information____
Name of Clinic/Hospital/Treatment Facility, etc.:_____________________________________

****

I authorize the above-named facility to release all of my medical and/or mental health records:

Specific information: ____

Date(s): ____

I specifically authorize the release of information pertaining to drug and alcohol abuse records:
Purpose of this release is for: (check one or more)

( ) Billing and payment of bill
( ) Continuity of care and discharge planning
( ) Other: ____

My consent may be revoked at any time. The only exception is when the information has already been released as instructed in the consent. If not previously revoked, this consent will terminate one (1) year after the date of my signing it. A photocopy or faxed copy of the release may be used in place of the original.

____ _______________
Signature Date

____
Parent/Legal Guardian Signature (if needed)

I specifically authorize the release of HIV/AIDS testing information, if this is a part of my record.

____ _______________
Signature Date

____
Parent/Legal Guardian Signature (if needed)

AUTHORIZATION TO RELEASE TREATMENT INFORMATION
TO CATHEDRAL HOME

Cathedral Home for Children
P.O. Box 520
Laramie, WY 82073

Resident Name: ___________________________
Social Security # __________________________
Date of Birth: _________ Phone: ___________
Address: _________________________________
City/State/Zip: ___________________________

****

Please obtain information from the following:____
Please send my treatment information **to**: _________**Cathedral Home for Children**_______________

Name of Practitioner:____

Name of person requesting information____
Name of Clinic/Hospital/Treatment Facility, etc.:____

****

I authorize the above-named facility to release all of my medical and/or mental health records:

Specific information: ____

Date(s): ____

I specifically authorize the release of information pertaining to drug and alcohol abuse records:
Purpose of this release is for: (check one or more)

( ) Billing and payment of bill
( ) Continuity of care and discharge planning
( ) Other: ____

My consent may be revoked at any time. The only exception is when the information has already been released as instructed in the consent. If not previously revoked, this consent will terminate one (1) year after the date of my signing it. A photocopy or faxed copy of the release may be used in place of the original.

____ _________________
Signature Date

____
Parent/Legal Guardian Signature (if needed)

I specifically authorize the release of HIV/AIDS testing information, if this is a part of my record.

____ _________________
Signature Date

____
Parent/Legal Guardian Signature (if needed)

CATHEDRAL HOME FOR CHILDREN
P.O. Box 520
Laramie, WY 82073
(307) 745-8997

CONSENT FOR THE EXCHANGE OF CONFIDENTIAL INFORMATION

I, ______________________ of ____
(Client's Name) (Client's Address)

authorize Cathedral Home to keep__________________ of ______________________
(Location)

informed about my treatment at Cathedral Home. This may include letters or telephone

conversations about my diagnosis, prescribed treatment, and response to treatment.

I understand that my records are protected under federal and specific state confidentiality laws and regulations and cannot be disclosed without my written consent and that in any event this consent expires automatically if

(1) I request that no further communication between these parties occur, or

(2) I terminate my treatment at cathedral home

______________________________ __________
Patient's Signature Date

______________________________ __________
Legal Guardian Date

______________________________ __________
Witness Date

CONSENT FOR MEDICAL CARE

I hereby authorize the Cathedral Home for Children (CHC) to obtain any necessary medical treatment for the following resident:____from the following individuals (1-8), unless any of these individuals has been marked through with a line and is followed by my initials:

1. CHC Nurse Practitioner
2. CHC Medical Director
3. Resident's designated physician, nurse practitioner, dentist, eye care provider, and audiologist.
4. CHC designated physician, nurse practitioner, dentist, eye care provider, and audiologist.
5. Emergency room personnel.
6. Psychiatrist
7. Psychologist
8. Hospital Personnel

I understand that the term, necessary medical treatment, pertains to the following items (1-9), and I give consent for each of these items, unless individual items are marked through with a line and followed by my initials:

1. Comprehensive history and physical exam
2. Screening exams that are deemed necessary during or after the history and physical
3. Recommended vaccinations
4. Acute illness care
5. Chronic illness management
6. Emergency medical treatment
7. Hospitalization, including psychiatric
8. Recommended dental and eye care
9. Psychological Testing/Psychiatric mental assessment

I can be reached at (phone) _____________________ and understand that I will be notified should emergency treatment be necessary and before any non-routine medical care (e.g. surgery, orthodontics, treatment of a new major medical illness) is initiated.

____ ___________________

Signature of Parent or Guardian Date

____

Relationship to Minor Child

____

DFS Signature

____

Person giving consent

Cathedral Home for Children
Medical Payment Information

Resident Name:____

DOB: _______________ SS#:_________________ Grade Level:_______
(The above information is essential for placement)

The resident has Medicaid: ___Yes ___No
Medicaid #_______________________

The resident has private insurance: ___Yes ___No
(NEED COPY OF CARD BOTH FRONT AND BACK)

Name of Insurance:____
Address & Phone #:____
____
Name of Insured:____
Address & Phone #:____
____
DOB of Insured:____________
SS# of Insured:_____________
Place of Employment:____
Address & Phone # :____
____

The above insurance covers: ___Medical ___Dental ____Optical

If you have separate coverage for dental or optical please give copies of all necessary cards front and back.

If you have any questions regarding any of this information needed, please contact:

Medical Service Manager
Cathedral Home for Children
PO Box 520
Laramie, Wy 82073
307-721-1574

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

NAME: ___________________________________ Date of Birth: _________________

As a resident of Cathedral Home for Children (CHC) you will receive a range of services that will be determined following an initial assessment and thorough discussion with your counselor and treatment team. The goal of the assessment process is to determine the best course of treatment. Typically, treatment is provided over the course of several months. The purpose of treatment is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be ready to talk to a counselor or therapist about these problems. Or, you may be here because your parent, guardian, doctor or teacher had concerns about you. When you meet with your counselor and treatment team, you will discuss these problems. They will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking about the issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor and treatment team. Privacy, also called confidentiality , is an important and necessary part of treatment. Most of the information you share with the staff at CHC is confidential and no information will be released outside the agency without written consent from your parent or guardian if you are under 18 years of age, or by yourself if you are an adult. There are, however, important exceptions to this rule that are important for you to understand before you share personal information in therapy. Confidentiality cannot be maintained when:

- You tell someone you plan to cause serious harm or death to yourself. Steps must be taken to inform a parent or guardian of what you have disclosed and how serious this threat is believed to be. We must make sure that you are protected from harming yourself.
- You tell someone you plan to cause serious harm or death to someone else who can be identified. Steps must be taken to inform a parent or guardian of what you have disclosed and we must inform the person who you intend to harm.
- You are doing things that could cause serious harm to you or someone else, even if you do not *intend* to harm yourself or another person. In these situations, we will need to use professional judgment to decide whether a parent or guardian should be informed.
- You tell someone you are being abused - physically, sexually, or emotionally - or that you have been abused in the past. In this situation, we are required by law to report the abuse to the Wyoming Department of Family Services.
- You are involved in a court case and a request is made for information about your therapy. If this happens, we will not disclose information without your written agreement *unless* a court requires us to do so. If we are required by the court to disclose information, our attorney will review the validity of this request.

There may be times when your counselor and/or treatment team feel that it would be important for your parents to know what is going on in your life. In these situations, we will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents,

we may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

Services

The psychological services we provide include individual, family, and group therapy, as well as psychological testing. Psychotherapy is not easily described in general statements. It varies depending on the personalities of the counselor and client, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy calls for an active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees of what you will experience.

Your counselor and treatment team will offer you some sense of what therapy will entail and how they will work with you to address your concerns. If you have questions about your program, you should discuss them with your counselor whenever they arise. You have the right to ask for the rationale for any aspect of your treatment or to decline any part of your treatment.

When you participate in testing, you have the right to an explanation of what the test or tests being administered are for and how they contribute to your treatment program, and you may decline participation at any time. You also have the right to a summary (which may be either verbal or written) of any test results. This testing gives us the basis for knowing you and how to get you through your treatment program as quickly as possible.

Individual counseling appointments are generally for 50 minutes and are typically scheduled once per week. Therapy group usually meet once a week for approximately 60 minutes. Before joining a group you must meet with one of the counselors to discuss your participation in the group and any questions or concerns you may have.

A range of mental health professionals, some of whom are in training, provide services at CHC. All professionals-in-training are supervised by licensed staff.

While psychotherapy and/or medication, may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications may have unwanted side effects.

As part of your program at CHC you may participate in recreation and/or wilderness therapy activities. Research has shown that these types of activities provide significant benefits for physical, emotional, and psychological health. There are risks inherent in these activities, and while every precaution is taken to minimize these risks, the potential exists for unintended outcomes or injury. Some of these unanticipated outcomes are reportable events to our accrediting agency (JCAHO). If you have a safety or quality of care concern that is not resolved by our administration, we encourage you to call the commission at 630-792-5264.

Professional Records

The laws and standards of our profession require that we keep Protected Health Information (PHI) about you in your clinical record. You clinical record includes information about your reasons for placement at CHC, a description of the ways in which your problem affects your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, results of clinical tests, any past treatment records that we receive from other providers, reports of any professional consultations, and copies of any reports that have been sent to anyone. Because these are professional records, they can be misinterpreted and/or upsetting to read. If you wish to review them, we will arrange for you to review them in the presence of your therapist or Director, or have them forwarded to another mental health professional with whom you can discuss the contents. Your clinical record serves as a:

- basis for planning your care and treatment
- means of communication among the health professionals who may contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided

Minors

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. Before giving parents any information we will discuss this with you, if possible, and do our best to handle any objections you may have with what we are prepared to discuss.

Conclusion

Your signature below indicates you have read this information and agree to abide by its terms during your placement at Cathedral Home.

____ ___________________

Signature of resident (parent/guardian) Date