Catholic Charities
Diocese of Covington

3629 Church Street
Covington, KY 41015

Dear Parent or Guardian,

The counseling program in this school offers services to children whose parents or teachers refer them. Typical reasons for a referral include concerns about a child's social skills, mood (for instance, unhappy or apathetic), maturity level, or difficulties at home, (for instance constant uncooperative or negative behavior.) All counselors are employees of Catholic Charities, which contracts with the school to provide counseling services.

If you wish to refer your child/ren to the program, please return the permission slip at the bottom of this page. I will try to see your child as soon as possible, but since a number of children are usually referred for assessment, it may take a few weeks. If your child needs help urgently, please call and let me know so that I can make your child a priority (859-581-8974).

When I receive the permission slip, the "Rights and Responsibilities" form and the "General Consent" form from you (see attached), I will call you so that we can discuss your concerns about your child. I will also talk with your child's teacher to get a better idea of how your child is doing in class.

My visits with your child will be 30-45 minutes in length, at a time that the teacher feels will be least disruptive. It may take up to four visits for me to get to know your child well enough to make a recommendation, and since I am not at the school daily, this process may take four to six weeks. During this time I may call you to share my insights and recommendations and to discuss any further concerns.

I am eager to work with the teachers and principal to make the school environment as supportive as possible for each child's emotional health. I may need to share important information about your child or the family situation directly with his/her teacher and/or principal, if it relates to the child's classroom performance and behavior.

I hope this information is helpful. **Please sign this permission slip, general consent form and read the rights and responsibilities forms in blue or black ink. Return them in the enclosed envelope to me at Catholic Charities (address on envelope), or return them to the school office as soon as possible.**

Sincerely,

School Counselor

I grant PERMISSION to our school's counselor from Catholic Charities to meet with and assess my child or my children on school premises during the school day. I also grant permission to the counselor to review my child/ren's school records, previous catholic charities school counseling records, and to obtain any information relating to my child/ren from his/her teacher or principal. I have read, and understand, the Client Rights and Responsibilities (**on the other side**), regarding this service.

****If you would like more than one child to be seen by the school counselor, please list all their names below.****

Child and/or Children's Name(s)	School
Parent's Name (Printed)	Date
Parent's Signature required in blue or black in	Case #

CLIENT RIGHTS AND RESPONSIBILITIES

Because of our interest assisting you in meeting your needs, and protecting your privacy under the Health Insurance Portability and Accountability Act of 1996, we have identified what we consider to be your essential rights in making use of our services, as well as equally important responsibilities which will make it possible for you to fully benefit from the particular service environment in which you will be participating. These rights and responsibilities are listed here and in the attached Notice of Privacy Practices for your information. You will be asked to read and sign this notice of Client's Rights & Responsibilities as well as a General Consent which allows Catholic Charities to share certain aspects of your protected health information for treatment, billing and health care operations. Your understanding of and signature on these two documents will be necessary prior to the provision of services.

RIGHTS

√ ***The right to know***

You have the right to know about and understand as completely as possible the intended results and effects, both positive and negative, of any kind of professional service in which you participate. As professional human service providers, we are strongly committed to an approach in which our clients are seen as partners in a learning, healing, and growing endeavor. We make a consistent effort to develop a service plan with you which is responsive to your needs in a direct, open, and collaborative manner. We also encourage you to ask questions about what you experience or to voice any concerns you have about the professional approaches we may use in moving toward the solutions you seek.

√ ***The right to confidentiality***

Since the focus of our work together involves areas of your life that can be very sensitive and personal, we are totally committed to serving you in a manner which respects your rights to privacy and confidentiality. We cannot disclose any information that you have given us in using the services which we offer without your permission. We will only share information with other outside professionals or receive records of your work with them if we have your written consent.

There are, however, legally mandated exceptions to this policy, one of which involves disclosure concerning abuse and neglect. As human service professionals, we are required by law and ethical mandate to report a reasonable suspicion of abuse or neglect to appropriate legal jurisdictions. In addition we are required to report our concerns should we suspect self-harm might come to a person with whom we are assisting, or that that person may harm another.

√ ***Graduate Internships***

Catholic Charities is a training facility engaging graduate interns who bring with them the latest in helping technologies from accredited programs at the colleges and universities in our area. An intern may be assigned as your service provider. Should an intern be assigned as your service provider you will be informed.

√ ***The right to complain***

If you are dissatisfied with your treatment or the services you receive, you have the right to contact the Executive Director and file a formal complaint. Should you choose to do so, you need to simply write or call the Executive Director. We treat these complaints very seriously and make every effort to resolve them in a just and fair manner.

√ ***The right to refuse or terminate service***

Since the professional services which we offer are voluntary in nature, you have the right to say no to any recommendations or approaches that are offered to you. In addition, you also have the right to decide how long you want to make use of our services and to terminate that service. (See below: *Termination of Services)*

RESPONSIBILITIES

√ ***Termination of Services***

If you decide to terminate service, we ask that you make this known directly to your service provider. While we respect your right to terminate services, ending can be an important step, so we encourage you to talk this decision over with your service provider. Discussing this decision can be an opportunity for mutual learning.

It is your responsibility to maintain sobriety and abstinence from drugs and/or alcohol while attending sessions and/or groups at CC. Should professional judgment determine that you are under the influence of a substance, including prescriptions drugs that are preventing you from being cognitively aware during sessions, services will be postponed until immediate sobriety is recovered. The professional staff may offer a referral for extensive chemical dependency services and/or detoxification.

Professional judgment towards safety considerations for clients and staff, and liability implications, will be made should you leave on your own under the influence, which could include legal interventions.

School Counseling General Consent & Client Information

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This form must be completed and signed for your child to see the School Counselor. This information is kept confidential. Please complete form in black or blue ink only.

Child's Name: _____ School: _____ Teacher: _____

Grade: _____ DOB _____ State & County of birth: _____

Address: _____ City: _____ Zip Code: _____

Parents'/Guardian's Names: _____

Occupation_____ Parent's Date of Birth _____

Household Income (Please check one): □10,000-14,999 □15,000-19,999 □20,000-29,999 □30,000-39,999 □40,000-49,999 □50,000-59,999 □60,000-69,999 □70,000-79,999 □80,000-89,999 □90,000 or over

Medical Insurance provider_____ Primary Dr._____

Type of Custody: □ Full, □ Joint, □ Temporary (If joint, please list name and phone number of joint parent): _____

Other services your child is involved with (Please check all that apply):

□ Case worker_____, □ Counselor/psychologist/psychiatrist_____

**To adhere to best practice in the delivery of mental health services a release of information may be requested to speak with these professionals.*

I wish to be contacted by Provider in the following manner (<u>please check all areas that would be an acceptable manner to contact you</u>);

- □ Home _____
- □ Cell _____
- □ Work _____
- □ fax information:_____
- □ Student Cell phone(optional)_____

Must check one of the 2 below options to receive end of service satisfaction survey:

- □ Email:_____
- □ Can mail information to my above home address

□ Provider may leave their name and phone number <u>only</u> when they reach a machine or with a person for numbers checked above.
□ Provider may leave a detailed message when they reach a machine or with a person for numbers checked above.

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1. Have there been any significant changes in your family situation recently? (moves, divorce, separation/custody change, new school, death/serious illness) Please explain:

2. Has anything happened to your family or your child that has caused distress? If yes please explain

3. List who lives in the home and how does your child relate to them?

Turn Over To Complete Case # _____

4. How does your child relate to peers?

5. What are your child's strengths?

6. How does your child perform academically? (grades, does not work to potential, learning challenges)
Comments:

7. Does your child have any medical or mental health conditions/diagnosis? Please list any medications your child takes regularly.

8. Is there a family history of medical/mental health /substance abuse? ___Yes ____No
Please explain:

9. Please check any of the following that apply to your child:

_____ Sleep disturbance (can't fall asleep, up too early, up at night)	_____ Fearful of new people/places/school	_____ Cries easily, often
_____ Oppositional: complying with bedtime, house rules, refusal to go to school, other	_____ Easily distracted/fails to finish things	_____ Feelings easily hurt
_____ Complains of body aches	_____ Daydreams	_____ Bullies others
_____ Bowel/urinary problems	_____ Impulsive behaviors (acts before thinking)	_____ Regressive behaviors: baby talk, whining/constant reassurance, sucks/chews on things
_____ Appetite concerns	_____ Always on the go/restless/squirmy	_____ Speech difficulty
_____ Behavior Problems	_____ Disturbs others	_____ Let's self be pushed around
_____ Problem making/keeping friends	_____ Irritable/quarrelsome	_____ Frequently tells lies/stories that are untrue
_____ Worries more than others	_____ Destructive/steals	_____ Substance use (specify below)

Please offer further explanation to any checked items and what you would like to see change for your child:

I understand that the services my child will receive while a client of Catholic Charities (Provider) are contingent upon my signature on this consent document.

Print Name of Authorized Parent/Guardian (if under 18)_____

Relationship to Client □ Parent □ Legal Guardian □ Other_____

Parent/Guardian Signature_____Date_____

CC Worker Signature_____Date_____

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