Allendale

ALLENDALE SCHOOL EMERGENCY INFORMATION

STUDENT NAME: _____

BIRTHDATE: _____

ADDRESS: _____

_____

GUARDIAN PHONE: _____ **GUARDIAN EMAIL ADDRESS:** _____

Parent/Guardian Information:

_____ _____
Name Relationship to Student

_____ _____
Name Relationship to Student

1) Place of Employment: ☐ Mother ☐ Father ☐ Other: _____

_____ _____
(Name of Company/Employer) (Telephone Number - include area code)

_____
(Cell Phone Number/ Pager number)

2) Place of Employment: ☐ Mother ☐ Father ☐ Other: _____

_____ _____
(Name of Company/Employer) (Telephone Number-include area code)

_____
(Cell Phone Number/ Pager number)

Allergies: _____

Other Medical Concerns: _____

Family Physician: Name: _____

Address: _____

Phone: _____

Insurance Company: _____ **Policy Number:** _____

***Copy of Insurance Card**

Does your child take medication on a regular basis? ☐ Yes ☐No

If yes please list medication, purpose, and name and number of prescribing physician:

_____

_____

Name: _____ Phone: _____

EMERGENCY NUMBER FOR: ☐ Mother ☐ Father ☐ Other: _____

_____
(Please include area code)

Contact person who can give emergency consent if parent is not available:

Name: _____ Relationship: _____

Address: _____
(Street) (City/State/Zip)

Phone: _____

Educational Service Agreement for Therapeutic Day School

Parental Responsibilities:

_____ of _____
(Name of Parent/Guardian, relationship) *(Name of Student)*

residing at _____
(Address, Street, City, State, Zip Code)

1. **Parental Participation Responsibilities:**
   a. I agree to attend all required staffings at Allendale Stepping Stone and/or LINC.
   b. I agree to participate in clinical consultation with the Allendale team.
   c. I agree to the best of my ability to let Allendale know how they can best support my child.
   d. I agree to become familiar with the therapeutic approach utilized at Allendale Stepping Stone and/or LINC.

2. **Parental Financial Responsibilities:**
   a. I agree to be responsible for all medical, dental and vision expenses incurred during the school day. The student's insurance coverage(s) are:

      1. Name of Insurance Company:_____
         Name of the policy holder:_____
         Policy Number:_____
         Phone Number:_____

      2. Name of Insurance Company:_____
         Name of the policy holder:_____
         Policy Number:_____
         Phone Number:_____

      3. Name of Insurance Company:_____
         Name of the policy holder:_____

Policy Number:_____

Phone Number:_____

b. ☐ My son/daughter is eligible for the reduced or free lunch program. I have completed an application.

☐ My son/daughter is not eligible for the free lunch program. I understand I will be charged $2.50 per day on a monthly basis for meals my child eats. I understand that payment is expected monthly.

c. I agree to provide paper, pencils, and other school supplies as required.

d. I agree to reimburse the school for damages to property incurred while my son/daughter is a student at Allendale Stepping Stone and/or LINC.

_____ _____

Signature of Parent/Guardian Date

Allendale—Stepping Stone/LINC Responsibilities:

Stepping Stone/LINC will:

1. **Education:**
   a. Implement goals and objectives as outlined in the IEP.
   b. Submit regular and routine reports for regularly scheduled staffings and other necessary reports the district may require.
2. **Clinical:**
   a. Provide clinical consultation, individual therapy, group therapy, and other family-supportive services as requested.
   b. Provide psychiatric and auxiliary services as needed.
   c. Provide information to parents regarding the treatment programming at Allendale.

3. **Case Management:**
   a. Inform parents and school district of dates and times of multidisciplinary staffing reviews.
   b. Regularly inform parents and school district representatives of placement progress.
   c. Conduct multidisciplinary staffings at regular intervals.
   d. Develop agreed-upon Life Plan and Discharge Goal.

_____

Signature of Therapeutic Day School Director

ALLENDALE ASSOCIATION
Services Consent Form

Therapeutic Day School ☒

Date: _____

Name: _____ ID#: _____

Birth Date: _____ Admission Date: _____

Guardian: _____ Program: _____

The proximity of the placement was reviewed upon pre-placement with the legal guardian and/or referring agency. The consensus of the Intake Committee was _____ is the most appropriate placement based upon the needs of the client in order to provide for his/her physical, social, educational, and emotional needs at the time of the admission.

Prior to the initiation of mental health services, Allendale Association shall obtain written or oral consent for these services demonstrating that the client or guardian, as applicable, knows all of the risks and costs involved in the treatment, including the nature of the therapeutic service, possible alternative services, and the potential risks and benefits of the services provided.

Allendale Association in providing therapeutic service/education to its clients, residents, and students, needs the authorization of the client, resident, student, and/or guardian in order to provide comprehensive therapeutic/educational services. Authorization is valid for one year and may be revoked at any time. **Please review each area needing authorization and indicate your wishes by placing an "X" in the appropriate box, and signing your initials.**

I/We the undersigned, hereby authorize Allendale Association to:

	Yes	No	N/A	Client Initial	Guardian Initial
Consent For All Routine Rehabilitative Services: I consent to the use of therapeutic service/education deemed advisable and in accordance with professionally accepted methods. I understand that the therapeutic service will include clinical consultation, individual and group therapy, and case management.	☐	☐	☐	_____	_____

Informed Consent Regarding Allendale's Behavior Management Techniques

Allendale's approved Behavior Management Techniques have been provided to me in a language I can understand. Questions I had regarding the techniques have been addressed. I understand that manual (physical) restraint may only be used when a youth presents a threat of physical harm to self or others. I consent to use of Allendale's approved behavior management techniques.

Yes	No	N/A	Client Initial	Guardian Initial
☐	☐	☐	_____	_____

Guardian Notification

Guardians will be notified if their child has displayed dangerous behaviors to self or others which may include time out and/or Physical restraint.

Yes	No	N/A	Client Initial	Guardian Initial
☐	☐	☐		

Informed Consent Regarding Allendale's Universal Rules

Allendale's Universal Rules have been explained and provided to me in a language I can understand. Questions I have regarding the rules have been addressed. I have received a written copy of the rules (in the School Handbook).

Yes	No	N/A	Client Initial	Guardian Initial
☐	☐	☐	_____	_____

Programmatic Searches

I have been advised that as part of Allendale's programmatic protocol, searches of students' belongings will be performed upon entry to the school and as deemed necessary**.**

Yes	No	N/A	Client Initial	Guardian Initial
☐	☐	☐	_____	_____

Permission to Search Student

I authorize Allendale staff to search a student for the purpose of determining possession of and/or confiscating illegal drugs, lethal weapons, fire-setting paraphernalia, or any item/substance which is potentially harmful to students, staff, or the school milieu.

Yes	No	N/A	Client Initial	Guardian Initial
☐	☐	☐	_____	_____

Mental Health Assessment

I consent for Allendale staff to interview and review records to determine need for mental health services and for establishing an Individual Treatment Program.

Family Assessment/Family Services

I consent for Allendale staff to conduct a family assessment/ social history including significant others as identified by the youth and family. I agree to participate in Clinical Consultations, the primary therapeutic intervention at Allendale. I understand that the levels of family service available may include, but are not limited to, Clinical Consultation and family therapy.

Yes	No	N/A	Client Initial	Guardian Initial
☐	☐	☐	_____	_____

Administration of Medication

I consent for authorized staff to administer medication as part of care and treatment under the direct supervision of Allendale's licensed medical consultant and at the direction of Allendale's registered nurse. A physician's order is required in order for any medication (prescription or over the counter) to be administered.

Yes	No	N/A	Client Initial	Guardian Initial
☐	☐	☐	_____	_____

Routine Medical/Dental

I consent for Allendale staff to provide routine first aid as defined and required by state licensing standards for child care institutions.

Yes	No	N/A	Client Initial	Guardian Initial
☐	☐	☐	_____	_____

Emergency Medical/Dental

I consent for Allendale staff to provide emergency medical/dental treatment and care including Emergency Room Care and/or hospitalization in those instances where it is not possible or feasible to secure the express consent of the guardian beforehand.

Yes	No	N/A	Client Initial	Guardian Initial
☐	☐	☐	_____	_____

Psychological and Psychiatric Evaluations

I consent for licensed Allendale staff to complete psychological and psychiatric evaluations when deemed appropriate for treatment and educational planning. Relevant data from earlier evaluations may be included in reports of current psychological, psychoeducational and psychiatric evaluations.

Yes	No	N/A	Client Initial	Guardian Initial
☐	☐	☐	_____	_____

Psychiatric Services/ Medication Monitoring

For students utilizing Allendale's consulting psychiatric service, I agree to participate in each psychiatric appointment and understand that parent involvement is required to receive psychiatric services.

Yes	No	N/A	Client Initial	Guardian Initial
☐	☐	☐	_____	_____

Electronic Devices, Media, and Internet Access

I have been provided and have read Allendale's Electronic Devices, Media, and Internet Policy. I understand that use of the internet is a privilege, and Allendale offers youth

use of the internet as an educational tool to enhance and reinforce learning. Allendale takes precautions to prevent access to materials that may be defamatory, inaccurate, offensive, or otherwise inappropriate to the learning environment. However, it is impossible to control all material and a user may discover inappropriate material, therefore, Allendale respects each parent/guardians right to decide whether or not to authorize internet access.

Out-of-State-Travel/Field Trips

Yes	No	N/A	Client Initial	Guardian Initial
☐	☐	☐	_____	_____

I consent for Allendale staff to take my child to Wisconsin on periodic trips at various times during the year with staff members not including overnight stays.

Field Trips

Yes	No	N/A	Client Initial	Guardian Initial
☐	☐	☐	_____	_____

I consent for Allendale staff to take my child on periodic short trips off campus to supplement educational programming.

Speech and Language Evaluations

Yes	No	N/A	Client Initial	Guardian Initial
☐	☐	☐	_____	_____

If determined by the IEP Team, I agree for my child to be evaluated by Allendale's speech/language pathologist to determine if speech/language services are needed.

Participation in Volunteer Program

Yes	No	N/A	Client Initial	Guardian Initial
☐	☐	☐	_____	_____

I consent for my child to participate in Allendale's Volunteer Program. This may include working with an Allendale volunteer under the supervision of Allendale Staff. This may include receiving assistance with schoolwork or participating in a activity around the school.

Consent to Allow Yearbook Photographs

Yes	No	N/A	Client Initial	Guardian Initial
☐	☐	☐	_____	_____

I consent for my child to be photographed and included in Allendale's annual School Yearbook.

Privacy/Confidentiality Policy

Yes	No	N/A	Client Initial	Guardian Initial
☐	☐	☐	_____	_____

I acknowledge having been offered Allendale's "Notice of Privacy Policies" and "Clients Rights Statement", My rights including the right to see and copy my record, to limit disclosure of my treatment information, and to request an amendment to my record, is explained in the policy. My right to make a complaint and file a grievance under state laws has also been explained. I understand that I may revoke in writing my consent for release of my treatment, except to extent Allendale has already made disclosures with my prior consent. I have been advised of the limits of confidentiality within the Allendale treatment

setting.

I have had the above service consent requests explained to me in a language I can understand and had the opportunity to ask questions and have those questions addressed. My signature below authorizes Allendale Association to provide the services for which I have checked "yes" above.

COMMENTS:_____

_____

_____

(Client if over 12 yrs.) Date

_____

Signature of Parent/Guardian Date
(If client is a minor, family or guardian is legally responsible for approving care prescribed)

_____

(Witness/Relationship) Date

_____

Signature of parent/guardian if client is 18 Years or older and is adjudicated incompetent. (Copy of Court Order included in file) Date

updated 6/18 130725, 10/15/2014, 05/25/2016

ALLENDALE ASSOCIATION
Other Services Consent Form

Date: _____

Name: _____ ID#: _____

Birth Date: _____ Admission Date: _____

Guardian: _____ Unit: _____

Allendale Association needs the authorization of the youth and/or guardian in order to provide the following family treatment services. Authorization is valid for one year and may be revoked at any time. **Please review the area needing authorization and indicate your wishes by placing an "X" in the appropriate box, and signing your initials.**

I/We the undersigned, hereby authorize Allendale Association to:

	Yes	No	N/A	Client Initial	Guardian Initial
Recording Psychotherapy I consent to use audio recording during family and individual psychotherapy meetings. The recordings will be used confidentially between the therapist and the clinical supervisor for supervision purposes. Recorded sessions may also be presented in group supervision with other Allendale therapists. Recordings are ultimately destroyed after use in supervision. This authorization in no way allows any other use of this recording.	☐	☐	☐	_____	_____
Audio Recording Clinical Consultation Sessions I consent to use of audio recording during clinical consultation sessions. The recordings will be used to prepare a transcript of the session for supervision purposes. Recorded sessions and/or the prepared transcript may also be presented in group supervision with other Allendale therapists and supervisors. Recordings are ultimately destroyed after use in supervision. This authorization in no way allows any other use of this recording.	☐	☐	☐	_____	_____

COMMENTS:_____

_____

Signature of Client (if over 12 yrs.) Date

_____

Signature of Legal Guardian Date

ALLENDALE ASSOCIATION
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW TREATMENT INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: April 14, 2003

We respect client confidentiality and only release treatment information about you in accordance with state and federal law. This notice describes our policies related to the use of the records of your care generated by Allendale Association.

Privacy Contact: If you have any questions about this policy or your rights contact Connie Borucki, Chief Operating Officer, at 847/245-6213.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
In order to effectively provide you care, there are times when we will need to share your confidential information with others beyond our agency. This includes for:

Treatment: We may use or disclose treatment information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside our agency that we are consulting with or referring you to.

Payment: With your written consent, information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes.

Healthcare Operations: We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, training staff.

Information Disclosed Without Your Consent: Under state and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies: Sufficient information may be shared to address the immediate emergency you are facing.

Follow Up Appointments/Care: We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We will leave appointment information on your answering machine unless you tell us not to.

As Required by Law: This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Governmental Requirement: We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations inspections and licensure. We are also required to share information, if requested with the U.S. Department of Health and Human Services to determine our compliance with federal laws related to health care and to Illinois state agencies that fund our services.

Criminal Activity or Danger to Others: If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur to someone.

CLIENT RIGHTS

You have the following rights under state and federal law:

Copy of Record: You are entitled to inspect the client record Allendale has generated about you. We may charge you a reasonable fee for copying and mailing your record.

***Release of Records*:** You may consent in writing to release of your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

***Restriction on Record*:** You may ask us not to use or disclose part of the treatment information. This request must be in writing. The Agency is not required to agree to your request if we believe it is not in your best interest to permit use and disclosure of the information. The request should be given to the Privacy Contact.

***Contacting You*:** You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct.

***Amending Record*:** If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this contact the Privacy Contact and ask for the *Request to Amend Health Information* form. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement you disagree with us. We will then file your statement and our response in your record.

***Accounting for Disclosures*:** You may request an accounting of any disclosures we have made related to your confidential information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to our Privacy Contact. We may charge you a reasonable fee for preparing this list.

***Questions and Complaints*:** If you have any questions or wish a copy of this Policy or have any complaints you may contact our Privacy Contact in writing at our office for further information. You also may complain to the Secretary of U.S. Department of Health and Human Services if you believe Allendale Association has violated your privacy rights. We will not retaliate against you for filing a complaint.

***Changes in Policy*:** Allendale reserves the right to change its Privacy Policy based on the needs of the agency and changes in state and federal law.

2/03 Revised 6/04 (privacy contact information)

THE RIGHTS OF ALLENDALE CLIENTS

1. Clients retain their constitutionally guaranteed rights, benefits, and privileges during the time they reside at or are treated at the agency.

2. Mental Health services cannot be denied because of age, sex, race, religious belief, ethnic origin, marital status, physical or mental disability, or criminal record unrelated to present dangerousness.

3. Services provided must follow an individual treatment plan formulated, as far as is feasible, with the client's and nearest of kin's participation.

4. Every client has the right to have disabilities accommodated as required by the American With Disabilities Act, section 504 of the Rehabilitation Act and the Human Rights Act [775 ILCS 5].

5. A guardian for clients who are under 18 years of age, or clients over the age of 18, shall be given the opportunity to accept or refuse medication or mental health services.

6. Every client has the right to an evaluation by a psychiatrist at least yearly, and if medications are prescribed, has the right to have the medication reviewed regularly.

7. Clients shall be informed of their right to contact: Guardianship and Advocacy Commission, (telephone number (312-793-5900) and/or Equip for Equality (telephone number (312-341-0022), and/or DCFS (Hotline telephone number (800-252-2873) should they have concern about their rights. Staff will offer assistance to clients in contacting these organizations at the client's request.

8. Clients have the right to unimpeded, private and uncensored communication with persons of their choice by mail, telephone, or visitation unless such communications are deemed harmful to the client by program administrator.

9. A client cannot be prevented from seeing his/her attorney or from sending and receiving mail to specified state officials and recognized advocacy groups.

10. Every client has the right to be free from physical coercion or punishment. Special treatment interventions (i.e., restraint, seclusion, etc.) may be used with a youth who is out of control and not able to prevent injury to self or others without staff help. Physical punishment is not allowed at Allendale.

11. Upon admission and as needed during treatment, clients have the right to a pain assessment and effective treatment of pain (i.e., injury, physical illness). Client/guardian personal/cultural/spiritual/ ethnic beliefs will be taken into account as appropriate.

12. Humane and adequate care shall be provided in the least restrictive environment possible; humane care implies that clients shall be free from abuse and neglect and exploitation. Allendale has specific procedures for reporting presumed abuse and neglect of any client. Every client has the right to be free from sexual touch by any adult and to be free of unwanted sexual touch by other clients and the right to report any unwanted touch and to have an occurrence investigated by appropriate personnel.

13. Food cannot be withheld as a punishment. However, a client who is out of control at the time a meal is served or who has recently returned from running away, may be kept back from the dining hall and served an alternate, but well-balanced meal in the cottage. Sweet treats or extra servings may be withheld as a

consequence for misbehavior where appropriate, but healthful snacks must be offered as scheduled into the daily menu. No one is forced to eat: refusal to eat will be documented so that the client's health is not endangered by missing too many meals.

14. Specific treatment interventions, such as restraint and seclusion are used strictly in accordance with DCFS Rule 384 and may not be used to punish or discipline a client and are used only in a humane and therapeutic manner with application of the restraint/seclusion by trained personnel. Restraint and seclusion must be used with specific time, review, and reporting constraints, as per DCFS Rule 384 and Allendale policy.

15. The client and/or the client's guardian, the Credentialed Evening Supervisor, any designated persons, and designated advocate organization shall be notified, with justification, of any client rights that are restricted by the professional responsible for overseeing their implementation and maintained in their clinical file.

16. Clients who are members of a recognized religious denomination shall have access to spiritual health services, as approved by guardians. Every effort will be made by staff to facilitate attendance at religious services by the clients expressing this desire, providing the client's behavior is not a problem.

17. Clients over 18 years who have no guardian have the right to use their money as they choose, including the right to deposit the money in their name with a financial institution or with the service provider. All personally owned money shall be returned to the client upon discharge.

18. No service provider or its employees shall be made a representative payee for a client without the client's informed consent.

19. Clients must be paid at least monthly wages for work performed as part of a vocational or workshop program.

20. Unless restricted to prevent harm to self or other, clients shall be permitted to receive, possess, and use personal property with the provision of reasonable storage.

21. If a client believes that any of these rights have been denied to him/her or unfairly restricted, the client and/or guardian is asked to contact the Credentialed Evening Supervisor at once, and a prompt exploration of the client's concern will ensue. A report will be made back to the client/guardian, and where a client's rights are found to have been unduly restricted or neglected, the client's rights will immediately be restored. If the client/guardian remains dissatisfied that the full rights of the client have been restored, the client/guardian is asked to telephone Guardianship and Advocacy Commission (telephone number (312-793-5900) or other advocacy organization; (Department of Children and Family Services Hotline telephone number is (1-800-252-2873). Any client/guardian has the right to contact Guardianship & Advocacy Commission or other advocacy organization for the first report of any suspected deprivation of rights, without first notifying Allendale. Attached is a list of addresses and phone numbers for the Guardianship and Advocacy Commission and the Equip for Equality, Inc.

22. Justification for restriction of a client's rights under the statutes cited in subsections (a) and (b) shall be documented in the client's record. Documentation shall include a plan with measurable objectives for restoring the client's rights that is signed by the client or the client's parent or guardian, the QMHP and the LPHA. In addition, the client affected by such restrictions, his or her parent or guardian, as appropriate, and any agency designated by the client pursuant to subsection (d)(2) of this section shall be notified of the restriction and given a copy of the plan to remove the restriction of rights.

23. If a client/guardian believes that a client has been subjected to neglect or abuse or exploitation of any sort, the client or guardian has the right to report such suspected abuse/neglect directly to the State Department of Children and Family Services' abuse/neglect hotline. (Telephone number 1-800-252-2873).

24. Allendale will assist clients in navigating a public payer's grievance process if issues with third party payment arise.

CONFIDENTIALITY:

25. Clinical record or communication may be disclosed WITHOUT THE CONSENT of the client or Guardian to the following:

    a) To the Department of Children and Family Services for wards of the state and/or for purposes of reporting presumed child abuse/neglect;
    b) An attorney or guardian ad litem who represents a minor (12 years of age or older) in any judicial or administrative proceeding, if granted by the court or administrative hearing officer.

26. Every client, 12 years old or older, has the right to review his/her file at an appropriate time and with appropriate supervision to guarantee constructive use and understanding of what is in the file. The following persons are entitled UPON REQUEST TO INSPECT AND COPY a client's record or part thereof with notation of what is copied:

    a) The parent/guardian of a client who is under 12 years of age;
    b) The client if he or she is over 12 years of age;
    c) The parent/guardian of a client, who is at least 12 but not yet 18 years of age, if the client is informed and does not object or if the therapist does not deny access;
    d) The guardian of a recipient who is 18 years or older;
    e) An attorney or guardian ad litem who represents a minor.

27. Information, including whether a person resides at or is treated by the agency, is only to be released to someone other than those listed above with written consent of those listed in #22 above.

GRIEVANCE PROCEDURE FOR ALLENDALE CLIENTS AND/OR GUARDIANS

If a client or guardian is concerned about an aspect of the care of service given by an Allendale staff person or has a grievance against a peer or a staff person, facility administrators want to be made aware of such situations so they can be corrected. The filing of a grievance will not in any way affect the quality, frequency, or continuance of services provided. The following procedure is followed:

A. Client reports his/her complaint to any staff within the agency. At any time, however, a client has a right to contact a Credentialed Supervisor or Administrator regarding the complaint/allegation. (A Credentialed Supervisor is available every day and an Administrator is on-call 24 hours a day, seven days a week.) The staff receiving the complaint must complete an Allendale Complaint/Allegation Form or give the client a form to complete. A client, under the client's rights and privileges policy of Allendale, is allowed access to his/her caseworker or advocate/guardian if he/she may desire.

B. The Complaint/Allegation form is forwarded to the Credentialed Supervisor (if made by another staff), the Director of the program/unit, then to the Quality Improvement Department. **If the complaint alleges child abuse, neglect, or exploitation the process from "G" to "H" is followed under the appropriate section below.

C. A protection plan will be put in place if the complaint is assessed to warrant the need.

D. The complaint will be immediately reviewed by identified staff and an assessment of the situation will be made.

E. If, after an immediate evaluation of the complaint and facts, there is reasonable evidence that staff on duty was in violation of agency policy/procedure, the staff is reprimanded with appropriate discipline as deemed necessary. Also, any program changes will be made if deemed necessary. The Vice President and Directors make the final determination.

F. The complainant is then notified of the internal evaluation and documentation of the concerns. A record of such grievances and the response to those grievances shall be maintained by the provider. If the evaluation does not satisfy the complainant, he/she has the right to appeal to the President of Allendale Association. The President will hear all sides of the issue and then make the final determination for the agency. Any appeals may also be made in accordance with #21 of these client rights.

**If complainant alleges child abuse, neglect, or exploitation the following steps will occur:*
The following people will be notified: Credentialed Supervisor, Vice President of Residential or Education, and the President. Client will receive all necessary medical attention and safety plan will be put in place. The DCFS Child Abuse & Neglect Hotline will be called.

If the DCFS Hotline accepts the call, DCFS is mandated to start the investigation by physically seeing the child within 24 hours of the call. They have 45-60 days to complete the full investigation. The Parent/Guardian will be notified of all calls made to the hotline, the hotlines' decision, and what to expect. Allendale Association will not interfere with any open state or police investigation.

If the DCFS Hotline does not accept the call, steps "C" through "F" will be followed.

If at any time a client or guardian believes his/her grievance has not been addressed or resolved by Allendale management and this process, the person may wish to contact the following agencies:

- Illinois Department of Children and Family Services
- Illinois Guardianship and Advocacy Commission
- Wisconsin Department of Health and Social Services
- Council on Accreditation
- Joint Commission on Accreditation of Healthcare Organizations

State of Illinois
Guardianship and Advocacy Commission

Fax Phone #	Office Location	Telephone #
217-524-0088	Office of the Director 421 East Capitol Avenue, Suite 205 Springfield, Illinois 62701-1711	217-785-1540 217-785-8981(Director)
312-793-4311	Office of the Director State of Illinois Building 160 N. LaSalle, Suite S-500 Chicago, IL 60601-3103	312-793-5908(Director) 312-793-5900
217-892-0803	East Central Regional Office 423 South Murray Road Rantoul, Illinois 61866	217-892-4611
618-833-5219	Egyptian Regional Office #7 Cottage Drive Anna, Illinois 62906-1669	618-833-4897
618-462-4554	Metro East Regional Office Pine Cottage 4500 College Avenue Alton, Illinois 62002-5099	618-462-4561
847-294-4263	North Suburban Reg. Office 9511 Harrison Avenue, FA 101 Des Plaines, Illinois 60016-1565	847-294-4264
309-693-5050	Peoria Regional Office 5407 North University, Suite 7 Peoria, Illinois 61614-4785	309-693-5001
815-987-7227	Rockford Regional Office 4302 North Main Street Rockford, Illinois 61103-5202	815-987-7657
708-338-7505	West Suburban Regional Office P.O. Box 7009 Hines, Illinois 60141-7009 (U.S. Mail) c/o Madden Mental Health Center Pavilion 9 Hines, Illinois 60141 (Messenger Mail)	708-338-7500

Equip for Equality, Inc.
The Illinois Corporation Advancing the Human and Civil Rights of Americans with Disabilities

Fax Phone #	Office Location	Telephone #
312-341-0295	Northeastern Region 11 East Adams Street, Suite 1200 Chicago, Illinois 60503 (Se habla espanol and American sign language)	800-537-2632 312-341-0022
309-786-2393	Northwestern Region 1612 Second Avenue P.O. Box 3753 Rock Island, IL 61204	800-758-6869 909-758-6868
217-523-0720	Central Region 427 East Monroe P.O. Box 276 Springfield, Illinois 62705	800-758-0464 217-544-0464
618-529-2101	Southern Region 103 South Washington, Suite 202 Carbondale, Illinois 62901	800-755-3304 618-457-3304

Accrediting Agencies

Organization	Contact Information
Council on Accreditation	120 Wall Street, 11th Floor New York, NY 10005 Toll-free 866-262-8088 212-797-1428 www.coanet.org
The Joint Commission	630-792-5800 or (toll-free) 800-994-6610 www.jointcommission.org (e-mail) patientsafetyreport@jointcommission.org

CLIENT'S STATEMENT OF HAVING BEEN INFORMED OF CLIENTS' RIGHTS:

This client has been informed of his/her right to be free from abuse and neglect.

I have been informed of my rights in accordance with MHDD Confidentiality Act and Chapter 2 of the MHDD Code, as well as the Confidentiality Act and the Health Insurance Portability and Accountability Act of 1996. I understand that my exercising of any of these rights, including the right to register a grievance, will not result in limitation or refusal of services. Services will not be denied, reduced, suspended or terminated for clients exercising these rights. Clients or guardians are allowed to present grievances to the highest level possible in the agency. By signing a copy of these Client Rights, I indicate that I have been given a copy of the rights and have had them explained to me in a manner and language that I can understand. The procedure for registering a grievance concerning my rights has also been explained to me so that I can understand the grievance procedure.

Client Name:_____

(Please print)

Client Signature:_____ Date:_____

Guardian Signature:_____ Date: _____

As a witness to the signing of these Client Rights, I document that these rights have been explained using a language or method of communication that the client understands and that he/she seems to understand them.

Witness Signature: _____Date: _____

Rev. 02/18/01; 08/12/02; 11/05; 1/31/06; 7/21/06; 1/23/2012; 10/15/2014; 3/2/2016

Allendale

Allendale Therapeutic Day School: Search Procedures

Upon entering the building, students must be prepared to undergo the following search procedures:

- Open containers will be consumed or emptied prior to entering the building.
- Search backpacks, tote bags, or other bags
- Empty all pockets
- Lift pant legs, show top of socks
- Be cooperative with staff as they use wand/metal detector
- Turn in CD players and IPODS (teacher discretion)

The following items will be confiscated if brought to school:

- Cell phones, cameras, and other picture taking or recording devices
- CD's with parental advisories
- Open containers consumed prior to entering building
- Lighter, alcohol, drugs or paraphernalia related to drugs or tobacco
- Toxic material will be confiscated
- Sharp objects deemed dangerous will be confiscated
- Violation of RESPECT program will result in confiscation of all electronic devices such as Gameboy, IPOD or PSP etc.

Other items not specifically listed here may be confiscated at staff discretion.

Personal items will be collected by staff and placed in individual bags to be returned at the end of the day. Arrangements will be made with parents to pick up contraband items.

Illegal items will not be returned and police may be called.

Allendale will <u>not</u> be responsible for any items that are lost, stolen or broken. Students are highly encouraged to leave valuable items at home.

Parent Signature_____ Date _____

Student Signature _____ Date _____

Allendale

Student Dress Code Policy

Policy:	**Date Issued**
Student Dress Code Policy	Reviewed 3/4/19

Students are expected to dress in a manner which will not disrupt the educational process, present a clear and present danger to the individual or the student body's health or safety, or cause an interference with work or create classroom or school disorder. The following guidelines are in effect for Allendale School:

- Clothing will be neat and clean. Excessively tight clothing is prohibited.
- Hats, headbands, sweatbands, bandannas, or other head coverage not appropriate to the situation or prevailing weather are not allowed. Hats, headbands, bandannas may not be worn indoors on any part of the body in any program area (except for safety or sanitary reasons).
- Gloves, wristbands and sunglasses may not be worn indoors.
- Outside jackets and coats may not be worn in class (at staff discretion).
- Clothing or jewelry which displays profanity, sexually suggestive messages, obscenity, slanderous or violent messages may not be worn.
- Clothing cannot display or depict items which a student cannot legally purchase or possess on school property (drugs, alcohol, tobacco).
- Clothing or items with slogans, symbols, or pictures related to death or Satanism may not be worn (this includes skulls which are music rock group symbols).
- Clothing or style of wear that can be interpreted as gang-related is prohibited. Staff will determine appropriateness of clothing; "intent" may not be gang-related.
- Tank tops must have two inch straps, no spaghetti straps, halter tops, or transparent clothing are not allowed.
- Midriff shall be covered at all times.
- Altered or unusually cut tank tops or T-shirts, clothing with holes or tears that show exposed skin may not be worn. Shirts must be worn on basketball courts.
- Shorts and skirts must extend beyond second knuckle or have a 3 inches seam.
- Baggy pants must be worn at natural waist level. Skin or underwear may not be exposed.
- Tight or low cut shirts, dresses, blouses, or sweaters are not allowed. Bra straps may not be exposed.
- Chains, wallet chains, and heavy key chains (other than appropriate jewelry) are not permitted.
- Shoes must be worn in all program areas unless student is on AWOL precaution.
- Shorts may be worn when weather is appropriate. Tight fitting, bike shorts, or spandex shorts are not permitted.
- Only stud type or small loop earrings are allowed. This restriction applies to all areas of body piercing.
- Tattoos of gang symbols are prohibited. Existing tattoos must be covered with clothing or Band-Aids.
- Picks, combs or brushes should not be displayed in student's hair during school programs.

Violations of dress code will be determined by staff and reported to supervisor.

Violations of the dress code will result in alternative clothing being offered or restriction to the classroom until compliance is demonstrated.

Repeated violations of the dress code will result in student receiving a minor critical. Conference with parents and school personnel will be considered.

I have been informed of the above policy and understand the expectation to comply.

Parent Signature_____ Date _____

Student Signature _____ Date _____

Allendale Internet Acceptable Use Policy

Allendale offers students use of the Internet as a tool to enhance and reinforce learning. Use of the internet is a privilege, and this privilege may be suspended and/or revoked for violations of the Acceptable Use Policy. Allendale carefully monitors student/youth use providing appropriate levels of staff supervision and utilizes software precautions to prevent access to materials that may be defamatory, inaccurate, offensive, or otherwise inappropriate in the learning environment. However, it is impossible to control all material and a user may discover inappropriate material. To that end, Allendale supports and respects each parent/guardian's right to decide whether or not to authorize internet access.

Internet Use Policy

1. Browsing certain sites (e.g., pornographic, weapons-related, or hate sites) or the use of chat rooms are not appropriate uses of computer resources.

2. Staff and students must accept responsibility for restricting access to undesirable material. Materials that contain profanity, obscene comments, sexually explicit references, expressions of bigotry, or information intended to cause harm are prohibited. Other inappropriate materials include any reference to information on how to consume or manufacture drugs, weapons, or other unauthorized materials.

3. Adhere to copyright laws and restrictions. Internet materials used in reports or other documents must be cited.

4. Downloading from the Internet without approval of Allendale staff is not allowed.

5. Using the Internet for commercial purposes or for political lobbying is prohibited.

6. Users are expected to abide by generally accepted rules of etiquette.

7. Use appropriate language (no swearing or vulgarities).

8. Don't reveal your name (or anyone else's), personal address, phone number.

9. Do not use another user's account or password.

10. Do not send or retrieve files dangerous to the integrity of any computer systems.

Allendale and its employees are not held responsible for any harm caused by materials or software obtained via the Internet.

Parent Signature_____ Date _____

Student Signature _____ Date _____

Allendale

Dear Parent/Guardian:

Allendale School is going to have a yearbook for the school year. In order for this to happen, and for your child to be included, we need you to authorize the enclosed consent form.

The yearbook is for the student's use only. Students will not be identified by name.

This will not be used in any way for fundraising. We want to give the students a permanent record of the school year, and their accomplishments.

Please return the enclosed form as soon as possible.

If you have any questions, contact the school at 847-356-3334.

Thank you.

Sincerely,

The Yearbook Committee

Enclosures

CONSENT TO ALLOW YEARBOOK PHOTOGRAPHS

I, _____, hereby give consent for _____,
parent/guardian *student's name*
age _____, to be photographed for the purposes of an annual yearbook at Allendale Association for the duration that _____ attends Allendale School.
student's name

I understand that any photographs taken will be identified by first name and last name initial only and will only be used in the yearbook. I hereby release Allendale Association, its officers, directors, employees, and students, as well as any associations, organizations, and/or schools affiliated with Allendale from all claims, damages, demands, or liability on account of, or arising out of, the use or publication of the student's picture.

_____ _____
Student Date

_____
Street Address

_____
City, state, zip

_____ _____
Parent/guardian Date

_____
Street Address

_____
City, state, zip

ALLENDALE
CAAEL SPORTS PARTICIPATION

- Participation in the CAAEL Sports Program is both a privilege and a responsibility. It is a privilege to develop your specific athletic skills with classmates in an organized setting.

- If your child is interested in participating in sports at Allendale through CAAEL sports, please sign the permission slip below for the sports he/she is interested in. Allendale has a “no cut” policy.

The following rules are required from each athlete participating in games in the CAAEL sports program.

1. I will demonstrate good sportsmanship at all times.
2. I will be a positive representative of my school at all games.
3. I will show that I can accept winning or losing a game in a gracious manner.
4. I will not use vulgar or objectionable language in school, at practice or at any athletic event.
5. I will follow all of the CAAEL rules in order to participate on game day.
    a. All school work is completed
    b. Off of Privilege Lost and Major Restriction
        i. The Core Team could also determine eligibility
    c. Corrective Units and Free Time Loss completed
    d. Off AWOL/HTO precautions for off-campus events
    e. Demonstrate a positive attitude
    f. Have completed a time off request from work

My child has permission to participate in the following sports. Check all that apply:

____ Flag Football League H. S.

____ Flag Football League Jr. High

____ Basketball League H.S.

____ Basketball League Jr. High

____ Softball League H.S.

____ Softball League Jr. High

_____ Chess League

_____ Volleyball League HS

_____ Volleyball League Jr. High

_____ Indoor Soccer League H.S.

_____ Indoor Soccer League Jr. High

Allendale requires each student/athlete to be covered by accident insurance. The signature of the parent/guardian on the athletic clearance form (attached) certifies that, along with permission for the student to participate, that the parent/guardian accepts the responsibility of maintaining an insurance program to

cover the student in the event of injury, that participation in the Allendale sports program is entirely voluntary, and acknowledges understanding that there are risks of injury as a result of participation. By granting permission for the student to participate in this program, the parent/guardian is agreeing to accept responsibility for the risks, and agrees to release and hold harmless the student's school, the School District and their employees and agents from any claims, demands, or causes of action arising from the child participating in the extracurricular program.

I have read the above rules and agree to abide by them. Should I not follow any rules, I realize I may be suspended from games and practices for the next scheduled event up to the remainder of the school year.

_____ _____

Student Signature Date

I (we) have read the above rules and will help the athlete in abiding by them.

_____ _____

Parent/Guardian Signature Date

Dear Parent/Guardian

The Vocational Education Program at Allendale Association attempts to take advantage of various programs offered by State that can benefit the students we serve. Our ability to do this is contingent upon securing permission from the parent or legal guardian. The sooner we can secure permission the sooner we can begin to process a student's application for enrollment.

One program of great usefulness to students is the **Secondary Transitional Experience Program (S.T.E.P.)** administered by the State of Illinois' **Department of Rehabilitation Services (D.R.S.)**. This program benefits your student now as he/she begins his/her vocational education training and continues to provide benefits once enrolled, as he/she will always have the opportunity to receive services related to getting a job and staying employed. The key is to get your child enrolled now while they are a student, rather than attempting to do this later on in life as an adult.

The reality is that it is easier and ultimately more beneficial for your child to enroll now rather than later. Your signature on the attached **STEP RELEASE FORM** allows us to forward the needed documentation to **D.R.S.** to qualify and enroll your child in **S.T.E.P.**

S.T.E.P. offers a wide range of services to assist your child in the employment process. Once enrolled your child can receive services as often as needed to gain and maintain successful employment. The services include vocational assessment, vocational counseling, job training, community-based work experience, independent living skills training, and coordination of supported employment services. Taking part in **S.T.E.P.** will not adversely affect participation or benefits from any other government program. The goal of **S.T.E.P.** is to *prepare your child for community based non-supported employment, independent living, and full community participation*. This is accomplished through the development of desirable work habits, the development of social and personal skills that help maintain successful employment, career exploration, setting realistic career goals, and meaningful work experience through on-the-job placement.

Areas in which **D.R.S.** will provides services are vocational rehabilitation, home services, centers for independent living, education, bureau of blind services, services for persons who are deaf or hard of hearing, disability determination services, client assistance programs, and assistance related to the **Americans with Disabilities Act.**

If you have any questions or concerns, please do not hesitate to contact Allendale's Vocational Education Coordinator at (847) 356-3334. Thank you for your cooperation.

Respectfully yours,

Vocational Education Coordinator

STEP & Work Release Form

We would like for _____to participate in a **Secondary Transition Experience Program (STEP)** at Allendale School. For your daughter/son/client to participate it is necessary for you to grant permission for Allendale to send the following information to the Department of Rehabilitation Services (DRS) of the State of Illinois:

1. Reported Disabilities
2. Physical Examination Report
3. Psychological Report(s) Psychiatric Report(s) Other Specialists Report(s)
4. Most Recent Transcript
5. Current Individual Education Plan (IEP)

STEP Release Form

I, _____, give consent to release the above information to
(parent/guardian name)

the State of Illinois Department of Rehabilitation Services (DRS) in order that

_____ can participate in the STEP program.
(student's name)

_____

Signature of Student Date

_____

Signature of Parent/Guardian Date

Allendale Vocational Training Release Form

As a training program, each student will earn sub-minimal wages for the tasks he/she performs. Residential students will have eighty percent of the monies they earn deposited into an interest bearing bank account. Money not spent by the student during their stay at Allendale will be mailed to them when they depart. Therapeutic day school students will receive the entire wages twice monthly.

I give permission for_____to participate in the vocational
(student's name)
training and work experience program provided by Allendale Association.

_____

Signature of Student Date

_____

Signature of Parent/Guardian Date

State of Illinois
Department of Human Services
Division of Rehabilitation Services
Consent for Services

I hereby give consent (permission) for _____ to receive and participate
(student's name)

in vocational rehabilitation services that will lead to employment.

_____
Parent or Guardian Signature

_____
Date

STATE OF ILLINOIS DEPARTMENT OF REHABILITATION SERVICES
Rights/Remedies

ELIGIBILITY FOR SERVICES:
A determination of eligibility must be made before a program of service can be developed for you. Any diagnostic services found to be needed will be provided by DORS at no cost to you or your family only if you are an applicant for services from the vocational rehabilitation program or the Home Services program. DORS will take action on your application within 60 calendar days.

PAYMENT FOR SERVICES:
You should not begin a medical service, purchase equipment, or incur any expense, and expect DORS to reimburse you or the vendor without having specific written authorization from DORS.

YOUR RESPONSIBILITIES AS A CLIENT:
Your cooperation, from the beginning of your eligibility determination and throughout your program, will affect its success. You must keep appointments and attend scheduled activities. You are responsible for carrying out medical and other professional instructions.

YOUR RIGHTS AND REMEDIES:
1. You will receive a letter stating the reason for any denial, modification or termination of service at least 15 working days before the action becomes effective.

2. You and/or your personal representative have a right to discuss any problem or complaint you may have about your program with your DORS representative or his/her supervisor. You are encouraged, however, to discuss the situation with your DORS representative before talking to the supervisor. If still dissatisfied with the results of the meeting with the DORS representative, you are entitled to a Leve1 I Hearing, where your case and decisions are reviewed by management personnel. Vocational Rehabilitation clients may skip this step and proceed directly to a Level II Hearing. A request for a hearing must be made to your DORS representative within 15 working days of the date you knew, or should have known, of the situation you wish to appeal.

3. If you are not satisfied with the Level I Hearing decision, or you are a Vocational Rehabilitation client and have skipped the Level I Hearing, you are entitled to a Level II Hearing. The administrator who conducted the Level I Hearing will give you the' information and help needed to request a Level II Hearing.

4. The Client Assistance Program (CAP) is available to provide information, assistance and representation with your services or in an appeal, You may contact CAP directly by dialing 1-(800) 641-3929 (voice TTY), or by mail at 100 North 1st Street, 1st Floor, Springfield, IL 62702.

5. You have a right to discuss with your WRS representative all decisions regarding the furnishing or denial of services and/or your eligibility for DORS services. If you are determined to be ineligible for DORS services, a written-record of your views and the reason for the decision by DORS will be placed in your file. Every person determined to be ineligible for VR services due to a disability being too severe will be given an opportunity to participate in an annual review of that determination decision with his/her DORS representative.

NOTIFICATION OF COMPLIANCE:
In compliance with the Illinois Human Rights Act, the Illinois Constitution, the Americans with Disabilities Act, the U.S. Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, 34 CFR 104, and the U.S. Constitution, DORS does not discriminate in admission or access to, or treatment or employment in the Department's programs of services. The Director of the Illinois Department of Rehabilitation Services is responsible for compliance.

CONFIDENTIALITY:
Any information you give to your DORS representative will be held confidential and will be used only when necessary to obtain services for you. If your DORS representative provides such information to another agency, that agency must also maintain confidentiality. DORS may report back to the person who sent you to DORS and tell him/her what services DORS is giving you.

During the course of determining your eligibility and service needs and provision of services, it may become necessary to communicate with other agencies in order to determine whether services they might provide would benefit you. If DORS determines such communication is essential to either determine what those programs might be or to find out what comparable benefits may be available it may release information without your consent. If such a release is made, it will be limited to only that information the other agency needs for the referral. Any further information may only be released after written consent is obtained from you.

Allendale

School Medication Administration Policy

Policy:	**Date Issued:**
School Medication Administration Policy per School Code	03/01/19; updated 02/10/2020 js

Parents and Guardians should make every effort to administer medication at home, before/after school hours. If it is absolutely necessary to administer medication during school hours for the critical health and well-being of the student, then the following policy and procedures must be adhered to:

1. Medications are defined as all prescription and non-prescription pharmaceuticals and preparations. This includes but is not limited to over-the counter pain relievers, fever reducers, cough drops, eye drops, contact lens solutions, inhalers, allergy medication, skin ointments/lotions.
2. All medication-both prescription and non-prescription- must be delivered in original packaging to the school by the parent/guardian or other responsible adult.
3. Medication containers must be labeled with name of the student, the name of the medication, the dosage, and the time the medication is to be administered.
4. All medication is brought to the medication office where the exact amount of medication is counted and signed for by designated staff. The medication is locked in a designated cabinet in a locked room.
5. A written order or a copy of the prescription by the prescribing doctor is required in order to administer medication-both prescription and non-prescription.
6. A "Consent for the Administration of Medication" form must also be signed by the parent/guardian in order to administer medication.
7. A nurse will disburse medication or, if a nurse is unavailable, by an administrator or a staff member trained in medication administration designated by a school administrator and nurse.
8. It is the parent/guardian responsibility to inform the school or nursing department of any changes in medication or the student's health. Any changes in medication administered at school must be accompanied by a physician's order and parental/guardian medication consent form.
9. It is the responsibility of the parent/guardian to collect any medications from school when the student is no longer taking that particular medication. If it is not collected, medicines will be safely disposed of.

ALLENDALE ASSOCIATION/STEPPING STONE PROGRAM
LAKE VILLA, ILLINOIS 60046

Consent for Administration of Medication

_____
Student's name

_____
Birth date

The undersigned authorize Allendale/Stepping Stone Program to administer the following medication_____ at (time)_____to _____as part of his/her care and treatment at Allendale/Stepping Stone. Medications are administered under the direction of the Allendale/Stepping Stone school nurse.

As parent/guardian, I understand that any medication given to my child is done so

only with my written consent and that I must supply the medication to be administered.

_____
Parent/guardian signature

_____
Date

Nursing Department Fax (847) 356-0364

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Revised 08/15/00

ALLENDALE ASSOCIATION
P.O. BOX 1088
LAKE VILLA, IL 60046
Request To Amend Health Information

Please fill in the following information**:**

1. Name and relationship of person making request:_____

2. Today's date:_____

3. Client's name:_____

4. Date of Birth:_____ SSN #:_____

5. Client Address:_____

6. Describe the information you want amended:_____
_____

7. Date(s) of information you want amended:_____

8. What is your reason for making this request?_____
_____
_____

9. Describe how the entry is incorrect, incomplete, or outdated?_____
_____

10. What should the entry say to be more accurate or complete?_____
_____
_____

11. Do you know of anyone who may have received or relied on the information in question?
Yes _____ No_____ If yes, please specify the name(s) and address(es) of the organization or individual(s):_____
_____

_____ _____
Signature of Client (12 years or older) Date

_____ _____
Signature of Parent/Guardian/Authorized Representative Date

_____
For Agency Use Only

Amendment has been: _____Accepted _____Denied

If denied, check the reason for denial:

___ PHI was not created by this practice

___ PHI is not part of the patient's designated record set

____ PHI is accurate and complete

Staff comments:_____

_____

Signature of staff person:_____ Date:_____

Print name and title:_____

Rev 07/18

AUTHORIZATION FOR RELEASE OF WRITTEN INFORMATION

I, _____ , D.O.B. _____ authorize The Allendale Association of
(Name of Client)

Lake Villa, Illinois to release **written information** from my clinical file for the episode of care beginning on

_____ to the following individuals (if applicable) for the purpose of treatment plan review.
(Admission Date)

Please circle and initial **all those that apply** and line out those that do not apply:

Funding Source **Legal Guardian**

School District(s) **Licensing or Accrediting Agencies**

Emergency Medical/Psychiatric Hospitalizations or Incarcerations **Other** _____

	NAME	RELATIONSHIP
Biological/Foster Parent(s) or Step Parent(s)	_____	_____
Surrogate Parent(s)	_____	_____
Emergency Contact Person	_____	_____
Probation Officer	_____	_____
Guardian Ad Litem	_____	_____

I recognize that these records and the information contained therein are confidential, and, in some instances, may be protected by various federal or state laws and regulations or both.

This authorization will be good from date of signing until **one year** and limited to only that information I have requested above to be given to the person/facility named herein, and that it will not be further disclosed or used for any purpose other than as stated in this authorization.

I understand that I may revoke this consent, in writing, at any time, except to the extent that action has been taken in reliance thereon.

I hereby release Allendale from any and all legal responsibility or liability that may arise from the disclosure or release of information, medical records, or portions thereof, including liability for violation of the right of having this information maintained in confidentiality and privacy.

SIGNATURE OF CLIENT _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

SIGNATURE OF WITNESS _____ DATE _____

AUTHORIZATION FOR RELEASE OF VERBAL INFORMATION

I, _____ , D.O.B. _____ authorize The Allendale Association of
(Name of Client)

Lake Villa, Illinois to release **verbal information** from my clinical file for the episode of care beginning on _____ to the following individuals (if applicable) for the purpose of treatment plan review.
(Admission Date)

Please circle and initial **all those that apply** and line out those that do not apply:

Funding Source [ ] DCFS [ ] DHS [ ] Private Ins.

[ ] ISBE - District # _____ [ ] Other _____

Legal Guardian **Guardian Ad Litem**

Biological/Foster Parent(s) or Step Parent(s) **Surrogate Parent(s)**

Emergency Contact Person **School District(s)**

Probation Officer **Licensing or Accrediting Agencies**

Emergency Medical/Psychiatric Hospitalizations or Incarcerations **Other** _____

I recognize that these records and the information contained therein are confidential, and, in some instances, may be protected by various federal or state laws and regulations or both.

This authorization will be good from date of signing until **one year** and limited to only that information I have requested above to be given to the person/facility named herein, and that it will not be further disclosed or used for any purpose other than as stated in this authorization.

I understand that I may revoke this consent, in writing, at any time, except to the extent that action has been taken in reliance thereon.

I hereby release Allendale from any and all legal responsibility or liability that may arise from the disclosure or release of information, medical records, or portions thereof, including liability for violation of the right of having this information maintained in confidentiality and privacy.

SIGNATURE OF CLIENT _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

SIGNATURE OF WITNESS _____ DATE _____