Safe Harbor Adolescent Recovery Program

SHARP

Intake Packet

13513 Division Street, Charlevoix, MI 49720
For availability or intake questions, Please Call (231) 547-4085
Or visit us on the web @
www.chxsharp.com

PLEASE FAX OR EMAIL ALL COMPLETED INTAKE INFORMATION TO: 616-439-1864
OR mcleanj@charlevoixcounty.org

THIS PACKET MUST BE COMPLETED AND RETURNED PRIOR TO THE YOUTH BEGINNING THE PROGRAM:

TABLE OF CONTENTS

SAFE HARBOR ADOLESCENT RECOVEY PROGRAM CHECKLIST

_____ SHARP Referral packet completed.

_____ Copy of psychological testing and reports if available.

_____ Copy of Psychiatric testing and reports if available.

_____ Copy of Substance Abuse Assessments and reports if available.

_____ (For Court referrals only) Court order placing youth in program.

The order shall also include 15 days of Secure Detention and 15 days of Day Treatment all held in abeyance to be used at the discretion of Safe Harbor Adolescent Recovery Program staff. Prior authorization will be received from the referring court prior to use of any days held in abeyance should sanctions be required. Any and all costs incurred by these sanctions are not included in the daily per diem rate but will be billed to the referring county on a monthly basis.

_____ Copy of up-to-date Immunization Records.

_____ Copy of insurance card; front and back.

_____ Parent signatures on all enclosed Intake packet forms.

_____ IEP (if applicable)

_____ Copy of Birth Certificate (required for school enrollment)

_____ Copy of youths Social Security Card

_____ Copy of unofficial transcript from last school attended

PURCHASE OF SERVICE
AGREEMENT
Foster Care

_____, hereinafter called "Placement Agency", enters into the following agreement, dated this _____ day of _____, Year _____ for the purchase of service with Safe Harbor Adolescent Recovery Program, hereinafter called "Provider" with principal offices located at 13513 Division Street, Charlevoix, MI 49720 for:

Youth's Name: _____ DOB: _____

The Placement Agency agrees to the following:

- Pay for care and treatment at a current per diem of **$160.00** and issue payment within thirty (30) days from receipt of Provider's invoice. Payment will be submitted for day of admission, but not for day of discharge. This agreement is not subject to per diem changes without expressed written approval by all parties.
- Submit to Provider a family and social summary; medical history including medical assistance and/or insurance information; school information; and any professional evaluation information.
- Provide payment for days' youth is on home visit, not to exceed 5 (five) days.

The Provider agrees to the following:

- Submit billing invoices by the tenth (10th) of each month. Invoice must include the billing month, youth's full name, youths admit and discharge dates, number of days' services provided for each youth, current per diem, cost extension of each youth, and a total amount for the entire invoice.
- Document, negotiate, and settle billing discrepancies within 90 days. Placement Agency will not honor invoices submitted for services rendered greater than 180 days.
- Furnish food, shelter, basic care, clothing, personal incidentals, general and special education, and routine health, medical, optical and dental care. Extraordinary medical expenses must be pre-approved by the Placement Agency.
- Provide social work services; group, individual and family counseling; transportation; tutoring; and recreational activities.
- Develop an initial child service plan in conjunction with the youth, family and assigned juvenile probation officer which outlines goals, anticipated length of stay, treatment objectives and other general plans within 45 days of placement. A copy shall be provided to the assigned juvenile probation officer.
- Provide monthly detailed written progress reports to the assigned juvenile probation officer.
- Provide a discharge summary, including school transcripts, within I O working days following notification of discharge.
- Agree to discontinue billing after 24 hours of youth absenting him/herself ("runaway"); and resume billing upon mutual agreement of youth's return.

_____ _____
Authorizing officials printed name Title

_____ _____
Signature Date

PARENT AND YOUTH SECTION

SHARP/Harbor Hall Program

Service Participation Consent and Contract for Services

I, ___ _____ hereby acknowledge that with my admission to SHARP/Harbor Hall. I understand that the services I will receive by SHAPR/Harbor Hall has been explained to my satisfaction. The risks, benefits and alternatives to treatment have also been explained. I also understand that the result of such treatment cannot be warranted or guaranteed. I agree to the following:

1) I will hold Harbor Hall, its agents, members or employees free from all liability for losses through fire, theft or personal injury while I am on or about the premises.

2) I agree to cooperate with all assessments, groups, individual therapy, didactic presentations, recreational and other therapy as prescribed by staff.

3) I understand that no matter how I came to need treatment at Harbor Hall, I am responsible for my conduct, recovery, and contribution to the therapeutic community I will be residing with while in treatment.

4) I understand that I am responsible for my own physical and mental behavior while in treatment.

_____ _____ _____ _____

Youth Signature Date Witness Signature Date

Parent Acknowledgement and Consent

I,___ _____ the parent, guardian or legal custodian of the above minor, acknowledge the above items and give my consent for participation in the SHARP/Harbor Hall program.

_____ _____ _____ _____

Parent or Guardian Signature Date Witness Signature Date

_____ _____

Parent or Guardian Signature Date

CONSENT FOR EMERGENCY/MEDICAL/DENTAL TREATMENT

I hereby authorize the Director, or in his absence his appointed designee of Safe Harbor Adolescent Recovery Program, to consent to any treatment deemed necessary on behalf of my child. In addition, I give permission for my child to receive health screening, immunization(s), tuberculin testing, and blood testing as needed. Such authorization will remain in effect while my child is in the program.

I do also hereby assume responsibility for expenses incurred as a result of said treatment.

_____

FIRST MIDDLE LAST (participant's name)

Parent or Guardian's name_____ Date_____

Parent or Guardian's Signature_____ SSN: _____

Address_____ City, State, Zip_____

Home Phone Number_____ Cell Phone Number_____

Name of Employer_____Phone: _____

Address_____City_____State_____Zip_____

In the event that I cannot be reached, program personnel are authorized to contact:

Name: _____ Phone: _____, who will act on my behalf in making any decision regarding my child.

Youth Information

Education History

School (current enrollment):_____Grade: _____

Address _____

City: _____ State _____ Zip_____

Phone **( )** _____ Fax**: ( )** _____

Does the client have a current or past history of Special Education Services (IEP or 504)? YES / NO
IF YES, PLEASE PROVIDE US WITH A COPY OF THE CLIENT'S MOST RECENT EVALUATION.

Personal Interests / Hobbies (include list of hobbies and interests and changes if noted):

_____

_____

_____

_____

Employment History

Employer	Length	Position	Outcome
1.			
2.			
3.			
4.			

Parental Information

Bio/adopted-Mother_____ Bio/adopted-Father _____

D.O.B._____ D.O.B. _____

Address_____ Address_____

City_____State MI____City_____State_____

Zip_____ Zip_____

Phone ( )___-_____ Phone ( )___-_____

Step-Mother_____ Step-Father _____

D.O.B. _____ D.O.B. _____

Address_____ Address_____

City_____State_____City_____State_____

Zip_____ Zip_____

Phone (_____)_____-_____ Phone (_____)_____-_____

Family History

- include names & ages of immediate and extended family members
- indicate which members are in the household of residence
- note history of mental illness, major medical problems, and/or alcohol/drug abuse and/or concerns

Family member	Relation	Age	In house	Medical Problems	Mental illness	Drug abuse	Alcohol abuse
1.	Bio-Dad						
2.	Bio-Mom						
3.	Step-Dad						
4.	Step-Mom						
5.							
6.							
7.							
8.							

Medical History

Insurance Provider: _____ Policy #: _____

Primary Care Provider/Doctor: _____ Last visit: _____

Address: _____

Dentist: _____ Last visit: _____

Address: _____

Medical Diagnoses:

1. _____ 2. _____

3. _____ 4. _____

Medical information

ALLERGIES (Rx, food, environmental):

_____

Current Medication	Dosage	X per day	Prescriber (Dr) / Address
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Please have the parent and/or teen complete this form, checking "yes" if the teen currently ***has, or had in the past,*** *any of the following conditions.* ***If "yes," please provide details.***

Yes	No	
___	___	Ever hospitalized?
___	___	Had any operations?
___	___	Accidents or broken bones?
___	___	Under the care of a doctor in the last nine months (Dr. name / diagnosis)?

_____ Asthma/Wheezing	_____ Frequent colds, sore throats, ear aches
_____ Tuberculosis	_____ Fatigue/tiredness
_____ Meningitis	_____ Eating disorder
_____ Diabetes	_____ Anemia
_____ Seizures/Epilepsy	_____ Pneumonia
_____ Ulcers	_____ Heart trouble
_____ Headaches	_____ Kidney Infection
_____ Bone/joint problems	_____ Strep Throat
_____ Skin problems	_____ Depression / Anxiety
_____ Speech problem	_____ Stomach pain
_____ Trouble sleeping	_____ Eye trouble / Glasses
_____ Physical Limitations	_____ Hearing trouble
_____ Teeth/Dental problems	_____ Urine symptoms
_____ Bowel Movement Problems	_____ Suicide attempt
_____ Menstrual problems, pain, or irregularities	

<u>Any special diet requirements?</u>

Vegetarian: _____

Vegan: _____

Kosher: _____

Gluten-free: _____

Other: _____

Safe Harbor Adolescent Recovery Program MEMO!

EFFECTIVE IMMEDIATELY!

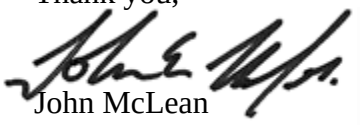
The following form (WRITTEN CLOSURE – MEDICAID) is included in this packet due to the recent Healthcare changes in processing applications for Medicaid. In order for any youth entering a foster home to have medical insurance coverage through the Medicaid system, the last known custodian of the coverage (generally a parent, grandparent or guardian) MUST SIGN OFF that the child is no longer in their custody (living at their residence) at this time.

This closure will allow the State of Michigan Department of Human Services to enter the youth under the foster parent home and ACTIVATE health insurance coverage for them.

Recently, counties have tried to just adjust the information in an effort to keep the Medicaid case information within their county of residence and we have found that the youth have had their insurance coverage INACTIVATED and coverage DENIED. The foster parents are paying out-of-pocket costs for prescriptions to ensure the youth is receiving the medication as needed and having to bill the court for reimbursement. However, in the future, failure to return the WRITTEN CLOSURE form will VOID any responsibility by the Safe Harbor Adolescent Recovery Program for prescription needs, medical or otherwise, dental needs and vision needs.

Please assist us in providing the best medical services for your child in a prompt and efficient manner.
We ask that ALL parents with or without MEDICAID coverage (such as those who have private insurance – BCBS, Priority Health, etc.) also sign the form and return it when submitting the Safe Harbor Adolescent Recovery Program INTAKE PACKET. In the future should we have to apply for Medicaid coverage for any reason we will have the form already on file and be able to apply for coverage promptly. This could be the result of loss of job or change in health coverage (the most common).
REMINDER – WE MUST HAVE CLEAR COPIES OF INSURANCE CARDS (Front and Back). Doctor's offices, Pharmacists, Hospitals and Dental clinics are requesting readable copies of insurance cards and at times denying services or prescription refills until the copy is received.

Thank you,



John McLean
Program Coordinator
Safe Harbor Adolescent Recovery Program
Round Lake High School

WRITTEN CLOSURE
MEDICAID

To: State of Michigan Department of Human Services

RE: _____ **DOB**:_____
Name of Minor

As of _____, the above mentioned minor no longer resides at my residence and is no
Today's date
longer in my care and custody. Please accept this notice as written closure for this Medicaid matter.

Thank you,

_____ _____
Signature of Parent/Guardian/Custodian Date

Safe Harbor Adolescent Recovery Program

Client Release of Information

INDENTIFYING INFORMATION			
TODAYS DATE	FULL NAME	CASE #	DATE OF BIRTH

I hereby authorize _____ ***to release information from my clinical record to:***

(List any doctors/facilities that may have records for your son/daughter)

SHARP STAFF:
John E. McLean, Program Director
Bert Rousseau, Assistant to the Director
Michael Gee, MA, LPC

S.H.A.R.P
13513 Division Street
Charlevoix, MI 49720
(231) 547-4085 Fax: (616) 439-1864

I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse (as permitted by MCL 330.1748, P.A. 258 of 1974 and 42 CFR Part 2).

SPECIFIC INFORMATION TO BE REQUESTED/DISCLOSED

- ☐ Notice of start/receipt of services
- ☐ Personal identifying information
  Name Age SSN
- ☐ Notice of end of services
- ☐ Physical therapy assessment
- ☐ Occupational therapy assessment
- ☐ Individual plan of service/treatment plan
- ☐ Alcohol/substance abuse
- ☐ Educational Legal
- ☐ Initial Assessment
- ☐ Diagnosis
  - ☐ Substance abuse
- ☐ Dietary assessment
- ☐ Psychological assessment
- ☐ Progress notes
- ☐ HIV/AIDS/ARC related
- ☐ Physical exam
- ☐ Psychiatric evaluation
- ☐ Psychiatric notes
- ☐ Annual assessment
- ☐ Psychological testing
- ☐ Psychotherapy notes
- ☐ Medications
- ☐ Financial information

LAB REPORTS TYPE	MEDICAL INFORMATION	OTHER

NOTES

PURPOSE OR NEED FOR REQUEST/DISCLOSURE

- ☐ Communication with primary care physician
- ☐ Provision/Continuation of services
- ☐ MI statewide homeless management information system
- ☐ Coordination of care
- ☐ Medication review
- ☐ Billing/Payment
- ☐ Eligibility determination
- ☐ Evaluation/Assessment
- ☐ Emergency contact
- ☐ Aftercare planning

OTHER

- I understand that authorizing the request/disclosure of information in my records is voluntary, and that my services will not be affected if I choose not to sign this form.

- I understand that I as the client/parent/guardian who signed this form can request to review or copy the information released/disclosed pursuant to this Authorization as allowed in 45 CFR 164.524, the Michigan Mental Health Code, 42 CFR Part 2, and any other applicable laws, rules and regulations.

- I understand that my information may be re-disclosed without my consent where allowed by law. I also understand that any release/disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by Federal Confidentiality Laws (P.L. 104-191 (HIPAA), 45 CFR Parts 160 and 164).

Client Release of Information

TODAYS DATE	FULL NAME	CASE #	DATE OF BIRTH

This authorization, except for action already taken, can be revoked at any time by verbal or written n o t i c e .
Without expressed revocation this authorization expires after one year, or sooner for any one or more of the following reasons:

A. Date:
B. Event:
C. Condition:

IF ALCOHOL OR DRUG ABUSE TREATMENT INFORMATION IS RELEASED: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

FOR ANY RELEASED CONFIDENTIAL INFORMATION: Pursuant to MCL 330.748(3); MSA 14.800(748) (3), the individual or organization in receipt of this confidential information shall redisclose this information to others only to the extent consistent with the authorized purpose for which the information was obtained

Client Signature	Date	Parent/Guardian/Representative Signature	Date

Witness Signature	Date	Second Witness Signature (if telephone request)	Date

Release must be completed for each provider son/daughter has records with. Make additional copies as needed.

PARENT PARTICIPATION AGREEMENT

Safe Harbor Adolescent Recovery Program has, as part of its overall program, a parent component involving parent support. Your participation in the parent support group meetings will enhance your parental and communication skills, allow you to receive feedback on your child's progress in the program, furnish you with information on social problems, and allow you to experience family recreational activities.

I understand that my involvement with my child's treatment includes participating and being involved in the Safe Harbor Adolescent Recovery Program parent component.

_____

Parent Signature Date

_____

Parent Signature Date

PERMISSION FOR THE USE OF PHOTOGRAPHS, SLIDES AND/OR VIDEOS FOR FUNDRAISING AND PUBLIC RELATIONS ACTIVITIES

On occasion, Safe Harbor Adolescent Recovery Program engages in public relations programs. In connection with these programs it is helpful to Safe Harbor Adolescent Recovery Plan to be able to use photographs, slides or video recordings of our staff and clients. The purpose of this Permission of Release Form is for you to give written permission to Safe Harbor Adolescent Recovery Program to take pictures or video record our clients and to use the same in fundraising public relations activities. If you will grant such permission to Safe Harbor Adolescent Recovery Plan, please sign in the space provided.

I, _____ give permission to Safe Harbor Adolescent Recovery
(participant's name)

Program to make and use photographs and/or recordings photographs, slides, and video recordings of me and to use them in connection with Safe Harbor Adolescent Recovery Program fundraising and public relations activities. I also consent to the use of my name in connection with Safe Harbor Adolescent Recovery Program public relations activities.

_____

Signature of Participant Date

_____

Signature of Parent/Guardian Date

RECREATIONAL PERMISSION/CONSENT

_____
(Participant's Name)

I, being the parent/guardian of the above name minor, authorize Safe Harbor Adolescent Recovery Program staff to supervise the recreational activities of the above named child, to permit her/him to attend and participate in all sports, camping, swimming, canoeing, picnics, visits to parks and lakes and any outings the representatives of Safe Harbor Adolescent Recovery Program deem beneficial.

In consenting to my child's participation in recreational activities, I also covenant not to sue Safe Harbor Adolescent Recovery Program, its agents, employees, servants and any corporation of firm under whose authority Safe Harbor Adolescent Recovery Program exists, on account of or in any way as a result of any injury which occurs while my child is involved in recreational activities.

_____
Signature of Parent/Guardian Date

VIDEO SURVEILLANCE POLICY

I understand that in order to promote the safety of Staff, foster parents, youth and visitors, as well as the security of its facilities and foster homes, SHARP may conduct video surveillance of any portion of its premises at any time, the only exception being private areas of restrooms/bathrooms & showers, and that video cameras will be positioned in appropriate places within and around SHARP facilities and homes, and used in order to help promote the safety and security of people and property. I hereby give my consent to such video surveillance.

_____
Signature of Participant Date

_____
Signature of Parent/Guardian Date

AUTHORIZATION FOR IMMUNIZATION

Parent/ Legal Guardian Name(s) _____

I, the biological parent(s) or legal guardian(s)* of _____ ___/___/___
Child name (please print) *Date of Birth*
give permission to the immunization clinic, to complete the vaccine screening form, and to the administration of all vaccines due at the time of visit unless specifically declined in writing.

** (Legal Guardianship requires written proof to be attached)*

This authorization is active until such time it is cancelled in writing or a new updated authorization is received.

Authorized Signature: _____ Date _____/_____/____

Authorized Name (please print) _____ Date of Birth: ____/____/____

Address: _____ Phone: (____)-_____-_____

IF DECLINING, PLEASE INDICATE RATIONAL BELOW:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature: _____ Date _____/_____/____

Name (please print) _____ Date of Birth: ____/____/____

PARENTAL AUTHORIZATION
FOR CHILD TO ATTEND RELIGIOUS SERVICES

In The Matter Of: _____ dob: _____

It is my understanding that foster parents and/or Non Secure Detention home operators may desire to attend religious services as they may schedule.

(*Please check specific boxes that apply and sign.)*

☐ **I as the Parent/Guardian *AUTHORIZE* my child to attend religious services while residing in a Charlevoix County Probate/Family Court licensed foster or Non Secure Detention home.**

☐ **Protestant** ☐ **Catholic** ☐ **Other _____**

☐ **I as the Parent/Guardian *DO NOT AUTHORIZE* my child to attend religious services while residing in a Charlevoix County Probate/Family Court licensed foster or Non Secure Detention home.**

Parent/Guardian: _____
Print Name

Parent/Guardian: _____ Date: _____
Signature

HOME VISIT GUIDELINES

____ Teens must be supervised by parents at all times unless SHARP Staff and Probation Officer have given prior approval.
____ The family home must be alcohol and drug free.
____ Teens must attend a 12-step meeting(s) when on overnight/weekend home visits
____ Teens are required to call in to Foster Parents each day they are on an overnight visit, they may leave a message with the date and time on the FP phone if they do not answer.
____ Teens will have NO contact with friends without prior approval from SHARP and Probation Officer.
____ **Nothing** is to be brought back to foster home without approval from foster parents. Please no valuables. This program is not responsible for personal items.
____ Teens are not to be in possession of any medication. All medications are to be kept locked up. Medications are to be transferred from adult to adult only.
____ Follow guidelines for dispensing medication to teen. ***(Any concerns /questions regarding Rx administration requires the parent to speak to foster parents)***
____ All information is to be communicated from adult to adult.
____ Teens are not to be in possession of any money.
____ Pick-ups and drop-offs of home visits must be prompt and timely. Any changes to the scheduled times requires adult contact. Drop-offs must have adult-to-adult contact. (Contact **required** between foster parent and family)
____ Rules of probations still apply when teens are on a home visit.
____ Any concerns during home visits need to be shared with **foster parents** or **SHARP Staff** the same day that the teen returns to the program.

In case of emergency during a home visit, contact the foster parent or Charlevoix County Sheriff Department at 231-547-4461 and request that the on-call referee for Charlevoix Probate / Family Court be paged.

I have read and understand that I will be held accountable for these rules.

_____ _____
Teen Signature Date

_____ _____
Parent(s) Signature Date

Safe Harbor Adolescent Recovery Program

RECOMMENDED ITEMS FOR FOSTER CARE YOUTH

The following items are the recommended personal items teens should bring while attending SHARP. Unless there is medical necessity for items other than what is listed here,

PLEASE LEAVE ANY ADDITIONAL ITEMS AT HOME!

GENERAL:
1 Casual Slacks
5 Jeans - no rips, tears, holes
2 Shorts (gym use)
2 Shorts (casual; fingertip length)
2 Sweaters / Sweatshirts (no hoodies allowed)
6 T-shirts (crew neck only; no tanks, spaghetti straps or V-necks)
2 Sneakers (1-gym / 1-casual outdoor use)
1 Belt – black/brown; no design; no cloth
2 Pajamas – separate from clothing worn during the school day
1 Bathing Suit (Female: 1 piece's only; Male: boxer short style)
2 Shorts (fingertip length)
12 Underwear (Females: no thongs)
3 Bras/ 3 Sport Bras
12 Pairs of matching socks
1 set of CLOTHES FOR COURT – Boys: bring tie

SEASONAL: BLACK long sleeve t-shirts (to wear under polos; NO GRAPHICS)
1 Light Coat
1 Heavy Coat
Snow / Ski pants (optional)
1 Winter Gloves
1 Winter Hat (NO BASEBALL CAPS)
1 Winter Boots (calf height)

Optional: Stamps & Stationary
Drawing pad / colored pencils
1 Slippers (foster home ONLY)
1 Sandals (foster home ONLY; NO OPEN–TOED SHOES ALLOW AT SCHOOL)

NOTE: No leggings
No razors

Basic toiletries will be provided for youth. A teen may bring their own personal items (straighteners, curling irons, blow dryer), however, **no aerosol products are allowed** (ie. colognes, perfumes, body sprays, nail polish, nail polish remover), and **no products containing alcohol.**

No jewelry .

Headphones are allowed for use in the classroom setting only and are required to be left at the school. They are **NOT** to be used for weekly home visits. Headphones are a privilege and not a necessity and may be revoked at any time.

Visitation Schedule

- **Week 1 -4:** Youth begins working in the program and completing various assessments. No visits during this time.

- **Week 5:** 4 hour visit with parent/ legal guardian; not to return to his/her home or community. The following criteria must be met:
  1. Achieve 75% overall on weekly progress report.
  2. All assessments completed by Treatment provider
  3. The youth displays stable behavior as evaluated by the counselor

- **Week 6:** Youth will continue to work within program. No visits scheduled.

- **Week 7:** Day visit with parent/ legal guardian; not to return to his/her home or community. The following criteria must be met:
  1. Achieve 80% overall on weekly progress report
  2. Must have successfully attended 4 hour visit
  3. Negative drug screen from previous visit, including nicotine.
  4. The youth displays stable behavior as evaluated by the counselor

- **Week 8:** No visits scheduled. The parent/guardian will be required to attend a family session. The following will be covered in the session:
  1. Youth's progress in treatment
  2. Youth's behavior during previous visits.
  3. A home Contract (Appendix 1) will be established to prepare for a home visit. Parents/guardians must attend this session prior to the youth receiving a home visit.

- **Week 9:** Overnight home visit. The following criteria must be met:
  1. Achieve 85% overall on weekly progress report.
  2. Home contract completed and signed.
  3. Negative drug screen from previous visit, including nicotine.
  4. Must have successfully completed day visit.
  5. The youth displays stable behavior as evaluated by the counselor

- **Week 10-program completion:** Fri-Sun home visit. The following criteria must be met:
  1. Achieve a 90% overall on weekly progress reports
  2. Negative drug screen from previous week, including nicotine.
  3. Must have successfully completed overnight visit.
  3. The youth displays stable behavior as evaluated by the counselor

SHARP Staff reserve the right to cancel any/or all visits if the youth is determined to be a risk to themselves or to the public. Any/all visits may be changed according to what is deemed to be in the best interest of the youth and/or parent.

_____ _____

Parent signature Teen signature

Telephone Usage

Youth are allowed one call per week to their probation officer during the hours of 9am and 3pm, Monday through Friday. Calls are limited to 15 minutes. Days are by first letter of last name.

Mondays:	A thru E	Tuesday:	F thru J
Wednesday:	K thru O	Thursday:	P thru T
Friday: U thru Z			

Probation officers, case workers, attorneys may contact the program anytime between 9am and 3pm to speak with their youth.

Calls home are not allowed during school hours (incoming or outgoing) unless it is an emergency; defined by grave illness or death in the immediate family. These calls are reserved for the foster home. Youth may contact family up to three times per week for a maximum of 15 minutes. These calls are subject to speaker phone monitoring to ensure conversations remain appropriate.

Daily Schedule

Monday thru Friday

7:00am-7:30am	Youth are picked up by county transit
8:00am	Arrive Round Lake Educational Center
8:00am-8:30am	Youth are checked in
8:30am-9:00am	Breakfast and bathroom breaks
9:00am-10:00am	Academics
10:00am-10:15am	Break
10:15am-10:30am	Bathroom break
10:30am-11:55am	Academics
11:55am-12:30pm	Lunch & clean-up
12:30pm-2:00pm	Academics
2:00pm-3:00pm	Gym/recess
3:00pm-5:15pm	Recovery group sessions
5:15ppm-5:30pm	Check-out and transit pickup back to foster home

- Individual sessions happen throughout the day
- Random drug testing throughout the week conducted by court staff

Saturday and Sunday

This time would be spent either on a scheduled home visit or with foster parents working on Life skills.