An aerial photograph of a lake with a dam in the foreground. The water is a light blue-green color. On the right side, there is a residential area with many houses and trees. The background shows a large body of water and a forested shoreline.

Safe Harbor Adolescent Recovery Program

# SHARP

## *Intake Packet*

951 Mill Street, East Jordan, MI 49727

For availability or intake questions, Please Call (231) 547-4085

Or visit us on the web @

[www.chxsharp.com](http://www.chxsharp.com)

**PLEASE FAX OR EMAIL ALL COMPLETED INTAKE INFORMATION TO: 616-439-1864  
OR [mcleanj@charlevoixcounty.org](mailto:mcleanj@charlevoixcounty.org)**

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

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## SAFE HARBOR ADOLESCENT RECOVERY 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 108 East Garfield., 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, youth's 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 10 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):

---

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## 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		

**Any special diet requirements?**

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.

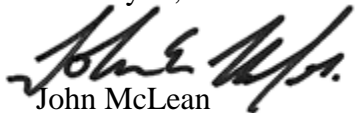
This closure will allow the State of Michigan Department of Human Services to enter the youth under the foster parent home and **ACTIVATE** health insurance coverage for them.

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 - South

**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

IDENTIFYING 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)

**S.H.A.R.P**

**SHARP STAFF:**

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

951 Mill Street  
 East Jordan, MI 49727  
 (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

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

LAB REPORTS TYPE	MEDICAL INFORMATION	OTHER
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### PURPOSE OR NEED FOR REQUEST/DISCLOSURE

<input type="checkbox"/> Communication with primary care physician	<input type="checkbox"/> Billing/Payment
<input type="checkbox"/> Provision/Continuation of services	<input type="checkbox"/> Eligibility determination
<input type="checkbox"/> MI statewide homeless management information system	<input type="checkbox"/> Evaluation/Assessment
<input type="checkbox"/> Coordination of care	<input type="checkbox"/> Emergency contact
<input type="checkbox"/> Medication review	<input type="checkbox"/> 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).





**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:

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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** – exceptions: girls are allowed one set of stud earrings.

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.

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Parent signature

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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
5:15pm-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.