YES HOUSE SCHOOL APPLICATION CHECK LIST

Are you currently expelled from Campbell County School District? _____

The Check List must be completed before a student can attend school.

EXPELLED STUDENT APPLICATION	NON-EXPELLED STUDENT APPLICATION
____ Fully Completed Application ____ CCSD Technology Waiver Filled Out & Signed ____ Free and Reduced Meal Application Filled Out ____ Fully Completed Clinical Packet. ▪ Letter to Parents/Guardians ▪ Patient Information Sheet ▪ Payment Agreement Signed ▪ Counseling Referral Form ____ Current School Physical ____ Counseling Intake with the Therapy Department ____ School Intake with the Principal and Liaisons ▪ Read Handbook ▪ Sign Handbook Acknowledgement _____	____ Fully Completed Application ____ CCSD Technology Waiver Filled Out & Signed ____ Free and Reduced Meal Application Filled Out ____ Current School Physical ____ School Intake with the Principal and Liaisons ▪ Read Handbook ▪ Sign Handbook Acknowledgement _____

PARENT INFORMATION SHEET

Here is what we need from you:

- Open communication with us regarding the needs of your family (you, your child and other family members).
- Help and coordination in making any necessary appointments while your child is here.
- Your signature on all consent forms.
- Your cooperation in completing the entire intake process.
- Any pertinent medical and prescription information.
- Your help in setting the specific limitations for your child.
- Your commitment in working with us to follow through with suggestions and recommendations made during, as well as after, the stay.
- Your cooperation in providing the necessary clothing and miscellaneous items that your child will need.
- Your cooperation with staff in following our various agency policies.

Things you probably want to know from us:

The following types of clothing and accessories are considered inappropriate: crop tops, belly shirts, low cut blouses, tees shirts printed with profanity, vulgar graphics or reference to drugs and alcohol. Also not permitted are potentially dangerous accessories and jewelry. Staff discretion shall be used in all above matters.

- Your child has the right to follow any spirituality activities during his/her stay. Parents will be responsible for any necessary transportation.
- We will provide a very safe, supervised, and structured environment.
- Phone calls from parents, therapists, lawyers, etc., are allowed whenever reasonable and appropriate. We ask that you call back if the time is inconvenient, if we are really busy or if we are eating.
- Phone calls from friends are prohibited. Please make personal calls at home.
- We believe that everyone should be treated with dignity and respect.
- We believe that everyone should be held accountable for his/her own individual choices and actions.
- We believe in and implement the use of time-outs, choices, and natural and logical consequences.

Date received _____ Date contacted:_____ Date of intake:_____

YES HOUSE SCHOOL APPLICATION

All questions MUST be answered thoroughly and accurately.

Incomplete or inaccurate applications will be discarded.

STUDENT: _____
(Last) (First) (Middle) (Other)

AGE: _____ DOB ____/____/_____ SOCIAL SECURITY #____-____-____

HOME ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

MAILING ADDRESS:_____
(STREET) (CITY) (STATE) (ZIP)

GUARDIAN'S EMAIL ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

RACE: ____HISPANIC/LATINO ____AFRICAN AMERICAN ____WHITE

____AMERICAN INDIAN ____BI-RACIAL

Height _____ Weight _____ Hair color _____ Eye color _____ Place of Birth _____

Spirituality _____

MOTHER/GUARDIAN NAME: _____

MOTHER'S ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

MOTHER'S EMPLOYER: _____ WORK PHONE: _____

FATHER'S NAME: _____

FATHER'S ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

FATHER'S EMPLOYER _____ WORK PHONE: _____

*Is household employment related to the Methane Industry YES/NO

Do you reside with your parents? _____ Yes _____ No If "no", explain: _____

_____

If parents are divorced or separated, who has custody of the student? _____

(A legal document stating custody must be provided to the school.)

____ If applicable, name and complete address for additional report card mailing: _____

_____

Names and ages of all members in the household living with the student:

1) _____ 2) _____
3) _____ 4) _____
5) _____ 6) _____

FIRST LANGUAGE SPOKEN BY STUDENT _____

Languages spoken in the home _____

Languages needed for correspondence between school and home _____

Current language(s) spoken and fully understood by student _____

Has this student ever attended a school in CCSD #1 before? ___ YES ___ NO If yes, when and where?
_____

Do you reside in Campbell County School District? ____If not, which district?_____

EMERGENCY CONTACT: _____ _____ PHONE: _____

OTHER IMPORTANT EMERGENCY INFORMATION: _____

_____

NO CONTACT LIST: _____

_____

Do you have a certificate of eligibility for the Federal Migrant Program? ___ YES ___ NO If so, last qualifying date? _____

SCHOOL HISTORY

SCHOOL LAST ATTENDED: _____

ADDRESS: _____

(STREET) (CITY) (STATE) (ZIP)

DATE OF WITHDRAWL: ___/____/____ CURRENT GRADE _____

GRADUATION DATE: _____

REASON FOR LEAVING: _____

_____

DISCIPLINARY RECORD (GRADES 7-12): _____

_____

Have you ever been expelled (not suspended)? ____ Yes ____ No

If "yes", please describe offense(s) and circumstances of the expulsion(s): _____

_____

_____

Do you receive IEP, 504, Title I, or Gifted services? ____ Yes ____ No

CLASSROOM SETTING: ____ REGULAR ____ SELF-CONTAINED ____ BOTH

CURRENT SERVICES BEING PROVIDED: _____

_____

_____

IEP CASE MANAGER NAME: _____ PHONE NUMBER: _____

Do you have any behaviors that might hinder the education of yourself or that of others? (EX. ADHD, truancy, anger, etc.) Please list and explain: _____

_____

_____

Has student repeated or been asked to repeat a grade? ___ YES ___ NO

If yes, when and what grade? _____

Activities that youth participated in: _____

How have you done in school (i.e. grades, behavior, organization, etc.)?_____

_____

LEGAL HISTORY

List all current and/or past involvement with the juvenile system, including referrals, adjudications, informal probations or dismissals.

YEAR	OFFENSE	PLACE

Are you currently on probation/diversion? _____YES _____NO If "yes" please explain why? _____

_____

_____

NAME OF PROBATION OFFICER: _____ COUNTY _____

MISC. INFORMATION

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? ____ YES ____ NO

WILL YOU NEED TO TAKE THEM AT SCHOOL? ____ YES ____ NO

If "yes", please describe the medications (include how many milligrams and how often taken) and the reasons for use: _____

_____

_____

_____

ARE YOU CURRENTLY WORKING? ____ YES ____ NO

EMPLOYER NAME: _____ PHONE NUMBER: _____

SUPERVISOR'S NAME: _____ TOTAL HOURS PER WEEK _____

Written questions (MANDATORY- Student must fill out):

ALL applicants must answer the following questions. Please answer each question in at least 2 sentences or more. You may use another piece of paper if necessary. The screening committee will look at these questions when deciding your acceptance to the YES House School.

1. Why should we accept you into our school? _____
_____
_____
_____
_____
2. Where do you see yourself in 90 days? _____
_____
_____
_____
_____
3. What choices did you make that brought you to our school? _____
_____
_____
_____
_____
4. What are your greatest strengths? _____
_____
_____
_____
_____
5. What are your greatest weaknesses? _____
_____
_____
_____
_____
6. What does the phrase "respect others" mean to you? _____
_____
_____
_____
_____
7. What does "work ethic" mean to you?
_____
_____
_____
_____

NOTICE AND CONSENT FOR EDUCATION PROGRAM CARE

_____ began attending the YES House Education Program at 905 Gurley Avenue on _____. With your consent, care may be provided to your child and family for the remaining time they are placed in our program, during which time a determination will be made as to what services may be appropriate to help resolve his/her problem.

By signing this agreement, you also consent to the Education Program obtaining emergency medical or dental care for your child, if you cannot be reached. You shall be notified within a reasonable time period.

As legal guardian(s), I/we understand that some of the information obtained during this intake will be used for statistical and finding purposes and submitted to state and/or federal agencies to collect and document various information about runaway and homeless youth.

The Education Program shall not be held liable for personal injury suffered by the child named above or inflicted by your child upon others for the duration of this agreement. The Education Program shall have the authority to transport child named above by its agents, employees or officers by any means of transportation to any location the Education Program deems necessary.

You also agree to meet periodically with staff from the Education Program to discuss the child's progress.

By signing this consent, you also agree to allow us to perform mandatory follow-up on the child after he/she has transitioned to another school, so that we may provide support for the child.

PARENT(S) AND/OR GUARDIAN(S)

X _____ Date: _____

X _____ Date: _____

Agency Involved with Youth

Name of Agency	Involved?	Contact Person & Phone #
Attorney		
DFS Worker		
Counselor		
P.O.		
Judge		
Diversion		
CA.S.A.		
Other:		

Date of Next Court Hearing or MDT**:** _____

Probation Status: ___ Diversion ___ CHINS ___ D.F.S. I.S.P. ___ Juvenile Probation I.S.P.

Indicate all that apply to the youth's functioning:

Basic Needs Issues _____

Difficulty Accessing Community Services _____

Truancy _____

School Related Problems _____

Family Conflict (Non-Violent) _____

Family Conflict (Violent) _____

Drug/Alcohol (abuse/experimentation) _____

At-Risk for Delinquent Behavior _____

Behavior Issues at Home _____

WAIVER OF CONFIDENTIALITY

Applicant and parent/guardian understand that information requested in this application will be used solely in the selecting of qualified candidates for YES House School. Both the teachers and the principal participate in the interviewing process here, and therefore it is understood that any information provided will be open to examination by all parties involved in this process. By voluntarily submitting this enrollment application, the applicant and parent/guardian waive all rights to privacy and/or confidence as it pertains to determining that acceptance or denial of the applicant's enrollment at YES House School.

NOTE: Any attempt to intentionally mislead, misrepresent or omit information requested on this application may result in the termination of consideration of this student's application for enrollment at YES House School. Please feel free to call (686-0669) if you have questions regarding any of the requested information.

Release of Information

Please Fill Out Completely

I, _____ authorize the Youth Emergency Services Education Program
(Parent/Guardian Name) and:

Initials (must fill in)

_____	DFS (see below)
_____	County Sheriff and/or Gillette Police Depts.
_____	Campbell County Attorney
_____	Campbell County Juvenile Probation
_____	Campbell County School District
_____	Other (specify)
_____	Other (specify)

to exchange oral, written, diagnostic, referral, education and/or treatment information from:

(dates) _____ to _____ about my child _____

(Date) (Date) (Name)

of whom I have legal custody. Specific information to be released:
Initial (must fill in)

_____	Name
_____	Diagnostic Information
_____	Referral Information
_____	Attendance Data
_____	Clinical Progress Data
_____	Education/Treatment/Termination Data
_____	Medical History and Exam Data
_____	Social Summary
_____	Other (specify) _____

For the purpose of keep statistics, obtaining required licensing information and reporting to our funding agencies, Y.E.S. House Education Program may also be required to release certain statistical information to the Department of Family Services. Since the Department of Family Services is our licensing agency and one of our funding sources, the Y.E.S. House Education Program may also be required to release other pertinent information regarding the placement of your child(ren) upon their specific request. Although there is no penalty for refusing to sign this authorization, it may be impossible to provide the requested services if this form is not signed and placement of your child(ren) with our facility could possibly be denied. This release of information form will remain in effect for one year unless otherwise indicated or a written request is received to terminate the authority of this form.

_____ _____
Signature Date Signature Date

_____
Witness Date

Medical Treatment Log

Name: _____ DOB: _____

Current Medications:	Dosage:	Doctor:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical Doctor: _____ Phone: _____

Psychologist: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Ind. Therapist: _____ Phone: _____

Family Therapist: _____ Phone: _____

(Doctor) (Date)

Last Psychological Evaluation: _____ _____

Last Substance Abuse Evaluation: _____ _____

Please provide a copy of child's current physical exam.

Any known allergies? _____ Please explain: _____

_____

_____

_____

_____

Campbell County Memorial Hospital

Consent for Medical Care of Minor Child(ren)

The undersigned is concerned for the health of below named child(ren) in the event of my absence.

This consent is made for the purpose of authorizing the hospital to provide emergency care treatment for the undersigned child(ren) in the event that I cannot be reached, or am physically unavailable to sign a consent for treatment form. In giving this consent, I understand that I am giving up the right to have an opportunity to have the hospital or the physician explain to me the risks involved in the procedures performed on the below named child(ren). I have weighed the risks in my mind of having the child(ren) go without treatment through my lack of ability to give immediate specific consent, and having procedures performed of which have risks attached that I am aware. In weighing these factors, I have decided that it would be best for my child(ren) to have treatment recommended by a physician or Campbell County Memorial Hospital and give my consent to those procedures.

I hereby waive any and all claims I may have against the hospital, its agents and/or employees for performing these procedures without giving me a breakdown of the possible risks involved prior to doing so. I make this waiver for myself, my spouse, if any, my heirs and assigns, anyone who has the care of my child(ren) while I am gone or unavailable, on behalf of the minor child(ren) listed below.

I understand that this consent will be in effect until _____ (if no time is filled in, it will be good for one year from the date signed). It can be revoked by me if I so desire by specifically directing the hospital that the consent is revoked. Signing papers authorizing others to give medical consent will not revoke this consent. I farther understand that this consent will be kept at the hospital and used in the event my child(ren) are in need of medical care during my absence.

I provide the following information to aid in any treatment of my child(ren).
Private physician: _____
Any know allergies: _____

Current medications:
_____

Name of Child Enrolled Age Date of Birth
_____

_____

Mother's name: _____ Phone (H) _____ (W) _____

Father's name: _____ Phone (H) _____ (W) _____

Address: _____

Insurance information, payment source (include policy numbers, address of insurance, if available, and your social security number): _____
_____

Where will parents be during school hours: _____

Signature: _____ Date:_____
Relationship: _____

Over the Counter (PRN) Medication

I, _____, as parent or guardian of _____
(Parent/Guardian) (Name of Child)
give permission for the above-mentioned child to have the following PRN medication, which I have initialed below.

___ Generic Tylenol ---------- 500 mg – 2 tablets every 6 hours as needed up to 8 per day
___ Generic Ibuprofen ---------- 200 mg – 1 tablet every 4-6 hours as needed up to 6 per day
___ Equate flu & cold medicine ---------- 2 soft gels every 4 hours as needed up to 4 doses per day
___ Equate allergy medicine ---------- 25 – 50 mg every 4-6 hours as needed up to 12 per day
___ Equate stomach relief ---------- 1-2 tablespoons every hour up to 8 doses per day
___ Equate sore throat spray ---------- 1 spray repeated every 2 hours as needed
___ Equate Tussin DM cough medicine ---------- 2 teaspoons every 6 hours up to 4 doses per day
___ Equate cough drops ---------- plain, without cough suppressant/ 1 as needed
___ Equate natural fiber laxative ---------- 1 teaspoon in 8 oz. water 3 times daily as needed
___ Orajel ---------- apply small amounts to gums
___ Equate Gas Relief---------- 125 mg, 1-2 soft gels after meals or at bedtime up to 4 per day
___ Insect repellant containing DEET ---------- use just enough spray to cover area, before going outside
___ Equate muscle rub ---------- apply to affected area 3-4 times a day
___ Anti fungal foot spray or powder ---------- spray or powder twice a day on affected area
___ Antacid ---------- 2-3 tablets as symptoms occur up to 7 tablets a day
___ Generic calamine lotion ---------- apply to affected area up to 3 times per day
___ Equate eye drops ---------- 1-2 drops in affected eye up to 4 times per day
___ Equate triple anti-biotic ointment---------- apply to affected area lightly 1-3 times per day
___ Equate first aid spray ---------- spray affected area lightly 2-3 times a day
___ Vitamins ---------- as prescribed by physician
___ Herbs ---------- as prescribed by physician
___ Midol ---------- 1 tablet every 8-12 hours, for menstrual cramps
___ Desenex cream (athlete's foot) ---------- apply thin layer over affected area 2-3 times a day
___ Equate multi-symptom/non drowsy flu relief ---------- 2 gel caps every 6 hours up to 8 per day
___ Equate multi-symptom/non drowsy cold relief ---------- 2 gel caps every 6 hours up to 8 per day
___ Other_____

Above are according to manufacturer's directions. Staff administering the medication should always compare instructions on bottle with above instructions and note any changes in manufacturer's instructions. Please follow updated instructions. Any deviation from the above requires physician's prescription. If symptoms persist by 3 days, further evaluation is required by PCP.

I understand that my child will not be given any medication unless it is checked on the list.

_____ _____
Parent/Guardian Date

_____ _____
Witness Date

YES HOUSE SCHOOL

PERMISSION FOR PRESCRIPTION MEDICATION

Name of Child_____ Age_____
Primary Healthcare Provider_____ Phone#_____
Address_____
Medication_____Dosage_____Route_____
Purpose of Medication:

_____

_____

Time of day medication is to be given_____
Medication given with food? Yes_____ No_____
Possible side effects_____
Anticipated number of days it needs to be given at School_____
Amount of medication brought to the School_____
Emergency Contact number#_____
I hereby give my permission for_____ to take the above prescription at the YES House School as ordered. I understand that it is my responsibility to furnish this medication.

Date_____ _____

Signature of Parent or Guardian

Note: The prescription medication is to be brought to the YES House School in its original pharmacy container appropriately labeled by the pharmacy or person with the prescriptive authority along with a copy of the medication authorization order.

Home Language Survey

Client Name: _____ Date: _____

School: _____ Grade: _____

1. What is the first language spoken by the client?

   _____ English

   _____ Spanish

   -------- Other, Specify _____

2. What languages are spoken at home?

   _____ English

   _____ Spanish

   _____ Other, Specify _____

3. What languages are spoken or understood by the client?

   _____ English

   _____ Spanish

   _____ Other, Specify _____

4. What languages do the parents speak to each other:
   _____ English
   _____ Spanish
   _____ Other, Specify _____

5. What languages do the parents speak to their friends?
   _____ English
   _____ Spanish
   _____ Other, Specify _____

6. In what language do the parents prefer to get correspondence from the school?
   _____ English
   _____ Spanish
   _____ Other, Specify _____

On-Site School
905 N. Gurley Ave.
Gillette, WY 82716

Phone: (307) 686-0669
Fax: (307) 686-2121

Dear Parents and Guardians,

Welcome and thank you for your interest in the Y.E.S. House School.

Th process for students that have been expelled from Campbell County School District requires completing a clinical assessment with someone from our therapy team. Attached is the financial packet that needs to be completed and returned with the school application. We ask for the financial packet to be completed to help determine if there is any financial assistance that could be utilized for the clinical assessment. Once the financial packet has been reviewed you will be contacted by our therapy team to schedule the clinical assessment. Our clinical assessments identify any therapeutic needs as well as any other services your child or family may benefit from through the Y.E.S. House as well as other community resources.

Our goal is to support you and your family throughout your child's education and beyond. If you have any questions or concerns, please feel free to contact our Clinical Director Misty Bruce @ 307-686-0669 ex. 1910 or mbruce@yeshouse.org.

Thank you,

Y.E.S House Education Program

YOUTH EMERGENCY SERVICES

905 North Gurley
Gillette, WY 82716
307-686-0669

PAYMENT AGREEMENT
(Therapy Services Only)

Our current professional fees are competitive with other practices in the area. They are based on $120.00 for a standard 55-minute session. Fees may be periodically adjusted, and you will be notified in advance of any adjustment.

Payment is due at the time of service. It is customary to pay for services when rendered unless other arrangements have been made in advance with our billing office.

If insurance is involved with your services, necessary forms will be supplied to help you expedite your insurance reimbursement. We will bill your insurance as a courtesy to you. The insurance checks may be sent to the policy holder if our facility is "out of network." Patients are responsible for all fees, regardless of insurance coverage. Please present your insurance card so we can make you a copy.

Youth Emergency Services also offers a sliding fee scale for patients with high insurance deductibles or individuals without health insurance. Below is the sliding fee scale our company utilizes.

Annual Household Income	Psychiatric Services per 15 minutes	Individual Services per 55 minutes	Group Services per 55 minutes	Residential/Group Treatment per day
0-9,999	$15	$10	$7.50	$125
10,000-19,999	$30	$15	$10	$140
20,000-29,999	$60	$30	$15	$155
30,000-39,999	$90	$45	$22.50	$170
40,000-49,999	$120	$60	$30	$185
50,000-59,999	$150	$75	$37.50	$200
60,000-69,999	$180	$90	$45	$215
70,000-79,999	$210	$105	$52.50	$230
80,000-89,999	$240	$120	$60	$245
90,000-99,999	$270	$120	$67.50	$260
100,000 & Above	$300	$120	$75	$275

There will be a $25.00 service charge on all returned checks.

Please allow for a 24-hour notice if you need to reschedule your appointment. For any missed appointments that are not cancelled at least 24 hours in advance you will be charged a $75.00 fee.

If collection becomes necessary by suit or otherwise, I, the undersigned, agree to pay all costs of collection, including all attorneys' fees, court costs, filing fees, including charges or commissions that may be assessed to us by any collection agency retained to pursue this matter, which may be as much as 50% of the principal balance owed.

I, the undersigned, have read the payment policies and do hereby agree to the terms of this payment agreement.

You will need to make an appointment with Linda prior to your child's first session to set up payment arrangements. At that time, we will also take a copy of your insurance card.

Please contact Linda at 307-686-0669 ext. 1002.

Dated this _____day of_____, 20____

Signature_____

Witness_____

PATIENT INFORMATION SHEET

Court Ordered? YES NO Program:_____

PATIENT
Last Name:_____ First Name:_____ Middle:____
Gender: M F Date of Birth:_____/_____/_____ Age:_____ SS#:_____

Mailing Address:_____ City/ST:_____ Zip:_____
Home Phone:_____ Cell Phone:_____

INSURANCE We need a front/back copy of your card(s) for our records.

Primary
Insurance Company:_____ Phone#:_____
Insured's Name:_____ ID/Policy#:_____
Insured DOB:_____ Group#:_____

Secondary
Insurance Company:_____ Phone#:_____
Insured's Name:_____ ID/Policy#:_____

RESPOSIBLE PARTY Complete this section if you are not the patient but are responsible for the bill.

Responsible Party:_____ Relation:_____

SS#:_____ Home Phone:_____ Work/Cell #:_____

Home Address:_____ City/ST:_____ Zip:_____
Mailing (If different than home):_____
Employer:_____ Occupation:_____
Monthly Household Income:_____

SIGNATURE (Patient, parent, Legal Guardian or Responsible Party)

Release of Information Signed? YES NO

I request services X_____ Date:_____

PAYMENT METHOD: Cash Credit Card Check