hope begins here.

[redacted]

For All DCFS Referring Community Partners —

The following packet is required for all new clients at HopeSprings Counseling Services. Please review the packet and complete the appropriate paperwork with the completed information and signatures.

Once signed, please send it back

By Mail:

Attention: Dustun Rhea
701 Devonshire Dr., Suite B16-B18
Champaign, IL 61820

Or Fax:

Fax: (217) 352-2635

Or Email:

drhea@cunninghamhome.org

Please feel free to contact us if you have questions/concerns. Our staff is available Monday–Thursday 8:30 AM-6:00 PM & Friday 8:30 AM–12:30 PM.

Thank you,

HopeSprings Counseling Services
217-531-2360
hopesprings@cunninghamhome.org

SECTION I

CFS-Form 431-I & CFS 600-3 Releases / Exchanges of Information

Per Procedure 327.4, Duties of the DCFS Guardian, the CFS-Form 431-1, Consent of Guardian for Mental Health Treatment, must be signed by the DCFS guardian or an Authorized Agent from the Consent Unit when contracting/linking Medicaid Community Mental Health Service.

Releases/Exchanges of information are needed from DCFS or an Authorized Agency that allows for legal releasing and receiving of information as well as open communication to provide the optimal care to the child. **For HopeSprings Counseling Services, we require the following releases/exchanges (CFS 600-3):**

1. Managed Care Organization (i.e. YouthCare) — For Billing Purposes
2. Foster Parents (if duel parents, both can be on the same release)
3. Authorized Agent for Case Management (If Applicable)
4. Primary Care Provider (PCP)
5. Psychiatrist/Psychologist/Behavior Specialist (If Applicable)
6. Biological Parents (If Applicable: Still in contact with child/youth)

Note: Releases / Exchanges of information are required **To/From** each entity listed above.
For example: YouthCare to HopeSprings **&** HopeSprings to YouthCare

CFS 431-1
Rev 4 2017

State of Illinois
Department of Children and Family Services

CONSENT OF GUARDIAN TO MENTAL HEALTH TREATMENT

As the legal custodian/guardian of _____, a minor whose birth date is _____, I am authorized to act, pursuant to 705 ILCS 405 2-11 or 705 ILCS 405/2-27, on behalf of the individual minor in making health care decisions, and I hereby consent to mental health treatment (excluding inpatient psychiatric hospitalizations and psychotropic medications) for the individual minor.

- ☐ Therapy
- ☐ Psychological Assessment
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Counseling
- ☐ Medication Monitoring
- ☐ EEG's and EKG's
- ☐ Blood Level Check

It is understood that such treatment will take place at

_____
(Name, address and telephone number)

THE ABOVE CONSENT IS VALID UNTIL _____
AND IS SUBJECT TO THE FOLLOWING SPECIAL CONDITIONS: _____

_____

The costs, nature and purpose of the treatment, possible alternative treatments, and the potential risks and benefits of the treatment have been explained to me. I understand that my refusal to consent to any of the above services may result in these consequences: _____

_____

I retain the right to revoke this authorization with written notice to the above-named provider prior to the expiration date. This authorization is valid until the minor is released from the specified treatment and or procedure, or until _____.

Date _____

Witness _____

_____
DCFS Guardianship Administrator

By _____
Authorized Agent

Address: _____

_____

cc: _____
(Service Office)

Telephone: _____
(8:30 a.m -5:00 p.m)

_____
(Evenings, Weekends, Holidays)

NOTE: THE CONSENT OF MINOR 12 YEARS OF AGE OR OLDER IS ALSO REQUIRED

SIGNED: _____ DATE: _____
(Signature of person 12 years of age or older)

CFS 600-3
Rev 7/2015

State of Illinois
Department of Children and Family Services

CONSENT FOR RELEASE OF INFORMATION

1. I, _____, hereby give consent to:

2. _____ _____
(Provider of Information) (Address)

3. to release information concerning _____ B.D _____

4. to: _____
(Address)

TYPE OF INFORMATION
(CIRCLE)

5. Medical (specify): _____

6. Mental Health (specify): _____

7. Education: _____

8. Social History/Assessment (specify): _____

9. Financial (specify): _____

10. Other (specify): _____

11. THE PURPOSE FOR REQUESTING THIS INFORMATION IS _____

_____

12. **Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether or not the consent is signed by the client or his/her personal representative.** HOWEVER, I UNDERSTAND THAT IF I REFUSE TO CONSENT, THE FOLLOWING MAY HAPPEN: _____

I understand that I have the right to inspect and copy the information disclosed, except for certain adoption records, certain information regarding the identity of a source of information or the location of the minor, or under certain circumstances where information was received from a minor under a promise of confidentiality.

I understand that I may revoke this consent at any time by notifying the Provider of Information listed in Line 2 above in writing. Revocation will be effective except to the extent that action has been taken in reliance on this consent. I also understand that, even if I do not revoke this consent, the consent will expire one year from the date provided on line 15 or line 16 below unless an earlier date is specified.

13 _____ _____
Signature of Minor 12 to 17 years of age Date

14 Further, I, _____, the parent, or the legal guardian or custodian, appointed pursuant to 705 ILCS 405/2-11 or 705 ILCS 405/2-27, am authorized to act on behalf of the individual minor, _____, and I hereby consent to this limited disclosure under the terms stated above. The legal guardian or custodian or parent is the legal representative of the unemancipated minor, pursuant to HIPAA, 45 CFR 164.502(g), unless otherwise required by law.

15. _____ _____ _____
Signature of Parent, Guardian, or Authorized Agent Date Date consent expires

Address _____

16 _____ _____ _____
Signature of Adult Consenting to Release of Own Records Date Date consent expires

Address _____

17. _____ _____ _____
Signature of Witness Relationship Date

REDISCLOSURE CONSENT: The information to be disclosed is confidential and is provided only to the party specified in the above consent. The receiving party cannot redisclose the information, with the exception of reports and other information that is required to be released to the court and certain parties to juvenile court proceedings as authorized by the Juvenile Court Act 705 ILCS 405. I (we) hereby consent to redisclosure to:

_____
(if none other, enter "none other").

_____ _____ _____
Signature of Consenting Party Date Date consent expires

_____ _____ _____
Signature of Minor 12 to 17 years of age Date Date consent expires

See reverse side of form for instructions

SECTION II

HopeSprings Counseling Services Forms for the New Client

The following documentation is completed as a part of the referral and scheduling process of all new clients of HopeSprings Counseling Services. **Please see the instructions for each document included below:**

1. **DCFS Youth in Care Attendance Contract:** Guardian (State Responsible) must sign on the Guardian line & Case Worker must sign on the Client Caseworker line.

2. **Client Rights & Informed Consent:** Guardian (State Responsible) must sign the Guardian Signature line.

3. **Fee Agreement and Financial Policy:** Guardian (State Responsible) must initial & sign on the Guardian Signature line & whomever will be responsible for late charges will sign the Party Responsible line.
   - If the guardian (State or Case Management Agency) is responsible for late charges, please be sure the responsible party or agency signs the Party Responsible line prior to returning.
   - If the foster family/parent is responsible for late charges, return the document with the "party responsible" line unsigned and we will get the foster family/parent to sign.

   NOTE: PAYMENT OF LATE CHARGES IS REQUIRED FOR ACCEPTANCE OF NEW CLIENTS.

4. **HIPAA Notice:** Guardian (State Responsible) must Initial & sign on Guardian Signature line.

5. **Handbook Acknowledgement:** Please see the handbook and Guardian (State Responsible) must sign the Guardian Signature line.

HopeSprings Counseling Services
a program of Cunningham Children's Home

DCFS Youth in Care Attendance Contract

Client Name: _____ Date _____

As an agent of this client's Legal Guardian, you are receiving this attendance contract to explain attendance expectations and responsibilities at HopeSprings Counseling Services. It is your responsibility to schedule and ensure that your client attends appointments with his/her assigned therapist in order to work on established treatment goals.

The Community Counseling Client Services Termination Produces state the following:

"Clients who fail to attend three consecutive appointments may have services terminated by Cunningham. These provisions may also apply to clients who repeatedly fail to cancel within 24 hours of their scheduled appointment. Repeated patterns of failing to attend appointments and/or give 24 hour notice of cancellation will be carefully reviewed by the Associate Director on a case by case basis to determine whether termination of services is the appropriate course of action.

As an alternative to termination of services, clients failing to attend or give adequate notice of cancellation may be asked to enter into a treatment contract which places expectations on their attendance and cancellation procedure. Depending on the circumstances services should be terminated either a) with advanced notice or b) immediately when clients do not agree to sign a treatment contract. Cunningham's Community Counseling Program will discontinue services at the time of the refusal.

Cunningham will provide written notice by mail that services are being terminated which will include alternative referrals for mental health services. These referrals will be reiterated to the client on the aftercare plan sent to the client via mail post-termination.

Clients terminated for this reason may request reopening of services if and when they are interested in engaging and participating in services and are willing to enter into a treatment contract placing expectations on their attendance and cancellation procedures."

By signing this agreement you agree to consistently ensure that your client attends scheduled therapy sessions. If a session needs to be canceled for any reason, you agree to do so at least 24 hours before your client's scheduled appointment time, and reschedule the appointment.

You understand that if your client does not consistently attend scheduled therapy sessions HopeSprings could decide to terminate their therapy services.

You also understand that if you choose to not sign this agreement, HopeSprings may decide to not move forward with your client's referral for services.

_____	_____
Client Signature (required if 12 or over)	Date
_____	_____
Guardian Signature	Date
_____	_____
Client Caseworker	Date
_____	_____
Intake/AR Specialist Signature	Date
_____	_____
Associate Director of Clinical Services	Date

HopeSprings Counseling Services

Client Rights and Informed Consent

Client Name: _____ Date: _____

Client Rights: Your rights shall be protected in accordance with Chapter 2 of the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5). Your right to confidentiality is governed by the Illinois Confidentiality Act and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Consistent with these requirements, you have the following rights as a client of HopeSprings:

- The right to be provided with appropriate mental health services in the least restrictive setting.
- The right to be free from abuse, neglect, and exploitation from staff and other clients while receiving treatment at HopeSprings.
- The right to have your rights, as well as any services you receive, explained in a language or method of communication you understand.
- The rights guaranteed to you by the United States Government and the State of Illinois. Services will not be denied, suspended, terminated, or reduced because you exercise your rights.
- The right to receive services without discrimination. You will not be denied mental health services because of age, sex, race, religious belief, ethnic origin, marital status, physical or mental disability or criminal record that is unrelated to present dangerousness.
- 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].
- The right to express opinions on issues concerning your case or treatment. You are considered to be competent (able to make decisions) unless a court has determined you are not.
- The right to have a copy of your Individualized Treatment Plan that describes the services that will be provided to you. Your Individualized Treatment Plan will be reviewed at least every six months.
- The right to participate in the development and review of your treatment plan, as appropriate. If you have concerns about your treatment plan or the services you receive, you and/or your guardian may request an in-house review of your care and treatment services by Cunningham staff not involved in your treatment.
- The right to review your treatment file.
    - If you are under the age of 12, your parent/guardian can view your file at any time.
    - If you are 12 or over, you can ask to review your file; however, your right to review your file may be limited to protect you or others from harm. If applicable, your parent/guardian always has a right to basic information about your treatment. Some records will not be released to your parent/guardian without your permission.

      You or your parent/guardian (if applicable) may write a note about any part of the file that is believed to be untrue. The note will be added to your file and included in any release of applicable record(s) .

      When you [or your parent/guardian (if applicable)] review your record, a staff member will be made available to answer questions and ensure the file remains secure.
- The right to confidentiality. If you are age 12 or over, you and your parent/guardian (if applicable) must give written consent to share information about you. Without your consent, records will not be shared unless your therapist believes it is in your best interest.
    - If you are under 12, your parent/guardian must give written consent to share information about you.
    - In some cases, your age does not matter and HopeSprings may release information without consent. Some examples include:
        - If you require hospitalization because you are at risk of hurting yourself or others.

- If you have been abused, neglected, or exploited.
- If required for reviews done by other agencies to determine if HopeSprings is following various rules, laws, and standards
- Information related to crimes that occur on the property or against the staff of HopeSprings or involve immediate danger to someone else.

- The right for you or your parent/guardian (if applicable) to present grievances or to appeal adverse decisions related to the services you receive. The grievance process will be explained to you. A record of such grievances and the responses to those grievances will be maintained. You have the right to appeal decisions about your grievances to the highest level possible in the agency. The decision of the President/CEO and/or the governing body, when applicable, shall constitute a final administrative decision at the agency level.
- The right to contact the public payer or its designee, if applicable, and to be informed by the public payer (or its designee) of your healthcare benefit. You also have the right for the public payer (or its designee) to inform you of the process for filing a grievance.
    - Illinois Department of Human Services, Division of Mental Health, 319 E. Madison Ave., Suite 3B, Springfield, IL 62701 (telephone: 217-782-6470).
    - Illinois Mental Health Collaborative, P.O. Box 06559, Chicago, IL 60606 (telephone: 866-359-7953)
    - Department of Human Services: DHS Family Community Center for Champaign County, 705 N. Country Fair Dr., Champaign, IL 61821 (telephone: 217-278-5005; DHS helpline 800-843-6154)
    - Illinois Department of Children and Family Services, 508 S. Race St., Urbana, IL (telephone: 217-278-5400)
    - Illinois Department of Human Services, Office of Inspector General, (OIG 24 hour hotline: 800-368-1463)
    - East Central Illinois Area Agency on Aging, 1003 Maple Hill Rd., Bloomington, IL 61704-9327, (telephone: 800-888-4456, 309-829-2065)
    - Department of Children and Family Services, Administrative Hearings Unit, 406 E. Monroe St., Station 15, Springfield, IL 62701 (telephone: 217-782-6655).
    - Illinois State Board of Education, 100 North First St., Springfield, IL 62777 (telephone: 217-782-4321).
    - HFS Appeal Line, Bureau of Hearings, 69 W. Washington, 4th Floor, Chicago, IL 60602 (telephone: 800-435-0774)

  In addition, there are other agencies whose purpose is to protect your rights as a client. The Guardianship and Advocacy Commission can be contacted at 2125 South First Street, Champaign, IL 61821 (telephone: 217-278-5577). Equip for Equality, Inc. can be contacted at 1 West Old State Capitol Plaza, Suite 816, Springfield, IL 62701 (telephone: 217-544-0464). The Illinois Department of Human Services Division of Mental Health Statewide Coordinator of Deaf and Hard of Hearing Services is located at 901 Southwind Road, Springfield, IL 62703 (telephone: 217-786-0023; videophone: 217-303-5807). The Office of Civil Rights is located at 233 North Michigan Avenue, Suite 240, Chicago, Illinois 60601 (telephone: 800-368-1019). If you need assistance, HopeSprings staff are available.

- The right to be notified of any restriction(s) of your right(s). Justification for any restriction to these rights shall be documented in your clinical record. Your parent or guardian (if applicable) as well as any agency you designate shall be notified of the restriction.
- You, or your parent/guardian (if applicable), have the right to refuse services. Refusal of these services may result in your case being closed when it compromises treatment and/or there is significant risk to your safety or the safety of others.

Informed Consent

- I am seeking services at HopeSprings Counseling Services, A program of Cunningham Children's Home. If I'm under the age of 18, I realize that my parent/guardian/funding agent is seeking services for me at HopeSprings.
- I consent to an assessment of my needs.
- I understand that a treatment plan will be developed based on an assessment of my needs and I will have the opportunity to participate in the development of the treatment plan.

- I understand that an emergency plan that identifies supports and resources I may access in the event of any emergency is included in the HopeSprings Handbook. Not only will I receive a copy of the HopeSprings Handbook, but a copy is also located on the program's website which provides 24 hour access to these resources.
- I consent to receive services offered by HopeSprings Counseling Services. A variety of treatment services are available to address my identified need (s). No guarantee or assurance has been given by anyone as to the results that may be obtained from services. I am responsible for actively participating in treatment services.
- Treatment services may be provided face-to-face or through distance counseling (telehealth) through synchronous digital and/or audio/video means. Synchronous means services are provided via real time audio/video interactions. HopeSprings Counseling Services will not provide distance counseling via e-mail, text or other methods that do not involve real time interactions.
- Appropriateness of telehealth services will be evaluated on an individual basis and you may decline use of this treatment modality. If you are receiving telehealth services, your therapist may determine at any time that this type of service is no longer appropriate. If face-to-face services are not possible, your therapist will provide alternative services options.
- Telehealth services are provided using HIPAA compliant encrypted technology purchased by HopeSprings Counseling Services. This technology is designed to protect the confidentiality and security of the communication between you and your provider. We will not use platforms that are not HIPAA compliant (e.g., Skype, FaceTime, etc.). It is important to note that the nature of electronic communications is such that privacy risks exist, and no one can guarantee that unauthorized persons will not gain access.
- I understand that there is the possibility of both risks and benefits. Treatment benefits may include an increase in positive feelings and behaviors, improved relationships with others and ultimately, improvement in the quality of my life. Treatment risks may include experiencing uncomfortable emotions (e.g., sadness). Risks associated with distance counseling (telehealth) may include your therapist having reduced ability to reliably assess your mood and/or status compared to face-to-face interactions. In addition, telehealth may provide less confidentiality (e.g., conversations being overheard or accessed) or less reliable connections (e.g., dropped calls, poor internet connection, etc.).
- I understand that staff members of HopeSprings Counseling Services are not permitted to follow or friend me (or my parent/guardian) on social media platforms (e.g., Facebook, Twitter, Instagram, etc.). This practice protects my confidentiality and supports a healthy therapeutic relationship with my therapist/ HopeSprings staff.
- I understand that if I present in a violent or threatening manner toward HopeSprings staff, I may be asked to enter a 30-day treatment contract which places expectations on my behavior in order to continue receiving services. I understand that these situations are managed on a case by case basis; however, if I continue to present in a violent and/or threatening manner, have multiple incidents of violent and/or threatening behavior over time, or are otherwise noncompliant with expectations, then my services could be terminated prior to 30 days from the date of the treatment contract. I also understand that if I do not agree to sign the treatment contract, HopeSprings will discontinue my services at the time of my refusal.
- I understand that if my needs are assessed by my therapist to be beyond what traditional therapy can provide that I may be asked to enter a treatment contract requesting that I engage in specific type(s) of treatment (e.g., inpatient or outpatient substance abuse, take psychotropic medication, day treatment, or inpatient psychiatric, etc.). I understand that if I do not agree to sign the treatment contract, HopeSprings will discontinue my services at the time of my refusal. I also understand that if I do not comply with the conditions of the contract, HopeSprings will discontinue my services in 30 days from the date of the treatment contract.
- While telehealth services provide the opportunity for services to be recorded via audio and/or video, no treatment services will be recorded without your consent. Any video/audio recording would be for the sole purposes of staff training and/or supervision and will never be made public. We request that you (client) do not record treatment services in any manner due to potential risks to your confidentiality (e.g., recording is accessed and/or uploaded by a third party). Cunningham has no ability to protect the confidentiality of recordings made by a client.
- I have been apprised of my rights and I have been informed of the services offered by HopeSprings. I also have received this information in writing.

Parent/Guardian

- I am the parent or guardian of a minor or guardian of an adult seeking services.
- I consent to an assessment of this client's needs.
- I understand that a treatment plan will be developed based on assessment of this client's needs and I will have the opportunity to participate in the development of the treatment plan.
- I understand that an emergency plan that identifies supports and resources the client and/or I may access in the event of any emergency is included in the HopeSprings Handbook. Not only will I receive a copy of the HopeSprings Handbook, but a copy is also located on the program's website which provides 24 hour access to these resources.
- I consent to this client's participation in the services offered by HopeSprings Counseling Services. A variety of treatment services is available to the client to address his/her identified needs(s). No guarantee or assurance has been given by anyone as to the results that may be obtained from services. Each client is responsible for active participation in treatment and services offered.
- Treatment services may be provided face-to-face or through distance counseling (telehealth) through synchronous digital and/or audio/video means. Synchronous means services are provided via real time audio/video interactions. HopeSprings Counseling Services will not provide distance counseling via e-mail, text or other methods that do not involve real time interactions.
- Appropriateness of telehealth services will be evaluated on an individual basis and you may decline use of this treatment modality for this client. If the client is receiving telehealth services, his/her therapist may determine at any time that this type of service is no longer appropriate. If face-to-face services are not possible, the therapist will provide alternative services options.
- Telehealth services are provided using HIPAA compliant encrypted technology purchased by HopeSprings Counseling Services. This technology is designed to protect the confidentiality and security of the communication between the client and his/her provider. We will not use platforms that are not HIPAA compliant (e.g., Skype, FaceTime, etc.). It is important to note that the nature of electronic communications is such that privacy risks exist, and no one can guarantee that unauthorized persons will not gain access.
- I understand that there is the possibility of both risks and benefits. Treatment benefits may include the client experiencing an increase in positive feelings and behaviors, improved relationships with others and ultimately, an improvement in the quality of the client's life. Treatment risks may involve the client experiencing uncomfortable emotions (e.g., sadness). Risks associated with distance counseling (telehealth) may include the therapist having reduced ability to assess client's mood and/or status compared to face-to-face interactions. In addition, telehealth may provide less confidentiality (e.g., conversations being overheard or accessed) or less reliable connections (e.g., dropped calls, poor internet connection, etc.).
- I understand that staff members of HopeSprings Counseling Services are not permitted to follow or friend the client or me on social media platforms (e.g., Facebook, Twitter, Instagram, etc.). This practice protects the confidentiality of the client and supports a healthy therapeutic relationship with the therapist/ HopeSprings staff.
- While telehealth services provide the opportunity for services to be recorded via audio and/or video, no treatment services will be recorded without your consent. Any video/audio recording would be for the sole purposes of staff training and/or supervision and will never be made public. We request that neither the client, you or any other third party record treatment services in any manner due to potential risks to your confidentiality (e.g., recording is accessed and/or uploaded by a third party). Cunningham has no ability to protect the confidentiality of recordings made by a client, his/her guardian or any other third party.
- I have been apprised of the client's rights and I have been informed of the services offered by HopeSprings. I have also received this information in writing.
- I am legally able to sign this form as this client's parent or legal guardian.

HopeSprings Counseling Services
Client Rights and Informed Consent Acknowledgement

I have been informed of the rights and responsibilities described above and understand how they apply to me as a client of HopeSprings Counseling Services. If I do not understand my rights or have questions about my rights and responsibilities, I may ask my therapist to explain them to me at any time.

Client Name (printed) Date

Client Signature Date

Guardian Signature (if applicable) Date

Witness Signature Date

As a Staff member of HopeSprings, I affirm that I have explained these rights to the client in a language or a method of communication he/she understands and believe these rights to have been understood. I have also reviewed the process for filing a grievance.

Staff Signature Date

HopeSprings Counseling Services
a program of Cunningham Children's Home

701 Devonshire Dr. Suites B16-18 • Champaign, Illinois 61820 • 217-531-2360

Fee Agreement and Financial Policy (DCFS)

Client Name: _____ Date: _____

☐Not Applicable (EAP Only)

This contains important information regarding fees and insurance. Please review and make sure you understand the policy. If you have any questions, please discuss with the Intake & Billing Coordinator or the Program Assistant BEFORE signing.

Before scheduling your first appointment, HopeSprings Counseling asks for credit or debit card information that will be kept on file to be used as a form of payment for co-pays, co-insurance, deductibles, late cancellations, missed appointments, and past due account balances. When a fee is applied to your account, the card you selected to be on file will be automatically charged on the date of the fee application.

Fee for Services

HopeSprings offers a wide variety of services. All services are provided by a professional and billed accordingly. Copays and other out of pocket expenses are due at the time of service.

Health Insurance: As a courtesy HopeSprings will submit claim information to your insurance provider, if applicable, to help assist with the cost of treatment.

- If insurance is being used, **ALL** co-pays and deductibles are due and charged at the time of service.
- Co-insurance and service fees will be charged at a later date once an insurance payment has been verified. Payment of these fees will be due at the next day of service after verification.
- If Medicaid is being used, any spenddown fees, if applicable, are due at the time of service.

- Eligibility of benefits is not a guaranteed reflection of benefits paid; therefore, you, as the policy holder, will be personally and fully responsible for any services not covered by insurance.

Client Responsibility for Payment: In general, clients are responsible for payment at the time of service.

- If you cannot pay for the services at the time of your appointment, you may not be seen.
- Co-insurance and service fees must be paid within 30 days of being applied to your account. A failure to pay this in the 30-day time frame may result in you being discharged from services.
- Accepted forms of payment are cash, check, credit cards (Visa, Mastercard, Discover, and American Express), and debit cards. Checks should be made payable to Cunningham Children's Home.
- If services are paid by check or credit/debit card and there are non-sufficient funds, a $25 fee will be charged in addition to the amount owed for services.
- If you do not have insurance or other benefits you may request the sliding scale application from the Program Assistant.

_____**Cancellations and Missed Appointments**: Insurance companies and Medicaid do not pay for missed or cancelled appointments. Cancellations require at least 24-hour notice by phone. If we are closed or otherwise unavailable, leave a confidential voicemail to cancel. If an appointment is cancelled or missed without the appropriate notice, you will be charged $25.00.

_____ **Late Cancellations**: HopeSprings understands that illnesses and emergencies happen. Each client will be gifted one free late cancellation per calendar year. For the free late cancel to be applied, you must inform us at the time of cancellation of appointment. For all other cancellations, you will be charged a $25.00 late cancellation fee (this is discounted from our usual hourly rate of $175.00)

_____**No Shows:** If you do not show up for your scheduled appointment and do not provide a minimum of 24 hour notice you will be charged a $25.00 fee, no exceptions. We are not like a doctor's office where we schedule multiple people an hour knowing some may not show up. Our providers set aside one hour specifically to see you. It is not acceptable to miss your appointment.

_____**Health Insurance**: Health insurances are used to assist in the payment process; however, you are ultimately responsible for payment. Should insurance leave an unexpected

balance on your account, you will be responsible for paying the balance upon notice. Services may be terminated in 30 days if your account is not paid in full.

To best serve our clients with private insurance, HopeSprings requires that you consent to the following information:

1. HopeSprings is authorized to bill my insurance company on my behalf for services provided.
2. I give permission to HopeSprings to release all information required to process payment with my insurance provider.
3. HopeSprings is authorized to act on my behalf for obtaining payment, and I authorize the rights to the claims and payments from my insurance to HopeSprings. Should I receive any reimbursement directly for services provided to me by HopeSprings, I will turn over the payment within ten business days.
4. I understand that HopeSprings will assist in submitting billings to my insurance company for payment but that not all mental health services are covered by insurance companies.

Financial and Benefit Information

1. I understand it is my responsibility to communicate any changes to my benefits or financial information, if applicable, to HopeSprings and that failure to do so may result in services being billed directly to me.
2. I understand that at a minimum, HopeSprings will require annual benefit information updates.
3. I understand that I am personally and fully responsible for the cost of any services not covered by my insurance OR payment of services in full under a sliding fee agreement.

By receiving services at HopeSprings, you, the client, acknowledge and agree to all the terms and conditions set forth in the Client Rights, Informed Consent, Fee Agreement and Financial Policy form.

Financial Policy Acknowledgement

I have been informed of the Fee Agreement and Financial policy as described above and understand how they apply to me as a client of HopeSprings Counseling Services. I authorize HopeSprings Counseling Services a Program of Cunningham Children's Home to charge my credit/debit card as needed according to the terms of this Fee Agreement.

_____

Client Name (printed) Date

_____

Client Signature Date

_____

Guardian Signature (if applicable) Date

_____

Party Responsible for Fees. Co-pays, etc.

_____

Witness Signature Date

HopeSprings
Counseling Services
a program of Cunningham Children's Home

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CONFIDENTIAL 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 (with modifications as of May 10, 2019).

We respect client confidentiality and only release confidential information about you in accordance with the Illinois and federal law. This notice describes our policies related to the use of the records of your care generated by this agency.

Privacy Contact: If you have any questions about this policy or your rights contact: Director of Quality Improvement at (217) 367-3728.

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 HopeSprings Counseling Services. These situations include:

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 HopeSprings 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. You have a right to restrict certain disclosures of your protected health information if you pay out of pocket in full for the services provided to you.

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 Illinois and federal law, information about you may 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 via voicemail, e-mail or text message 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.

Coroners. In the event of your death, we are required to disclose information about the circumstances of your death to a coroner who is investigating it.

HIPAA NOTICE OF PRIVACY PRACTICES

Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such a audits, investigations, inspections and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. 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 or for coordination of your care.

Criminal Activity. 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.

Fundraising. As a not-for-profit provider of health care services, we need assistance in raising money to carry out our mission. We may contact you to seek a donation. You will have the opportunity to opt out of receiving such communication. You may also opt out of our providing your contact information for any marketing that results in compensation to HopeSprings Counseling Services.

OHCA Participation. HopeSprings is a covered entity under HIPAA. As a covered entity, HopeSprings participates with other behavioral health service agencies (each, a "Participating Covered Entity") in the IPA Network established by Illinois Health Practice Alliance, LLC ("Company"). Through Company, the Participating Covered Entities participate in joint quality assurance activities, and/or share financial risk for the delivery of health care with other Participating Covered Entities, and as such qualify to participate in an Organized Health Care Arrangement ("OHCA"), as defined by the Privacy Rule. As OHCA participants, all Participating Covered Entities may share the PHI of their patients for the Treatment, Payment and Health Care Operations purposes of all the OHCA participants.

CLIENT RIGHTS

You have the following rights under Illinois and federal law:

Copy of Record. You are entitled to inspect the client record HopeSprings has generated about you. We may charge you a reasonable fee for copying and mailing your record. These fees will be based on limits set by State law (Illinois State Comptroller's office) which are adjusted periodically. As our client, you will not be charged a handling fee nor will anyone designated as your personal representative.

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. Except as described in this Notice or as required by Illinois or federal law, we cannot release your protected health information without your written consent.

Restriction of Record. You may ask us not to disclose part of the clinical information. This request must be in writing. HopeSprings Counseling Services is not required to agree to your request if we believe it is 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. We will also be glad to provide you information by e-mail if you request it. If you wish us to communicate by e-mail you are also entitled to a paper copy of this privacy notice.

HIPAA NOTICE OF PRIVACY PRACTICES

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 that you disagree with us. We will then include your statement as well as 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 will notify you of the cost involved in preparing this list.

Notification of Breach. You have a right to be notified if there is a breach of your unsecured protected health information. This would include information that could lead to identity theft. You will be notified if there is a breach or a violation of the HIPAA Privacy Rule and there is an assessment that your protected information may be compromised.

Questions and Complaints. If you have 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 the U.S. Department of Health and Human Services if you believe HopeSprings Counseling Services has violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy. HopeSprings Counseling Services reserves the right to change its Privacy Policy based on the needs of the Agency and changes in state and federal law.

HIPAA NOTICE OF PRIVACY PRACTICES

CLIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by HopeSprings Counseling Services and its employees or designees. I authorize the services deemed necessary or advisable by my caregivers to address my needs. (_____)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION. I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the health care operations of HopeSprings Counseling Services. I authorize HopeSprings Counseling Services to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that HopeSprings may release objective clinical information related to my diagnosis and treatment, which may be requested by my funding agent.
(_____)

PRIVACY POLICY. I acknowledge having been offered copies of HopeSprings' "Notice of Privacy Practices" and "Client Rights Statement". My rights, including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are explained in the privacy policy. My right to make a complaint and file a grievance under Illinois law has also been explained. I understand that I may revoke in writing my consent for release of my confidential health information, except to the extent that HopeSprings has already made disclosures with my prior consent. (_____)

_____ _____
, Client Signature Date

_____ _____
Guardian Signature Date

_____ _____
Witness Signature Date

rev. 05/10/19

Handbook Acknowledgment

I understand that by signing this I acknowledge that I received information on where/how to access the online Handbook, which includes copies of my Client Rights, Informed Consent, Grievance Process, Fee Agreement, and Financial Policy. I understand that I may ask to have the handbook printed out for me upon request.

If I have questions about information in the handbook, I understand that I should talk with my therapist.

_____ _____

Client Signature Date

_____ _____

Guardian Signature (if applicable) Date

SECTION III

Intake Sheet & Handbook

Included in this section is an intake sheet that must be filled out by either the DCFS Authorized Agency Case Worker or the foster parent. Please fill out as much as you can as this helps HopeSprings Counseling Services create a file within the client database.

Please be sure to include the DCFS Client Number at the top of the Intake Form.

Lastly, in this section is a copy of the Handbook for the Client and/or the foster family to keep and review as well as for the Authorized Agency to review.

HopeSprings Counseling Services
a program of Cunningham Children's Home

701 Devonshire Dr. Suites B16-18 • Champaign, Illinois 61820 • 217-531-2360

The following information is needed to complete registration with your insurance company. Please complete the form and return it to the front desk. If you need assistance, please feel free to ask at the front desk or call the office at 217.531.2360.

CLIENT INFORMATION: ALL INFORMATION IN THIS SECTION PERTAINS TO THE CLIENT

First Name:	M.I.	Last Name:	Name Suffix (Jr., II):

Street Address:	City:	State:	Zip Code:

County:	Mother's Maiden Name:

DOB (MM/DD/YYYY):	Gender:	Race:

Primary Language:	Hispanic Origin: Yes ☐ No ☐

Marital Status: Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

U. S. Citizenship: Yes ☐ No ☐	Military Status: Veteran ☐ Not a Veteran ☐

Last Grade or Degree Completed:

Employment: Full time ☐ Part time ☐ Unemployed / Laid off ☐ Not in labor force ☐

SSI/SSDI Eligibility: Not Eligible ☐ Eligible-receiving payments ☐ Eligible-not receiving payments ☐
Other (please, explain): ☐

Household Information:

Household Size:	Age of Caregiver (if applicable):

Living Arrangement: Lives alone ☐ Lives with relatives ☐ Lives with non-relatives ☐

Annual Household Income: $ _____ Annual Client Income: $ _____

CONTACTS:

Parent/Guardian # 1 Contact:

Name:	Relationship:	Address:	Phone #:

Parent/Guardian # 2 Contact:

Name:	Relationship:	Address:	Phone #:

Emergency Contact: ***Contact must live outside the Client's home***

Name:	Relationship:	Address:	Phone #:

Medical-Primary Care Physician (PCP) Information:

Name:	Clinic:	Address:	Phone #:

Date of Last Physical:	Currently Prescribed Medication: Yes ☐ No ☐

Medical Center nearest home address:

Name:	Address:	Phone #:

Police Department nearest home address:

Name:	Address:	Phone #:

HopeSprings Counseling Services

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Client Rights, Expectations, and Responsibilities Handbook

Welcome to HopeSprings Counseling Services,

A Program of Cunningham Children's Home

For more than120 years, Cunningham Children's Home has developed great expertise in working with youth in crisis and their families. As the needs of our community change and grow, Cunningham believes it's time to share our expertise with everyone.

We welcome the opportunity to provide you with high quality counseling services. This manual outlines your rights as a client, your responsibilities while receiving counseling services and the expectations of those receiving services at HopeSprings.

Cunningham's mission is to nourish hope through effective solutions so children thrive and families flourish. HopeSprings provides hope and healing directly to youth and families in our community. We offer a safe and nurturing environment that allows opportunity for growth, healing, and recovery. Counselors are highly trained in trauma-informed care and are able to use their expertise to help guide the recovery process.

Treatment Process

When you seek treatment at HopeSprings you will be assigned a therapist. You and your therapist will work together to complete a comprehensive assessment and treatment plan. You are the most important person involved in your treatment. You have choices in your treatment, which include involving your family or others in your treatment.

With your input, the treatment plan guides your treatment. It identifies treatment goals, objectives, and measureable outcomes for you to work on with your therapist. The treatment plan also identifies the types of services, frequency and duration of the services you will receive as well as the staff responsible for providing the service. You and your therapist will review your treatment plan at least every six months. As you make progress or circumstances change, changes can be made to your treatment plan. Your therapist will go over benefits, risks, side effects, and alternatives of your treatment during the treatment planning process.

It is important that you attend your scheduled sessions consistently. If you need to cancel or reschedule your appointment, please do so with at least 24 hour notice so that we can offer the appointment time to someone else who may be waiting. If you are not consistent in attending your therapy appointments, you could be discharged from services. If you miss three consecutive therapy sessions or your overall attendance is inconsistent, HopeSprings could terminate your services.

60 days following the completion of your treatment or termination of services, your therapist or a HopeSprings staff person will contact you to see how your recovery is going. They will review the progress made while at HopeSprings and explore your desire and/or need for additional services. These services could be counseling services at HopeSprings or services provided at other social service agencies in the community.

Counseling Services

The staff at HopeSprings have diverse training and certification in these areas:

- ARC (Attachment, Self-Regulation, and Competency)
- Attachment Disorders
- Attention Deficit Hyperactivity Disorder
- Autism Spectrum Disorders
- Child physical abuse, sexual abuse, and neglect
- Collaborative Problem-Solving
- Domestic Violence and Sexual Assault
- Eye Movement Desensitization and Reprocessing (EMDR)
- Major Depressive Disorder, Bipolar Disorder, and other Mood Disorders
- Neurosequential Model of Therapeutics (NMT)
- Neurosequential Model of Education (NME)
- Oppositional Defiant and other Behavioral Disorders
- Parent/child relational issues
- Play Therapy
- Post-Traumatic Stress Disorder and other Anxiety Disorders
- PracticeWise MAP
- SPARCS (Structured Psychotherapy for Adolescents Re-experiencing Chronic Stress)
- Skills-Streaming
- Trauma-Informed Care (TIC)
- Trauma-Focused Cognitive Behavioral Therapy

Through HopeSprings, therapists will address these issues by offering trauma-informed care through individual, family, and group sessions in office or home.

Staff Certified in Trauma-Focused Cognitive Behavioral Therapy

Trauma-Focused Cognitive Behavioral Therapy is a components-based treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles and techniques.

Children and parents learn new skills to help process thoughts and feelings related to traumatic life events; manage and resolve distressing thoughts, feelings, and behaviors related to traumatic life events; and enhance safety, growth, parenting skills, and family communication.

Scheduling and Cancelling Appointments

To schedule an appointment, call (217) 531-2360. If you need to cancel or reschedule your appointment, please call 24 hours in advance. We will reschedule your appointment and be able to offer your cancellation to someone else in need. While we understand that certain circumstances do not allow you to cancel 24 hours in advance, we appreciate as much notice as possible.

Hours:

8:30 a.m.-6:00 p.m. Monday-Thursday

8:30 a.m.-12:30 p.m. Friday

Crisis line numbers are provided on page 21 for after hour emergency needs.

Injuries

If you are injured while at HopeSprings, you should notify staff immediately, regardless of how minor you believe the injury to be.

Emergency Evacuation Information

Look for Emergency Evacuation (Fire Evacuation-Tornado Shelter) diagrams posted throughout HopeSprings Counseling Services.

In the event of an emergency, it is important to remain calm, quiet, and listen for instructions. Should a fire alarm go off staff will support you to the closest exit. If a tornado weather warning is issued, staff will escort you to the designated area.

Client Emergency Situation

Should a client emergency situation arise and a panic alarm is activated, please remain calm and follow instructions given to you by your therapist/HopeSprings staff.

Weapon Free Environment

HopeSprings prohibits weapons of any kind in or around the facility. This includes guns, knives, tire irons, mace, or other similar items. This prohibition also includes individuals who have a valid conceal carry permit. HopeSprings Counseling has posted the Illinois No Concealed Gun sticker on the front door entering the facility. Local law enforcement will be called if weapons are brought into the facility.

Smoke-Free Environment

HopeSprings prohibits smoking or use of other tobacco products, and illicit drugs inside the facility. Smoking outside must be a minimum of 15 feet from the entryway and is prohibited under the blue awning.

Drug-Free Environment

HopeSprings prohibits illicit drugs of any kind in or around the facility. Any person discovered with illicit drugs will be asked to leave HopeSprings immediately. If the person refuses, local law enforcement will be notified immediately. Any person found to be under the influence will be asked to reschedule their appointment. HopeSprings will request any person under the influence to call someone for a ride if they drove themselves to their appointment.

Expectations for all Clients:

- Check in at the reception area and be prepared to confirm your insurance information, address, and phone number
- Be on time for your appointment. If you are 15 or more minutes late for your appointment, you will need to reschedule your appointment and it will be considered a client missed appointment.
- Complete all required assessments in a timely manner.
- Keep your cell phone on silent and/or vibrate, and refrain from taking or making calls where your conversation will be disruptive to others.
- If you need to use the restroom, please ask and someone will direct you to the facilities
- All parents/guardians/care givers are responsible for minor children and their behavior.
- Use responsible behavior and language throughout the clinic. Profanity, racial, sexual or discriminatory comments, and/or verbal abuse toward anyone will not be tolerated.
- Tell your therapist or a HopeSprings staff if you have been abused, neglected, or exploited. All Cunningham/HopeSprings staff are mandated reporters. Mandated reporters are required to call the DCFS Hotline when they have **reasonable cause to believe** that a child known to them in their professional or official capacity may be an abused or neglected child. The Hotline worker will determine if the information given by the reporter meets the legal requirements to initiate an investigation.

Note: Rules that are broken or disregarded will be addressed by the nature and severity of the infraction. This could range from a simple reminder or discussion to a change in treatment plan, or discharge from services. The above expectations should be followed at all times when at HopeSprings Counseling Services.

As a client of HopeSprings Counseling Services, you have the following responsibilities:

To know and abide by all the responsibilities and expectations outlined in the handbook.

- To know your rights as a client of this agency and to be considerate and respectful of the rights of both clients and staff.
- To use the grievance procedure if you feel your rights are being violated.
- To respect and honor the confidentiality and privacy of others.
- To know the names of the staff working with you
- To be honest and forthcoming about matters which relate to your services.
- To participate to the best of your ability in services and follow the recommendations offered by staff
- To actively engage in and attend services as they are prescribed on your treatment plan.
- To keep appointments and cancel appointments with at least 24 hours notice if you cannot keep them.
- To report changes in your condition to those responsible for your care and welfare.
- To respect the property belonging to HopeSprings/Cunningham, other clients, and HopeSprings staff members. HopeSprings staff members and others clients have the ability to take legal action to recover the cost of his/her damaged property.
- To be responsible for your personal property while receiving service at HopeSprings. HopeSprings /Cunningham is not responsible for lost or stolen property.
- To refrain from any form of physical or verbal abuse or threat toward staff or other clients. Violation of this responsibility could result in immediate discharge from services and grounds for legal involvement if appropriate.
- To inform the Program Assistant/Accounts Receivable Specialist of any changes in your address or other contact information, financial situation or insurance coverage.
- To ask questions any time you do not understand something
- If you are no longer interested in services, you agree to notify your assigned therapist or the Program Assistant.

Please do NOT...

- Tamper with fire alarms or any other safety equipment.
- Make verbal or physical threats of violence against any HopeSprings/Cunningham staff or other clients.
- Destroy property belonging to HopeSprings/Cunningham, HopeSprings/Cunningham staff members, or other clients
- Use intimidation against staff or other clients
- Carry or conceal any type of weapon
- Distribute or sell drugs of any kind
- Consume or bring alcoholic beverages, drugs or non-prescribed medication to HopeSprings Counseling Services.
- Smoke or chew tobacco inside HopeSprings Counseling Services or smoke within 15 feet of the HopeSprings awning.
- Bring food into the clinic, including the reception area.
- Ask to borrow money from HopeSprings/Cunningham staff or other HopeSprings/ Cunningham clients
- Enter into a staff office, Play Therapy/Sensory Room, Conference Room, or Intake office without being accompanied by staff.
- Enter the area of HopeSprings that is designated as 'Employees Only'
- Sleep or lie down on the couches, chairs, rearrange furniture, lean chairs back against walls, put feet on the furniture, or adjust the window blinds.
- Come behind the reception desk without being accompanied by HopeSprings/ Cunningham staff.
- Use your cell phone camera, or any other camera/recording device, to take pictures or record therapy sessions, treatment services, HopeSprings/Cunningham staff, or clients.
- Leave children/adolescents in the reception area without supervision. HopeSprings does not provide any type of supervision of children/adolescents.

Appropriate Dress

Clients are responsible for wearing appropriate clothing when at HopeSprings Counseling Services. If you are not dressed appropriately, staff will discuss it with you.

- Cover up. Sagging, short, low-cut or see-through clothing is not appropriate dress.
- Do not wear clothing that advertises drugs or alcohol.
- Shoes are required at all times

As a person served at HopeSprings, your rights include, but are not limited to:

- The right to be provided with appropriate mental health services in the least restrictive setting.
- The right to be free from abuse, neglect, and exploitation from staff and other clients while receiving treatment at HopeSprings.
- The right to have your rights, as well as any services you receive, explained in a language or method of communication you understand.
- The rights guaranteed to you by the United States Government and the State of Illinois. Services will not be denied, suspended, terminated, or reduced because you exercise your rights.
- The right to receive services without discrimination. You will not be denied mental health services because of age, sex, race, religious belief, ethnic origin, marital status, physical or mental disability or criminal record that is unrelated to present dangerousness.
- 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].
- The right to contact the Guardianship and Advocacy Commission and Equip for Equality, Inc. Staff shall offer assistance to a client in contacting these groups, giving each client the address and telephone number of the Guardianship and Advocacy Commission and Equip for Equality, Inc.
- The right to contact the public payer or its designee and to be informed of the public payer's process to follow a grievance.

- Physical restraint/seclusion is not utilized in the HopeSprings Counseling Services Program.
- The right to express opinions on issues concerning your case or treatment. You are considered to be competent (able to make decisions) unless a court has determined you are not.
- The right to have a copy of your Individualized Treatment Plan that describes the services that will be provided to you. Your Individualized Treatment Plan will be reviewed at least every six months.
- The right to participate in the development and review of your treatment plan, as appropriate. If you have concerns about your treatment plan or the services you receive, you and/or your guardian may request an in-house review of your care and treatment services by Cunningham staff not involved in your treatment.
- The right to review your treatment file.
    - If you are under the age of 12, your parent/guardian can view your file at any time.
    - If you are 12 or over, you can ask to review your file; however, your right to review your file may be limited to protect you or others from harm. If applicable, your parent/guardian always has a right to basic information about your treatment. Some records will not be released to your parent/guardian without your permission.
      You or your parent/guardian (if applicable) may write a note about any part of the file that is believed to be untrue. The note will be added to your file and included in any release of applicable record(s).

      When you [or your parent/guardian (if applicable)] review your record, a staff member will be made available to answer questions and ensure the file remains secure.

- The right to confidentiality. If you are age 12 or over, you and your parent/guardian (if applicable) must give written consent to share information about you. Without your consent, records will not be shared unless your therapist believes it is in your best interest.
    - If you are under 12, your parent/guardian must give written consent to share information about you.
    - In some cases your age does not matter and HopeSprings may release information without consent. Some examples include:
        - If you require hospitalization because you are at risk of hurting yourself or others.
        - If you have been abused, neglected, or exploited.
        - If required for reviews done by other agencies to determine if HopeSprings is following various rules, laws, and standards

    - Information related to crimes that occur on the property or against the staff of HopeSprings or involve immediate danger to someone else.
- The right for you or your parent/guardian (if applicable) to present grievances or to appeal adverse decisions related to the services you receive. The grievance process will be explained to you. A record of such grievances and the responses to those grievances will be maintained. You have the right to appeal decisions about your grievances to the highest level possible in the agency. The decision of the President/CEO and/or the governing body, when applicable, shall constitute a final administrative decision.

- The right to be notified of any restriction(s) of your right(s). Justification for any restriction to these rights shall be documented in your clinical record. Your parent or guardian (if applicable) as well as any agency you designate shall be notified of the restriction. Your parent or guardian (if applicable), the QMHP (therapist), the LPHA (Director of Community-Based Services or Associate Director of Clinical Services), and you will receive a plan with measureable objectives showing how your rights will be restored. The plan will be signed by all parties listed above.

- You, or your parent/guardian (if applicable), have the right to refuse services. Refusal of these services may result in your case being closed when it compromises treatment and/or there is significant risk to your safety or the safety of others.

My rights as a client at HopeSprings Counseling Services, A program of Cunningham Children's Home have been explained to me and I understand what they are. I have read (or had read to me) and received a copy of the document entitled Client Rights Statement. I also understand that the rules which describe these rights are available to me if I want. I have received a copy of Grievance Process describing the process for filing a compliant.

Informed Consent

As a client of HopeSprings Counseling Services, it is important for you to have a full understanding and awareness of what you are consenting to when you begin therapy and assessment services.

- I am seeking services at HopeSprings Counseling Services, A program of Cunningham Children's Home. If I'm younger than 18, I realize that my parent/guardian/funding agent is seeking services for me at HopeSprings.
- I consent to an assessment of my needs.
- I understand that a treatment plan will be developed based on an assessment of my needs and I will have the opportunity to participate in the development of the treatment plan.
- I consent to receive services offered by HopeSprings Counseling Services. A variety of treatment services are available to me to address my identified need (s). No guarantee or assurance has been given by anyone as to the results that may be obtained from services. I am responsible for actively participating in treatment services.
- I understand that there is the possibility of both risks and benefits. Treatment risks may include experiencing uncomfortable emotions (e.g., sadness). Treatment benefits may include a decrease in negative feelings and behaviors, improved relationships with others and ultimately, improvement in the quality of my life.
- I understand that if I present in a violent or threatening manner toward HopeSprings staff, I may be asked to enter a 30-day treatment contract which places expectations on my behavior in order to continue receiving services. I understand that these situations are managed on a case by case basis; however, if I continue to present in a violent and/or threatening manner, have multiple incidents of violent and/or threatening behavior over time, or are otherwise noncompliant with expectations, then my services could be terminated prior to 30 days from the date of the treatment contract. I also understand that if I do not agree to sign the treatment contract, HopeSprings will discontinue my services at the time of my refusal.
- I understand that if my needs are assessed by my therapist to be beyond what traditional therapy can provide that I may be asked to enter a treatment contract requesting that I engage in specific type(s) of treatment (e.g., inpatient or outpatient substance abuse, take psychotropic medication, day treatment, or inpatient psychiatric, etc.). I understand that if I do not agree to sign the treatment contract, HopeSprings will discontinue my services at the time of my refusal. I also understand that if I do not comply with the conditions of the contract, HopeSprings will discontinue my services in 30 days from the date of the treatment contract.
- I understand that HopeSprings may wish to use staff observation as well as video/audio equipment as part of treatment services. Any video/audio recordings are for

professional review only (staff training and supervision) and will not be made public. I will be informed prior to the use of any observation and/or video/audiotaping. I have the right to decline the use of observation and/or video/audiotaping.

- I have been apprised of my rights and I have been informed of the services offered by HopeSprings. I also have received this information in writing.

Parent/Guardian

- I am the parent or guardian of a minor or guardian of an adult seeking services.
- I consent to an assessment of this client's needs.
- I understand that a treatment plan will be developed based on assessment of this client's needs and I will have the opportunity to participate in the development of the treatment plan.
- I consent to this client's participation in the services offered by HopeSprings. A variety of treatment services is available to the client to address his/her identified needs(s). No guarantee or assurance has been given by anyone as to the results that may be obtained from services. Each client is responsible for active participation in treatment and services offered.
- I understand that there is the possibility of both risks and benefits. Treatment risks may involve the client experiencing uncomfortable emotions (e.g., sadness). Treatment benefits may include a decrease in negative feelings and behaviors, improved relationships with others and ultimately, an improvement in the quality of the client's life.
- I understand that HopeSprings may wish to use staff observation as well as video/audio equipment as part of treatment services. Any video/audio recordings are for the professional review only (staff training and supervision) and will not be made public. I will be informed prior to the use of any observation and/or video/audiotaping. I have the right to decline the use of observation and/or video audiotaping.
- I have been apprised of the client's rights and I have been informed of the services offered by HopeSprings. I have also received this information in writing.
- I am legally able to sign this form as this client's parent or legal guardian.

HopeSprings' Grievance Process

As a client at HopeSprings Counseling Services, a Program of Cunningham Children's Home, you have a right to file a grievance (complaint) about the services you receive, decisions that are made or how you are treated. This explains what a grievance is, how to file a grievance, and how HopeSprings/Cunningham staff will respond to a grievance. If you have more questions about this process, talk with your therapist or the associate director of clinical services.

1. What Is A Grievance?
   A grievance is a complaint. Grievances can be about many things, but most grievances involve how you are treated, services you receive or decisions that are made that you believe are not the best for you.

2. Who Can File A Grievance?
   - You (the client)
   - Your legal guardian (if applicable)
   - Professional staff involved in your case

3. How Do I File A Grievance?
   a. Ask for a grievance form from your therapist or the Program Assistant. The form has 3 questions:
      1) What are you filing a grievance/complaint about?
      2) What right(s) have been violated?
      3) What would you like to see happen in response to your grievance/complaint?

   *If you need help filling out the form, any staff person can help you. Be sure to sign and date the completed grievance form.

   b. The completed form may be given to the Program Assistant or to your therapist. The person who receives the grievance will sign and date the grievance form and make a copy for you.

   c. The grievance form will then be given to Ann Pearcy, the Director of Community-Based Services. Ann will decide who will review the grievance. Depending on the issue, it may be reviewed by either Ann or the Associate Director of Clinical Services.

   d. Either Ann or the Associate Director of Clinical Services will schedule a meeting with you to talk about the grievance. After the meeting, Ann or the Associate Director of Clinical Services will schedule a meeting with you to talk about the grievance. After the meeting, Ann or the Associate Director of Clinical Services will send you a letter telling you what was decided. This step may take up to 10 business days.

You have the right to contact the following agencies if you believe your rights have been violated

Client Rights/Advocacy Agencies:	State Agencies:
Guardianship & Advocacy Commission Eastern Central Regional Office 2125 S. 1st Street Champaign, IL 61820 (217) 278-5577; (866) 274-8023	Illinois Department of Human Services Division of Mental Health 319 East Madison Ave., Suite 3B Springfield, IL 62701 (217) 782-6470
Equip for Equality 235 S. Fifth St. Springfield, IL 62705 (217) 544-0464; (800) 758-0464 TTY (800) 610-2779	Illinois Mental Health Collaborative P.O. Box 06559 Chicago, IL 60606 (866) 359-7953 TTY (866) 880-4459
Illinois Department of Human Services Division of Mental Health Statewide Coordinator of Deaf & Hard of Hearing Services 901 Southwind Road Springfield, IL 62703 Voice (217) 786-0023; Fax (217) 786-0024 Video Phone (217) 303-5807	Department of Human Services: DHS Family Community Center for Champaign County 705 N. Country Fair Dr. Champaign, IL 61821 (217) 278-5605 DHS Help Line: (800) 843-6154
The Office of Civil Rights (OCR) 233 North Michigan Avenue Chicago, IL 60601 (800) 368-1019	Illinois Department of Children & Family Services 508 South Race Street Urbana, IL 61801 (217) 278-5400
	Illinois Department of Human Services Office of Inspector General OIG 24 Hour Hotline: (800) 368-1463
	East Central Illinois Area Agency on Aging 1003 Maple Hill Road Bloomington, IL 61704-9327 1-800-888-4456 (309)829-2065
	Department of Children and Family Services Administrative Hearings Unit 406 E. Monroe Street Springfield, IL 62707 (217) 782-6665
	Department of Juvenile Justice Contact your assigned parole agent.
	Illinois State Board of Education 100 North First Street Springfield, IL 62777 (217) 782-4321

	HFS-Appeal Line Bureau of Hearings 69 West Washington, 4th Floor Chicago, IL 60602 (800) 435-0774, TTY:(877)734-7429

HopeSprings Counseling Services

701 Devonshire Dr., Suite B16-18, Champaign, IL 61873

Phone: (217) 531-2360 fax: (217) 352-2635

Crisis Line Numbers:

CARES Crisis Line:	(800) 345-9049 (773) 523-4504 (TTY)
Champaign/Ford County	
Rosecrance Crisis Line:	(217) 359-4141
Vermilion County	
Crosspoint Human Services Crisis Line:	(217) 443-5566
Crosspoint Domestic Violence Hotline:	(888) 549-1800
Iroquois/Kankakee County	
Harbor House Crisis Line:	(815) 932-5800
Piatt County	
Mental Health Center Crisis Line:	(217) 762-4357
McLean County	
Center for Human Services Crisis Line	(309) 827-5351
DeWitt County	
Human Resource Center Crisis Line:	(217) 935-9496
Edgar/Coles/Clark County	
LifeLinks Crisis Line:	(866) 567-2400
Macon County	
Heritage Crisis Line:	(217) 362-6262
National Crisis Hotlines	
Suicide Hotline:	(800) 784-2433; (800) 273-8255 (800) 799-4889 (TTY)
LGBT Youth Suicide Hotline:	(866) 4-U-TREVOR
The Warm Line: Peer & Family Support: Available M-F 8 AM – 5PM	(866) 359-7953 (866) 880-4459 (TTY)