Family Service Association OF GREATER ELGIN

1. Please enter information on the child being referred for counseling:

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male ○ Transgender ○ Non-binary

Street Address: _____ Apt./Unit #: _____

City: _____ State: _____ Zip Code: _____ Mobile Phone: _____

Home Phone: _____ Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Email

What school is your child attending? _____

Child's preferred language for counseling?
○ English ○ Spanish ○ Other

Client's Ethnicity
☐ White ☐ African American ☐ Asian ☐ American Indian ☐ Pacific Islander ☐ Other

Client's Hispanic Origin

_____

2. Who suggested that you see a Counselor?

☐ No-one (self-referral) ☐ Friend ☐ Family member

_____ _____ _____

☐ School ☐ Probation Officer ☐ Other

_____ _____ _____

☐ IL Department of Children & Family (DCFS)

_____

If "other", please specify

_____

3. Please provide parent information.

Guardian's Name: _____ Date of Birth: _____ Guardian's Primary Language _____

Does child live in the same household as the parents / guardians?
☐ Yes ☐ No

If No, please type in parent's address in the box below:

Home Phone:

Mobile Phone:

Email:

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Email

4. Emergency Contact Information.

Emergency Contact Name:

Relationship:

Phone Number:

5. Will you be using insurance to cover the cost of treatment?

○ Yes
○ No

6. Please provide your insurance information:

Primary Insurance Company

Member ID# / RIN#

7. Will you need financial assistance (sliding scale) to cover the cost of treatment?

○ Yes
○ No

Sliding Scale Fee Information:

Please continue to fill out the eligibility forms. FSA Staff will send you another email with information to complete the application.

According to agency policy, we provide services regardless of the ability to pay. Therefore, we offer a sliding fee discount based on annual income and family size. Families and clients who will need access to a sliding scale fee must document their adjusted gross income by submitting their most recent 1040 form (taxes); or 2 to 4 household pay stubs.

For those individuals who receive entitlement benefits (SSI, SSDI, or SNAP), a copy of their award letter will also need to be submitted with the application for a sliding scale fee.

The discount will apply to all services provided by Family Service Association of Greater Elgin. It will not apply to any service that we might refer you to, including but not limited to primary care services, prosocial activities, other assessments or evaluations, substance abuse treatment, etc.

For your information, the following is our fee schedule and fee collection policy:

Fees: The agency fees are as follows:

- Case Management $155.00 per hour
  - Client Centered Consultation
  - Case Management Services
  - Family & Community Support Services
- Therapy Services $175.00 per hour
  - Integrated Assessment & Treatment Planning (IATP)
  - Individual / Couple / Family Therapy
  - Mental Health Crisis Intervention
  - Groups ($60 per hour)
- Psychiatric Services $300.00 per hour
  - Psychiatric Evaluation Services
  - Medication Monitoring Services

At your initial assessment appointment, your clinician will review this information and fee policy with you during your appointment.

Please provide the following information through the next set of questions.

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8. **Please provide a copy of your insurance / medical card. Please take a photo of the front and back of the card.**

9. **Have your insurance card available for the following questions. Please provide your insurance information regarding your private insurance PPO policy / TPL Insurance.**

Primary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name / Policy Holder _____ Insurer / Policy Holder Contact #: _____ Insured / Policy Holder Date of Birth _____ Insurance's Customer Service Contact # _____

Secondary Insurance Company _____ Member ID / Policy #: _____ Group Number: _____

Client Relationship to Insured: _____ Insured Name / Policy Holder: _____

Insured / Policy Holder Date of Birth: _____ Insured / Policy Holder Contact #: _____

Insured Customer Service #: _____

10. **Please provide any medical providers that you currently see. This can include your primary doctor and any counselors.**

Medical Providers	Name of Provider	Treatment	Medication (dosage, frequency & time of day)
Primary Care Doctor			
Medical specialist			
Counselor			
Other			

11. **List all persons currently living in your household:**

	Name	Age	Gender	Relationship to you	Is this individual needing therapy?
1					
2					
3					
4					
5					

12. **In order to aid in collaboration and to improve treatment are any of your family members currently in treatment with FSA staff?**

○ Yes
○ No

13. **Please describe what has led you to seek out counseling now and how long has this been a concern for you and your family?**

Has this concern lasted at least 6 months?
☐ Yes ☐ No

14. **Over the past 6 months, have you or your child struggled with any of the following emotional/behavioral problems? Check all that apply:**

☐ Talks back to parents, teachers, other adults	☐ Refuses to follow through on request from parents, teathers, other authority figures	☐ Bullies, or threatens others
☐ Blames others for their own mistakes and behaviors	☐ Aggressive towards other people and property	☐ Lacks remorse or guilt
☐ Refuses to accept consequences of their behavior	☐ Initiates fights	☐ Struggles with stealing and / or lying
☐ Refuses to attend school	☐ Has thoughts of wanting to hurt others or hurting animals	☐ Excessive running away from home and not returning for hours
☐ Engages in risky behavior that could potentially danger the child and / or others	☐ Violent temper / difficulties in controlling anger	☐ Suicidal thoughts
☐ Depression / sadness / excessive crying	☐ Hopelessness and / or worthlessness	☐ Irritability
☐ Mood swings	☐ Isolation / Withdrawn from friends, family, activities	☐ Not interested in activities anymore
☐ Sleeping too much / too little	☐ Eating Concerns / Significant weight loss / weight gain	☐ Fatigue / loss of engergy
☐ Racing thoughts	☐ Low self - esteem	☐ Flashbacks about past trauma expereinces
☐ Difficulties with communicating needs / feelings	☐ Panic / Anxiety / Worry	☐ Other(s)

If "other(s)", please specify

15. What would you like to gain from Counseling now? How would things be different if the difficulties were resolved?

16. How have you been coping with this problem until now?

17. Over the last 2 weeks, how often have you been bothered by any of the following problems?

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
Feeling interest or pleasure in doing thing?	0	1	2	3
Feeling down, depressed, or hopelfess	0	1	2	3
Trouble falling asleep or staying asleep, or sleeping too much	0	1	2	3
Poor appetitive or overeating	0	1	2	3
Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposit - being so fidgety or restless that you have been moving around a lot more than usuale	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

18. If you checked off any problems, how difficult has these made it for you to do your work, take care of things at home, in school, or get along with other people?

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

19. Over the last 2 weeks, how often have you been bothered by any of the following problems?

GAD-7	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it's hard to sit still	0	1	2	3
Becoming easily annoyed or irrittable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

20. If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or in school, or get along with other people?

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

DCFS Contract Agencies:

We encourage you to reach out to the following agencies, which are contracted through the Department of Children and Families (DCFS), to provide therapeutic care to you and your family. You can also follow up with your assigned DCFS contract agencies.

You can also reach out to the local DCFS agency for additional support.

- Elgin DCFS Office: 847-888-7620
- Aurora DCFS Office: 630-801-3400
- DeKalb DCFS Office" 815-787-5300

You can submit the completed questionnaire; however, at this time, FSA cannot provide treatment. If you are experiencing a mental health crisis, please contact:

- 9-8-8
- 1-800-345-9049, for CARES to determine S.A.S.S. eligibility for a mental health assessment.