Out of County
Residential Treatment
RTP Long-Term Program
Intake Packet

- Treatment Program Referral and Admission Letter
- RTP Referral Form
- Medical Authorization and Release of Information
- Visitation Form
- Center for Family Health Treatment Agreement
- Juvenile Face Sheet
- RTP Brochure
- Directions to Jackson County Youth Center

JACKSON COUNTY YOUTH CENTER

930 Fleming Avenue – Jackson Michigan 49202
Phone (517) 788-4460 – Fax (517) 788-4661
www.mijackson.org/YouthCenter

Chuck Baker
Director

Tuwann Worthey
Assistant Director

Out of County
Long-Term
Residential Treatment Program (RTP)
Referral and Admission Process

The following outlines the process for the Jackson County Youth Center's Residential Treatment Program for Michigan Counties needing treatment options for delinquent juveniles.

The referring county will contact the Jackson County Youth Center Treatment Supervisor at (517) 768-2755 or E-mail: mjones@mijackson.org to inquire about available treatment space.

If treatment space is available, the referring county will fax or E-mail the following documents back to the Treatment Supervisor:

- Completed RTP Referral Form
- Completed Medical Authorization and Release of Information
- Completed Visitation Form
- Completed Center for Family Health Authorization
- Juvenile Face Sheet

The Treatment Supervisor will contact the referring Probation Officer for any further information needed, communicate the status of the referral process, and arrange an RTP interview for the youth and their family. Youth Center Director reserves the right to deny referrals at their discretion.

Information for Disposition:

- Signed valid court order, indicating the "minor is to be placed in the Residential Treatment Program (RTP) at the Jackson County Youth Center. The director or his designee has authority to authorize and consent to routine medical, dental, surgical or other health and emergency medical or surgical treatment and/or provision of medical records."

Information for Disposition Continued:

- Minor is to follow all RTP rules and complete all treatment goals.
- Parents/Guardians are to actively participate in the minor's treatment, which includes visitation, provide clothing, attend Nurturing Parenting class, participate in Family Counseling sessions, and to be available for weekend home visits when eligible.
- It is recommended that the Juvenile will be reviewed every 90 days with their referring court, to assess progress and further planning. Review hearings to be conducted via Polycom. If in-person appearance is necessary, transportation arrangements will be arranged by Jackson County's Treatment Supervisor.
- Juvenile will be transported by Jackson County Youth Center's staff back to their county for psychiatric or specialized medical appointments.
- Juvenile will be provided dental, medical, and individual counseling, through Jackson County Youth Center's services.

The Jackson County Youth Center will bill at ***the end of each month at the rate of $200.00 per day. Terms are net 30 days.*** The day of release will not be billed to the referring county. ***If a resident goes AWOL from the program, their bed space will be held up top 48 hours and the referring county will be charged $200.00 per day.***

In the event the youth needs to be returned to the referring county (limited bed space, extreme medical needs, suicidal watch with one on one care, and/or extreme volatile behaviors, etc.) the Jackson County Youth Center will give a **7-day notice** to the referring county to find alternative placement.

The Jackson County Youth Center is equipped with a Polycom system and can be found in the SCAO directory to provide video hearings if desired by the referring county.

Sincerely,

Chuck Baker, MA
Director

Residential Treatment Program Referral

I. A RTP Referral Form completed in its entirety to include:

A. Significant Family Problems/Areas to focus on include
1. Family History of substance abuse/mental illness
2. History of abuse/neglect within family
3. Relationship of family members

B. School History will include
1. Special Education Classification
2. Any relevant information on school behavior/conduct

C. Probation Officer's Assessment of Youth will include
1. Probation Officer's Impressions
2. List of Student's Strengths and Weaknesses

D. Current/Past Placements
1. Include all services and treatments utilized or referred to by Caseworker
2. Include all court requested services
3. Include all other services or treatments

E. Peers, Associates and Gangs will include
1. List of all known negative and positive peers
2. Gang affiliations
3. Any other information deemed appropriate

F. Any other information Probation Officer deems appropriate

G. Attachment Copies required
a. Insurance Card
b. Medical Authorization
c. Birth Certificate
d. Face Sheet
e. History of Petitions

RES. 985

Probation Officer's Name

JACKSON COUNTY CIRCUIT COURT
FAMILY DIVISION

MINOR'S NAME: DOB: CAUSE #:

A. SIGNIFICANT FAMILY PROBLEMS/AREAS TO FOCUS ON: (Relationships, abuse, neglect, substance abuse, members attending family programs, etc.)

B. SCHOOL CA-60, SIGNIFICANT CONTENT : (Suspensions, special education labels, attachments from CA-60, if any, etc.)

C. PROBATION OFFICER'S IMPRESSIONS OF CHILD'S BEHAVIOR:
(Include specific strengths and weaknesses)

D. OTHER PLACEMENTS AND AGENCY CONTACTS: (include therapist, dates in therapy, attachments from psychological evaluation, if any)

E. PEERS, ASSOCIATIONS and GANGS

F. OTHER

G. ATTACHMENT COPIES:

- ☐ Insurance Card
- ☐ Medical Authorization
- ☐ Social Security Card
- ☐ Birth Certificate
- ☐ Face Sheet
- ☐ History of Petitions

APPROVAL BY _____ **Date Referred**: _____

Youth Services Director

POLICY 1160 –a / Forms 560 / DET. 2295

JACKSON COUNTY CIRCUIT COURT – FAMILY DIVISION

312 South Jackson Street, Jackson, Michigan 49201

Phone (517) 768-2779 FAX (517) 788-4623

MEDICAL AUTHORIZATION & RELEASE OF INFORMATION

Name of Minor: _____ **DOB**: _____ **SS#**_____
First Middle Last

Caseworker: _____ **Case No:** _____ **Res. ID #** _____

Jackson County Youth Center

I am the parent or guardian of the above-named minor, who is temporarily placed in the protective custody of the Jackson County Circuit Court - Family Division at the Youth Center or in Foster Care Placement (Court). While the Minor is in the Court's custody, I authorize Court personnel to initiate all of the following activities:

- Obtain any examination deemed necessary to protect the Minor's health;
- Obtain any necessary treatment and/or treatment records (medical, mental health, psychiatric, or substance abuse), medication, hospital admittance, surgical, or emergency services deemed necessary to protect the Minor's health;
- Utilize Genoa Pharmacy for prescriptions and/or refills; and
- Schooling, recreation, athletic programs, and counseling services as necessary.

I further grant permission for the Court personnel to obtain all information from any doctor (medical or mental health), school, clinic, agency, or institution, and the Court personnel may release any of the obtained information to interested officials regarding the Minor.

I authorize the Minor to have Dental Care while in custody and to have my insurance billed for services. ☐ **Yes** ☐ **No**

I also understand that I will be notified by court personnel of any prescription(s), treatment or emergency care that is necessary, and I agree to cooperate in executing all necessary forms, including doctor, hospital, or insurance forms, as soon as I am notified of the need to do so. If I fail to do so, I will reimburse the Court for any expenses incurred.

A copy or facsimile of this signed authorization may act as the original.

_____ _____
Parent/Guardian (**Please Print**) **Signature** of Parent/Guardian Date

_____ _____
Minor (**Please Print**) **Signature** of Minor Date

_____
Address

_____
City State Zip

_(____)_____ __(____)_____
Home Phone Number Cell Phone Number

INSURANCE INFORMATION: _____
Name of Carrier: **Policy Number:** **Group Number:**

MEDICAL INFORMATION:_____
Name of Family Physician: Phone Number:

ALLERGIES:
- ☐ Bee Stings
- ☐ Food: _____
- ☐ Medicines: _____
- ☐ _____
- ☐ _____

CHRONIC CONDITIONS:
- ☐ Asthma
- ☐ Diabetes
- ☐ Seizure Disorder
- ☐ Mental Health _____
- ☐ Other: _____

Medications and/or physical ailments: _____

WITNESSED BY:_____ DATE:_____

Revised 08/01/2013, 2/2017, 5/2017, 1/2019

VISITATION INFORMATION: Name of Minor: ______________________________ Date: ___________

This document may list up to, but not exceed 5 authorized visitors. Only parents, grandparents, step-parents and legal guardians are allowed to visit the above named minor. Any persons listed in the "Other" category must have prior approval from the Director or designee of the Youth Center before being allowed to visit.

Relatives Name:______________________________ DOB: _____________ Phone Number ____________________

Relationship: ☐ Mother ☐ Father ☐ Grandparent ☐ Legal Guardian ☐ Step Parent ☐ Other ____________________

Address:____________________________________ Comments:*(i.e., one visit only on 03/10/08, in wheelchair, explain "other" title.)*

____ ____

____ ____

____ ____

Relatives Name:______________________________ DOB: _____________ Phone Number ____________________

Relationship: ☐ Mother ☐ Father ☐ Grandparent ☐ Legal Guardian ☐ Step Parent ☐ Other ____________________

Address:____________________________________ Comments:*(i.e., one visit only on 03/10/08, in wheelchair, explain "other" title.)*

____ ____

____ ____

____ ____

Relatives Name:______________________________ DOB: _____________ Phone Number ____________________

Relationship: ☐ Mother ☐ Father ☐ Grandparent ☐ Legal Guardian ☐ Step Parent ☐ Other ____________________

Address:____________________________________ Comments:*(i.e., one visit only on 03/10/08, in wheelchair, explain "other" title.)*

____ ____

____ ____

____ ____

Relatives Name:______________________________ DOB: _____________ Phone Number ____________________

Relationship: ☐ Mother ☐ Father ☐ Grandparent ☐ Legal Guardian ☐ Step Parent ☐ Other ____________________

Address:____________________________________ Comments:*(i.e., one visit only on 03/10/08, in wheelchair, explain "other" title.)*

____ ____

____ ____

____ ____

Relatives Name:______________________________ DOB: _____________ Phone Number ____________________

Relationship: ☐ Mother ☐ Father ☐ Grandparent ☐ Legal Guardian ☐ Step Parent ☐ Other ____________________

Address:____________________________________ Comments:*(i.e., one visit only on 03/10/08, in wheelchair, explain "other" title.)*

____ ____

____ ____

____ ____

CENTER FOR FAMILY HEALTH
Opening the door to health care for all

Treatment Agreement
School Based Health Centers

Services Provided at
Northeast Health Center/Teen Health Center at Parkside/Jackson High Health Center

(*) Current Michigan Law states that these services do not require parental consent

- Physicals exams for school, sports, and camp
- Treatment for acute & chronic, illness & injuries
- Vision/hearing screenings and follow-up
- Dental exams, cleanings, x-rays
- Immunizations
- Basic laboratory services & tests
- Crisis Intervention*
- Administration of medication
- Referrals for specialty services
- Substance abuse education, counseling & referrals*
- Gynecological services*
- Pregnancy testing and referrals*
- Sexually transmitted disease screenings, treatment, and counseling*
- HIV screening and referrals*
- Physical/sexual abuse counseling & referrals*
- Individual, group, family, and community education
- Mental health and psycho-social assessment, counseling, & referrals* (if patient is 14 an older)

SERVICES NOT PROVIDED
No birth control pills or devices are dispensed or prescribed
No abortion counseling, referrals or services provided

Authorization for Treatment

Patient Name: _____ **D.O.B.:**_____

☐ **Medical**: I, hereby voluntarily request, consent to, and authorize Center for Family Health physicians, nurse practitioners, physicians assistants, behavioral health clinicians or other practitioners to provide medical and surgical treatment including but not limited to, diagnostic procedures, lab testing, and administration of medications, as is deemed necessary and advisable.

☐ **Dental:** I hereby voluntary request, consent to, and authorize Center for Family Health dentists, hygienists to provide dental treatment including but not limited to dental exams, cleanings, x-rays, sealants, and fluoride treatments.

My signature indicates I have read both sides of this form and I am giving consent to medical and/or dental treatment and the terms below.

Signature of Parent or Guardian: _____ **Date:** _____

Relationship to Patient_____ **Date:** _____

- I understand parental consent is required for services at the Northeast Health Center/Teen Health Center at Parkside/Jackson High Health Center for students under the age of 18 and services can be provided without my presence. Crisis intervention and emergency care do not require parental consent. I understand that I may withdraw my permission for services upon written notice to the Northeast Health Center/Teen Health Center at Parkside/Jackson High Health Center at any time

- I further understand and acknowledge that an HIV test may be performed upon me or my child, without written consent, under the circumstances that a Center for Family Health employee sustains exposure to my blood or other bodily fluids

PLEASE READ OTHER SIDE

Agreement to Pay for Services

- I authorize Center for Family Health to release my medical information necessary to Medicare, Medicaid, or other insurance carrier, to process claims and further authorize payment of medical benefits payable directly to Center for Family Health.
- I understand that Center for Family Health will file and complete the necessary steps to collect my insurance payment.
- I understand that I am responsible for any account balance that is not covered by insurance or for any services rendered at the Center for Family Health according to the sliding fee scale. This includes any deductibles or co-payment portions of my bill after insurance payment.

Authorization and Consent to Access, Use and Disclosure of Protected Health Information to/from Jackson Community Medical Record, LLC

- I consent to, and authorize the Center for Family Health to store my personal protected health information in an electronic health record through the Jackson Community Medical Record, LLC.
- I consent to the Center for Family Health and its designees accessing through and/or using and/or disclosing my individually identifiable health information (medical and dental information) to Jackson Community Medical Record, LLC, for treatment, payment or healthcare operations, including for my continuing care.
- I authorize the release of my treatment notes and test results to my Primary Care Provider for purposes of coordination of care.

Privacy Practice Acknowledgement

- I am aware that the Center for Family Health has a HIPAA (Health Insurance Portability and Accountability Act) Notice of Privacy Practices.
- I may request a copy at any time by contacting Teen Health Center at Parkside/Northeast Health Center.

JUVENILE FACE SHEET

CASE NUMBER: _____ DATE OF REFERAL: _____ WORKER: _____

CHILDREN: List the 1st child as the one specified on the petition. Next, list the siblings in order by age.

#	NAME (Print) Last Name First	Age	D.O.B	Birthplace	Sex	Prev. Ct Exp.	School/ Employer	Grade	School Record
1									
2									
3									
4									
5									
6									
7									
8									

Race	Sex	Height	Weight	Hair	Eyes	SSN	Atty.

Stepmother	Father	Parents Full Name	Mother	Stepfather
		Address		
		Telephone		
		Birthdate		
		Race		
		Occupation		
		Employer		

Agencies, relatives and other interest in Youth

	Relation to Child	Telephone #	Address
1.			
2.			
3.			
4.			

Diagnoses: _____Doctor: _____
Current Services: _____
Past Services: _____
Child lives with: _____ Medications: _____
OTHER:

The Jackson County Youth Center is happy to serve the Jackson community, as well as neighboring court jurisdictions.

ADMISSION CRITERIA:

Candidates for admission into the Residential Treatment program must:

1. Have a parent/guardian who is willing to participate with the youth's treatment.
2. Have a stable home environment to return to during and after treatment.
3. Be between the ages of 13 and 16 years, 4 months.
4. Possess sufficient emotional and social skills to participate in the treatment program (non-psychotic, non-sociopath, non-mentally impaired).
5. Not have been adjudicated on a violent crime (i.e. CSC 1st, Murder, Attempted Murder, etc.)

DENIAL OF ADMISSION:

The Jackson County Youth Center reserves the right to deny admission to any resident at the discretion of the Youth Center Director.

Vision

To be the premier juvenile justice facility in the state, partnering with the community by offering opportunities for change.

Mission

To ensure the safety of the community by investing in the lives of detained youth.

Values

- Safety and Security
- Leaders, Learners, & Mentors
- Culturally Sensitive
- Dignity

930 Fleming Ave.
Jackson, MI 49202
Phone (517) 788-4460
Fax (517) 788-4661
www.mijackson.org/YouthCenter

Jackson County Youth Center

Residential Treatment Program

Serving youth and their families for over 30 years

OVERVIEW

The Residential Treatment Program (RTP) is a co-ed group treatment program designed to meet the needs of delinquent youth ages 13-16 years. The program is composed of seven phases intended to gradually develop residents' individual and group responsibility for actions and behaviors.

As residents progress through the phase system, they are expected to assume additional responsibilities within the program, at home, and in the community.

The RTP is a medium security treatment program where residents are eligible to earn weekend home visits, recreational activities, and participate in community service projects.

The minimum amount of time required to successfully complete the RTP is just over five months. However, residents work through the RTP at their own pace depending on their readiness to make change and ability to achieve treatment objectives.

EDUCATION

The Jackson County Youth Center School Program is supervised and staffed by the Jackson County Intermediate School District. The program consists of three full-time certified special education teachers and one teacher assistant. The staff are supported by the part time services of a school social worker, teacher consultant, and a school psychologist.

TREATMENT MODULES

The following are examples of ongoing treatment modules that take place within the RTP. Please note that these modules are not expected to meet the needs of all youth. Each resident will receive a full battery of assessments and an individualized treatment plan will be developed focusing on the resident's unique strengths, abilities, and treatment needs.

- Anger Management
- Assertiveness Training
- Family & Individual Counseling
- Parent Education
- Group Therapy
- Cognitive Behavioral Therapy
- Aftercare/Reintegration Services

DRUG TESTING

All RTP residents are required to submit to drug testing and breathalyzers as required by Youth Center staff. These tests are regularly given after weekend home visits, as well as randomly throughout the program.

REFFERALS

If you would like more information, or are interested in making a referral to the Residential Treatment Program, please contact:

Misty Jones, MA, LLPC, NCC
Treatment Supervisor
Office: (517) 768-2755
Fax: (517) 788-4661
E-Mail: mjones@mijackson.org

JACKSON COUNTY CIRCUIT COURT

Youth Center Division
930 Fleming Avenue - Jackson Michigan 49202
Phone (517) 788-4460 Fax (517) 788-4661

Diane M. Rappleye
Judge of Probate

Chuck Baker
Director of Youth Center

RE: Directions to the Jackson County Youth Center

FROM: Lansing Area – take U.S. 127 to I-94. East on I-94 to Elm Street Exit (141). South on Elm to Seymour, right on Seymour to Floral. Right on Floral to Fleming.

FROM: East and West Area – take I-94 to the Elm Street exit (141). South on Elm to Seymour. Right on Seymour to Floral. Right on Floral to Fleming.

Any questions please call 517-788-4460 and ask for a Supervisor