



**Personal Frontiers, Inc.**

- Est 1976 -  
Recover Your Life  
Wyoming Certified Provider  
CARF Accredited

Physical: 310 S. Miller Ave., Ste. G • Gillette, WY • 82716

Mailing: PO Box 754 • Gillette, WY • 82717

P: 307-686-1189 • F: 877-502-2977

CLIENT NAME: \_\_\_\_\_ SSN: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS (Mailing): \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

ADDRESS (Physical): \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE:(\_\_\_\_) \_\_\_\_\_  Text  Voicemail EMAIL: \_\_\_\_\_

**MARITAL STATUS:**  Single  Married  Widowed  Separated  Divorced **SEX:**  Male  Female

**BILLING INFORMATION**  If same as above check here

RELATIONSHIP TO PATIENT: \_\_\_\_\_

FIRST NAME: \_\_\_\_\_ MIDDLE INITIAL: \_\_\_\_\_ LAST NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ WORK PHONE:(\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_

SSN: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

**EMPLOYMENT INFORMATION**

EMPLOYER'S NAME \_\_\_\_\_

OCCUPATION \_\_\_\_\_ BUSINESS ADDRESS \_\_\_\_\_

BUSINESS PHONE \_\_\_\_\_

**INSURANCE INFORMATION**

INSURANCE COMPANY \_\_\_\_\_

POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

POLICY HOLDER \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

**Appointments:** A 24-hour notice on all appointment cancellations is required. If you do not give notice or **NO SHOW**, you will be billed \$25.00. This charge is applicable regardless of payment type. After the second missed appointment, you will be required to pay a \$25.00 non-refundable fee to book the appointment.

**PAYMENT AGREEMENT** I, the undersigned client/guardian, agree to pay for all services rendered to me or my ward immediately upon demand. I further agree that in the event of non-payment of any amounts due under this agreement, I will pay all reasonable attorney fees and court costs that may be incurred. I agree that in the event this agreement is assigned to an agency for collection, I promise to pay an additional collection fee of 35% of the unpaid balance due.

I certify that all the information that I have provided is true and correct to the best of my knowledge. I will notify you of any changes in my health status or in the above information. I have read and understand the above policies and agree to abide by these conditions.

\_\_\_\_\_  
SIGNATURE - PATIENT OR RESPONSIBLE PARTY

\_\_\_\_\_  
DATE



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## Personal Frontiers Disclosure Statement

### Clinical Education and Licensures | Certifications

*Counselors' credentials are available for inspection upon request.*

**Provider**

Sarah Leger-Hayworth, MS, LPC

**Professional Education**

Master of Science, Mental Health

Counseling, Walden University

Bachelor of Science, Criminal Justice,

Kaplan University

**Licensure Status**

WY Licensed Professional Counselor, LPC-1505

CO Licensed Professional Counselor, LPC-0018795

**Provider**

Brenda Engle, PMHNP-BC

**Professional Education**

Licensed Advanced Psychiatric Nurse

Practitioner, WY

ANCC Certified National Advanced

Nurse Practitioner

Master of Science in Nursing- Regis

College, Boston MA

**Licensure Status**

WY PMHNP-BC 38852.1580

**Provider**

Kristi Holum, MS, LPC

**Professional Education**

MS, Clinical Counseling

Bellevue University, NE

BA, Agriculture Education

Oklahoma State University

**Licensure Status**

WY Licensed Professional Counselor, LPC – 2032

**Case Manager**

Timothy Blinksop

**Professional Education**

Gillette College

Studying Human Services

**Licensure Status**

Working on Peer Specialist Certification

**Case Manager**

Kim Krogman, AS, CAPA

**Professional Education**

AS, Addiction Studies

Casper College

**Licensure Status**

Certified Peer Specialist

WY Certified Addiction Practitioner

Assistant, CAPA-72

**Provider**

Renee Harnish

**Professional Education**

MS, Addiction Studies

Grand Canyon University

**Licensure Status**

WY Licensed Provisional Addiction

Therapist, PAT-089

**Case Manager**

Samantha Buck

**Professional Education**

AS, General Studies

Gillette College/NWCC

Certificate of Completion Addiction Studies

**Licensure Status**

Applying for Certified Addiction Practitioner Assistant License

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Professions Licensing Board. The Board can be reached at 2001 Capitol Avenue, Room 127, Cheyenne WY 82002, (307)777-7788. The Mental Health Professions Licensing Act requires this disclosure statement.

You are entitled to receive information regarding the counseling team credentials, the methods of therapy, the techniques used, the duration of your therapy (if known), and both the billing process and fee structure, which will be discussed with you by the Personal Frontiers, Inc. (PFI) Staff prior to beginning treatment. You may ask to have a different counselor, seek a second opinion from another therapist or terminate therapy at any time.

There is no designated time limit to services; however, it is the expectation that service frequency will decrease over time. The group, individual, and family services vary in intensity to meet the changing needs of individuals, families, and/or caregivers; to assist them in the home and community settings; and to provide a sufficient level of service as an alternative to the individual's need for a higher level of care. Your counselor also has the right to terminate therapy if he/she determines that (1) the relationship is no longer in the best interest of the client, (2) the client is a threat to the safety of the therapist or other clients at this agency, or (3) the client is consistently unwilling to follow the treatment plan agreed upon by the counselor and client during therapy.

In a professional relationship, sexual intimacy with a client is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant, or certificate holder.

The information provided by and to you during therapy sessions is legally confidential and cannot be released without your written consent. However, the PFI clinical staff members work as a team and may disclose your information to one another to best support your treatment. As part of the standard training process, a Clinical Intern and Certified Addictions Practitioner Assistant provide counseling services under the direct supervision of PFI's designated qualified supervisor, who may hear information disclosed in your sessions to provide unlicensed practitioners with feedback and ensure that quality care is being provided. Please note, all information disclosed within sessions will be recorded and records will be maintained per federal and state regulations for seven (7) years before being destroyed in accordance with rules and regulations.



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As of March 1, 1999 Wyoming has implemented a privileged communication statute. This law states that, when involved in legal proceedings (civil, criminal or juvenile) clients retain the right to privacy with the exception to the circumstances listed in W.S. 33-38-113:

- Abuse or harmful neglect of children, the elderly or disabled or incompetent individuals is known or reasonably suspected
- The validity of a will of a former client is contested
- Information related to counseling is necessary to defend against a malpractice action brought by a client
- An immediate threat of physical violence against a readily identifiable victim is disclosed to the counselor
- In the context of civil commitment proceedings, where an immediate threat of self-inflicted harm is disclosed to the counselor
- The client alleges mental or emotional damages in civil litigation, or his/her mental or emotional state becomes an issue in any court proceeding concerning child custody or visitation
- The patient or client is examined pursuant to a court order
- In the context of investigations and hearings brought by the client and conducted by the board, where violations of this act are at issue

If a legal exception arises during therapy, if feasible, you will be informed accordingly.

***However, it is PFI's heartfelt commitment to you and to your process that we maintain confidentiality in this relationship and adhere to the Code of Ethics of the American Counseling Association, American Association for Marriage and Family Therapy, and National Association of Alcoholism and Drug Abuse Counselors.***

The confidentiality of alcohol and drug abuse patient records maintained by Personal Frontiers, Inc. is protected by federal law and regulations. Generally, PFI may not tell a person outside this organization that a client is participating in treatment or disclose any information identifying a client as an individual with a substance misuse problem unless:

- The client consents in writing
- The disclosure is allowed by a court order or
- The disclosure is made to medical personnel in a medical emergency

I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party.

Client or Responsible Party Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Complaints can be filed with:**

Wyoming Department of Health  
Office of Healthcare Licensing & Surveys  
400 Quest Building  
6101 N. Yellowstone Road  
Cheyenne, WY 82002  
307-777-7123 or [wdh-ohls@health.wyo.gov](mailto:wdh-ohls@health.wyo.gov)  
or visit [health.wyo.gov/aging/hls/](http://health.wyo.gov/aging/hls/)

OR

Wyoming State Board of Nursing  
<https://wybn.boardsofnursing.org/complaint>



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## FINANCIAL POLICIES

The professional services provided by the agency are for your benefit. All fees charged by this agency are your responsibility. For your convenience we accept cash, check, MasterCard, Visa, and money orders.

### Due at the time of service

Payment for Assessments, Intakes, Consults, Educational classes and Family Programming are due at the time of service unless prior arrangements have been made.

- All payment arrangements should be made before or at the time service is rendered. Should it be necessary to make payment arrangements, the following guidelines will be used:
- Should you need assistance in payment of your treatment care, please notify us immediately.

### Insurance

We will bill any commercial insurance as a courtesy and make every effort to collect benefits on the insurer's behalf for a period of 90 days. After 90 days from the date of service, the account will be treated as a **self-pay** account, and you will be required to submit payment in full or make acceptable arrangements for payment. Professional care is provided to you, our client, not to an insurance company. Thus, the insurance company is ultimately responsible to you, the client, and you are responsible to the agency. For us to file your insurance, we need to be provided with **COMPLETE AND ACCURATE** insurance information to avoid delays in payment (i.e.: name, address, group, etc. of your primary insurance). Failure to provide us with correct information will result in you being responsible for your account. **You are responsible for all fees not covered by your insurance company. This includes deductibles and co-pays.** Our office cannot accept responsibility for negotiating a settlement on a disputed claim. If you dispute the amount of payment made by your insurance company, you should contact your insurance carrier, your human resources department, or your agent directly.

**Medicaid Patients:** Personal Frontiers, Inc. is a Wyoming Medicaid provider. If you are covered by Medicaid, you are required to provide your Medicaid ID Card before services for Medicaid to pay.

### Financial options for clients without insurance:

**Sliding Fee:** A sliding fee scale may be available based on gross family income. Proof of income or non-income is required to qualify for sliding fees. Please let us know immediately if you would like to apply for the sliding fee schedule.

**Grants:** Each year Personal Frontiers applies for government grants to assist with the cost of treatment. To qualify you must have a gross family income at or less than 200% of the Federal Poverty Guidelines. If you feel you may qualify, please ask for a grant application.

**Unpaid Accounts:** Patients with unpaid delinquent accounts or accounts which have been written to bad debt or collection, may be denied treatment if the treatment is not deemed necessary.

**Collections:** Accounts over 90 days past due will be turned over to a collection agency unless prior arrangements have been made with the Director. I understand that if I fail to abide by this agreement, I relinquish my right to anonymity for the purpose of collection.

### AUTHORIZATION TO PAY INSURANCE BENEFITS

I hereby authorize payments directly to the above-named facility of the insurance for these services. **I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO PERSONAL FRONTIERS, INC. FOR CHARGES NOT COVERED BY INSURANCE OR DESIGNATED THIRD PARTY PAYEE.**

### PAYMENT AGREEMENT

I, the undersigned client/guardian, agree to pay for all services rendered and/or goods sold to me or my ward immediately upon demand. I further agree that in the event of non-payment of any amounts due under this agreement I will pay all reasonable attorney fees and court costs that may be incurred. I agree that in the event this agreement is assigned to an agency for collection, I promise to pay an additional collection fee of 40% of the unpaid balance due.

**A \$25.00 fee will be assessed for any missed appointment without 24-hour notice of cancellation.**

*The undersigned certifies that having read the forgoing, received a copy thereof if requested, and is the patient or is duly authorized by the patient's general agent to execute the above and accept its terms.*

\_\_\_\_\_  
Print Name

X \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Signature of Client or Client's Representative: Date Time Relationship

Witness \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Signature Represents Witness for Entire Document Date Time



## **NOTICE OF PRIVACY POLICIES AND PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Effective: April 14, 2003

Your information will only be released in accordance with state and federal laws and the ethics of the American Counseling Association, American Association for Marriage and Family Therapy, and National Association of Alcoholism and Drug Abuse Counselors. The following notice describes Personal Frontiers, Inc. policies related to the use and disclosure of the client healthcare information.

### CONFIDENTIALITY

You have the right to confidentiality as protected by Federal Regulation (C.F.R. 42 part 2 and C.F.R. 45) which prohibits disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations, except in cases of imminent life threatening physical danger to the client or others, instances of legally reportable child and adult abuse and/or neglect, and to qualified state and federal personnel and to authorized peer reviewers, consultants and supervisors under written oath of confidentiality. Also, under W.S.33-18-113, privileged communications, the client and counselor may refuse to disclose and prevent the disclosure of confidential communication. All sessions and written records pertaining to counseling are held in strictest confidence. Personal Frontiers, Inc. (PFI) Clinical Staff reviews cases weekly and your information may be shared among the listed counselors on the disclosure statement.

### **Uses and Disclosures for Treatment, Payment, and Health Care Operations**

Personal Frontiers, Inc. may use or disclose your protected health information for treatment, payment, and health care operations purposes with your consent.

- "Protected health information" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
  1. Treatment is services provided, managed, or coordinated related to your health care and other services, including consultation and referral sources, related to your health care.
  2. Payment is when PFI verifies your insurance coverage and processes claims to collect fees or obtains reimbursement for your healthcare. Examples of payment are when PFI discloses your protected health information to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  3. Health Care Operations are activities that relate to the performance and operation of the practice of PFI. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within PFI such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of PFI, such as releasing, transferring, or providing access to information about you to other parties.

### **Uses and Disclosures Requiring Authorization**

PFI may use or disclose protected health information for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when PFI is asked for information for purposes outside of treatment, payment and health care operations, an authorization will be obtained from you before releasing this information except in situations described below. Your clinical team will also need an authorization before releasing psychotherapy notes of private counseling sessions, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than protected health information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) information was already obtained or released (used or disclosed) prior to the revocation; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

### **Uses and Disclosures with Neither Consent nor Authorization**

PFI may use or disclose protected health information without your consent or authorization in the following circumstances:

- **Child Abuse:** If PFI knows or has reasonable cause to believe or suspect that a child has been abused or neglected, or if PFI staff observe any child being subjected to conditions or circumstances that would reasonably result in abuse or neglect, PFI must immediately report it to the field or regional offices of the Wyoming Department of Family Services or local law enforcement agency or cause a report to be made.
- **Adult and Domestic Abuse:** If PFI staff have reasonable cause to believe that an elderly or disabled adult is being or has been abused, neglected, exploited, or abandoned, or is committing self-neglect, staff members are required by law to report such information immediately to a law enforcement agency or to the Wyoming Department of Family Services.
- **Health Oversight:** If you file a complaint against a clinical staff member with the Mental Health Professions Licensing Board, PFI staff may disclose to them confidential mental health information that is relevant to that complaint.
- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and PFI will not release such information without written authorization from you or your legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.



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- Serious Threat to Health or Safety: PFI shall not disclose any information communicated for the purpose of diagnosis, evaluation, or treatment of any mental or emotional condition or disorder, in the absence of an express waiver of the privilege except where an immediate threat of physical violence against a readily identifiable victim is disclosed to a PFI staff member.
• Workmen's Compensation: If you file a worker's compensation claim, that is a release of information for the duration of the benefit period, and upon request and upon notice to you, PFI must release mental health records pertaining to your injury to the Wyoming Workmen's Compensation Division or your employer.
• National Security: Protected health information may be disclosed to authorized federal authorities for national security or intelligence purposes or to correctional institutions or law enforcement officials who have lawful custody of such information of the inmate or patient under certain circumstances.

Access to Confidential Information by: Agency Personnel, Outside Funding Sources and Multidisciplinary Teams

- Staff of PFI including therapist, administrative staff and volunteers may have access to protected health information for purposes of performing their duties only and are restricted from releasing any information without the expressly authorized consent of the client.
• PFI is subject to the oversight of certain State and Federal funding sources whose contracts may require them to have access to certain records for audit purposes. Any authorized personnel of such agencies will sign a confidentiality statement prior to having access to any client information.
• In some cases where a multidisciplinary team may collaborate in order to provide comprehensive treatment to a patient and family for the purpose of diagnosis or treatment, the client will be asked to sign a release for the team.

Client Rights

- Restrictions: You have the right to request restrictions on certain uses and disclosures of your protected health information. However, these requests must be in writing and PFI is not required to agree to a restriction you request.
• Alternative Communications: You have the right to request and receive confidential communications of protected health information by alternative means and at alternative locations. (Example: You want bills sent to another address for privacy reasons.) This request must be in writing, specify the alternative means or location, and give a satisfactory explanation.
• Inspect and Copy: You have the right to request to inspect or obtain a copy of protected health information as long as this information is maintained in the record. PFI may deny your request under certain circumstances, but in some cases you may have this decision reviewed. Requests must be made in writing. There is a charge for copies of records. On your request, PFI will discuss with you the details of this process.
• Amendment: You have the right to make a written request for an amendment of your protected health information. This request must include an explanation as to why the information should be amended. PFI may deny your request. On your request, PFI will discuss with you the details of the amendment process.
• Accounting: You generally have the right to receive an accounting of disclosures of protected health information regarding you for the past six years but not before April 14, 2003. On your request, PFI will discuss with you the details of the accounting process.
• Paper Copy: You have the right to obtain a paper copy of this notice.
• Filing a complaint: You have the right to file a complaint in writing with the PFI Executive Director or with the Office of Civil Rights.

Clinical Staff Duties:

Each clinical staff member is required by law to maintain the privacy of protected health information and to provide you with a notice of legal duties and privacy practices with respect to it. Clinical staff members reserve the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, clinical staff members are required to abide by the terms currently in effect. If policies and procedures are revised, this notice will be changed and made available upon request.

Complaints

If you are concerned that a PFI staff member has violated your privacy rights, or you disagree with a decision made about access to your records, please discuss it with PFI Clinical Director or you may file a written complaint with the Executive Director. You may also file a complaint with:

Mental Health Professionals Licensing Board

2001 Capitol Ave., Room 105

Cheyenne, WY 82002

P: (307) 777-7788 • F: (307) 777-3508

I have read the preceding information and understand my rights as a client or client's responsible party.

Print Name

X

Signature of Client or Client's Representative:

Date

Time

Relationship

Witness

Signature Represents Witness for Entire Document

Date

Time



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### CLIENT RIGHTS STATEMENT

As a client of Personal Frontiers, Inc., you have the following rights:

- to be entitled to respect and dignity in an environment that affords security and privacy;
- to receive services that are protected under the laws of confidentiality and to receive a Privacy Notice as well as other information concerning your rights in regard to the use, storage, and disclosure of healthcare information;
- to receive services regardless of race, sex, national origin, creed, physical or mental handicap, or personal ability to pay;
- to know the reasons for or purpose of the services provided and to consent to receiving these services;
- to receive an individual evaluation and treatment based upon your needs, abilities, and goals, including your active participation in the development of your individualized treatment plan;
- to ensure that your needs and preferences are not neglected and to receive any information needed to make informed decisions concerning the services you receive;
- to ensure your fees are adequately and fairly assessed;
- to express your preferences concerning the choice of service provider;
- to review your records upon reasonable request and as provided by law;
- to refuse treatment or withdraw from services at any time;
- to be free from physical abuse, sexual abuse, harassment, and physical punishment imposed by program employees;
- to be free from psychological abuse, including humiliating, threatening, and exploitive action on the part of program employees;
- to be free from fiduciary abuse associated with program employees holding in trust anything of value that belongs to you;
- to be informed of and treated in compliance with the DOT regulations; and
- to receive assistance from the program in facilitating a referral to recommended services.

### CONSENT TO TREATMENT

I certify that my rights have been fully explained to me. I agree to each of them and remain desirous of treatment services provided by this program in accordance with these rights.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date



**LEGAL INFORMATION**  
(if applicable)

For us to best help you through the legal system please provide the following information:

Are you here today due to a violation of a law?      YES              NO

**COURTS:**

Do you have a court date?                              YES              NO

Date: \_\_\_\_\_

Have you been ordered by a Judge to be here?      YES              NO

**IF YES:**

Date of Court Order: \_\_\_\_\_

Which Court did you appear in?              District              Circuit              Municipal (City)

City \_\_\_\_\_ State \_\_\_\_\_

**ATTORNEY:**

Do you have an Attorney?                              YES              NO

**IF YES:**

Is your Attorney a Public Defender?              YES              NO

Did your Attorney refer you here?              YES              NO

Attorney's Name: \_\_\_\_\_

Contact Information: \_\_\_\_\_

**PROBATION/PAROLE:**

Are you currently on Probation or Parole?              YES              NO

**IF YES:**

Supervised: \_\_\_\_\_              Unsupervised: \_\_\_\_\_

Adult: \_\_\_\_\_              Juvenile: \_\_\_\_\_

State: \_\_\_\_\_              Federal: \_\_\_\_\_

What Jurisdiction office are you under? County \_\_\_\_\_ State \_\_\_\_\_

What is the name of your current Probation/Parole Officer? \_\_\_\_\_

**DEPARTMENT OF FAMILY SERVICES (DFS)**

Were you referred/required to be here by DFS?      YES              NO

**IF YES:**

Who is your Case Worker? \_\_\_\_\_

**VOA HALFWAY HOUSE**

Are you a resident of the VOA in Gillette?              YES              NO

**IF YES:**

Who is your Case Worker? \_\_\_\_\_

**DEPARTMENT OF TRANSPORTATION**

Did the DOT refer you here?                              YES              NO