COST

The cost of the alcohol and drug evaluation is established by the provider. It is the responsibility of the defendant to pay for the evaluation. However, providers must offer alcohol and drug evaluations at a reduced fee to defendants who can prove inability to pay the full cost according to established program standards.

REGULATIONS

Providers that conduct DUI evaluations for the Court or the Office of the Secretary of State are licensed and regulated by the Illinois Department of Human Services, Division of Alcoholism and Substance Abuse. Professional evaluators working in these programs must meet standards prescribed by the Department. Programs are inspected and must conform to applicable Department Rules and Regulations in order to maintain licensure.

COMPLAINTS

The Department has statutory authority to investigate providers who conduct alcohol and drug evaluations for DUI defendants. Questions or complaints regarding DUI services rendered should be directed to:

Illinois Department of Human Services
Division of Alcoholism and Substance Abuse
Licensing and Certification
401 South Clinton Street, Second Floor
Chicago, Illinois 60607
312-814-3840

If you have any questions about alcohol or other drugs, call:

Illinois Department of Human Services
Division of Alcoholism and Substance Abuse
1-866-213-0548 (toll-free Voice)
1-866-843-7344 (toll-free TTY)

If you have questions about Illinois Department of Human Services (IDHS) programs or services please call or visit your local Family Community Resource Center (FCRC). We will answer your questions.
If you do not know where your FCRC is or if you are unable to go there, you may call the automated helpline 24 hours a day at:

1-800-843-6154
1-800-447-6404 (TTY)

You may speak to a representative between:
8:00 a.m. - 5:30 p.m.
Monday - Friday (except state holidays)

Visit our website at:
www.dhs.state.il.us

Programs, activities and employment opportunities in the Illinois Department of Human Services are open and accessible to any individual or group without regard to age, sex, race, sexual orientation, disability, ethnic origin or religion. The department is an equal opportunity employer and practices affirmative action and reasonable accommodation programs.

DHS 4499 (R-02-14) DHS/DASA DUI Processes and Evaluations
Printed by the Authority of the State of Illinois.
200 copies P.O.#14-1086

State of Illinois
Department of Human Services

DUI Processes and Evaluations

INTRODUCTION

In Illinois, anyone arrested for driving under the influence of alcohol and/or other drugs (DUI) must undergo an alcohol and drug evaluation before sentencing can occur for the DUI offense, or restricted or full driving privileges can be granted by the Office of the Secretary of State.

The purpose of the evaluation is to determine the extent of the defendant's alcohol and/or drug use and its associated risk to current or future public safety. The following areas are reviewed: the defendant's driving history, chemical test results (blood alcohol content), Objective Test score and category, and the interview with an evaluator.

The focus of the interview is past and current alcohol and drug use, specifically as it relates to driving history. Defendant responses are checked against the driving record, the Objective Test score, the results of the chemical testing, and possibly other corroborative sources. Inconsistencies must be reconciled between the defendant and the evaluator. If not, the evaluation will have no validity and could result in the following consequences:

- Denial of driving privileges by the Office of the Secretary of State.
- A request by the Court or the Office of the Secretary of State to undergo another evaluation at the defendant's expense.
- Delay of sentencing for the DUI or consideration for restricted or full driving privileges.

When the evaluation is completed, a classification and a recommendation will be determined by the evaluator and recorded on the Alcohol and Drug Uniform Report form for the Court or the Office of the Secretary of State. This form will then be sent to the Court or given to the defendant to take to the Office of the Secretary of State for the driver's license hearing.

The classification will be one of the following:

- Minimal Risk
- Moderate Risk
- Significant Risk
- High Risk

RECOMMENDATIONS

The minimum recommendation to the Court or the Office of the Secretary of State related to each classification is as follows:

Minimal Risk

Completion of a minimum of ten hours of DUI Risk Education.

Moderate Risk

Completion of a minimum of ten hours of DUI Risk Education and a minimum of 12 hours of early intervention provided over a minimum of four weeks with no more than three hours per day in any seven consecutive days, subsequent completion of any and all necessary treatment, and, after discharge, active ongoing participation in all activities specified in the continuing care plan, if so recommended, following completion of the early intervention.

Significant Risk

Completion of a minimum of ten hours of DUI Risk Education and a minimum of 20 hours of substance abuse treatment and, after discharge, active ongoing participation in all activities specified in the continuing care plan.

High Risk

Completion of a minimum of 75 hours of substance abuse treatment and, after discharge, active ongoing participation in all activities specified in the continuing care plan.

In all cases, it is at the discretion of the Cour to determine what type of recommendation, if any, will ultimately become a part of the sanction for the DUI offense. However, if the alcohol and drug evaluation is for the Office of the Secretary of State in relation to the return of full or limited driving privileges, the defendant will be required to complete any recommendations contained in the alcohol and drug evaluation.

The defendant has the right to reject the completed alcohol and drug evaluation, to withdraw from the process at any time, or to seek a second opinion by obtaining another evaluation. However, any information provided may be released to the Court or the Office of the Secretary of State, upon request If the evaluation procedure is not completed, notice will be sent to the Court or the Office of the Secretary of State.

JB Pritzker, *Governor*

James T. Dimas, *Secretary-designate*

100 South Grand Avenue East • Springfield, Illinois 62762
401 South Clinton Street • Chicago, Illinois 60607

INFORMED CONSENT

In order to obtain an Alcohol and Drug Evaluation for the Circuit Court or the Office of the Secretary of State, I agree to provide the following information:

- A copy of my driving abstract or a written summary of my driving history obtained from the Office of the Secretary of State;
- The written results of any chemical testing or documentation of refusal of such testing that occurred after my arrest for driving under the influence of alcohol and/or other drugs (DUI); and
- Alcohol and drug use history from first use to present.

I also attest to the fact that I have not undergone any other alcohol and drug evaluation as a result of my DUI arrest or if I have, I agree to provide a copy of all such evaluations, if completed and/or the name and address of such program(s). I also give my consent for this program to obtain information from any program(s) where I previously began and/or completed any alcohol and drug evaluation relative to my arrest for DUI. I have read the Department of Human Services brochure entitled "DUI Processes and Evaluations" explaining the alcohol and drug evaluation procedure. I understand that I have the right to withdraw from this evaluation process at any time, refuse the completed alcohol and drug evaluation or seek a second opinion by obtaining another evaluation. I further understand that any information I do provide can be released to the Circuit Court, the Office of the Secretary of State or the Department of Human Services upon request. If I do not complete the evaluation or do not return to sign and obtain my copy of the evaluation within 30 days of its completion date, notice will be sent to the Circuit Court or the Office of the Secretary of State along with any relevant information pertaining to my involvement with this program.

______________________________ ______________
Offender Signature *Date*

______________________________ ______________
Parent/Guardian Signature (If offender is under age 18) *Date*

Witnessed:

______________________________ ______________
Signature *Date*

IF CONSENT IS NOT GIVEN, PLEASE INDICATE THAT YOU HAVE READ THIS FORM BY INITIALING ON THIS LINE. ____________

JB Pritzker, *Governor*

James T. Dimas, *Secretary-designate*

100 South Grand Avenue East • Springfield, Illinois 62762
401 South Clinton Street • Chicago, Illinois 60607

REFERRAL LIST VERIFICATION FORM

I have been shown a listing of licensed DUI and/or substance abuse treatment programs. I understand that I may seek any necessary services at the program of my choice.

______________________________ ______________
Offender Signature *Date*

______________________________ ______________
Evaluator Signature *Date*

The following is a listing of agencies in Lake County, IL licensed to provide DUI services, as included in the Illinois Substance Use Prevention and Recovery (SUPR) Directory of licensed service providers. Should you choose to complete your recommended services at one of these, or another SUPR licensed agency, please contact them as soon as possible to begin working towards completion of recommended services. The URL below will take you to a list of all SUPR-licensed providers in the state, though not all are licensed for DUI Services. Please don't hesitate to call us if you are having difficulty locating a provider.

SUPR LICENSED SITES SORTED BY COUNTY/CITY/TOWNSHIP- CCA/PROGRAM NAME

About Change Counseling 118 Barrington Commons Ct. Barrington, IL 60010 630-669-7161		Nicasa Behavioral Health 1113 Greenwood Ave Waukegan, IL 60087 847-244-4434	Renacer Latino, INC. 620 Washington St. Waukegan, IL 60085 847-336-7302
Addictions Associates Therapy, Inc. 322 Peterson Road Libertyville, IL 60048 847-549-0083	DUI & Addictions Counseling Center, INC. 333 E. Route 83 STE B7 Mundelein, IL 60060 847-949-4596	Nicasa Behavioral Health English and Spanish Available 31979 N. Fish Lake Rd. Round Lake, IL 60073 847-546-6450	Presence Behavioral Health – Lake Bluff 71 Waukegan Rd. STE 900 Lake Bluff, IL 60044 847-493-3575
Allied Psychological Services 501 W Peterson Rd. #101 Libertyville, IL 60048 847-680-3842	Behavioral Services Center 5101 Washington St. Suite 11 Gurnee, IL 60031 847-673-8577	Nicasa Behavioral Health 2900 N. Main St. Buffalo Grove, IL 60069 847-634-6422	Treatment Centers of Illinois- 1020 Milwaukee Ave. STE 310 Deerfield, IL 60015 877-785-0111
Arlington Center For Recovery, LLC 21457 Milwaukee Ave. Deerfield, IL 60015 847-427-9680	Gateway Foundation 25480 W. Cedarcrest Ln. Lake Villa, IL 60046 847-356-8205	Fresh Start DUI And Counseling Services,INC. 2504 Washington St. STE200E Waukegan,IL 60085	Weckler and Associates, Limited 68 Ambrogio Dr. STE101 Gurnee, IL 60031 847-662-5588
Behavioral Services Center 25975 N. Diamond Lake Rd. Mundelein, IL 60060 847-929-4068	L.S. Berkley and Associates 1207 Old McHenry Rd. STE 212 Buffalo Grove, IL 60089 847-478-8332	Northwestern Lake Counseling 214 Washington St. Ingleside, IL 60041 847-587-8400	Western Lake Counseling and DUI Programs, LLC 21 W. Grand Ave. Fox Lake, IL 60020 847-587-9700
Mcdermott Center/Lake County IL. Probation & 215 W.Water St. Waukegan IL, 60085 847-377-3675	Nicasa Behavioral Health Zion Township Bldg. 1015 27th St. Zion, IL 60099 847-546-6450	Soft Landings at Highland Park 1910 1st Street Suite 2N Highland Park, IL 60035 630-261-9220	Behavior Services Center 310 S. Greenleaf St. STE205 Gurnee,IL 60031 847-673-8577
Arden Shore Child and Family Services 329 N. Genesee Street Waukegan, IL 60085 847-623-1730	Calming Solutions 123 Water Street Waukegan, IL 60085 847-406-9527	Mathers Recovery, LLC 81 E. Grand Avenue Fox Lake, IL 60020 847-462-6099	Victory Vision 500 West Central Road Suite 100 C Mount Prospect, IL 60056 847-788-9622
		Renacer Latino, INC. 900 N. Lake St. STE 100 Mundelein, IL 60060 847-336-7324	***Cook County provider** ****Services provided in additional languages**

NEED A LAWYER? DON'T KNOW WHO TO CALL?

LAWYER REFERRAL SERVICE

1) The LCBA Lawyer Referral Service (LRS) is designed to make it easy for a person to contact an attorney who practices in Lake County. Now you have two choices; by phone or online.

   You can call the Lawyer Referral Service at (847) 244-3140 from 9:00 a.m. to 3:00 p.m. Monday through Friday (closed between 12:00 p.m. to 1:00 p.m. and holidays).

   When you call, a representative will ask you to briefly state your legal problem. **The LRS cannot give legal advice**, but will refer you to an attorney you may contact to make an appointment or receive a phone consultation.

   All referrals are to PRIVATE attorneys that will charge customary legal fees for any further legal services rendered.

   The Lawyer Referral Service makes its referrals based upon an attorney's area of practice, experience, language spoken and geographic location. Referrals are NOT made based on an attorney's fees.

   THIS IS A TELEPHONE SERVICE ONLY! NO WALK IN REFERRALS WILL BE GIVEN.

OR

2) You can visit us 24 hours a day online at www.lakebar.org
   Click on "Find a Lawyer" and you will be provided with the contact information of a Lawyer Referral Service attorney.

The Lake County Bar Association was founded in 1911 by attorneys practicing law in Lake County. There are over 800 lawyers in the LCBA and many of them have agreed to accept referrals in their field of concentration. All LRS attorneys must meet certain eligibility requirements in order to serve in the Lawyer Referral Service. If you need an attorney in a certain area of law, the LRS is available to help you locate an attorney who is familiar in that field of concentration.

Call us today at (847) 244-3140 or visit us online at www.lakebar.org

Nicasa
Behavioral Health Services

10-hour Risk Reduction Education Program

- Quick entry and rapid completion
- 10 hours can be completed within one week
- Several class schedules available
- Morning and evening classes available
- English and Spanish speaking classes

If you have any questions about the Risk Reduction Program call:

- Waukegan office: (847) 244-4434
- Round Lake office: (847) 546-6450
- Buffalo Grove office: (847) 634-6422

If you wish to complete the 10-hour Remedial Education class at Nicasa, we offer various schedules and locations to best meet your needs:

1. **Buffalo Grove** – 2900 Main St, (847) 634-6422
2. **Round Lake** – 31979 N. Fish Lake Rd, (847) 546-6450
3. **Waukegan** – 1113 Greenwood, (847) 244-4434

PLEASE CALL THE OFFICE WHERE YOU WISH TO TAKE THE CLASS TO SCHEDULE AN INTAKE AND REGISTER FOR THE NEXT AVAILABLE DATE.

NOTICE

IF YOU REGISTER <u>TODAY</u> FOR YOUR INITIAL 10-HOUR RISK REDUCTION EDUCATION CLASS,

YOU WILL RECEIVE THE $25 RISK REDUCTION INTAKE APPOINTMENT AT NO COST!!!

If you complete the 10 hours that you sign up for today as agreed, you will receive an additional $25 off the 1-hour intake appointment for any remaining hours you may need.

Please refer to this slip when scheduling your intake.

This offer does not apply if you are eligible for sliding fee scale.

Classes and/or treatment may be completed with another agency. Please refer to the following website: www.dhs.state.il.us

REFERRAL FORM

FREE GAMBLING CONSULTATION

PLEASE SPEAK TO CLIENT SERVICES STAFF BEFORE YOU LEAVE TODAY, OR CALL APPOINTMENT SETTERS AT 847-201-8134 OR
847-201-8527 TO SCHEDULE YOUR **FREE** GAMBLING CONSULTATION.
PLEASE HAVE YOUR CALENDAR HANDY.
WE LOOK FORWARD TO HEARING FROM YOU!

Rev. 9/5/2017

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

Your health record contains personal information about you and your health. State and federal law protects the confidentiality of this information. "Protected health information"(PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. The confidentiality of alcohol and drug abuse Client records is specifically protected by Federal law and regulations. The confidentiality of mental health client records is specifically protected by state law. Nicasa is required to comply with these additional restrictions. This includes a prohibition, with very few exceptions, on informing anyone outside the program that you attend the program or disclosing any information that identifies you as an alcohol or drug abuser. The violation of these laws or regulations by this program is a crime. If you suspect a violation you may file a report to the appropriate authorities in accordance with Federal regulations or applicable law.

How We May Use and Disclose Health Information About You

- **For Services.** We may use medical and clinical information about you to provide you with services.
- **For Payment.** With your authorization, we may use and disclose medical information about you so that we can receive payment for the services provided to you. If you are receiving substance abuse treatment services, this will only be done with your authorization.
- **For Health Care Operations.** We may use and disclose your protected health information ("PHI") for certain purposes in connection with the operation of our program.
- **Without Authorization.** Applicable law also permits us to disclose information about you without your authorization in a limited number of other situations, such as with a court order. These situations are explained on the following pages.
- **With Authorization.** We must obtain written authorization from you for other uses and disclosures of your PHI.

Your Rights Regarding Your PHI. You have the following rights regarding PHI we maintain about you:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted in certain circumstances, to inspect and copy PHI that may be used to make decisions about your care. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of the disclosures that we make of your PHI.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.
- **Complaints.** You have the right to file a complaint in writing to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. ***We will not retaliate against you for filing a complaint.***

If you have any questions about this Notice of Privacy Practices, please contact Nicasa's Privacy Officer at Nicasa, 31979 Fish Lake Road, Round Lake, IL 60073, (847) 546-6450

This Notice of Privacy Practices describes how we may use and disclose your protected health information ("PHI") in accordance with all applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will make available a revised Notice of Privacy Practices by posting a copy on our website NICASA.ORG, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

How We May Use and Disclose Health Information About You

Listed below are examples of the uses and disclosures that Nicasa may make of your protected health information ("PHI"). These examples are not meant to be exhaustive. Rather, they describe types of uses and disclosures that may be made.

Uses and Disclosures of PHI for Services, Payment and Health Care Operations

Services. Your PHI may be used and disclosed by your physician, counselor, program staff and others outside of our program that are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and any related services. This includes coordination or management of your health care with a third party, consultation with other health care providers or referral to another provider for health care treatment. For example, your protected health information may be provided to the state agency that referred you to our program to ensure that you are participating in treatment. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of the program, becomes involved in your care. Except for emergency services, we will not send your PHI to an outside health care provider who is caring for you unless you give us written authorization to do so.

Payment. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If you are in a substance abuse treatment program, we will not use your PHI to obtain payment for your health care services without your written authorization. If you are in a mental health program, we may use your PHI to obtain payment for your health care services without your written authorization.

Healthcare Operations. We may use or disclose, as needed, your PHI in order to support the business activities of our program including, but not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician or counselor. We may also call you by name in the waiting room when it is time to be seen. We may share your PHI with third parties that perform various business activities (e.g., billing or typing services) for Nicasa, provided we have a written contract with the business that prohibits it from re-disclosing your PHI and requires it to safeguard the privacy of your PHI.

We may contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also contact you concerning Nicasa's fundraising activities.

Other Uses and Disclosures That Do Not Require Your Authorization

Required by Law. We may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Health Oversight. We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors) and peer review organizations performing utilization and quality control. If we disclose PHI to a health oversight agency, we will have an agreement in place that requires the agency to safeguard the privacy of your information.

Medical Emergencies. We may use or disclose your protected health information in a medical emergency situation to medical personnel only. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect. However, the information we disclose is limited to only that information which is necessary to make the initial mandated report.

Deceased Clients. We may disclose PHI regarding deceased Clients for the purpose of determining the cause of death, in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death.

Research. We may disclose PHI to researchers if (a) an Institutional Review Board reviews and approves the research and a waiver to the authorization requirement; (b) the researchers establish protocols to ensure the privacy of your PHI; (c) the researchers agree to maintain the security of your PHI in accordance with applicable laws and regulations; and (d) the researchers agree not to redisclose your protected health information except back to Nicasa.

Criminal Activity on Program Premises/Against Program Personnel. We may disclose your PHI to law enforcement officials if you have committed a crime on program premises or against program personnel.

Court Order. We may disclose your PHI if the court issues an appropriate order and follows required procedures.

Interagency Disclosures. Limited PHI may be disclosed for the purpose of coordinating services among government programs that provide mental health services where those programs have entered into an interagency agreement.

Public Safety. If you are in a mental health treatment program only, we may disclose PHI to avert a serious threat to health or safety, such as physical or mental injury being inflicted on you or someone else.

Uses and Disclosures of PHI With Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization. You may revoke this authorization at any time, unless the program or its staff has taken an action in reliance on the authorization of the use or disclosure you permitted.

Your Rights Regarding your Protected Health Information
Your rights with respect to your protected health information are explained below. Any requests with respect to these rights must be in writing. A brief description of how you may exercise these rights is included.

You have the right to inspect and copy your Protected Health Information
You may inspect and obtain a copy of your PHI that is contained in a designated record set for as long as we maintain the record. A "designated record set" contains medical and billing records and any other records that the program uses for making decisions about you. Your request must be in writing. We may charge you a reasonable cost-based fee for the copies. We can deny you access to your PHI in certain circumstances. In some of those cases, you will have a right to appeal the denial of access. Please contact our Privacy Officer if you have questions about access to your medical record.

You may have the right to amend your Protected Health Information
You may request, in writing, that we amend your PHI that has been included in a designated record set. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of it. Please contact the Nicasa Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of some types of Protected Health Information disclosures.
You may request an accounting of disclosures for a period of up to six years, excluding disclosures made to you, made for treatment purposes or made as a result of your authorization. We may charge you a reasonable fee if you request more than one accounting in any 12 month period. Please contact our Privacy Officer if you have questions about accounting of disclosures.

You have a right to receive a paper copy of this notice.
You have the right to obtain a copy of this notice from us. Any questions should be directed to our Privacy Officer.

You have the right to request added restrictions on disclosures and uses of your Protected Health Information.
You have the right to ask us not to use or disclose any part of your PHI for treatment, payment or health care operations or to family members involved in your care. Your request for restrictions must be in writing and we are not required to agree to such restrictions. Please contact our Associate Director if you would like to request restrictions on the disclosure of your PHI.

You have a right to request confidential communications.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable, written requests. We may also condition this accommodation by asking you for information regarding how payment will be handled or specification of an alternative address or other method of contact. We will not ask you why you are making the request. Please contact the Client Services Department if you would like to make this request.

Complaints

If you believe we have violated your privacy rights, you may file a complaint in writing to us by notifying Nicasa's Privacy Officer at Nicasa, 31979 Fish Lake Road, Round Lake, IL 60073, (847) 546-6450 . **We will not retaliate against you for filing a complaint.** You may also file a complaint with the U.S. Secretary of Health and Human Services as follows:

200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257

The effective date of this Notice is April 14, 2003.

Effective February 29, 2016

Service Fees

EVALUATIONS

Service	Fee
DUI	$150
Narrative Substance Abuse/Gambling	$200
Mental Health Assessment	$200
Locus Assessment	$100
Secretary of State Part 1	$100
Secretary of State Part 2	$500

INDIVIDUAL SERVICES

Service	Unit		Fee	Your costs
Substance Abuse/Mental Health	1 hour	@	$100	
Treatment Plan	1 hour	@	$100	
AODA Intake	1/2 hour	@	$25	
Moderate Intake	1 hour	@	$100	
Significant/High Risk/IOP Intake	1 hour	@	$125	
Youth Intake	1 hour	@	$100	

OUTPATIENT GROUP

Service	Unit		Fee	Estimated hours*	Estimated costs
Substance Abuse	1 hour	@	$28		
Mental Health	1 hour	@	$28		
AODA	1 hour	@	$14		
TRACK	1 hour	@	$10		

INTENSIVE OUTPATIENT GROUP

Service	Unit		Fee	Estimated days/ hours*	Estimated costs
Substance Abuse/Mental Health	1 day	@	$250		
or	1 hour	@	$28		

TOXICOLOGY

Service	Fee
Urinalysis drug screen	$60
Redi Strip alcohol screen	$40

OTHER

Service	Unit		Fee	Estimated hours*	Estimated costs
Parenting	1 hour	@	$28		
GOALS	total program	@	$140		

Estimated cost of your treatment $__________

***Total number of hours/days is based on a client's individual treatment plan and progress and is subject to change.**

Client Signature

Date

C:\Users\scastro\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\3JFMU33\Fee Schedule 2016 (1)

Nicasa Behavioral Health CLIENT RIGHTS

Nicasa provides treatment for individuals and families. Your rights are protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code (405 ILCS 5). Although each of Nicasa's individual programs vary in the type of care offered, the following policies and procedures are made to improve the dignity of all clients and to protect their rights as human beings. These rights will be given to you in all cases.

You have the right:

1. To personalized treatment that is fair, with no unfairness shown because of your race, religion, gender, age, ethnicity, sexual orientation, sexual identity, HIV status, or disability.
2. To have your disabilities accommodated as required by the Americans with Disabilities Act section 504 of the Rehabilitation Act and the Human Rights Act.
3. To be treated at all times with dignity and respect in a setting that is free from the following: physical punishment or abuse; sexual abuse or harassment; psychological abuse including humiliating, threatening and exploitive actions; verbal abuse; neglect; and exploitation for financial gain.
4. To treatment in a setting that is the least interfering to your personal freedom and that provides privacy within the limits of the agency's capabilities.
5. To know that any testing you have regarding HIV/AIDS will be anonymous and that your HIV/AIDS status and testing will remain completely confidential.
6. To know the clinical staff responsible for your care, their credentials, qualifications, and professional experience.
7. To participate in your treatment and discharge planning, including periodic review of your treatment plan.
8. To confidentiality and privacy governed by the Confidentiality Act and the Health Insurance Portability and Accountability of 1996.
9. To confidentiality and privacy and to know that confidentiality is limited by law in cases such as medical emergencies, suspected child abuse, court order, suspected abuse of adults who cannot protect themselves, threats to the lives of others, and any other instances specified by law when disclosure may be made without client's consent.
10. To know that identifiable photographs, video tape, films, etc., will not be made or used without your written consent, nor will you be required to make public statements which acknowledge gratitude to Nicasa, NFP for its services.
11. To complain, initiate a grievance, or report any inappropriate activity without fear of reprisal or retaliation.

For clients receiving mental health services, clients have the right to:

a) Contact the Guardianship and Advocacy Commission and Equip for Equality, Inc.
b) Assistance in contacting these groups, giving each client the address and telephone number of the Guardianship and Advocacy Commission and Equip for Equality,

Inc.: GUARDIANSHIP AND ADVOCACY COMMISSION 160 N. LaSalle Street, Suite S500 Chicago, IL 60601 Voice: (312) 793-5900 or (866) 274-8023 Fax: (312) 793-4311 Website: www.gac.state.il.us.

c) The right or the guardian's right to present grievances up to and including the provider's executive director or comparable position.

d) The right not to be denied, suspended or terminated from services or have services reduced for exercising any rights; and

e) The right to contact the public payer or its designee and to be informed of the public payer's process for reviewing grievances.

12. To give your informed consent, informed refusal, and/or expression of choice (and to be advised of the consequences of your decisions) in regard to service delivery, release of information, the availability of concurrent services, composition of your service delivery team, and your involvement in research projects.

13. To know that Nicasa adheres to all federal and state-required research guidelines and ethics, and to refuse to participate in any research projects without compromising your access to services.

14. To have access and/or referral to legal entities for appropriate representation, as well as access to self-help and advocacy support services.

15. To have access to your record and other information pertinent to your treatment planning, and to have that information released in a timely and appropriate manner that will facilitate decision making. The only exception to this right being the restrictions permitted by federal law (HIPAA) which include psychotherapy notes and information compiled in reasonable anticipation of or for use in a civil, criminal, or administrative action or proceeding.

16. To a prompt investigation and resolution of alleged infringement of these rights.

17. To know that all other legal rights to which you are entitled will be recognized and enforced while you are a client at Nicasa.

18. To request an ethics review/investigation of any staff member without fear of reprisal.

For Residential Clients

19. (For residential clients) To visitation in a suitable area by all concerned persons who have been clinically determined to be of benefit to your treatment in accordance with agency policies.

20. To the receipt and sending of mail without censor and to know that your mail will not be read by staff members.

21. To conduct private telephone conversations in accordance with agency policy unless contraindicated by clinical considerations.

I understand the nature of treatment with Nicasa, and my signature indicates consent to treatment with Nicasa, NFP.

Client Signature: ________________________________ Date: ______________

Client's level of understanding: Satisfactory _____ Unsatisfactory _____

I have explained these rights to the individual (or guardian of the individual) and have provided him or her a copy of it. A copy of this form has been filed in the individual's clinical record.

Staff Signature: ________________________________ Date: ______________

Duplicate copy of Client Rights statement given to Client's:

Family ______ Significant Other ______ Guardian ______

Nicasa Request for Confidential Means of Communications

☐ ORIGINAL ☐ CHANGE

Today's Date: ______________

Client's Name: ______________________________ Client # ______________

Client's Birth Date ______________ Social Security Number ____-____-____

Client's Address: ____

Daytime Telephone ______________ Evening Telephone ______________

Nicasa may contact you by mail, phone or fax. This communication may include your protected health information. If you do not wish to be contacted by one or more of these methods please specify below:

DO NOT CONTACT ME AS FOLLOWS: ______________________________

If you wish to be contacted at an address other than the one stated above, please specify below:
PLEASE CONTACT ME AT: ______________________________

If the restrictions affect my payment arrangements, payment will be made as follows:

____

I understand that Nicasa will agree to all reasonable requests, but may deny a request if I do not clearly provide an alternative means of contact, or if I do not provide information as to how payment, if applicable, will be made. Nicasa will notify me in writing of its response to my request.

Signature of Client ______________________________ Date ______________

Signature of Client's Personal Representative ______________________________ Date ______________

THIS SECTION TO BE COMPLETED FOR CHANGE IN CONFIDENTIAL MEANS OF COMMUNICATION ONLY

For Organization Use Only:

Date Request Received: ______________

Date of Written Response: ______________

Action taken (CHECK ONE): _____ Approved _____ Denied

Staff person signature ______________________________ Date ______________

Emergency Notification

I_____________________________, hereby authorize Nicasa staff to contact the following persons in the case of an emergency.

Primary Contact:

____

Name

____

Phone

Secondary Contact: (to be contact if primary contact cannot be reached)

____

Name

____

Phone

If you have a medical emergency and cannot communicate with First Responders, the following will be shared with emergency personnel:

- Name
- Address
- Date of Birth

Please initial and complete the following if you wish this information to be released to emergency personnel:

_____All medications that you have disclosed at Nicasa that you are taking

Initials

_____The following allergies and/or medical condition(s): ____________________

Initials

____

______________________________ ____________________

Client Signature Date

If you are able to communicate, Nicasa will release no private health information to First Responders.

Nicasa Criminal Justice System Referral

Client#____________________

I, ________________________________, whose social security number is ________________, hereby consent to communication between Nicasa and:

- ____ Circuit or District Court of ________________ County ordering me to treatment (including the Judge and District Attorney)
- ____ Illinois Department of Corrections and Parole
- ____ ________________ County Department of Corrections
- ____ ________________ County Department of Probation (name): ____________________
- ____ City of ________________ Police Department
- ____ ________________ County Sheriff's Department
- ____ Treatment Alternatives for Safe Communities ("TASC")
- ____ Defense Attorney (name): ________________

Information will be disclosed for the purpose of informing the criminal justice agencies listed above of my participation and progress in Nicasa programs, including any of the following information: Assessment, Completion Letters, Diagnosis, Treatment Plan or Summary, Current Treatment Update, Medication Management Information, Toxicological Reports/Drug Screens, Educational Information, Discharge/Transfer Summary, Legal History , Other:____.

I understand that Nicasa is providing treatment to me in reliance on this authorization permitting disclosure to criminal justice agencies. Therefore, I understand that this authorization will remain in effect and cannot be revoked by me until final disposition of the proceeding that gave rise to the criminal justice system referral. At that time, I may revoke this authorization as follows: in writing mailed to Nicasa at 31979 Fish Lake Road, Round Lake, IL 60073. If not revoked, this authorization will terminate one year after the date of discharge or final disposition of the proceeding giving rise to the criminal justice system referral, whichever is later.

A person who receives confidential information may redisclose and use it only to carry out that person's official duties.

______________________________ ________________

Signature of client Date

______________________________ ________________

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Nicasa's Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Client Name:______________________________________
DOB: ____
SSN:____

I hereby acknowledge that I have received a copy of Nicasa's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Nicasa's Privacy Officer at 847-546-6450.

____
Signature of Client **Date**

____
Signature or Parent, Guardian or Personal Representative * **Date**

____
* If you are signing as a personal representative of a client, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ **Client Refuses to Acknowledge Receipt:**

____
Signature of Staff Member **Date**

Nicasa Behavioral Health Services

CONSENT FOR SERVICES

I authorize and consent that I, ____, receive evaluation and/or education/intervention, as a result of ________________ ____.

The nature and purpose of the service, the possible complications, the possible alternatives to such services, the risks involved and the possible consequences have been fully explained to me by ____________________________________.

I understand that no guarantee or assurance has been given me, by anyone, as to the results of the service.

I also have been informed that my records and disclosures will be kept absolutely confidential except only as the law may otherwise require such disclosures.

This consent for services is revocable by either party through written notice. In such instances, the case will be closed and maintained for possible future use. After closing the case, the same standards of confidentiality and accessibility to records will be upheld.

____
Signature of Client

____
Signature of Witness

____
Signature of Parent or Guardian

____________________ ________________
Client ID # Date

CLIENT #________________

DATE : ________________

IN THE PAST YEAR....

	Yes	No
1. Have you often found yourself thinking about gambling (e.g., reliving past gambling experiences, planning the next time you will play or thinking of ways to get money to gamble) ?	☐	☐
2. Have you needed to gamble with more and more money to get the amount of excitement you are looking for?	☐	☐
3. Have you become restless or irritable when trying to cut down or stop gambling?	☐	☐
4. Have you gambled to escape from problems or when you are feeling depressed, anxious or bad about yourself?	☐	☐
5. After losing money gambling, have you returned another day in order to get even?	☐	☐
6. Have you lied to your family or others to hide the extent of your gambling?	☐	☐
7. Have you made repeated unsuccessful attempts to control, cut back or stop gambling?	☐	☐
8. Have you risked or lost a significant relationship, job, educational or career opportunity because of gambling?	☐	☐
9. Have you sought help from others to provide the money to relieve a desparate financial situation caused by gambling?	☐	☐

Score ☐