Brooke's Place provides support groups, therapy services and community education to empower children, teens, young adults and their families to thrive in the midst of grief.

Thank you for reaching out to our *Brooke's Place Therapy Services.*

Our *Therapy Services* offers individual/family counseling to children, teens and young adults ages 3-20s and their adult caregivers, who are grieving or anticipating the death of a significant person. We are guided by 4 principles in supporting grieving children and their families: grief is a natural reaction to the death of a loved one for children, teens and adults; within each individual is the natural capacity to heal oneself; the duration and intensity of grief are unique for each individual; and caring and acceptance help in the healing process. Our team of professional therapists at Brooke's Place has completed extensive training and holds a Doctoral degree, mental health licensure or is licensed eligible in Indiana.

Enclosed you will find *a Therapy Services Intake Form, a Therapeutic Disclosure Form and a Scholarship Form* that outlines our fees and other policies. Please be assured that all information you complete is kept strictly confidential and can only be released with your written approval. Please complete these forms and fax or mail them to Brooke's Place. Upon receiving your information, one of our Staff will call you to set up a therapy appointment.

If you have any questions, call our office at 317-705-9650.

We hope that your experience with Brooke's Place is beneficial to you.

Carol A. Braden, LMHC
Clinical Director of Programs & Services

Therapy Services Intake Form

Please complete every page of this form. All information will be kept **strictly confidential**, unless you give us written permission to release your information.

- FILL OUT 1 INTAKE FORM PER PERSON WHO IS SEEKING COUNSELING –
FAX #: 317-705-9654

Today's Date: _____
Client Name: (First, MI, Maiden, Last): _____ M □ F □
Client Date of Birth: _____

Parent/Guardian Name (if client(s) is a minor): _____

Client information or Parent/Guardian Information (if client is a minor):

Home Phone (__) _____ Work Phone (__) _____

Cell Phone (__) _____ Other Phone (__) _____

Address:_____ City, State:_____ Zip: _____

County: _____ Email: _____

Employer: _____

Emergency Contact _____
Name Relationship Phone

Please answer these questions about the person(s) who died:

Name _____
Date of Birth: ___ / ___ / ___
Date of Death: ___ / ___ / ___

This death was: [] sudden [] unexpected
Cause: [] illness (cause) _____
If prolonged illness, indicate length: _____
[] accident (type) _____
[] suicide [] homicide

Relationship of deceased to the client: [] Mother [] Father [] Brother [] Sister [] Daughter [] Son
[] Grandfather [] Grandmother [] Aunt [] Uncle [] Cousin [] Friend [] Grandchild [] Spouse [] Former Spouse
[] Other: (list) _____

Was the client living with this person at the time of death? [] Yes [] No

If not, how long has it been since the client last saw this person? _____

Relationship between the client and the person who died before the death, in your opinion (circle)

1	2	3	4	5	6	7
Not close at all			Close			Very close

Has the client been told everything about the death? [] Yes [] No Note: _____

Was the client involved in the funeral and burial? [] Yes [] No Note: _____

Please list any changes the client has experienced which have occurred since the death of this person:
[] Moved to a new home [] If child/teen~ changed schools [] New job or parent has a new job [] Sleep patterns
[] Family's finances have suffered [] Parent has a new relationship or remarriage [] Eating patterns
[] Behavior changes (list)_____
_____

_____

Therapy Services Intake Form

What, if any, counseling or peer support has the client received?

_____

_____

Has the client ever been hospitalized for drug/alcohol or psychiatric reasons?

( ) Yes ( ) No If yes, when and where? _____

At this time, is the client seeking counseling for:

( ) Self ( ) Individual ( ) Family ( ) Both

Is the client a United States citizen?

( ) Yes ( ) No

Child's parents are/were: [] single [] married [] divorced [] widowed [] separated

How long separated/divorced? _____

Were the parents living together at the time of death? [] Yes [] No

Family's Gross Annual Household Income:

( ) $0 - 15,000	( ) $25,001 - 30,000	( ) $40,001 - 45,000	( ) $55,001 - 60,000
( ) $15,001 - 20,000	( ) $30,001 - 35,000	( ) $45,001 - 50,000	
( ) $20,001 - 25,000	( ) $35,001 - 40,000	( ) $50,001 - 55,000	

Race: _____ Religion: _____

Does the client have any medical conditions? If so, please explain. _____

Is the client taking any medications? If so, please list. _____

How did you hear about Brooke's Place? _____

(please be specific and use space below)

Name of person referring: _____

Address of person/agency/organization: _____ City _____ Zip _____

Please use this space to share any concerns or information you want the Brooke's Place Therapy Services to know about what the client is experiencing:

_____

_____

_____

_____

_____

_____

_____

What are the **best times and days** the client has available for appointments?
(Please check all that apply)

( ) 8am - 12pm	( ) Monday	( ) Thursday
( ) 12pm - 3pm	( ) Tuesday	( ) Friday
( ) 3pm – 5pm	( ) Wednesday	
( ) 5pm – 8pm		

COMMUNICATION OF PRIVATE MENTAL HEALTH INFORMATION AUTHORIZATION

Please (√) all that are acceptable forms of communication to provide quality client care:

□ I authorize the staff of the BPTS (Brooke's Place Therapy Services) to leave a message regarding my Private Health Information on home voicemail/answering machine.

□ I authorize the staff of the BPTS to leave a message regarding my Private Health Information on work voicemail/answering machine.

□ I authorize the staff of the BPTS to leave a message regarding my Private Health Information on mobile voicemail.

□ I authorize the staff of the BPTS to leave a message regarding my Private Health Information through my email address.

□ I authorize the staff of the BPTS to mail written communication to my home address.

By signing below, I acknowledge that the above information is correct and hereby give authorization for the release of my private mental health information by the acceptable forms checked above.

_____ _____

Client signature or Parent/Guardian signature (if client is a minor) Date

Therapeutic Disclosure Form

Please sign below to indicate your understanding of the following Brooke's Place Therapy Services policies & procedures:

1. **Principles:**
   - Brooke's Place was founded in 1998 with the belief that every child, teen, young adult and family deserves the opportunity to grieve in a supportive and understanding environment. Based on these beliefs, the principles of Brooke's Place are:

   a. Grief is a natural reaction to the death of a loved one for children, teens, young adults and adults.
   b. Within each individual is the natural capacity to heal.
   c. The duration and intensity of grief are unique for each individual.
   d. Caring and acceptance assist in the healing process.

   _____ initial

2. **Confidentiality:**
   - The therapeutic relationship is a privileged relationship and the content of all discussions, testing, notes and evaluations are protected. This information can only be released by your signed consent. _____ initial

3. **Exceptions to Confidentiality:**

   While the therapeutic relationship is confidential, the professional standards and Indiana Law require these exceptions:
   - When physical harm is threatened against another person or against one's self,
   - When physical abuse or neglect is directed at a child or adult,
   - When records are subpoenaed by a state or federal court,
   - Any other provision covered under Indiana Code 25-23.6 et. Seq.

   _____ initial

4. **Fee Policy:**
   - **The Standard Fee for the *Therapy Services Intake session* is $120.00.**
   - **The Standard Fee for *each additional therapy session* is $100.00.**
   - ***Payment for counseling services is your responsibility and due at the time of your counseling appointment.***
   - Any unpaid balance is due prior to the next appointment.

   _____ initial

5. **Insurance:**
   - Brooke's Place does not bill insurance companies.
   - The filing of an insurance claim is the responsibility of the client.
   - Our clients are responsible for seeking reimbursement directly from their insurance companies.
   - Many insurance companies offer mental health benefits as part of their coverage. We suggest you check with your insurance provider to determine the requirements for insurance coverage. Your insurance company will want to know the credentials of the Provider of Service. You will want to ask your insurance company about deductible requirements, percentage of co-payment and number of sessions per year.

   _____ initial

6. **Cancellation Policy:**
   - To CANCEL an appointment, call your therapist or Brooke's Place (317-705-9650, ext. 201) and leave a message.
   - An appointment is considered a **NO SHOW** if no cancellation occurs.
   - An appointment is ALSO considered a **NO SHOW** if it is canceled less than 24 hours prior to the scheduled appointment, except under extraordinary circumstances.
   - **EACH NO SHOW is charged at $50.00.**
   - You will be required to pay the balance prior to scheduling your next appointment.
   - If two consecutive appointments are missed without explanation or advance notice, we will notify you about next steps.

   _____ Initial

Therapeutic Disclosure Form

7. **Parent/Guardian Policies:**
   - **During the therapy session of our youth clients who are under 18 years of age,** we ask that the parent/guardian remain in our office waiting area. Brooke's Place needs written permission from a parent/guardian for a youth under 18 years of age (with a valid driver's license) to drive to a counseling session without their parent/guardian. You may give this written permission directly to your child's therapist.
   - As a parent/guardian, if you have something to ask or discuss with the therapist, **please schedule an appointment with the therapist.** Please do not request to meet with them for a few minutes while your child is in the waiting area.

_____
initial

8. **Relationships with therapists and Brooke's Place clients:** Brooke's Place therapists honor the privacy and confidentiality of Brooke's Place clients and their families. Given the legal and ethical standards of the therapeutic relationship, therapists do not make contact with families outside of Brooke's Place. Sometimes this makes it uncomfortable about whether to say "hi" at the grocery store or not. We do not initiate contact, but are happy to respond to our clients. Relationships between Brooke's Place therapists and clients is limited to Brooke's Place activities. This preserves the unique therapeutic relationship provided at Brooke's Place. There can be a few limited exceptions, which need to be approved prior to an event, by the Brooke's Place Clinical Director. If you have a current relationship with anyone affiliated with Brooke's Place, please let us know. If at any time a therapist makes contact with you or your children outside of Brooke's Place, please notify us immediately.
   I agree not to establish a personal and/or intimate relationship with Brooke's Place staff and therapists during program services and for six months after closing. This includes any contact via social media. _____
   initial

9. **Additional policies:**
   - Please notify the Brooke's Place main office if your phone number or address changes. Also let us know if there are specific instructions for contacting you; e.g., some clients prefer not to be called at work.
   - Please be on time for your appointment. If you are late, you will only get the remainder of the session, but will be charged for the entire session.
   - Brooke's Place is a violence-free, drug-free and smoke-free environment. Weapons, smoking, or being under the influence of a chemical substance will not be allowed on the premises at any time.
   - *Grievance Policy:* Please direct any concerns regarding your therapy services to your therapist. If you remain dissatisfied regarding your concerns with your therapy services at Brooke's Place, contact the Clinical Director of Programs & Services.

_____
initial

I have read the policies of the Brooke's Place Therapy Services, and the additional information provided in the Therapeutic Disclosure Form. Please have all persons seeking counseling sign this form.

Name _____ Date _____

Authorization to Release Information:
If insurance reimbursement is being pursued the client, I hereby authorize Brooke's Place for Grieving Young People to release my clinical diagnosis and prognosis information acquired in the course of my examination or treatment to my insurance carrier.

Signed _____ Date _____
(Client or Parent if Minor) (Expires 6 months after last session)

Therapy Services Scholarship Application

In order to provide scholarships, we rely on the generosity of individuals, corporations and foundations to ensure that grief counseling is available to individuals and families who may want and need it but may not be able to afford it. To evaluate your individual needs, Brooke's Place requires that you share as much information as possible about your financial situation. *All information is confidential and treated with sensitivity.*

Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Contact Phone: _____

Email Address: _____

Income Information

To qualify for scholarship assistance, you must provide a recent pay-stub or verification of unemployment and latest W2 forms.

In all cases, "income" refers to your "gross" earnings before deductions, not to the "net" amount of your paycheck. You should include all sources of income for you and other income earning members of your household, including tips, bonuses, child support payments, and unemployment and/or disability compensation.

Check your total household gross income:

( ) Under $15,000	( ) $25,001 - $30,000	( ) $40,001 - $45,000	( ) $55,001 - $60,000
( ) $15,001 - $20,000	( ) $30,001 - $35,000	( ) $45,001 - $50,000	
( ) $20,001 - $25,000	( ) $35,001 - $40,000	( ) $50,001 - $55,000	

List all Household Members Including Applicant

Name	**Age**	**Relationship**
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____
7._____	_____	_____

Do you claim any dependent children on your tax return?

( ) No ( ) Yes, I claim this many children on my tax return: _____

Therapy Services Scholarship Application

This information is for tracking purposes only and is not considered when making any determination about financial assistance.

Marital Status:

( ) Unmarried, living alone
( ) Unmarried, living with friend or partner
( ) Unmarried, living with parents
( ) Married, living with spouse
( ) Separated, still legally married
( ) Divorced
( ) Widowed
( ) Other'

Ethnicity:

( ) Caucasian
( ) African American/Black
( ) Latino/Hispanic
( ) Asian/Pacific Islander
( ) American Indian
( ) Other

I, _____ do hereby certify that I have read and completed the Brooke's Place for Grieving Young People Scholarship Assistance Application indicating the total number of persons in my household and the total gross annual income received during the past twelve (12) months as required to determine eligibility on the basis of financial need.

This certification is being made with the full knowledge and understanding that this statement and all applicable documents deemed necessary to substantiate my eligibility is subject to full disclosure and verification by authorized personnel at Brooke's Place for Grieving Young People.

I declare that the statements in this application are true and correct to the best of my knowledge. If requested, I will provide further substantiation of all facts, including current income. I hereby authorized Brooke's Place to obtain employment income information verification from my employer. I agree to inform Brooke's Place for Grieving Young People of any material change in my financial status and employment.

Applicant's Name: _____

Applicant's Signature: _____

Date: _____