Client Name:_____

Client ID: _____

SACRAMENTO CHILDREN'S HOME
Giving children & families a better tomorrow since 1867

# Wraparound Informed Consent

*PERMISSION TO TREAT*
I hereby volunteer for admission to outpatient mental health services, and consent to care and treatment at the Wraparound Program. If I am the caregiver or guardian of a minor in treatment, I consent to their care and treatment at the Wraparound Program.

*CONFIDENTIALITY*
I understand that in general, no information can be released about a client without my prior written consent. Exceptions include those required by state law when the safety of my child or others is at risk (i.e. emergency interventions; suspected child/elder abuse or neglect; or danger to self/others), and as required for financial audits, legal mandates, program evaluations, team collaboration/consultation/supervision, and/or internal and external utilization reviews.

*CANCELLATION OR NO SHOW POLICY*
Consistent attendance and participation is the key to progress in treatment. Cancellations must be made 24 hours prior to the appointment time and I or my child may not be seen if I/we are not available more than 15 minutes past the start of the appointment. If a pattern of inconsistent participation develops, a participation contract will be created as agreed upon with my clinician. I or my child may be discharged from the program if more than 3 appointments have been missed without proper notice or if there is no face-to-face contact for over 30 days.

*SERVICES/DURATION OF SERVICES*
The Wraparound Program offers therapy; case management; skill building; crisis intervention; client/caregiver advocacy; telehealth (live-steaming video) and medication support to those who meet medical necessity, as defined by Sacramento County. Services are voluntary, goal-oriented and time limited, based on my or my child's treatment plan (goals) and progress. Services are provided by trained members of SCH staff including, but not limited to, board-registered licensed therapists and therapist interns who receive on-site clinical supervision from licensed staff. Either I or my child will begin transitioning to closure of services when sufficient progress has been made or prior to turning age 21 years, which may involve ending services or being referred to another provider that offers more appropriate services. I and/or my child will collaborate with my therapist regarding progress in treatment and my clinician can provide details concerning the anticipated length of services. I may request a copy of the treatment plan (goals) from the respective therapist.

*SUPERVISION OF CHILDREN*
Unless otherwise agreed upon, I understand that my child must be accompanied by an adult on the Sacramento Children's Home campus and in the Wraparound reception area and may not be left without my supervision. I will also sign them in, monitor them and ensure that they are signed out and picked up at the close of the appointment.

*TRANSPORTATION RELEASE*
In some instances, staff may transport me or my child. I consent to transportation and understand that in some cases my child will be picked up or dropped off at an agreed upon location and in the care of an agreed upon adult. Transportation support is contingent upon my participation in services and can be discussed with my treatment team _____ (initial).

**I have read and/or had the above information explained to me:** _____
Client Signature:

| _____ | _____ | _____ |
|---|---|---|
| Representative Name/Relationship: | Representative Signature: | Date: |
| _____ | _____ | _____ |
| SCH Staff Name: | SCH Staff Signature: | Date: |

*Your Therapist is registered with The Board of Behavioral Sciences (BBS). The BBS receives and responds to complaints regarding services provided within the scope of practice of Marriage and Family Therapists, Clinical Social Workers and Professional Clinical Counselors. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.*