Association House of Chicago

AHC Intake Form

IMPORTANT : Please complete all fields. Missing fields will delay the timely processing of intake records.

PROGRAM INTAKE RECORD

Staff completing Intake Form:	
Intake Date (MM / DD / YYYY):	
Enrolling Program:	AHHS
Referral Type:	☐ Colbert ☐ Community ☐ Williams

Referral type only used for the following BH Programs : **685 CST, 695 CST, 695 ACT**

PROGRAM DISCHARGE RECORD

Reason for Discharge:	☐ Deceased ☐ Hospitalized ☐ Need for higher level of care ☐ Need for lower level of care	☐ Moved ☐ No Service for 3 months ☐ No Service for 6 months ☐ No Service for 12 months	☐ No Services recommended ☐ Program Closed ☐ Referred to another Agency ☐ Transferred to another program/Agency	☐ Refused treatment ☐ Successful completion ☐ Unsuccessful completion ☐ Withdrew / No Show ☐ Not Known

Discharge Date (MM / DD / YYYY):	

PARTICIPANT INTAKE RECORD

First Name:		**M.I.**		**Last Name:**	
Address:				**Apt./Suite#:**	
City:				**State:**	
Zip Code:				**Phone (*10 digits*):**	

What Neighborhood do you live in?

Date of Birth (MM / DD / YYYY):

Gender:	☐ Female ☐ Male ☐ Transgender Female	☐ Transgender Male ☐ Non-Binary ☐ Chose not to respond	**Sexual Orientation:**	☐ Heterosexual ☐ Gay	☐ Lesbian ☐ Bi-Sexual ☐ Chose not to respond

Languages spoken: *(Check all that apply)*	☐ English ☐ Spanish ☐ Polish ☐ Other ☐ Chose not to respond	**If other language:**	
Do you have a physical, mental, and/or developmental disability?	☐ Yes	☐ No	☐ Chose not to respond
How much of your household's expenses are you responsible for?	☐ None ☐ Less than half ☐ Half	☐ More than half ☐ All ☐ Chose not to respond	
Health Coverage: *(Check all that apply)*	☐ HMO ☐ PPO ☐ None ☐ Medicaid ☐ Medicare ☐ Other	☐ Chose not to respond	
Race: *(Check all that apply)*	☐ African / African American ☐ Asian / Asian American ☐ Caucasian / White	☐ Latino / Hispanic ☐ Native American / American Indian ☐ Pacific Islander	☐ Chose not to respond
Ethnicity: Specify if **Race** was Latino / Hispanic *(Check all that apply)*	☐ Central American ☐ Cuban ☐ Dominican	☐ Mexican ☐ Puerto Rican ☐ South American	☐ Chose not to respond
Present Domestic Status:	☐ Single (Never married) ☐ Married ☐ Domestic Partner	☐ Divorced ☐ Separated ☐ Widowed	☐ Chose not to respond

PARTICIPANT INTAKE RECORD *(continued…)*

Religious Affiliation:
☐ Agnostic ☐ Atheist ☐ Baptist ☐ Catholic ☐ Christian Non-Denominational ☐ Don't Know ☐ Jewish ☐ Lutheran ☐ Methodist ☐ Muslim ☐ Other ☐ Pentecostal ☐ Presbyterian ☐ Chose not to respond

Do you have children? ☐ **Yes.** Fill in next section regarding children information. ☐ **No.** Also no if participant chooses not to respond.

DoB and Gender of children:
- **MM/YYYY** is sufficient if they cannot recall exact day. Just default to **1st** of the month.
- Use options available for participant Gender.

Child #1	***Child #2***	***Child #3***	***Child #4***	***Child #5***
DoB:	DoB:	DoB:	DoB:	DoB:
Gender:	Gender:	Gender:	Gender:	Gender:
Child #6	***Child #7***	***Child #8***	***Child #9***	***Child #10***
DoB:	DoB:	DoB:	DoB:	DoB:
Gender:	Gender:	Gender:	Gender:	Gender:

Number of people living in the household? _____ Enter **1** if participant chooses not to respond.

Living Arrangements:
☐ CHA / Subsidized ☐ CILA / Supervised Residential ☐ Foster Home ☐ Group Home ☐ Halfway House ☐ Homeless ☐ Homeowner ☐ Hotel / Motel ☐ IMD / SMHRF ☐ Living with parents ☐ Nursing Facility / SLP ☐ Rental ☐ Shelter ☐ Temporarily staying with friends / family ☐ Chose not to respond

Date you moved into present address:
- **MM/YYYY** is sufficient if they cannot recall exact day. Just default to **1st** of the month.

Are you a veteran? ☐ Yes ☐ No ☐ Chose not to respond

Occupational Status:
☐ Day Labor ☐ Disabled / Unable to Work ☐ Full-Time ☐ Homemaker ☐ Part-Time ☐ Retired ☐ Self-Employed ☐ Student ☐ Unemployed / Looking ☐ Unemployed / Not Looking ☐ N/A (child) ☐ Chose not to respond

Individual **Source of Income:** *(Check all that apply)*
☐ Employment ☐ None ☐ Unemployment Security ☐ Pension ☐ SSI / SS ☐ Chose not to respond

Individual **Source of Benefits:** *(Check all that apply)*
☐ Other Public benefit ☐ TANF / LINK card ☐ Chose not to respond

Individual **Monthly Income:** $ _____
- *Enter $0.00 if participant has "None" or chose not to respond*

Household **Source of Income:** *(Check all that apply)*
☐ Employment ☐ None ☐ Unemployment Security ☐ Pension ☐ SSI / SS ☐ Chose not to respond

Household **Source of Benefits:** *(Check all that apply)*
☐ Other Public benefit ☐ TANF / LINK card ☐ Chose not to respond

Household **Monthly Income:** $ _____
- *Enter $0.00 if participant has "None" or chose not to respond*
- *The household income cannot be less than individual income.*

Are you currently in school? ☐ Yes ☐ No ☐ Chose not to respond

Highest level of education completed:
☐ N/A (under age 18) ☐ 8th grade or less ☐ 9th-11th grades ☐ High School Diploma ☐ GED ☐ Vocational Certificate ☐ Some college ☐ Associates Degree ☐ Bachelor's Degree ☐ Post Graduate (Masters or Doctorate) ☐ Chose not to respond

How did you hear about AHC:
☐ AHC Referral ☐ AHC Website ☐ Brochure/Flier/Poster ☐ External Referral ☐ Online/Google Search ☐ Social Platforms (Facebook/Twitter) ☐ TV/Radio ☐ Word of mouth ☐ Chose not to respond

EMERGENCY CONTACT INFORMATION

Full Name:		**Phone (*10 digits*):**		**Relationship:**	

Revised 07/01/2020

ASSOCIATION HOUSE HIGH SCHOOL
Student Contact Information

STUDENT'S INFORMATION				
Legal Last Name:	Legal First Name:		Legal Middle Name:	
Preferred Last Name:	Preferred First Name:		Preferred Middle Name:	
DOB:	Age:	Legal Sex (F/M/X/N):		Affirmed Gender (F/M/X/N):
Address:		Apt#:	**Chicago, IL**	Zip Code:
Student's Phone Number:				
Student's E-mail address:				
Are you: ☐ Single ☐ Single (Parenting) ☐ Married ☐ Sep/Div/Wid				
Who do you live with?				

LEGAL GUARDIAN'S CONTACT INFORMATION				
Parent 1/Legal Guardian/Advocate	Language: ☐ English ☐ Spanish ☐ Other_____			
Name:	Last Name:			
Phone #:	Email:			
Address:	Apt#:	City:	State:	Zip Code:
Parent 2/Legal Guardian/Advocate	Language: ☐ English ☐ Spanish ☐ Other_____			
Name:	Last Name:			
Phone #:	Email:			
Address:	Apt#:	City:	State:	Zip Code:

EMERGENCY CONTACTS **(must be 25 years or older)**			
Name:	Age:	Phone #:	Relationship:
Name:	Age:	Phone #:	Relationship:
Name:	Age:	Phone #:	Relationship:

With my signature, I understand that a parent/guardian or emergency designee will be contacted and informed of an emergency and early dismissal. I also understand that they will be contacted as long as I'm enrolled at AHHS, regardless of age.

STUDENT

Print Student's Name	Student's Signature	Date

GUARDIAN

If the student is under 18 years of age, a parent/legal guardian needs to sign below.

Print Guardian's Name	Guardian's Signature	Date

School Enrollment Form

Chicago Public Schools

Please print or type:

Student Information

SCHOOL NAME

YCCS - Association House High School

STUDENT ID#	**School Use Only:** Prevent duplicate student records. Search in SIS for an existing Student ID before creating a new one.	**REGISTRATION GRADE LEVEL** *(when first entering CPS)*
LEGAL LAST NAME	**LEGAL FIRST NAME**	**LEGAL MIDDLE NAME**
GENERATION (Jr., etc)	**BIRTH DATE** *(mm/dd/yyyy)*	**LEGAL SEX (F/M/X/N)**
***AFFIRMED GENDER (F/M/N)** ***Optional.** For more information regarding affirmed gender and affirmed name, please visit: **Supporting Gender Diversity Toolkit**	***AFFIRMED FIRST NAME** ***AFFIRMED MIDDLE NAME** ***AFFIRMED LAST NAME**	**STUDENT'S SIBLINGS' NAMES IF CURRENTLY ENROLLED IN CPS:**

Personal Information

BIRTH CERTIFICATE ON FILE ☐ YES ☐ NO	**BIRTH VERIFICATION TYPE**	
***BIRTH COUNTRY**	**BIRTH STATE**	**BIRTH CITY**

*Complete if student was not born in the United States (US) or one of its Territories:

DATE OF FIRST ENROLLMENT IN ANY US SCHOOL:	**FULL YEARS COMPLETED SCHOOL IN US:**	**School Use Only:** Note that *"Date of first enrollment in any US School"* becomes a required field in SIS if *"Birth Country"* is not the US or one of its Territories.

Student Address/Phone

PHYSICAL (HOME) ADDRESS (include unit number if applicable)	City	State	Zip	**HOME PHONE #**	
MAILING ADDRESS (include unit number if applicable) (if different than Home)			City	State	Zip

Included Information

FEDERAL ETHNIC AND RACE CATEGORIES: ***(Enter information into SIS from the Race and Ethnicity Survey form)***

HOME LANGUAGE SURVEY: ***(Enter information into SIS from the Home Language Survey form)***

PARENT/GUARDIAN CONTACTS: ***(Enter information into SIS from the Request for Emergency and Health Information form)***

EMERGENCY/HEALTH INFORMATION: ***(Enter information into SIS from the Request for Emergency and Health Information form)***

Enrollment

***SCHOOL TRANSFERRING FROM ((if not a Chicago Public, Charter or Contract School)**	**CITY AND STATE**

***IS THE STUDENT IN GOOD STANDING?** ☐ YES ☐ NO

***(Instructions to school:** for out-of-state public school or any private school students, a certification of "good standing" should be received from the Parent/Guardian. Refer to CPS Policy 10-0623-PO1 for more information.)*

LAST CHICAGO PUBLIC, CHARTER, OR CONTRACT SCHOOL ATTENDED

IS THE STUDENT RECEIVING ANY TYPE OF SPECIAL EDUCATION SERVICES? ☐ YES ☐ NO

***(Instructions to school:** if yes, please notify the Case Manager.)*

STUDENT ENROLLED BY (Print Name and Relationship)

Enrollment Status Codes:

01 – No Former School
02 – Chicago Public School (to incl. Charter/Contract)
03 – Chicago Private School
04 – IL Public Schl, not Chicago
05 – IL Private Schl, not Chicago
06 – US Public Schl, not Illinois
07 – US Private Schl, not Illinois
08 – Not in USA

Signature of Parent/Guardian
Must have an original signature; an electronic signature is not acceptable

Date of Enrollment

School Use Only:	ENROLLMENT STATUS CODE *(insert a # from the left)*	GRADE LEVEL	HOMEROOM/DIVISION #

Request for Emergency and Health Information

Chicago Public Schools

PARENTS/GUARDIANS: The school must have on file emergency information that can be used to contact you. Please print clearly.
Whenever there is a change in this information, immediately notify the school in writing.

SCHOOL NAME	STUDENT ID#
YCCS - Association House High School	

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

STUDENT HOME ADDRESS (include unit number if applicable) City State Zip

BIRTH DATE *(mm/dd/yyyy)*	HOMEROOM #	HOME/PRIMARY PHONE #
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CONFIDENTIAL INFORMATION BOX 1

Complete this box only if (1) it reflects your child's current living situation; OR **(2)** it reflects your living situation if you are a youth not living with a Parent or Guardian. (Your answer will help school staff with enrollment and may enable the student to receive additional services.)
Check one box:

- ☐ in a car/park/other public place/abandoned building/substandard housing
- ☐ doubled-up
- ☐ in a hotel/motel/trailer park/camping ground
- ☐ in a shelter
- ☐ in transitional housing

School Note: If any box is checked, see the CPS Policy 702.5.

CONFIDENTIAL INFORMATION BOX 2

Is there a current Order of Protection or Civil No Contact Order which concerns this student?
☐ **YES** ☐ **NO**

Is there a current Temporary Restraining Order or Injunction which concerns this student?
☐ **YES** ☐ **NO**

School Note: If "Yes," follow CPS Policy 704.4 procedures. Enter information in *Legal Alert* field and update contact information, as needed, in SIS.

PARENT/GUARDIAN AND EMERGENCY CONTACT INFORMATION: *Add extra contacts on additional page, if needed.*

	PRIMARY PARENT/GUARDIAN CONTACT ☐ DCFS Contact	PARENT/GUARDIAN CONTACT ☐ DCFS Contact	PARENT/GUARDIAN CONTACT ☐ DCFS Contact
Contact First Name, Last Name			
Relationship to Student			
Check all that apply:	☐ Lives With ☐ Gets Mailings ☐ Emergency ☐ Permission to Pick up	☐ Lives With ☐ Gets Mailings ☐ Emergency ☐ Permission to Pick up	☐ Lives With ☐ Gets Mailings ☐ Emergency ☐ Permission to Pick up
Home Address, if different from student's *(include unit number if applicable)*			
Primary Phone Number	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work
Secondary Phone Number	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work
Third Phone Number	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work
E-mail Address			
*** Communication Language**			
Requires Translator	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**

* CPS communicates via phone calls. Select the language that should be used to communicate with you. Languages available for mass communication at this time are English and Spanish (note: other languages upon availability).

List the name of a relative, neighbor, family friend, or trusted adult who can also be notified in an emergency and has permission to pick up the student:

NAME	RELATIONSHIP	TELEPHONE #

ADDRESS

FAMILY DOCTOR'S NAME, ADDRESS, AND PHONE NUMBER:

I authorize you to call my family doctor, if necessary, in an emergency: ☐ **YES** ☐ **NO**

NAME	ADDRESS (include unit number if applicable) City State Zip
TELEPHONE #	

STUDENT HEALTH INSURANCE: (select only one of the three)

- ☐ Illinois Medical Card/All Kids: provide student's medical ID # _____ *(9-digit number located on back of card).*
- ☐ No Insurance: are you interested in applying for the Illinois Medical Card/All Kids? ☐ **YES** ☐ **NO**
- ☐ Private/Employer Health Insurance: no additional information needed.

CHILDREN OF MILITARY PERSONNEL (optional)

As the Parent or Guardian, are you a member of a branch of the armed forces of the United States? ☐ **YES** ☐ **NO**

If yes, are you either deployed to active duty or expect to be deployed to active duty during the school year? ☐ **YES** ☐ **NO**

Parent/Guardian Signature **Date**

Must have an original signature. An electronic signature is not acceptable.

RETAIN 1 YEAR AFTER SUPERSEDED OR STUDENT HAS PERMANENTLY WITHDRAWN

Home Language Survey 2024-2025

Office of Language and Cultural Education

Chicago Public Schools

Complete this Home Language Survey at the student's initial enrollment in a Chicago Public School.

The state requires the district to collect a Home Language Survey for every new student. This information is used to count the students whose families speak a language other than English at home. It also helps to identify the students who need to be assessed for English language proficiency and may be eligible for English Learner services.

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

SCHOOL NAME

YCCS - Association House High School

STUDENT ID #	NETWORK	ROOM #
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English

If the answer to either question is yes, the law requires the school to assess your child's English language proficiency.

1. **Is a language other than English spoken in your home?** ☐ **Yes** ☐ **No** **Which language?** _____
2. **Does the student speak a language other than English?** ☐ **Yes** ☐ **No** **Which language?** _____

Spanish/Español

Si la respuesta a cualquiera de las preguntas es "Sí", la ley requiere que la escuela evalúe la competencia de su niño en inglés.

1. **¿Se habla algún otro idioma que no sea inglés en su hogar?** ☐ **Sí** (yes) ☐ **No** (no) **¿Cuál idioma?** _____
2. **¿Habla el estudiante algún otro idioma que no sea inglés?** ☐ **Sí** (yes) ☐ **No** (no) **¿Cuál idioma?** _____

Chinese / 中文

如果兩個問題中有任何一題的答案為 "是"，根據法律要求，學校將評測您子女的英語水平。

1. 庆語之外的其他語言？ ☐ 是的 (yes) ☐ 不是 (no) 什么语言？ _____
2. 女是否說英語之外的其他語言？ ☐ 是的 (yes) ☐ 不是 (no) 什么语言？ _____

Arabic / العربية

إذا كانت الإجابة على أي من السؤالين نعم، فإن القانون تطلب من المدرسة تقييم إتقان طفلك للغة الإنجليزية .

1. هل تُستخدم لغة أخرى غير اللغة الإنجليزية في منزلك؟ ☐ نعم (yes) ☐ لا (no) اي لغة؟ _____
2. هل يتحدث الطالب لغة أخرى غير اللغة الإنجليزية ؟ ☐ نعم (yes) ☐ لا (no) اي لغة؟ _____

Polish/Polski

Jeśli udzielili Państwo twierdzącej odpowiedzi na którekolwiek z pytań, przepisy wymagają aby szkoła sprawdziła poziom znajomości języka angielskiego waszego dziecka.

1. **Czy mówi się w domu językiem innym niż angielski?** ☐ **Tak** (yes) ☐ **Nie** (no) **Jakim językiem?** _____
2. **Czy uczeń mówi innym językiem niż angielski?** ☐ **Tak** (yes) ☐ **Nie** (no) **Jakim językiem?** _____

Ukrainian / Українська

Якщо ви відповіли «Так» на будь-яке з цих запитань, школа буде зобов'язана за законом оцінити рівень володіння вашою дитиною англійською мовою.

1. **Чи розмовляєте Ви вдома іншою мовою окрім англійської?** ☐ **Так** (yes) ☐ **Ні** (no) **Якою мовою?** _____
2. **Чи розмовляє Ваша дитина іншою мовою окрім англійської?** ☐ **Так** (yes) ☐ **Ні** (no) **Якою мовою?** _____

Signature of School Official _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

Must have an original signature; an electronic signature is not acceptable

OFFICE USE ONLY

Please make sure both questions are answered completely and that the parents/guardians sign and date the form.

If the language spoken by the parent/guardian is not included on either page of this form, please visit the OLCE Employee Intranet Page, Forms, and click on "Home Language Survey in Additional Languages" which will take you to ISBE's HLS page.

If the parent/guardian does not speak English and the school does not have staff who speaks the parent/guardian's language, identify the language spoken by the parent/guardian through any assistance available in the school, i.e. using interpretation services from a vendor.

ASPEN REGISTRATION PROCESS

All five fields have to be entered on Aspen: date, answer to question 1, Home language, answer to question 2, and Native language.

When a language other than English is reported for only one of the questions on the form, that Non-English language has to be listed as both Home and Native Language in Aspen.

If there are two different languages other than English listed, enter the language identified in question 2 as both Home and Native language. If there is more than one language listed in question 2, check with the family, since only one of the languages can be entered on Aspen.

English can be entered as the Home language ONLY if both questions are answered No and English is listed for both questions.

If the language is not included on the list of languages available on Aspen, enter "Other" temporarily, but contact OLCE as soon as possible so that the district can ask ISBE to add the new language. An Student Reclassification Recommendation (SRR) will have to be submitted to OLCE to correct the language at a later date.

Maintain Home Language Survey in the Student Cumulative Folder. If the student is an English Learner (EL), maintain the original survey in the Cumulative Folder and also maintain a copy of the survey in the student's English Learner Folder.

Home Language Survey 2024-2025

Office of Language and Cultural Education

Chicago Public Schools

Complete this Home Language Survey at the student's initial enrollment in a Chicago Public School.

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

SCHOOL NAME

YCCS - Association House High School

STUDENT ID #	NETWORK	ROOM #
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Bosnian/Serbian(Latin) Bosanski/Srpski

Ukoliko ste na bilo koje od ovih pitanja odgovorili sa „Da", škola će biti zakonski dužna da procijeni nivo znanja engleskog jezika kod vašeg djeteta.

1. Da li se u kući govori na stranom jeziku (različitom od engleskog)? ☐ **Da** (yes) ☐ **Ne** (no) **Koje jezike?**
2. Da li učenik govori neki drugim jezikom (različit od engleskog)? ☐ **Da** (yes) ☐ **Ne** (no) **Koje jezike?**

Vietnamese / Tiếng Việt

Nếu câu trả lời cho một trong hai câu hỏi trên là có thì luật pháp yêu cầu trường học phải đánh giá khả năng thông thạo Anh ngữ của con quý vị.

1. Ngôn ngữ khác tiếng Anh có được sử dụng trong nhà quý vị không? ☐ **Có** (yes) ☐ **Không** (no) **Ngôn ngữ gì?**
2. Con quý vị có nói một ngôn ngữ khác ngoài tiếng Anh không? ☐ **Có** (yes) ☐ **Không** (no) **Ngôn ngữ gì?**

Urdu / اردو

اگر کسی بھی سوال کا جواب ہاں میں ہے تو ، قانون کے تحت اسکول سے آپ کے بچے کی انگریزی زبان کی مہارت کا اندازہ لگانا پڑتا ہے .

کیا آپ کے گھر میں انگریزی کے علاوہ کوئی دوسری زبان بولی جاتی ہے ؟ ☐ ہاں (yes) ☐ نہیں (no) کون سی زبان؟

کیا طالب علم انگریزی کے علاوہ کوئی دوسری زبان بول سکتا ہے ؟ ☐ ہاں (yes) ☐ نہیں (no) کون سی زبان؟

Pashto/انګلیسي

که د هري پوښتنېخواب هو وي، قانونله مخینووونخي ارتیا لري چېستاسو د ماشوم د انګلیسي ژبې مهارت ارزونه وکړي.

آیاستاسو په کور کښ انګلیسیپرته بله ژبه ویلکیږي؟ ☐ هو (yes) ☐ نه (no) کومه ژبه؟

آیا ستاسو ماشوم د انګلیسي پرته په بله ژبه خبرې کوي؟ ☐ هو (yes) ☐ نه (no) کومه ژبه؟

Gujarati / [ગુજરાતી]

તમારા બાળકના અંગ્રેજી ભાષાના કૌશલ્ય માટે આકારણી કરાવવા માંગે છે. જો બન્નેમાંથી કોઈ એક પ્રશ્નનો જવાબ પણ હા માં હોય તો, કાયદો શાળા પાસે

1. શું આપના ઘરમાં અંગ્રેજી સિવાયની ભાષા અન્ય કોઈ ભાષા બોલ આવે છે? ☐ હા (yes) ☐ ના (no) કઈ ભાષા?
2. શું વિદ્યાર્થીઓ અંગ્રેજી સિવાયની કોઈ ભાષા બોલે છે? ☐ હા (yes) ☐ ના (no) કઈ ભાષા?

Yoruba / Yorùbá

Tí ìdáhùn sí ibéèrè nàá bá jẹ́ Bẹ́ẹ̀ni, ôfin bèèrè pé kí ilé-ẹ̀kọ́ nàá ṣe ìgbéléwọ̀n bí ọmọ rẹ ṣe gbọ́ èdè Gẹ̀ẹ́sì si.

1. Njẹ́ ẹ n so èdè miran yatọ si Èdè-Gẹ̀ẹ́sì ninu idile yin bí? ☐ **Bẹ́ẹ̀ni** (yes) ☐ **Bẹ́ẹ̀kọ** (no) **Edè wo?**
2. Ṣe akẹ́kọ̀ọ́ nàá n so èdè miran yatọ sí èdè-Gẹ̀ẹ́sì bí? ☐ **Bẹ́ẹ̀ni** (yes) ☐ **Bẹ́ẹ̀kọ** (no) **Edè wo?**

Russian / Русский

Если на любой из этих вопросов дан утвердительный ответ, согласно законодательству школа должна оценить уровень владения английским языком вашего ребёнка.

1. Вы говорите у себя дома на ином языке, нежели на английском? ☐ **Да** (yes) ☐ **Нет** (no) **На каком языке?**
2. Ваш ребёнок говорит на ином языке, нежели на английском? ☐ **Да** (yes) ☐ **Нет** (no) **На каком языке?**

Tagalog/Tagalog

Ayon sa batas, kung "Oo" ang sagot sa parehong tanong, kailangan suriin ng paaralan ang kakayahan at kaalaman na mag-aaral sa wikang Ingles.

1. May iba pa bang lengguwahe bukod sa Ingles na ginagamit sa iyong tahanan? ☐ **Mayroon** (yes) ☐ **Wala** (no) **Anong wika?**
2. May ginagamit ba na ibang lenggguwahe ang mag-aaral bukod sa Ingles? ☐ **Mayroon** (yes) ☐ **Wala** (no) **Anong wika?**

Signature of School Official **Date** **Parent/Guardian Signature** **Date**

Maintain Home Language Survey in the Student Cumulative Folder. If the student is an English Learner (EL), maintain the original survey in the Cumulative Folder and also maintain acopy of the survey in the student's English Learner Folder.

Must have an original signature; an electronic signature is not acceptable

Race and Ethnicity Survey

Chicago Public Schools

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

GENDER	SCHOOL NAME
	YCCS - Association House High School
BIRTH DATE	SCHOOL ID#
	533

Instructions

Please answer the questions below. Both questions must be answered. Part A asks about the student's ethnicity and Part B asks about the student's race. If you decline to respond to either question, the school district is required to provide the missing information by observer identifi cation.

PART A

Is this student Hispanic/Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) Choose only one.

- ☐ **No, not Hispanic/Latino**
- ☐ **Yes, Hispanic/Latino**

The question above is about ethnicity, not race. No matter which answer you selected, continue and respond to PART B below by marking one or more boxes to indicate what you consider this student's race to be.

PART B

What is the student's race? Choose one or more.

- ☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affi liation or community attachment.)
- ☐ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
- ☐ **Black or African American** (A person having origins in any of the black racial groups of Africa.)
- ☐ **Native Hawaiian or Other Pacifi c Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacifi c Islands.)
- ☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

Student Medical Information 2024 - 2025

Chicago Public Schools

This form must be updated and returned to school each school year.

Please let your school know about your child's health and health care. This is a good way to keep your child safe. The information is CONFIDENTIAL and will be shared only with CPS staff who need to know (Nurse, Principal, Designee, or Clerk).

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

GENDER (F / M / X / N)	STUDENT DATE OF BIRTH	SCHOOL NAME
		YCCS - Association House High School

STUDENT ID #	GRADE	ROOM #
		533

1. DOES YOUR CHILD HAVE ANY KNOWN HEALTH CONDITIONS?

☐ YES ☐ NO

If your child has a health condition, please schedule an appointment with your school nurse. Please check all that apply:

☐ Allergies (food or other)

List Allergies: _____

☐ Asthma

Year Diagnosed _____

☐ Seizures/Epilepsy

Year Diagnosed _____

☐ Diabetes (please select one) ☐ Type 1 ☐ Type 2 ☐ Other

Year Diagnosed _____

☐ Sickle Cell Disease

Year Diagnosed _____

☐ Other _____ Year Diagnosed _____

2. MY CHILD HAS A PRIMARY DOCTOR ☐ YES ☐ NO

If yes, please provide the healthcare provider's name and phone number:

Name _____ **Phone number** _____

☐ **I give permission for my child's school nurse or designee to talk to the doctor about my child's health.**

3. MY CHILD IS COVERED BY HEALTH INSURANCE: ☐ YES ☐ NO

If your child needs health insurance call Healthy CPS 773-553-KIDS (5437).

This Form is **NOT** the same as a **"Plan of Care"** (detailed medical care instructions to keep your child safe). If your child has a health condition that may require action at school, please provide school with documentation from your physician and schedule an appointment with your school nurse. Complete a "Medical Plan of Care Form" at cps.edu/oshw (or get it from the school nurse), and return it to school. **If your child has a health condition, please schedule an appointment with the school nurse.**

Please return the form to the school nurse. If the student has a health condition, parents must schedule a meeting with the school nurse.

Parent/Guardian Name _____ **Date** _____ **Phone Number** _____

Parent/Guardian Signature _____ **Email** _____

Must have an original signature.
An electronic signature is not acceptable.

Nurses Use Only **Reviewed by (Initials)** _____ **Date** _____

Revised February 2024

THE FORM IS STORED IN THE STUDENT'S HEALTH RECORD

CPS Family Income Information Form 2024 - 2025

Chicago Public Schools

The purpose of this form is for CPS to obtain information about families' income to determine school funding. CPS and your school may receive additional funding based on the number of low-income families enrolled. Please complete this form and return it to the school's main office.

Parents—Please return form to school by **October 30, 2024.**

Schools—Please enter into ODA by **November 20, 2024.**

please print or type:

STUDENT LAST NAME	STUDENT FIRST NAME	STUDENT MIDDLE NAME
SCHOOL NAME Association House High School	STUDENT ID	DOES YOUR FAMILY HAVE INTERNET SERVICES AT HOME? ☐ YES ☐ NO

PART 1: Household Information — List all members of your household living with you.
**Foster Children (legal responsibility of welfare agency or court)*

PART 2: SNAP/TANF number of any member of your household *(go to part 6)*

FOSTER CHILD?	CPS STUDENT?	ALL HOUSEHOLD MEMBER NAMES Last / First / M.I.	DATE OF BIRTH	DHS SNAP OR TANF CASE NUMBER (LAST 9 DIGITS)
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			

PART 3: Homeless, Runaway Child, or child enrolled in Head Start

☐ HOMELESS
☐ RUNAWAY
☐ HEAD START

Homeless, Runaway or Head Start Liaison Signature

Date

PART 4: List Household Members With Income *(SKIP THIS if you answered any of parts 2 or 3)*
Enter the amount of income and how often it is received for each household member.
Frequency: Weekly, Every 2 Weeks, Twice Monthly, Monthly, Annually

OTHER INCOME can be but not limited to Welfare, Child Support, Retirement, Social Security, Worker's Compensation, and Unemployment.

HOUSEHOLD MEMBER NAMES WITH INCOME First / Last / M.I.	GROSS INCOME *(before deductions)*	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Annually	OTHER INCOME	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Annually
	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐

PART 5: Opt in for information about other benefits.

☐ **YES!** I am interested in applying for a waiver of instructional fees.

☐ **YES!** I am interested in applying for the Supplemental Nutrition Assistance Program (SNAP) and/or the Medicaid Program. *Or call 773-553-5437*

☐ **YES!** This student/these students have a parent who is a veteran or active military member. *Students with a parent who is a veteran or active military may qualify for a fee waiver.*

Signature

PART 6

Signature: I certify that all above information is true and all income is reported. I understand that information gathered from this form will be used to calculate Federal funding and screen CPS students for eligibility for other benefits and that school officials may verify (check) the information as being accurate; and that if I purposely give false information, I may be prosecuted. I consent to the district sharing eligibility status in order to receive benefits based on eligibility status.

Signature of adult household member

Parent / Guardian First Name

Parent / Guardian Last Name

Address

Zip Code

Date

Must have an original signature. An electronic signature is not acceptable.

RETAIN IN FIIF FOLDER FOR 4 YEARS

CPS Family Income Information Form 2024 - 2025

Chicago Public Schools

PART 7: Children's Racial and Ethnic Identities *(Optional)*

MARK ONE ETHNIC IDENTITY:

- ☐ Hispanic / Latino
- ☐ Not Hispanic / Latino

MARK ONE OR MORE RACIAL IDENTITIES:

- ☐ Asian
- ☐ Black / African American
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ White
- ☐ American Indian / Alaska Native

Instructions For Completing Family Income Information Form

IF YOUR HOUSEHOLD RECEIVES BENEFITS FROM SNAP/TANF, FOLLOW THESE INSTRUCTIONS:

Part 1: List all of the household members and date of birth (for students). (Attach another application if necessary.)

Part 2: List the DHS case number (SNAP or TANF) of any household member that corresponds with their name in Part 1. Do not use your Medicare card number.

Skip to Part 5: If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign.

Part 6: Sign the Form.

Part 7: Check the appropriate box to indicate your racial and ethnic identities.

IF YOU ARE APPLYING FOR A HOMELESS, RUNAWAY, OR HEAD START CHILD, FOLLOW THESE INSTRUCTIONS:

Part 1: List all of the household members and date of birth (for students).

Skip to Part 3: Check the appropriate box; obtain date and signature of Homeless, or Runaway Liaison/Coordinator.

Skip to Part 5: If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign.

Part 7: Check the appropriate box to indicate your racial and ethnic identities.

IF YOU ARE APPLYING FOR A FOSTER CHILD, FOLLOW THESE INSTRUCTIONS:

If all children in the household are foster children:

Part 1: List Students name, date of birth and check the box for "Foster Child" to the left of your foster child's name.

Skip to Part 5: If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign.

Part 6: Sign the Form.

IF SOME CHILDREN IN THE HOUSEHOLD ARE FOSTER CHILDREN:

Part 1: List Students name, date of birth and check the box for "Foster Child" to the left of your foster child's name.

Skip to Part 4: Follow the instructions under ALL OTHER HOUSEHOLDS INSTRUCTIONS (Part 4) below.

Part 5: If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign.

Part 6: Sign the Form.

Part 7: Check the appropriate box to indicate your racial and ethnic identities.

ALL OTHER HOUSEHOLDS, FOLLOW THESE INSTRUCTIONS:

Part 1: List all of the household members and date of birth (for students).

Skip to Part 4: Follow these instructions to report total household income:

Column 1: Name
List the first and last name of each person in your household who receives income, related or not (such as grandparents, other relatives, or friends. Attach another sheet of paper if necessary.).

Columns 2 & 3: Gross Income Amounts and Frequency
The Gross Income is the amount earned before taxes and other deductions. It should be noted on pay stubs. This is not the same as take-home pay. List the amount each person receives from these sources. Round to the nearest dollar. All other sources of income should also be noted on this application. Next to each amount fill in the circle that indicates how often the person receives their stated income (weekly, every other week, twice a month, monthly, or annually). If you do not wish to disclose your income, please note "decline to answer" in this section. Be aware that if you are low-income, failure to share household income information could reduce the funds your school may otherwise receive.

Part 5: If you are interested in sharing application information with Medicaid or SNAP agencies, check the box and sign.

Part 6: Sign the Form.

Part 7: Check the appropriate box to indicate your racial and ethnic identities.

SCHOOL USE ONLY

Initial Determination: ☐ **ELIGIBLE (Free or Reduced)** ☐ **INELIGIBLE (Denied, N/A or ?)**

CONFIRMATION *(Only for those applications selected for verification)*

Signature of Confirming Official (Required) _____ **Date** _____

Must have an original signature. An electronic signature is not acceptable.

RETAIN IN FIIF FOLDER FOR 4 YEARS

School Messaging Consent Form

Chicago Public Schools

Dear Parent/Guardian/Student if age 18 or older:

Your school and the district will periodically want to send information regarding school or district events, updates or initiatives. We will utilize a phone messaging system to remind you about these events, updates, and initiatives; including report card distribution, field trips, community events, parent-teacher conferences, announcements, COVID-19 information and screenings, and more. To ensure you receive periodic school- or district-related notifications and reminders, your consent is needed below.

In the event of an emergency, whether or not consent is on file, you will be informed through all contact information provided. Emergency calls include weather closures, health risks, threats, unexcused absences, and other situations affecting the health or safety of students and faculty. Emergency calls will be sent to all phone numbers, including cellular numbers, listed on the student's record. Please make sure these numbers are updated with your school.

Please fill out and return this form to ensure you receive informational calls and texts.

By signing this form, you are authorizing Chicago Public Schools to use an automated system to periodically deliver automated informational calls or text messages to the phone number(s) provided below. If you change your phone number or no longer wish to receive automated calls and texts, you agree to inform Chicago Public Schools immediately. By signing below, you agree that this consent will remain valid and you will continue to receive automated phone calls and text messages unless or until you revoke your consent. Standard messaging rates and data may apply.

☐ **I CONSENT as outlined in the above section.**

☐ **I DO NOT CONSENT as outlined in the above section.**

please print or type:

Student Last Name | **First Name** | **Middle Name** | **Birth Date (mm/dd/yyyy)**

Name of Parent/Guardian/Student if age 18 or older

Association House High School

School Name | **Grade** | **Student ID #**

Signature of Parent/Guardian/Student if age 18 or older | **Date**

Must have an original signature. An electronic signature is not acceptable.

PRIORITY #1

Last Name | **First Name**

Primary Phone ☐ Cell ☐ Home ☐ Work | **Secondary Phone** ☐ Cell ☐ Home ☐ Work | **Third Phone** ☐ Cell ☐ Home ☐ Work

PRIORITY #2

Last Name | **First Name**

Primary Phone ☐ Cell ☐ Home ☐ Work | **Secondary Phone** ☐ Cell ☐ Home ☐ Work | **Third Phone** ☐ Cell ☐ Home ☐ Work

PRIORITY #3

Last Name | **First Name**

Primary Phone ☐ Cell ☐ Home ☐ Work | **Secondary Phone** ☐ Cell ☐ Home ☐ Work | **Third Phone** ☐ Cell ☐ Home ☐ Work

Media Consent Form and Release

Chicago Public Schools

Consent/Release

I hereby consent to have my child photographed, digitally recorded, video taped, audio taped and/or interviewed by the Board of Education of the City of Chicago (the "Board") or the news media when school is in session, either in person or hosted remotely, or when my child is under the supervision of the Board. Further, I consent for these photos, digital recordings, video tapes, audio tapes and/or interviews to be shared with third parties who have received written approval from the Office of Communications. I understand in the course of the above described activities that the Board might like to celebrate my child's accomplishments and work. Therefore, I further consent for the Board's release of information on my child's name, academic/non-academic awards and information concerning my child's participation in school-sponsored activities, organizations and athletics.

I also consent to the Board's use of my child's name, photograph or likeness, voice or creative work(s) on the Internet or on a CD or any other electronic/digital media or print media electronic which may include honorary banners/signs displayed in, near, or around the school building or community.

As the child's parent or legal guardian, I agree to release, indemnify and hold harmless the Board, its members, trustees, agents, officers, contractors, volunteers and employees from and against any and all claims, demands, actions, complaints, suits or other forms of liability that shall arise out of or by reason of, or be caused by the use of my child's name, photograph or likeness, voice or creative work(s), on television, radio or motion pictures, or on the Internet, or on a CD, or any other electronic/digital media or print media or in connection with my child's participation in virtual school events and/or celebratory activities.

It is further understood and I do agree that no monies or other consideration in any form, including reimbursement for any expenses incurred by me or my child, will become due to me, my child, our heirs, agents, or assigns at any time because of my child's participation in any of the above activities or the above-described use of my child's name, photograph or likeness, voice or creative work(s).

I understand that I may cancel this consent by providing written notice to the principal. I also understand that my consent is valid for one school year, including the following summer.

Instructions: Check Box #1 or Box #2

☐ **1. I consent as outlined in the above consent/release section.**

☐ **2. I DO NOT consent as outlined in the above consent/release section.**

Please print or type:

Student Last Name	First Name	Middle Name	Birth Date (mm/dd/yyyy)

Name of Parent/Guardian/Student if age 18 or older

School Name	Grade	Student ID #
Association House High School		

Signature of Parent/Guardian/Student if age 18 or older	Date

Must have an original signature. An electronic signature is not acceptable.

I understand that I have the right to inspect and copy my student's records, challenge the contents of such records; and limit my consent to the designated records or designated portions of information within the records.

Association House of Chicago

Media/Marketing Consent Release Form

This form is for:

____ Participant
____ Staff
____ Other: _____
(please specify)

Name of "Individual" for whom this release is provided:

_____

Name of parent or legal guardian (if applicable):

_____

☐ I give consent for AHC to use any photographs, video and audio recordings of Individual. These materials may be used for marketing and social media purposes. I understand media assets may be released to funding partners for promotional purposes.

☐ I **do not** give my consent.

I may revoke this consent at anytime in writing to AHC. If I revoke consent, it will not apply to marketing materials and information already disclosed to the public.

I understand and agree that there will be no fee paid, nor expected for consent to the above. I have consented with no promise of future service or under the threat of service removal.

_____ _____
Signature of individual Date

_____ _____
Parent/legal guardian Date

ASSOCIATION HOUSE HIGH SCHOOL

RELEASES	Student Initials	Guardian Initials
LIABILITY RELEASE I relieve Association House of Chicago, Association House High School and it's staff and all persons connected with the school/agency, from all financial liability and all other responsibility because of accidents or any other situation which may occur to myself, my children, or any family member or persons associated with me while participating in all activities and field trips carried out by Association House, whether these activities and trips be in the classroom or anywhere on the premises of any/all Association House or off campus.	_____	_____
MEDICAL RELEASE I give permission to render medical care to my minor daughter/son in case of an emergency. I understand that I will be contacted as soon as possible after service has been rendered.	_____	_____
INFORMATION RELEASE I do hereby, authorize the Association House of Chicago and Association House High School and its authorized representatives to contact and obtain personal information, educational records and verification of post-secondary education or advanced training. I understand that this request is permanent and will remain in effect until I request in writing that the permission(s) be removed.	_____	_____

STUDENT	With my signature, I acknowledge that I have read and understand all the releases outlined here.		
	Print Student's Name	Student's Signature	Date

GUARDIAN	If the student is under 18 years of age, a parent/legal guardian needs to sign below.		
	Print Guardian's Name	Guardian's Signature	Date

AHHS			
	Print AHHS Staff's Name	AHHS Staff's Signature	Date

ASSOCIATION HOUSE HIGH SCHOOL

SCHOOL POLICIES AND PROCEDURES	Student Initials	Guardian Initials
STUDENT RESPONSIBILITIES I, as a student, will share the responsibility to improve my academic achievement and achieve the state's high standards. Specifically, I will: • Do my homework every day and ask for help when I need it. • Read at least 30 minutes every day outside of school time. • Give my parents or the adult who is responsible for my welfare, all notices and information received by me from my school every day.	_____	_____
POLICIES AGREEMENTS I agree to abide by Association House High School's policies and the Chicago Public Schools Uniform Discipline Code. I attest that I have read and understand the policies and if I choose not to follow them, accept the consequences. I am also acknowledging the fact that I have received a copy of these policies.	_____	_____

STUDENT	With my signature, I acknowledge that I have read and understand the policies and procedures outlined here.		
	Print Student's Name	Student's Signature	Date

GUARDIAN	If the student is under 18 years of age, a parent/legal guardian needs to sign below.		
	Print Guardian's Name	Guardian's Signature	Date

AHHS			
	Print AHHS Staff's Name	AHHS Staff's Signature	Date

ACKNOWLEDGEMENT OF RECEIPT OF THE STUDENT DISCIPLINE POLICY

I have received and read the Discipline Policy. I am aware of my rights and responsibilities under the Discipline Policy. Furthermore, I understand that acts of misconduct or inappropriate student behavior will result in interventions and consequences as stated under the Discipline Policy.

Print Student's Name	Student's Signature	Date

PARENT/GUARDIAN AGREEMENT

Students may not be excluded from live classroom instruction. Schools may use virtual restorative rooms or reflection opportunities as a support intervention. These opportunities provide the opportunity to engage in the restorative process and may not be longer than one (1) period in duration and only during asynchronous instruction, and not during synchronous instruction. Further, the opportunity must be monitored at all times by a teacher or school administrator and the student's parent/guardian must be immediately notified of the referral.

Student with disabilities may not receive discipline for conduct that is a manifestation of their disability. For all students, administrators and educators will implement school-wide behavioral support plan, where applicable, or individual student Behavior Support Plan in an effort to support student conduct.

Discipline Procedural Safeguards

Parents/guardians and students have all their rights and due protections when facing discipline or removal from remote and/or hybrid learning as if they were physically in school full time. These include the right to notice, discipline hearings, and in some instances the right to appeal or file a complaint. Please see the Student Code of Conduct for more details regarding these procedures for suspensions, expulsions, and transfers.

Discipline hearings will be held virtually during the 2020-21 school year, due to COVID-19 safety restrictions. Parents/guardians who are prevented from successfully participating in the hearing virtually due to a documented medical condition or other circumstances should contact the school principal or Youth Connection Charter School to request an accommodation.

I am the parent or guardian of the above-named student. I have received and read the Discipline Policy. I understand that by signing this document, I agree to support and promote the goals of the discipline policy and make every effort to work with the school in resolving all disciplinary matters.

Print Parent/Guardian's Name	Parent/Guardian's Signature	Date

ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

Chicago Public Schools

PARENT/STUDENT CONSENT FOR AGENCY INVITATION TO IEP MEETING

Date: _____

Dear _____,

An annual IEP meeting, including consideration of needed post-secondary goals and transition services, will be held this school year. We must invite a representative of the agency or agencies which may be responsible for providing post-secondary transition services. In order for us to invite these agency representatives, we need your written consent. The specific agency/agencies that may be invited to your IEP meeting are:

- ☐ Department of Human Services/Division of Rehabilitation Services (DRS),
- ☐ Department of Human Services Division of Developmental Disability (or PAS Agency)
- ☐ Division of Specialized Care for Children
- ☐ Post-Secondary Education Disability Services Representative
- ☐ Other _____

Please check below indicating your consent or refusal for that agency to be invited to the IEP meeting. Please note, your consent to invite the above listed representatives does not guarantee the representative will attend; rather, it allows an invitation to be extended.

Sincerely,

_____ _____

Case Manager or School Representative Phone

Please choose one.

☐ **I DO** give my consent to have the above listed agency/agencies invited to the IEP meetings. This consent is valid for one year from the signature date. I understand that my consent is voluntary and may be revoked at any time before the identified agency representatives can be invited to the IEP meeting.

☐ **I DO NOT** give my consent to have the above listed agency/agencies invited to the IEP meetings.

_____ _____

Signature of Parent or Student (18 years or older) Date

_____

Print Parent or Student (18 years or older) Name

Parent or Student (18 years or older) refused to sign this for but verbally provided consent or refusal for an agency to be invited to the upcoming IEP meeting.

☐ **Parent or Student (18 years or older) verbally provided consent** to have the above listed agency/agencies invited to the IEP meetings. This consent is valid for one year from the signature date. Parent/student understands that consent is voluntary and may be revoked at any time before the identified agency representatives can be invited to the IEP meeting.

☐ **Parent or Student (18 years or older) verbally indicated that he/she DOES NOT** give consent to have the above listed agency/agencies invited to the IEP meeting.

_____ _____

School Case Manager ***Date***

Parent/Guardian Authorization to Send IEP/504 Documents and Related Information via Electronic Mail

Student Name: _____ **Date of Birth:** _____ **ID#:** _____

I hereby give my permission to the Chicago Public Schools - District #299 (CPS) to provide me with copies of my child's eligibility, Individualized Education Program (IEP), and 504 related documents via electronic mail (email). I understand that receiving such confidential information via email could increase the risk that this information could be inadvertently accessed by third parties. By signing this form, I assume all risks associated with the security of this emailed documentation. I understand by granting permission to send the IEP and eligibility documents via email, CPS will continue to send these documents via email until I notify the case manager at my child's current school, in writing, that I am revoking authorization to provide such documents via email.

Information to be emailed to parent/guardian:

Check all that apply

- ☐ Notification of Conference
- ☐ Evaluation Reports, including Learning Environment Interventions form
  - ☐ Draft copies
  - ☐ Finalized copies
- ☐ IEP Documents, including but not limited to data collection forms and SSCA documents
  - ☐ Draft copies
  - ☐ Finalized copies
- ☐ 504 Documents, including but not limited to assessments and data collection forms
  - ☐ Finalized copies
- ☐ IEP Progress Reports and Report Cards
- ☐ School Assignment Letter

Certification of email address:

I hereby certify that _____ is my email address, and it is the only email address that Chicago Public Schools may utilize to provide the above-mentioned eligibility and IEP/504-related documents via email.

If I do not give my permission, I understand that the above-mentioned eligibility and IEP/504-related documents will be provided to me by the Chicago Public Schools via United States Mail or personal hand delivery.

Parent/Guardian/Adult Student's Signature: _____

Date: _____

Association House of Chicago

Participant Rights and Responsibilities

As a participant of Association House of Chicago (AHC), you have entitled rights outlined in the Illinois Mental Health and Developmental Disabilities Confidentiality Act, Chapter 2 of the Illinois Mental Health and Developmental Disabilities Code [405 ILCS 5], American with Disabilities Act of 1990, Federal Confidentiality Regulations (42 C.F.R. Part 2) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. These rights include, but are not limited to, the following:

As a participant in an Association House program, you have the Right to:

1. To be free from abuse, neglect (i.e. physical or psychological pain, demeaning, shaming or degrading language or activity), corporal punishment and exploitation (i.e financial and/or sexual).
2. Be informed of your rights and to receive a copy of this notice, even if you agreed to receive it electronically.
3. Access services and not be denied on the basis of race, religion, ethnicity, disability, sexual orientation or HIV status, pregnancy, military status or military discharge.
4. Services provided in the least restrictive environment available;
5. The right to have disabilities accommodated as required by the Americans With Disabilities Act, Section 504 of the Rehabilitation Act and Human Resource Act [775 ILCS 5].
6. Give or withhold informed consent regarding treatment and regarding confidential information about the patient;
7. Refuse treatment or any specific treatment procedure and a right to be informed of the consequences resulting from such refusal.
8. To be treated fairly without regard to your gender and sexual orientation, race, religion, ethnic background, handicapping condition, national origin, age or financial standing. Maintain all of your legal and civil rights while receiving services.
9. Confidentiality which includes: my Protected Health Information that is part of my participant case file and HIV/AIDS status and testing and anonymous testing. If I choose to disclose information regarding my HIV/AIDS status, staff cannot inform anyone else unless I give written consent. Information about my status will not be kept in my record.
10. To choose your own providers and change providers if necessary.
11. Be protected from harming yourself or others. Use of medical and mechanical restraints is prohibited, in addition seclusion, adverse stimuli, withholding nutrition and hydration is prohibited.
12. An unnecessarily punitive restriction (i.e. withholding or cancelling visits, forced exercise, punitive work assignments, punishment by peers and group punishment) as a disciplinary action or as a way to eliminate a negative behavior is prohibited.
13. Communicate with people in private, without obstruction or censorship by staff. Communication may be restricted to protect you or others from harm, harassment or intimidation.
14. Receive, possess and use personal property unless it is determined that certain items are harmful to you or others.
15. Use your money as you choose, unless you are prohibited from doing so under a court guardianship order.
16. Deposit your money at a bank or place it for safe-keeping with a service provider, AHC staff may not act as payee.
17. Be paid for work you are asked to perform which benefits the service provider; however you may be required to do personal housing chores without being paid.
18. I and/or my legal guardian have the right to be actively involved in determining my services, service planning and discharge of services. I have the right to ask questions and be informed about other services available. I will be offered services based on my presenting needs.
19. Participate in any team meeting about you.
20. To be notified of any restriction of your rights and provided a written Plan as to how your rights will be restored. You and your parent or guardian have a right to a copy of this Plan. Your parent or guardian and any agency designated by you will be invited to participate in the development of the Plan with includes measureable objectives for restoring your rights that is signed by you, your parent or guardian, the QMHP and the LPHA.
21. Continue to receive services unless you voluntarily withdraw, or you meet the criteria for discharge from the services.
22. Look at your case file and other information about you.
23. Request that inaccurate information be amended or corrected in your case file.
24. Know if the service provider is not meeting quality standards and to look at written survey reports describing the quality of services.
25. Know what services are available to you (receive services that are the most appropriate for your needs).
26. Inspect and copy certain Protected Health Information (PHI) used to make decisions about your health care benefits.

27. To contact the Guardianship and Advocacy Commission, Equip for Equality, and the Illinois Department of Children and Family Services. If you need assistance in contacting these organizations, a staff member will assist you.
28. To be provided services in my primary language or in a method of communication I understand, and documentation of such explanation shall be placed in my record.
29. The right to contact the public payer or its designee and to be informed of the public payer's process for reviewing grievances.
30. Be informed of any service cost, if applicable, prior to participation in services.
31. Refuse to participate in any research, trial, and investigations.
32. I have the right to refuse to participate in services or any recommendations from staff. If staff makes recommendations to refer me for other services either within AHC or to an outside agency, they will be discussed with me. Staff will inform me of the consequences if I refuse service or medications.
33. You or your guardian can present a grievance. You will be provided a description of the route of appeal available when a person disagrees with an organization's decision or policies.
34. Receive an accounting of certain disclosures of your Protected Health Information (PHI) made by us and a written access report that indicates who has accessed electronic protected health information maintained by AHC.
35. However, you are not entitled to an accounting of several types of disclosures including, but not limited to:
    - Disclosures made for payment, treatment or operation and administration of AHC
    - Disclosures made to you
    - Disclosures made before April 14, 2003
    - Disclosures you authorized in writing
    - Disclosures made incidental to otherwise permissible disclosures
36. Right to opt out of fundraising solicitation and explain the process for the opt-out right.
37. Right to know when your personal information is shared with the DHS Firearms Owner's Identification Mental Health Reporting System. AHC is mandated to report information on persons in Illinois that have: adjudicated mentally disabled persons; voluntarily admitted to a psychiatric unit; determined to be a "Clear and Present Danger", and determined to be "Developmentally Disabled/Intellectually Disabled."
38. Right to contact Illinois Healthcare and Family Services (HFS) or its designee and to be informed by HFS or its designee of the participants' healthcare benefit and the process for reviewing grievances.

Visions Substance Abuse Program participants' information is protected by Federal Confidentiality Regulations (42 C.F.R. Part 2) as well as applicable State and Federal Regulations.

Buena Vista Community Independent Living Arrangement (CILA) Program participants have the right to remain in the CILA program unless they voluntarily withdraw from the program or meet the criteria set forth in Rule 199.21, that is:

1. The behavior of an individual places the individual or others in serious danger; or
2. The individual is to be transferred to a program offered by another agency and the transfer has been agreed upon by the individual;
3. The individual's guardian, the transferring agency and the receiving agency; or
4. The individual no longer benefits from CILA services.

Buena Vista CILA participants or guardians are permitted to purchase and use the services of private physicians and other mental and developmental disabilities professionals of their choice. In such case, this information will be documented in the Service Plan.

Your Responsibilities include, but are not limited to, the following:

1. Provide accurate information.
2. Participate in planning and evaluating services.
3. Keep appointments.
4. Notify staff 24 hours in advance if you are unable to keep an appointment.
5. Pay your fees fully and on time in those programs where a fee is required.
6. Follow agency and program rules and procedures.
7. Keep the agency safe. No smoking, no carrying of firearms, no gang activity, and no alcohol or drugs on the premises.
8. Treat with respect all AHC staff and other participants.
9. Respect AHC property and the property of other participants.

In order to provide a safe and respectful environment, each participant is responsible for following the guidelines of both AHC and the individual program in which they are receiving services. Any violation of the rules and responsibilities may result in a restriction or loss of privileges for the participant. Violations will result in an immediate meeting with the participant and program staff and depending upon the violation, consequences that are specific to the program rules will be discussed. During the meeting the conditions in which the rights and privileges for a participant will be reinstated will be discussed. Depending upon the severity of the violation, immediate suspension or termination from the program may be necessary.

Participant Notice of Privacy (Revised 2/27/2020)

How AHC May Use Your Information:

AHC is permitted by HIPAA privacy regulations to use and disclose your Protected Health Information (PHI) in order to provide services (as described below) without your authorization:

- **For treatment.** AHC may use your PHI to provide you treatment and services. For example, so that your treatment and care are coordinated, case managers may discuss your condition with your physician. AHC may disclose your PHI to others who are involved in your care. AHC may disclose information to consultants and referral sources and payers, to make appointments and provide follow up information. Please note, however, that disclosure of psychotherapy notes beyond the treating therapist generally requires your specific authorization.
- **For payment.** AHC may use and disclose your PHI to determine plan eligibility, responsibility for coverage and benefits and to facilitate payment for the treatment and services you receive from health care providers. For example, to make sure that you receive the correct benefits and claims are paid accurately, AHC may also use your PHI for utilization review and case management activities.
- **Other Permitted Uses and Disclosures**
  - For reporting and notification of potential physical abuse, neglect or domestic violence to an appropriate government authority
  - If I threaten to cause harm to others or myself
  - If I have a medical emergency
  - For public health and safety
  - For health oversight activities (e.g. OIG)
  - For judicial and administrative proceedings
  - When requested by law enforcement officials with appropriate release or warrant
  - When requested by a coroner or medical examiner with appropriate release or warrant
  - When requested by certain organ, eye or tissue donation programs with appropriate release or warrant
  - When requested by specialized government functions (e.g., military and veterans' activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations)
  - If AHC uses or discloses PHI for underwriting purposes, AHC will not use or disclose for that purpose PHI that includes your identifying information. AHC may disclose your PHI to a family member, relative, close personal friend, or any other person whom you identify, when that information is directly relevant to the person's involvement with your care or payment related to your care. AHC also may use your PHI to notify a family member, your personal representative, another person responsible for your care, or certain disaster relief agencies of your location, general condition, or death. If you are incapacitated, there is an emergency or you otherwise do not have the opportunity to agree to or object to this use or disclosure, AHC will do what in their judgment is in your best interest regarding such disclosure and will disclose only information that is directly relevant to the person's involvement with your health care.
  - For the purposes of funding, accreditation, audit, licensure, statistical compilation, research, evaluation, or other similar purpose, my record may be used by the person(s) conducting the review to the extent that this is necessary to accomplish the purpose of the review. No personal identifying data will be disclosed without my prior written consent, except as allowed by the AHC Confidentiality Policy and as may be dictated by the respective funding state agencies. I understand that my record may be one of those and I agree to allow it to be included in the audit.
  - Newsletters and other communications. We may use your personal information in order to communicate to you via newsletters (including electronic newsletters or mailings).
  - Covered Entity participates with other behavioral health services agencies (each, a “Participating Covered Entity”) in the IPA Network established by Illinois Health Practice Alliance, LLC (“Company”). Through Company, the Participating Covered Entities have formed one or more organized systems of health care in which the Participating Covered Entities participate in joint quality assurance activities for the delivery of health care with other Participating Covered Entities, and as such qualify to participate in an Organized Health Care Arrangement (“OHCA”), as defined

by the Privacy Rule. As OHCA participants, all Participating Covered Entities may share the PHI of their patients for the Treatment, Payment and Health Care Operations purposes of all of the OHCA participants.

Required Uses and Disclosures
Upon your request, AHC is required to give you access to your PHI in order to inspect and copy it. You may always request and receive a copy of health information that is maintained as an Electronic Health Record (as defined by the HIPAA rules). You may also have an Electronic Health Record sent to another entity or person, so long as the request is clear, conspicuous, and specific and made in writing. AHC is also required to use and disclose your PHI when requested by the Secretary of the Department of Health and Human Services to investigate or determine AHC's compliance with the privacy regulations.

Right to Request Restrictions
You may ask us to restrict how AHC uses and discloses your PHI to carry out payment, treatment, or health care operation and administration. You may also ask us to restrict disclosures to your family members, relatives, friends, or other persons you identify who are involved in your care or payment for your care. Also, any entity covered by the HIPAA privacy rules (such as a business associate of AHC or a provider) must comply with an individual's request that a specific health care item or service not be disclosed to AHC, even for payment or health care management, if the individual or other person outside AHC has paid the full amount due. While AHC will consider all requests for restrictions carefully, we are not required to agree to a requested restriction, except for a requested restriction which pertains only to a health care item or service for which the individual or other person outside Association House of Chicago has paid the full amount due.

Right to Receive Notice of a Breach
AHC is required to notify you by first class mail or by email of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable and undecipherable to unauthorized users. The notice is required to include the following information:

- A brief description of the breach, including the date of the breach and the date of its discovery if known;
- A description of the type of Unsecured Protected Health Information involved in the breach;
- Steps you should take to protect yourself from potential harm resulting from the breach;
- A brief description of actions we are taking to investigate the breach, mitigate losses and protect against further breaches;
- Contact information, including a toll-free telephone number, e-mail address, Web site or postal address to permit you to ask questions or obtain additional information. In the event the breach involves 10 or more participants who contact information is out of date we will post a notice of the breach on the home page of our Web site or in a major print or broadcast media. If the breach involves more than 500 participants in the state or jurisdiction we will send notices to prominent media outlets. If the breach involves more than 500 participants, we are required to immediately notify the Secretary of the U.S, Department of Health and Human Services. We also are required to submit an annual report to the Secretary of the U.S. Department of Health and Human Services of a breach that involved more than 500 participants during the year and will maintain a written log of breaches involving less than 500 participants.
- You may request to receive your PHI by alternative means or at an alternative location if you reasonably believe that other disclosure could pose a danger to you.

Grievance Procedure

AHC has a Participant Rights Grievance Procedure if you feel your rights have been violated. The agency encourages you to discuss any grievance that you may have with your direct service staff. However, if you feel that you are unable to do so, you can contact the Participant Rights Officer, who is available to assist you with this procedure or to answer any questions, address concerns, or to provide clarification about services. AHC's Participant Rights Officer is available during office hours Monday thru Friday 9:00am until 5:00 pm and can be reached at 773-772-7170. For calls outside of office hours, please leave a voicemail message and your call will be returned the next business day. Any complaint, concern, or grievance will not result in retaliation or barriers to service. Complaints or concerns will be reviewed and investigated in accordance with the Participant Rights/Grievance Policy. Not withstanding, the above provisions, when the agency determines that it cannot provide services due to issues of capacity, danger, or appropriateness, and then it reserves the right to discontinue services. The agency will provide you notice of at least 10 days in advance of action to deny, modify, reduce and/or terminate services.

In the event that you feel that your grievance was not resolved in a manner that you see fit, you have the right to contact the following agencies, as applicable.

The Participant Rights Officer shall keep complete and accurate records of grievances received the subject matter of those grievances and the resolutions. The records shall be monitored in accordance with the Quality Improvement Program and kept on file for a period of 7 years by the Participant Rights Officer.

The Agency representative's decision on the grievance shall constitute a final administrative decision.

For Programs in Behavioral Health, Developmental Disabilities and Addiction Services	Department of Human Services Bureau of Licensure, Accreditation and Certification 401 N. 4th Street, 2nd Floor Springfield, IL. 62702 (217) 557-9282	Department of Human Services Office of the Inspector General 901 Southwind Rd. Springfield, IL. 62703 (800) 368-1463	For Substance Use Program Only: Department of Human Services Division of Alcoholism and Substance Abuse Licensing 401 S. Clinton St, 2nd Floor Chicago, IL 60607 (312) 814-3840
For Programs in Child Welfare	Department of Children and Family Services Administrative Hearings Unit 406 E, Monroe Street Station 15 Springfield, IL. 62704-1498 (217) 782-6655 or 800-232-3798		
For All Programs	Guardianship and Advocacy Commission PO Box 7009 Hines, IL 60141 (866) 274-8023	Equip for Equality 20 N Michigan Suite 300 Chicago, IL. 60602 (312) 341-0022	Secretary of the U.S. Department of Health and Human Services 200 Independence Avenue, S.W. Washington, DC 20201 1-877-696-6775

For more information regarding "Participant Rights and Responsibilities" speak with your program manager or contact the Participant Rights Officer at 773-772-7170.

I may not be denied, suspended or terminated from services or treatment or have these reduced for exercising my rights.
By signing this I acknowledge that my rights as stated above were explained to me and I have been offered a copy of this document.

_____ _____ _____ _____
Participant (12 years and older) Date Guardian (if under 18 years old) Date

I, _____, in my role as Association House of Chicago staff, have explained to this participant his/her rights and consider that s/he has understood these rights.

_____ _____
Staff Date

*Valid for one year after date signed. Must be reviewed, acknowledged and signed annually.

Agency Hours of Operation:

1116 N. Kedzie, Chicago, IL	Monday- Thursday : 8:00am – 8:00pm Friday: 8:00am-7:00pm Saturday: 9:00am- 1:00pm Sunday: Closed
Dulcinea Residencial and Buena Vista CILA Programs:	Open 24 hours