West Central Regional Juvenile Center, Non-Secure Detention 30 Day Evaluation Program

The focus of this program is one of assessment. While the child may participate in psychological and psychiatric evaluations, which could result in a mental health diagnosis, the program will emphasize a complete assessment of both internal and external factors. Recommendations may be made to target change in the child's environment or systems that are external to the youth. The process of assessing the child's situation is done in partnership with the client and their family. The involvement of the child and their family in the assessment process is vital to making change and solving problems. The assessment program will target the problems and needs that are identified by the assessment team, but will also strive to identify and cultivate the strengths the child and family have. By recognizing and building upon the identified strengths, many children are able to overcome or offset many problem areas.

Population Served

Youth Ages 10-18 who have been referred by a county pre-placement screening team, and have an identified need for evaluation services are eligible for this program.

Evaluation Team

The assessment service is administered by a team of human service professionals including a licensed psychologist, psychiatric nurse specialist, licensed family therapist, registered nurse, a school representative, an assessment coordinator, and facility staff which includes an assigned case manager.

Description of the Program

Each assessment is individually designed to fit the identified client's needs. The 30-Day Evaluation Program may include the following components:

- Psychological Assessment
  - Substance Use Diagnosis
- Psychiatric Assessment
- Medical Assessment
- Educational Assessment
- Social/Family Assessment
- Leisure skills Assessment
- Daily Living Observations
- Life Skills Assessment

The assessment will produce a comprehensive written report detailing intervention recommendations. This report will include a detailed plan of activities and services and is aimed at assisting the family in integrating the youth back into the community.

Referral Contact:

Dylan Shimell, Non-Secure Detention Supervisor
West Central Regional Juvenile Center
729 11th St N, Moorhead, MN 56560
Phone: (218) 299-7573 Fax: (218) 299-7533
Email: dylan.shimell@claycountymn.gov

Clay County 30 Day Evaluation Program Referral Form

- It is the responsibility of the referral source to secure all the appropriate releases of information.
- No referral will be accepted for programming until all past treatment and other pertinent information is received and reviewed.
- Upon reviewing all submitted information, the 30-Day Program Supervisor will contact you with a decision of admittance into the program and a potential start date.

Send all information to:

West Central Regional Juvenile Center, 30-Day Evaluation Program
Dylan Shimell, Non-Secure Detention Supervisor
729 11th St N, Moorhead, MN 56560
Phone: (218) 299-7573 Fax: (218) 299-7533

Date: _____

Referral Source: _____ Agency: _____

Phone number email address of referral source: _____

_____

Name of Adolescent: _____ DOB: _____

Address: _____

Mother: _____

Address: _____ Phone Number: _____

Email:

Father: Phone Number: _____

Address: _____

Email:

Reason for Referral:

Although many of the following components of the evaluation are completed on every participant, please review the following components that you feel are possible problem areas, or where there are identified assessment needs.

Please attach relevant documents regarding the following categories:

Psychological: _____
Date of last diagnostic / Who completed assessment? _____
Are there any current mental health diagnoses? If so, what are they? _____
_____

Psychiatric: _____
Previous services / medications? _____

Medical: _____
Date of last physical? _____ Health concerns? _____

Rule 25 Chemical Dependency Evaluation: _____
Date of last Chemical Use Assessment: _____

Education: _____
School and Grade / IEP? _____

Family Services: _____
_____

Family (list of members & DOB):	**Name**	**DOB/ or age**
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Any other pertinent information:

West Central Regional Juvenile Center

Dylan Shimell
729 11th Street North
Moorhead, Minnesota 56560
218-299-7573
Fax:(218) 299-7533

West Central Regional Juvenile Center Informed Consent for Release and Exchange of Release

We are asking for your consent to release and exchange the information about you. Your information may be shared with the agencies or persons you indicate below. You have the right to look at this information. You may request copies of the information before you give your consent. A summary of your privacy rights and the use of this information are found below.

Client Name:_____ **DOB:**_____

- I understand I may give my consent to release information amongst all the agencies listed below:

Agencies/Persons	Print Name	Signature	Date
West Central Regional Juvenile Center			
30-Day Evaluation Program Clay County			
_____ County Social Services			
Lakeland Mental Health, Inc.			
_____ County Court Services			
Moorhead Public School District #152			
Clay County Social Services - Rule 25 Assessor			
Lutheran Social Service of MN			

- I understand that this information will be released and exchanged in order to receive services. This information will be shared with staff that need to provide services to myself or my family.
- I understand that I may cancel this consent, or any part of it, upon written notice unless the information has already been released. My consent ends when I no longer receive services. It will automatically end one year from the date signed below.
- I understand that I may refuse to give my consent to release and exchange information. I understand that if I do not share this information, I may not receive all the services my family or I need, or for both which I am eligible.

_____ _____

Signature of the person for whom consent is being granted **Date**

_____ _____

Signature of the parent or guardian granting consent **Date**

Worker/Agency initiating consent: _____/_____

Health Insurance Information:

Juvenile's name: _____

Insurance Company: _____

Insurance Company Address: _____

Telephone No. of the Insurance Company: _____

Policy Holder and their relationship to child: _____

ID Number: _____

Group Number: _____

Primary Provider: _____

Secondary Insurance: _____

Is there any other health insurance coverage you know of: _____

_____

Any other pertinent information:

CLEAR FORM