D/KS CRF
(Rev 09/10)

MENTAL HEALTH PROGRAM CLIENT RESPONSIBILITIES

CONTRACT AGENCY: **AACF Therapy Center**
ADDRESS: **719 Massachusetts St., Suite 115**
Lawrence, KS 66044

TELEPHONE NUMBER: **(785) 840–0374**

You are required to participate in a counseling program. This letter lists some of your responsibilities in the program. Other rules of the program will be discussed by your probation officer and counselor.

1. It is your responsibility to report as directed. Should the above telephone number not be working, or should you otherwise not be able to make contact by calling that number, you shall call the alternative number listed below until you are able to visit with either your counselor or probation officer. The alternative number is: **(913) 735-2400**.

2. Failure to report as directed for any reason is a violation of your conditions of supervision. Other than minor adjustments in scheduling, your counselor is not authorized to excuse you from reporting as directed. Failing to report for counseling and/or urinalysis will be reported to the probation officer as a "no show." You must contact your probation officer immediately if you are unable to comply with these program requirements. Lack of transportation, scheduling problems derived from employment or school participation, child care problems, and bad weather are generally unacceptable reasons for failure to comply with this program. Illness is an acceptable reason only if verified by the probation officer with a doctor's statement or other medical records indicating an extreme temporary disability.

3. You shall pay a copayment of $ _____

4. You shall call _____(785) 840-0374_____ on _____ to schedule an initial appointment.

It is important that you realize fully your responsibilities in the mental health treatment program. Any questions you might have should be directed to your probation officer. Your participation in this program is a requirement of your continued supervision. With your assistance and cooperation, the goals of addressing the mental health treatment condition and satisfactorily completing your period of supervision will be achieved.

_____ _____
CLIENT DATE

cc: AACF

_____ _____
USPO DATE