K'IMA:W MEDICAL CENTER

OFFICE OF DOMESTIC VIOLENCE AND SEXUAL ASSAULT PREVENTION
P.O. BOX 1288 Hoopa, California 95546 PHONE: (530) 625-4061

CONFIDENTIAL CLIENT INTAKE FORM

(Official Use Only) ***Referred by:***

□ Self (Walk In) □ Phone Call (Self Admittance) □ CFS ICWA □ Behavioral Health □ IHS □ KTJUSD □ DHHS □ TANF
□ Tribal Court_____ □ Tribal Police Officer _____ □ County Sheriff's Department Officer _____
□ HVTC □ Medical Provider □ DA/Victim Witness □ Other DV Program_____ □ County Department_____
□ Other:_____ Advocate Name: _____ Client Case No:_____

Name:_____City:_____State:_____ Zip:_____
Address:_____ City:_____State:_____ Zip:_____
Physical Address:_____ City:_____State:_____ Zip:_____
Are you or your family in danger? *(Circle One)* ***Yes or No *If YES, Why?***_____
Are you seeking Protection? *(Circle One)* ***Yes or No *IF NO, do you have a Restraining Order?*** *(Circle One)* ***Yes or No***
Tribal Court Case No: County Court Case No: Expiration Date:

Home Phone: _____ Cell: _____ Message: _____
Is it safe to call you on these phone numbers? *(Circle One)* **Yes or No** * If NO, how should we contact you?_____
Email:_____DOB:_____AGE:_____ Height:_____

What is your gender identity? *(Check One)* ☐ Female ☐ Male ☐ Transgender ☐ Gender non-conforming
Tribe:_____ Roll No:_____Affilation:_____
Do you have children? *(Circle One)* Yes or No * If "Yes," please list below:

Children(s) Name:	**(List) M or F:**	**DOB:**	**Age:**	**Tribal Affiliation:**	**Other Parent Name/Address:**

Do you have custody? *(Circle One)* Yes or No *If "Yes," where did you file for Custody?
Tribal Court Case No: County Court Case No: Attorney/Spokesperson Name:

Perpetrator Name: Age: DOB (If known):
Last Known Address: City: State: Zip Code:
Hair Color: Eye Color: Weight: Height: Gender: (Circle One) M or F
Any Scares: Tattoos: Do they own a fire arm?
Vehicle Make/Model/Year/Color: License Plate No:

****Briefly explain current situation (i.e. Where did the incident happen? Who was there, and what happened?):*** _____

Requesting Services: □ *Domestic Violence* □ *Sexual Assault* □ *Legal* □ *Safety Planning*
□ *Emergency Shelter* □ *Emergency Supplies* □ *Mental Health* □ *Cultural & Support Groups* □ *Transportation*
□ *Education* □ *Employment* □ *Assistance with Financial Independence/Employment* □ *Sexual Trafficking Education*
□ *Safety Planning* □ *Medical* □ *Mental Health* □ *Tribal Court Advocacy* □ *Other:* _____

I hereby acknowledge and understand that the Office of Domestic Violence and Sexual Assault Prevention will able to assist me with limited services under Grant guidelines; and I will work with my advocate to provide all information asked, and will comply with all Policy & Procedures unless I choose to terminate services, or a year after the date agreement signed. (Please Sign and Date Below).

Print Full Legal Name: Signature: Date/Time

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Confidentiality Agreement Form

Name:_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Cell:**_____ **Message:**_____

The Office of Domestic Violence and Sexual Assault Prevention is a program within K'ima:w Medical Center that works with the Child and Family Services Department. Within the guidelines of HIPPA and Indian Health Services, your personal information is taken on a need to know basis. Privacy and confidentially of client is of the upmost importance.

Please read or have your Advocate read each paragraph, then initial each if you choose to agree with the terms on this confidentiality agreement:

1. The Office of Domestic Violence and Sexual Assault Prevention will not share any information regarding you and your whereabouts to anyone, without prior written consent.
2. The Office of Domestic Violence and Sexual Assault will not release any documentation or information regarding you without prior proper written consent.
3. The Office of Domestic Violence does report data to the funding sources on services provided, but does not require names and or details of individuals.
4. This agreement can be revoked by either party at anytime and does not affect the services individuals have or will be provided.

I hereby acknowledge and understand that the Office of Domestic Violence and Sexual Assault will adhere to the above agreement, until terminated by myself or from a year after the date agreement signed. (Please Sign and Date below).

_____ _____ _____

Print Name Signature: Date:

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- EMERGENCY NEEDS FORM -

The Office of Domestic Violence and Sexual Assault Prevention is a program within K'ima:w Medical Center that works with the Child and Family Services Department. Contingent on funding availability the program may be able to provide up to $100 per individual for displaced participants. As a general guideline each participant will be able to receive a (toiletries care package) and one time clothing allowance. (Items requested and received by Participant).

Client NO:_____ DATE:_____

Toiletries: Clothing: Miscellaneous:

For Official Use Only:
Coordinator/Advocate Approval:_____
Date Routed to Fiscal:_____
Date Received Purchase Order Received from Fiscal:_____

Once approved, items will be routed through the Kima:w Medical Center Fiscal Department to process, the Coordinator will purchase items with the participant and have them sign that they received items listed above, and attach a copy of the receipt to the form, and return the original receipt with a confidential client tracking no. to Fiscal for audit purposes.

Print Name _____ Signature: _____ Date: _____

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- EMERGENCY SHELTER AGREEMENT -

The Office of Domestic Violence and Sexual Assault Prevention is a program within K'ima:w Medical Center that works with the Child and Family Services Department. Contingent on funding availability the program may be able to provide up to one night, not to exceed three nights in a hotel. The location will not be listed, or placed in the case file, as it is confidential. If the participant chooses to bring their own vehicle, the program has no way of protecting their confidentiality, and it is at their own risk.

Safety Guidelines: *(Initial Below)*

_____Participant agrees that the "Emergency Shelter" location is to remain confidential, no third party family members allowed in the emergency placement.
_____No Drugs or Alcohol will be permitted in the emergency shelter
_____No parties in the emergency shelter
_____No Unauthorized overnights of individuals that are not in the case plan
_____Participant is responsible for any damaged or stolen items upon their stay
_____No Photos of Emergency Shelter or information of location on Social Media
_____No Incidentals will be allowed to be charged to the room
_____No information shall be given to the Abuser to insure safety

I, acknowledge by signing this document that I will release the liability and hold Kima:w Medical Center, Office of Domestic Violence and Sexual Assault Prevention from any risk of emergency shelter. Furthermore, I acknowledge that if I violate any of the guidelines listed above I may be violation of the Emergency Shelter rules and my services for Emergency Shelter may be suspended.

_____ _____ _____

Print Name Signature: Date:

For Official Use Only:
Coordinator/Advocate Approval:_____ Client No:_____
Date Routed to Fiscal:_____
Date Received Purchase Order Received from Fiscal:_____

Once approved, items will be routed through the Kima:w Medical Center Fiscal Department to process, the Coordinator will purchase items with the participant and have them sign that they received items listed above, and attach a copy of the receipt to the form, and return the original receipt with a confidential client tracking no. to Fiscal for audit purposes.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 08-31-2019
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. The information is to be disclosed by:	And is to be provided to:
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research ☐ Other *(Specify)* _____
☐ Personal Use ☐ Insurance ☐ Disability ☐ Health Information Exchange (IHS/Other _____)

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

☐ Only the period of events from _____ to _____
☐ Other *(specify) (CHS, Billing, etc.)* _____
☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated. For Health Information Exchange authorizations, it is recommended to expire in at least five years.

_____
(Specify new date)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2. may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION	NAME *(Last, First, MI)*	RECORD NUMBER
	ADDRESS	
	CITY/STATE	DATE OF BIRTH