



# Ac P Yurok Tribe Health and Human Services

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## I. Healthy Circles Intake Form

### Screening and Needs Assessment

#### Client Information

Name:	DOB:		
City:		Zip:	
Physical Address:			
Phone:	Message Phone:		
Tribal ID:			

Release of Information attached

#### Emergency Contact Information

Name	Address	Phone	Relationship

#### Please Identify Risk Factors

<input type="checkbox"/> Living in Area with High Crime Rate <input type="checkbox"/> Absent Parent (Single Parent Families) <input type="checkbox"/> Parents not High School Graduates <input type="checkbox"/> Living with Caretaker Relative <input type="checkbox"/> Member of Low Income Household <input type="checkbox"/> Living on or Near Reservation or Rancheria lands <input type="checkbox"/> Prenatal Substance Use	<input type="checkbox"/> Involvement in Juvenile Justice System <input type="checkbox"/> Living in Unstable School District <input type="checkbox"/> Low Academic Performance or Attendance <input type="checkbox"/> Low Self Esteem or Negative Self-Perception <input type="checkbox"/> Victim of Bullying <input type="checkbox"/> Member/Ally of the LGBTQ Community	<input type="checkbox"/> Experiencing or Exposed to Substance Abuse Issues <input type="checkbox"/> Pregnant/Parenting Teen <input type="checkbox"/> Experiencing or Exposed to Domestic Violence <input type="checkbox"/> Homelessness / Housing Issues / Runaway <input type="checkbox"/> Family Impacted by Suicide <input type="checkbox"/> Family Impacted by Opioid Crisis
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<b>Immediate Needs</b>					
	Discussed	Current	New Referral	Organization	Contact Person
<b>HEALTHCARE</b>					
Medicated Assisted Recovery					
Mental Health Counseling					
Substance Abuse Counseling					
12 Step Group					
Recovery Supports					
Smoking Cessation					
Public Health					
Home Nursing- (Healthy Families Field Nursing)					
Healthy Moms					
<b>ECONOMIC STABILITY</b>					
TANF/Tribal TANF					
Employment					
General Relief					
Child Support					
Diapers					
<b>COMMUNITY &amp; ENVIRONMENT</b>					
Housing Authority					
Housing Energy Assistance					
Family Stabilization Program (job/rent etc)					
Housing Support Program					
Harrington House					
Transportation					
Car Seat					
<b>EDUCATION</b>					
Headstart/Early Headstart					
Play Groups					
Community Resource Centers					
<b>COMMUNITY &amp; SOCIAL</b>					
Tribal Motherhood/Fatherhood					
Linguistic and Cultural Programs					
Tribal Mentor					
Domestic Violence Programs: Yurok or Tolowa dee-ni' or County					
North Coast Rape Crisis Center					
<b>FOOD</b>					
CALFresh					
WIC					
Local Food Banks					
Plan of Safe Care					
Other					

Assessments: To access service tailored to your needs and that of your family's, we ask your permission to conduct applicable assessments with you

	Date Discussed	Date Referred	Date Completed	Organization	Contact Person
ACES					
ASAM level for client (.5 – 4)					
Ask Revise Refer					
Cultural Connections					
Four 4 Ps Plus					
Mental Health: Edinburgh PHQ9					
NCFAS					
SDOH					
TANF (At-Risk)					
Eat, Sleep, Console					

Referral to Healthy Circles		Name of Tribal TANF Worker: Contact Information:				
Organization (write name of organization)	Date Discussed	Date Warm-hand off	Date of Tribal TANF Meeting	Name	Contact Information	
OBGYN/Hospital						
Tribal Agency NAME						
County Agency NAME						
MAT Provider						
Other Provider						



# Yurok Health and Human Services



## Plan of Safe Care

## I. Preliminary Information

Contact Information			
Name of Parent 1:		DOB:	
City:			Zip:
Physical Address:			
Phone:		Message#:	
Name of Tribe and Tribal ID:			
Name of Parent 2:		DOB:	
City:			Zip:
Physical Address:			
Phone:		Message#:	
Name of Tribe and Tribal ID:			
Infant Name:		DOB:	
Infant's Siblings' Names		Ages	Living With
Living with Parent 1; Parent 2; Other _____ (relationship to infant)			
Physical Address (if different from parents):			
Phone:		Message#:	
Tribal ID:			
City:			
Emergency Contact Information			
Name	Address	Phone	Relationship

## II. Building My Healthy Circle (Family Wellness Team)

My Family, Friends, Tribe, and Community Resources are here to support me attain **Pyuech we-son-o-wok** (a state of being when everything is just as it should be—balanced/wellness)

	Name	Organization/Phone Number/Contact Information
Family		
Friends		
Mentor/Navigator		
Family Advocate		
Service Provider		
Service Provider		
Others		

To attain Pyuech 'we-son-o-wek, I must first identify my challenges. Please circle all substances used in the past year.

<b>Methadone</b>	<b>Opioids</b>		
<b>Buprenorphine</b>	Benzodiazepines		
<b>Naltrexone</b>	Methamphetamine		
<b>Prescribed opioids for chronic pain</b>	Amphetamine		
<b>Prescribed benzodiazepines</b>	<b>Kratom</b>		
<b>Marijuana</b>	Other		
<b>Nicotine/Tobacco</b>	Other		
<b>Alcohol</b>	Other		

What Steps Can I take to overcome my challenges (for example, open to using NARCAN):

- 1.
- 2.
- 3.

## II. Prenatal Period

My Prenatal Plan	
My Immediate need: (Ex Housing, Food, Transportation, car seat, diapers, etc.)	
1.	
2.	
Please list healthy goals you would like to achieve during your pregnancy (Ex: Prenatal Vitamins, nutritional classes, exercise, AOD meeting,	
1.	
2.	

My Prenatal Appointment	
Scheduled Date: _____ Time: _____ Place: _____ Care Provider: _____	

### Information I can expect at my Prenatal Visit



My Birth Plan
Due Date: _____; Emergency Contact: _____
Schedule registration at the hospital: Mad River, Saint Joe's, or Sutter Coast or Other: _____ Address: _____; Telephone: _____; With: _____; Date: _____
Important Things to Know About me:
Special Instructions for Delivery and Birth: (Ex. I would like to labor naturally/or receive pain medication when I arrive at the hospital)
In the Case of a Caesarean Section:
Important Issues, Fears, or Concerns:
Important People I Would Like in the Room While I Give Birth

### III. Post-Partum Period

My Post- Partum Plan
My Immediate Needs:
My first 10 days at home: (Ex. I will receive a baby basket by date: _____ from: _____ Schedule home visits from nurse, whose name, address, telephone number are:
Please discuss whether you would be open to family or friends helping you in your home with your baby? Other children?



Sleeping Arrangements Mother/Baby:	Feeding Mother/Baby:
Visitors:	

Do you plan to have another baby within the next 12 months? (if appropriate, birth control discussion)

#### IV. Infant Needs

My Baby	
Prenatal Exposure History:	
Hospital Care: (Ex. NICU, APGAR, Length of stay, Diagnosis)	
Follow up Pediatric Care:	Provider:
Other Medical Care or Developmental Concerns:	
Referral to Trauma Informed Early Child Care:	
Referral to Early Intervention and Other Services:	

