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

□ Living in Area with High Crime Rate	□ Involvement in Juvenile Justice System	□ Experiencing or Exposed to Substance Abuse Issues
□ Absent Parent (Single Parent Families)	□ Living in Unstable School District	□ Pregnant/Parenting Teen
□ Parents not High School Graduates	□ Low Academic Performance or Attendance	□ Experiencing or Exposed to Domestic Violence
□ Living with Caretaker Relative	□ Low Self Esteem or Negative Self-Perception	□ Homelessness / Housing Issues / Runaway
□ Member of Low Income Household	□ Victim of Bullying	□ Family Impacted by Suicide
□ Living on or Near Reservation or Rancheria lands	□ Member/Ally of the LGBTQ Community	□ Family Impacted by Opioid Crisis
□ Prenatal Substance Use		

Immediate Needs					
	Discussed	Current	New Referral	Organization	Contact Person
HEALTHCARE					
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					
ECONOMIC STABILITY					
TANF/Tribal TANF					
Employment					
General Relief					
Child Support					
Diapers					
COMMUNITY & ENVIRONMENT					
Housing Authority					
Housing Energy Assistance					
Family Stabilization Program (job/rent etc)					
Housing Support Program					
Harrington House					
Transportation					
Car Seat					
EDUCATION					
Headstart/Early Headstart					
Play Groups					
Community Resource Centers					
COMMUNITY & SOCIAL					
Tribal Motherhood/Fatherhood					
Linguistic and Cultural Programs					
Tribal Mentor					
Domestic Violence Programs: Yurok or Tolowa dee-ni' or County					
North Coast Rape Crisis Center					
FOOD					
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.

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