INTAKE CHECKLIST

Welcome to Kewa House Emergency Youth Shelter,

Kewa House Emergency Youth Shelter provides a safe and secure shelter for youth 0 – 17 years old in need of short-term housing due to ever-changing home dynamics, homeless or at risk of being homeless. This checklist will assist you in preparing for full admission into the program.

CLIENT NAME: _____
REFERING AGENCY/NAME: _____

1. _____ **Kewa House Intake Form**
2. _____ **Rapid Covid- 19 Test**
3. _____ **Medical Clearance**
4. _____ **Vaccination card-youth 5yrs and older**
5. _____ **Birth Certificate, Baptismal Certificate, Affidavit Document**
6. _____ **Certificate of Indian Blood**
7. _____ **Social Security Number**
8. _____ **Medicaid Card**
9. _____ **Updated Immunization Record**
10. _____ **Court Documents**
11. _____ **Juvenile Probation Parole Documents**
12. _____ **Criminal Record (State/Tribal/Federal)**

INTAKE COMPLETED BY: **Date:**

_____ _____

MANAGER SIGNAURE: **Date:**

_____ _____

Date of Admission to Kewa House Emergency Youth Shelter:

_____

For referral information please contact Diego Calabaza, Kewa House Manager.

Office: (505) 585-0114; On Call Number: (505) 220-1546
House Managers Number (505) 862-1883

Client ID #_____

INTAKE FORM

Client Number: _____
Room/Bed Assignment: _____/_____

Client Demographics:

Client Name: _____ _____
Last First MI

Gender: ☐ Male ☐ Female Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____
DOB: _____ Age: _____ State of Birth: _____ County of Birth: _____
Current Address: _____ City: _____ State: _____Zip Code: _____
Tribal affiliation: _____ Enrollment number: _____

Referral Demographics

☐Tribal/BIA ☐Social Service ☐Tribal Courts/ Probation ☐Residential Hardship ☐Law Enforcement ☐ Self-Referral
Contact Name: _____ Agency/Program: _____
Address: _____ City: _____ State: ____ Zip Code: _____
Office Telephone: _____Cell: _____ Message #: _____

Parent Demographics

☐ Mother ☐ Father ☐ Legal Guardian:
Name: _____
Address: _____
Tribal Affiliation: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____

☐ Mother ☐ Father ☐ Legal Guardian:
Name: _____
Address: _____
Tribal Affiliation: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____

Emergency Contacts

Contact Name: _____Relationship: _____ Phone: _____
Contact Name: _____Relationship: _____ Phone: _____

Are there any Parent/Family Contact Restrictions? ☐Yes ☐No (if yes, indicate reason)
_____
_____

CYFD/Social Services Custody

Has client previously been in CYFD/Tribal Social Service custody? ☐Yes ☐No Date & length: _____
Is client in custody of: CYFD/Tribal Social Service ☐Yes ☐ No
Is client involved in CYFD/Social Service/Law Enforcement investigation? ☐Yes ☐No
If Yes, Explain_____

JPPO/Courts custody

Has client previously been involved with the Juvenile Probation Parole? ☐No ☐Yes
If yes, Date and length of time_____
Is client currently involved with Juvenile Probation Parole Office? ☐ Yes ☐ No
Has client been in Juvenile Detention this year? ☐No ☐Yes
If yes, explain: _____

Length of stay requesting:

Children ages 0-6 are expected to stay no longer than 14 days.

☐ 1day or less ☐ 2-7 days ☐ 7-14 days ☐ 14-30 days will need to request with a formal letter made to Kewa House Case manager and Manager. The letter will be taken under view and agencies will be notified of decision as soon as possible.

Reason/Contributing factors for Homelessness or Critical Family Issues

☐Child Abuse/Neglect	☐Disability	☐Natural Disaster/Fire
☐Runaway	☐Mental Illness	☐Trafficking/Exploitation
☐Alcohol/Substance Abuse	☐HIV/AIDS	☐Aged out of foster care
☐Release from Jail	☐Natural Disaster	☐Economic
☐Eviction	☐Unemployment	☐Incarcerated Parent
☐Victim of Domestic Violence	☐Family Dispute/overcrowding	☐Other_____

Is client a domestic violence victim or survivor? ☐Yes ☐No

If yes, when did the most recent experience of domestic violence occur:

_____

Agency Placement status What is your client's living custody arrangements (check all that apply)?

☐ Re-unification with Biological Family ☐Foster Placement ☐ Guardianship ☐ other(explain)_____

What agencies are you working with for Treatment Foster Care?

_____

EDUCATION/ SCHOOL

Is Client enrolled in school ☐ Yes ☐ No, If yes, School Name: _____Grade_____

Previous school attended: _____Last grade completed: _____

Has Client ever been suspended from school? ☐Yes ☐ No If yes, reason for suspension:

_____

Educational Development Plan:

Client ID #_____

HEALTH

Client Insurance Information

☐Medicaid Centennial Care Provider: _____Policy Number: _____

☐Private Name: _____ Policy/ Group Number: _____

☐IHS Chart Number: _____

Medication

Does client take medication? ☐Yes ☐No

If yes, list:

Medication Name:	Dosage/times:	Does client have medication on hand?
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No

Does client have any allergies to medication (prescribed/ over the counter) ☐Yes ☐No

If yes, list:

Medication Name	Reaction

Current Health Conditions

☐Birth Defect/Delays ☐Respiratory ☐Immunological ☐Other_____

☐Developmental Delays ☐Integumentary ☐Gastrointestinal

☐Musculoskeletal ☐Endocrine

☐Ears, Eyes, Nose, Throat ☐Neurological ☐Urinary

☐Cardiovascular

If any checked please explain:

_____

_____

Does client have any physical disability? ☐Yes ☐No

Clients current Mental Health Status? ☐Excellent ☐Good ☐Fair ☐Poor

Does client have any allergies (i.e. food, pollen, animal) ☐Yes ☐ No, if yes, list:

Name	Reaction

Female Residents

Is Client currently pregnant? ☐Yes ☐No if yes, Expected due date: _____

Is client on any Birth Controls? ☐Yes ☐No If yes, explain: _____

CHILD DEVELOPMENT

DEVELOPMENT AGE 0-6

Does client have any developmental delays? ☐ Yes ☐ No (if yes explain)

_____

Clients who are accepted to the Kewa House will be screened to do assessment for the 0-5 years old. (ASQ) Ages and Stages of Questionnaire Assessment for early intervention.

Can your child do the following: ☐Roll Over ☐Crawl ☐Sit Alone ☐Smile ☐Cooing/Babbling ☐Cries when Diaper Change/or is Hungry ☐Stand Alone ☐Walk Alone ☐Say single Words/Phrases ☐Short sentences ☐Feeds Self ☐Dresses Self ☐Toilet Trained ☐Run ☐Jump

Are there any Developmental concerns currently that we need to know?

_____

_____

_____

Communication Development:

Does client communicate by:(check all that apply)? ☐ Crying ☐Playful sounds ☐Pointing with index fingers ☐☐Words ☐Phrases ☐ Sentences ☐Sign Language ☐Picture Communication ☐Eye pointing ☐Electronic ☐talking devices.

How much of the clients speech is understandable to you? ☐Some ☐Most ☐All

How much of the client's speech is understandable to others? ☐Some ☐Most ☐ All

What are some things the client say's currently (give examples of speech)

_____

_____

NUTRITION AGE 0-6:

Is client currently enrolled with the Woman Infant Children Program? ☐Yes ☐No (if yes indicate which tribe program enrolled) _____

Is client currently Breastfeeding? ☐Yes ☐NO (how long?) _____

Is client nursing from bottle? ☐Yes ☐NO (if yes is there a special and/or specific bottle) _____

Is client using Sippy Cup? ☐Yes ☐No

Is client eating baby food? (6months and older) ☐Yes ☐No

Is client allergic to any other Formula Brand? ☐Yes ☐No (if yes indicate what brand) _____

Is client allergic to any Baby cereal? ☐Yes ☐No (if yes, indicate) _____

Does client feed him/herself? ☐Yes ☐NO (if yes, please explain) _____

Does Client (8 months and older) use Open Cup? ☐Yes ☐NO

Does Client feed her/himself with utensils? ☐ Yes ☐ No

DIAPER:

Does client easily get diaper rash when using SPECIFIC diapers? ☐Yes ☐No (if yes indicate brand)

_____

Is client allergic to Diaper Rash Cream? ☐Yes ☐NO (if yes indicate brand and which brand you prefer to use)

_____

CLIENT AUTHORIZED CONTACT INFORMATION

Client Name: _____Parent/Legal Guardian/Referring Agency: _____
Phone: _____
Caseworker/Probation Officer: _____ Phone: _____
Agency On-call: _____ Phone: _____
To protect the confidentiality of residents from unwanted calls or visitors, staff will refer to the Authorized Contact List prior to allowing incoming and outgoing contact. All visits/passes (day and night passes) must be approved by the parent/legal guardian and/or agency. Visitors must abide by all Covid-19 restrictions. Zoom meetings/ or phone call visits may be available if needed. Visitor(s) must be over the age of 18. Visitor(s) under the age of 18 must be accompanied by authorized adult.

Authorized Phone Calls: Phone calls are limited to 10 minutes and are monitored.

Name	Relationship	Contact Number

Authorized Visitors: Visitors must check-in upon arrival and show proof of a valid state issued identification card (over the age of 18).

Name	Relationship	Contact Number

Authorized Check-Out: Check-out must be approved and communicated with all parties involved. Authorized adult taking child must show proof of valid state issued identification card and documentation from referring agency giving permission.

Name	Relationship	Contact Number

Any additions and/or deletions of individuals may only be done by parent/legal guardian or referring agency in writing.

I, the client, and parent/legal guardian agree to the above list of authorized contacts.

Client Signature: _____ Date: _____

Parent/Legal Guardian/Referring Agency: _____ Date: _____

Client ID #_____

CONSENT FOR CARE AND SERVICE OF A MINOR

I, the undersigned Parent/Legal Guardian, hereby consent Kewa House Emergency Youth Shelter with the physical address of 9 Cedar Tree Park Santo Domingo, N.M. 87052 the authority to obtain medical treatment and provide care for the following child: _____

(*Print clients name*)

The above care provider shall have the authorization to:

- Obtain and provide counseling services by licensed clinicians.
- Obtain educational services including but not limited to, school or education program enrollment, IEP services, immunization requirements, and sports physicals.
- Obtain medical treatment and procedures for the client as may be appropriate for medical, vision, and dental check-ups by physicians, hospital, and clinic personnel as well as other appropriate health care providers.
- Obtain medical treatment and procedures for the client as may be appropriate in emergency circumstances, including treatment by physicians, hospital and clinic personnel, and other appropriate healthcare providers.
- Obtain routine medical treatment from appropriate healthcare providers if symptoms of illness occur.
- File legal reports for the client in instances including but not limited to absconding from shelter, abuse, and neglect. (Mandated reporting)

This consent of temporary authority shall begin on _____/_____/_____ and shall remain effective until terminated by the undersigned.

Client Name: _____

DOB: _____

Parent/Legal Guardian, Referring Agency Name: _____

Signature: _____

Kewa House Staff Name: _____

Signature: _____

Please provide Clients health insurance information below

Insurance Co.: _____

Policy Number: _____

Policy Holder: _____

Client ID #_____

CONSENT/AUTHORIZATION
FOR OVER-THE-COUNTER MEDICATION

I, the parent and/or legal guardian of _____, acknowledge that Kewa House must implement a protocol for allowing over the counter medication to be provided at the facility if needed.

☐ **DO NOT AUTHORIZE** Kewa House Emergency Youth Shelter to administer any over the counter medication.
☐ **AUTHORIZE** Kewa House Emergency Youth Shelter to administer over the counter medication as directed. I do understand that if any complications occur that the Kewa House Emergency Youth Shelter will not be held responsible, but with the understanding that proper medical attention will be provided.

The following list of items are over the counter and first aid relief medications available on the premises for use without being prescribed by a physician:

First Aid Cream
Hydrocortisone
Lip Aid Ointment
Dental Relief (orajel)
Lubricant eye drops
Aleve 220mg
Triple Antibiotic
PepTum 262mg
Imodium 2mg
Ibuprofen 200mg
Excedrin 250mg
Tylenol 250mg
Cold Relief 325mg
Tums Antacid 5mg
Aspirin 325mg
Cough Drops 7.5mg
Hydrogen Peroxide
Antiseptic Spray
Burn Spray
Instant cool cold spray
Muscle relief gel

THERE MAY BE ADDITIONAL MEDICATIONS USED BUT NOT LISTED

***For clients ages 0-6, Kewa House staff will set an appointment for client to be seen by a Pediatrician at the Kewa Health Center.**

Client signature: _____ Date: _____

Parent/Legal Guardian/Referring Agency Signature_____ Date: _____

Kewa House Staff: _____ Date: _____

Client ID #_____

CLIENT RIGHTS AND POLICIES

Kewa House supports, protects, and enhances the rights of the clients. Kewa House does not make discriminatory distinction for refusal, admission, or services to any referral based solely on consideration of tribe, religion, ancestry, sex, physical or mental handicap.

Client Rights

1. The right to privacy and confidentiality of client records
2. The right to preparation and maintenance of accurate and complete records during the clients' association with the facility Kewa House.
3. The right to place in a manner consistent with the least restrictive environment
4. The right to reasonable access to a legal custodial and a family member through visitations, video conferencing, telephone access and opportunity to send and receive mail when deemed appropriate
5. The right to receive authorized visitors on program schedule visiting days
6. The right to utilize personal possessions allowed by facility
7. The right to follow or abstain from the practice of religion
8. The right to reasonable daily opportunities for physical and outdoor exercise
9. The right to a nourishing, well-balanced, varied, appetizing diet, clothing, and housing
10. The right to prompt and adequate medical attention
11. The right to clean, safe, and comfortable environment
12. The right to a free public education and services
13. The right to dignity and respect
14. The right to express opinions
15. The right to receive adult guidance, supervision, and support
16. The right to protection from harm

Conditions of these rights due to the treatment or program plan, or to protect the health, safety, and welfare of the child, must be clearly documented in the client's file. These rights are in accordance with the New Mexico Children's Code **32a-6a-12.**

I understand the limits to confidentiality include the following

1. Disclosure of Child abuse and/or neglect
2. Disclosure of risk to self or others

I acknowledge that I have read and understand the youth rights policy and that I have been given a copy of Kewa House notice of privacy practice.

Parent/ Legal Guardian/ Referring Agency Signature: _____

Client Signature: _____

Kewa House Staff Signature: _____

Client ID #_____

KEWA HOUSE– Notice of Privacy Practices

This notice informs how confidential information may be disclosed and how clients gain access to this information. Please review it carefully. Clients have the right to obtain a paper copy of this notice upon request.

For additional information, please contact The Kewa House Manager Didra Humetewa: *didra.humetewa@kewa-nsn.us* or Kewa Family Wellness Center Director Craig Sandoval: *craig.sandoval@kewa-nsn.us*

Client Behavioral Health Information – Under Federal Law, Client behavioral health information is protected and confidential. Client behavioral health information, which is archived or up to fifteen (15) years, includes intake information, progress notes, treatment and service plans, evaluations, diagnosis, and other treatment and/or service summaries.

Client Behavioral Health Information

Treatment: Kewa House will continue to support and follow the youth's treatment plan created by primary behavioral health provider.

Behavioral Health Care Options: Kewa House may disclose client health information to conduct standard operations, including proper administration of records, evaluations of service quality, and to assess the service outcomes for clients served.

Appointment Reminders: Kewa House will record client appointments and contact referring agency for arrangements for client scheduled appointments.

As required by law: Kewa House will disclose appropriate client health information in compliance with HIPAA regulations when required in the event of suspected child abuse and neglect as required by Federal, State, or local law.

Behavioral Health Oversite: Kewa House may disclose client information in compliance to HIPAA regulations to behavioral health oversite agencies for authorized use by law. (i.e. audits, investigations, inspections, and licensure).

Judicial and administrative Proceedings: Kewa House may release client information in response to appropriate court orders, subpoenas, warrants, or summons.

Client Rights

Clients, guardians, and/or legal guardians have rights to client personal health information.
The following describes client rights and how to exercise them:

Right to Inspect and Obtain Copies:

Client, guardian(s), and/or legal guardian(s) have the right to view and request duplicate personal health information in client service and billing records. This right does not include the right to view and duplicate charting notes. To view and duplicate client personal health information, client must submit request in writing to Kewa House Program Manager. In certain limited circumstances, we may deny your request to inspect and copy your record. If request is denied, client may request in writing an appeal to the Program Manager and Kewa Family Wellness Center Director.

Client ID #_____

KEWA HOUSE-Notice of Privacy Practices continued

Right to Amend Your Information:
If a client, guardian(s), and/or legal guardian(s) believes the information his/her record is incorrect or incomplete, a client, guardian(s), and/or legal guardian(s) may request any information to be amended. To request an amendment, request must be made in writing, submitted to Kewa House Program Manager, and must contain a reason that supports request for amendment. We may deny client request for amendment if information was not created by Kewa House Staff and is not part of the information which would be permitted to view and duplicate.

Right to an accounting of Disclosure:
A client, guardian(s), and/or legal guardian(s) may request a list of instances where Kewa House has properly disclosed in accordance with HIPAA regulations of client health information for reasons other than treatment, payment, or behavioral health care operations. Client, guardian(s), and/or legal guardian(s) must submit request in writing to Kewa House Program Manager. Client, guardian(s), and/or legal guardian(s) must state a time, which may not be more than six years.

Right to request restrictions:
Client, guardian(s), and/or legal guardian(s) may request restriction on certain uses and disclosures of client health information. Kewa House is not required to agree to such restrictions, if in agreement, Kewa House will abide by restrictions. To request restriction, client must take request in writing to Kewa House Program Manager, stating what information client wants to limit and to whom limits apply.

Right to confidential communications:
Client, guardian(s), and/or legal guardian(s) has the right to request the way Kewa House communicates any client information. For example, client, guardian(s), and/or legal guardian(s) can request that we only correspond by mail to a specific address, fax, or by phone. To request confidential communication, client, guardian(s), and/or legal guardian(s) must submit request in writing to Kewa House Program Manager. Kewa House will accommodate all reasonable requests.

Legal Duty
Kewa House is required by law to protect and maintain the privacy of client information. The Privacy Notice will be posted in facility. Client, guardian(s), and/or legal guardian(s) may also request a copy of this notice at any time. For more information about Kewa House privacy practices, please contact Kewa House Program Manager.

Complaints
If client, guardian(s), and/or legal guardian(s) is concerned that Kewa House has violated client privacy rights client, guardian(s), and/or legal guardian(s) may contact Kewa House Program Manager. Client may also send a written complaint following the organizational structure. The Kewa House Program Manager will provide client, guardian(s), and/or legal guardian(s) with appropriate information. Client will not be penalized in any way for filing a complaint.

Client ID #_____

RELEASE OF LIABILITY

I, _____, release the Kewa House Emergency Youth Shelter and staff of any claims, demands, causes of action, and judgement of civil liability of any kind arising out of any (including but not limited to) delivery of services to minor.

Responsibility for Personal Belongings

I understand that Kewa House Youth Shelter takes no responsibility for the damage or theft of client's personal property. Client's property will be inventoried and stored for safe keeping in a locked area. In the event a client leaves the program without following appropriate discharge procedures, Kewa House holds no responsibility for the retention or orderly return of belongings to the client, guardian(s), and/or legal guardian(s). If a client runs away or is involuntary removed from the facility, Kewa House will store belongings and unclaimed property will be returned to referral agencies.

Household Damage Policy

Any damage done to Kewa House facility or furnishings will be the responsibility of the parent/ legal guardian and/or referring agency in the event that a client causes any damage to the shelter.

Signatures

Client: _____ Date: ____/___/_____

Parent/Legal Guardian/Referring Agency: _____ Date: _____/____/_____

Kewa House Staff: _____ Date: _____/____/_____

Client ID #_____

Authorization for Release of Information

I, _____, hereby give my permission for Kewa House Emergency Youth
(Parent/Guardian/Agency)
Shelter to receive from/ and release to:

Name of Agency: _____ Name of Agency: _____
Contact Person: _____ Contact Person: _____
Address of Agency: _____ Address of Agency: _____
Phone & Fax: _____ Phone & Fax: _____

Name of Agency: _____ Name of Agency: _____
Contact Person: _____ Contact Person: _____
Address of Agency: _____ Address of Agency: _____
Phone & Fax: _____ Phone & Fax: _____

The following information regarding: _____
(Name of client)

Description of information to be disclosed:
(Client should check each item to be disclosed)

☐Medical Information ☐Legal/Judicial/Court records ☐Progress Notes ☐School Records
☐Psychiatric or Psychological Evaluations ☐Follow up ☐CYFD Documents ☐Treatment Plan or Summary
☐Demographic information ☐Continuing Care Plan ☐Assessment and Diagnosis ☐Treatment Participation
☐Other: _____

The purpose of disclosure authorized herein is to: Facilitate case staffing, collaborate program planning, and establish discharge goals.

I understand that my records are protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPPA), 45C.F.R Parts 160 &164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by HIPPA privacy law.

Kewa House Emergency Youth Shelter is hereby released from any legal liability that arises from this disclosure once the Parent/guardian/agency or client has signed voluntarily. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken on the consent, and that in any event this authorization expires automatically as follows. The Consent of Release is valid for (1) year (12 months). After 12 months, consent must be renewed.

I understand that the covered entity seeking authorization will not condition services on whether I sign the authorization. I understand I am entitled to receive a copy of this authorization after it is signed.
_____I would like a copy of this release. _____I decline to accept a copy of this release.

_____ _____ _____ _____
Signature of Parent/Guardian/Agency Date Signature of Client Date

_____ _____
Signature of Kewa House Staff Date

Client ID #_____