CHILDHAVEN
SERVICES INQUIRY
(AGES 0-21 YEARS)

Child's Name: _____ **Date:** _____

Child's Date of Birth: _____ **Child's Race/Ethnicity:** _____

Child's Primary Language: _____**Child's Telephone:** _____

Child's Current Address: _____

Child's Current Residence: ☐ Shelter ☐ Group Home ☐ Juvenile Justice ☐ Foster Care
☐ Family/Biological/Adoptive Home ☐Relative/Other: _____

Caregiver/Contact Person Name: _____

Name/Relationship of Person Making this Service Inquiry: _____

Telephone: _____ **Agency:** ☐ Social Services ☐ Probation ☐ FI/FA ☐ Other: _____

Authorization for Release of Protected Information (Check either written or verbal below)

☐ **Written Authorization**

I _____ agree to release the information on this form to Childhaven, Inc. This information will
(Legal Guardian)
be used to determine which services are required. I understand that I may cancel this authorization at any time by submitting a *written* request to Childhaven, except where a disclosure has already been made in reliance on my prior authorization.

Signature: _____ Date: _____ Relationship to Client: ☐Client ☐Parent/Legal Guardian

☐**Verbal Authorization**

Client/guardian gave verbal consent over the phone to release this information to a Childhaven staff.

Name of person giving verbal consent**:** _____ Relationship to Client: ☐Client ☐Parent/Legal Guardian

Signature/Title of Childhaven Staff: _____ Date: _____

FORM INSTRUCTIONS

1. Check the applicable box for each question on page 2.
2. If "YES" is checked, **circle all behaviors that apply**. Failure to circle the appropriate behaviors will result in your services inquiry being marked "INCOMPLETE".
3. This list is not exhaustive. If you have a question about whether to check "YES," please indicate the issues under the COMMENTS section or you can call us at 505-592-0630.
4. You can return this form to 406 Airport Rd. Farmington NM 87401 or fax to 505-564-8368.

COMMENTS AND/OR ADDITIONAL INFORMATION:

_____

_____

_____

_____

This tool was adapted from the Mental Health Screening Tool created by the California Institute for Mental Health and will assist us in our assessment of child's needs.

Client Name: _____ DOB: _____

Yes	No	Topic	Over 90 days ago
☐	☐	1. Has this child been a danger to him/herself or to others in the last 90 days? **Circle all that apply:** Attempted suicide; made suicidal gestures; expressed suicidal ideation; assaultive to other children or adults; reckless and/or puts self in dangerous situations; attempts to or has sexually assaulted or molested other children.	☐
☐	☐	2. Has this child experienced severe physical or sexual abuse or has s/he been exposed to extreme violent behavior in the last 90 days? **Circle all that apply**: Subjected to or witnessed extreme physical abuse, domestic violence or sexual abuse, e.g., severe bruising in unusual areas, forced to watch torture or sexual assault, witness to murder.	☐
☐	☐	3. Does this child have behaviors that are so difficult that maintaining him/her in his current living or educational situation is in jeopardy? **Circle all that apply**: Persistent chaotic, impulsive or disruptive behaviors; daily verbal outbursts; excessive noncompliance; constantly challenges the authority of caregiver; requires constant direction and supervision in all activities; requires total attention of caregiver; overly jealous of caregiver's other relationships; disruptive levels of activity; wanders the house at night; excessive truancy; fails to respond to limit setting or other discipline.	☐
☐	☐	4. Has the child exhibited bizarre or unusual behaviors in the last 90 days? **Circle all that apply**: History or pattern of fire-setting; cruelty to animals; excessive, compulsive or public masturbation; appears to hear voices or respond to other internal stimuli (including alcohol or drug induced); repetitive body motions (e.g., head banging) or vocalizations (e.g., echolalia); smears feces.	☐
☐	☐	5. Does the child have problems with social adjustment? **Circle all that apply**: Regularly involved in physical fights with other children or adults; verbally threatens people; damages possessions of self or others; runs away; truant; steals; regularly lies; mute; confined due to serious law violations; does not seem to feel guilt after misbehavior.	☐
☐	☐	6. Does this child have problems making and maintaining healthy relationships? **Circle all that apply**: Unable to form positive relationships with peers; provokes and victimizes other children; gang involvement; does not form bond with caregiver, etc	☐
☐	☐	7. Does this child have problems with personal care? **Circle all that apply**: Eats or drinks substances that are not food; regularly enuretic (wets pants) during waking hours (subject to age of child); extremely poor personal hygiene.	☐
☐	☐	8. Does this child have significant functional impairment? **Circle all that apply**: No known history of developmental disorder and behavior interferes with ability to learn at school; significantly delayed in language; "not socialized" and incapable of managing basic age appropriate skills; is selectively mute.	☐
☐	☐	9. Does this child have significant problems managing his/her feelings? **Circle all that apply**: Severe temper tantrums; screams uncontrollably; cries inconsolably; significant and regular nightmares; withdrawn and uninvolved with others; whines or pouts excessively; regularly expresses the feeling that others are out to get him/her; worries excessively and preoccupied compulsively with minor annoyances; regularly expresses feeling worthless or inferior; frequently appears sad or depressed; constantly restless or overactive; etc.	☐
☐	☐	10. Does this child have a history of psychiatric hospitalization, psychiatric care and/or prescribed psychotropic medication? **Circle all that apply**: Child has a history of psychiatric care, either inpatient or outpatient, or is taking prescribed psychotropic medication.	☐
☐	☐	11. Is this child known to abuse* alcohol and/or drugs? **Circle all that apply** Child regularly uses alcohol or drugs. *It is NOT abuse if drug use is part of a religious practice or spiritual ceremony that is approved by tribal leaders or a medicine person and is a common practice in traditional ways.	☐
☐	☐	12. Has this child experienced abuse, neglect or abandonment in the last 90 days? **Circle all that apply**: Subjected to the removal from their home and placed in alternative custody. (i.e. relatives home or shelter).	☐
☐	☐	13. Has this child had a Forensic Interview at Childhaven? **Circle all that apply:** Child has had an interview in the last 3 months, 6 months, 12 months, or over a year. If known, interview date:_____	☐

*revised 2/14/20

INITIAL INTAKE RECORD

Date of Intake: _____ Intake Time: _____

CLIENT IDENTIFYING DATA

Client Name: _____

DOB: _____ Age: _____ Gender: Female ☐ Male ☐ Trans-MTF ☐ Trans - FTM ☐ Genderqueer-Trans ☐ Decline to Answer ☐

Sexual Orientation: Heterosexual ☐ Bisexual ☐ Asexual ☐ Gay ☐ Lesbian ☐ Pansexual ☐ Queer ☐ Other ☐ Decline to Answer ☐

Physical Address: _____ City/State/Zip: _____

Mailing Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Does the client have children? [Yes] [No]

Race: (Circle one.)
Asian, African American, Anglo, American Indian, Multi-Racial Tribal Affiliation: _____

Ethnicity: Hispanic / Non-Hispanic Census #: _____

Primary Language: _____ Secondary Language: _____

SCHOOL INFORMATION

School Name/Address: _____

Grade: _____ IEP: ☐Yes ☐No If Yes, details: _____

Status: ☐Attending ☐Suspended ☐ Dropped/Withdrew ☐Expelled ☐Other: _____

Can client attend school ASAP? ☐Yes ☐No (If No, staff will contact Social Worker for approval)

COMMENTS OR CONCERNS:

_____

_____

_____

INSURANCE INFORMATION

Medicaid: ☐Yes ☐No ☐ Private Insurance: _____

Medicaid Type: ☐ BCBS ☐ Presbyterian ☐ WesternSky ☐ FFS ☐ Other: _____

Group or ID #: _____

SSN #: _____ Eligibility Status: _____

MEDICAL INFORMATION

Primary Care Physician: _____ Phone #: _____

Primary Care Physician Address: _____

Client Name: _____ DOB: _____

City _____ State _____ Zip Code _____

Psychiatrist: _____ Phone #: _____

Emergency Contact Name: _____ Phone #: _____

☐I **DO** or ☐ **DO NOT** authorize communication between my PCP and Childhaven, Inc.

☐I **DO** or ☐ **DO NOT** authorize communication between my psychiatrist and Childhaven, Inc.

Advanced Directives

Advanced Directives are a document for individuals 18 years of age and older, in which you give instructions about your healthcare, what you want done or not done, if you cannot speak for yourself. Advanced directives have been explained to me and:

☐ I have an Advanced Directive in place and have provided a copy to Childhaven
☐ I would like information/forms on Advanced Directives
☐ I choose to not receive information/forms on Advanced Directives
☐ I am not 18 years of age or older

MEDICATION/OTC/HERBAL/VITAMINS

☐ No medication used at this time.

Name of Medication	Dosage/Frequency	Reason	Side Effects

Allergies/significant medical conditions/chronic illnesses:

_____

Medical/Dental issues that require immediate attention:

_____

RESPONSIBLE PARTY INFORMATION

Legal Guardian: _____ Relationship to client: _____

DOB: _____ SSN: _____

Address (complete if the address is different from client's address)

Number/Street: _____

City: _____ State: _____ Zip Code: _____

Home or Cell: _____ Work Phone: _____

Employer Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Mother: _____ ☐Natural ☐Adoptive ☐Step ☐Foster

DOB: _____ SSN: _____

Address (if the address is different from client's address)

Number/Street: _____

Client Name: _____ DOB: _____

City: _____ State: _____ Zip Code: _____

Home or Cell: _____ Work Phone: _____

Employer Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Father: _____ ☐Natural ☐Adoptive ☐Step ☐Foster

DOB: _____ SSN: _____

Address (if the address is different from client's address)

Number/Street: _____

City: _____ State: _____ Zip Code: _____

Home or Cell: _____ Work Phone: _____

Employer Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

OTHER CONTACTS

Stepparent/s: _____ Phone Number: _____

Foster/Adoptive Parent(s): _____ Phone Number: _____

JPO: _____ Phone Number: _____

Social Worker: _____ Agency: _____

Other: _____ Title: _____ Phone Number: _____

Please check all the ways we may contact you: ☐ Call Home ☐ Call Work ☐ Cell: Call or Text ☐ Other

☐ Email Address: _____

Can we identify ourselves as **Childhaven** if we call you? ☐ Yes ☐ No

HOUSEHOLD COMPOSITION

Name	Age	Gender	Relationship

Household Income per month: _____ Assistance: _____

Responsible Party: _____

Client Name: _____ DOB: _____

REASON CHILD IS IN NEED OF SERVICES

Circle all that apply:

Neglect	Suspected Physical Abuse	Suspected Sexual Abuse	Court Order
Runaway/Homeless Youth	Disrupted Foster Home	Witness of Crime	Family Problems
Adult Arrested - DV	Adult Arrested - Alcohol or Drugs	Child - Alcohol or Drugs	Mental Health Issues Adult Child
Other:			

Brief description: _____

Physical or Sexual Abuse (if yes, by whom and when)? _____

Has this been reported to Law Enforcement? _____

Was a Forensic Interview conducted, if yes, when? _____

By signing below you agree to the best of your knowledge you have advised Childhaven of all medical/mental issues of which you are aware. If any issues arise that might affect the safety or well-being of this child/youth or any other clients/staff in this facility it could cause immediate removal from certain services.

Legal Guardian (print name): _____ Date: _____

Signature: _____ Phone: _____ Cell: _____

Client Signature (14+ years old): _____ Date: _____

FOR SHELTER USE ONLY:

Lead Intake Agency: ☐CYFD/State ☐Law Enforcement ☐Tribal: _____

Law Enforcement Signature: _____ Print Name: _____

Law Enforcement: ☐FBI ☐Aztec ☐Bloomfield ☐Farmington ☐Sheriff ☐Tribal ☐Other: _____

☐I DO want to place this child on a 48 hour hold -- CALL SCI 1 - 800 - 797 - 3260

☐I DO NOT want to place this child on a 48 hour hold -- child may be released to: _____

**SCI does not need to be called.

Who called child into (State Centralized Intake) SCI: _____

Name of SCI worker: _____ Date: _____ Time: _____ am/pm

Social Worker (print name): _____ Date: _____

Signature: _____ Phone: _____ Cell: _____

Method of Payment: ☐ CBH ☐ Navajo Nation ☐ CYFD ☐ Private Pay: _____
☐ Other: _____

Staff Signature: _____ **Date:** _____

Client Name: _____ DOB: _____

Childhaven
Consent for Treatment

I, _____, having legal custody of
(Parent/Guardian Printed Name)
_____, a minor, do consent and
(Minor/Client Printed Name)
authorize Childhaven and its agents to provide services to said minor on my behalf. I understand that these services will include but not be limited to therapeutic services as well as various mental health assessments conducted by appropriate, qualified person(s) and/or other agencies upon referral by Childhaven.
I, _____, having legal custody of said
(Parent/Guardian Printed Name)
minor, release Childhaven and its agents of any claims, demands, causes of action, judgments or civil liability of any kind arising out of any program activities, care, or treatment including but not limited to delivery of services to said minor. Services may include one or more of the following programs: Shelter, Respite, Family Advocate, and Outpatient Behavioral Health (including individual and/or family therapy).

I understand that any consent given may be withdrawn in writing at any time and will be documented as part of the client's record. I understand that if consent is revoked, treatment must be promptly discontinued, except in cases in which abrupt discontinuation of treatment may pose an immediate risk. In such cases, I understand that treatment may be phased out to avoid any harmful effects.

I have been informed that I will be contacted regarding any changes of health of said minor. I have also been informed that all information on individuals served by this program is strictly confidential and except as noted above cannot be released without consent of the individuals and/or guardians, within the guidelines of the Freedom of Information Act.

I have been informed that the staff must notify the appropriate authorities if it is determined that the client may be a danger to his/herself or others and in matters of abuse/neglect.

_____ _____
Signature of Legal/Physical Guardian Date

_____ _____
Signature of Minor (if over the age of 14) Date

_____ _____
Witness Date

Client Name:	DOB:	Date of Admission:

CHILDHAVEN CONSENT TO RELEASE
CONFIDENTIAL BILLING INFORMATION

I, _____ _____
Name of Parent/Legal Guardian Agency (if applicable)

Hereby authorize Childhaven to release information concerning my child/client:

_____ _____
Client's Name Date of Birth

I authorize Childhaven to release basic demographic information for purposes of billing services & reporting outcomes regarding the client's services to the following: Tribal Social Services, The State of New Mexico, Managed Care Organization (Presbyterian, WesternSky or Blue Cross Blue Shield), San Juan County and other funding sources.

I understand that I may revoke this authorization at any time by giving written notice to Childhaven. However, I also understand that any information prior to my revoking this authorization shall not be considered a breach of my right to confidentiality. I have a right to examine and copy the information to be disclosed unless Childhaven determines that such disclosure may not be in my best interest and has so documented my record. This authorization unless revoked prior to such time, shall expire 18 months from discontinuation of Childhaven services.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

Client Name:	DOB:	Date of Admission:

CHILD'S RIGHTS

Each child shall have personal rights which include but are not limited to the following:

1. To be treated with respect, dignity, consideration, and compassion.

2. To receive services free of discrimination on the basis of race, color, sex/gender, ethnicity, national origin, religion, age, class, sexual orientation, physical and or mental ability.

3. To be provided with a humane psychological and physical environment. The child shall be provided safe, healthful and comfortable accommodations, furnishings and equipment that are appropriate to his/her needs and access to individual storage space for his/her private use including bed, linens and secure storage. **

4. Reasonable daily opportunities for physical exercise and outdoor exercise and reasonable access to recreational areas and equipment, including equipment adapted to the child's developmental and physical needs. Access to a nourishing, well-balanced, varied and appetizing diet.

5. To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature including, but not limited to, interference with the daily living functions of eating, sleeping, or toileting, withholdings of shelter, clothing or aids to physical functioning.

6. To not be subjected to physical, sexual, verbal and /or emotional abuse or threats. Freedom from adverse stimuli and substantial deprivation with access to protection and advocacy system.

7. To be free to attend religious/cultural services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice or to abstain from the practice of religion.

8. Not to be locked in any room, building or facility by day or night. **

9. To participate in the creating of a plan which outlines services you choose to receive. A child fourteen years of age or older is presumed to have capacity to consent to treatment without consent of the child's legal guardian.

10. To be informed about services and options available to you including a physical exam upon admission unless within 6 months with a complete physical every 12 months after. Prompt and adequate medical attention for a physical ailment.

11. To reach an agreement with Childhaven staff about the frequency of contact you will have, either in person or over the phone.

12. To withdraw your voluntary consent to participate in services.

13. To have your records to treated with confidentiality according to applicable laws.

14. To have information released only in the following circumstances:
    - When you sign a written release of information;
    - When there is a medical emergency;
    - When a clear and immediate danger to you or to others exists;
    - When there is possible child or elder abuse and/or
    - When ordered by a court of law.

Homes/Facilities shall not be prohibited by this provision from locking exterior doors and windows or from establishing house rules for protection of the children so long as the children can exit from the residence/facility.

15. To be free of the administration of medication or chemical substance not authorized by a physician.

Name:	**DOB:**	**DOA:**

16. Informed consent of a child's legal custodian shall be obtained before treatment or habilitation, including psychotherapy or psychotropic medications for children under 14. Psychotropic medications may be administered to a child 14 years or older with the informed consent of the child and the child's legal guardian will be notified.

17. To file a grievance about services you are receiving or denial of services.

18. To receive visitors of the child's own choosing on a daily basis, as approved by legal guardian or court order during designated times, provided the rights of others are not infringed upon including but not limited to attorney, physician Clients have the right NOT to visit with someone. **

19. Reasonable access to a legal custodian and a family member through visitation, videoconferencing telephone access and opportunity to send and receive mail.

20. To wear his/her own clothes. **

21. To possess and control his/her own cash resources, unless otherwise agreed to in the child's service plan with the child's authorized representative. Childhaven staff/volunteer/contractor may counsel and advise clients on money management and savings. **

22. To have access to his/her own appropriate personal possessions and toiletries. **

23. To have access to a telephone, make and receive phone calls, provided that such calls are not prohibited by court order or by the child's authorized representative, in accordance with house rules. Cell phone use is restricted. **

24. To have access to writing materials and postage stamps reasonably available for the child's use. To send and receive correspondence unless prohibited by court order or by the child's authorized representative. **

25. Work: a child shall not be permitted to work in any job that does not comply with the Fair Labor Standards Act of 1938.

26. Chores: children shall be assigned household chores appropriate to their age and developmental level. Chores cannot be used as a form of discipline. **

27. Motor Vehicles: No Childhaven staff/contractor/volunteer may imply or give permission in any way, shape or form for youth to take Drivers Education, obtain a Driver's License or be allowed to drive a Childhaven staff/volunteer/contractor car. Approval from authorized representative is required for the use of motor vehicle, for further information see Childhaven Transportation Policy and Procedure. **

28. To have information released when you sign a written release of information, when there is a medical emergency, when a clear and immediate danger to you or to others exists, when there is possible child or elder abuse, or when ordered by a court of law.

29. Be placed in a manner consistent with the least restrictive means possible.

30. Prompt and adequate medical attention for a physical ailment.

31. A free public education. In no event shall a child be allowed to remain in an out-of-home treatment or habilitation program for more than ten days without receiving educational services.

32. A child and the child's legal guardian shall be provided notice of rights immediately upon admission to such program.

NOTE: "Authorized representative" refers to "any person or entity authorized by law to act on behalf of the child." Such a person or entity may include but not be limited to the child's parent, a legal guardian, or conservator.

** *Denotes clause does not apply to any Childhaven community-based program.*

Name:	**DOB:**	**DOA:**

As a participant in Childhaven Services, you have the responsibility…

1. To treat other clients and staff of this program with respect and courtesy.
2. To protect the confidentiality of other clients you encounter at this agency.
3. To participate as much as you are able in creating your service plan.
4. To let Childhaven staff know any concerns you have about your service plan or changes in your needs.
5. To make and keep appointments to the best of your ability, or if possible to phone to cancel or change an appointment time.
6. To stay in communication with Childhaven by informing us of changes in your address or phone number and responding to our calls or letters to the best of your ability.
7. To not subject staff or other clients to physical, sexual, verbal and/or emotional abuse or threats.

NOTE: By signing below you acknowledge that you have received, read, and understand this document.

_____	_____
Signature of Child/Youth	Date
_____	_____
Childhaven Staff/Contractor	Date
_____	_____
Childhaven Staff/Contractor	Date
_____	_____
Childhaven Staff/Contractor	Date
_____	_____
Legal Guardian	Date

Name:	**DOB:**	**DOA:**

Childhaven
Client Grievance Procedure

Policy:

Childhaven provides clients with an acceptable means of expressing any complaints or concerns they may have with a Childhaven service, staff, volunteer, and/or contractor.

Procedure:

If a client or legal guardian has a concern regarding a Childhaven service, staff, volunteer, or contractor they should make the program aware of their concern/grievance. Initially, this may be addressed verbally with the Program Director. If the client or legal guardian does not feel the matter was resolved, the client/ legal guardian may submit a written grievance to Childhaven, 807 W. Apache Street, Farmington, NM 87401. All written grievances will be placed in the mailbox of the appropriate Program Supervisor. Within 72 hours of receipt, the Program Director will contact the client to discuss the matter. The Program Director's decision will be in writing, with copies placed in the client's file and sent to the client, no later than 10 working days. All verbal and written grievances will be addressed by the agency's Continuous Quality Improvement Committee to ensure satisfactory follow-up and agency-wide improvement of services, when necessary.

If the Program Supervisor does not satisfy the client/legal guardian's needs, the client/legal guardian may forward the grievance in writing to the Chief Executive Officer. The Chief Executive Officer will then investigate the complaint and contact the client/legal guardian within 10 working days. The Chief Executive Officer's decision will be in writing, with copies placed in the client's file and sent to the client/legal guardian, no later than 10 working days of notification. The decision of the Chief Executive Officer will be final.

Clients/legal guardians whose concerns are not satisfactorily addressed by the agency's administration have the ability to contact the agency's funding sources with grievances. These may be found on our website: www.childhavennm.org.

I have read and understand the Childhaven Client Grievance Procedures.

_____
Client Signature Date

_____
Parent/Guardian Signature Date

_____
Witness Signature Date

Client Name:	DOB:	Date of Admission:

CHILDHAVEN
APPOINTMENT CANCELLATION AND NO-SHOW POLICY

The goal of our services at Childhaven, Inc is to provide support to you and your family which help you reach your goals. As part of our commitment to you, we strive to fulfill your appointment needs. We ask that you make a commitment to treatment by attending scheduled appointments and arriving to appointments on-time. In order to continue to meet your needs, we found that it has become necessary to implement a "no-show and cancellation" policy when clients fail to keep their scheduled appointment.

Therapy

- Once a client has three (3) no show or late cancelled appointments, the client will be discontinued from Childhaven therapy services and referred to another agency.
- When the client or client's guardian has missed two (2) appointments, and phone contact is successful, the Childhaven Services Coordinator will discuss a better time and day of week for future appointments.
- If the client's guardian declines services after the assessment is completed, the file will be transferred to the Family Advocate if applicable and they will continue checking in with family from that point on.
- Client may be able to reschedule services after a six-month period if they are able to abide by this policy.
- If you find you cannot keep an appointment, our Services Coordinator will work with you to reschedule for a time that better meets your needs. We thank you in advance for taking the time to notify Childhaven of changes to your schedule in a timely manner and Childhaven we will make every effort to accommodate client scheduling requests.

Assessments

- Once a client has two (2) no show assessment appointments, the client will be discontinued from Childhaven outpatient therapy services and referred to another agency. Client will be able to reschedule services after a six-month period.

In order to avoid this result:

- Therapist or Services Coordinator will call the morning of the scheduled assessment and the Therapist will call evening before/morning of the first few reoccurring scheduled therapy sessions to remind client/clients guardian of the appointment.
- If you must miss an appointment, please contact Childhaven at least 24 hours in advance (or by 3 p.m. on Friday for a Monday appointment).
- Appointments that are not cancelled at least 24 hours in advance are considered "NO SHOWS"
- Exceptions to this policy are emergencies and/or unavoidable circumstances as determined by Childhaven.
- Clients will be sent letters informing them of the first and second "No Shows" or late cancellations if there has not been contact via phone call. If the patient's guardian is CYFD, or if JPO is the referring party, a copy of the no show/cancellation letter will be sent to the Social Worker and/or Probation Officer.

Client Name:	DOB:	Date of Admission:

CHILDHAVEN
APPOINTMENT CANCELLATION AND NO-SHOW POLICY

- If it is necessary to close the client's case, the Therapist will have that conversation at the last therapy session if applicable. Otherwise, written communication that the case has been closed, will be sent to the last known mailing address within 5 business days advising client that their case has been closed.
- Clients have the right to appeal that decision and are given 15 days to submit the appeal in writing with their address and phone number to the Program Director.

Code of Conduct

• By attending therapy sessions, it is understood by the family that the appointment time is reserved for the client only. No siblings, cousins, aunts, uncles, grandparents, etc. will be allowed in the therapy rooms.

• Since the time is reserved for the client, this also means that the legal guardian of the child may be called back into the therapy room occasionally for discussion with the Therapist for an extended and varying amount of time. The Services Coordinator (Front Desk) is not responsible for watching any other children that are brought with the client to the appointment, and no child is allowed to be left alone on Childhaven property. Knowing this information, please plan accordingly and avoid bringing nonessential people to the appointments.

• If you have nowhere else to take the other children, or you are the sole provider and caretaker of the children, Childhaven offers a service called Behavioral Health Respite Care located down at the Shelter. The clients Therapist, Family Advocate or the Services Coordinator can help you set this service up for the other children while you are at the therapy session at CAC with the client.

• If you are going through the court process regarding custody, please provide Childhaven a copy of the parenting plan or custody agreement at the time of the first therapy appointment. This allows Childhaven to ensure that only appropriate parties receive information on the client or are allowed on site while the client is in session.

• Due to limited space, only people essential to each appointment (i.e. the client and legal guardian) should attend the appointment.

• It is our goal to provide a safe and calming environment for our clients and their family. Any arguments, intense conversations, loud play or screaming needs to occur outside the Childhaven lobby. This also applies to children who are not able to stay at a reasonable sound level while playing or they are not able to be calmed when upset. We understand that "kids are kids" and they enjoy playing, but we have clients that are sensitive to sound and hectic situations so it is important for us to cater to their needs as best as we can since this environment is for healing.

• Childhaven reserves the right to ask anyone to leave the lobby to ensure we maintain a therapeutic environment.

• If water is needed, please ask and you will be provided a cup with water. There is a "One at a time" policy in regard to bathroom use. The Services Coordinator will escort one person at a time to

CHILDHAVEN
APPOINTMENT CANCELLATION AND NO-SHOW POLICY

the bathroom and wait for them in the kitchen until they finish. The only exceptions to this policy are if a legal guardian has to assist a small child or it is a Childhaven foster parent who may escort them.

I, _____ (guardian), have read the above policy and agree to attend scheduled appointments at Childhaven for _____ (client). I understand that having "No Show" or Cancelled appointments could cause discontinuation of services.

_____ _____
Legal Guardian Signature Date Client Signature Date

_____ _____
Foster Parent Signature (if applicable) Date Childhaven Staff Signature Date

Client Name:	DOB:	Date of Admission:

Childhaven
Notice of Privacy Practice
Your Privacy Matters to Us

Childhaven, Inc. may collect health information, including mental health and substance abuse information, for the purpose of providing quality service to you. The people providing services to you may use your information or disclose it to others. **This notice describes how medical information about you/your child may be used and disclosed and how you can get access to the information. Please review it carefully.**

We are required by law to protect your health information. We are also required to abide by the practices described in this notice.

Uses and Disclosures of Health Information
We will generally get your written authorization before using or disclosing your health information outside Childhaven, Inc. However, there are some situations, as described herein, when we do not need your written authorization before using your health information or sharing it with others.

We may share your health information with doctors, nurses, pharmacists and other treatment providers who are involved in providing health-related services to you, and they may, in turn, use that information to diagnose or treat you.

We may use or disclose your health information so that we can obtain payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement after you have been treated or to obtain prior approval for services.

We may use or disclose your health information in order to conduct our normal business operations. For example, we may use your health information to evaluate the performance of our staff in serving you, or to educate our staff on how to improve the care they provide for you.

We may use your health information when we contact you with a reminder that you have an appointment for treatment or to tell you of a related service that may be of interest to you.

We may use or disclose your health information in an emergency or for an important public need.

If you do not object, we may disclose your health information to a family member, relative, or close personal friend who is involved in your treatment or payment for that treatment. We may also disclose your health information to help notify or locate a family member or other person responsible for your care.

We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your authorization.

We may use or disclose your health information if we are required by law to do so. We also will notify you of these uses and disclosures if notice is required by law.

We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities.

We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence.

We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facilities and services.

We may disclose your health information if we are ordered to do so by a court or administrative hearing officer that is handling a legal matter or to persons authorized by a court to receive the information.

We may disclose your health information to law enforcement officials for the following reasons:

- To comply with court orders or laws;
- Identifying or locating a suspect, fugitive, witness, or missing person;
- If you have been the victim of a crime;
- Your death resulted from criminal conduct;
- To report a crime that occurred on your property; or
- To report a crime discovered during an offsite investigation as required by law.

We may use or disclose your health information when necessary to prevent a serious threat to your health or safety of to the health or safety of another person or the public.

We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

If you are in the Armed Forces, we may disclose health information about your to appropriate military command authorities for activities they may deem necessary to carry out their military mission.

If you are a placed in protective custody by a state or tribal social worker or placed on a 48 hour hold with law enforcement or placed in prevention placement by your parent or guardian. We may disclose your health information, if necessary, to provide you with health care, or to maintain safety, security and good order where you are being placed or to where you are being transferred.

We may disclose your health information for worker's compensation or similar programs that provide benefits for work-related injuries.

In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner.

We may use or disclose your health information if we have removed any information that might reveal who you are.

We may disclose your health information to a person or company as required by the US Food and Drug Administration.

We will ask for your written authorization before using your health information or sharing it with others or any other purpose, for example, in order to participate in a research project.

Your Rights Regarding your health information
You generally have the right to inspect and copy your health information. You may be charged for copying and mailing costs.
You have the right to require that we amend your health information if you believe it is inaccurate or incomplete.

You have the right to receive a list from us, called an accounting list which provides information about when and how we have disclosed your health information to outside persons or organizations. Many routine disclosures we make will not be included on the list, but the list will identify non-routine disclosures of your information. You may be charged a fee if you request more than one accounting within a 12 month period.

You have the right to request further restrictions on the way we use your health information or share it with others. We are not required to agree to the restriction you request but if we do, we will be bound by our agreement.

You have the right to request that we contact you in a way that is more confidential for you, such as at work instead of at home.

You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

You may request a paper copy of this notice, even if you have previously agreed to receive this notice electronically.

The effective date of this Notice of Privacy Practices is April 14, 2003. We may change our privacy practices from time to time. We may make the changed notice effective for health information we already have. If we change the notice, we will provide you with the revised notice, and the current notice will be available in all Childhaven locations.

If you believe your privacy rights have been violated, you may file a complaint with the Chief Executive Officer at Childhaven, at 807 W. Apache, Farmington, NM 87401. Should you ever make a complaint, it will not be held against you.

Thank you for taking the time to read this important information. After you have carefully read the Notice, please sign the attached acknowledgment and return it to Childhaven office at the address provided above.

CHILDHAVEN NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

Please print

CLIENT	Client Name (Last, First, Middle)	Social Security Number	Date of Birth (Month, Day, Year) / /
	Client Address (No. and Street, City, State, Zip Code)		Telephone Number ( )

I acknowledge that I was offered or provided a copy of Childhaven, Inc.'s Notice of Privacy Practices effective April 14, 2003. I was given an opportunity to ask questions at the address or phone number listed on the Notice of Privacy Practice.

SIGNATURE	Signature of Client or Personal Representative	Date / /
	If signed by Personal Representative, Relationship to Client	

Please return the signed acknowledgement to Childhaven, Inc. office at the address printed below, or to the office which is providing service to you.

Childhaven, Inc., 807 West Apache, Farmington, New Mexico 87401

Client Name:	DOB:	Date of Admission:

Childhaven Permission for
Observance/Reading of Client Sessions by Student

PERMISSION

I _____ legal guardian of _____ (client) give permission for Bachelor and Master Level students to observe therapy sessions and/or read session notes, treatment plans and assessments.

PRIVACY

I understand that neither the client name nor the family's name or any identifying information will be shared in any form outside of Childhaven. This is solely used in the student intern education process and the student interns are subject to the same HIPAA (Health Information Protection & Privacy Act) standards of confidentiality.

_____ _____

Legal Guardian Signature Date

_____ _____

Witness Signature Date