

# United American Indian Involvement, Inc.

1125 West Sixth Street, Suite 103 Los Angeles, CA 90017 (213)202-3970 Fax (213)202-3977

## INFORMED CONSENT AND DISCLOSURE OF SERVICES

I understand that the services provided by the United American Indian Involvement, Inc. (UAI) include direct services as well as referral and linkage services.

### UAI PROVIDES THE FOLLOWING SERVICES AS APPROPRIATE TO EACH CLIENT:

- ◆ Substance Use/Abuse Services
- ◆ Case Management Services
- ◆ Employment Services
- ◆ Social Services (Housing, Nutrition, Transportation)
- ◆ Senior Activities
- ◆ Cultural/Spiritual Activities
- ◆ Medical Services
- ◆ Benefits Coordination
- ◆ Mental Health Services
- ◆ Referral to Medical Services
- ◆ Referral to Dental Services
- ◆ Referral to Residential Treatment/Detox
- ◆ Referral to Sober Living
- ◆ Referral to Traditional Practitioners

The direct services listed above are provided free of charge to all qualified UAI Clients. UAI staff will work with the clients to secure services and funding available from various resources outside of UAI. Neither UAI nor any UAI programs guarantee payment for services that are referred to an appropriate health or substance abuse treatment provider.

Initials \_\_\_\_\_ I understand that this consent acknowledges my participation in the services provided by UAI & requires the discussion of my health conditions and health needs with a UAI staff member.

Initials \_\_\_\_\_ I authorize UAI staff to provide the necessary or advisable health screening, assessments and evaluations for the purpose of providing direct services and linkage/referral services for:

Myself \_\_\_\_\_ (Print Name)

My Child \_\_\_\_\_ (Print Child's Name)

Initials \_\_\_\_\_ I understand that some or all of my/my child's personal health information may be shared among UAI Professional Staff and outside Service Providers in order to link me/my child to the appropriate services and to provide active case management services.

Initials \_\_\_\_\_ I understand that UAI and any UAI Programs are not responsible for fees to outside service providers unless I obtain a written referral/authorization for payment from my Case Manager prior to service.

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### Patient Release(s) of Information

I, \_\_\_\_\_ hereby authorize UAI to request and receive copies of my/my child's medical/social services and/or employment information for any services that I receive from outside service providers. I understand that this information will be used to update my records and UAI and to provide appropriate Case Management follow-up and referral services. I further understand and agree that requests for specific information regarding HIV/AIDS status and/or treatment, treatment for drug, alcohol or substance abuse and information related to the treatment of mental health, developmental or psychiatric conditions require a separate consent.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

### Release of Information/Assignment of Benefits

UAI has my permission to release information for myself/my child as needed for insurance processing and to release payment to UAI.

I HEREBY AUTHORIZE TREATMENT

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

UAI Staff Witness: \_\_\_\_\_ Date: \_\_\_\_\_

United American Indian Involvement, Inc.

Los Angeles, California

CLIENT REGISTRATION INTAKE FORM

All Information provided is CONFIDENTIAL

UAI Staff Use Only

\_\_\_\_ New \_\_\_\_ Update

HR# \_\_\_\_\_

Important: If client is under the age of 18 years, this form is to be filled out and signed by legal parent or guardian.

Today's Date: \_\_\_\_\_

Client's Full Name: \_\_\_\_\_ Other Name(s) Used: \_\_\_\_\_

Sex: (Circle One) Male Female T/G Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Sec. # \_\_\_\_-\_\_\_\_-\_\_\_\_

Place of Birth: (City and State) \_\_\_\_\_ Marital Status: \_\_\_\_\_ (i.e. married, single)

Present Address: \_\_\_\_\_  
Street City State Zip Code

Home Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Office: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Other: (\_\_\_\_)\_\_\_\_-\_\_\_\_  
Message or cell phone number?

Do you have internet access? (Circle one) Yes No If yes, where do you access the internet? \_\_\_\_\_

Email Address: \_\_\_\_\_@\_\_\_\_\_.com

When did you move to your current community? \_\_\_\_\_ (i.e. June 1<sup>st</sup>, 1975)

Living Arrangements: (Circle one) Living with Family Homeless In Treatment Other: \_\_\_\_\_

Preferred Method of Contact: (Circle one) Mail Phone E-mail

May we send you generic health messages through e-mail? (Circle one) Yes No

TRIBAL INFORMATION

Tribal Affiliation: \_\_\_\_\_ (Reservation, Rancheria, Native Corp., Public Law Land)

Blood Quantum: \_\_\_\_\_ Enrollment # \_\_\_\_\_ Other Tribes: \_\_\_\_\_  
(i.e. Full 3/4 1/2 1/4 1/8)

PARENT INFORMATION

Mother / Guardian 1: \_\_\_\_\_  
Last Name First Relationship to client

Telephone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ (\_\_\_\_)\_\_\_\_-\_\_\_\_ @\_\_\_\_\_.com  
Cell Phone Alt. Phone Email Address

Father / Guardian 2: \_\_\_\_\_  
Last Name First Relationship to client

Telephone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ (\_\_\_\_)\_\_\_\_-\_\_\_\_ @\_\_\_\_\_.com  
Cell Phone Alt. Phone Email Address

EMERGENCY CONTACT

Name: \_\_\_\_\_  
Last Name First Relationship to client

Address: \_\_\_\_\_  
Street City State Zip Code

Telephone: \_\_\_\_\_  
Home Phone # Work Phone # Mobile Phone #

NEXT OF KIN (NOT LIVING WITH YOU)

Name: \_\_\_\_\_  
Last Name First Relationship to client

Address: \_\_\_\_\_  
Street City State Zip Code

Telephone: \_\_\_\_\_  
Home Phone # Work Phone # Mobile Phone #

Continue on back side



United American Indian Involvement, Inc.

Los Angeles, California

**CLIENT REGISTRATION INTAKE FORM**

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UAII Staff Use Only

\_\_\_\_ New \_\_\_\_ Update

HR# \_\_\_\_\_

**Household:**

Name	Relationship to client	Sex	AI/AN	DOB	Source of Income	Amount Received
1. Client	Self					
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10						
Total # in household _____					Total Household Monthly Income	

**Employment Information:**

Employer	Address	Phone	Employment Status
			Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/>
Employer (Spouse's info)	Address	Phone	Employment Status
			Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/>

Employer (If Minor, Father's info)	Address	Phone	Employment Status
			Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/>
Employer (If Minor, Mother's info)	Address	Phone	Employment Status
			Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/>

Continue on next page



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Los Angeles, California

CLIENT REGISTRATION INTAKE FORM

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UAI Staff Use Only

\_\_\_\_ New \_\_\_\_ Update

HR# \_\_\_\_\_

**Health Insurance Information:** Do you have medical health insurance? **Yes No**

If **yes**, please indicate type: (Check one or more boxes that apply and provide further insurance information as requested below)

<input type="checkbox"/> <b>Medicare</b> (Circle one)	<input type="checkbox"/> <b>Medi-Cal:</b> _____	<input type="checkbox"/> <b>Family Pact</b>	<input type="checkbox"/> <b>HMO:</b>
_____			
Part A	(i.e. Health Net, Kaiser, Molina, etc)		(i.e. Blue Cross, Blue Shield, Cigna, etc.)
Part B	Is your Medi-Cal Insurer: (circle one)		
Part D	a. Straight Medi-Cal or		
Railroad	b. Under a Managed Care Plan		
<input type="checkbox"/> <b>Kaiser Permanente</b>	<input type="checkbox"/> <b>Private:</b> _____	<input type="checkbox"/> <b>PPO:</b> _____	<input type="checkbox"/> <b>Veteran</b>
	(i.e. Blue Cross, Blue Shield, Cigna, etc.)	(i.e. Blue Cross, Blue Shield, Cigna, etc.)	
Health Insurance ID #: _____	Eligibility Date or Insurance Issue Date: ____/____/____		
Primary Care Provider: _____	(i.e. Dr. Jane Doe, M.D.)	PCP Phone #: ( ) _____ - _____	

Are you a veteran? (Circle One) **Yes No** (If yes, Patient Reg. Staff will ask you additional questions)

Primary Language Spoken: \_\_\_\_\_ Other Languages Spoken: \_\_\_\_\_

Do you identify yourself as Hispanic or Latino? (Circle one) **Yes No Unknown Decline to Answer**

Race: (if other than Amer. Indian) \_\_\_\_\_

**My Signature is a statement that the information provided on this form is true and correct**

_____	____/____/____	_____	____/____/____
Client Signature or Parent / Legal Guardian	Date	UAI Staff Initials	Date

## Client's Bill of Rights and Responsibilities

**The client has the right to receive services and to exercise the following rights without regard to gender, culture, ethnic group identification, economic status, education level, disability, age, creed, religion or sexual orientation. This statement shall not preclude United American Indian Involvement, Inc. (UAI) from emphasizing services for the American Indian/Alaska Native (AI/AN) community:**

- ❖ The client has the right to receive considerate and respectful care and to be accorded dignity in contact with staff, volunteers, board members, and other persons.
- ❖ The client has the right to be free from verbal, emotional, physical abuse and/or inappropriate sexual behavior.
- ❖ The client has the right to expect that all communications and records pertaining to his/her care be treated as **confidential** except in cases of threat to self or others, child abuse, elder or dependent adult abuse or court order. The client's written permission shall be obtained before their records can be made available to anyone not directly concerned with their care. UAI shall assure confidentiality in accordance with Title 42, Code of Federal Regulations, Part 2.
- ❖ The client has the right to know the name of the provider who has primary responsibility for coordinating their care and the names and professional relationships of other providers who will see them.
- ❖ The client has the right to obtain complete and current information concerning their diagnosis, treatment, and prognosis in terms that the client can be reasonably expected to understand.
- ❖ The client has the right to participate in decisions regarding their care unless the health or safety of self or others is being compromised or the client is in an altered state.
- ❖ The client has the right to refuse treatment to the extent permitted by law, and to be informed of the health care consequences of the action.
- ❖ The client has the right to be accorded access to his or her file.
- ❖ The client has the right to leave the premises even against the advice of their providers.
- ❖ The client has the right to expect that UAI will make reasonable response to all requests for services and provide clear explanations for any services that cannot be provided.
- ❖ The client has the right to expect reasonable continuity of care and to know in advance the time and location of appointments.
- ❖ The client has the right to know what the program rules and regulations are that apply to his/her participation in the program.
- ❖ The client has the right to be advised if the provider proposes to engage in research or perform experimentation that in any way affects their care. The Client has the Right to Refuse participation in Experimental Research.

- ❖ The client has the right to be accorded safe, healthful and comfortable accommodations to meet his or her needs.
- ❖ The client's rights will be extended to and apply to any person who is identified to have legal responsibility to make decisions regarding the care of the client.
- ❖ The client has the right to appeal a discharge or file a complaint with the Program Director according to the grievance procedure\*.

**CLIENTS HAVE THE RESPONSIBILITY TO:**

- ❖ Provide accurate and complete information concerning your health history, financial status and/or any other information that is required by UAII in order to provide services.
- ❖ Inform UAII and/or referring facilities if you are not able to keep any appointments 24 hours prior to the scheduled appointment.
- ❖ Request further information concerning anything you do not understand.
- ❖ Speak with the Program Director if you are having difficulty with any staff member.
- ❖ Treat the staff and other clients in a respectful and courteous manner.
- ❖ Follow all rules and guidelines for program participation and use of the UAII facilities.

**UAII HAS THE RIGHT TO:**

- ❖ Refuse service to any client who is verbally or physically abusive or threatening to any staff member or other client (on the phone or in person).
- ❖ Refuse service to any client who is under the influence of alcohol, drugs or other substance.
- ❖ Suspend or terminate services of any client who does not comply with the guidelines or rules that are outlined for use of UAII programs or facilities.

**I have reviewed the Client's Bill of Rights and Responsibilities and understand what my rights and responsibilities are as described above. Furthermore, I understand that I may file a grievance using UAII procedures\* if I feel these rights have been violated.**

Print name of Client \_\_\_\_\_

Signature of Client \_\_\_\_\_

Date \_\_\_\_\_

Signature of UAII Staff \_\_\_\_\_

Date \_\_\_\_\_

**\* The Grievance Policy and Consumer Complaint/Grievance Forms are available at the front desk upon request.**

# United American Indian Involvement

## Acknowledgment declaring awareness of 2013 Notice of Privacy Practices

I hereby acknowledge that I am aware that UAI has a Notice of Privacy Practices (NPP) which details or summarizes my rights involving my protected health information (PHI). This notice is available to me in both printed and electronic formats. UAI has this notice clearly posted on the walls in all UAI waiting areas; has printed hard copies and is viewable on our website [www.uaii.org](http://www.uaii.org). Copies and a detailed explanation of this notice are available to me upon request.

_____	_____	_____
Print Name of Consumer	Signature	Date
Or		
_____	_____	_____
Print Name of Representative	Representative's Signature	Date



### UAI Staff Only

Did the client request a copy of the NPP?

- Yes**
  - A summary version of NPP (copy)
  - Detailed copy version of NPP (copy)
- No**
  - Patient refused a copy, but a brief explanation of the contents of the NPP was provided and the patient understands how they would be able to obtain a copy.
  - Other: \_\_\_\_\_

_____	_____	_____
UAI Staff (Print)	Staff Signature	Date



# United American Indian Involvement, Inc.

1125 West 6th Street, Suite 103 • Los Angeles, California 90017

Tel: (213) 202-3970 • Fax: (213) 202-3977 • uaii.org



**Robert Sundance Family  
Wellness Center**

1125 West 6th Street  
Suite 103  
Los Angeles, CA 90017  
Tel: (213) 202-3970  
Fax: (213) 975-9255

- Inpatient/Outpatient Alcohol/Drug/Mental Health
- Nutrition
- Senior Services
- Sober Living
- Workforce Development Program

**Los Angeles American  
Indian Health Project**

Tel: (213) 202-3970  
Fax: (213) 202-3977

- Primary Care Health Services
- Health Insurance - Enrollment Assistance
- Public Health and Case Management Services
- Diabetes Management and Prevention
- Nutrition Education

**Los Angeles American  
Indian Clubhouse**

Tel: (213) 202-3976  
Fax: (213) 202-3977

- High School Program
- Prevention Workshops
- Summer Camps
- Camping, hiking, sports
- Field Trips
- Recreational/Social Activities

**Seven Generations Child  
and Family Counseling  
Services/System of Care**

Tel: (213) 241-0979  
Fax: (213) 241-0925  
seven\_generations@hotmail.com

- Child & Family Counseling
- Crisis Interventions/Case Management/Parenting Training
- Domestic Violence & Sexual Assault Counseling
- Child Abuse Treatment Program
- Family Preservation
- Prevention and Aftercare
- Innovations

www.uaii.org

RE: SEX OFFENDERS

For all using UAII services,

We at United American Indian Involvement, Inc. strive to keep a safe environment for everyone, while utilizing our services. Due to the fact that we have a high school at our facility, and that we provide services to children, youth and families, we require any person who is registered as a sex offender to voluntarily disclose their status when present at our facility or when receiving services.

If you are a registered sex offender, please make an appointment to see me with the proper documentation specifying your restrictions, so we can try to accommodate your service needs. Information received will be kept confidential or utilized on a need to know basis for relevant staff members. Disclosures of a sex offender status will not result in a refusal of services. However, the time, place, and manner of providing services may be regulated and scheduled to ensure the safety of UAII employees and other clients.

**If you are a registered sex offender and you are identified through public information such as the Megan's Law Website, and you do not self-report, UAII has the right to refuse service.**

Respectfully,

Jerimy Billy  
Chief Executive Officer

Acknowledged by Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Initials: \_\_\_\_\_

Revised: September 21, 2015



Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Mother's Name: \_\_\_\_\_  
Last Name, First Middle Initial Last Name, First Middle Initial

**Immunization Registry Notice to Patients and Parents (TB)**

Immunizations or 'shots' prevent serious diseases. Tuberculosis (TB) screening tests help to determine if you may have TB infection and can be required for school or work. Keeping track of shots/TB tests you have received can be hard. It's especially hard if more than one doctor gave them. Today, doctors use a secure computer system called an *immunization registry* to keep track of shots and TB tests. If you change doctors, your new doctor can use the registry to see the shot/TB test record. It's your right to choose if you want shot/TB test records shared in the *California Immunization Registry*.

**How Does a Registry Help You?**

- Keeps track of all shots and TB tests (skin tests/chest x-rays), so you don't miss any or get too many
- Sends reminders when you or your child need shots
- Gives you a copy of the shot/TB record from the doctor
- Can show proof about shots/TB tests needed to start child care, school, or a new job

**How Does a Registry Help Your Health Care Team?**

Doctors, nurses, health plans, and public health agencies use the registry to:

- See which shots/TB tests are needed
- Remind you about shots needed
- Prevent disease in your community
- Help with record-keeping

**Can Schools or Other Programs See the Registry?**

Yes, but this is limited. Schools, child care, and other agencies allowed under California law may:

- See which shots/TB tests children in their programs need
- Make sure children have all shots/TB tests needed to start child care or school

**What Information Can Be Shared in a Registry?**

- patient's name, sex, and birth place
- parents' or guardians' names
- limited information to identify patients
- details about a patient's shots/TB tests

What's entered in the registry is treated like other private medical information. Misuse of the registry can be punished by law. Under California law, only your doctor's office, health plan, or public health department may see your address and phone number.

**Patient and Parent Rights**

It's your legal right to ask:

- not to share your (or your child's) registry shot/TB test records with others besides your doctor\*
- not to get shot appointment reminders from your doctor's office
- to look at a copy of your or your child's shot/TB test records
- who has seen the records or to have the doctor change any mistakes

If you DO want your or your child's records in the registry, do nothing. You're all done.

If you DO NOT want your doctor's office to share your immunization/TB test information with other registry users, request a "Decline or Start Sharing/Information Request Form" from your doctor's office or download it from the CAIR website (<http://cairweb.org/cair-forms/>).

For more information, contact the CAIR Help Desk at 800-578-7889 or [CAIRHelpDesk@cdph.ca.gov](mailto:CAIRHelpDesk@cdph.ca.gov)

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
(Your signature or parent or legal guardian)

\* By law, public health officials can also look at the registry in the case of a public health emergency.

United American Indian Involvement  
Staying Healthy Assessment  
**5-8 Years**

			HRN	CM / Program	
Child's Name (first & last)	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		Today's Date	Grade in School:
Person Completing Form <input type="checkbox"/> Parent <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Guardian <input type="checkbox"/> Other				School Attendance Regular? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.</i>				Need Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				<b>Staff Use Only:</b>	
1	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	N/A	Nutrition
2	Does your child eat fruits and vegetables at least two times per day?	No	Yes	N/A	
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	N/A	
4	Does your child drink more than one small cup (4-6 oz.) of juice per day?	Yes	No	N/A	
5	Does your child drink soda, juice drinks, sports drink, energy drinks, or other sweetened drinks more than once per week?	Yes	No	N/A	
6	Does your child brush and floss her/his teeth daily?	No	Yes	N/A	Dental Health
7	Does your child have any dental caries or tooth pain?	No	Yes	N/A	
8	Does your child exercise or play sports most days of the week?	Yes	No	N/A	Physical Activity
9	Are you concerned about your child's weight?	Yes	No	N/A	
10	Does your child watch TV or play video games less than 2 hours per day?	Yes	No	N/A	
11	Does your home have a working smoke detector?	Yes	No	N/A	Safety
12	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	N/A	
13	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	N/A	
14	Do you always place your child in a booster seat in the back seat (or use a seat belt if your child is over 4'9")?	Yes	No	N/A	
15	Does your child spend time near a swimming pool, river, or lake?	No	Yes	N/A	
16	Does your child spend time in a home where a gun is kept?	No	Yes	N/A	
17	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	N/A	
18	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	No	Yes	N/A	
19	Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	N/A	

United American Indian Involvement  
Staying Healthy Assessment  
**5-8 Years**

20	Has your child been hit or hit someone in the past year?	No	Yes	N/A	Mental Health	
21	Has your child ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	N/A		
22	Does your child often seem sad or depressed?	No	Yes	N/A		
23	Does your child spend time with anyone who smokes cigarettes / e-cigarettes or vapes?	No	Yes	N/A		Tobacco Exposure
24	Does your child have any medial conditions?	No	Yes	N/A		Other Questions
<i>If yes, please describe:</i>						
25	Do you have any other questions or concerns about your child's health, development or behavior?	No	Yes	N/A		
<i>If yes, please describe:</i>						

**Parent / Legal Guardian Authorization**

I acknowledge that the information provided is correct regarding my child's health and behaviors.

Parent / Legal Guardian Name	Signature	Date
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RD / PHN / Clinic Staff	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered		DV	Alcohol	Depression
<input type="checkbox"/> Nutrition <input type="checkbox"/> Physical Activity <input type="checkbox"/> Safety <input type="checkbox"/> Dental Health <input type="checkbox"/> Tobacco					Negative			
					Present			
					Past			
					Refused			
					Unable to screen			
Staff initials: _____ Date: _____					Staff Initials: _____ Date: _____			
STAFF REVIEW (CM / PHN / CLINIC CARE PROVIDER)								
Comments:						Did you meet with the client?		
1st Reviewer Signature		Print Name		Date		If yes, were all the clients needs met at this time?		
Comments:						Did you meet with the client?		
2nd Reviewer Signature		Print Name		Date		If yes, were all the clients needs met at this time?		