VIOLENCE IS NOT A NATIVE AMERICAN TRADITION

QUAPAW NATION

FAMILY VIOLENCE PROGRAM

58150 S 66 RD

MIAMI, OK 74354

PHONE 918-238-3152

FAX 918-238-3332

GUIDELINES FOR ELIGIBILITY

- Live in Ottawa County
- Victim of Domestic Violence, Sexual Assault, or Stalking
- Other Documentation may need to be provided

Required Documentation for Services

1. Police report, protective order, witness statement or willingness to file
2. Proof of birthdate & age of self & children
3. Proof of residency
4. Signed releases of information
5. Social security cards for household members
6. Income verification of last 3 months
7. TANF, commodity or food stamp verification

We need a copy of your Tribal Membership or CDIB card **IF APPLICABLE**

(this is not a requirement for the service)

Quapaw Nation
Family Service Department
Domestic Violence Programs

Client Information

Date: _____

Name: _____
First M. Last Maiden Nickname

Address: _____

_____
City State County Zip code

Phone: _____ Alternative: _____

Is it OK to contact to you at these numbers? Yes_____ No_____

DOB: _____ SSN: _____

Race/Ethnicity: _____

If Native American/Alaskan Native what Tribe? _____

Roll Number: _____

US Citizen: yes_____ no _____

Current Marital Status: _____ Military History:_____

Employer: _____ Telephone: _____

Annual Income: _____

TANF / SSI / VA Benefits (Circle One) $_____Amount

Food Stamps $_____Amount

Caseworker County and Name: _____

Has client ever received services from Quapaw Nation: Yes_____ No_____

If Yes, When: _____

Has client ever received services from a Domestic and/or Sexual Violence Agency?

other than Quapaw Nation?

If Yes Where and When: _____

Physical Description of Client/Self (Include size, distinguishing characteristics,

Height_____ Weight_____ Eye Color_____ Hair_____

Tattoos or Scars: _____

Education

High School: _____ GED:_____ College:_____

Currently a student? _____

Years of school completed: _____ Certificate/Degree: _____

Desire to Continue Education: _____ Area of Interest: _____

List Skills and/or Experience: _____

_____

Family/Relationship Information: _____

Current Living Arrangements: _____

List family in chart below: (Do not include Client)

Full name	Date of Birth	Ethnicity	M/F	Grade	With Whom do they Live?
SELF					

Relationships/Marriages

Name	Length of Relationship	Still In the Relationship

Drug/Alcohol Screening------This information is confidential and for our files only

Have you ever used illegal substances? Yes_____ No _____ Frequency _____

Have you ever abused prescription drugs? Yes_____No____ Frequency_____

Have you ever used alcohol excessively? Yes____ No_____ Frequency_____

Are you presently under the influence of alcohol or drugs? _____

Substance of Choice: _____ Age first used: _____

Secondary Age first used: _____

Tertiary: _____ Age used: _____

Have you ever received treatment for substance abuse? Yes _____ No_____

(List Dates and Facilities)

1) _____
2) _____
3) _____

Pertinent Medical Information

List all current medical information:

_____
_____
_____
_____

Is client currently under the care of a physician? Yes_____ No_____

Doctors Name	Address	Phone	Contact Yes/No

Is Client Currently Pregnant? Yes____ No____ If Yes, how many months _____

Complications _____

Is Client currently under the care of a Mental Health Professional? Yes_____No_____

Name of Mental Health Professional: _____ Phone: _____

Diagnosis: _____

Has Client ever attempted Suicide: Yes_____ No_____

Method of Attempted Suicide: _____

Perpetrator / Abuser Information

Name: _____
First M.I. Last

Address: _____
City State County Zip

Relationship:
( ) Husband
( ) Common Law
( )Ex-Husband
( ) Dating Partner
( ) Ex Partner
( ) Father
( ) Stepfather
( ) Boyfriend
( ) Son
( ) Brother
( ) Other

DOB: _____ Age: _____ SSN: _____

Height: _____ Weight: _____ Eye color: _____ Hair color: _____

Distinguishing Characteristics: _____

_____

Race/Ethnicity: _____ Native American, which Tribe _____

Employer: _____ Address: _____

Telephone Number: _____

Protective Order(s) Filed: Where_____ Date_____/_____/_____
City/State/County

Where _____ Date ____/_____/_____
City/State/County

Are there any outstanding warrants for the perpetrator/abuser? Yes _____ No _____

If Yes, What County: _____

Does the Perp./Abuser own a vehicle? Yes _____ No _____

Make: _____ Model: _____ Year: _____ Color: _____ Tag #: _____

Does the abuser have weapons? Yes _____ No _____

If Yes, What kind(s)? _____

Has the Perp/ Abuser ever strangled you? Yes_____ No _____

If Yes, when was the most recent incident of strangulation?

_____

Is the Perp/Abuser enrolled in the IMPACT Program? Yes _____ No _____

Has the Perp/Abuser ever been treated for a mental illness? Yes_____ No_____

Does the Perp/Abuser have a history of drugs/alcohol use? Yes _____ No _____

If Yes, What is the Drug of Choice? _____

Presenting Problem

Date of Last Incident: _____

History/Nature of Abusive Relationship:

_____

_____

_____

How long has the abuse been occurring: _____

Type of Abuse: (Check ALL that apply)

Physical Emotional Psychological Sexual

Verbal Stalking Other _____

Type of Abuse experienced in previous relationships: (Check ALL that apply)

Physical _____ Emotional _____ Psychological _____ Sexual _____

Verbal _____ Stalking _____ Other _____

Type of weapons used in last Incident: (Circle ALL that apply)

Firearm Knife Hands Feet Car Other

Were police ever called? Yes _____ No _____

Report Filed _____

Name of Law Enforcement Agency/Deputy: _____

How many incidents were the police involved? _____

Was medical attention needed for injuries sustained from the abuse? _____

With this signature, I am giving informed, written consent to receive services from Quapaw Nation Family Violence Program my signature verifies receipt of:

_____ Application

_____ Confidentiality Notice

_____ Release of Information

Client/Parent or Guardian Signature: _____ Date _____

Release of Liability

I agree not to hold the Quapaw Nation liable for any injuries sustained by me or my children while receiving services being transported in company or private staff vehicle, participating in outdoor activities. for any loss of personal property due to theft or disaster. or from any results of reasonable search and seizure.

Client Signature: _____ Date: _____

Emergency Medical Care

I agree to let Quapaw Nation Family Violence staff member or volunteer transport me and/or my dependents to the nearest medical facility in an emergency in which I am incapacitate or unavailable to accompany my dependents (If I am unavailable) for emergency care. In signing this form shall devoid the Quapaw Nation of any liability in an emergency situation.

Client Signature: _____ Date: _____

In the case of an emergency, contact:

Name

_____

Address

_____

Phone

_____

Relationship to Client

_____

Name

_____

Address

_____

Phone

_____

Relationship to Client

_____

Name

_____

Address

_____

Phone

_____

Relationship to Client

_____

Release from Medical Treatment

I have been advised by _____ of the Quapaw Nation Family Violence Program. that I/or my children might have need of medical attention while receiving services, I have been advised that transportation can be provided for me to go to the nearest medical facility providing emergency medical care I choose, however, not to seek medical care upon this advice and release the Quapaw Nation of all liability resultant from my decision not to seek medical treatment. I hate been made aware that the withholding of medical treatment to a child may be regarded as an act of child abuse or neglect and may be reported to the proper authorities through the Quapaw Nation Indian Child Welfare department.

Client/Parent or Guardian Signature _____ Date _____

_____ _____

Quapaw Nation Staff Date

If this information has been supplied by someone other than the client, please fill out the information below.

Name: _____

Relation to Client: _____

Address: _____

Phone: _____

Quapaw Nation
Family Violence Program
Confidentiality Notice

We firmly believe in our client's right to privacy, with few exceptions, everything that you reveal to us will be kept strictly confidential and no one will have access to information about you unless you give explicit, written permission.

Due to legal and ethical restrictions (43 0.S. C 3-313), the only exceptions strict confidentiality.

1. If a staff person or volunteer suspects physical or sexual abuse of a child or Incapacitated adult;

2. If a staff or volunteer is concerned that the client is in serious danger of harming Self or others;

3. If court ordered, certain information may have to be released;

4. If you give written permission to release information to a specific person or organization;

5. If a medical emergency occurs while you are et one of our facilities.

I understand my rights end limitations to confidentiality as outlined above,

_____ _____

(Client/Guardian's Signature) (Date)

_____ _____

(Quapaw Tribe Staff Signature) (Date)

ACTION:

REFERRALS:

CONTACTS:

Family Services

CLIENT RELEASE OF INFORMATION

READ FIRST: Before you decide whether or not to let Family Services share some of your confidential information with another agency or person, an advocate at Family Services will discuss with you all alternatives and any potential risks and benefits that could result from sharing your confidential information. If you decide you want Family Services to release some of your confidential information, you can use this form to choose what is shared, how it's shared, with whom, and for how long.

I understand that Family Services has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow Family Services to release some of my personal information to certain individuals or agencies.

I, _____, authorize to share the following specific information with:
(print name)

WHO I WANT TO HAVE MY INFORMATION:	Name: Specific Office at Agency: Phone number

The information may be shared: O In person O By phone O By fax O By mail O By email

O *I understand that electronic email (e-mail) is not confidential and can be intercepted and read by other people.*

What info about me will be shared:	(List as specifically as possible, for example: name, dates of service, any documents)
Why I want my info shared:	(List as specifically as possible, for example: to receive benefits)

PLEASE NOTE: There is a risk that a limited release of information can potentially open up access by others to all of your confidential information held by Family Services.

I understand that:

O I do not have to sign a release form. I do not have to allow Family Services to share my information. Signing a release form is completely voluntary. That this release is limited to what I write above. If I would like Family Services to release information about me in the future, I will need to sign another written, time-limited release.

O Releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from Family Services.

O Family Services and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.

This release expires on _____ (date) _____ (time) *Expiration should meet the needs of the victim, which is typically no more than 15-30 days, but may be shorter or longer.*

I understand that this release is valid when I sign this form and that I may withdraw my consent to this release at any time either orally or in writing.

Date: _____

Signature: _____ Time: _____ Witness: _____

Reaffirmation and Extension (if additional time is necessary to meet the purpose of this release)

I confirm that this release is still valid, and I would like to extend the release until

_____ (new date) _____ (new time)

Signature: _____