Family Resource Center

Archuleta County Collaborative Management Program

DEMOGRAPHICS

(Please attach to CFSA)

** Please note: Information that is collected will not be shared without a release, nor will it be used to make any judgments. All families are unique and that is what makes life beautiful – please answer honestly so we can provide the best support. :)*

Adult Information

Intake Date_____

Legal First Name: _____ Date of Birth: _____

LegalLast Name: _____ Ethnicity: _____

Physical Address: _____ Primary Language: _____

County_____ Mailing Address: _____

Tribal Membership:_____ State: _____ Zip Code: _____

Gender:_____ County_____

City: _____ Email: _____

Phone Number: _____ Marital Status_____

Permission to text: Yes No

** If you prefer text messaging, please note that text message or messaging platforms are not HIPAA compliant.*

Do you have health Insurance? Yes No

Yearly Family Income Before Taxes _____

How Did You hear about PCI?_____

Do You have a diagnosed Disability? Yes No

Are you pregnant Yes No N/A

Is anyone is the Household Pregnant Yes No

Are you or your spouse a Veteran? Yes No

What is Your Highest Level of Education _____

What is your Housing Situation? _____

Are You Employed? Yes No

Employment Status Full-time Part-Time Seasonal

Do you or anyone in your family have dental coverage? _____

Do You Feel Safe in Your relationships?_____

Please Check what services your family is receiving currently:

TANF ___
SNAP ___
WIC____
Housing assistance ____
Child Support ___
Domestic Violence Services___
Disability Benefits ___
Workmans Comp____
Social Security Benefits____
EOC Assistance ___
LEAP___
CMP Services___
High Fidelity Wraparound services___
Services through a Food Bank____
Safe Care____

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DEMOGRAPHICS (cont.)

How Many Children in the Home:_____
How many Adults in the Home: _____

Children/s Information

Primary Child for Family Support Services: There will be room on other pages to list other children. For family development services it is requested to keep one primary child in mind when setting goals for the family. This is usually the child you hope will benefit the most from these services.

Legal First Name: _____ Legal Last Name: _____
Date of Birth: _____ Grade Level: _____
Gender:_____ Ethnicity _____
School Name: _____ Disability: Yes No
Immunizations up to date: Yes No Behavioral Challenges: _____

Does your child have an IEP, 504, or any other educational plans/support?

- Yes Type:_____
- No

Do you need support for you and your child with education plans or resources?

- Yes
- No

Other Children In Home: Phone information for children is only needed if they are in high school or at an age that they are involved in family goal setting as well.

1) Legal First Name:_____Legal Last Name :_____ DOB_____
Ethnicity_____ Gender_____ Language _____
Tribal Status_____ Grade Level _____ Phone_____

2) Legal First Name:_____Legal Last Name :_____ DOB_____
Ethnicity_____ Gender_____ Language _____
Tribal Status_____ Grade Level _____ Phone_____

3) Legal First Name:_____Legal Last Name :_____ DOB_____
Ethnicity_____ Gender_____ Language _____
Tribal Status_____ Grade Level _____ Phone_____

4) Legal First Name:_____Legal Last Name :_____ DOB_____
Ethnicity_____ Gender_____ Language _____
Tribal Status_____ Grade Level _____ Phone_____

5) Legal First Name:_____Legal Last Name :_____ DOB_____
Ethnicity_____ Gender_____ Language _____
Tribal Status_____ Grade Level _____ Phone_____

6) Legal First Name:_____Legal Last Name :_____ DOB_____
Ethnicity_____ Gender_____ Language _____
Tribal Status_____ Grade Level _____ Phone_____

🌟 Pagosa Community Initiative Family Services 🌟

SMART Goal Activity Sheet

Helping You Set Goals You Can Achieve

Name: _____ Date: _____

What is a SMART Goal?

A SMART Goal is:

✅ Specific – clearly says *what* you want to do

✅ Measurable – you'll know *when you've done it*

✅ Achievable – realistic for you right now

✅ Relevant – meaningful and helpful for your life

✅ Time-bound – has a *deadline or timeline*

Step 1: Brainstorm

What is one thing you want to accomplish?

(Example: Save $300, Find part-time work, Improve communication with my child, Attend a parenting class)

My goal idea:

_____

S = Specific

What exactly do I want to accomplish?

_____

M = Measurable

How will I know I've reached this goal?

_____

A = Achievable

Is this possible for me to do right now? What do I need to help me?

_____

R = Relevant

Why is this goal important to me or my family?

_____

T = Time-bound

When do I want to complete this by?

_____

Step 3: My SMART Goal Statement

Example: "I will save $300 for emergency expenses by setting aside $25 each week for the next 12 weeks."

My SMART Goal:

_____

_____

What is one thing I can do this week to start?

_____

Who can support me or help me stay on track?

_____

Progress Check

☐ I have written my SMART goal

☐ I have taken my first step

☐ I know who can help me

☐ I will check in on my goal on this date: _____

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RELEASE OF INFORMATION

I, _____, give Pagosa Community Initiative consent to release and receive information from the following organizations/parties (check all that apply):

Pagosa Community Initiative Staff__
Authentic Solutions__
HighCountryCounseling__
Axis Health__
Bridges Program__
Pagosa Springs Elementary__
Pagosa Springs Middle School__
Pagosa Springs High School__
Pagosa Peak Open School__
San Juan Mountain School__
Goal Academy__
Wings Early Childhood Center__
Seeds of Learning__
Tri County HeadStart__
San Juan Basin Health__
Pagosa Springs Medical Center__
Pagosa Medical Group__
San Juan Boces__
Archuleta Dept. of Human Services__
Southwest Center of Independence__
Forge Martial Arts__
La Plata Family Center Coalition__
Pagosa Outreach__
Rise above Violence __
Hickory Ridge__
Archuleta Housing Authority__
Aspire__
Collaborative Management Program__
Other: _____
Other: _____
Other: _____
Other: _____

This release is valid for one year from _____ to _____

Participant Signature: _____ Date: _____

PCI Staff signature: _____ Date: _____

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*This release of information can be revoked at any time. If you wish to revoke please notify staff.
I, _____, request to revoke this release of information as of today's date _____.

Participant Signature: _____ PCI Staff Signature: _____

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Conflict of Interest Disclosure

We live in a small community, therefore we run into conflicts of interest on a regular basis. A conflict of interest involves a conflict "real, perceived, or potential" between the public duty and private interest of an employee, in which the private interest can influence the performance of their job duties. Conflict of interest can be defined as:

- Distant relation to a family intervention specialist
- Spouse/family member/ child who is working with the same family intervention specialist
- Ongoing custody matters that involve both parents being served by Pagosa Community Initiative
- Protection orders in place with other community members

**Please share anything you think could be considered a conflict of interest with the intervention specialist.*

A conflict of interest will *not* result in discharge or refusal of services; however, both parties will need to sign the following consent to work around any conflict of interest. If there is a DIRECT conflict of interest with the intervention specialist completing your intake, please inform them so that steps can be taken to refer to another staff member who can provide support.

Examples of DIRECT conflict of interest:

- Immediate family to intervention specialist
- Spouse or close friend of intervention specialist
- History of severed professional relationship with intervention specialist

Other examples of individuals that may not be served due location and nature of PCI:

- Registered sex offenders
- Active gang affiliation
- Severe substance use without substance use treatment
- History of violent crimes related to child or elder abuse

HIPAA Disclosure

HIPAA requires our agency to protect sensitive information from being disclosed without your written consent. In other words, your business is your business and this information cannot be shared with anyone unless you provide written consent.

Court Requirements

Testifying is against policy for PCI staff. We may be present in court for emotional support, and are permitted to report class or family intervention services attendance. However, outside of this we cannot testify, nor can we submit any opinions regarding any member of PCI.

- **I understand and agree to the terms above**

Participant Signature: _____ Date: _____

Family Intervention Specialist Signature: _____ Date: _____

Family Resource Center

Data Consent Form

As part of your participation in this program, the Colorado Department of Early Childhood will store information related to you, your household members, and the program activities you participate in. This information will be collected by program staff and/or provided to the CDEC. The CDEC will use the information gathered to record your progress in the program and to conduct research on the program.

All information gathered through the program will be kept confidential. The data will be stored in an encrypted, cloud-based storage system and password-protected secure network which are managed by the Colorado Department of Early Childhood. Only the CDEC, program staff, and the CDEC's research partners and program intermediaries will have access to your data. Organizations with which we share data for the purpose of evaluation and program support are bound by a confidentiality agreement and are not allowed to share your personal identifiable information. Your identity will never be revealed in any publications, presentations, or reports resulting from the program and data will always be presented in aggregate form. The CDEC will only share personally identifiable information as required by law. By signing below, you are agreeing to these terms.

Caregiver Signature

_____

Date _____

Archuleta County Collaborative Management Program

AUTHORIZATION TO SHARE INFORMATION

Name of Child/Youth: _____

Date of Birth: _____

Ethnicity of Child/Youth: _____

Name of Parent/Guardian: _____

As a participant in the Collaborative Management Program (HB1451/ISST), by signing this release I give permission allowing the following agencies to share information with one another. Only the information necessary to collaborate more effectively and serve your family better will be shared. We may interact with the following agencies during this process to help create a coordinated plan that will best meet your family's needs. Please mark the agencies that you agree can share information with each other to best serve your family:

Pagosa Community Initiative Staff__
Authentic Solutions__
HighCountryCounseling__
Axis Health__
Bridges Program__
Pagosa Springs Elementary__
Pagosa Springs Middle School__
Pagosa Springs High School__
Pagosa Peak Open School__
San Juan Mountain School__
Goal Academy__
Wings Early Childhood Center__
Seeds of Learning__
Tri County HeadStart__
San Juan Basin Health__
Pagosa Springs Medical Center__
Pagosa Medical Group__
San Juan Boces__
Archuleta Dept. of Human Services__
Southwest Center of Independence__
Forge Martial Arts__
La Plata Family Center Coalition__
Pagosa Outreach__
Rise above Violence __
Hickory Ridge__
Archuleta Housing Authority__
Aspire__
Collaborative Management Program__
Other: _____
Other: _____
Other: _____
Other: _____

The purpose of this form is to enable agencies to make appropriate recommendations and allow them to better serve your child/youth/family through coordinated service planning and delivery.
The agencies and providers will share confidential information only in our presence or in situations where they need the information to manage or provide services to the child/youth/family or other person/persons for whom I/we are legally responsible (ward). This may include encrypted emails. This authorization is valid for past, present and future CMP services. This authorization expires one year from the date I/we sign the form, when the sharing of information is no longer needed to manage or provide services to our

youth/ward, or when I/we revoke this authorization, whichever is sooner. Any information shared and gathered by this program prior to the expiration or revocation of this release may continue to be used by the program for statistical and program evaluation purposes.
I have read and agree to the following (please initial each paragraph below):

_____ I understand that the following types of information may be shared: information that identifies me/my/our family, my child/youth/ward; records which have information about disabilities, diagnosis, evaluations, or treatment; drug and/or alcohol treatment information; sex offender evaluations and treatment information; work school and social reviews and histories; education records; plans about

services or benefits, eligibility information; information on finances; placement histories; medical psychiatric and psychological histories; information related to HIV-related care; or legal history. This authorization covers all admissions and/or contact with the above listed agencies and service providers. This authorization allows a free exchange of this information between and among the agencies that you are working with.

_____ I understand that agencies may need to share information among themselves more than once and/or with other staff working for the agencies.

_____ I understand I can revoke this authorization at any time except for information already shared through this authorization. From the date of the revocation forward, agencies and providers will not share information unless it was already lawfully released, or the law allows them to, without my authorization, unless it is for the purpose of program evaluation or compiling statistical data.

By signing this Authorization form, I agree that I have read and understood the information contained in it.

_____ Date _____
Signature of Parent/Guardian (If you are not a parent, please indicate your authority to act for the child. If you are a foster parent, please provide a copy of the court order.)

_____ Date _____
Signature of Youth (as appropriate)

_____ Date _____
Signature for Revocation (as appropriate)

Notice to Recipient: This authorization is specific to the House Bill 1451: Collaborative Management Program.