Dear Friend,

Thank you for your interest in Safe Haven Maternity Home. You have made an important decision in your life. We are here to help you with any needs which may arise because of that decision.

Included in this packet are all the necessary forms which are designed to inform you of your rights and responsibilities while staying at Safe Haven. With this packet you should also receive a copy of our Guidelines and Rules for Group Living. Anything not directly covered in these pages will be covered further on a one on one basis.

You will be expected to pursue your educational needs, with our assistance while at Safe Haven. You will also be expected to keep appointments made on your behalf. You may be required to undergo certain diagnostic medical tests during your stay, these may be necessary to insure that you have a healthy baby.

Documents we ask you to sign are contracts between you and Safe Haven. We want to provide you with the best possible care we can, but we need your help to make this happen. We want to provide you with the support system within the community while you are here and after you have left our residence, so we ask that you participate in the activities we provide.

You have an opportunity to make the months you spend at Safe Haven a time of personal growth and learning. We look forward to being a part of your growth and hope that we will be considered a blessing to you.

We feel God has provided us with the chance to help you during a difficult time in your life and our greatest hope is that you will see that you are cared for and are special in God's family.

In service and love,
The Safe Haven staff
SAFE HAVEN MATERNITY HOME
Summary Sheet

Resident’s Name_______________________ Referred by_____________________

SS#_______________________ D.O.B._______________________ Marital Status_____________________

Date of Admission_____________________ Religious Preference_____________________

Name(s) and Birthdate(s) of children________________________________________

________________________   ____________________

Parent or Legal Guardian________________________ Phone_____________________

Address______________________________________________________________

Medical Information
In Case of Emergency Notify:
Name_________________________________________ Phone_____________________

Insurance Information (Attach copy)
OHP _____  Medical Card _______  Private Insurance__________________________

Policy#______________________________________________________________

Known Allergies________________________________________________________

Physician_______________________________ Phone_____________________

School ____________________ Phone_____________________

Day Program_________________________ Phone_____________________

Mental Health Counselor______________ Phone_____________________

Employer___________________________ Phone_____________________

Child Care Provider_____________________ Phone_____________________

Any Agency Staff Providing Services:
AFS_________________________________ Phone_____________________

SCF Caseworker_______________________ Phone_____________________

Name______________________________ Phone_____________________

Name______________________________ Phone_____________________

Responsible Party Signature________________________ Date_____________________

Safe Haven Maternity Home
New Resident Intake Packet 3
10/15
SAFE HAVEN MATERNITY HOME
RESIDENT RIGHTS AND RESPONSIBILITIES

AS A RESIDENT OF SAFE HAVEN YOU HAVE A RIGHT TO:

- A safe, stable, secure and nurturing environment.

- Physical, psychological, emotional, educational, legal and medical issues addressed within the context of the boundaries and expertise of Safe Haven together with community resources, programs/individuals associated with promoting its mission.

- Be treated respectful and given freedom to express opinions or concerns.

- Develop and demonstrate personal boundaries.

- Make choices regarding parenting and adoption.

- Pursue a grievance or complaint in accordance within safe Haven policies.

- Use of personal “quiet time” or “think time”. However, a pattern of “isolation and/or avoidance” is behavior not conducive to the life skills learning environment and will be discouraged.

- Have other residents respect your right to privacy, personal property and personal quiet time.

- Be excused for two days from any program requirements or routine due to illness or other limitations. Medical directives are necessary for any long period of limited activity.

- Have all personal information kept confidential, unless a release is authorized by you for other individuals/agencies working for or with Safe Haven.

- Terminate being a resident at Safe Haven, at any time; however, once this has been acted upon, your vacancy will be filled by the next person on the waiting list. Exceptions: Girls placed by OYA or SCF are under jurisdiction of their guidelines for termination of residency.

- To be considered for re-admission into Safe Haven at a later date. (to be determined case by case and with a 30 day signed contract)
SAFE HAVEN MATERNITY HOME
GRIEVANCE PROCEDURE

All residents have a right to a grievance procedure.

A resident may share a concern or complaint to the Program Manager and/or House Mothers who then have the responsibility to investigate and make a collective judgment on the matter.

If a resident has a concern regarding a Program Manager and/or House Mothers, she may register the complaint either verbally to the Executive Director or write the concern down. The Director will then look into the concern.

If concern is with the Executive Director, a resident may file her complaint in writing to the Board of Directors (address will be made available). The Board will hear her concern at the next scheduled board meeting. A written response will be made to the resident within two weeks of the meeting.

If the concern is urgent, the board can call a special meeting, to be set up by the Board Chairman. Written response to the resident will be made within 1-2 days of this special meeting of the board.

No appeals beyond the board are possible.

Acceptance Policy

Safe Haven Maternity Home offers service to anyone regardless of race, ethnicity, religion, mental or physical handicap, including HIV. Diversity is welcomed and no one is refused because of inability to pay.

We accept pregnant women; we are licensed for ages 13-17 and on occasion accept other ages. We accept infants only, but in special circumstances an exception can be made for toddlers.

Safety for all residents of Safe Haven is a number one priority therefore, potential residents of Safe Haven Maternity Home will be denied access based on the following:

- Currently/recently suicidal (within past 60 days)
- Current/recent assault incidents (charged, yet unresolved)
- Current drug/alcohol use
- Refusal to submit to Urine Analysis (UA)
- History of sex offender behavior, fire starting or animal abuse

* unless approved by the Executive Director
Name:__________________________________________ Date__________________

HOUSING

Current/most recent living situation_________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

EDUCATION HISTORY

Where did you attend school?_____________________________________________________
Highest grade completed?_________
Did you graduate?_______
Have you received any specialized training?___________
Please explain:______________________________________________________________
_____________________________________________________________________________

EMPLOYMENT HISTORY

Number of jobs held in the past year?_______
Reason no longer employed?_____________________________________________________
Additional work skills you may have?_____________________________________________
Work attitudes and habits:
    How do you see yourself in the workplace?_____________________________________
    What kind of employee do you consider yourself?_______________________________
_____________________________________________________________________________

Job seeking skills (ie, writing resumes, Job interviewing techniques, etc.)
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
SAFE HAVEN MATERNITY HOME
Screening/page 2

MEDICAL HISTORY

LAST EXAMS
Physical:
  Date:_________ Findings:_____________________________________________
  Due Date:____________

Dental: Date:_________ Findings:___________________________________________

Vision: Date:________ Findings:_____________________________________________

What actions do you feel are needed to improve your physical health?____________

MENTAL HEALTH HISTORY

Check each category that you have (ever) experienced:
  ____ Depression  ____ Emotional Abuse
  ____ Mental Illness  ____ Suicide thoughts/attempts
  ____ Sexual Abuse  ____ Treatment for any of the
  ____ Physical Abuse  aforementioned

LEGAL HISTORY

Do you have a valid driver’s license? Yes_____ No _____
If no, why not?_________________________________________________________________________

If no driver’s license, do you have photo I.D.? Yes_____ No _____

Do you have car insurance? Yes_____ No_____ Insurance Information________________
_________________________________________________________________________________

Arrest record:
Charge________ Date________ Conviction________ Sentence________________________
Charge________ Date________ Conviction________ Sentence________________________

Drug Court____________ Date_______ Sentence______________________________________
Probation/Parole Officer?________________________ Phone:____________________
Upcomming Court date?____________

FAMILY/SOCIAL SUPPORT NETWORK:
Parents________________ Siblings________________ Other____________________

What are your interests and hobbies?________________________________________

Are you involved in any organizations (church, school, service)?____________
____________________________________________________ Friends__________________
SAFE HAVEN MATERNITY HOME
Screening/page 3

SOCIAL SERVICES HISTORY

Please check the agencies you are working with or have worked with in the past:

- Adult and Family Services
- Services to Children & Families
- Mental Health
- Veterans Administration
- Social Security Administration
- Parole and Probation
- Umpqua Training & Employment
- Worker’s Compensation
- Food Stamp Program
- Disability Services
- Support Enforcement
- Vocational Rehabilitation
- Employment Office
- D.C. Housing Authority
- ADAPT

The following services are provided for your benefit. Please check the top three (3) in order of priority:

- Social Skills
- Housing/Independent Living
- Personal Counseling
- Money Management
- Legal Services
- Housekeeping Skills
- Health/Nutrition Information
- Problem Solving Skills
- Parenting Skills
- Job Improvement
- Education GED
- Job Training
- Alcohol/Drug Counseling
- Other

COMMENTS

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________
SAFE HAVEN MATERNITY HOME
LIABILITY RELEASE AGREEMENT

(Keep on File for Resident Usage)

PLEASE INITIAL

_______ I have received, read and had the rules and guidelines for group living explained to me and agree to abide by them.

_______ I understand the Safe Haven cannot and will not be held responsible for any injury occurring to myself or anyone of my acquaintance, while I am in the program.

_______ I understand and agree that should I leave, or be dismissed, my clothes and personal items will be taken with me upon departure. Anything left over 30 days (without special arrangements for pickup), will become property of Safe Haven.

_______ I understand the Safe Haven will not be responsible for any personal property left, lost or stolen, from the premises of the house or property.

_______ I understand that I am to open all mail and or packages in the presence of staff. Although the staff will not read my mail, they may examine the contents of any bulky envelopes or packages.

_______ I understand my belongings can be searched and checked upon arrival to Safe Haven. A check list documenting my belongings will be updated during my stay at Safe Haven.

_______ I realize that upon entrance into Safe Haven, with the aid of the staff, I will develop a personal schedule and I agree to abide the same.

____________________________________  __________________________
Resident Signature                  Date

____________________________________  __________________________
Parent/Guardian Signature           Date
Resident's Name: ________________________________ Date: ____________

Please initial the following as they are gone over:

- House rules and expectations
- Medication procedures and Medication Log
- Emergency procedures/names & numbers posted (ie drill and equipment)
- Grocery shopping days and procedures meals and menus laundry
- Where house chores list is posted
- Acceptance Policy
- Passes (all weekend outing requests must be in by Thursday)
- Phone policy
- House meetings (ie: conflict resolution, problem solving)
- Resident rights and responsibilities
- Resident grievances
- Resident Income and Savings
- Adoption Option/counseling
- Belongings and valuables policy
- Permission to treat
- Release of information
- Agreement for drug testing
- Model release
- Health services
- ISP planning

Resident Signature ___________________________________________ Date ____________

Staff Signature ___________________________________________ Date ____________

Parent/Guardian Signature ____________________________________ Date __________
SECTION 2
SAFE HAVEN MATERNITY HOME
Release of Information

Name: ______________________________  D.O.B. __________  S.S. # __________________

I authorize the following individuals or agencies:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

(Name) ____________________________  (Address) ____________________________

Including records of:
☐ Yes  ☐ No  Family History
☐ Yes  ☐ No  Employment/Unemployment
☐ Yes  ☐ No  Educational Reports
☐ Yes  ☐ No  Alcohol/Drug Treatment
☐ Yes  ☐ No  Mental Health Services
☐ Yes  ☐ No  Medical/Psychiatric Treatment

Alcohol/drug, Mental Health and Medical records include all aspects of diagnosis, treatment and prognosis. Educational records include both behavioral and progress reports.

I agree that the agencies and individuals listed above may share and exchange information about my family and circumstances. ☐ Yes  ☐ No

Purpose: the information received will be used to evaluate my situation and to plan for and coordinate services for me and my family, or for other purposes as specified: __________________________

____________________________________________________________________________________

This permission is good for one year beginning ______________________

I can cancel this at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

☐ Client  ☐ Guardian
☐ Parent  ☐ Legal Custody  ____________________________  ____________________________

Parent/Guardian  Staff Signature  Date

To those receiving information under this authorization: This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless Authorized by other laws.

This is a true copy of the original authorization document ____________________________  ____________________________

Safe Haven Maternity Home  15
New Resident Intake Packet  10/15
SAFE HAVEN MATERNITY HOME
PERMISSION TO TREAT

I. ________________________________ GIVE PERMISSION TO SAFE HAVEN
TO TREAT MINOR INJURIES,(I.E., CUTS, MINOR BURNS, SCRAPES). I UNDERSTAND
THAT STAFF OF SAFE HAVEN HAS COMPLETED CPR AND FIRST AID THROUGH THE
AMERICAN RED CROSS.

I ALSO GIVE PERMISSION TO SAFE HAVEN STAFF TO TRANSPORT, EITHER BY SAFE
HAVEN VAN OR AMBULANCE, TO THE LOCAL HOSPITAL, IF NECESSARY FOR
TREATMENT OF INJURY.

CLIENT___________________________________ DATE____________________

PARENT OR LEGAL GUARDIAN_______________________________

SAFE HAVEN STAFF________________________________________________________

This consent will remain in effect only while the client is a resident of Safe Haven.
SAFE HAVEN MATERNITY HOME

AGREEMENT FOR DRUG TESTING

I understand that on acceptance into Safe Haven Maternity Home, the Program Manager or (ED) has the right to request that I submit to drug analysis testing. I understand that if there is a concern that I am using or abusing drugs, or alcohol, the Safe Haven staff will be of assistance in finding a more appropriate program for my needs.

_______________________________________        ___________________
Resident Signature                      Date

_______________________________________        ___________________
Staff Signature                        Date

_______________________________________        ___________________
Parent/Guardian Signature               Date

Dates of Testing

Date   Result   Staff Initials

Date   Result   Staff Initials

Date   Result   Staff Initials
Confidentiality Policy
(as outlined in Guidelines and Rules)

Confidentiality is the preservation of privileged information about someone else. This information can be obtained because of group living situations and within the development of relationships. Each resident at Safe Haven Maternity Home is entitled to complete confidentiality not only by staff but also by other residents. It is Safe Haven’s policy that all information about every resident is strictly confidential and stays within the walls of the home. Any information or knowledge you may have about a resident’s life or situation is not to be brought to the attention of other clients in the home. To protect privacy and dignity, we ask that you acknowledge and affirm your intent to keep all information confidential and will not share any information outside of the home. Breaking confidentiality could result in immediate termination from Safe Haven’s program.

If you have a safety or criminal concern it should be brought to a staff member to look into. Please refer to our grievance policy to handle concerns with staff members and follow its directive.

If there is a concern of abuse or neglect please immediately report to a Safe Haven Maternity Home staff so we can ensure the safety of the abused/neglected individual and assist you in filing a report through the abuse hotline at 855-503-SAFE (7233). Reporting a valid case of abuse/neglect is not a breach of confidentiality.

What I hear or observe about clients, staff or other volunteers while here will remain confidential. I agree to protect the privacy of client information I am given access to. I agree to keep this information in the strictest confidence and the failure to do so may result in my being terminated from the program.

____________________________________  ______________________
Resident/Staff/Volunteer Signature                     Date
SAFE HAVEN MATERNITY HOME

MODEL RELEASE

I HEREBY GRANT TO SAFE HAVEN MATERNITY HOME THE IRREVOCABLE AND UNRESTRICTED RIGHT TO USE AND PUBLISH PHOTOGRAPHS OF ME, AND/OR MY INFANT FOR THE PURPOSE OF PROMOTING, OR EDITORIALIZING THE ACTIVITIES OF SAFE HAVEN. I HEREBY RELEASE SAFE HAVEN AND THEIR LEGAL REPRESENTATIVES FROM ALL CLAIMS AND LIABILITY RELATING TO SAID PHOTOGRAPHS.

NAME: ________________________________

ADDRESS: ________________________________

CITY, STATE, AND ZIP: ________________________________

IF A MINOR CHILD, SIGNATURE OF GUARDIAN

INITIAL ON OF THE FOLLOWING OPTIONS:

PHOTO OF ME ONLY ________________

PHOTO OF MY INFANT ONLY ____________

PHOTO OF BOTH ________________

NAME USE TO REMAIN ANONYMOUS? Yes No

NAME USE OK Yes No

_______________________________________        ___________________
Resident Signature                    Date
SAFE HAVEN MATERNITY HOME
Resident Income and Savings Policy

For the protection of the residents of Safe Haven Maternity Home and to help them get started upon leaving, all residents income will be collected by the program manager and distributed as follows:

**Basic Schedule**

Income
- $100 ($125 with child) Allowance
- 75% toward Program Services, up to maximum of $500
- 25% toward bills and savings (remainder to bills and savings once Program Services has been paid)

Volunteer hours for any program service fees left unpaid (Paid at $10/hour)

Food Stamps/Income
- $130 ($200 with child (+$50 each additional child)) Food & Groceries

Any income up to, and including $100 per month will be distributed back to the resident, by the program manager as a monthly allowance. Upon the resident's written request any portion of this may be put into savings.

The savings amount, less personal expenses (i.e. telephone calls), will be returned to the resident upon their discharge. The savings will be paid in two payments, 75% within 48 hours of discharge and the balance 31 days later.

**CONTRACT FOR INDEPENDENT PLANNING**

I UNDERSTAND THAT UPON ACCEPTANCE INTO SAFE HAVEN MATERNITY HOME AN INDEPENDENCE PLAN WILL BE SET UP FOR ME.

THIS PLAN IS TO HELP ME ESTABLISH GOALS FOR MY FUTURE AND PROGRESS TOWARDS INDEPENDENCE.

I AGREE TO ESTABLISH A PLAN AND FOLLOW THE DIRECTIVES OF SAFE HAVEN IN IMPLEMENTING THESE IN A TIMELY MANNER.

I UNDERSTAND THAT I WILL BE EXPECTED TO PARTICIPATE IN PROGRAMS THAT HELP ME MEET MY GOALS AND THE GOALS SET FOR ME BY SAFE HAVEN.
SAFE HAVEN MATERNITY HOME
CONTRACT FOR FINANCIAL PLANNING

DATE___________________________

I AM PRESENTLY RESPONSIBLE FOR CERTAIN DEBTS IN THE AMOUNT OF:

__________________________________      ______
AMOUNT TO WHOM

__________________________________
AMOUNT TO WHOM

__________________________________
AMOUNT TO WHOM

AND REQUEST ASSISTANCE IN SETTING UP A PLAN TO PAY THESE DEBTS IN A TIMELY MANNER.

__________________________________    ______________________________
RESIDENT STAFF
SECTION 3
SAFE HAVEN MATERNITY HOME
Health Services Provided

Safe Haven will provide each resident with the means of procuring a medical card if eligible.

If resident has private insurance, a copy of such will be forwarded to resident personal file.

Translink Transportation is to be used for all medical appointments. Residents can schedule their transportation by calling 888-518-8160.

Safe Haven will require a signed release by resident for their primary physician. Information released to staff of Safe Haven is on a need to know basis- to insure proper care pre and post pregnancy.

Safe Haven will require a Urine Analysis (UA) within two weeks of acceptance into our program and if needed a referral to appropriate agency (ie ADAPT, Crossroads, Serenity Lane).

Safe Haven will be available to attend delivery if necessary or if requested by resident.

Safe Haven staff will provide transportation to obtain prescriptions for residents in a timely manner.
SAFE HAVEN MATERNITY HOME
Medication Policy

All medications (meds) being taken by residents will be distributed by staff to include Over the Counter (OTC): (ie: non Aspirin, pain relievers, cough & cold remedies) at prescribed times, and shall be documented.

All prescription medications, including narcotics, will be kept in a locked cabinet or in a locked box in the refrigerator. Residents at no time shall have direct access to these medications.

All residents on prescription medications are not allowed to discontinue use without specific medical approval or direction. The only exception is PRN (as needed) meds.

All discontinued or no longer needed medications will be disposed of by the staff & a witness & will be documented on appropriate log sheet.

Juvenile residents (those under 18) MUST REQUEST their medication at the prescribed times. Staff is NOT allowed to initiate distribution of any medication to juveniles without their verbal request.

Diet pills & laxatives are not allowed for any reason and any attempt at acquiring these will be reported to the Program Manager ASAP. Stool softeners are permitted with medical approval.

All residents are allowed and encouraged to take vitamins, they do not need to be logged.

Residents may use Over the Counter Treatments (ointments, drops, and sprays) as needed following the label directions.

Any questions about what medications must be logged or concerns of medication taken by any resident should be brought to the attention of the Program Manager.

_________________________________________________   _____________________
Resident Signature                          Date

_________________________________________________   _____________________
Parent/Guardian/Responsible Party Signature  Date
# Safe Haven Maternity Home

## Alcohol and Other Drug Matrix

<table>
<thead>
<tr>
<th>Substance</th>
<th>Age of First Use</th>
<th>Date of Last Use</th>
<th>Highest Level Quantity/Frequency</th>
<th>Current Pattern</th>
<th>Ingestion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
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<tr>
<td>Nicotine</td>
<td></td>
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<tr>
<td>Marijuana</td>
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<tr>
<td>Meth/Crank</td>
<td></td>
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<tr>
<td>Caffeine</td>
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<tr>
<td>LSD/Shrooms/Peyote</td>
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<tr>
<td>Amphetamine/xtrops</td>
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<tr>
<td>Inhaleants (gas glue, aerosols)</td>
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<tr>
<td>Vivarin, Nodoz, Sominex</td>
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<tr>
<td>Cocaine (crack)</td>
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<tr>
<td>Tranquilizers (Valium, Haldol)</td>
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<tr>
<td>Heroin/opium/morphine/methadone</td>
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<tr>
<td>Amylnitrate, rush, poppers</td>
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<tr>
<td>Barbs, downers</td>
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<tr>
<td>Quaaludes</td>
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<tr>
<td>PCP/AngelDust</td>
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<td>Designer</td>
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<tr>
<td>Steroids</td>
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<tr>
<td>Diet pills</td>
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<tr>
<td>Other</td>
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</table>

AOD of Preference: 1. __________________ 2. __________________ 3. ________________

Comments: ________________________________________________________________
SAFE HAVEN MATERNITY HOME
Relationship History

Present social relationship (describe):
________________________________________________________________________
________________________________________________________________________

Dating history (describe):
________________________________________________________________________

When did you become sexually active?
________________________________________________________________________

Has there ever been any verbal, physical, sexual abuse in your relationships?
If yes, please describe:
________________________________________________________________________

Marital Status: Married___Never married___Divorced___Separated___
Widowed___Living together____

Status of relationship over the past year
________________________________________________________________________

Is the father of your baby supportive of you?
________________________________________________________________________

Is he planning to help provide for your child?
________________________________________________________________________

Is his family supportive of you and your relationship?
________________________________________________________________________

Is his family planning to be supportive of the baby?
________________________________________________________________________

Will the baby’s Father be available for parenting classes?
________________________________________________________________________

How do you feel about the baby’s father?
________________________________________________________________________

Do you wish to continue in a relationship with your child’s Father?
________________________________________________________________________

Do you feel the baby’s Father will make a good parent?
________________________________________________________________________
SAFE HAVEN MATERNITY HOME
Family History

Birth Father__________________________________________________________
If deceased, cause of death:______________________________________________
Your age when he died?__________________________________________________
What kind of relationship did (do) you have with your father?__________________
______________________________________________________________________

Birth Mother___________________________________________________________
If deceased, cause of death?_____________________________________________
Your age when she died?_______________________________________________
What kind of relationship did (do) you have with your mother?______________
_______________________________________________________________________

Do you have other people who you feel were like a parent to you?____________
_______________________________________________________________________

<table>
<thead>
<tr>
<th>Siblings</th>
<th>Name</th>
<th>Nature of relationship</th>
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<tbody>
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</tbody>
</table>

Have any of the above family members abused drugs or alcohol?
_______________________________________________________________________

Are any of the family members presently in recovery who had abused
chemicals?________________________________________________________________

Describe your home life, growing up:________________________________________
________________________________________________________________________

Do you wish your family life could have been different?_____________________

Describe how you would like your family life to be:__________________________
SAFE HAVEN MATERNITY HOME
Psychological History

Have you ever been treated for psychological, emotional, or behavioral problems? If yes, please explain the difficulty. __________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Have you ever been treated for mental illness? ____________________________
If so when and where? ____________________________
How do you deal with stress? __________________________________________
____________________________________________________________________________________

Have you ever been treated for chemical dependency? ___________________
When: ________________________________________
Where: ________________________________________
Still in recovery? ________________________________________
____________________________________________________________________________________
What groups or individuals have you had as a support for staying clean from chemical usage_______________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Are you still currently involved with a support group? ______________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Have you ever been treated for emotional, verbal, physical, sexual abuse or rape? ______
If so, who provided the treatment? ____________________________________________
____________________________________________________________________________________

Have you ever received counseling or Mental Health services in the past? ______
If yes, with whom? ____________________________________________
____________________________________________________________________________________

Have you ever been involved with Children’s Services? ______________________
Please explain the circumstances: __________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Have you in the _____ past or _____ present, thought of suicide? ______________________
Have you ever made any suicide attempts? ____________
If yes, please describe circumstances: ____________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Were you hospitalized? __________ Where? ____________________________
Are you currently feeling suicidal? ____________________________________________
____________________________________________________________________________________

Are you currently receiving mental health counseling? ____________________________
If yes, please state with whom, how long, and the phone number: ____________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
SAFE HAVEN MATERNITY HOME
Legal History

Have you been arrested? (Y) (N) Please list/explain situation:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Have you ever been stopped by police but not arrested?____________
Explain:________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Have you been in jail/detention in the past two years? (Y) (N) If yes, please
explain:________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Were drugs/alcohol involved? (Y) (N)
If yes, please give the terms of your probation/ parole and give the name and
phone number of your parole/ probation officer:________________________________________________________________________
________________________________________________________________________

Nature of pending legal problems:__________________________________________
Pending court dates:_______________________________________________________

Please describe any history of assault charges:________________________________
________________________________________________________________________

Any child abuse charges?___________________________________________________
Explain:__________________________________________________________________
________________________________________________________________________
SAFE HAVEN MATERNITY HOME
Spiritual Life

Do you have a higher source of power you believe in?

Religious Background:
Church Affiliation?
Present involvement?

Would you want to participate in a study of the Bible?

Would you want to attend church or religious group activities, while you are at Safe Haven?

Do you have a church of choice?

Do you want to have prayer with the staff or other people on a regular basis?

Would you want to have counseling by a minister or person from a spiritual prospective?

Do you want a Bible of your own?

Any other spiritual resources you would like to have?

Have you participated in any Satanic or occult practices?
Have you or a loved one been subject to any abuse by those practicing Black Magic?

Do you have any fears, nightmares, emotional disturbances, or strange apparitions associated with any past religious activities? (Including occultic)?

Do you desire help in understanding how spiritual activities and associations may have affected how you feel about yourself and life?

Do you desire to have prayer on your behalf?

Do you have any special requests?
Safe Haven Maternity Home
Policies, Rules & Guidelines Acknowledgment and Agreement

I _______________________________ certify that I meet the requirements of the program and
_________________________________________ acknowledge the following by initialing each item below:

_____ I acknowledge that I have received and read a copy of the Safe Haven Maternity
Home Rules & Guidelines for Group Living. I understand that the policies, rules, and benefits
described are subject to change or may be revised based on the organization’s particular
circumstances of a given situation. I understand that this handbook replaces any and all prior
verbal and written communications.

_____ I acknowledge that I have received and read a copy of the Safe Haven Maternity
Home Intake Packet. I understand that the policies, rules, and benefits described are subject to
change or may be revised based on the organization’s particular circumstances of a given
situation. I understand that this handbook replaces any and all prior verbal and written
communications.

_____ I have read and understand the contents of the Guidelines & Rules for Group Living and
will act in accord with these policies and procedures as a condition of my residency with Safe
Haven Maternity Home.

_____ I have read and understand the contents of the Resident Intake Packet and will act in
accord with these policies and procedures as a condition of my residency with Safe Haven
Maternity Home.

_____ I have read and understand the contents of the Resident Rights & Responsibility
Statement and will act in accord with these policies and procedures as a condition of my
residency with Safe Haven Maternity Home.

_____ I have read and understand the contents of the Grievance Procedure and will act in
accord with these policies and procedures as a condition of my residency with Safe Haven
Maternity Home.

_____ I have read and understand the contents of the Acceptance Policy and will act in
accord with these policies and procedures as a condition of my residency with Safe Haven
Maternity Home.

I understand that if I have questions or concerns at any time about the Resident Intake Packet or
the Rules & Guidelines for Group Living Handbook, I will direct my questions to Safe Haven Staff
for clarification.

Please read all the contents of the Resident Intake Packet and the Rules and Guidelines for
Group Living carefully to understand these conditions of residency before you sign this
document.

Resident’s Printed Name ___________________________________ Guardian’s Signature ______________________

Resident’s Signature ________________________ Date ____________

Safe Haven Maternity Home
New Resident Intake Packet
SAFE HAVEN MATERNITY HOME
ISP (Individual Service Plan) Agreement/Behavior Management Policy

The following actions will result in a warning (write-up), corrective action, including referral to appropriate agencies and/or dismissal.

- Violating a no contact order
- Staff verbal abuse
- Association with known drug users
- Dirty urinalysis, possession of drugs, and/or being under the influence of any intoxicant
- Not being where resident said they were going to be
- Drug-a-log (talking about and/or glorifying drug or alcohol use)
- Violating house rules/guidelines

Physical violence of any type will not be tolerated. Violation of this rule could result in assault charges being filed. This rule extends to staff members also. We will not tolerate disrespectful treatment, threatening behavior, rudeness, verbal abuse, obscene language, deliberate harassment, causing division, or ganging up on any resident or staff. Any of these actions will result in a warning (write-up), corrective action and/or dismissal.

Corrective Action will be based on client development, repeated occurrences, and client skill set; done at staff discretion.

Three strike rule - Three warnings will constitute immediate termination from program.

I understand and agree for Safe Haven Maternity Home to develop a personal service plan for me each month (or as needed) and I agree to follow through on all of the actions and services identified in this plan. All parties will be notified when, and if, any changes are made.

The information included in this service plan represents a general plan of services and activities. It is not entitlement to such services nor a legal contract that guarantees the delivery of services herein described. For description of client rights and responsibilities, you will be given a copy for reference.

The Safe Haven program will utilize warnings, write ups and dismissals when needed and Safe Haven dollars are given to reinforce positive behavior. See above behavior management policy for details.

_________________________________________________   _____________________
Resident Signature                                      Date

_________________________________________________   _____________________
Parent/Guardian/Responsible Party Signature             Date

_________________________________________________   _____________________
Safe Haven Staff Signature                              Date
**SAFE HAVEN MATERNITY HOME**  
**Individual Service Plan (ISP)**

**RESIDENTS NAME_______________________________________________**

**TODAYS DATE______________________________________________**

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<th>Identified problems</th>
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6. Short Term Plan________________________________________________________
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**SAFE HAVEN MATERNITY HOME**
**Individual Service Plan (ISP)**

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SAFE HAVEN MATERNITY HOME
Individual Service Plan (ISP)

RESIDENTS NAME______________________________________________________________

TODAYS DATE____________________________

Identified problems- To be reviewed____ 30  60  90  Days
1 HOUSING______________________________________________________________
2 EDUCATION/EMPLOYMENT____________________________________________
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SAFE HAVEN MATERNITY HOME
Individual Service Plan (ISP)

RESIDENTS NAME__________________________________________________________

TODAY'S DATE______________________________________________________________

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1 HOUSING______________________________________________________________
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SECTION 5
SAFE HAVEN MATERNITY HOME
Exit Summary/Discharge plan

Name____________________________________ D/O/B________________________________

Admission Date________________________________ Exit Date________________________________

Number of Bed Nights Provided____________________________________________________________

Infant born While in Residence_________________________ D/O/B________________________

Forwarding Address____________________________________ Phone__________________________

Please check that of the following you participated In/or Completed:

_____GED (graduated____)

_____School____________(Parents Program graduated______)

_____College____________________

_____Umpqua Training and Employment Program

_____Employment__________________________Location____________________________________________

_____Parenting Classes

_____Birthing Classes

_____One to One counseling Provided by__________________________________________

_____Group Counseling

_____Alcohol and Drug Program

_____Nutrition Classes

_____Church or Spiritual Group

_____Recreational Activities

_____A.A. or N.A.

_____Volunteered_____________________________Location________________________________

_____Budgeting Class

OTHER:

Medical Services Provided:

_____Physical Doctor___________________________Date________

Follow-up Doctor___________________________Date________

_____Dental Doctor___________________________Date________

Follow-up Doctor___________________________Date________

_____Vision Doctor___________________________Date________

Follow-up Doctor___________________________Date________

_____Hearing Doctor___________________________Date________

Follow-up Doctor___________________________Date________

COMMENTS OR REFFERALS:

________________________________________________________________________

Residents Signature Date ________________________

Staff Signature Date ________________________

Safe Haven Maternity Home
New Resident Intake Packet

10/15
RESIDENT EXPERIENCES AT SAFE HAVEN

THE REASON I NEEDED SAFE HAVEN WAS BECAUSE__________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

THE THING THAT HELPED ME MOST WAS____________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

WHAT I LEARNED WHILE AT SAFE HAVEN WAS_______________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

MY SUGGESTIONS FOR MAKING SAFE HAVEN A BETTER PLACE TO BE ARE_______________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

DATE ______________________________________

NAME: ______________________________________

____________________________________________________________________________________
SAFE HAVEN MATERNITY HOME
CONTRACT FOR READMITTANCE

I understand and agree to the following terms for returning to residency at Safe Haven:

1. I will be subject to random Urine Analysis (UA’s).

2. I will be on a ______day “probationary period”. During this time, (including weekends) I will leave the premises for required activities and/or medical/legal appointments, only. Overnight and other visits are prohibited for the duration of this contract.

3. I agree to be compliant with all rules and program expectations.

Other________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Contract will be reviewed in ________days.

________________________________  ________________________________
Resident Signature              Date             Responsible Party             Date

________________________________
Staff Signature                  Date