Chugachmiut Behavioral Health
1840 Bragaw Street, Suite #110
Anchorage, AK 99508
Phone: (907) 562-4155 Fax: (907) 278-0300

Welcome to Behavioral Health Services!

Our Behavioral Health program provides treatment services for those who have concerns about emotional health, family problems, and substance use issues. Our trained person-centered providers can assist with family problems, parenting issues, and a range of other concerns like depression and anxiety. Please talk with your counselor about the options for including your family members, as appropriate or as you desire, into your counseling services.

Please fill out the attached forms, including: 1) basic information, 2) rights and consent to treat, 3) obligations, 4) the Alaska Screening Tool, and 5) the Client Status Review to give us information about how to assist with your concerns. We will develop an assessment and a treatment plan as a road map to help us get you to your counseling destination. Also, your counselor will discuss safety plans (exits, fire extinguishers, and first aid kits) with you to ensure your safety while you are in our facilities.

We are delighted to introduce you to our treatment services. Always remember that these are your services, so your participation in all aspects (such as setting goals and attending sessions) is vital to the counseling process. If, at any time, you feel that you would be better served elsewhere, please talk to our counselors about other options including transfers to other counselors, other services, or services after termination of services. Please see our brochure for additional information. If you have any questions, please let our staff know.

For 24-hour assistance, you can call the Crisis Line at (907) 891–0444.

Your Chugachmiut Behavioral Health Staff

Client Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU CAN BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Pledge Regarding Mental Health Information

The privacy of your mental health information is important to us. We understand that your health information is personal and we are committed to protecting it. Once you receive services with Chugachmiut, we create a record of care and the treatment you receive here at Chugachmiut. We maintain this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share information about you. It also describes your rights and certain duties we have regarding the use and disclosure of protected mental health information.

Our Legal Duty

The Law Requires Us To:

1. Keep your health information private except in certain circumstances required by law.

2. Provide you with this notice describing our legal duties, privacy practices, and your rights regarding your health information.

3. Follow the terms of the notice that is now in effect.

We Have the Right To:

1. Change our privacy practices and terms of this notice at any time, provided the changes are permitted by law.

2. Make effective the changes in our privacy practices and new terms of our notice for all health information we keep, including information previously created or received before the changes.

Notices of Changes in Privacy Practice:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available.

Use and Disclosure of Your Protected Mental Health Information

The following section describes different ways that we use and disclose protected health information. Not every use and disclosure will be listed. ***We will not use or disclose your mental health information for any purpose not listed***

below without your written authorization. Any specific written authorization you provide may be revoked, by you, at any time by an in-person, phone or written request.

Treatment Purposes: Upon your request or in an emergency medical situation, we may share your health information in order to prevent loss of life or limb (including medicinal interactions, allergies, etc.). Any medical disclosures beyond this will require your disclosure request.

Payment Purposes: We may use and disclose your health information, only to the extent permitted by HIPAA laws, for payment purposes. We may submit requests for payment to your insurance company. The insurance company maintains the right to request certain information from us regarding care given. We will provide the required information to them about you and the care given so that you may access your insurance benefits.

Operation Purposes: We may share your health information for our business-related matters, such as CARF and Medicaid audits, billing services, accounting, legal services and for statistical purposes (your name will be removed whenever possible). We may also use and disclose your health information for our health care operations. This may include measuring and improving quality, evaluating the performance of employees, conducting training programs and getting the accreditation, certificates, licenses and credentials we need to serve you.

Other Disclosures and Uses Required/Permitted by Law Include:

Abuse and Neglect: All practitioners of Chugachmiut are **mandated** by Alaska State Law to report suspected abuse and neglect of children, elderly and persons with disabilities.

Court Proceedings: We may disclose your protected information in the course of any judicial or administrative proceeding as allowed or required by law, with your specific written consent, or as directed by a judge's court order.

Harm to Self or Others: To avert a life-threatening situation, we may disclose your protected information consistent with applicable law to prevent an imminent threat to the health and safety of a person or the public.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws, pursuant to court orders, reporting limited information concerning identification and location at the request of law enforcement officials, reporting death, crimes on our premises and crimes in emergencies.

Notification: In the event of an emergency, hospitalization, and with your permission, we may use or disclose your protected information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, about your general condition. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to professional judgment.

Workers Compensation: If you are seeking compensation through Workers Compensation, we may disclose your protected information to the extent necessary to comply with laws relating to Workers Compensation.

Other Uses: Other uses and disclosures besides those identified in this notice will only be made as authorized by law or with your specific written consent, which you may revoke in writing at any time.

Your Information Rights:

The health and billing records we maintain are the physical property of Chugachmiut. The information in it, however, belongs to you.

You have a right to:

- Request a restriction on certain uses and disclosures or your file by delivering the request, in writing to our office. We are not required to grant the request, but we will carefully review any request received.
- Obtain a paper copy of this notice by making a request at our office.
- Request that you be allowed to inspect and/or receive a copy of your file and/or billing record. You may exercise this right by delivering your written request to our office.

  If you are a parent of legal guardian of a minor, please note that certain portions of the minor's file may not be accessible to you. This determination is made by the minor's therapist if he/she determines that your access to the file would be harmful.

- Request that your file be amended to correct incomplete or incorrect information by delivering a written request to our office. We are not required by law to make such amendments, but we will carefully review any request received. Additionally, we will retain a copy of the request for modification in the record.
- Revoke authorizations that you made previously, except to the extent information or action has already been taken, by delivering a written revocation to our office.
- Review this notice before signing any consent authorizing use and disclosure of your protected information for treatment, payment, and operation purposes.

I acknowledge that I have read and understood the above privacy policies.

_____ _____

Signature **Date**

_____ _____

Counselor Signature **Date**

Revised: 12/1/2020

Consent for Treatment

- I understand that I am voluntarily seeking services from Chugachmiut, Inc. and that both Chugachmiut and I have the right to terminate program services at any time by simply notifying the other party of this intention. Chugachmiut will make appropriate referral on its part.
- Program services may include, where appropriate, training, personal skills development, progress evaluations, counseling, medication referral, psychological testing, or referral to another agency. I understand that a therapist will immediately refer me elsewhere for adequate, mutually agreed upon treatment should a situation arise where the therapist-client relationship in not conducive to therapy or where the mental health clinic is not equipped to handle my particular situation.
- No training or service program shall be performed on my behalf unless I, or my guardian, has participated in its planning and have agreed to it.
- I understand that if I have any complaints regarding services or concerns about my service, I have the right to use the Chugachmiut Grievance Process at any time to resolve these issues to my satisfaction.

I understand the above information and terms and I consent to participate in the counseling process at Chugachmiut.

_____ _____

Client's Signature Date

_____ _____

Staff Signature Date

Revised: 2/28/2020

Chugachmiut

CLIENT INFORMATION FORM

Name: _____ Today's Date: _____
(First, Middle, Last)

Address: _____
Address City State Zip Code

Village: _____

Home Phone: _____ Cell: _____

May we leave a message at either of these numbers? _____

Social Security Number: _____ D.O.B.: _____

Gender: _____Male _____Female

Medicaid Number: _____
Other Health Insurance: _____ Policy Number: _____

Email Address: _____

Emergency Contact: _____ Phone: _____

Demographics

Race(s): Check all that apply	**Alaska Native**	**Ethnicity: Check One**
☐ American Indian	☐ Aleut or Sugpiaq	☐ Not Spanish/Hispanic/Latino
☐ Asian	☐ Athabascan	☐ Spanish/Hispanic/Latino
☐ Black/African American	☐ Haida or Tlingit	☐ Hispanic-specific not specified
☐ Caucasian	☐ Inupiat	☐ Puerto Rican
☐ Native Hawaiian	☐ Tsimshian	☐ Cuban
☐ Pacific Islander	☐ Yupik	☐ Mexican
☐ Other	☐ Other Alaska Native	☐ Chicano/Other Hispanic

Special Needs: Check all that apply	**Education: Check one**	**English Fluency: Check one**
☐ None	☐ K-11, How many years? _____	☐ Excellent
☐ Acquired Brain Injury	☐ GED	☐ Good
☐ Autism	☐ High School Diploma	☐ Moderate
☐ Developmentally Disabled	☐ Vocational Training after HS	☐ Poor
☐ Fetal Alcohol Spectrum Disorder	☐ Special Education Classes	☐ Not at all
☐ Major Difficulty in Ambulating or Non-ambulation (Walking)	☐ Bachelor's Degree	**Veteran Status: Check one**
☐ Mod to Severe Medical Problems	☐ Graduate Work (No Degree)	☐ Never in Military
(Continues on Next Page)	**(Continues on Next Page)**	(**Continues on Next Page)**

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☐ New Immigrant ☐ Organically Based Problem ☐ Severe Hearing Loss or Deaf ☐ Traumatic Brain Injury ☐ Visual Impairment or Blind ☐ No Response ☐ Other	☐ Master's Degree ☐ Doctorate Degree ☐ Post-Secondary 1 Year ☐ Post-Secondary 2 Years ☐ Post-Secondary 3 Years ☐ Post-Secondary 4+ Years (No Degree) ☐ None ☐ Other	☐ Reserves/Nat Guard - Combat ☐ Reserves/Nat Guard - No combat ☐ Military Dependent ☐ Active Duty Combat ☐ Active Duty No Combat Retired - Combat ☐ Retired – No Combat ☐ Veteran Other Era _____ ☐ Vietnam - Combat ☐ Vietnam – No Combat ☐ Not Applicable

Financial and Household Information

Employment Status: Check One	Primary Income Source: Please Check One	Expected Payment Source
☐ Disabled ☐ Full Time ☐ Part Time ☐ Homemaker ☐ Armed Forces ☐ Resident/Inmate ☐ Retired ☐ Seasonal Employee/in season ☐ Seasonal Employee/out of season ☐ Student ☐ Unemployed/Not Seeking ☐ Unemployed/Subsistence ☐ Unemployed/Looking for work ☐ Not in Labor force ☐ Other	☐ None ☐ Tribal Assistance Program ☐ Alaska Native Corp Dividends ☐ Alimony ☐ Alaska PFD ☐ Child Support ☐ Employment ☐ Interest and other ☐ Public Assistance/Welfare ☐ Parent's Income ☐ Retirement/Survivor/Disability Pension ☐ Social Security ☐ Self-Employment ☐ Spouse/Significant Income ☐ Social Security Retirement ☐ SSI (Social Security Income) ☐ Unemployment Compensation ☐ Other	☐ Aetna ☐ AK Native Health Care ☐ Blue Cross/ Blue Shield ☐ Cigna ☐ Self-Pay ☐ HMO ☐ Indian Health Service ☐ Medicaid ☐ Medicare ☐ Moda Health ☐ Other Government Grant ☐ Other Native Health Care ☐ Other Private ☐ Other Public ☐ Other

Household Income: Check One	Occupation: Check One	
☐ $0 - $999 ☐ $1,000 - $4,999 ☐ $5,000 - $9,999 ☐ $10,000 - $19,999 ☐ $20, 000 - $29,999 ☐ $30,000 - $39,999 ☐ $40,000 - $49,999 ☐ $50,000 and over	☐ Accommodation and food service ☐ Administrative and support services ☐ Agriculture, forestry, fishing, hunting ☐ Arts, entertainment, recreation ☐ Utilities ☐ Wholesale Trade ☐ Construction ☐ Education Services ☐ Finance and Insurance ☐ Government	☐ Health Care/Social Assistance ☐ Information Management ☐ Manufacturing ☐ Mining, Quarry, Oil and Gas ☐ Other Services ☐ Professional/Managerial ☐ Real Estate ☐ Retail Trade ☐ Self-employed ☐ Transportation and Warehousing ☐ Other ☐ Not Applicable

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INTAKE QUESTIONNAIRE
ADULT/ADOLESCENT

In order for us to best serve you, it is helpful if we have some background information regarding your situation. Please answer all questions to the best of your knowledge. Any information provided will be kept confidential as outlined in the Privacy Policy.

Name: _____ Date: _____

Client Family History
Your Birth Order *(Please Circle)*: 1 2 3 4 5 6 7 8 9 Other: ____

Current Marital Status:
____ Single ____ Engaged ____ Married ____ Separated
____ Divorced ____ Widowed ____ Single w/ children
____ Single without children

Marital History (Number of marriages and status):
_____
_____
_____

Current living situation? _____Excellent _____Good _____Fair _____Poor
If Fair or Poor, please explain:
_____
_____

Where do you currently reside? _____

Number of people living in your home, including yourself? _____
Number of children living in your household? _____
Number of children living outside your household? _____

Number of days absent from school in the last 30 day (Youth Only)? _____

Have you ever been a victim of domestic violence? _____Yes _____No

Please describe any special circumstances of which you feel your counselor should be aware:
_____
_____

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Occupation: _____

Religious/Spiritual Preference: _____

Client Medical History:

Current health status: _____Excellent _____Good ____Fair _____Poor
If fair or poor, please explain: _____

How long has it been since your last physical exam? _____
Name of clinic office/current physician: _____
Phone number: _____

Do you have a medical advanced directive on file? Yes or No

If not, would you like to receive a referral to a medical provider who can help you set up a medical advanced directive? Yes or No

Do you have a history of any of the following? *(Please mark all that apply):*

_____ Alcoholism
_____ Alzheimer's/Dementia
_____ Cancer
_____ Drug Abuse
_____ Heart Disease
_____ Heart Attack
_____ High Blood Pressure
_____ Learning Disability
_____ Pain Management
_____ Smoking, Vaping, Chewing Tobacco
_____ Thyroid Problems
_____ Other Chronic or Serious Health Problem:
_____
_____

Current prescribed medications for medical or mental health conditions:

Medication	Dosage	Date	Reason

Childhood Health:

Are the child's vaccinations up to date? _____ Yes _____ No

List any significant injuries:

_____
_____

List any chronic/serious health problems:

_____

_____

Childhood Developmental History:

While pregnant, did your mother use: _____ Alcohol _____ Drugs _____ Both _____N/A

Client started school: _____ Early *(Before age 5)* _____ On Time *(Age 5)* _____ Late *(After age 5)*

Please list significant milestones in your educational history (Skipped a grade, Held back a grade, Took honors classes): _____

Language Comprehension: ☐Deficient ☐ Adequate ☐Proficient
Hearing: ☐ Good ☐ Poor ☐ Absent
Vision: ☐ Good ☐ Poor ☐ Absent

Drug and Alcohol Use:

Have you ever used drugs or Alcohol? _____ Yes _____ No
Date of first use: _____
Date of last use: _____

Substance	Frequency of Use	Amount	Length of Use	Age of First Use

Longest period of sobriety: _____
Prior stays for residential treatment for a substance abuse issue? _____ Yes _____ No
Substance abuse treatment location: _____

History of Tobacco Use or Exposure

Do you smoke tobacco? _____ Yes _____ No
Do you chew tobacco? _____ Yes _____ No
Do you vape/use e-cigs? _____ Yes _____ No
Are you exposed to secondhand smoke? _____ Yes _____ No

Would you like more information on?
Commercial Tobacco: _____ Yes _____ No
Vaping/e-cigs: _____ Yes _____ No

2nd/3rd hand smoke: _____ Yes _____ No

Client Mental Health History:
Have you previously sought counseling? _____Yes _____No
If yes, please indicate the reason:
_____
_____

Do you have a history of any of the following?
_____ Anxiety/Panic Attacks _____ Anger
_____ Addiction _____ Bipolar
_____ Depression _____ Schizophrenia

Have you ever attempted suicide? _____ Yes _____ No When: _____
Please explain what happened:
_____
_____
_____
Do you currently have a plan to harm yourself or others? _____ Yes _____ No
Please explain:
_____
_____

Predominant Mood (How you feel most of the time. Pick all that apply):
_____ Anxious _____ Depressed _____ Fearful _____ Flat (No emotion) _____ Happy
_____ Just so-so _____ Sad _____ Very excited (Manic)

Appetite: _____ Good _____ Poor _____ Fair _____ Intense
Weight: _____ Stable _____ Loss _____Gain ____ Binging _____ Purging (Vomiting)

Sleep: Number of hours/night: _____ _____ Restful _____ Unrestful
Experiencing: _____ Wake up frequently _____ Nightmares _____ Night terrors
_____ Repeating dreams _____ Repeating Nightmares _____ Insomnia
Socialization: _____ Many active friendships _____ Few active friendships
_____ Little social contact

Prior medications for treatment of mental health conditions: _____ Yes _____ No

Medication	Dosage	Length of Use	Effective?
			Y N
			Y N
			Y N
			Y N
			Y N

Prior hospitalization for a mental health issue? _____ Yes _____ No
If yes, on how many occasions? _____ Where? _____

Current Emotional Health:

Please circle the number that best describes the severity of your problem.
0 = None 1 = Minor 2 = Moderate 3 = Significant 4 = Very Serious

Anxiety	0 1 2 3 4
Depression	0 1 2 3 4
Thoughts of Death/Suicide	0 1 2 3 4
Sleep Problems	0 1 2 3 4
Mood Swings	0 1 2 3 4
Grief	0 1 2 3 4
Physical Abuse – Current	0 1 2 3 4
Physical Abuse – Childhood	0 1 2 3 4
Sexual Abuse or Assaults	0 1 2 3 4
Marriage Problems	0 1 2 3 4
Relationship problems with children	0 1 2 3 4
Problems with parents/extended family	0 1 2 3 4
Problems with work/school	0 1 2 3 4
Sexual Problems	0 1 2 3 4
Problems with alcohol/Drugs	0 1 2 3 4

In your own words, what brings you to counseling:

_____
_____
_____

Family Medical History (Please list any significant medical history within your immediate and extended family – Mother/Father/Brothers/Sister/Spouse/Children):

_____
_____
_____

Family Mental Health History:

Please list any significant mental health history within your immediate and extended family. (Mother/Father/Brothers/Sister/Spouse/Children):

_____

_____

_____

Has any family member ever experienced or been hospitalization for a psychiatric, emotional, or substance abuse disorder? _____ Yes _____ No

Legal History

Number of arrests in the past 30 days? _____

Reason:

_____

_____

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ALASKA SCREENING TOOL

Client Name: _____ **Client Number:** _____

Staff Name: _____ **Date:** _____

Info received from: (include relationship to client) _____

Please answer these questions to make sure your needs are identified. Your answers are important to help us serve you better. If you are filling this out for someone else, please answer **from their view**. Parents or guardians usually complete the survey on behalf of children under age 13.

SECTION I – Please estimate the number of days in the **last 2 weeks** (enter a number from 0-14 days): **0-14 days**

1. Over the last two weeks, how many days have you felt little interest or pleasure in doing things? ..... _____
2. How many days have you felt down, depressed or hopeless? ..... _____
3. Had trouble falling asleep or staying asleep or sleeping too much? ..... _____
4. Felt tired or had little energy? ..... _____
5. Had a poor appetite or ate too much? ..... _____
6. Felt bad about yourself or that you were a failure or had let yourself or your family down? ..... _____
7. Had trouble concentrating on things, such as reading the newspaper or watching TV? ..... _____
8. Moved or spoken so slowly that other people could have noticed? ..... _____
9. Been so fidgety or restless that you were moving around a lot more than usual? ..... _____
10. Remembered things that were extremely unpleasant? ..... _____
11. Were barely able to control your anger? ..... _____
12. Felt numb, detached, or disconnected? ..... _____
13. Felt distant or cut off from other people? ..... _____

SECTION II – Please check the answer to the following questions based **on your lifetime.**

14. I have lived where I often or very often felt like I didn't have enough to eat, had to wear dirty clothes, or was not safe ..... ☐ Yes ☐ No
15. I have lived with someone who was a problem drinker or alcoholic, or who used street drugs ..... ☐ Yes ☐ No
16. I have lived with someone who was seriously depressed or seriously mentally ill ..... ☐ Yes ☐ No
17. I have lived with someone who attempted suicide or completed suicide ..... ☐ Yes ☐ No
18. I have lived with someone who was sent to prison ..... ☐ Yes ☐ No
19. I, or a close family member, was placed in foster care ..... ☐ Yes ☐ No
20. I have lived with someone while they were physically mistreated or seriously threatened ..... ☐ Yes ☐ No
21. I have been physically mistreated or seriously threatened ..... ☐ Yes ☐ No
    a. If you answered **"Yes"**, did this involve your intimate partner (spouse, girlfriend, or boyfriend)? ..... ☐ Yes ☐ No

ALASKA SCREENING TOOL

SECTION III – Please answer the following questions based **on your lifetime.** (D/N = Don't Know)

22. I have had a blow to the head that was severe enough to make me lose consciousness ..... ☐ Yes ☐ No ☐ D/N
23. I have had a blow to the head that was severe enough to cause a concussion . ☐ Yes ☐ No ☐ D/N

If you answered "Yes" to 22 or 23, please answer a-c:

a. Did you receive treatment for the head injury? ..... ☐ Yes ☐ No
b. After the head injury, was there a permanent change in anything? ..... ☐ Yes ☐ No ☐ D/N
c. Did you receive treatment for anything that changed?..... ☐ Yes ☐ No

24. Did your mother ever consume alcohol? ..... ☐ Yes ☐ No ☐ D/N
    a. **If Yes**, did she continue to drink during her pregnancy with you? ..... ☐ Yes ☐ No ☐ D/N

SECTION IV – Please answer the following questions based on the **past 12 months.**

25. Have you had a major life change like death of a loved one, moving, or loss of a job? .... ☐ Yes ☐ No
26. Do you sometimes feel afraid, panicky, nervous or scared? ..... ☐ Yes ☐ No
27. Do you often find yourself in situations where your heart pounds and you feel anxious and want to get away? ..... ☐ Yes ☐ No
28. Have you tried to hurt yourself or commit suicide? ..... ☐ Yes ☐ No
29. Have you destroyed property or set a fire that caused damage?..... ☐ Yes ☐ No
30. Have you physically harmed or threatened to harm an animal or person on purpose? ... ☐ Yes ☐ No
31. Do you ever hear voices or see things that other people tell you they don't see or hear? ..... ☐ Yes ☐ No
32. Do you think people are out to get you and you have to watch your step?..... ☐ Yes ☐ No

SECTION V – Please answer the following questions based on the **past 12 months.**

33. Have you gotten into trouble at home, at school, or in the community, because of using alcohol, drugs, or inhalants? ..... ☐ Yes ☐ No
34. Have you missed school or work because of using alcohol, drugs, or inhalants? ..... ☐ Yes ☐ No
35. In the past year have you ever had 6 or more drinks at any one time? ..... ☐ Yes ☐ No
36. Does it make you angry if someone tells you that you drink or use drugs, or inhalants too much?..... ☐ Yes ☐ No
37. Do you think you might have a problem with alcohol, drug or inhalant use?..... ☐ Yes ☐ No

THANK YOU for providing this information! Your answers are important to help us serve you better.

CLIENT STATUS REVIEW

Case Number: _____

Type of CSR: ___Initial ___90-135 Day Follow-Up ___Discharge Administered by:_____

Date Completed: _____/_____/_____ Name: _____

Are you completing this survey for? (Please check one) ☐ I filled this out by myself (age 12 and older)
☐ I filled this out for a child/youth (Under age 12) ☐ Someone helped me fill this out

What best describes the reason you came in for services today? Select all that apply…
☐ I decided on my own ☐ I was encouraged by others (like family, friends, etc.)
☐ I was required to come (including court order, Office of Children's Services, etc.)

Health and Quality of Life	**# of Days**
1. How many days during the past 30 days was your physical health (including physical illness and/or injury) **not** good?	
2. How many days during the past 30 days was your mental health (including depression and/or problems with emotions, behavior, or thinking) **not** good? ----------	
3. How many days during the past 30 days did poor physical or mental health keep you from doing your usual activities, such as taking care of yourself, work, or recreation?----------	
4. How many days during the past 30 days have you had thoughts about suicide or hurting yourself? ----------	
	# of Times
5. In the past 30 days, how many times have you used emergency medical services such as the hospital, emergency room, or emergency medical technicians/health aides? ----------	
6. In the past 30 days, have you had an intimate partner slap, punch, shove, kick, choke, hurt, or threaten you? ☐ Yes ☐ No	

Substance Use	**# of Days**
7. How many days during the past 30 days have you had at least one alcoholic beverage? ----------	
8. How many days during the past 30 days have you had 4 or more alcoholic beverages? ----------	
9. How many days during the past 30 days have you used marijuana or illegal drugs (including medications not as prescribed or directed)? ----------	

Legal Involvement	
10. In the past 30 days, have you had any legal involvement (legal charges, court appearance, arrests, probation or parole) ☐ Yes ☐ No	
	# of Times
11. In the past 30 days, how many times have you been arrested? ----------	
12. In the past 12 months, how many times have you been arrested? ----------	

Health Behavior	**# of Days**
13. How many days during the past 30 days have you smoked cigarettes, pipes, or cigars AND/OR used chewing tobacco, snuff, or snus? ----------	
14. How many days during the past 30 days have you smoked 20 or more cigarettes per day? ----------	
15. How many days during the past 7 days did you participate in any physical activities or exercise such as running, sports (basketball, baseball etc.), swimming, bicycling or walking for exercise? ----------	
	# of Times
16. During the past 7 days, how many times did you drink 100% fruit juice or eat fruit? ----------	
17. During the past 7 days, how many times did you eat vegetables? ----------	

Case Number: _____

18. Please answer each question by putting an **X** in the space that best describes how you feel about each item. Please use only one **X** for each question

How do you (or your child) feel about:	Terrible	Unhappy	Dissatisfied	Mixed	Satisfied	Pleased	Delighted
Your housing?							
Your ability to support your basic needs of food, housing, etc.?							
Your safety in your home or where you sleep?							
Your safety outside your home?							
How much people in your life support you?							
Your friendships?							
Your family situation?							
Your sense of spirituality, relationship with a higher power, or meaningfulness of life?							
Your life in general?							

Please Answer Questions 19 – 21 if you have received services from this agency.

19. Please answer each question by putting an **X** in the space that best describes how you feel about each item. Please use only one **X** for each question.

How do you feel about the services you (or your child) received?	Terrible	Unhappy	Dissatisfied	Mixed	Satisfied	Pleased	Delighted
I was treated with respect.							
I was given information about my rights.							
I helped to choose my treatment goals.							
I felt comfortable asking questions about my treatment.							
I was able to get all the services I needed.							
Because of the services I received:							
I am better able to handle daily life.							
I am getting along better with other people.							
I am better able to cope when things go wrong.							
The quality of my life has improved.							

20. What did you like about the services you received? _____

_____

21. What did you dislike about the services you received? _____

_____

Please Answer Questions 22 – 25 with the assistance of agency staff.

22. Which one of the following best describes your housing situation/living arrangement? (In the past 30 days, where have you been living most of the time?) (please check one)

- ☐ Adult in private residence – independent living (may live with others, but capable of self-care)
- ☐ Adult in private residence – dependent living (heavily dependent on others for daily living assistance)
- ☐ Child living in private residence (not in foster home)
- ☐ Foster home/foster care
- ☐ Homeless or shelter
- ☐ Jail or correctional facility
- ☐ Crisis residence (short term stabilization)
- ☐ Residential care facility (assisted living, halfway house, group homes, board & care)
- ☐ Residential treatment facility for:
  - ☐ Mental Health ☐ Substance Abuse ☐ Co-occurring Disorder
- ☐ Institutional care facility (care provided 24 hours, 7 days/week) (hospital, other inpatient psychiatric facility, nursing facility/home)
- ☐ Other (please describe) _____

23. Did you attend school at any time in the past three months? Yes ☐ No ☐

If you checked **'Yes,'** please indicate below the grade/educational **level you attended in the past three months**.

If you checked **'No,'** please indicate below the highest grade/educational **level you have completed**.

____ Grade Level (Write in Grade Level 1-12 or GED)

- ☐ No years of schooling
- ☐ Nursery School/Pre-School (Including Head Start)
- ☐ Kindergarten
- ☐ Self-Contained Special Education Class (No equivalent grade level)
- ☐ Vocational School
- ☐ College Undergraduate Freshman (1st year)
- ☐ College Undergraduate Sophomore (2nd year)
- ☐ College Undergraduate Junior (3rd year)
- ☐ College Undergraduate Senior (4th year)
- ☐ Graduate or Professional School (Master's, Doctoral, Medical, Law)

24. Which one of the following best describes your employment status during most of the previous **week**? (please check one)

- ☐ Employed full time working for money (30 or more hours per week); includes Supported Employment and Armed Forces
- ☐ Employed part time working for money (less than 30 hours per week); includes Supported Employment and Armed Forces
- ☐ Unemployed - actively looking for employment or laid off from job (and awaiting to be recalled) in the past 30 days
- ☐ Not in labor/work force (not employed and not actively looking for employment during the past 30 days); if you checked this box, please check one of the following:
  - ☐ Homemaker
  - ☐ Retired
  - ☐ Disabled
  - ☐ Volunteer
  - ☐ Sheltered/Non-competitive employment
  - ☐ Not Yet School Age
  - ☐ Student
  - ☐ Job training program
  - ☐ Engaged in subsistence activities
  - ☐ Other (please describe) _____
  - ☐ In Residential Care Facility
  - ☐ In Residential Treatment Facility
  - ☐ Inpatient of Institutional Care Facility
  - ☐ Inmate of Jail or Correctional Facility

25. Over the past 7 days, which one of the following best describes the number of hours you engaged in productive activities (e.g., school, employment, volunteering in community service, subsistence activities, etc.)? (Please check one of the boxes below)

☐ less than 10 hours ☐ 10-20 hours ☐ 21-30 hours ☐ 31-40 hours ☐ 41-50 hours ☐ More than 50 hours

Chugachmiut Behavioral Health
1840 Bragaw Street, Suite #110
Anchorage, AK 99508
Phone: (907) 562-4155 Fax: (907) 278-0300

Consent for Release of Confidential Information

Client Name: _____ **Date of Birth:** ____/____/_____

I authorize the mutual exchange of information and communication between Chugachmiut Behavioral Health and _____.

Phone #: _____, Fax #: _____

I am aware that disclosure information may include alcohol and drug abuse information, and/or psychological or psychiatric information. I authorize the information to be exchanged:

Please Initial which information will be released

_____ Acknowledge attendance in treatment
_____ History pertinent to this referral
_____ Diagnosis
_____ Urinalysis results
_____ Treatment plan
_____ Treatment records
_____ Discharge summary, Status
_____Treatment recommendations
_____ Substance abuse assessment
_____ Program compliance
_____ Prognosis
_____ Psychological/Psychiatric assessment
_____ Psychological/Psychiatric reports
_____ Medical Records
_____ Other

The above information is to be exchanged for the purpose of:

_____

_____

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, or other State and Federal Law and the Health Insurance Portability and Accountability Act (HIPAA). These laws and regulations prohibit any further disclosure of this information without the specific written consent of the person to whom the records pertain, or as otherwise permitted by these laws and regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Regulations also prohibit the use of this information to investigate or prosecute any alcohol or drug patient in misdemeanor, criminal, or civil matters. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it previous to written revocation of this document and that in any event this consent expires.

Specific Date, Event or Condition of Expiration:

_____

**(If left blank, this specific authorization will expire six months from the date of my signature.)*

Signature of Client: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____
(If client is under 18 years old)

Signature of Witness: _____ **Date:** _____

Revised: 03/26/19