



Chugachmiut

**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 relationship problems, parenting issues, and a range of other concerns like depression and anxiety.

Program services may include screenings, assessments, treatment planning, life skills development, mental health counseling, substance use treatment, case management, recovery camp, group therapy, and referral for medication when needed.

Please fill out the attached forms: 1) Notice of Privacy Practices, 2) Consent for Treatment & Billing, 3) Client Information, 4) Intake Questionnaire, 5) Alaska Screening Tool, 6) Client Status Review.

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. Weapons or other dangerous objects, illegal drugs, and medications not prescribed to the client are not permitted at the clinics. Chugachmiut reserves the right to search the client and to confiscate such objects upon reasonable probable cause. The clinics' obligation to provide a safe environment for care must override the individual's right to privacy.

The clinics reserve the right to place restrictions on any services due to unsafe behaviors and/or attitudes. Chugachmiut may reinstate access to programs if identified behaviors and/ or attitudes have discontinued, and it is deemed safe to resume services.

Your counselor will complete an assessment and develop a treatment plan with you to meet your personal goals. Should a situation arise where the therapist-client relationship is not conducive to therapy or where the behavioral health clinic is not equipped to handle your situation, a Behavioral Health staff will immediately refer you elsewhere for adequate, mutually agreed upon treatment. It is understood that you are voluntarily seeking services from Chugachmiut and that both you and Chugachmiut have the right to terminate program services at any time by simply notifying the other party of this intention. Chugachmiut will make appropriate referrals on its part.

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. Chugachmiut has served the region for fifty years. The organization has witnessed growth in both the communities and the individuals who live in the Chugach region. 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*

**CHUGACHMIUT  
NOTICE OF PRIVACY PRACTICES**



THIS NOTICE DESCRIBES:

- HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
- YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION, INCLUDING HOW YOU CAN GET ACCESS TO THIS INFORMATION
- HOW TO FILE A COMPLAINT CONCERNING A VIOLATION OF THE PRIVACY OR SECURITY OF YOUR HEALTH INFORMATION, OR OF YOUR RIGHTS CONCERNING YOUR INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY. YOU HAVE A RIGHT TO A COPY OF THIS NOTICE (IN PAPER OR ELECTRONIC FORM) AND TO DISCUSS IT WITH OUR PRIVACY OFFICER AT 907-562-4155 IF YOU HAVE ANY QUESTIONS.

**This notice applies to records maintained by Chugachmiut Health and Behavioral Health Services.**

Chugachmiut respects your privacy and understands that your health information is a private and sensitive matter. We make a record of the care and services you receive at Chugachmiut which is called your protected health information (PHI). We need this information to give you quality health care and comply with the law. For example, this information includes your symptoms, test results, diagnosis, treatment, health information from Chugachmiut and other health care providers, and billing and payment information related to those services. We will not disclose your information to others unless you authorize us to do so, or unless the law authorizes or requires us to do so.

This privacy notice will tell you about: (1) the ways that we may use and disclose PHI about you; (2) your privacy rights; (3) special rules for patients of Chugachmiut's substance use disorder (SUD) treatment programs; and (4) Chugachmiut's responsibilities in using and disclosing your PHI.

**WHO WILL FOLLOW THIS NOTICE:**

- Any staff or other individuals authorized by Chugachmiut to access, handle, or enter information into your health record; and
- Any member of a volunteer group we allow to help you while you are receiving services at Chugachmiut.

**CHUGACHMIUT'S RESPONSIBILITIES:**

**We are required by law to:**

- Keep your PHI private and secure;
- Give you this Notice of our legal duties and privacy practices with respect to PHI;
- Notify you of your specific rights as to PHI, including substance use disorder records that are subject to 42 C.F.R. Part 2;
- Let you know promptly if a breach occurs that may have compromised the privacy or security of your PHI; and
- Follow the terms of the Notice of Privacy Practices currently in effect.

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We have the right to change our practices regarding the PHI we create or maintain. If we make changes, we will update this Notice. You may obtain the most recent copy of this Notice by calling and requesting a copy, visiting any of our Chugachmiut programs and asking for it, or by visiting our website: [www.Chugachmiut.org](http://www.Chugachmiut.org).

**HOW CHUGACHMIUT MAY USE & DISCLOSE YOUR PHI:**

The following is an explanation of some of the ways your PHI may be used and disclosed:

**Treatment:** We can use your PHI for treatment purposes and can share it with other individuals or entities providing you with health care. For example, Chugachmiut may share your medication information with a specialist that we refer you to in order to avoid treatment that might cause a negative reaction with your medication.

**Payment:** We can use and share your PHI to bill and obtain payment for the services we provide to you. For example, insurance companies may need information about services you received at a Chugachmiut clinic in order to authorize payment. In addition, if someone else is responsible for your health care costs, we may disclose information to that person about services we provided to you when we seek payment.

**Health Care Operations:** We can use and share your PHI to run Chugachmiut's clinics and programs, improve your care, and make sure all patients receive quality care. For example, we may use your PHI to evaluate the performance of our staff, or to evaluate services provided at Chugachmiut.

**Electronic Health Information Systems:** Your PHI will be available to providers who use the Alaska Tribal Health System's shared electronic health record.

**Health Information Exchange:** We participate in a health information exchange that combines information from other participating healthcare facilities. This allows providers and health plans involved in your care to access PHI submitted by other providers and facilities for legitimate purposes, including treatment, payment, and operations. Once information is entered into these systems, it can be amended, but it cannot be removed. You are permitted to request information about documentation regarding who has accessed your information through the electronic health information exchange. You may "opt out" of including your health information in the exchange. If you opt out, then your PHI will only be available to providers who use the Alaska Tribal Health System's shared electronic health record. Your provider will have information on how to make this request.

**Appointment Reminders:** We may use and disclose PHI to contact you as a reminder that you have an appointment for treatment or health care at Chugachmiut. We may use and disclose health care information during the reminder call, but the information disclosed will be kept to what is necessary to remind you of the appointment.

**Interpreters:** In order to provide you proper care and services, we may use the services of an

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interpreter. This may require the use or disclosures of your PHI to the interpreter or others facilitating the provision of interpreter services.

**Other Treatments and/or Health Products:** We may use and disclose your PHI to tell you about treatment options or alternatives or about health-related products or services that may be of interest to you.

**Research:** Under certain circumstances, we may use and disclose PHI about you for research purposes, both with and without your permission. Before we disclose your PHI without your permission, we will verify that researchers meet specific requirements under HIPAA to protect your PHI, and if appropriate, obtain approval from the authorized body that ensures the protection of human research subjects.

**Funeral Directors/Coroners/State Medical Examiner:** We can disclose PHI about you to funeral directors, coroners, and the state medical examiner, consistent with applicable law to allow them to carry out their duties.

**Public Health:** We may disclose your PHI for public health activities that can include the following:

- Prevention or control of disease, injury or disability;
- Reports of births and deaths;
- Reports of abuse or neglect of children, elders, and dependent adults;
- Reports of reactions or problems with medications or health products; and
- Helping with product recalls.

**Workers' Compensation Laws:** We will disclose your PHI as authorized by law when you have made a workers' compensation claim.

**Correctional Institutions:** If you are in jail or prison, we may disclose your PHI to the Department of Corrections for your health and the health and safety of others.

**Law Enforcement:** We may disclose limited PHI about you to law enforcement for certain purposes, such as to report criminal conduct that occurred on our premises, to locate you if you are the suspect of a crime, to avert a serious and imminent threat to health or safety, or when required by law, such as to report certain injuries caused by guns or knives.

**Tissue Donation, Organ Procurement and Transplant:** We may disclose your PHI to organ procurement organizations.

**Health and Safety Oversight:** We will disclose your PHI to a health oversight agency when required by law. These oversight activities include audits, investigations, and medical licensure.

**Preventing a Serious and Imminent Threat:** We may use or disclose your PHI if we believe in good faith that doing so is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or of the public. Disclosure must be to a person reasonably

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able to prevent or lessen the threat, including a friend, family member, employer, provider, or law enforcement.

***Disaster Relief Purposes:*** We may disclose your PHI to disaster relief agencies or law enforcement to assist in notification of your condition to family or others in case of a disaster.

***Military and Veterans:*** If you are a member of the armed forces, Chugachmiut may release your PHI as required by military command authorities.

***Court Orders, Lawsuits and Disputes:*** We may disclose your PHI in response to a warrant, subpoena, court or administrative order in accordance with applicable law.

***National Security and Intelligence Activities:*** We may release your PHI to authorized federal officials for intelligence, counter intelligence and other national security activities authorized by law.

***Business Associate Agreements:*** We may disclose your PHI to individuals and organizations that assist Chugachmiut with treatment, health care operations, or payment and have agreed to protect the confidentiality of your PHI. For example, Chugachmiut may disclose PHI to consultants or attorneys who assist us in complying with our legal obligations.

***Other Uses and Disclosures:*** We may also use and disclose your PHI as specifically required or authorized by applicable laws for other reasons not specifically listed here.

***Notification of Family and Others:*** Unless you specifically object, we may release PHI about you to a friend or family member who is involved in your health care, or payment for care, while you are receiving services, if appropriate under the circumstances. In emergency cases where you are unavailable or incapacitated, or do not otherwise object, we may also tell your family or friends your location and general condition. If you would like to restrict the PHI provided to family or friends involved in your care or payment for care, please contact the Privacy Officer at the number at the end of this notice.

***Uses and Disclosures That Require Your Authorization:*** Other than the uses and disclosures described above, PHI will be used or disclosed only with your written permission. For example, we will not use or share psychotherapy notes without your permission outside of limited circumstances, we will not use or share your health information for marketing without your permission, and we will not sell your health information without your permission. If you tell us we can share your information, you can change your mind at any time. Let us know in writing if you do change your mind.

***Potential for Redisclosure:*** Information legally shared by Chugachmiut may be able to be shared again by the recipient and may no longer have the same privacy protections.

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**SPECIAL RULES FOR SUBSTANCE USE DISORDER PATIENT RECORDS**

If you receive substance use disorder (SUD) treatment, diagnosis, or referral for treatment through Chugachmiut Behavioral Health Services, any information that identifies you as a SUD patient may have additional protection under the federal confidentiality regulations at 42 C.F.R. Part 2 ("Part 2"). This information, known as Part 2 records, has additional restrictions on its use and disclosure. Chugachmiut will determine whether your information is protected by Part 2.

In general, Chugachmiut must obtain your written consent before disclosing PHI protected by Part 2 to people or organizations outside of Chugachmiut Behavioral Health Services. Chugachmiut may condition SUD treatment on receiving your consent to disclosure for treatment, payment, or health care operations purposes. However, Part 2 permits Chugachmiut to release your PHI subject to Part 2 without your consent in certain circumstances, including:

- Pursuant to a written agreement between Chugachmiut and another organization that provides services to Chugachmiut, where the other organization has agreed to protect the privacy of your information;
- For certain research, audit, or evaluation purposes;
- For public health purposes, where there is no reasonable basis to believe that the information could be used to identify you as a SUD patient;
- To report a crime against Chugachmiut Behavioral Health Services personnel or that took place on Chugachmiut Behavioral Health Services property;
- To medical personnel in a medical emergency when your consent cannot be obtained;
- To report suspected child abuse or neglect to appropriate authorities; and
- Pursuant to a court order.

In other situations not listed here, we will obtain your consent before disclosure. For example, we will obtain your consent before disclosing your SUD information for treatment, payment, or health care operations purposes. You may also revoke your written consent by providing a written statement to us. This revocation will not apply to any uses or disclosures already made based on your prior consent.

SUD records, or testimony about the content of such records, shall never be used or disclosed in any civil, administrative, criminal, or legislative proceedings against you unless you have consented, or the use or disclosure is required by a valid court order. SUD records will only be used or disclosed based on a court order after notice and an opportunity to be heard is provided to you or Chugachmiut as required by law. A court order authorizing use or disclosure of SUD records must be accompanied by a subpoena or other legal mandate compelling disclosure before the records can be used or disclosed.

You may provide Chugachmiut with a single written consent form allowing us to use and disclose your SUD records for all future treatment, payment, or health care operations purposes. Records disclosed based on such consent form to another health care provider, health plan, or to a business associate of Chugachmiut may be further disclosed by the recipient without your additional consent,

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as long as the additional disclosures are in line with general federal protections for PHI. However, such records still cannot be shared by the recipient in civil, criminal, administrative, or legislative proceedings against you without your written consent or pursuant to a valid court order, as described above.

**YOUR INDIVIDUAL RIGHTS REGARDING YOUR PHI**

You have specific individual rights regarding your health information. This section explains your rights.

**Notice:** You have the right to receive a copy of this Notice, in paper or electronic form.

**Questions:** You have the right to ask questions about any information contained in this Notice and to discuss this information with the person listed on Page 1.

**Right to Request Restrictions on Use:** You have the right to ask Chugachmiut to limit certain uses and disclosures of your PHI. If you want to limit use and disclosure, you must submit the request in writing. We are not required to grant the request, except under special circumstances, such as a restriction on information provided to an insurer for services that you paid for out-of-pocket.

**Right to Request Confidential Communications:** You may request that Chugachmiut communicate with or contact you by a particular means (mail, e-mail, fax, etc.) or at a particular location. These requests must be made in writing and we have a form available for this type of request. Chugachmiut will accommodate reasonable requests.

**Right to Get A Copy of Your Medical Record:** You may request to see and/or get an electronic or paper copy of your PHI. We will provide you with a copy or summary of your health information, usually within 30 days of the request. We may charge a reasonable, cost-based fee.

**Right to Request A Correction to Your Medical Record:** You have the right to ask us to correct health information about you that you think is incorrect or incomplete. We may say “no” to your request, but we will tell you why in writing within 60 days of your request.

**Right to Know About Disclosures of Your Information:** You have the right to request a list (an “accounting”) of certain disclosures of your PHI made by Chugachmiut, for up to a period of six years following disclosures. This list will not include disclosures to third party payers, or disclosures for treatment or health care operations purposes. Other exceptions to the accounting requirement include, but are not limited to, disclosures made subject to your right of access, to individuals involved in your care, for national security purposes, and for the health and safety of inmates or detainees. You may request an accounting at any time. Chugachmiut is only required by law to provide one accounting without charge during any 12-month period. We will notify you of the cost involved if you request this information more than once in a 12-month period.

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You also have the right to request a list of the disclosures of your electronic SUD records made over the last three years, including where those disclosures were for the purpose of treatment, payment, or health care operations.

***Right to Not Receive Fundraising Communications:*** You have the right to elect not to receive any fundraising communications from Chugachmiut.

***RIGHT TO ASK FOR HELP, EXPRESS A CONCERN, OR MAKE A COMPLAINT***

*If you have questions, want more information, want to report a problem about the handling of your PHI, or want to file a written complaint because you believe your privacy rights have been violated, you may contact:*

**Privacy Officer**  
c/o Chugachmiut Health Services  
1840 Bragaw Street, Suite 110  
Anchorage, Alaska 99508  
907-562-4155  
Email: [privacyofficer@chugachmiut.org](mailto:privacyofficer@chugachmiut.org)

*You may also file a written complaint regarding a violation of HIPAA or 42 C.F.R. Part 2 with the Office of Civil Rights online at <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf> or by sending a written complaint to:*

**Centralized Case Management Operations**  
U.S. Department of Health and Human Services  
200 Independence Avenue. S.W.  
Room 509F, HHH Building  
Washington, D.C. 20201

Violation of the protections established by 42 C.F.R. Part 2 for substance use disorder patient records is a crime. You may file a complaint regarding a violation with the U.S. Attorney's Office in Anchorage, reachable by mail at 222 West 7<sup>th</sup> Ave., Room 253 #9, Anchorage, AK 99513, or by phone at (907) 271-5071.

***Chugachmiut will not retaliate or discriminate against you due to reports you've made to us or the federal government regarding your privacy rights.***

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**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

Effective Date April 14, 2003, Revised July 11, 2025

Chugachmiut's Notice of Privacy Practices provides information about how Chugachmiut may use and disclose your protected health information (PHI). You have the right to review the Notice before signing this acknowledgment. As stated in the Notice, the terms of the notice may change. If the Notice is changed, you may obtain a revised copy by contacting the Privacy Officer or asking any Chugachmiut health service team member.

By signing this form, you acknowledge receipt of Chugachmiut's Notice of Privacy Practices, and have had sufficient opportunity to review its contents and ask any questions of Chugachmiut.

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Date

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Printed Name of Patient

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Printed Name of Authorized Representative

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Signature of Patient or Authorized Representative



## MY CONSENT FOR HEALTH SERVICES TREATMENT AND BILLING

I consent to treatment which may be performed during the visit and for ongoing health care as a patient of Chugachmiut, including emergency treatment of services, which may include, but are not limited to: laboratory procedures, x-ray examinations, medical and/or surgical treatment and/or procedures, anesthesia and/or medical services rendered under the general and special instructions of the patient's physician, healthcare provider or surgeon.

I understand that:

- A) It is customary, except in emergencies or unusual circumstance, that major procedures are not carried out until the patient has discussed them with the physician or other health professionals and has agreed to the procedure(s);
- B) Each patient has the right to refuse any proposed procedure(s) and/or treatment(s);
- C) No patient will be involved in any research or experimental procedure(s) without his/her full knowledge and consent; and
- D) I understand that no guarantee has been made to me as to the result or cures that may be obtained from examination or treatment.
- E) I understand that Chugachmiut is a teaching facility and that resident physicians "physician in training", medical students, nursing students and other health professional students may be involved in my care. I recognize that these residents and students are supervised by experienced staff. My primary physician and/or healthcare provider have full authority and responsibility for my care. I understand I may refuse care by any resident or students at any time, and that such refusal will not result in any reduction of the quality of care provided.

In the event that a healthcare worker has an exposure to my blood or body fluids during the course of my care at Chugachmiut, I hereby give my consent to be tested for the presence of communicable diseases that may cause risk to the healthcare worker. The results of these tests will be retained with my confidential medical information. I will not be charged for the testing, and the results will be sent to my primary healthcare provider. I understand that testing will be done through Chugachmiut and that I may contact them with any questions or concerns regarding this issue.

## FINANCIAL MATTERS

### My Financial Obligation for Services Provided to Me

I understand payment in full is required within thirty (30) days of service. I may be asked to remit in full if my insurance has not paid within the time frame. I may make special payment arrangements if this creates a financial hardship by talking to a billing representative at the clinic or contacting the billing department at 907-334-0106. Should the account be referred to a collection agency or an attorney for collections, I understand I shall pay actual attorney fees and collection expenses.

Upon request, Chugachmiut will make a good faith effort to give the patient, guarantor, resident or client, an estimate of charges using the most current pricing for the same or similar services.



These estimates provide no guarantees or limitation to a person's actual billed charges due to the inability to predict all the services and equipment that may be required to comply with the individual plan of care.

### **My Authorization for Direct Payment of Insurance Benefits to Chugachmiut**

I authorize, whether I sign as an agent or as a patient, direct payment to Chugachmiut any insurance benefits otherwise payable for services related to the visit and ongoing health care. It is understood that I am financially responsible for all charges not covered by this assignment including those that are excluded from coverage by my insurance carrier.

### **My Consent to Chugachmiut to Release Information**

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize Chugachmiut to disclose portions of my record, including healthcare records, to any person and/or corporation which may be liable to pay for my clinic(s) services.

### **GENERAL INFORMATION Safe**

#### **Environment for Health Care**

Weapons or other dangerous objects, illegal drugs, and drugs not prescribed to the patient, by the patient's physician or healthcare provider are not permitted at the clinic(s). The clinic's obligation to provide a safe environment for care must override the individual's right to privacy. Chugachmiut reserves the right to search the patient, guarantor, resident or clients and to confiscate such objects upon reasonable probable cause.

#### **Personal Valuables**

I understand that the clinic(s) have advised that I should leave my personal property, money, and valuables at home or with family/friends. I agree that the clinic(s) shall not be liable for any loss or damage to said personal property, money, or valuables and waive all such claims. I understand that the clinic(s) is not responsible for the safekeeping of my personal property, money, or valuables left by me in the clinic(s) public areas or in patient, resident or clients rooms.

**By signing my signature, I acknowledge that I have read and understand MY CONSENT FOR HEALTH SERVICES TREATMENT AND BILLING regarding treatment for myself or if signing as a parent or guardian, for my minor child or the person for whom I am responsible.**

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Current Phone Number(s)

Printed Patient Name

Date of Birth

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Signature of Patient

Date

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Signature of Guardian, Relative or Responsible Party

Date



Chugachmiut

## CLIENT INFORMATION FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(First, Middle, Last)

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

May we leave a message at either of these numbers? \_\_\_\_\_

Email Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_

Other Health Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to You: \_\_\_\_\_

Occupation: \_\_\_\_\_

Religious/Spiritual Preferences: \_\_\_\_\_

Cultural Background: \_\_\_\_\_

Reason For Visit: \_\_\_\_\_

### Demographics

Race:		Ethnicity:
<input type="checkbox"/> Aleut or Sugpiaq <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Athabascan (Other than American Indian) <input type="checkbox"/> Black/African American <input type="checkbox"/> Caucasian or White <input type="checkbox"/> Haida <input type="checkbox"/> Inupiat	<input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Alaska Native <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Tlingit <input type="checkbox"/> Tsimshian <input type="checkbox"/> Yupik <input type="checkbox"/> Other	<input type="checkbox"/> Not Spanish/Hispanic/ Latino/Mexican <input type="checkbox"/> Spanish/Hispanic/Latino <input type="checkbox"/> Hispanic <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Chicano/Other Hispanic
Sex:	Gender Identity:	Sexual Orientation:
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> No Response <input type="checkbox"/> Female Becoming Male <input type="checkbox"/> Female Formerly Male <input type="checkbox"/> Male Becoming Female <input type="checkbox"/> Male Formerly Female	<input type="checkbox"/> Woman <input type="checkbox"/> Man <input type="checkbox"/> Bigender <input type="checkbox"/> Cisgender <input type="checkbox"/> Gender Fluid <input type="checkbox"/> Gender Neutral <input type="checkbox"/> Gender Non-conforming <input type="checkbox"/> Genderqueer <input type="checkbox"/> Non-binary <input type="checkbox"/> Other <input type="checkbox"/> Transgender	<input type="checkbox"/> Aromantic <input type="checkbox"/> Asexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay <input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Lesbian <input type="checkbox"/> Other <input type="checkbox"/> Panromantic <input type="checkbox"/> Pansexual <input type="checkbox"/> Queer



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## Demographics Continued

Education:	Military Status:	
<input type="checkbox"/> K-12, how many years? _____ <input type="checkbox"/> General Education Degree (GED) <input type="checkbox"/> High School Diploma <input type="checkbox"/> Vocational Training Beyond HS <input type="checkbox"/> Special Education Ungraded Classes <input type="checkbox"/> Undergraduate Work (no degree) <input type="checkbox"/> Associate Degree <input type="checkbox"/> Baccalaureate Degree (BA, BS) <input type="checkbox"/> Graduate Work (no degree) <input type="checkbox"/> Master's Degree	<input type="checkbox"/> Doctorate/Professional Degree <input type="checkbox"/> Post-Secondary 1 Year <input type="checkbox"/> Post-Secondary 2 Years <input type="checkbox"/> Post-Secondary 3 Years <input type="checkbox"/> Post-Secondary 4 Years <input type="checkbox"/> Other <input type="checkbox"/> No Schooling	<input type="checkbox"/> Never in Military <input type="checkbox"/> Vietnam Era Veteran <input type="checkbox"/> Gulf War Veteran <input type="checkbox"/> Iraq War Veteran <input type="checkbox"/> Afghan War Veteran <input type="checkbox"/> Retired from Military <input type="checkbox"/> Reserves or National Guard <input type="checkbox"/> Veteran <input type="checkbox"/> On Active Duty <input type="checkbox"/> Military Dependent

## Financial and Household Information

Employment Status:	Source of Income:	Primary Payment Source:
<input type="checkbox"/> Disabled <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Homemaker <input type="checkbox"/> Armed Forces <input type="checkbox"/> No Response <input type="checkbox"/> Not in Labor Force – Other <input type="checkbox"/> Not Seeking Work <input type="checkbox"/> Other <input type="checkbox"/> Resident/Inmate <input type="checkbox"/> Retired <input type="checkbox"/> Seasonal Emp, In-Season <input type="checkbox"/> Seasonal Emp, Out of Season <input type="checkbox"/> Student <input type="checkbox"/> Unemployed, Looking for Work <input type="checkbox"/> Unemployed, Not Seeking Work <input type="checkbox"/> Unemployed, Subsistence Lifestyle	<input type="checkbox"/> None <input type="checkbox"/> Alaska Native Corp Dividends <input type="checkbox"/> Alimony <input type="checkbox"/> Alaska PFD <input type="checkbox"/> Child Support <input type="checkbox"/> Employment <input type="checkbox"/> Interest and other <input type="checkbox"/> Other <input type="checkbox"/> Public Assistance/Welfare Pay <input type="checkbox"/> Parent's Income <input type="checkbox"/> Railroad Retirement <input type="checkbox"/> Retirement/Survivor/Disability Pension <input type="checkbox"/> Social Security Disability (SSDI) <input type="checkbox"/> Self-Employment <input type="checkbox"/> Supplemental Security Ins (SSI) <input type="checkbox"/> Spouse's or Significant Other's Income <input type="checkbox"/> Social Security <input type="checkbox"/> Unemployment Compensation <input type="checkbox"/> Tribal Assistance Programs	<input type="checkbox"/> Aetna <input type="checkbox"/> Moda Health <input type="checkbox"/> Other government grant <input type="checkbox"/> Other Native Health Care <input type="checkbox"/> Other Private <input type="checkbox"/> Other Public <input type="checkbox"/> Unknown <input type="checkbox"/> AK Native Health Care <input type="checkbox"/> Worker's compensation <input type="checkbox"/> Blue Cross/Blue Shields <input type="checkbox"/> CIGNA <input type="checkbox"/> HMO <input type="checkbox"/> Indian Health Service <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare
Annual Household Income:	Health Insurance:	
<input type="checkbox"/> \$0 - \$999 <input type="checkbox"/> \$1,000 - \$4,999 <input type="checkbox"/> \$5,000 - \$9,999 <input type="checkbox"/> \$10,000 - \$19,999 <input type="checkbox"/> \$20,000 - \$29,999 <input type="checkbox"/> \$30,000 - \$39,999 <input type="checkbox"/> \$40,000 - \$49,999 <input type="checkbox"/> \$50,000 and over	<input type="checkbox"/> None <input type="checkbox"/> Blue Cross/Blue Shield (BCBS) <input type="checkbox"/> Commercial <input type="checkbox"/> Medicare Conditionally Primary <input type="checkbox"/> Group Policy <input type="checkbox"/> Health Maintenance Organization (HMO) <input type="checkbox"/> Individual Policy <input type="checkbox"/> Long Term Policy <input type="checkbox"/> Litigation <input type="checkbox"/> Medicare Part B	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medigap Part B <input type="checkbox"/> Medicare Primary <input type="checkbox"/> Other Government Service <input type="checkbox"/> Other Public Insurance <input type="checkbox"/> Other Private Insurance <input type="checkbox"/> Other (e.g., TRICARE) <input type="checkbox"/> Supplemental Policy <input type="checkbox"/> VA Insurance <input type="checkbox"/> Unknown



## 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: \_\_\_\_\_

Marital History (Number of marriages): \_\_\_\_\_

Current living situation? \_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor

If fair or poor, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Number of people living in your home, including yourself: \_\_\_\_\_

Number of children living in your household: \_\_\_\_\_

Number of children living outside your household: \_\_\_\_\_

Status of family relationships: \_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor

If fair or poor, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Client Medical History:

Current health status: \_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor

If fair or poor, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of your last physical exam: \_\_\_\_\_

Name of health clinic/primary care physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Do you have a medical advance directive on file? \_\_\_\_\_ Yes \_\_\_\_\_ No

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



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

- |   |   |
|---|---|
| <input type="checkbox"/> Alcoholism           | <input type="checkbox"/> Learning Disability                      |
| <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Pain Management                          |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Smoking, Vaping, Chewing Tobacco         |
| <input type="checkbox"/> Drug Abuse           | <input type="checkbox"/> Thyroid Problems                         |
| <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Other Chronic or Serious Health Problem: |
| <input type="checkbox"/> Heart Attack         |   |
| <input type="checkbox"/> High Blood Pressure  |   |

**Current prescribed medications for medical conditions:**

Medication	Dosage	Date	Reason

Any known allergies to medications: \_\_\_\_\_

Use of complimentary health approaches (e.g., natural products, tai chi, meditation, massage):  
\_\_\_\_\_

Any dental concerns: \_\_\_\_\_

Pregnant? \_\_\_\_\_ Yes \_\_\_\_\_ No      If yes, are you receiving prenatal care? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have a need for assistive technology? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Childhood Health (for children/adolescents ONLY):**

Are the child's immunizations up to date? \_\_\_\_\_ Yes \_\_\_\_\_ No

Speech functioning:  Good  Poor  Absent

Hearing functioning:  Good  Poor  Absent

Vision functioning:  Good  Poor  Absent

**Childhood Developmental History:**

Client started school: \_\_\_\_\_ Early (Before age 5) \_\_\_\_\_ On Time (Age 5) \_\_\_\_\_ Late (After age 5)

Please list any developmental delays you had in school: \_\_\_\_\_

Please list any learning difficulties you experienced: \_\_\_\_\_



### Client 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

### Client Mental Health History:

Have you previously received treatment for your mental health?  Yes  No

If yes, please indicate the reason: \_\_\_\_\_

Have you ever been diagnosed with any of the following?

Anxiety Disorders  Attention-deficit/hyperactivity Disorders  Bipolar Disorders  
 Depression Disorders  Eating Disorders  Trauma Disorders

Prior hospitalization for a mental health issue?  Yes  No

If yes, on how many occasions? \_\_\_\_\_ Where? \_\_\_\_\_

Prior medications for treatment of mental health conditions?  Yes  No

If yes, please describe the effectiveness: \_\_\_\_\_



### Current prescribed medications for mental health conditions:

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

### Client 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

**Appetite:**  Poor  Fair  Good  Intense  
 Binging (Overeating)  Purging (Vomiting)

**Weight:**  Stable  Loss  Gain

**Sleep:**  Number of hours/night  Restful  Restless

**Experiencing:**  Wake up frequently  Nightmares  Night terrors  
 Repeating dreams  Repeating nightmares  Insomnia

**Socialization:**  Many active friendships  Few active friendships  
 Little social contact

Do you feel you need more social support?  Yes  No



## **Client Legal History and Current Involvement:**

Any current legal involvement? \_\_\_\_\_  
\_\_\_\_\_

Legal history: \_\_\_\_\_  
\_\_\_\_\_

## **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 attempted or completed suicide? \_\_\_\_\_ Yes \_\_\_\_\_ No

Has any family member ever experienced abuse, violence, neglect? \_\_\_\_\_ Yes \_\_\_\_\_ No

## **Family Substance Abuse History:**

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

\_\_\_\_\_  
\_\_\_\_\_

# 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

1. How many days during the past 30 days was your physical health (including physical illness and/or injury) **not** good? \_\_\_\_\_ # of Days \_\_\_\_\_
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? \_\_\_\_\_ # of Days \_\_\_\_\_
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? \_\_\_\_\_ # of Days \_\_\_\_\_
4. How many days during the past 30 days have you had thoughts about suicide or hurting yourself? \_\_\_\_\_ # of Days \_\_\_\_\_

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? \_\_\_\_\_ # of Times \_\_\_\_\_
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

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

### 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? \_\_\_\_\_ # of Times \_\_\_\_\_
12. In the past 12 months, how many times have you been arrested? \_\_\_\_\_ # of Times \_\_\_\_\_

### Health Behavior

13. How many days during the past 30 days have you smoked cigarettes, pipes, or cigars AND/OR used chewing tobacco, snuff, or snus? \_\_\_\_\_ # of Days \_\_\_\_\_
14. How many days during the past 30 days have you smoked 20 or more cigarettes per day? \_\_\_\_\_ # of Days \_\_\_\_\_
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 Days \_\_\_\_\_
16. During the past 7 days, how many times did you drink 100% fruit juice or eat fruit? \_\_\_\_\_ # of Times \_\_\_\_\_
17. During the past 7 days, how many times did you eat vegetables? \_\_\_\_\_ # of Times \_\_\_\_\_

# CLIENT STATUS REVIEW

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.**

# CLIENT STATUS REVIEW

Case Number: \_\_\_\_\_

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 (1<sup>st</sup> year)
- College Undergraduate Sophomore (2<sup>nd</sup> year)
- College Undergraduate Junior (3<sup>rd</sup> year)
- College Undergraduate Senior (4<sup>th</sup> 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  Not Yet School Age  In Residential Care Facility
- Retired  Student  In Residential Treatment Facility
- Disabled  Job training program  Inpatient of Institutional Care Facility
- Volunteer  Engaged in subsistence activities  Inmate of Jail or Correctional Facility
- Sheltered/Non-competitive employment  Other (please describe) \_\_\_\_\_

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