



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

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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.

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

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 7th 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.

Date

Printed Name of Patient

Printed Name of Authorized Representative

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 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.

Current Phone Number(s)

Printed Patient Name

Date of Birth

Signature of Patient

Date

Signature of Guardian, Relative or Responsible Party

Date



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"/> Athabaskan (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



Demographics Continued		
Education: <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		Military Status: <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: <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	Source of Income: <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	Primary Payment Source: <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: <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	Health Insurance: <div> <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 </div> <div> <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 </div>	



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: _____



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	# of Days
1. How many days during the past 30 days was your physical health (including physical illness and/or injury) not good?	<input type="text"/>
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? -----	<input type="text"/>
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?-----	<input type="text"/>
4. How many days during the past 30 days have you had thoughts about suicide or hurting yourself? -----	<input type="text"/>
	# 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? -----	<input type="text"/>
6. In the past 30 days, have you had an intimate partner slap, punch, shove, kick, choke, hurt, or threaten you? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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

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








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? -----	<input type="text"/>
14. How many days during the past 30 days have you smoked 20 or more cigarettes per day? -----	<input type="text"/>
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? -----	<input type="text"/>
	# of Times
16. During the past 7 days, how many times did you drink 100% fruit juice or eat fruit? -----	<input type="text"/>
17. During the past 7 days, how many times did you eat vegetables? -----	<input type="text"/>

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)

- | | |
|--|--|
| <input type="checkbox"/> Adult in private residence – <u>independent living</u> (may live with others, but capable of self-care)
<input type="checkbox"/> Adult in private residence – <u>dependent living</u> (heavily dependent on others for daily living assistance)
<input type="checkbox"/> Child living in private residence (not in foster home)
<input type="checkbox"/> Foster home/foster care
<input type="checkbox"/> Homeless or shelter
<input type="checkbox"/> Jail or correctional facility | <input type="checkbox"/> Crisis residence (short term stabilization)
<input type="checkbox"/> Residential care facility (assisted living, halfway house, group homes, board & care)
<input type="checkbox"/> Residential treatment facility for:
<input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Co-occurring Disorder
<input type="checkbox"/> Institutional care facility (care provided 24 hours, 7 days/week) (hospital, other inpatient psychiatric facility, nursing facility/home)
<input type="checkbox"/> 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)
<input type="checkbox"/> No years of schooling
<input type="checkbox"/> Nursery School/Pre-School (Including Head Start)
<input type="checkbox"/> Kindergarten
<input type="checkbox"/> Self-Contained Special Education Class (No equivalent grade level)
<input type="checkbox"/> Vocational School | <input type="checkbox"/> College Undergraduate Freshman (1 st year)
<input type="checkbox"/> College Undergraduate Sophomore (2 nd year)
<input type="checkbox"/> College Undergraduate Junior (3 rd year)
<input type="checkbox"/> College Undergraduate Senior (4 th year)
<input type="checkbox"/> 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)

- | | | |
|--|--|--|
| <input type="checkbox"/> Employed full time working for money (30 or more hours per week); includes Supported Employment and Armed Forces
<input type="checkbox"/> Employed part time working for money (less than 30 hours per week); includes Supported Employment and Armed Forces
<input type="checkbox"/> Unemployed - actively looking for employment or laid off from job (and awaiting to be recalled) in the past 30 days
<input type="checkbox"/> 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: | <input type="checkbox"/> Homemaker
<input type="checkbox"/> Retired
<input type="checkbox"/> Disabled
<input type="checkbox"/> Volunteer
<input type="checkbox"/> Sheltered/Non-competitive employment | <input type="checkbox"/> Not Yet School Age
<input type="checkbox"/> Student
<input type="checkbox"/> Job training program
<input type="checkbox"/> Engaged in subsistence activities
<input type="checkbox"/> Other (please describe) _____ |
| <input type="checkbox"/> In Residential Care Facility
<input type="checkbox"/> In Residential Treatment Facility
<input type="checkbox"/> Inpatient of Institutional Care Facility
<input type="checkbox"/> 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