

Maniilaq Association/Behavioral Health Services Intake and Admission Form

Client Profile			
Name (First Middle Last):	Maiden or Other Name:	Preferred Name:	
Social Security Number:	Medicaid Number:	DOB:	Age:
Mailing Address:	City, State, Zip:	Phone #(s):	
Alternate Contacts (Name, Phone #, Address):		Collateral Contacts (Name, Phone #, Address):	
Treatment Preferred: <input type="checkbox"/> In Person <input type="checkbox"/> Telehealth <input type="checkbox"/> No Preference			
Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female Becoming Male	<input type="checkbox"/> Male Formerly Female
	<input type="checkbox"/> Female	<input type="checkbox"/> Female Formerly Male	<input type="checkbox"/> Male Becoming Female
Ethnicity:	<input type="checkbox"/> Not Spanish/Hispanic/Latino/Mexican	<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Hispanic – Origin NOS
	<input type="checkbox"/> Spanish/Hispanic/Latino	<input type="checkbox"/> Cuban	<input type="checkbox"/> Chicano/Other Hispanic
	<input type="checkbox"/> Hispanic – Origin Unspecified	<input type="checkbox"/> Mexican	
Communities:	<input type="checkbox"/> Kotzebue	<input type="checkbox"/> Kivalina	<input type="checkbox"/> Ambler
	<input type="checkbox"/> Noatak	<input type="checkbox"/> Noorvik	<input type="checkbox"/> Kiana
	<input type="checkbox"/> Shungnak	<input type="checkbox"/> Kobuk	<input type="checkbox"/> Selawik
			<input type="checkbox"/> Buckland
			<input type="checkbox"/> Deering
			<input type="checkbox"/> Other _____
Race:	<input type="checkbox"/> Not Collected	<input type="checkbox"/> Aleut	<input type="checkbox"/> Native Hawaiian
	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian	<input type="checkbox"/> Pacific Islander
	<input type="checkbox"/> American Indian	<input type="checkbox"/> Haida	<input type="checkbox"/> Tlingit
	<input type="checkbox"/> Athabascan	<input type="checkbox"/> Yupik	<input type="checkbox"/> Inupiat
			<input type="checkbox"/> Tsimshian
			<input type="checkbox"/> Black/African American
			<input type="checkbox"/> Other Alaska Native
			<input type="checkbox"/> Other (specify): _____
Special Needs:	<input type="checkbox"/> None	<input type="checkbox"/> Autism	<input type="checkbox"/> Developmentally Disabled
	<input type="checkbox"/> Major Difficulty in Ambulating	<input type="checkbox"/> FASD	<input type="checkbox"/> Moderate to Severe Medical Or
	<input type="checkbox"/> Non-Ambulation	<input type="checkbox"/> New Immigrant	Problems
	<input type="checkbox"/> Organically Based Problem	<input type="checkbox"/> TBI (Traumatic Brain Injury)	<input type="checkbox"/> Severe Hearing Loss or Deaf
	<input type="checkbox"/> Sex Offender Registry	<input type="checkbox"/> SO Priority Population	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Visual Impairment or Blind	<input type="checkbox"/> Acquired Brain Injury	
Sexual Orientation:	<input type="checkbox"/> Not Collected	<input type="checkbox"/> Asexual	<input type="checkbox"/> Bi-Sexual
			<input type="checkbox"/> Heterosexual
			<input type="checkbox"/> Homosexual
English Fluency:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Moderate
			<input type="checkbox"/> Poor
			<input type="checkbox"/> Not at All
Education:	<input type="checkbox"/> No Schooling	<input type="checkbox"/> Bachelor’s Degree	<input type="checkbox"/> Post-Secondary 1 Year
	<input type="checkbox"/> Current Student	<input type="checkbox"/> Graduate Work	<input type="checkbox"/> Post-Secondary 2 Years (AA Degree)
	<input type="checkbox"/> GED	<input type="checkbox"/> Master’s Degree	<input type="checkbox"/> Post-Secondary 3 Years
	<input type="checkbox"/> HS Diploma	<input type="checkbox"/> Doctorate Degree	<input type="checkbox"/> Post-Secondary 4+ Years (No Degree)
	<input type="checkbox"/> Special Education	<input type="checkbox"/> Vocational Training	
Highest Grade Completed:			Number of Days Absent in the Past Month:

Veteran Status:	<input type="checkbox"/> Never in Military	<input type="checkbox"/> Retired from Military
	<input type="checkbox"/> Military Dependent	<input type="checkbox"/> Retired from Military; No Combat
	<input type="checkbox"/> On Active Duty; Combat	<input type="checkbox"/> Vietnam Era Veteran; Combat
	<input type="checkbox"/> On Active Duty; No Combat	<input type="checkbox"/> Vietnam Era Veteran; No Combat
	<input type="checkbox"/> Iraq War Veteran; Combat	<input type="checkbox"/> In Reserves/National Guard; Combat
	<input type="checkbox"/> Afghan War Veteran; Combat	<input type="checkbox"/> In Reserves/National Guard; No Combat
	<input type="checkbox"/> Separated, Non-Combat, Honorable Discharge	
	<input type="checkbox"/> Separated, Non-Combat, Other Than Honorable Discharge	

Intake Information

If Female, Are You pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Due Date?
------------------------------	------------------------------	-----------------------------	-----------

Are You an Injection Drug User?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Last Injected?
---------------------------------	------------------------------	-----------------------------	----------------

Presenting Problem: (Please number your top 3 in the order of importance)	<input type="checkbox"/> None	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Medical/Somatic
	<input type="checkbox"/> No Response	<input type="checkbox"/> Thought Disorder	<input type="checkbox"/> Psychological/Emotional
	<input type="checkbox"/> Alcohol and Drugs	<input type="checkbox"/> Depression	<input type="checkbox"/> Financial
	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Social/Interpersonal	<input type="checkbox"/> Poverty
	<input type="checkbox"/> Drugs	<input type="checkbox"/> Marital	<input type="checkbox"/> Child Abuse Perpetrator
	<input type="checkbox"/> Suicide Attempt/Threat	<input type="checkbox"/> Coping with Daily Roles/Activities	<input type="checkbox"/> Sexual Abuse Perpetrator
	<input type="checkbox"/> Child Abuse Victim	<input type="checkbox"/> Domestic Violence Perpetrator	<input type="checkbox"/> Domestic Violence Victim
	<input type="checkbox"/> Sexual Abuse Victim	<input type="checkbox"/> Runaway Behavior	<input type="checkbox"/> Legal
	<input type="checkbox"/> Family (non-marital)	<input type="checkbox"/> Other _____	

Presenting Problems (in Clients Own Words):

--

Special Initiative:	<input type="checkbox"/> None	<input type="checkbox"/> CASII-Matrix	<input type="checkbox"/> Psychiatric Emergency Services
	<input type="checkbox"/> APIC	<input type="checkbox"/> CASII-PLL	<input type="checkbox"/> Women with Children
	<input type="checkbox"/> TBI	<input type="checkbox"/> CASII-TIP	<input type="checkbox"/> Bring the Kids Home
	<input type="checkbox"/> DVSA		

Admission Information

How many times have you been admitted for substance use treatment?	
--	--

How much substance use related hospitalizations have you had in the past six months?	
--	--

How many times have you been admitted for mental health treatment?	
--	--

How many times have you been hospitalized for mental health treatment?	
--	--

Do you take medication (psychotropic) for a mental health related problem?	
--	--

Rank your overall health:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
----------------------------------	------------------------------------	------------------------------------	-------------------------------	-------------------------------	-------------------------------

Number of times you have attended a self-help program in the 30 days preceding the date of admission to treatment services. Includes attendance at AA, NA, and other self-help/mutual support groups focused on recovery from substance abuse and dependence:

<input type="checkbox"/> No attendance in the past month	<input type="checkbox"/> 1-3 times in the last month	<input type="checkbox"/> 4-7 times in the last month
<input type="checkbox"/> 8-15 times in the last month	<input type="checkbox"/> 16-30 times in the last month	<input type="checkbox"/> frequency unknown

Financial Information

Employment Status:	<input type="checkbox"/> Employed Full-Time	<input type="checkbox"/> Student	<input type="checkbox"/> Not in Labor Force, Other
	<input type="checkbox"/> Employed Part-Time	<input type="checkbox"/> Retired	<input type="checkbox"/> Seasonal, In Season
	<input type="checkbox"/> Disabled	<input type="checkbox"/> Unemployed, Looking	<input type="checkbox"/> Seasonal, Out of Season

	<input type="checkbox"/> Unemployed, Subsistence Lifestyle <input type="checkbox"/> Unemployed, Not Looking <input type="checkbox"/> Not Seeking Work <input type="checkbox"/> In the Armed Forces <input type="checkbox"/> Homemaker <input type="checkbox"/> Resident/Inmate <input type="checkbox"/> Other _____
Occupation:	<input type="checkbox"/> Accommodation/Food Service <input type="checkbox"/> Health Care and Social Assistance <input type="checkbox"/> Agriculture/Forestry/Fishing <input type="checkbox"/> Information <input type="checkbox"/> Arts, Entertainment, Recreation <input type="checkbox"/> Management of Companies/Enterprises <input type="checkbox"/> Construction <input type="checkbox"/> Manufacturing <input type="checkbox"/> Utilities <input type="checkbox"/> Mining, Quarrying, Oil and Gas Extraction <input type="checkbox"/> Educational Services <input type="checkbox"/> Other Services except Public Administration <input type="checkbox"/> Finance and Insurance <input type="checkbox"/> Retail Trade <input type="checkbox"/> Government <input type="checkbox"/> Administrative/Support Services <input type="checkbox"/> Real Estate, Rental/Leasing <input type="checkbox"/> Professional, Scientific, Technical Services <input type="checkbox"/> Transportation and Warehousing <input type="checkbox"/> Self-Employed <input type="checkbox"/> Wholesale Trade <input type="checkbox"/> None
Estimated Annual Household Income:	
Primary Income Source:	<input type="checkbox"/> None <input type="checkbox"/> Parent's Income <input type="checkbox"/> SSI <input type="checkbox"/> AK Native Dividend <input type="checkbox"/> Railroad Retirement <input type="checkbox"/> SSI/SSDI Never <input type="checkbox"/> AK PFD <input type="checkbox"/> Unemployed Compensation <input type="checkbox"/> SSI/SSDI Previous <input type="checkbox"/> Alimony <input type="checkbox"/> Self-Employment <input type="checkbox"/> Social Security <input type="checkbox"/> Child Support <input type="checkbox"/> Tribal Assistance Program <input type="checkbox"/> SSDI <input type="checkbox"/> Employment <input type="checkbox"/> Spouse/Significant Other's Income <input type="checkbox"/> Interest and Other <input type="checkbox"/> Public Assistance/Welfare <input type="checkbox"/> Retired, Survivor, or Disability Pension <input type="checkbox"/> Other _____
Expected Payment Source:	<input type="checkbox"/> Aetna <input type="checkbox"/> HIS <input type="checkbox"/> Other Native Health Care <input type="checkbox"/> HMO <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Private <input type="checkbox"/> Blue Cross/Shield <input type="checkbox"/> Medicare <input type="checkbox"/> Sliding Fee Scale, Self-Pay <input type="checkbox"/> Cigna <input type="checkbox"/> No Charge <input type="checkbox"/> Sliding Fee Scale, no Charge <input type="checkbox"/> AK Native Health Care <input type="checkbox"/> Other Government Grant <input type="checkbox"/> VA Insurance <input type="checkbox"/> HMO <input type="checkbox"/> Individual Policy <input type="checkbox"/> Personal Payment (cash) <input type="checkbox"/> IHS <input type="checkbox"/> Other _____
Household Composition	
Marital Status:	<input type="checkbox"/> Cohabiting <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Single (never married) <input type="checkbox"/> Widowed
Household Composition:	<input type="checkbox"/> Lives Alone <input type="checkbox"/> Lives with Relatives <input type="checkbox"/> Lives with Non-Relatives <input type="checkbox"/> Lives with Children <input type="checkbox"/> Lives with Adolescents <input type="checkbox"/> Lives with Significant other <input type="checkbox"/> Other <input type="checkbox"/> Lives with Significant Others and Children
Living Arrangement:	<input type="checkbox"/> Private Residence without Supportive Services <input type="checkbox"/> Private Residence with Supportive Services <input type="checkbox"/> Residential Treatment <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Group Home <input type="checkbox"/> Shelter <input type="checkbox"/> Foster Care <input type="checkbox"/> Hospital (non-psychiatric) <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Homeless <input type="checkbox"/> Hospital (psychiatric) <input type="checkbox"/> Halfway House <input type="checkbox"/> Nursing Home <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Other _____ <input type="checkbox"/> Therapeutic Foster Care <input type="checkbox"/> Crisis Residence

Number of children in residential setting			Number of people living with client		
Number of children in residential setting receiving services			Number of children in household		
Legal History					
Legal Status:	<input type="checkbox"/> Court Ordered, Mental Health	<input type="checkbox"/> Court Ordered, DJJ Custody	<input type="checkbox"/> Court Ordered, parent's custody		
	<input type="checkbox"/> 90 Day Commitment	<input type="checkbox"/> Incarcerated	<input type="checkbox"/> Informal Probation		
	<input type="checkbox"/> 30 Day Commitment	<input type="checkbox"/> 180 Day Commitment	<input type="checkbox"/> None/No Involvement		
	<input type="checkbox"/> Case Pending	<input type="checkbox"/> Deferred Prosecution	<input type="checkbox"/> OCS Custody		
	<input type="checkbox"/> Comm. Sentencing	<input type="checkbox"/> Deferred Sentence	<input type="checkbox"/> Probation/Parole		
	<input type="checkbox"/> Court Ordered Evaluation	<input type="checkbox"/> Emer. Commitment	<input type="checkbox"/> Protective Custody		
	<input type="checkbox"/> Court Ordered, Substance Abuse	<input type="checkbox"/> Furlough/Rehab Leave			
	<input type="checkbox"/> Title 12, Not Guilty by Reason of Insanity				
Number of arrests in the last 30 days:					

By signing below, I certify all information is true and correct to the best of my knowledge.

Client Printed Name

Client Signature

Date

Guardian Printed Name

Guardian Signature

Date

BHS Staff Printed Name

BHS Staff Signature

Date