

Alaska Family Services
Phone (907) 376-4000 * FAX (907) 373-1135

CONSENT FOR DISCLOSURE OF INFORMATION

I, _____ DOB: _____, request/authorize **Alaska Family Services BHTC** to
_____ Disclose information to: _____ and/or _____ Obtain information from:
(nature and amount of information to be disclosed; as limited as possible)

Name: (Self) _____
Address: _____
Phone: _____

Initial all that apply.

_____ UA Results	_____ Attendance
_____ Assessment/Interpretive Summary	_____ Discharge Summary
_____ Treatment Plan/Case Reviews	_____ Leave message for client to contact agency
	Other: _____ _____

For the purpose(s) of:

_____ Further Treatment	_____ Personal
_____ Legal Request	_____ Other _____ _____
_____ Coordination of Care	

Disclosure is to be: **verbally, in writing and/or by facsimile (fax).**

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: _____ 90 days after discharge, or _____ other terms: _____ (specification of the date, event or conditions upon which this consent expires) IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL TERMINATE ON ___/___/___.

I understand that generally Alaska Family Services may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may denied treatment if I do not sign a consent form.

By my signature below I indicate that I have read this document or have had it read to me, that I fully understand its meaning, that I consent to its terms knowingly and voluntarily, that I have not been under any undue duress or influence nor under the influence of alcohol or drugs in making this agreement.

Signature: _____ Date: ___/___/___
Client

Signature: _____ Date: ___/___/___
Parent, guardian, or person authorized to sign for client

Signature: _____ Date: ___/___/___
Witness

This notice accompanies a discloser of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CRF Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

ALASKA FAMILY SERVICES
5851 E. Mayflower Ct.
Wasilla, AK 99654
Phone(907)376-4000 Fax(907)373-1135

CLIENT PROFILE		Date _____
First Name _____	Maiden Name _____	
Middle Name _____	Provider Client ID _____	
Last Name _____	Alternate Name(s) _____	
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Alternate Name(s) _____	
Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/> - <input type="text"/> - <input type="text"/> - <input type="text"/> Age _____	Home Phone _____	Fax _____
Social Security Number _____	Work Phone _____	Other Phone _____
Driver's License Number _____	State _____	Cell Phone _____
Medicaid Number _____	Email address _____	
Home Street Address _____		
City _____ State _____ Zip _____		
Mailing/Billing Address _____		
City _____ State _____ Zip _____		

Race	<input type="checkbox"/> Aleut <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Athabascan <input type="checkbox"/> Black/African American <input type="checkbox"/> Caucasian <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 (Specify): _____
Ethnicity	<input type="checkbox"/> Not Spanish/Hispanic/Latino Mexican <input type="checkbox"/> Chicano/Other Hispanic <input type="checkbox"/> Cuban <input type="checkbox"/> Hispanic-specific origin not specified <input type="checkbox"/> Mexican American <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Spanish/Hispanic Latino
Community of Origin (city, town or village where you currently reside) _____	

Special Needs	<input type="checkbox"/> None <input type="checkbox"/> Developmentally Disabled <input type="checkbox"/> Major Diff. In Ambulatory or Nonambulation <input type="checkbox"/> Moderate to Severe Medical Problems <input type="checkbox"/> Organically Based Problem <input type="checkbox"/> Severe Hearing Loss or Deaf <input type="checkbox"/> Traumatic Brain Injury (TBI) <input type="checkbox"/> Visual Impairment or Blind <input type="checkbox"/> Other <input type="checkbox"/> Unknown
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English Fluency	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Moderate <input type="checkbox"/> Poor <input type="checkbox"/> Not at all
Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Other (Specify) _____
Interpreter Needed	<input type="checkbox"/> Yes <input type="checkbox"/> No

Education	<input type="checkbox"/> Highest Completed Grade is _____ <input type="checkbox"/> HS Diploma <input type="checkbox"/> BA/BS Degree <input type="checkbox"/> AA Degree <input type="checkbox"/> GED <input type="checkbox"/> Voc Training (Beyond HS) <input type="checkbox"/> Master's
Veteran Status	<input type="checkbox"/> Rsrvs/Nat Guard:Combat <input type="checkbox"/> Never in Military <input type="checkbox"/> Rsrvs/Nat Guard:Noncombat <input type="checkbox"/> Other (Specify): _____
Citizenship	<input type="checkbox"/> United States <input type="checkbox"/> Other (Specify): _____

Collateral Contacts			
1)	First Name _____	Last Name _____	Relation _____
Address _____			
Home Phone _____		Work Phone _____	Cell Phone _____
		Other _____	
Can we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No Consent On File? <input type="checkbox"/> Yes <input type="checkbox"/> No			

First Name _____ Last Name _____ Relation _____

Address _____
Home Phone _____ Work Phone _____ Cell Phone _____ Other _____

Can we contact? Yes No Consent On File? Yes No

Who referred you to our agency? (Specify Agency and Name of Person) _____

Why are you seeking services at our agency? _____

In your own words, what problem(s) would you like our agency to help you with?

Have you ever received services from our agency? Yes No If yes, when and what type of services did you receive?

Are you currently receiving mental health and/or substance abuse treatment services from any other agency? Yes No If yes, which agency and what type of services?

Medical Status (Admission Profile)

If female are you pregnant? Yes No Unknown If yes, what is your Due Date? _____

Are you an Injection Drug User? Yes No If yes, when was the last time you injected drugs? _____

How many times have you been admitted into any program(s) for substance abuse treatment? How would you rank your overall Health? Excellent Very Good Good Fair Poor Unsure

How many non-treatment substance abuse related hospitalizations have you had in the past 6 months? Do you have any Mental Health Problems? Yes No If yes, please describe below

How many times have you been admitted into any program(s) for mental health treatment? _____

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

How many months since your last discharge? _____

Do you use tobacco? Yes No If yes, what type do you use? Cigarette Cigars/Pipes Combination Smokeless Tobacco

Alcohol and Drug Use History

Drug	Age at 1 st use:	Age at regular use:	Age at heaviest use:	Heaviest use frequency and amounts:	Past 12 months frequency and amounts:	# of days used in last 30 days:	Date last used	Method of use (oral, smoked, injected, snorted):
Alcohol								
Amphetamine (Adderall, Dexedrine, Concerta, Ritalin, diet drugs)								
Caffeine								
Cannabis (Marijuana, hashish)								
Cocaine/Crack								
Hallucinogens (MDMA/ecstasy, ketamine, LSD, mushrooms)								
Inhalants ("whippets", gasoline, glue, paint, Dust-Off, hair spray, nitrous oxide)								
Methamphetamine ("crank"; "crystal"; "ice")								
Nicotine								
Opioids (heroin, methadone, morphine, opium, oxycodone, hydrocodone, codeine)								

Drug	Age at 1st use:	Age at regular use:	Age at heaviest use:	Heaviest use frequency and amounts:	Past 12 months frequency and amounts	# of days used in last 30 days:	Date last used	Method of use (oral, smoked, injected, snorted):
Phencyclidine (PCP, Angel Dust, etc.)								
Sedatives or Anxiolytic (Valium, Xanax, Klonopin, Ativan, Rohypnol, GHB)								
Synthetic Drugs (K2/Spice, MDMA/Bath salts)								
Over the counter drugs (DXM, "skittles", cough medications, No-Doz, sleep aids, Benedryl, dramamine)								
Prescription Drugs (any drugs you have been prescribed)								
Other Drugs (ex. Steroids, Salvia)								

IV Use? Yes No

Do you believe alcohol and/or drugs cause problems in your life? Yes No

Did either of your biological parents have a problem with alcohol or drugs?

Explain:

Client treatment history (Where? When? For how long?)

CLIENT ADMISSION FORM

Financial/Household Information

<p>Employment Status: Check One</p> <ul style="list-style-type: none"> <input type="checkbox"/> Disabled <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time <input type="checkbox"/> Homemaker <input type="checkbox"/> Armed Forces Medicaid <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 Employee/in season <input type="checkbox"/> Seasonal Employee/out season <input type="checkbox"/> Student <input type="checkbox"/> Unemployed/Not seeking work <input type="checkbox"/> Unemployed/Subsistence <input type="checkbox"/> Unemployed/Looking for work 	<p>Occupation (O-Net): Check One</p> <ul style="list-style-type: none"> <input type="checkbox"/> Accommodation & Food Services <input type="checkbox"/> Administrative & support Services <input type="checkbox"/> Agriculture, Forestry, Fishing, & Hunting <input type="checkbox"/> Arts, Entertainment, & Recreation <input type="checkbox"/> Construction <input type="checkbox"/> Educational Services <input type="checkbox"/> Finance & Insurance <input type="checkbox"/> Government <input type="checkbox"/> Health Care & Social Assistance <input type="checkbox"/> Information <input type="checkbox"/> Management of Companies & Enterprises <input type="checkbox"/> Manufacturing <input type="checkbox"/> Mining, Quarrying, Oil & Gas Extraction <input type="checkbox"/> Other Services (Except Public Admin.) <input type="checkbox"/> Professional, Scientific, & Technical Svcs. <input type="checkbox"/> Real Estate & Rental & Leasing <input type="checkbox"/> Retail Trade <input type="checkbox"/> Self-Employed <input type="checkbox"/> Transportation & Warehousing <input type="checkbox"/> Utilities <input type="checkbox"/> Wholesale Trade <input type="checkbox"/> None <input type="checkbox"/> Not Applicable 	<p>Insurance Type: Check One</p> <ul style="list-style-type: none"> <input type="checkbox"/> Auto Insurance Policy <input type="checkbox"/> Indian Health Service <input type="checkbox"/> None <input type="checkbox"/> Commercial <input type="checkbox"/> Medicare Conditionally Primary <input type="checkbox"/> Group Policy <input type="checkbox"/> Health Maint. Org. (HMC) <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"/> Medicare Primary <input type="checkbox"/> Other Public <input type="checkbox"/> Other Private <input type="checkbox"/> Other <input type="checkbox"/> Personal payment (cash- no ins) <input type="checkbox"/> Supplemental Policy <input type="checkbox"/> Private Insurance <input type="checkbox"/> VA insurance
<p>Primary Income Source: Check one</p> <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Tribal Assistance Programs <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 & Other <input type="checkbox"/> Other <input type="checkbox"/> Public Assistance/Welfare Pay <input type="checkbox"/> Parent's Income <input type="checkbox"/> Spouse/Significant Other Income <input type="checkbox"/> Retirement/Surv/Disability Pension <input type="checkbox"/> Social Security Disability (SSDI) <input type="checkbox"/> SSI <input type="checkbox"/> SSI/SSDI Never <input type="checkbox"/> SSI/SSDI Previous <input type="checkbox"/> Unemployment Compensation 	<p>Annual Household Income:</p> <p><i>Approximate or exact numeric amount and include Alaska PFD's if applicable</i></p> <hr/>	<p>Expected Payment Source: Check One</p> <ul style="list-style-type: none"> <input type="checkbox"/> Aetna <input type="checkbox"/> AK Native Health Care <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> CIGNA <input type="checkbox"/> Client Self Pay <input type="checkbox"/> HMO <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> No Charge <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"/> Sliding Scale; client partial payment <input type="checkbox"/> Sliding Scale, No Charge

<p>Household Composition: Check One</p> <ul style="list-style-type: none"> <input type="checkbox"/> Client Lives alone <input type="checkbox"/> Lives with Adolescents <input type="checkbox"/> Lives with Children <input type="checkbox"/> Lives with Non-relatives <input type="checkbox"/> Lives with Relatives <input type="checkbox"/> Lives with Significant Other(s) <input type="checkbox"/> Significant Other & Children 	<p>Living Arrangement: Check One</p> <ul style="list-style-type: none"> <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Correction/Detention Facility <input type="checkbox"/> Crisis Residence <input type="checkbox"/> Foster Care <input type="checkbox"/> Group Home <input type="checkbox"/> Halfway House <input type="checkbox"/> Homeless <input type="checkbox"/> Hospital for Non-psychiatric purposes <input type="checkbox"/> Hospital for psychiatric purposes <input type="checkbox"/> Nursing home <input type="checkbox"/> Private Residence w/out supportive services <input type="checkbox"/> Private residence w/supportive services <input type="checkbox"/> Residential Treatment <input type="checkbox"/> Shelter <input type="checkbox"/> Therapeutic Foster Care <input type="checkbox"/> Transitional Housing
<p>Marital Status: Check one</p> <ul style="list-style-type: none"> <input type="checkbox"/> Never Married-single <input type="checkbox"/> Married <input type="checkbox"/> Cohabiting <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed 	<p>Living in Home: Answer all</p> <p>Number of people living with client: # _____</p> <p>Number of children in household: # _____</p> <p>Number of children in Residential Setting: # _____</p> <p>Number of children in Residential Setting receiving services: # _____</p>

Number of Days Abstinent (no use of alcohol, Marijuana, or illegal drugs) in Last 30 Days: _____

Do You Currently Use Tobacco: **Check one**

____ Cigarettes ____Cigars/Pipes ____Combo ____Smokeless Tobacco ____No

Number of Arrests in **past 30** days: # _____

**ALASKA FAMILY SERVICES
BEHAVIORAL HEALTH TREATMENT CENTER
Telephone: (907) 376-4000*FAX: (907) 373-1135**

Family Questionnaire

1. By whom were you raised? _____
2. Do you have any siblings? If so what are their ages and gender? _____

3. As a child how would you describe your relationship with your parents?
a. caring b. strained c. supportive d. honest e. abusive f. critical g. happy h. loving i. conflicted
j. nonexistent k. other _____
4. As a child how would you describe your relationship with your siblings?
a. caring b. strained c. supportive d. honest e. abusive f. critical g. happy h. loving i. conflicted
j. other _____
5. Currently how would you describe your relationship with your parents?
a. distant b. caring c. strained d. supportive e. conflicted f. loving g. happy h. nonexistent
i. other _____
6. Currently how would you describe your relationship with your siblings?
a. caring b. strained c. supportive d. honest e. distant f. critical g. conflicted
h. other _____
7. Are you married or do you have a significant other? _____ How long have you had this relationship? _____
How did you meet? _____
If you are separated or divorced describe your past relationship. _____
8. How would you describe your child's relationship with their mother / father?
a. caring b. strained c. supportive d. distant e. conflicted f. happy g. nonexistent
h. other _____
9. How would you describe your current relationship?
a. caring b. strained c. supportive d. honest e. abusive f. critical g. happy h. loving i. conflicted
j. other _____
10. Children: Please identify age, gender and describe your relationship with your children using *two words* such as happy, distant, caring, critical, honest, abusive or loving

	Age	Gender	Description of Relationship
1			
2			
3			
4			
5			
6			

- | | | |
|--|------|-------|
| 11. Things in our family are unpredictable and tend to become chaotic. | True | False |
| 12. I have often been called into school to discuss my child's behavior. | True | False |
| 13. I would like to improve my family relationships. | True | False |

Alaska Family Service
BEHAVIORAL HEALTH TREATMENT CENTER
Telephone: (907) 376-4000*FAX: (907) 373-1135

Client Orientation Checklist

**Client
Initials**

1. Information about Alaska Family Services:
 - Reviewed Assessment and provided any corrections needed.
 - Received, heard and/or read the Adult Client Handbook.
 - Agency Hours of Operation: *Monday through Friday, 8:00 AM to 5:30 PM*
 - After Hours Services Access: *Telephone 376-4000, leave your name and telephone number with the answering service, the on-call counselor will telephone you.*
2. Policies regarding:
 - **Smoking: *OUTSIDE IN THE BACK OF THE BUILDING IN THE LEFT-HAND CORDER; DO NOT LIGHT UP UNTIL YOU ARE AT THE SMOKING AREA. DO NOT LEAVE YOUR BUTTS ON THE GROUND. NEVER SMOKE IN FRONT OF THE BUILDING.***
 - **Perfume and/or Cologne: *DO NOT WEAR ANY PERFUME OR COLOGNE TO GROUPS AND/OR INDIVIDUAL SESSIONS. Many people are allergic to many of them, and can become very ill.***
3. Client contribution to Quality of Care:
 - Client Satisfaction Survey: *While attending treatment, Clients will annually complete a survey.*
 - Suggestion box: *There is a suggestion box at the front desk for Client use.*
 - Group evaluations: *Evaluation of groups is incorporated into the group progress note completed at the end of the group session.*
4. Program Assignment:
 - Levels of Care: *Intensive Outpatient or Outpatient with progressive levels of decreasing intensity as your success in the recovery process continues.*
 - Counselor assignment: *You will be assigned a primary counselor.*
 - Group meeting times: *Women's Program: 9:30 AM to 12:30 PM*
Community Services: 6:00 PM to 9:00 PM
 - Individual Counseling Sessions: *Scheduled at the front desk*
 - Transition criteria and procedures: *Based upon your individual progress toward achieving your individual goals as described in your individual treatment plan.*

***A tour of the building including fire/emergency evacuation exits, fire/emergency assembly location, restrooms, group rooms, suggestion box and counselor offices will be given the day you start treatment. You will receive a copy of the group rules for the appropriate program when you start treatment.

I certify that I have received the Adult Client Handbook, and will follow the rules and regulations; if I have any questions about my rights I can discuss it with my counselor

Client Signature

Date

Staff Signature

Date

ALASKA FAMILY SERVICES
Behavioral Health Treatment Center
Telephone: (907) 376-4000*FAX: (907) 373-1135

CLIENT MEDICAL RELEASE/ EMERGENCY INFORMATION FORM

For Your Safety, the following information will be kept in a secure area, accessible only to staff members, while you are attending group.

All information must be current in case of emergency. Please complete the following:

I, _____, hereby give my consent to be given emergency medical treatment in the event of an accident, injury or illness.

I hereby release the Alaska Family Services and its representatives from any liability rising from an emergency situation in which it is deemed necessary to pursue medical treatment.

In case of an emergency, Alaska Family Services may contact:

1. _____
Name/Relationship Phone #

2. _____
Name/Relationship Phone #

Drug Allergies: _____

Medications: _____

Other medical conditions: _____

Insurance Information or Medicaid number: _____

By signing below I authorize disclosure of the above information to appropriate emergency personnel

Signature/date

ALASKA FAMILY SERVICES
BEHAVIORAL HEALTH TREATMENT CENTER
Phone (907) 376-4000 * FAX: (907) 373-1135

CLIENT NOTICE

This notice describes how medical and drug and alcohol related information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

General Information

Information regarding your health care, including payment for health care, is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320d et seq., 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2. Under these laws, Alaska Family Services (AFS) may not say to a person outside AFS that you attend the program, nor may AFS disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by federal law.

Alaska Family Services must obtain your written consent before it can disclose information about you for payment purposes. For example, AFS must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before AFS can share information for treatment purposes or for health care operations. However, federal law permits AFS to disclose information *without* your written permission:

1. Pursuant to an agreement with a qualified service organization/ business associate;
2. For research, audit or evaluations;
3. To report a crime committed on AFS' premises or against AFS personnel;
4. To medical personnel in a medical emergency;
5. As allowed by an authorizing court order.
6. Physical or sexual abuse or neglect committed against a child or elderly person
7. Suicidal or homicidal threats or attempts
8. Internal Communications

For example, AFS can disclose information without your consent to obtain legal or financial services, or to another medical facility to provide health care to you, as long as there is a qualified service organization/business associate agreement in place.

Before AFS can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing.

YOUR RIGHTS

Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health information. AFS is not required to agree to any restrictions you request, but if it does agree then it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.

You have the right to request that we communicate with you by alternative means or at an alternative location. AFS will accommodate such requests that are reasonable and will not request an explanation from you. Under HIPAA you also have the right to inspect and copy your own health information maintained by AFS, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.

Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in AFS' records, and to request and receive an accounting of disclosures of your health

related information made by AFS during the six years prior to your request. You also have the right to receive a paper copy of this notice.

AFS may deny a client request for amendment if it determines that the information or record:

- **Was not created by an AFS employee**
- **Is not part of a designated record set**
- **Is accurate and complete**

A client, whose request for amendment is denied, may pursue the next appropriate level of the client grievance procedure.

AFS' Duties

AFS is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. AFS is required by law to abide by the terms of this notice. AFS reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. Any revisions to this policy will be distributed to you at your next scheduled session or appointment.

Complaints and Reporting Violations

You may complain to AFS and the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated under HIPAA. You may file a complaint if you believe your privacy rights have been violated by completing a complaint form (available at the front desk) and following the steps of the Grievance Procedures. You will not be subject to retaliation for filing such a complaint.

A violation of the Confidentiality Law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.

Contact

For further information, contact *AFS by telephoning 376-4000.*

Effective Date

8/03

Acknowledgement

I hereby acknowledge that I received a copy of this notice.

Dated: _____

Patient Signature: _____

Alaska Family Services
BEHAVIORAL HEALTH TREATMENT CENTER
Phone: 907-376-4000 Fax: 907-373-1135

CONSUMER GRIEVANCE PROCEDURE

PROCEDURE

GENERAL

1. Consumers have a right to file a grievance without intimidation and there will be no retaliation against a consumer that files a grievance.
2. Consumers will be informed of the Alaska Family Services "Consumer Grievance Procedure" upon entry to services. A copy of this form will be signed and included in the consumer's clinical record.
3. Consumers may designate a representative or an advocate to assist with all steps of the grievance process.
4. Consumers may request assistance from an Alaska Family Services office administrative staff member in filing a grievance.
5. Grievances may be submitted in writing (attachment), orally/in person, through email or over the telephone. Grievances submitted orally will be documented (attachment) in writing by the staff member receiving the report from the consumer.
6. Grievances that are not resolved by Alaska Family Services within 30 days will be referred to the Division of Behavioral Health within five (5) working days.
7. Grievances involving abuse, neglect or unnecessary seclusion or restraint will immediately be elevated to Level Four: Board of Directors.
8. All Federal, State, and local laws regarding confidentiality will be followed. Appropriate releases of information (ROI) forms will be obtained as necessary for investigation and retained in the consumer's clinical record.
9. Documentation of the grievance process, including decisions will be included in the consumer's clinical record and Alaska Family Services' administrative files.
10. Decisions made to resolve the grievance will be carried out and documented by the appropriate Alaska Family Services staff.

LEVEL ONE: INFORMAL

A consumer should attempt to resolve her/his complaint on an informal basis with the counselor or staff person before entering the formal grievance process.

LEVEL TWO: FORMAL

If the grievance is not resolved at Level One, the consumer shall submit the grievance for review by the Alaska Family Services Clinical Director. The grievance shall outline the nature of the grievance, the circumstances from which it arose, and the remedy or correction desired. Within five (5) working days after the grievance is received, the Clinical Director shall render her/his decision in writing with copies to the consumer and the Chief Executive Officer. If a decision cannot be made within five (5) working days the Clinical Director will notify the consumer and Chief Executive Officer explaining why and identifying when the grievance process will be completed at this level.

LEVEL THREE: CHIEF EXECUTIVE OFFICER

If the grievance is not resolved at Level Two, the consumer shall submit the grievance to the Chief Executive Officer. The Chief Executive Officer will render her/his decision within five (5) working days of receiving the grievance.

LEVEL FOUR: BOARD OF DIRECTORS (GOVERNING BOARD)

If the grievance is not resolved at Level Three, the consumer shall submit the grievance to the Board of Directors within five (5) working days after receipt of a response at Level Three. The Board, or its Executive committee shall meet with all parties involved, at the next regularly scheduled Board meeting. The Board shall make their decision known in writing within five (5) working days following the meeting.

LEVEL FIVE: DIVISION OF BEHAVIORAL HEALTH

If the grievance is not resolved at Level Four, the consumer shall submit the grievance to the State of Alaska, Division of Behavioral Health within five (5) working days after receipt of a response at Level Four. The Division shall designate a State employee to investigate the complaint and provide the consumer a decision in writing. The decision of the Division of Behavioral Health is final

I have read and understand the Consumer Grievance Procedures.

Printed name

Consumer Signature

Date

Agency Representative Signature

Date

Alaska Family Services
BEHAVIORAL HEALTH TREATMENT CENTER
Phone: 907-376-4000 Fax: 907-373-1135

HEALTH REVIEW AND RISK ASSESSMENTS

Health History:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Any major illness or injury in the last 5 years
<input type="checkbox"/>	<input type="checkbox"/>	Any head or brain injuries, disorders or illnesses
<input type="checkbox"/>	<input type="checkbox"/>	Any seizures or epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Eye disorders or impaired vision (except corrective lenses)
<input type="checkbox"/>	<input type="checkbox"/>	Ear disorders, loss of hearing or balance
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease or heart attack; other cardiovascular condition
<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery (valve replacement/bypass, angioplasty, pacemaker)
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Muscular disease
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	Lung disease, emphysema, asthma, chronic bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease, dialysis
<input type="checkbox"/>	<input type="checkbox"/>	Liver disease
<input type="checkbox"/>	<input type="checkbox"/>	Digestive problems
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or elevated blood sugar controlled by:
	<input type="checkbox"/>	<input type="checkbox"/> diet
	<input type="checkbox"/>	<input type="checkbox"/> pills
	<input type="checkbox"/>	<input type="checkbox"/> insulin
<input type="checkbox"/>	<input type="checkbox"/>	Nervous or psychiatric disorders, e.g., severe depression
<input type="checkbox"/>	<input type="checkbox"/>	Loss of, or altered consciousness
<input type="checkbox"/>	<input type="checkbox"/>	Fainting, dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Problems with eating or sleeping
<input type="checkbox"/>	<input type="checkbox"/>	Dental problems
<input type="checkbox"/>	<input type="checkbox"/>	Stroke or paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Missing or impaired hand, arm, foot, leg, finger, toe
<input type="checkbox"/>	<input type="checkbox"/>	Spinal injury or disease
<input type="checkbox"/>	<input type="checkbox"/>	Chronic low back pain
<input type="checkbox"/>	<input type="checkbox"/>	Regular, frequent alcohol use
<input type="checkbox"/>	<input type="checkbox"/>	Narcotic or habit forming drug use
<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a personal physician or health clinic?

Date of last Physical Exam: _____

1. Females:

Number of sexual partners in the last year (circle): 0-1 2-5 5-10 10+

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Use protection when sexually active.
<input type="checkbox"/>	<input type="checkbox"/>	Past or present sexual relations with someone who has HIV, AIDS, or Hepatitis.
<input type="checkbox"/>	<input type="checkbox"/>	Sexual relations while under the influence of drugs or alcohol.
<input type="checkbox"/>	<input type="checkbox"/>	Traded sex for drugs or alcohol.
<input type="checkbox"/>	<input type="checkbox"/>	Had sex against your will.
<input type="checkbox"/>	<input type="checkbox"/>	Pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	Gynecological Issues _____
<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases:
	<input type="checkbox"/>	Herpes
	<input type="checkbox"/>	Syphilis
	<input type="checkbox"/>	Chlamydia
	<input type="checkbox"/>	Genital Warts
	<input type="checkbox"/>	Other: _____

2. Males:

Number of sexual partners in the last year (circle): 0-1 2-5 5-10 10+

Date of last prostrate exam: _____

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Use protection when sexually active
<input type="checkbox"/>	<input type="checkbox"/>	Past or present sexual relations with someone who has HIV, AIDS, or Hepatitis.
<input type="checkbox"/>	<input type="checkbox"/>	Sexual relations while under the influence of drugs or alcohol.
<input type="checkbox"/>	<input type="checkbox"/>	Traded sex for drugs or alcohol.
<input type="checkbox"/>	<input type="checkbox"/>	Had sex against your will.
<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases:
	<input type="checkbox"/>	Herpes
	<input type="checkbox"/>	Syphilis
	<input type="checkbox"/>	Chlamydia
	<input type="checkbox"/>	Genital Warts
	<input type="checkbox"/>	Other: _____

3. Tuberculosis Risk Assessment:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Prolonged, productive cough that produces discharge
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood
<input type="checkbox"/>	<input type="checkbox"/>	Fever and chills
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	<input type="checkbox"/>	Weight loss
<input type="checkbox"/>	<input type="checkbox"/>	Feeling "run down" or easily tired
<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain
<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	Exposed to a person with tuberculosis or TB
<input type="checkbox"/>	<input type="checkbox"/>	Immigrated or a refugee within the last 10 years
<input type="checkbox"/>	<input type="checkbox"/>	Moved to US from Mexico, Vietnam, China, India, Haiti, Korea, Philippines, or Polynesia
		Date of last Tuberculosis test: _____
<input type="checkbox"/>	<input type="checkbox"/>	Test was positive
<input type="checkbox"/>	<input type="checkbox"/>	Completed treatment for Tuberculosis

Medical problems of biological parents you may have inherited, such as a tendency toward heart disease, diabetes, or cancer.

List all Medications:

<u>Name:</u>	<u>Dosage:</u>	<u>Frequency:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all Allergies:
