



HINAMAUKA

Instructions to Completing Forms

(Please read carefully before completing form below)

1. Make sure you fill out the Screening Information Forms and the attached consents completely. Any missing information may delay the screening and admission process.
2. The consents are very important to complete. Without the consents, Federal law prohibits Hina Mauka from releasing information and we cannot contact the appropriate agencies or individuals to assist in your case.
3. If more than one consent is needed for a referral agency, individual or family member, please download, complete and sign “**Consent: Referral/Individual/Family**” from the Hina Mauka website.
4. Please download, read and sign the “**ADAD and HIPAA Privacy Notice**” from the Hina Mauka website.
5. You may also download the “**What to Bring**” form if you are applying for residential treatment.
6. If you have any medical or psychiatric conditions that require attention, please have all your doctor’s evaluation, medication information and updated reports fax with your application. This will help expedite the screening process. Download “**Medical Consents**”, complete and sign if we need to contact your doctor. Please fax with your packet.
7. If you are appropriate for services you will be placed on the waitlist (residential only) and a case manager will contact you to inform you of such status. **There is no waitlist for Outpatient services.**
8. It will be your responsibility to contact the case manager daily to remain on the waitlist. No contacts will lead to removing your name from the waitlist.
9. Once you are approved for admission, a staff member will call you to schedule an admit date. You must come in by 9am of the scheduled admit date. Please plan accordingly.

Remember, all forms should be complete. If the information does not apply, please write **N/A. Do not leave any blanks.**

You may also walk in between the hours of 9am to 2pm Monday thru Friday except holidays to apply for services.

**Kaneohe Walk-In Clinic
45-845 Pookela Street
Kaneohe, Hawaii 96744**

**Waipahu Walk-In Clinic
94-216 #307 Farrington Highway
Waipahu, Hawaii 96797**

Once you have all forms and ready, Please fax to appropriate phone numbers on the Screening Information Form. Mahalo!



HINAMAUKA

SCREENING INFORMATION FORM

(To determine eligibility and appropriateness for Hina Mauka services)

PLEASE FAX TO:
Kaneohe intake: 236-2626
Waipahu Intake: 671-7727
Case Management Referrals: 247-6507

Personal Information: (Please answer all the questions or mark NA).

Date: _____

Name: _____

(First, Middle Initial, Last)

Home Address: _____

State: _____ City _____

Zip Code: _____

Home Phone: _____

Cell Phone: _____

Employer: _____

Employment Status (check one):

Full-Time Part-Time Unemployed

Health Insurance: _____

Membership #: _____

Previous Alcohol/Drug Treatment

Where _____

Date _____

Drugs Treated for _____

Completed? Yes No

Where _____

Date _____

Drugs Treated for _____

Completed? Yes No

Have you been in a controlled environment

In the past 30 days? (Check one):

_____ No _____ Alcohol/Drug Treatment

_____ Jail _____ Medical Treatment

_____ Other _____ Psychiatric Treatment

Last period of incarceration:

From: _____ To: _____

Who referred you? _____

Referral phone number: _____

May we contact them? Yes No

SSN#: _____

Birth Date: _____ Age: _____

Birth Place: _____

Gender (Check all that apply) Male Female

Transgender Male to Female Female to Male

Highest Grade Completed: _____

Ethnicity: _____

Marital Status (check one):

Never Married Divorced Now Married

Widowed Separated Living Together

Number of Children ____ Ages _____

Veteran (circle one): Yes No

VA Case Worker: _____

Do you smoke cigarettes? Yes No

How much per day? _____

Are you pregnant? Yes No N/A

If yes, how many months? _____

Do you use needles to get high? Yes No

If yes, what drug? _____

Next of Kin (In case of emergency):

Name: _____

Phone: _____

Primary Source of Support (check one):

_____ Wages/Salary _____ Disability

_____ Public Assistance _____ Other

_____ Retirement _____ None

Current Living Arrangements (check one): Homeless Dependent Living Independent Living

Substance Abuse Information: Please list the type of drugs/alcohol used recently, last date used (month, day, year, etc.), how much (gram, 1/2 gram, 1 bottle, etc.), how often (daily, weekly, 3X/month, etc.):

| Drug Used | Date of Last Use | How Much | How Often |
|-----------|------------------|----------|-----------|
| | | | |
| | | | |
| | | | |

1. Experience any complications from using or drinking? Yes No (ex. shakes, moody, cold sweats, medical, psychiatric problems, legal problems, etc.) If yes, explain: _____

2. Spend a lot of time using or drinking or recovering from using or drinking? Yes No Explain: _____

3. Have you given up important activities because of your using or drinking? (Family, work, school, etc.) Yes No Please explain your answer: _____

4. Did you know that using and/or drinking is causing problems for you? Yes No If yes, describe these problems: _____

5. Do you have a history of overdose? Yes No. If yes, Last time you overdose? _____
6. History with detox? Yes No. If yes, when, where and from what? _____

Medical/Psychiatric Information:

7. Do you have a history of seizures? Yes No. If yes, explain: _____

8. Have you ever been told you have any communicable diseases: Yes No. If yes, What? _____

9. Please provide dates for: Last physical: _____ Last TB test: _____
Where: _____
10. Current medical problems: *(please list condition, how long you had it, treating doctor and medications if any.)*

| Medical Condition | How Long | Treating Physician | Medication(s) |
|-------------------|----------|--------------------|---------------|
| | | | |
| | | | |
| | | | |

11. Current psychiatric problems: *(please list condition, how long you had it, treating doctor and medications if any.)*

| Psychiatric Condition | How Long | Treating Physician | Medication(s) |
|-----------------------|----------|--------------------|---------------|
| | | | |
| | | | |
| | | | |

12. Do you know who your Primary Care Physician (PCP) is? Yes No. If yes please provide:
Name: _____ Phone: _____ Consent to contact? Yes No
13. Allergies? Yes No. Describe: _____

14. Vision problems: Yes No. Do you wear glasses? Yes No
15. Hearing problems: Yes No. Do you wear a hearing aid? Yes No
16. Do you speak English? Yes No. If no, do you have an interpreter? Yes No.
17. Do you have a Case Manager? Yes No. If yes, please select one of the following:
 AMHD CER ICM MHK IHS CCS Other: _____
18. Case Manager's Name _____ Phone _____
19. Do you hear/see/feel things that aren't there? Yes No Describe: _____

20. Have you ever attended Anger Management or Domestic Violence classes? Yes No. If yes, did you complete? Yes No. Explain: _____
21. Have you ever attempted suicide? Yes No. Have you thought about it? Yes No.
 If yes to the above, when? _____ Last time? _____
 Are you contemplating suicide at this time? Yes No. If yes, would you consent to us helping you at this time? Yes No. Describe action taken: _____

22. Have you ever harmed yourself? Yes No. If yes, would you like someone to talk to about this situation? Yes No. Describe action taken: _____

23. Have you ever harmed anyone else? Yes No. If yes, would you like someone to talk to about this situation? Yes No. Describe action taken: _____

Legal Encumbrance

24. How many convictions in the past 2 years: _____ Describe: _____

25. Any pending charges? Yes No. If yes, please describe: _____

26. Pending court dates: _____ When/where? _____
27. On probation or parole? Probation Parole Other: _____
28. CPS/CWS involvement? Yes No. If yes, may we contact your worker? Yes No
 Worker name: _____ Phone number: _____
29. Have you ever been convicted of an offense that was sexual in nature? Yes No. If yes, did you receive treatment for it? Yes No. Did you complete treatment? Yes No. If yes,

please give date of completion: _____ If not, please explain why you did not complete treatment: _____

30. Have you ever been convicted of a violent crime? Yes No. If yes, please explain: _____

31. How much of your time in the past 3 years, have you engaged in illegal activities?
 25% 50% 75% 100% None. If you wish, please explain your answer: _____

32. What percentages of the people you associate with engage in illegal activities?
 25% 50% 75% 100% None. If you wish, please explain your answer: _____

Recovery Support Services

33. Religious preference: Christian Buddhist Catholic Other: _____
Are you currently active? Yes No. If yes, how often? _____

34. 12-step or Self-help involvement: AA NA Alnon Other: _____
Are you currently active? Yes No. If yes, how often? _____

35. Family support: Yes No. Please explain your answer: _____

(Please document recommendation and comments on Communication Flow Sheet)

Information gathered during the screening process is used to determine eligibility and appropriateness for treatment services rendered by Hina Mauka. Additional information may be required by Hina Mauka to make an appropriate recommendation for treatment. I, the client, understand that the information provided does not constitute admission into treatment and that more information may be needed to accurately determine eligibility and appropriateness for treatment services. I, the client, also understand it will be my responsibility to attain all documents and information needed to determine eligibility and appropriateness. Hina Mauka may assist in the process; however, the primary responsibility to attain additional information will be the client. By signing below, I agree that the information provided on this form to be accurate and true to the best of my knowledge.

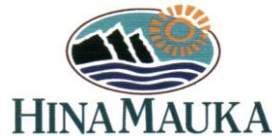
Client Signature

Date

Staff Signature

Date

Entered in WIC 2:
Entered on WITS Waitlist



Consent to Release/Obtain Confidential Information

I, _____, authorize
(Print name of client)

Hina Mauka _____ to disclose to _____
(Medical Insurance Company/Agency/Office)

To communicate with and disclose the following information: *(nature and amount of information as limited as possible)*

[Client to initial each category that applies]

Initial below

- _____ My name and other identifying information (e.g., DOB, client #, and address)
- _____ Attendance (to include dates)
- _____ Discharge plan (to include discharge date and transfers)
- _____ Discharge summary (to include discharge status)
- _____ Appointments (to include medical, legal, and vocational)
- _____ Appeals: I hereby grant Hina Mauka the right to appeal on my behalf in cases that my medical provider denies my coverage
- _____ Other Intake criteria, progress of treatment, continued stay, authorization updates and discharge criteria.

The purpose of the disclosures authorized in this consent is for: **Discussing medical, psychiatric and treatment status with designated insurance plan representative.**

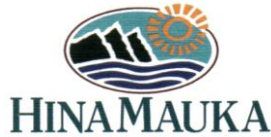
I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R pts 160 & 164, and cannot be disclosed 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 in reliance on it, and that in any event this consent expires automatically as follows:

1 year from discharge date
(Specification of the date, event, or condition upon which this consent expires)

Dated: _____
(Signature of client)

PROHIBITION ON RE-DISCLOSURE OF INFORMATION CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT

This notice accompanies a disclosure 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 the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR 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.



Consent to Release/Obtain Confidential Information

I, _____, authorize
(Print name of client)

Hina Mauka _____ to obtain from _____
(Medical Insurance Company/Agency/Office)

To communicate with and disclose the following information:

[Client to initial each category that applies]

Initial below

- _____ My name and other identifying information (e.g., DOB, client #, and address)
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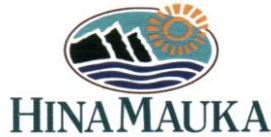
1 year from discharge date

(Specification of the date, event, or condition upon which this consent expires)

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Consent to Release/Obtain Confidential Information

I, _____, authorize
(Print name of client)

Hina Mauka _____ to disclose to _____
(Referring agency/Individual/Family)

To communicate with and disclose the following information: *(nature and amount of information as limited as possible)*

[Client to initial each category that applies]

Initial below

- _____ My name and other identifying information (e.g., DOB, client #, and address)
- _____ Attendance (to include dates)
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- _____ Appointments (to include medical, legal, and vocational)
- _____ Other Progress status in treatment

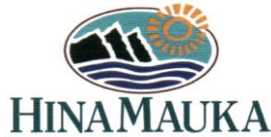
The purpose of the disclosures authorized in this consent is for: **Consultation on behalf of the client’s progress in treatment.**

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 & 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 in reliance on it, and that in any event this consent expires automatically as follows:

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