HINA MAUKA

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!

Client Name:_____
Date: _____

HINA MAUKA

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, ½ gram, 1 bottle, etc.)*, how often *(daily, weekly, 3X/month, etc.):*

Drug Used	Date of Last Use	How Much	How Often

Client Name:_____
Date: _____

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: _____

Client Name:_____

Date: _____

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,

Client Name:_____
Date: _____

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)

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Information gathered during the screening process is used to determine eligibility and appropriateness for <u>treatment</u> 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

Client Name:_____
Date: _____

Entered in WIC 2: ☐
Entered on WITS Waitlist ☐

HINA MAUKA

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-DISCLOSUREOF 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.

Client Name:_____
Date: _____

HINA MAUKA

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)

_____ Attendance (to include dates)

_____ Discharge plan (to include discharge date and transfers)

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Client Name:_____
Date: _____

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)

_____ Discharge plan (to include discharge date and transfers)

_____ Discharge summary (to include discharge status)

_____ 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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Client Name:_____
Date: _____

HINA MAUKA

Consent to Release/Obtain Confidential Information

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(Print name of client)

Hina Mauka to obtain from_____
(Referring agency/Individual/Family)

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[Client to initial each category that applies]

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_____ Discharge plan (to include discharge date and transfers)

_____ Discharge summary (to include discharge status)

_____ 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 clients' progress in treatment.**

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