FAMILY CENTERED SERVICES OF ALASKA
Application for Behavioral Health Services

☐ ATOP Wraparound	☐ Residential Treatment Center
☐ YESS	☐ Wasilla Therapeutic Group Home (TFGH)
☐ Fairbanks Therapeutic Group Home (TFGH)	☐ Wasilla Out-patient Wraparound (WOW)
☐ Fairbanks Therapeutic Foster Care	☐ Wasilla Therapeutic Foster Care
☐ ACT Co-Occurring Treatment Home	☐ Clinical Only-Wasilla/Fairbanks (circle one)

The guardian of a person under 18 years old must complete this application. If you are not the guardian or 18, the guardian must sign the application before submission.

Who referred you to this agency? _____

Is this an OCS placement? ☐ Yes ☐ No If yes, attach family contact plan.

Has the child received Mental Health services in the past? ☐ Yes ☐ No Within the last year? ☐ Yes ☐ No

What are your immediate and long-range goals for treatment?

IMMUNIZATIONS, LEGAL CUSTODY DOCUMENTS, AND COPY OF IEP OR 504 PLAN

☞A copy of the following must be attached to the application to avoid delays in the application review process.

☐ Immunization record is attached ☐ Copy of IEP and/or 504 Plan attached ☐ Custody documents attached

CHILD'S CURRENT LIVING ARRANGEMENTS AND STATUS

Sex: ☐ Male ☐ Female Birth Date: _____

Ethnicity: ☐ Asian/Pacific Islander ☐ Black/African American ☐ Hispanic ☐ White/Caucasian ☐ American Indian

☐ Alaskan Native – If yes, Tribal Affiliation_____ ☐ Other: _____

Last Name: _____ First Name: _____ MI: _____

Street Address:_____ City: _____

State: _____ Zip: _____ Mailing Address (if different): _____

Phone #:_____ Birthplace or Community Tie: _____

Social Security #:_____ U.S. Citizen: ☐ Yes ☐ No

Legal Guardian's name:_____Address_____Phone #_____

Is the child in State's custody? ☐ Yes ☐ No Child's end of custody date: _____

Is the child involved with the Juvenile Justice System? ☐ Yes ☐ No Probation end date: _____

Have parental rights been terminated? ☐ Yes ☐ No ☐ Mother ☐ Father ☐ Both Date of termination: _____

If yes, you must attach a copy of the court order documenting child's custody status and provide the following information:

Probation/ Social Worker's name:_____ Phone #_____

Does the child have a GAL? ☐ Yes ☐ No Name_____ Phone #_____

Does the child have a lawyer? ☐ Yes ☐ No Name_____ Phone #_____

Does the child have: ☐ Developmental Disability ☐ Physical Disability ☐ Medical Disability

☐ Limitation of mobility ☐ Limitation of hearing ☐ Limitation of speech ☐ Limitation of vision

Is the child adopted? ☐ Yes ☐ No FASD/FAE? ☐ Yes ☐ No ☐ Unknown

Did the child's disability begin before the age of 18? ☐ Yes ☐ No

REASON FOR APPLICATION AND SUPPORTING INFORMATION

Please check the box that applies to the child's behavior during a typical day. Include items that affect the family's daily routine.

☐ Anxiety or nervousness	☐ Sadness(less severe than being depressed)	☐ Fears of Phobias
☐ Depressed	☐ Low Self-esteem	☐ Feelings of hopelessness
☐ Feelings of helplessness	☐ Eating Problem (too much or too little)	☐ Moody
☐ Tantrums	☐ Lacking Sense of belonging	☐ Hyperactive
☐ Obsessive/Compulsive Behaviors	☐ Sleeping Problems	☐ Use of Drugs/Inhalants
☐ Use of Alcohol	☐ Other: _____	

Briefly describe how the behaviors affect the daily routine currently and how long they have been present.

CHILDHOOD RELATED TRAUMA

Please note any childhood related trauma that the child has experienced. Please explain below.

☐ Physical Abuse (Child Physically Abused)	☐ Chronic Neglect (by a family member)
☐ Emotional Abuse (incl. verbal abuse)	☐ Sexual Assault (by a family member)
☐ Domestic Violence (Spousal Abuse)	☐ Sexual Abuse-Rape (Outside the family)
☐ Other_____	☐ Other _____

Does the child have a history of any of the following? Please explain below.

☐ Property damage	☐ Suicide attempts	☐ Suicide Gestures
☐ Injury to animals	☐ Injury to other persons	☐ Homicidal threats or acts
☐ Fire Setting		

ALCOHOL AND OTHER DRUG USE

☐ NO KNOWN OR SUSPECTED USE

Has the child ever been assessed or treated for substance abuse? ☐ Yes ☐ No

CURRENT LIVING STATUS

Name of person(s) with whom the child lives—list all who live in the household. If the child is incarcerated or hospitalized at this time, list household members where he/she will reside upon release.

Name	Relationship to Child	Age or DOB	Occupation or School Grade

FAMILY INFORMATION

MOTHER: Does the child live with the mother? ☐ Yes ☐ No ☐ Occasionally

Does the mother have supervised visits? ☐ Yes ☐ No Does the mother have unsupervised visits? ☐ Yes ☐ No

If no, is the mother involved in the child's life? ☐ Yes ☐ No

Name:_____ Age or DOB:_____

Mailing Address: _____

Physical Address (if different): _____

Home phone #:_____ Work phone # :_____

Occupation:_____ Marital status: M S D W

FATHER: Does the child live with the father? ☐ Yes ☐ No ☐ Occasionally

Does the father have supervised visits? ☐ Yes ☐ No Does the father have unsupervised visits? ☐ Yes ☐ No

If no, is the father involved in the child's life? ☐ Yes ☐ No

Name:_____ Age or DOB:_____

Mailing Address: _____

Physical Address (if different): _____

Home phone #:_____ Work phone #:_____

Occupation:_____ Marital status: M S D W

Is contact with any family member restricted? ☐ Yes ☐ No Who? _____

SCHOOL STATUS

Is the child presently enrolled and attending school (or will be during next school year)? ☐ Yes ☐ No
If yes, answer the following questions:

Is the child Special Education Certified? ☐ Yes ☐ No **If yes,** attach a copy of the child's current IEP and school records.

School Name:_____ Teacher's Name: _____

Current grade level:_____ Enrolled: ☐ Full-time ☐ Part-time

Attends school: ☐ 1 day or less per week ☐ 2-3 days per week ☐ 4 or more days per week ☐ rarely misses school

Reasons for above absences: _____

Is tardiness a problem? ☐ No ☐ Yes—how often and why? _____

Been diagnosed with learning disabilities? ☐ Yes ☐ No Specify-_____

Is there a 504 Plan? ☐ Yes ☐ No **If yes,** attach a copy of the current 504 Plan.

MEDICAL INFORMATION & PSYCHOLOGICAL HISTORY

State and Federal regulations require that each child receiving Mental Health services have a complete medical history included in their file. Please complete the attached Medical History Screening.

PHYSICIANS

Please list the physicians, specialists, or clinics that have evaluated or treated the child within the past 2 years.
Start with the current or most recent Pediatrician or Family Physician.

Physician's Name	Address / City / State / Zip	Telephone Number

Dentist's Name	Address/City/State/Zip	Telephone Number

Date of most recent medical exam:_____ **Date of most recent dental exam:**_____
*** (If no exam within the past year, one will be completed within 30 days of admittance).**

Current Height:_____ Current Weight: _____

Please list all current medications the child is taking:

Name of medication	Dosage	When is it taken?	Who prescribed it?

Does your child have any allergies or bad reaction to medication? ☐ Yes ☐ No

Please list all allergies:

Allergy	Reaction	Treatment

THERAPISTS

Please list all therapists, psychologists, psychiatrists, and/or mental health professionals who have evaluated or treated the child within the past 2 years. Start with the current or most recent.

Therapist/Psychiatrist	Address / City / State / Zip	Telephone Number

PLACEMENT HISTORY

Has the child ever been hospitalized or placed in a residential treatment facility, group home, foster care home, or an informal placement? ☐ Yes ☐ No

Name of the Home or Facility	Dates	Reasons for Placement	Length of Stay

Please list the reason(s) for leaving the placements listed above.

What are the child's and family's immediate and long term goals in order to be successful in home, school, and community?

Is there any additional information you would like to add?

NAMES OF PERSON(S) COMPLETING THIS APPLICATION

One signature must be of a legal guardian. If the application is submitted by the Office of Children's Services and the parent's rights have not been terminated, a parent must sign the application.

Name (please print)	Signature	Date	Phone #
Name (please print)	Signature	Date	Phone #

Please send the application (Attn: Admissions Coordinator) to:
Confidential fax (907) 374-1640 or email applications@fcsa-ak.com

Do You Have or Have You Had: *(Check & describe all that apply to you)*			
Last 6 weeks	**History**	**Type**	**Describe**
☐	☐	Major illnesses	
☐	☐	Severe fatigue after little activity	
☐	☐	Unusual swelling or lumps	
☐	☐	Heart problems in self or family	
☐	☐	Blurred vision or difficulty seeing	
☐	☐	Shortness of breath	
☐	☐	Hearing problems, buzzing or ringing	
☐	☐	Swollen feet or ankles	
☐	☐	Persistent colds or coughs	
☐	☐	Severe headaches	
☐	☐	Problems with your sleep or rest	
☐	☐	Bleeding gums or teeth problems	
☐	☐	Aching joints or muscles	
☐	☐	Constipation or diarrhea	
☐	☐	Major injures/surgeries	
☐	☐	Recent changes in your weight	
☐	☐	Any problem with urination	
☐	☐	Blood in your stool or urine	
☐	☐	Ear infection	
☐	☐	Asthma or other respiratory problems	
☐	☐	Vomiting more than 3 times per week	
☐	☐	Mouth sores more than 3 times per week	
☐	☐	Cravings for non-food items	
☐	☐	Seizures or epilepsy	
☐	☐	Diabetes	
☐	☐	Tuberculosis	
☐	☐	IV Drug Use	
☐	☐	HIV+	
Females Only			
☐	☐	Pregnant	
☐	☐	Any unusual vaginal discharge:	
☐	☐	Excessive menstrual bleeding	

HEALTH INSURANCE INFORMATION

Please complete information in this section based on your current insurance coverage. If the child is covered by Medicaid and is also covered by a private health insurance policy, you must list the health insurance information in the space provided below in order for FCSA to bill Medicaid. Submitted Applications will ***not*** be processed without insurance information. **A copy of the child's Denali Kid Care Card and/or Other Insurance Card must be attached**.

Client Name:_____ Client Date of Birth: _____

Section A.

☐ Yes, I have Medicaid or Denali Kid Care

Medicaid or Denali Kid Care #_____ Coverage Dates_____to _____

☐ No, I do not have other health insurance – Skip to Section B.

☐ Yes, I have other health insurance – Complete information below

Insurance Company Name:_____ Policy Number: _____

Company Address:_____ Group Name: _____

Company City / State / Zip:_____ Group Number: _____

Policy Holder's Name:_____ Policy Start Date: _____

Policy Holder's Address:_____ Policy End Date: _____

Policy Holder's City / State / Zip: _____

Policy Holder's Social Security Number: _____

Policy Holder's Date of Birth:_____ Policy Holder's Phone #: _____

*If the child has a secondary insurance policy, please use page 2 (Section C).

Section B.

The State of Alaska requires that FCSA collect the following information:

Please list your gross annual household income:$_____

***If you claim this child as a dependent on your federal income tax return, your income will also be used in determining the child's Medicaid eligibility. If you do not claim the child as a dependent, only the child's income will be considered in determining Medicaid eligibility.**

_____ _____

Parent or Guardian Name (please print) Phone #

_____ _____

Parent or Guardian Signature Date

Health Insurance Information (continued…)

Section C.

Insurance Company Name:_____ Policy Number: _____

Company Address:_____ Group Name: _____

Company City/ State/ Zip:_____ Group Number: _____

Policy Holder's Name:_____ Policy Start Date: _____

Policy Holder's Address:_____ Policy End Date: _ Policy Holder's City/ State/ Zip: _____

Policy Holder's Social Security Number: _____

Policy Holder's Date of Birth:_____ Policy Holder's Phone # _____

FAMILY CENTERED SERVICES OF ALASKA
Authorization to Share Information

CLIENT #: _____

Client Name_____DOB_____SSN _____

Name of Parent / Legal Guardian: _____

I understand that FCSA may release the minimum necessary information regarding my health services as part of my treatment, to receive payment or for normal business operations. In addition, to assist FCSA in providing quality services I hereby authorize Family Centered Services of Alaska to share information about my child and family, as indicated by my initials and written instruction below. In doing so, I am aware that I may, without penalty, refuse consent for the authorization to share information to any of the persons or agencies at any time.

(1) List the agencies or persons working with your child/family. Please spell out the name instead of using acronyms.

(2) Indicate whether FCSA may share information to the person/agency by **placing your initials** in the "YES" or "NO" column.

(3) Look at the **Information Code** below. For each "YES" list the information that may be shared with that agency or that person by writing the appropriate numbers. If you have special instructions, i.e. only certain information shared only with certain people, write them down.

INFORMATION CODE:

1 – ISP	**5 = Psychotherapy Notes**	**9 = Assessments/ Eval Reports**	**13 = Social Histories/ Reports**
2 = IEP	**6 = OCS Reports**	**10 = Drug & Alcohol Treatment**	**14 = Probation Reports**
3 = Speech/ OT/ PT Reports	**7 = Medical Reports**	**11 = Progress Report**	
4 = School Incident Reports	**8 = Psychological Reports**	**12 = Discharge Summary**	

Note: Categories 1-14 do **not** include information about various communicable diseases (HIV, AIDS, ARC, TB, and Hepatitis). A separate authorization form is required to share this information.

1. Name of Agency/Person	**2. YES (initials)**	**NO (initials)**	**3. Type of Information to be Shared: (List By Code Number Above)**
Parent:			
Mental Health Service Agencies:			
Psychiatrist			
School District:			
OCS:			
Hospital:			
Physician:			
Foster Parent:			
Medicaid			
Family Focus:			
Other:			

Authorization to Share Information (Continued...)

I understand that the purpose of FCSA is to provide case coordination, assessment and intervention services to eligible children, youth and their families. I also understand that allowing FCSA to share information about my child and family helps them determine eligibility for services and coordination of community based programs and services, and determine insurance and other benefits.

I understand that information exchanged as a result of this authorization will be shared only with those persons in an agency with a legitimate need for such information. A person or agency sharing information under this authorization may not subsequently share this information unless further disclosure is expressly permitted by written authorization.

My authorization is voluntary and shall be effective from: to , not to exceed one year or 90 days after discharge from services, whichever is sooner.

My signature verifies my authorization for information sharing and that I have read this form and/or have had it read to me and explained in language that I can understand. I may withdraw my authorization at any time by completing the withdraw authorization section below though it will not change any action taken between date of original signature and date of revocation.

_____ _____

Signature of Parent/ Legal Guardian Date Signed

Parent/Legal Guardian to Place Initials Here: _____

_____ _____

Signature of Witness Date Signed

To withdraw your authorization sign below:

I withdraw my authorization for FCSA to share information to the persons/agencies listed on this Authorization.

_____ _____

Signature of Parent/Legal Guardian Date Signed

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For Office Use Only

❑ Referral Packet Only

_____
Date Application Received

Child's Initials _____ DOB _____ Gender_____

Administrative review by:_____ Date_____

Clinical review by:_____ Date_____

Accepted:_____YES Client #_____ Admission date_____Time_____

Program Clinician:_____

Denied ___ If denied; GAF at time of Referral _____ Client IQ_____Referred to_____

Program:

- ❑ -ATOP Wraparound
- ❑ -YESS
- ❑ -Fairbanks Therapeutic Group Home (TFGH)
- ❑ -Fairbanks Therapeutic Foster Care
- ❑ -ACT – Co-Occurring Treatment Home
- ❑ -Residential Treatment Center
- ❑ -Wasilla Therapeutic Group Home (TFGH)
- ❑ -Wasilla Out-patient Wraparound (WOW)
- ❑ -Wasilla Therapeutic Foster Care
- ❑ -Clinical Only – Wasilla/Fairbanks (circle one)

Dates of pre-placement visits _____ &_____(applies to foster & group foster homes)

Request for additional documentation: Date_____Person Contacted _____

Documents requested:

Reason for Denial:

Guardian Contacted:_____Date & Time: _____

Routing: ❑ -Original application and letter to client file

Copies to: ❑ -Nurse ❑ -Program Clinician ❑ -Program Manager