



Consent for COVID-19 Vaccination

I, \_\_\_\_\_ (Parent/Legal Guardian Name) for  
\_\_\_\_\_ (Client Name)

Give consent for my child to be inoculated against COVID-19 when the vaccine becomes available.

Do not give consent for my child to be inoculated against COVID-19 when the vaccine becomes available.

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

**FAMILY CENTERED SERVICES OF ALASKA**  
***Application for Behavioral Health Services***

- |  |   |
|--|---|
| <input type="checkbox"/> ATOP Wraparound                         | <input type="checkbox"/> Residential Treatment Center                 |
| <input type="checkbox"/> YESS                                    | <input type="checkbox"/> Wasilla Therapeutic Group Home (TFGH)        |
| <input type="checkbox"/> Fairbanks Therapeutic Group Home (TFGH) | <input type="checkbox"/> Wasilla Out-patient Wraparound (WOW)         |
| <input type="checkbox"/> Fairbanks Therapeutic Foster Care       | <input type="checkbox"/> Wasilla Therapeutic Foster Care              |
| <input type="checkbox"/> ACT Co-Occurring Treatment Home         | <input type="checkbox"/> 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.**

Did someone refer you to our agency? \_\_\_\_\_

If not, where did you hear about us?  Radio  TV  Google  Facebook  Other

\_\_\_\_\_

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.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anxiety or nervousness         | <input type="checkbox"/> Sadness(less severe than being depressed) | <input type="checkbox"/> Fears of Phobias         |
| <input type="checkbox"/> Depressed                      | <input type="checkbox"/> Low Self-esteem                           | <input type="checkbox"/> Feelings of hopelessness |
| <input type="checkbox"/> Feelings of helplessness       | <input type="checkbox"/> Eating Problem (too much or too little)   | <input type="checkbox"/> Moody                    |
| <input type="checkbox"/> Tantrums                       | <input type="checkbox"/> Lacking Sense of belonging                | <input type="checkbox"/> Hyperactive              |
| <input type="checkbox"/> Obsessive/Compulsive Behaviors | <input type="checkbox"/> Sleeping Problems                         | <input type="checkbox"/> Use of Drugs/Inhalants   |
| <input type="checkbox"/> Use of Alcohol                 | <input type="checkbox"/> 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.

- |   |   |
|---|---|
| <input type="checkbox"/> Physical Abuse (Child Physically Abused) | <input type="checkbox"/> Chronic Neglect (by a family member)   |
| <input type="checkbox"/> Emotional Abuse (incl. verbal abuse)     | <input type="checkbox"/> Sexual Assault (by a family member)    |
| <input type="checkbox"/> Domestic Violence (Spousal Abuse)        | <input type="checkbox"/> Sexual Abuse-Rape (Outside the family) |
| <input type="checkbox"/> Other _____                              | <input type="checkbox"/> Other _____                            |

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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Property damage   | <input type="checkbox"/> Suicide attempts        | <input type="checkbox"/> Suicide Gestures          |
| <input type="checkbox"/> Injury to animals | <input type="checkbox"/> Injury to other persons | <input type="checkbox"/> Homicidal threats or acts |
| <input type="checkbox"/> 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 admission).

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](mailto:applications@fcsa-ak.com)**

**Do You Have or Have You Had:** *(Check & describe all that apply to you)*

**No Medical History**

<b>Last 6 weeks</b>	<b>History</b>	<b>Type</b>	<b>Describe</b>
<input type="checkbox"/>	<input type="checkbox"/>	Major illnesses	
<input type="checkbox"/>	<input type="checkbox"/>	Severe fatigue after little activity	
<input type="checkbox"/>	<input type="checkbox"/>	Unusual swelling or lumps	
<input type="checkbox"/>	<input type="checkbox"/>	Heart problems in self or family	
<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision or difficulty seeing	
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	
<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems, buzzing or ringing	
<input type="checkbox"/>	<input type="checkbox"/>	Swollen feet or ankles	
<input type="checkbox"/>	<input type="checkbox"/>	Persistent colds or coughs	
<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches	
<input type="checkbox"/>	<input type="checkbox"/>	Problems with your sleep or rest	
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums or teeth problems	
<input type="checkbox"/>	<input type="checkbox"/>	Aching joints or muscles	
<input type="checkbox"/>	<input type="checkbox"/>	Constipation or diarrhea	
<input type="checkbox"/>	<input type="checkbox"/>	Major injures/surgeries	
<input type="checkbox"/>	<input type="checkbox"/>	Recent changes in your weight	
<input type="checkbox"/>	<input type="checkbox"/>	Any problem with urination	
<input type="checkbox"/>	<input type="checkbox"/>	Blood in your stool or urine	
<input type="checkbox"/>	<input type="checkbox"/>	Ear infection	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma or other respiratory problems	
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting more than 3 times per week	
<input type="checkbox"/>	<input type="checkbox"/>	Mouth sores more than 3 times per week	
<input type="checkbox"/>	<input type="checkbox"/>	Cravings for non-food items	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures or epilepsy	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	
<input type="checkbox"/>	<input type="checkbox"/>	IV Drug Use	
<input type="checkbox"/>	<input type="checkbox"/>	HIV+	
<b>Females Only</b>			
<input type="checkbox"/>	<input type="checkbox"/>	Pregnant	
<input type="checkbox"/>	<input type="checkbox"/>	Any unusual vaginal discharge:	
<input type="checkbox"/>	<input type="checkbox"/>	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.

<b>INFORMATION CODE:</b>			
<b>1 – ISP</b>	<b>5 = Psychotherapy Notes</b>	<b>9 = Assessments/ Eval Reports</b>	<b>13 = Social Histories/ Reports</b>
<b>2 = IEP</b>	<b>6 = OCS Reports</b>	<b>10 = Drug &amp; Alcohol Treatment</b>	<b>14 = Probation Reports</b>
<b>3 = Speech/ OT/ PT Reports</b>	<b>7 = Medical Reports</b>	<b>11 = Progress Report</b>	
<b>4 = School Incident Reports</b>	<b>8 = Psychological Reports</b>	<b>12 = Discharge Summary</b>	
<i>Note:</i> Categories 1-14 do <b>not</b> include information about various communicable diseases (HIV, AIDS, ARC, TB, and Hepatitis). A separate authorization form is required to share this information.			

<b>1. Name of Agency/Person</b>	<b>2. YES (initials)</b>	<b>NO (initials)</b>	<b>3. Type of Information to be Shared: (List By Code Number Above)</b>
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