FAMILY CENTERED SERVICES OF ALASKA
Application for Behavioral Health Services

☐ 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)

Service Delivery Preference: In person only Video/Telehealth services only Either in person or video/telehealth

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.

☐ 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 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

Do You Have or Have You Had: *(Check & describe all that apply to you)*			
☐ **No Medical History**			
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 Exchange Verbal Information

Client Name: ____ Date of Birth: ______________________

As the parent or legal guardian of the above-named client, I understand that FCSA may release the minimum necessary information regarding the child's health services as part of treatment (including to FCSA contracted clinicians, foster parents or psychiatrists), to receive payment or for normal business operations. In addition, I hereby authorize FCSA to exchange verbal information about the above-named client, as indicated below. I am aware that I may, without penalty, refuse consent for the authorization to exchange verbal information to any of the persons or agencies at any time.

Note: A separate authorization is required to share hard copies or digital copies of information as well as information regarding various communicable diseases (HIV, AIDS, ARC, TB and Hepatitis)

FCSA may verbally communicate with the following people or agencies regarding the selected information:

1. **Person or Agency Name: ____**

Check all that apply

	Diagnosis
	Incidents
	Medications
	Placement
	Referrals
	School Progress
	Treatment Progress

2. **Person or Agency Name:____**

Check all that apply

	Diagnosis
	Incidents
	Medications
	Placement
	Referrals
	School Progress
	Treatment Progress

3. **Person or Agency Name:____**

Check all that apply

	Diagnosis
	Incidents
	Medications
	Placement
	Referrals
	School Progress
	Treatment Progress

4. Person or Agency Name:____

Check all that apply

	Diagnosis
	Incidents
	Medications
	Placement
	Referrals
	School Progress
	Treatment Progress

5. Person or Agency Name:____

Check all that apply

	Diagnosis
	Incidents
	Medications
	Placement
	Referrals
	School Progress
	Treatment Progress

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 the above-named child 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 to those persons in an agency with a legitimate need for such information. A person or agency receiving information under this authorization may not subsequently share that information unless further disclosure is expressly permitted by written authorization.

My signature verifies my authorization for verbal information exchange and that I have read this form and/or have had it read to me and explained in a language that I can understand. I may withdraw my authorization at any time.

______________________________ ____________________

Legal Guardian Signature Date

______________________________ ____________________

Witness Signature Date

Family Centered Services of Alaska
Authorization to Request Client Records

Client Name:	
I hereby authorize____ to Release Information to Person/Agency: Family Centered Services of Alaska	
Address: 1825 Marika Road	
City/State/Zip: Fairbanks, AK 99709	
Phone: 907-474-0890	**Fax: 907-374-1640**

Information Requested:

☐ **Psychological Assessments**	☐ **Immunizations**
☐ **Clinical Progress Notes**	☐ **Individualized Education Plans**
☐ **Discharge Summary**	☐ **Medical Records**
☐ **Incident Reports**	☐ **Other:**

This protected health information is being used or disclosed for the following purposes:
acceptance into FCSA services

This authorization expires one year from the date of signature and is given voluntary in writing for the above stated purpose. I have read this form and/or I have had it read to me and explained in a language that I can understand. This authorization will remain in effect until the expiration date unless it is revoked earlier. This authorization can be revoked at any time, by contacting the FCSA Privacy Officer and completing the withdraw authorization section below; this will not change any action taken between the original authorization date and date of revocation. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state regulations.

Parent/Legal Guardian: ______________________________ **Date:** ______________

Print Name: ____

I withdraw my authorization for persons/agencies to share information as listed on this Authorization

____ ______________________

Signature of Parent/Legal Guardian Date Signed

8-19-21

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