



FCSA Application for Behavioral Health Services

Check list:

Please include the following documents with the application to avoid delays in processing *(if applicable)*:

- Application for Behavioral Health Services
- Immunization records
- IEP/504 Plan
- Custody Documents
- Current List of medications from prescribing physician
- Clinical documentation and/or a completed Authorization to Request Records from from current/previous provider

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) |

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.

- | | | |
|---|--|---|
| <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

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

No Medical History

Last 6 weeks	History	Type	Describe
<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+	
Females Only			
<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 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

<input type="checkbox"/>	Diagnosis
<input type="checkbox"/>	Incidents
<input type="checkbox"/>	Medications
<input type="checkbox"/>	Placement
<input type="checkbox"/>	Referrals
<input type="checkbox"/>	School Progress
<input type="checkbox"/>	Treatment Progress

2. Person or Agency Name: _____

Check all that apply

<input type="checkbox"/>	Diagnosis
<input type="checkbox"/>	Incidents
<input type="checkbox"/>	Medications
<input type="checkbox"/>	Placement
<input type="checkbox"/>	Referrals
<input type="checkbox"/>	School Progress
<input type="checkbox"/>	Treatment Progress

3. Person or Agency Name: _____

Check all that apply

<input type="checkbox"/>	Diagnosis
<input type="checkbox"/>	Incidents
<input type="checkbox"/>	Medications
<input type="checkbox"/>	Placement
<input type="checkbox"/>	Referrals
<input type="checkbox"/>	School Progress
<input type="checkbox"/>	Treatment Progress

4. Person or Agency Name: _____

Check all that apply

<input type="checkbox"/>	Diagnosis
<input type="checkbox"/>	Incidents
<input type="checkbox"/>	Medications
<input type="checkbox"/>	Placement
<input type="checkbox"/>	Referrals
<input type="checkbox"/>	School Progress
<input type="checkbox"/>	Treatment Progress

5. Person or Agency Name: _____

Check all that apply

<input type="checkbox"/>	Diagnosis
<input type="checkbox"/>	Incidents
<input type="checkbox"/>	Medications
<input type="checkbox"/>	Placement
<input type="checkbox"/>	Referrals
<input type="checkbox"/>	School Progress
<input type="checkbox"/>	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:	
<input type="checkbox"/> Psychological Assessments	<input type="checkbox"/> Immunizations
<input type="checkbox"/> Clinical Progress Notes	<input type="checkbox"/> Individualized Education Plans
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Medical Records
<input type="checkbox"/> Incident Reports	<input type="checkbox"/> 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