AK Child & Family understands that the decision to apply for services often comes at a time of stress for families. We appreciate your interest in our agency and look forward to working with you. Upon receiving a referral the Director of Admissions will notify you of its receipt and notify you of the Intake Clinical Therapist who has been assigned to screen and process the referral. If at any point you have questions or concerns about the intake process please do not hesitate to contact the assigned Intake Clinical Therapist (907)346-2101 or the Director of Admissions at (907)348-9262.

In order to ensure that applications are processed as timely as possible the following documents should be submitted along with this application for services:

Attached?	Requested Documentation
◯ Yes ◯ No	Release of Information Forms (preferred ones are included in this application)
◯ Yes ◯ No	Custody Document (must be Legal document)
◯ Yes ◯ No	Psychological and/or Psychiatric Evaluations
◯ Yes ◯ No	Disposition Report (if applicable)
◯ Yes ◯ No	Discharge Summaries from previous placements/treatments
◯ Yes ◯ No	Copy of School Records (especially IEPs, BIPs and any documentation related to suspensions, detentions or expulsions).
◯ Yes ◯ No	Immunization Records
◯ Yes ◯ No	Most recent physical exam
◯ Yes ◯ No	Master Treatment Plan to Include two most recent reviews
◯ Yes ◯ No	Insurance information (complete attached sheet and provide copy of subscriber's ID, DOB and SSN).
◯ Yes ◯ No	Copy of child's Birth Certificate
◯ Yes ◯ No	Copy of child's Social Security Card
◯ Yes ◯ No	Tribal Enrollment Verification (if applicable)

Confidential Application for CARES SERVICES

AK CHILD & FAMILY

Please direct questions and completed applications to the AK Child & Family Admissions Department at 4600 Abbott Road, Anchorage AK 99507. Referral email: admissionsoffice@akchild.org Phone: (907)346-2101/ Fax: (907)348-9230

Date Completed:_____ **Completed By:** _____

Referred Student: _____

Preferred or Cultural Name:

_____

Date of Birth: _____**SS#:**_____

Biological Gender: Select One

Identified Gender: Select One

Sexual Orientation: Select One

Race: _____**Ethnicity:** _____

Tribal Affiliation:_____

Preferred Language: _____

Is an interpreter needed? ◯Yes ◯No

Current Placement: _____

Current Placement Contact Name and Info:

_____

_____

Release of Information for Current Placement?
◯Yes ◯No

Most Current Psychiatric Diagnosis Name and Code

_____

_____

_____

_____

Please list any recent medical or psychiatric testing that has occurred for this youth in the past year:

_____

_____

_____

_____

_____

Smoking Status: Select One

Military Status: Select One

Are Parental Rights Still Intact? ◯Yes ◯No

Parent's Name: _____

Phone: _____

Email: _____

Address: _____

City/State/Zip:_____

Legal Custodian? ◯Yes ◯No

Parent's Name: _____

Phone: _____

Email: _____

Address: _____

City/State/Zip:_____

Legal Custodian? ◯Yes ◯No

Custodian (if not parent):

_____ Phone:

_____ Email:

_____

Address: _____

City/State/Zip:_____

Household Income and Number of Household Members (for grant and state reporting)**:**

_____

How did you hear about AK Child and Family?

_____

Does your family have an URGENT need for any of the following?

☐Housing ☐Transportation ☐Food

☐Medication ☐Childcare ☐Utilities

Consent to use Telehealth Services

AK Child & Family

Telehealth services may be used in the course of treatment at AK Child & Family. The service that is used is secure and encrypted in order to protect the privacy of the services. These services are not required and will only be conducted with the consent of the student and / or parent / guardian. Telehealth services are subject to the following procedures and understandings :

- Telehealth services provide the benefit of face to face interaction although you will not be in the same room as your provider . Whether or not to utilize Telehealth services will be a mutual decision agreed upon by both the student / guardian / parent and service provider. In some cases, the service provider may recommend services that require the student / guardian / parent's physical presence if reasonably possible.
- Telehealth services will be scheduled in advance at a designated time agreed upon by both the student / parent / guardian and provider.
- Telehealth services provided via computer should be accessed through a safe and secure connection . Be sure to use a computer that is in a confidential or private area and always fully exit all online counseling sessions when they are complete.
- Telehealth services may also include online functionality , such as posting of notes or chat logs during the session. This information may be printed by your provider, and if so, it will be treated as confidential.
- If Telehealth services cannot be conducted due to technical difficulties , you should immediately contact your provider to schedule a new session.

Using Telehealth services is entirely voluntary and will not impact the quality of care you receive from AK Child & Family should you decide not to use these services. AK Child & Family will not condition treatment or payment for health care on whether or not you use Telehealth services or sign this agreement.

AK Child & Family is not liable for any claims and / or damages arising from following:

i. Interruption in the ability to conduct Telehealth services due to technical difficulties , technical maintenance, or system failure.
ii. Access by friends, family members or other third parties who may enter the room on the patient side during Telehealth sessions .
iii. Breaches of privacy and security due to the fault of the third party videoconferencing provider.

Telehealth Consent

By signing below, you acknowledge that you have read and fully understand the information in this document. You have been given the risks and benefits of such services and technologies, and understand the risks associated with online communications with AK Child & Family, and consent to the conditions as indicated herein. In addition, you agree to adhere to the policies set forth above, as well as any other instructions or guidelines that AK Child & Family may impose for using the electronic communications.

Parent / Guardian Printed Name _____ Date _____

Parent / Guardian Signature _____ Date _____

Witness _____ Date _____

AKCHILD & FAMILY

Insurance Information

AK Child & Family

Youth Name: _____ **Youth DOB:** _____

Primary Insurance _____ Insurance ID _____

Group # _____ Rx# _____

Insurance Address _____ Insurance Phone _____

_____

Policy Holder's Name _____ DOB _____

Policy Holder's Address_____ SSN _____

_____

Secondary Insurance _____ Insurance ID _____

Group # _____ Rx# _____

Insurance Address _____ Insurance Phone _____

_____

Policy Holder's Name _____ DOB _____

Policy Holder's Address_____ SSN _____

_____

Tertiary Insurance _____ Insurance ID _____

Group # _____ Rx# _____

Insurance Address _____ Insurance Phone _____

_____

Policy Holder's Name _____ DOB _____

Policy Holder's Address_____ SSN _____

_____

For Office Use Only:

Admit Date: _____ Unit Admitted to: Select One

☐ Copy of Insurance Card Received ☐ Medicaid Consent for Enrollment Received

☐ Copy of Birth Certificate Received ☐ Copy of SSN Card Received

APPENDIX C OPTIONAL

Appointing an Authorized Representative

Would you like to allow someone to represent you on all matters related to your application and case?

You can give a trusted person or an organization permission to talk about your application and case with us, see your information, and act for you on matters related to your Public Assistance case. This person is called an "authorized representative." An authorized representative can make changes to your Public Assistance case and has access to the information in your case file. You will be held responsible for any change that is made to your case by your appointed authorized representative, up to and including potential fraud charges.

The Division of Public Assistance can release any information regarding your application and case to your authorized representative or any member of the organization indicated on this form. More than one person or organization can serve as your authorized representative.

You can appoint, withdraw, or change an authorized representative at any time. If you ever need to change your authorized representative, contact the Division of Public Assistance. *If you are a legally appointed representative for someone on this application and provide proof, you do not need to complete this section.*

Name of Authorized Representative (First name, Middle name, Last name) or Organization		Phone Number
Ak Child and Family		907-346-2101
Authorized Representative's Address	Apartment or suite number	Email
4600 Abbott Rd		jgage@akchild.org
City	State	ZIP code
Anchorage	AK	99508

⊗ New ○ Change ○ Addition ○ Remove this person or organization as my authorized representative

OR

Permission to Release Information

Is there anyone that you would like us to share information with about your application and case?

By completing this section, you can give permission for the following person or organization to receive information about your Public Assistance application and benefit status, but they will not have the ability to act on your behalf like an authorized representative. You give the Division of Public Assistance permission to release information about your case status to this additional person or organization. You may cancel this release at any time by contacting the Division of Public Assistance.

Name of person (First name, Middle name, Last name) or Organization		Phone Number
AK Child and Family		907-346-2101
Address	Apartment or suite number	Email
4600 Abbott Rd		jgage@akchild.org
City	State	ZIP code
Anchorage	AK	99508

AND

Applicant / Recipient's Signature	Date (mm/dd/yyyy)
Applicant / Recipient's Printed Name	Social Security Number or Case Number

To be valid, this form must be signed by the applicant or recipient.

Authorization for Exchange of Information
AK Child & Family

I hereby authorize AK Child & Family to exchange personal health information between AK Child & Family

and Name: Medicaid _____ Fax: _____

Address: _____

for Student Name: _____ Date of Birth: _____

PLEASE RETURN FORM TO: ATTENTION: Admissions Department

AK Child & Family • 4600 Abbott Road Anchorage, AK 99507 • (907) 346-2101 • Fax (907) 348-9230

INFORMATION TO BE RELEASED / REQUESTED FOR THE FOLLOWING PURPOSE:

☐ Treatment ☐ Legal Request ☐ Insurance Claim ☐ Other: _____

Please check specific information to be released:

- ☐ Progress Notes
- ☐ Consultations
- ☐ Neuropsychological Assessment
- ☐ Psychological Assessment(s)
- ☐ Treatment Plan and Review(s)
- ☐ Intake / Mental Health Assessment
- ☐ Psychiatric Assessment
- ☐ Discharge / Continuing Care Summary
- ☐ Medical History / Physical Exam
- ☐ Medical / Dental Aftercare Plan
- ☐ Medical and Laboratory Results
- ☐ Physician Orders
- ☐ Verbal exchange of all information to aid in assessing and / or treating student
- ☐ UA Results
- ☐ School Records *(Transcripts, Disciplinary Reports, IEP, Other Plans)*
- ☐ Immunization Records
- ☐ Special Education Records

This information may be used for continuation of care. I understand this authorization will expire on _____ and / or **6 months following the date of discharge from any AK Child & Family,** revocation of custody or guardianship, or upon written revocation, whichever comes first. This authorization may be revoked prior to the expiration, but not retroactively. Photo static and / or facsimile copies of this authorization will be considered as valid as the original.

PROHIBITION ON REDISCLOSURE: *This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations restrict any use of this information to investigate or prosecute any alcohol or drug abuse patient. Disclosure of patient information is permitted with the patient's written consent: however, disclosures to central registries and in connection with criminal justice referrals must meet the following specific regulations: (42 CFR 2.32 and 2.33). This information disseminated from AK Child & Family.*

I acknowledge that the information to be released is protected by Federal law and may include information regarding drug / alcohol abuse, sexually transmitted diseases / HIV and / or Hepatitis B. My signature below authorizes the release of this information.
I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment.
I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

Student: _____ Date: _____

Parent / Guardian: _____ Date: _____

Witness: _____ Date: _____

Authorization for Exchange of Information

AK Child & Family

I hereby authorize AK Child & Family to exchange personal health information between AK Child & Family

and Name: Last Medication Management Provider Fax: _____

Address: _____

for Student Name: _____ Date of Birth: _____

PLEASE RETURN FORM TO: ATTENTION: Admissions Department

AK Child & Family • 4600 Abbott Road Anchorage, AK 99507 • (907) 346-2101 • Fax (907) 348-9230

INFORMATION TO BE RELEASED / REQUESTED FOR THE FOLLOWING PURPOSE:

☐ Treatment ☐ Legal Request ☐ Insurance Claim ☐ Other: _____

Please check specific information to be released:

☐ Progress Notes
☐ Consultations
☐ Neuropsychological Assessment
☐ Psychological Assessment(s)
☐ Treatment Plan and Review(s)
☐ Intake / Mental Health Assessment
☐ Psychiatric Assessment
☐ Discharge / Continuing Care Summary
☐ Medical History / Physical Exam
☐ Medical / Dental Aftercare Plan
☐ Medical and Laboratory Results
☐ Physician Orders
☐ Verbal exchange of all information to aid in assessing and / or treating student
☐ UA Results
☐ School Records *(Transcripts, Disciplinary Reports, IEP, Other Plans)*
☐ Immunization Records
☐ Special Education Records

This information may be used for continuation of care. I understand this authorization will expire on _____ and / or **6 months following the date of discharge from any AK Child & Family,** revocation of custody or guardianship, or upon written revocation, whichever comes first. This authorization may be revoked prior to the expiration, but not retroactively. Photo static and / or facsimile copies of this authorization will be considered as valid as the original.

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I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

Student: _____ Date: _____

Parent / Guardian: _____ Date: _____

Witness: _____ Date: _____

Authorization for Exchange of Information

AK Child & Family

I hereby authorize AK Child & Family to exchange personal health information between AK Child & Family

and Name: Last Outpatient Therapeutic Provider Fax: _____

Address: _____

for Student Name: _____ Date of Birth: _____

PLEASE RETURN FORM TO: ATTENTION: Admissions Department

AK Child & Family • 4600 Abbott Road Anchorage, AK 99507 • (907) 346-2101 • Fax (907) 348-9230

INFORMATION TO BE RELEASED / REQUESTED FOR THE FOLLOWING PURPOSE:

☐ Treatment ☐ Legal Request ☐ Insurance Claim ☐ Other: _____

Please check specific information to be released:

☐ Progress Notes
☐ Consultations
☐ Neuropsychological Assessment
☐ Psychological Assessment(s)
☐ Treatment Plan and Review(s)
☐ Intake / Mental Health Assessment
☐ Psychiatric Assessment
☐ Discharge / Continuing Care Summary
☐ Medical History / Physical Exam
☐ Medical / Dental Aftercare Plan
☐ Medical and Laboratory Results
☐ Physician Orders
☐ Verbal exchange of all information to aid in assessing and / or treating student
☐ UA Results
☐ School Records *(Transcripts, Disciplinary Reports, IEP, Other Plans)*
☐ Immunization Records
☐ Special Education Records

This information may be used for continuation of care. I understand this authorization will expire on _____ and / or **6 months following the date of discharge from any AK Child & Family,** revocation of custody or guardianship, or upon written revocation, whichever comes first. This authorization may be revoked prior to the expiration, but not retroactively. Photo static and / or facsimile copies of this authorization will be considered as valid as the original.

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I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

Student: _____ Date: _____

Parent / Guardian: _____ Date: _____

Witness: _____ Date: _____

Authorization for Exchange of Information

AK Child & Family

I hereby authorize AK Child & Family to exchange personal health information between AK Child & Family

and Name: Primary Doctor _____ Fax: _____

Address: _____

for Student Name: _____ Date of Birth: _____

PLEASE RETURN FORM TO: ATTENTION: Admissions Department

AK Child & Family • 4600 Abbott Road Anchorage, AK 99507 • (907) 346-2101 • Fax (907) 348-9230

INFORMATION TO BE RELEASED / REQUESTED FOR THE FOLLOWING PURPOSE:

☐ Treatment ☐ Legal Request ☐ Insurance Claim ☐ Other: _____

Please check specific information to be released:

☐ Progress Notes
☐ Consultations
☐ Neuropsychological Assessment
☐ Psychological Assessment(s)
☐ Treatment Plan and Review(s)
☐ Intake / Mental Health Assessment
☐ Psychiatric Assessment
☐ Discharge / Continuing Care Summary
☐ Medical History / Physical Exam
☐ Medical / Dental Aftercare Plan
☐ Medical and Laboratory Results
☐ Physician Orders
☐ Verbal exchange of all information to aid in assessing and / or treating student
☐ UA Results
☐ School Records *(Transcripts, Disciplinary Reports, IEP, Other Plans)*
☐ Immunization Records
☐ Special Education Records

This information may be used for continuation of care. I understand this authorization will expire on _____ and / or **6 months following the date of discharge from any AK Child & Family,** revocation of custody or guardianship, or upon written revocation, whichever comes first. This authorization may be revoked prior to the expiration, but not retroactively. Photo static and / or facsimile copies of this authorization will be considered as valid as the original.

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I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment.
I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

Student: _____ Date: _____

Parent / Guardian: _____ Date: _____

Witness: _____ Date: _____

Authorization for Exchange of Information

AK Child & Family

I hereby authorize AK Child & Family to exchange personal health information between AK Child & Family

and Name: Private Insurance _____ Fax: _____

Address: _____

for Student Name: _____ Date of Birth: _____

PLEASE RETURN FORM TO: ATTENTION: Admissions Department

AK Child & Family • 4600 Abbott Road Anchorage, AK 99507 • (907) 346-2101 • Fax (907) 348-9230

INFORMATION TO BE RELEASED / REQUESTED FOR THE FOLLOWING PURPOSE:

☐ Treatment ☐ Legal Request ☐ Insurance Claim ☐ Other: _____

Please check specific information to be released:

- ☐ Progress Notes
- ☐ Consultations
- ☐ Neuropsychological Assessment
- ☐ Psychological Assessment(s)
- ☐ Treatment Plan and Review(s)
- ☐ Intake / Mental Health Assessment
- ☐ Psychiatric Assessment
- ☐ Discharge / Continuing Care Summary
- ☐ Medical History / Physical Exam
- ☐ Medical / Dental Aftercare Plan
- ☐ Medical and Laboratory Results
- ☐ Physician Orders
- ☐ Verbal exchange of all information to aid in assessing and / or treating student
- ☐ UA Results
- ☐ School Records *(Transcripts, Disciplinary Reports, IEP, Other Plans)*
- ☐ Immunization Records
- ☐ Special Education Records

This information may be used for continuation of care. I understand this authorization will expire on _____ and / or **6 months following the date of discharge from any AK Child & Family,** revocation of custody or guardianship, or upon written revocation, whichever comes first. This authorization may be revoked prior to the expiration, but not retroactively. Photo static and / or facsimile copies of this authorization will be considered as valid as the original.

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I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment.
I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

Student: _____ Date: _____

Parent / Guardian: _____ Date: _____

Witness: _____ Date: _____

Authorization for Exchange of Information
AK Child & Family

I hereby authorize AK Child & Family to exchange personal health information between AK Child & Family

and Name: Anchorage School District Fax: _____

Address: 5530 E. Northern Lights Blvd, Anchorage, AK 99504

for Student Name: _____ Date of Birth: _____

PLEASE RETURN FORM TO: ATTENTION: Admissions Department

AK Child & Family • 4600 Abbott Road Anchorage, AK 99507 • (907) 346-2101 • Fax (907) 348-9230

INFORMATION TO BE RELEASED / REQUESTED FOR THE FOLLOWING PURPOSE:

☐ Treatment ☐ Legal Request ☐ Insurance Claim ☐ Other: _____

Please check specific information to be released:

- ☐ Progress Notes
- ☐ Consultations
- ☐ Neuropsychological Assessment
- ☐ Psychological Assessment(s)
- ☐ Treatment Plan and Review(s)
- ☐ Intake / Mental Health Assessment
- ☐ Psychiatric Assessment
- ☐ Discharge / Continuing Care Summary
- ☐ Medical History / Physical Exam
- ☐ Medical / Dental Aftercare Plan
- ☐ Medical and Laboratory Results
- ☐ Physician Orders
- ☐ Verbal exchange of all information to aid in assessing and / or treating student
- ☐ UA Results
- ☐ School Records *(Transcripts, Disciplinary Reports, IEP, Other Plans)*
- ☐ Immunization Records
- ☐ Special Education Records

This information may be used for continuation of care. I understand this authorization will expire on _____ and / or **6 months following the date of discharge from any AK Child & Family,** revocation of custody or guardianship, or upon written revocation, whichever comes first. This authorization may be revoked prior to the expiration, but not retroactively. Photo static and / or facsimile copies of this authorization will be considered as valid as the original.

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Student: _____ Date: _____

Parent / Guardian: _____ Date: _____

Witness: _____ Date: _____

Authorization for Exchange of Information

AK Child & Family

I hereby authorize AK Child & Family to exchange personal health information between AK Child & Family

and Name: Last School/School District_____ Fax: _____

Address: _____

for Student Name:_____ Date of Birth: _____

PLEASE RETURN FORM TO: ATTENTION: Admissions Department

AK Child & Family • 4600 Abbott Road Anchorage, AK 99507 • (907) 346-2101 • Fax (907) 348-9230

INFORMATION TO BE RELEASED / REQUESTED FOR THE FOLLOWING PURPOSE:

☐ Treatment ☐ Legal Request ☐ Insurance Claim ☐ Other: _____

Please check specific information to be released:

- ☐ Progress Notes
- ☐ Consultations
- ☐ Neuropsychological Assessment
- ☐ Psychological Assessment(s)
- ☐ Treatment Plan and Review(s)
- ☐ Intake / Mental Health Assessment
- ☐ Psychiatric Assessment
- ☐ Discharge / Continuing Care Summary
- ☐ Medical History / Physical Exam
- ☐ Medical / Dental Aftercare Plan
- ☐ Medical and Laboratory Results
- ☐ Physician Orders
- ☐ Verbal exchange of all information to aid in assessing and / or treating student
- ☐ UA Results
- ☐ School Records *(Transcripts, Disciplinary Reports, IEP, Other Plans)*
- ☐ Immunization Records
- ☐ Special Education Records

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I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

Student:_____Date: _____

Parent / Guardian:_____Date: _____

Witness:_____Date: _____