Behavioral Health Services
Intake Admission

Date_____________

Client Name (First and Last) ____

Gender ☐Female ☐Male ☐Other

If female, maiden name required ____

Date of Birth (mm/dd/yyyy) ____

Social Security Number ____

Medicaid ID Number ____

Phone Number(s) ____

Email Address ____

Mailing Address: PO Box ____

City, State, Zip ____

Physical Address: Street, Apartment ____

City, State, Zip ____

Emergency Contact Name & Relationship ____

Emergency Contact Phone Number ____

Are you the person seeking services? Yes ☐ No ☐

Client Demographics

Race(s): ***Check all that apply***	Alaska Native:	Ethnicity: ***Check one***
❒ American Indian ❒ Asian ❒ Black/African American ❒ Caucasian ❒ Native Hawaiian ❒ Pacific Islander ❒ Other ❒ Unknown	❒ Aleut ❒ Athabascan ❒ Haida ❒ Inupiat ❒ Tlingit ❒ Tsimshian ❒ Yupik ❒ Other Alaska Native	❒ Not Spanish/Hispanic/Latino ❒ Chicano ❒ Cuban ❒ Hispanic ❒ Mexican American ❒ Puerto Rican ❒ Spanish/Hispanic/Latino ❒ Unknown
Veteran Status: *Check one*	**Expected Payment Source: *Check One***	**Insurance Type: *Check One***
❒ Never in Military ❒ Reserves/Nat. Guard- combat ❒ Reserves- no combat ❒ Military Dependent ❒ Active duty combat ❒ Active duty no combat ❒ Retired from military ❒ Veteran other eras ❒ Vietnam vet combat ❒ Vietnam vet no combat ❒ Unknown	❒ Blue Cross/Blue Shield ❒ CIGNA ❒ Medicaid ❒ Client Self Pay ❒ Other _____________	❒ None ❒ Private Insurance ❒ VA insurance ❒ Other ❒ Unknown

Village of Residence:____

Are you a compacting village member? ☐Yes ☐No If yes which village: ______________________

Intake Information

Intake Staff: ______________________________ Date: ____________________

Initial Contact: ***Check one***

❒ Phone ❒ Drop In (Orientation) ❒ Hospital/On Call Intervention	❒ Community Service Patrol ❒ By Appointment ❒ Other

Source of Referral: ***Check one***

❒ ASAP ❒ Federal Probation ❒ Office of Children's Services ❒ Department of Corrections/Jail ❒ Correctional Agency (Probation or Parole) ❒ Court – Civil Proceedings ❒ Court – Criminal Proceedings ❒ Individual/Self Referral ❒ Crisis/Respite Care ❒ Alaska Native Hospital ❒ Detox or Residential Program	❒ API ❒ Assisted Living Facility ❒ Attorney ❒ Developmental Disabilities Residential Program ❒ Developmental Disabilities Program ❒ Drug Program, Employer (EAP) ❒ Halfway House ❒ Nursing Home ❒ Other Mental Health (not including psychiatrist) ❒ Other

Admission Type: ☐ First Admission ☐ Readmission

Pregnant: ☐ Yes ☐ No ☐ Unknown

If yes, projected due date: _____/_____/_____

Injection Drug User: ☐ Yes ☐ No ☐ Unknown

On Psychotropic Medication: ☐ Yes ☐ No

Pharmacotherapy Planned: ☐ Yes ☐ No

Presenting Problem(s) Why are you seeking services? ____

____

____

____

Consent and Authorization

I consent to receive services provided by Copper River Native Association Behavioral Health Services.

______________________________ ____________
Client Signature Date

______________________________ ____________
Guardian Signature (if applicable) Date

I authorize CRNA Behavioral Health Services to release to the insurance carrier such informationas necessary for the completion of my claim. This information will generally be limited to diagnosis, dates of service, and person(s) rendering services.

______________________________ ____________
Client Signature Date

______________________________ ____________
Guardian Signature (if applicable) Date

Behavioral Health Services
Guarantor (responsible payer/party) Information

Please submit your insurance information (Medicaid ID, insurance card, etc.)
If you do not submit this information you may be charged for services.

Responsible Party for Payment ☐Client ☐Other Party (i.e. Guardian or Spouse)

If applicable, list Other Party's information below:

Guarantor Name (First and Last) ____________________
Relationship to Patient ____________________
Date of Birth (mm/dd/yyyy) ____________________
Social Security Number ____________________
Mailing Address: PO Box ____________________
City, State, Zip ____________________
Physical Address: Street, Apartment ____________________
City, State, Zip ____________________
Phone Number(s) ____________________

Race(s): ***Check all that apply***	Alaska Native: **Blood Quantum**: _______	Ethnicity: ***Check one***
❐ American Indian ❐ Asian ❐ Black/African American ❐ Caucasian ❐ Native Hawaiian ❐ Pacific Islander ❐ Other ❐ Unknown	❐ Aleut ❐ Athabascan ❐ Haida ❐ Inupiat ❐ Tlingit ❐ Tsimshian ❐ Yupik ❐ Other Alaska Native	❐ Not Spanish/Hispanic/Latino ❐ Chicano ❐ Cuban ❐ Hispanic ❐ Mexican American ❐ Puerto Rican ❐ Spanish/Hispanic/Latino ❐ Unknown
Employment Status: ❐ Full Time ❐ Part Time ❐ Student ❐ Disabled ❐ Unemployed	If employed, list current employer(s): ____________________ ____________________ If a student, list school(s) currently attended: ____________________	

Consent and Authorization

I authorize CRNA Behavioral Health Services to release to the insurance carrier such information as necessary for the completion of my claim. This information will generally be limited to diagnosis, dates of service, and person(s) rendering services.

____________________ ____________
Client Signature Date

____________________ ____________
Guardian Signature (if applicable) Date

Behavioral Health Services
Consent for services

I,____ voluntarily consent to receive services from Behavioral Health Services.

Initial all when received:

__________ I have received a copy of CRNA Patient Rights and Responsibilities.

__________ I have received a copy of CRNA Grievance Procedure Policy.

__________ I have received a copy of CRNA Privacy Practices (HIPAA/CFR 42).

__________ I have received a copy of CRNA Billing Practices/Mandatory Legal Fees.

__________ I have received a copy of CRNA Sliding Fee Scale.

__________ I have received a copy of CRNA Program Policies.

__________ I have received a walk-through of relevant facilities. Safety equipment waspointed out to me and safety drills were explained (if applicable).

My rights and responsibilities as a client, grievance policy and procedures, confidentiality practices, and all available services have been explained to me in an understandable format, and I understand and agree with them.

The sliding fee schedule and billing practices have been explained to me and I understand and acknowledge that the amount agreed upon is reasonable and just. I further acknowledge that I agree to this of my own free will.

I understand this statement may be altered any time my circumstances change significantly. I agree to notify this agency of any change in my income, resources or other circumstancespertinent to this statement as soon as possible.

My consent to receive services does not waive my legal rights as recognized under Alaska and federal law.

__________________________________ __________
Signature of Client Date

__________________________________ __________
Signature of Parent/Guardian (If Applicable) Date

__________________________________ __________
Signature of Witness Date