Instructions to Completing Forms
(Please read carefully before completing form below)

1. Make sure you fill out the Screening Information Forms and the attached consents completely. Any missing information may delay the decision and screening process.
2. The consents are very important to complete. Without the consents, Federal law prohibits Hina Mauka from releasing information and we cannot contact the appropriate agencies or individuals to assist in your case. Consents are as follows:
   - **Health Insurance Consents**: Use if you have a medical plan. To be used to authorize services on your behalf. Please list the plan you have (HMSA, Aloha Care, Ohana, etc.).
   - **Legal Non-Provider Entity**: Use if you have a PO, PD, case manager, non-treating/diagnosing agency, etc. List phone number if possible.
   - **Family and Relatives**: Use if you have family, significant other, friends, advocate, etc.
   - **Treating Provider Entity**: Use this form for your doctors and other treating providers (agency or individuals). List phone numbers if possible.
3. If more than one consent is needed download or make as many copies as you need. One consent per agency, individual or family member.
4. Please download, read and sign the “ADAD and HIPAA Privacy Notice” from the Hina Mauka website.
5. You may also download the “What to Bring” form if you are applying for residential treatment.
6. If you have any medical or psychiatric conditions that require attention, please have all your doctor’s evaluation, medication information and updated reports fax with your application. This will help expedite the screening process. Download “Medical Consents”, complete and sign if we need to contact your doctor. Please fax with your packet.
7. If you are appropriate for services you will be placed on the waitlist (residential only) and a case manager will contact you or your advocate to inform you of such status. **There is no waitlist for Outpatient services.**
8. Once you are approved for admission, a case manager will call you to schedule an admit date. You must come in by 9am of the scheduled admit date. Please plan accordingly.

Remember, all forms should be complete. If the information does not apply, please write N/A. **Do not leave any blanks.**

You may also walk in between the hours of 9am to 2pm Monday thru Friday except holidays to apply for services.

**Kaneohe Walk-In Clinic (Residential)**
45-845 Pookela Street
Kaneohe, Hawaii 96744
Fax: (808) 236-2626

**Waipahu Walk-In Clinic**
94-830 Hikimo Street
Waipahu, Hawaii 96797
Fax: (808) 671-7727

You may also fax all your documents to the appropriate phone numbers on the Screening Information Form. Mahalo!
SCREENING INFORMATION FORM
(To determine eligibility and appropriateness for Hina Mauka services)
(Please answer all the 36 questions or mark NA).

Personal Information:
Date: __________________________
Name: __________________________
(First, Middle Initial, Last)
Home Address: ____________________
State: ___________ City ___________
Zip Code: ________________________
Home Phone: ______________________
Cell Phone: ________________________
Employer: _________________________
Employment Status (check one):
☐ Full-Time ☐ Part-Time ☐ Unemployed

Who referred you? ☐ CARES ☐ PO ☐ Self ☐ Other
Referral phone number:
May we contact them? ☐ Yes ☐ No
SSN#: __________________________
Birth Date: ___________ Age: ___________
Birth Place: ________________________

Gender (Check all that apply) ☐ Male ☐ Female
☐ Transgender ☐ Male to Female ☐ Female to Male
Ethnicity: __________________________

Marital Status (check one):
☐ Never Married ☐ Divorced ☐ Now Married
☐ Widowed ☐ Separated ☐ Living Together
Number of Children _____ Ages _____
Do you have a family member currently in treatment

Veteran (circle one): ☐ Yes ☐ No
VA Case Worker: ____________________
Do you smoke cigarettes? ☐ Yes ☐ No
How much per day? ___________________
Are you pregnant? ☐ Yes ☐ No ☐ N/A
If yes, how many months?
Do you use needles to get high? ☐ Yes ☐ No
If yes, what drug? ___________________

Next of Kin (In case of emergency):
Name: ___________________________
Phone: ___________________________

Drug Used Information: Please list the type of drugs/alcohol used recently, last date used (month, day, year, etc.), how much (gram, ½ gram, 1 bottle, etc.), how often (daily, weekly, 3X/month, etc.).

<table>
<thead>
<tr>
<th>Drug Used</th>
<th>Date of Last Use</th>
<th>How Much</th>
<th>How Often</th>
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Are you incarcerated now? ☐ Y ☐ N
If yes, list the dates below:
From: __________ To: __________

Primary Source of Support (check one):
☐ Wages/Salary ☐ Disability
☐ Public Assistance ☐ Other
☐ Retirement ☐ None

Client Name: ____________________
Date: ________________
1. Experience any complications from using or drinking? □ Yes □ No (ex. shakes, moody, cold sweats, medical, psychiatric problems, legal problems, etc.) If yes, explain: __________________________________________

2. Spend a lot of time using or drinking or recovering from using or drinking? □ Yes □ No  Explain:

3. Have you given up important activities because of your using or drinking? (Family, work, school, etc.) □ Yes □ No Please explain your answer: __________________________________________

4. Did you know that using and/or drinking is causing problems for you? □ Yes □ No  If yes, describe these problems: __________________________________________

5. Do you have a history of overdose? □ Yes □ No. If yes, Last time you overdose? ____________

6. History with detox? □ Yes □ No. If yes, when, where and from what? ______________________

**Medical/Psychiatric Information:**

7. Do you have a history of seizures? □ Yes □ No. If yes, explain: __________________________

8. Have you ever been told you have any communicable diseases: □ Yes □ No. If yes, What? __________________________

9. Please provide dates for: Last physical: __________ Last TB test: _______ MMR: _______

   Where: __________________________________________

10. Current medical problems: *(please list condition, how long you had it, treating doctor and medications if any.)*

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<tr>
<th>Medical Condition</th>
<th>How Long</th>
<th>Treating Physician</th>
<th>Medication(s)</th>
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11. Current psychiatric problems: *(please list condition, how long you had it, treating doctor and medications if any.)*

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<th>Psychiatric Condition</th>
<th>How Long</th>
<th>Treating Physician</th>
<th>Medication(s)</th>
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12. Do you know who your Primary Care Physician (PCP) is? □ Yes □ No. If yes please provide: Name: __________________ Phone: __________________ Consent to contact? □ Yes □ No

13. Allergies? □ Yes □ No. Describe: __________________________________

14. Vision problems: □ Yes □ No. Do you wear glasses? □ Yes □ No

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Client Name: __________________________

Date: _________________
15. Hearing problems: □ Yes □ No. Do you wear a hearing aid? □ Yes □ No
16. Do you speak English? □ Yes □ No. If no, do you have an interpreter? □ Yes □ No
17. Do you have a Case Manager? □ Yes □ No. If yes, please select one of the following:
   □ AMHD □ CER □ ICM □ MHK □ IHS □ CCS □ Other: __________________________
18. Case Manager's Name __________________________ Phone ____________________
19. Do you hear/see/feel things that aren’t there? □ Yes □ No Describe: __________________

20. Have you ever attended Anger Management or Domestic Violence classes? □ Yes □ No. If yes, did you complete? □ Yes □ No. Explain: ____________________________________________
21. Have you ever attempted suicide? □ Yes □ No. Have you thought about it? □ Yes □ No.
   If yes to the above, when? __________________________ Last time? __________________
   Are you contemplating suicide at this time? □ Yes □ No. If yes, would you consent to us helping you at this time? □ Yes □ No. Describe action taken: ________________________________

22. Have you ever harmed yourself? □ Yes □ No. If yes, would you like someone to talk to about this situation? □ Yes □ No. Describe action taken: ________________________________
23. Have you ever harmed anyone else? □ Yes □ No. If yes, would you like someone to talk to about this situation? □ Yes □ No. Describe action taken: ______________________________________

Legal Encumbrance (Applicants must complete this section and sign corresponding consents if applicable)
1. On probation or parole? □ Probation □ Parole □ HOPE Probation □ Other: _______________
2. Probation/Parole Officer Name: ______________________ AO#: ______________________
3. Any pending charges? □ Yes □ No. If yes, please describe: ______________________________

4. Were your charges/convictions violent in nature? □ Yes □ No. If yes, please explain _______
   ____________________________________________
5. Pending court dates: ___________________________ When/where? ______________________
6. How many convictions in the past 2 years: _______ Describe: ______________________________

7. Have you ever been a part of a gang? □ Yes □ No. If yes, would it be difficult for you to refrain from gang related activities during treatment? □ Yes □ No
8. CPS/CWS involvement? □ Yes □ No. If yes, may we contact your worker? □ Yes □ No
   Worker name: __________________________ Phone number: ______________________
9. Have you ever been convicted of an offense that was sexual in nature? □ Yes □ No. If yes, did you receive treatment for it? □ Yes □ No. Did you complete treatment? □ Yes □ No. If yes,
10. Have you ever been convicted of a violent crime? □ Yes □ No. If yes, please explain: ______

11. How much of your time in the past 2 years, have you engaged in illegal activities?
   □ 25% □ 50% □ 75% □ 100% □ None. If you wish, please explain your answer: ______

12. What percentages of the people you associate with engage in illegal activities?
   □ 25% □ 50% □ 75% □ 100% □ None. If you wish, please explain your answer: ______

Recovery Support Services

13. Religious preference: □ Christian □ Buddhist □ Catholic □ Other: ________________
    Are you currently active? □ Yes □ No. If yes, how often? ______________________

14. 12-step or Self-help involvement: □ AA □ NA □ Alnon □ Other: ________________
    Are you currently active? □ Yes □ No. If yes, how often? ______________________

15. Family support: □ Yes □ No. Please explain your answer: ________________________

16. What services are you applying for? □ Residential □ Outpatient □ Not Sure

17. Living Arrangements (check one): □ Homeless □ Living with Family/Friends □ Living Alone
    How Long? ________ Do you want to improve your living arrangements? □ Yes □ No

Information gathered during the screening process is used to determine eligibility and appropriateness for treatment services rendered by Hina Mauka. Additional information may be required by Hina Mauka to make an appropriate recommendation for treatment. I, the client, understand that the information provided does not constitute admission into treatment and that more information may be needed to accurately determine eligibility and appropriateness for treatment services. I, the client, also understand it will be my responsibility to attain all documents and information needed to determine eligibility and appropriateness. Hina Mauka may assist in the process; however, the primary responsibility to attain additional information will be the client. Hina Mauka has the right to determine a client inappropriate for our services. By signing below, I agree that the information provided on this form to be accurate and true to the best of my knowledge.

Client Signature ___________________________ Date ___________________________

Staff Signature ___________________________ Date ___________________________

Client Name: _____________________________ Date: ___________________________
Consent to Obtain/Disclose Confidential Information
Health Insurance Only

I, _______________________________________________________________, authorize

(Print name of client)

Hina Mauka to obtain/disclose to ____________________________________________

(Medical Insurance Company/Agency/Office)

Nature of information to be disclosed: (information disclosed should be relative to the purpose of disclosure)

Client Initial:

_____ Name and other identifying information (e.g., DOB, client #, and address)

_____ Medical, Psychiatric and substance abuse information relevant to the current treating condition

_____ Progress in treatment, discharge planning and summaries related to the treating condition

_____ Scheduled treatment dates to include; appointments, missed and attended treatment dates

_____ Appeals: I hereby grant Hina Mauka the right to appeal on my behalf in cases that my medical provider denies my coverage

_____ Other: ______________________________________________________________________________

The purpose of the disclosures authorized in this consent is for: Provide medical, psychiatric and substance abuse information for the purpose of attaining insurance authorization relevant to the treating condition.

I understand that my substance abuse disorder and treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been in reliance on it, and that in any event this consent expires automatically as follows:

I year from discharge date

(Specification of the date, event, or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Date: ___________________  ______________________________

(Signature of client)  (Signature of person signing consent if not client)

Describe authority to sign on behalf of client: ________________________________

PROHIBITING RE-DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.
Consent to Obtain/Disclose Confidential Information
Legal and Non-Treating Provider Entity

I, _______________________________________________________________, authorize

(Print name of client)

Hina Mauka to obtain/discard to __________________________________________

(Representing Agency/Entity. One consent per agency/entity)

(Representative Name(s): PO, PD or other. If more than one name, list them on this line.)

Nature of information to be disclosed: (information disclosed should be relative to the purpose of disclosure
Client Initial:
____ Full Name
____ Treatment Attendance, (to include dates)
____ Treatment Progress (periodic reports as required)
____ Legal and/or Criminal History (is applicable)
____ Discharge Planning and Summaries (consultation and reporting)
____ Other __________________________________________

The purpose of the disclosures authorized in this consent is for: Consultation on behalf of the client’s substance abuse/mental health treatment relative to the treating condition.

I understand that my substance abuse disorder and treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been in reliance on it, and that in any event this consent expires automatically as follows:

1 year from discharge date
(Specification of the date, event, or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Date: ___________________  __________________ ______________________

(Signature of client)  (Signature of person signing consent if not client)

Describe authority to sign on behalf of client: __________________________________________

PROHIBITING RE-DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION
This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.
Consent to Obtain/Disclose Confidential Information
Family-Relatives-Supporters

I, _______________________________________________, authorize
(Print name of client)

Hina Mauka ______________________________ to obtain/disclose to______________________________
(Full name of family/relative. One per consent)

Nature of information to be disclosed:
Client Initial:
____ Name and other identifying information (e.g., DOB, client #, and address)
____ Progress in treatment, discharge planning and summaries related to the treating condition
____ Scheduled treatment dates to include; appointments, missed and attended treatment dates
____ Other: ______________________________________________________________________________

The purpose of the disclosures authorized in this consent is for: Encouraging support for the client prior to treatment, during treatment and after treatment.

I understand that my substance abuse disorder and treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been in reliance on it, and that in any event this consent expires automatically as follows:

1 year from discharge date
(Specification of the date, event, or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Date: __________________________
(Signature of client)

(Signature of person signing consent if not client)

Describe authority to sign on behalf of client: ________________________________________________

PROHIBITING RE-DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION
This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

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Client Name: ______________________________
Date: ______________________________

[Signature of person signing consent if not client]
Consent to Obtain/Disclose Confidential Information
Treating Provider Entity

I, _______________________________________________________________, authorize

(Print name of client)

Hina Mauka to obtain/disclose to __________________________________________

(Doctor, Psychiatrist, Psychologist, treatment agency, etc. One consent per agency)

Nature of information to be disclosed: (information disclosed should be relative to the purpose of disclosure
Client Initial:

_____ Full Name

_____ Diagnosis, evaluation, assessment and treatment recommendations

_____ Treatment Attendance, (to include dates)

_____ Treatment Progress (periodic reports as required)

_____ Legal and/or Criminal History (is applicable)

_____ Discharge Planning and Summaries (consultation and reporting)

_____ Other ________________________________________________________________________________

The purpose of the disclosures authorized in this consent is for: Consultation on behalf of the client’s substance abuse/mental health treatment relative to the treating condition.

I understand that my substance abuse disorder and treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been in reliance on it, and that in any event this consent expires automatically as follows:

1 year from discharge date

(Specification of the date, event, or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Date: ___________________ _____________________________

(Signature of client)

(Signature of person signing consent if not client)

Describe authority to sign on behalf of client: ______________________________________________________

PROHIBITING RE-DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION
This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

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Client Name: __________________________

Date: __________________________