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:
   - **Heath 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.

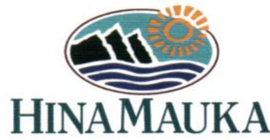
Kaneohe Walk-In Clinic (Residential)
45-845 Pookela Street
Kaneohe, Hawaii 96744
Fax: (808) 236-2626

Waipahu Walk-In Clinic
94-830 Hikimoe 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!

 ☐ Input into WIC 2

Client Name:____________________
Date: ____________________



SCREENING INFORMATION FORM

(To determine eligibility and appropriateness for Hina Mauka services)

Personal Information: (Please answer all the 36 questions or mark NA).

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

Health Insurance: ____________________

Membership #:_______________________

Previous Alcohol/Drug Treatment

Where ______________________________

Date ______________________________

Drugs Treated for ____________________

Completed? ☐ Yes ☐ No

Where ______________________________

Date ______________________________

Drugs Treated for ____________________

Completed? ☐ Yes ☐ No

Have you been in a controlled environment In the past 30 days? (Check one):

______ No ______ Alcohol/Drug Treatment

______ Jail ______ Medical Treatment

______ Other ______ Psychiatric Treatment

Are you incarcerated now? ☐ **Y** ☐ **N**

If yes, list the dates below:

From: ___________ **To:** _____________

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

Highest Grade Completed: _______________

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 here at Hina Mauka? ☐ Yes ☐ No If yes, who? ______________________

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: _________________________________

Primary Source of Support (check one):

______ Wages/Salary ______Disability

______ Public Assistance ______ Other

______ Retirement ______ None

Substance Abuse 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.)*:

Drug Used	Date of Last Use	How Much	How Often

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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.)*

Medical Condition	How Long	Treating Physician	Medication(s)

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

Psychiatric Condition	How Long	Treating Physician	Medication(s)

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

 ☐ Input into WIC 2

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: ___________________________
    ____

<u>Legal Encumbrance</u> *(Applicants <u>must</u> 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, please give date of completion: _________ If not, please explain why you did not complete treatment: ____
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 Dat

Rev: 7.19.20 ☐ Input into WIC 2

Client Name:____________________

Date: ____________________

COVID-19 Pandemic
Impact Statement Form

1. Has you experienced any loss of employment/business or financial hardship as a result of the COVID-19 pandemic?

☐ No
☐ Yes. If yes, please explain: ____
____
____
____

2. Would you be interested in receiving employment/vocational assistance? ☐ Yes ☐ No

3. Has you experienced any mental, physical health problems or increase in alcohol and/or substance use as a result of the COVID-19 pandemic?

☐ No
☐ Yes. If yes, please explain: ____
____
____
____

4. Would you be interested in receiving employment/vocational assistance? ☐ Yes ☐ No

5. Any other problems/challenges related to COVID-19 pandemic you would like inform us about?

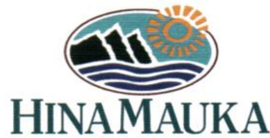
☐ No
☐ Yes. If yes, please explain: ____
____
____
____

Print Name: ____ Date: ______________

Signature: ____

****:I acknowledge by my signature that the above information I provided to be accurate and true.****

Rev: 7.19.20 ☐ Input into WIC 2 **Client Name:**____________________
Date: ____________________



Consent to Obtain/Disclose Confidential Information
Third Party Payor (Health Insurance)

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 including my 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 including 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:

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.

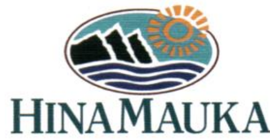
Date: ___________________ ____
(Signature of client)

____
(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.

Rev: 7.19.20 ☐ Input into WIC 2 **Client Name:**____________________
Date: ___________________



Consent to Obtain/Disclose Confidential Information
Non-Treating Provider Entity (Legal, Representative)

I, ____, authorize
(Print name of client)

Hina Mauka ____________ to obtain/disclose 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 to include my substance abuse information (periodic reports as required)

_____ Legal and/or Criminal History (is applicable)

_____ Discharge Planning and Summaries including my substance abuse information (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)

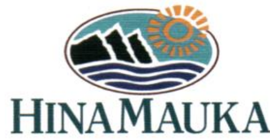
____
(Signature of person signing consent if not client)

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.

☐ Input into WIC 2

Client Name:____________________
Date: ___________________



Consent to Obtain/Disclose Confidential Information
Family-Relatives-Supporters (Support Systems)

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.

Consent to Obtain/Disclose Confidential Information
Treating Provider Entity (Other treating agencies)

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 including substance abuse information
_____ 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) including substance abuse information
_____ 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.

Rev: 7.19.20 ☐ Input into WIC 2

Client Name:____________________
Date: ___________________