



HINAMAUKA

Instructions to Completing Forms

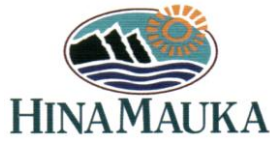
(Please read carefully before completing form below)

1. Make sure you fill out the Screening Information Forms (6pages) and the attached consents completely. Any missing information may delay the screening and admission 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 are to come in by 9am of the scheduled admit date.** Please plan accordingly.
9. 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!



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 _____

here at Hina Mauka? Yes No If yes, who? _____

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 _____

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, 1/2 gram, 1 bottle, etc.), how often (daily, weekly, 3X/month, etc.):

Drug Used	Date of Last Use	How Much	How Often

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

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, 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



HINAMAUKA

COVID-19 Screening Questionnaire

Name: _____ Date: _____ Temp: _____

COVID-19 SCREENING QUESTIONNAIRE

1. Have you previously been tested for COVID19? Yes No
If yes, when? _____ & where? _____ Results: Negative Positive
2. Have you traveled outside of Hawaii.in the past 14 days? Yes No
If yes, dates/location traveled: _____
3. Have you come into contact with any individual that has traveled outside of the Hawaii in the past 14 days?
 Yes No
If yes, dates/location traveled: _____
4. Have you had contact with any individual with cold or flu-like symptoms? Yes No
5. In the last 14 days have you or anyone in your household have close contact with a person who has tested positive for the COVID-19? Yes No
6. In the last 14 days have you or anyone in your household have close contact with a person who has been instructed to self-isolate, self-monitor or self-quarantine? Yes No
7. Have you experienced any of the following in the past 14 days?
 - a. Fever Yes No
 - b. Chills Yes No
 - c. Body/muscle aches Yes No
 - d. Malaise/fatigue Yes No
 - e. Headache Yes No
 - f. Cough Yes No
 - g. Sore throat Yes No
 - h. Runny nose Yes No
 - i. Swollen lymph glands Yes No
 - j. Nausea, vomiting, diarrhea Yes No
 - k. Shortness of breath Yes No
 - l. Loss of taste or smell Yes No
 - m. Repeated shaking with chills Yes No
8. Have you recently sought medical attention in a Hospital, Emergency Room, Urgent Care, or Primary Care Provider's office?
 Yes No
If yes, date seen: _____ & reason for seeking care: _____



HINAMAUKA

COVID-19 PANDEMIC IMPACT STATEMENT

1. Have you recently experienced employment/business hardship as a result of the COVID-19 pandemic?

No

Yes. If yes, please explain: _____

Last date range of employment? From: _____ To: _____

Would you be interested in receiving assistance for these hardships? Yes No

2. Have 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: _____

Would you be interested in receiving services for these issues? Yes No

3. If available, would rental/mortgage/financial assistance for you or a household member be helpful at this time?

No

Yes. If yes, please explain: _____

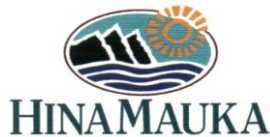
(Eligible participants must complete the necessary requirements to receive rental/mortgage/financial assistance. Please see Rental Relief Housing Assistance Program Requirements)

Print Name: _____

Date: _____

Signature: _____

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



**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)

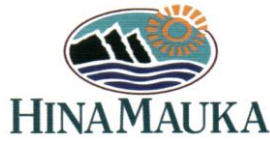
Describe authority to sign on behalf of client: _____

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: 9.29.20 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

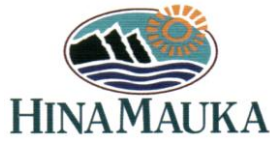
This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, 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.

Rev: 9.29.20

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.



HINAMAUKA

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.