HINA MAUKA

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!

 ☐ Input into WIC 2

Client Name:_____
Date: _____

HINA MAUKA

SCREENING INFORMATION FORM

(To determine eligibility and appropriateness for Hina Mauka services)

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

Date: _____

Who referred you? ☐ CARES ☐ PO ☐ Self ☐ Other

Name: _____
(First, Middle Initial, Last)

Referral phone number: _____
May we contact them? ☐ Yes ☐ No

Home Address: _____

SSN#: _____

State: _____ City _____

Birth Date: _____ Age: _____

Zip Code: _____

Birth Place: _____

Home Phone: _____

Cell Phone: _____

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

Employer: _____

Employment Status (check one):
☐ Full-Time ☐ Part-Time ☐ Unemployed

Highest Grade Completed: _____

Ethnicity: _____

Health Insurance: _____

Membership #: _____

Marital Status (check one):
☐ Never Married ☐ Divorced ☐ Now Married
☐ Widowed ☐ Separated ☐ Living Together

Previous Alcohol/Drug Treatment

Where _____

Number of Children ____ Ages _____

Date _____

Do you have a family member currently in treatment here at Hina Mauka? ☐ Yes ☐ No If yes, who? _____

Drugs Treated for _____

Veteran (circle one): ☐ Yes ☐ No

Completed? ☐ Yes ☐ No

VA Case Worker: _____

Where _____

Do you smoke cigarettes? ☐ Yes ☐ No

Date _____

How much per day? _____

Drugs Treated for _____

Are you pregnant? ☐ Yes ☐ No ☐ N/A

Completed? ☐ Yes ☐ No

If yes, how many months? _____

Have you been in a controlled environment

Do you use needles to get high? ☐ Yes ☐ No

In the past 30 days? (Check one):

If yes, what drug? _____

_____ No _____ Alcohol/Drug Treatment

Next of Kin (In case of emergency):

_____ Jail _____ Medical Treatment

Name: _____

_____ Other _____ Psychiatric Treatment

Phone: _____

Are you incarcerated now? ☐ Y ☐ N

Primary Source of Support (check one):

If yes, list the dates below:

_____ Wages/Salary _____ Disability

From: _____ **To:** _____

_____ 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

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

Rev: 9.29.20 ☐ Input into WIC 2

Client Name:_____
Date: _____

HINA MAUKA

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: _____

HINA MAUKA

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.****

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Client Name:_____
Date: _____

HINA MAUKA

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.

HINA MAUKA

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.

Client Name:_____
Date: _____

HINA MAUKA

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.

HINA MAUKA

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.