



## 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

HAWAII DISASTER RESPONSE STATE PROGRAM (HI-DRS) FORM

(Please complete form by answering the questions to qualify for treatment subsidies)

1. Between 2018 up to the present, did any of the Natural Disasters listed below impact you? Please place a check mark in the appropriate box:

- a. Kauai Flooding (4/2/18) [ ]
b. Kauai Disaster Heavy Rains and Landslides (4/15/18) [ ]
c. Oahu Flooding (4/19/18) [ ]
d. Hawaii Lava (5/3/18) [ ]
e. Hurricane Lane (8/21/18) [ ]
f. Hurricane Olivia (9/9/18) [ ]
g. Heavy Rains Pali Highway (2/22/19) [ ]
h. Heavy Rain (Maui) (2/26/19) [ ]
i. Maui Fire (7/12/19) [ ]
j. Kauai Flooding (4/21/20) [ ]
k. Hurricane Douglas (7/23/20) [ ]
l. Heavy Rains and Flooding (3/9/21) [ ]
m. Wildfire County of Hawaii (8/4/21) [ ]

2. If you checked any box(s) listed above, please explain in your own words how you were impacted by the natural disaster?

Four horizontal lines for handwritten response.

By signing below, I attest that my statement above to be accurate and true.

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Witnessed by:

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_



**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.



**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.

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**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.