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:
   - **Health Insurance Consents**: Use if you have a medical plan. To be used to authorize services on your behalf. Please list the plan you have (HMSA, Aloha Care, Ohana, etc.).
   - **Legal Non-Provider Entity**: Use if you have a PO, PD, case manager, non-treating/diagnosing agency, etc. List phone number if possible.
   - **Family and Relatives**: Use if you have family, significant other, friends, advocate, etc.
   - **Treating Provider Entity**: Use this form for your doctors and other treating providers (agency or individuals). List phone numbers if possible.

3. If more than one consent is needed download or make as many copies as you need. One consent per agency, individual or family member.

4. Please download, read and sign the “ADAD and HIPAA Privacy Notice” from the Hina Mauka website.

5. You may also download the “What to Bring” form if you are applying for residential treatment.

6. If you have any medical or psychiatric conditions that require attention, please have all your doctor’s evaluation, medication information and updated reports fax with your application. This will help expedite the screening process. Download “Medical Consents”, complete and sign if we need to contact your doctor. Please fax with your packet.

7. If you are appropriate for services you will be placed on the waitlist (residential only) and a case manager will contact you or your advocate to inform you of such status. **There is no waitlist for Outpatient services.**

8. Once you are approved for admission, a case manager will call you to schedule an admit date. **You 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: ___________________________  Who referred you? □ CARES □ PO □ Self □ Other

Name: ___________________________ Referral phone number: ___________________
(First, Middle Initial, Last)

Home Address: ___________________ May we contact them? □ Yes □ No

State: ___________ City ___________ SSN#: ___________________
Zip Code: ________________________

Home Phone: _____________________ Birth Date: ___________ Age: ___________

Cell Phone: ______________________ Birth Place: _______________________

Employer: ________________________

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

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

Highest Grade Completed: ___________________

Ethnicity: ________________________

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: ___________

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.):

<table>
<thead>
<tr>
<th>Drug Used</th>
<th>Date of Last Use</th>
<th>How Much</th>
<th>How Often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Page 1-Section 1

Rev: 11.29.21  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.)

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>How Long</th>
<th>Treating Physician</th>
<th>Medication(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Psychiatric Condition</th>
<th>How Long</th>
<th>Treating Physician</th>
<th>Medication(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Page 3-Section 1
Client Name: ___________________________
Date: ___________________________
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                                                                               Date

Page 4-Section 1
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?

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

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:

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

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

I have been provided a copy of this form.

Date: ___________________ ___________________ ____________________
(Signature of client)

(Signature of person signing consent if not client)

Describe authority to sign on behalf of client: ______________________________________________________

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

Rev: 11.29.21
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: 11.29.21

Client Name: ______________________

Date: ______________________
Consent to Obtain/Reveal Confidential Information
Family-Relatives-Supporters (Support Systems)

I, _______________________________________________________________, authorize
(Print name of client)

Hina Mauka to obtain/disclosed 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.

Rev: 11.29.21

Client Name: __________________________

Date: __________________________
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:

I year from discharge date

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

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

I have been provided a copy of this form.

Date: __________________________

(Signature of client)

(Signature of person signing consent if not client)

Describe authority to sign on behalf of client: ____________________________________________________________

PROHIBITING RE-DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION

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