ALASKA FAMILY SERVICES
5851 E. Mayflower Ct.
Wasilla, AK 99654
Phone(907)376-4000 Fax(907)373-1135

CLIENT PROFILE Date _____

First Name _____ Maiden Name _____

Middle Name _____ Provider Client ID _____

Last Name _____ Alternate Name(s) _____

Gender ☐Female ☐Male Alternate Name(s) _____

Date of Birth ☐☐/☐☐/☐☐☐☐ Age _____ Home Phone _____ Fax _____

Social Security Number _____ Work Phone _____ Other Phone _____

Driver's License Number _____ State _____ Cell Phone _____

Medicaid Number _____ Email address _____

Home Street Address _____

City _____ State _____ Zip _____

Mailing/Billing Address _____

City _____ State _____ Zip _____

Race	☐Aleut ☐Caucasian ☐Pacific Islander	☐American Indian ☐Haida ☐Tlingit	☐Asian ☐Inupiat ☐Tsimshian	☐Athabascan ☐Native Hawaiian ☐Yupik	☐Black/African American ☐Other Alaska Native ☐Other (Specify):_____
Ethnicity	☐Not Spanish/Hispanic/Latino Mexican ☐Mexican American	☐Chicano/Other Hispanic ☐Puerto Rican	☐Cuban ☐Spanish/Hispanic Latino	☐Hispanic-specific origin not specified	

Community of Origin (city, town or village where you currently reside) _____

Special Needs	☐None ☐Moderate to Severe Medical Problems ☐Traumatic Brain Injury (TBI) ☐Unknown	☐Developmentally Disabled ☐Organically Based Problem ☐Visual Impairment or Blind	☐Major Diff. In Ambulatory or Nonambulation ☐Severe Hearing Loss or Deaf ☐Other

English Fluency	☐Excellent ☐Good ☐Moderate ☐Poor ☐Not at all
Primary Language	☐English ☐Other (Specify)_____
Interpreter Needed	☐Yes ☐No

Education	☐Highest Completed Grade is _____	
	☐HS Diploma ☐BA/BS Degree ☐AA Degree ☐GED ☐Voc Training (Beyond HS) ☐Master's	
Veteran Status	☐Rsrvs/Nat Guard:Combat ☐Rsrvs/Nat Guard:Noncombat	☐Never in Military ☐Other (Specify): _____
Citizenship	☐United States ☐Other (Specify):_____	

Collateral Contacts

1) First Name _____ Last Name _____ Relation _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____ Other _____

Can we contact? ☐Yes ☐No Consent On File? ☐Yes ☐No

First Name _____ Last Name _____ Relation _____

_____ _____ _____

_____ _____ _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____ Other _____

Can we contact? ☐Yes ☐No Consent On File? ☐Yes ☐No

Who referred you to our agency? (Specify Agency and Name of Person) _____

Why are you seeking services at our agency? _____

In your own words, what problem(s) would you like our agency to help you with?

Have you ever received services from our agency? ☐Yes ☐No If yes, when and what type of services did you receive?

Are you currently receiving mental health and/or substance abuse treatment services from any other agency? ☐Yes ☐No If yes, which agency and what type of services?

Medical Status (Admission Profile)

If female are you pregnant? ☐Yes ☐No ☐Unknown If yes, what is your Due Date? _____

Are you an Injection Drug User? ☐Yes ☐No If yes, when was the last time you injected drugs? _____

How many times have you been admitted into any program(s) for substance abuse treatment? ☐

How would you rank your overall Health? ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor ☐Unsure

How many non-treatment substance abuse related hospitalizations have you had in the past 6 months? ☐

Do you have any Mental Health Problems? ☐Yes ☐No If yes, please describe below

How many times have you been admitted into any program(s) for mental health treatment? ☐

How many times have you been hospitalized for mental health treatment? ☐

How many months since your last discharge? ☐

Do you use tobacco? ☐Yes ☐No If yes, what type do you use? ☐Cigarette ☐Cigars/Pipes ☐Combination ☐Smokeless Tobacco

CLIENT ADMISSION FORM

Financial/Household Information

Employment Status: **Check One**	Occupation (O-Net): **Check One**	Insurance Type: **Check One**
☐ Disabled	☐ Accommodation & Food Services	☐ Auto Insurance Policy
☐ Employed Full Time	☐ Administrative & support Services	☐ Indian Health Service
☐ Employed Part Time	☐ Agriculture, Forestry, Fishing, & Hunting	☐ None
☐ Homemaker	☐ Arts, Entertainment, & Recreation	☐ Commercial
☐ Armed Forces Medicaid	☐ Construction	☐ Medicare Conditionally Primary
☐ Not in Labor Force/Other	☐ Educational Services	☐ Group Policy
☐ Not Seeking Work	☐ Finance & Insurance	☐ Health Maint. Org. (HMC)
☐ Other	☐ Government	☐ Individual Policy
☐ Resident/Inmate	☐ Health Care & Social Assistance	☐ Long Term Policy
☐ Retired	☐ Information	☐ Litigation
☐ Seasonal Employee/in season	☐ Management of Companies & Enterprises	☐ Medicare Part B
☐ Seasonal Employee/out season	☐ Manufacturing	☐ Medicaid
☐ Student	☐ Mining, Quarrying, Oil & Gas Extraction	☐ Medicare Primary
☐ Unemployed/Not seeking work	☐ Other Services (Except Public Admin.)	☐ Other Public
☐ Unemployed/Subsistence	☐ Professional, Scientific, & Technical Svcs.	☐ Other Private
☐ Unemployed/Looking for work	☐ Real Estate & Rental & Leasing	☐ Other
	☐ Retail Trade	☐ Personal payment (cash- no ins)
	☐ Self-Employed	☐ Supplemental Policy
	☐ Transportation & Warehousing	☐ Private Insurance
	☐ Utilities	☐ VA insurance
	☐ Wholesale Trade	
	☐ None	
	☐ Not Applicable	

Primary Income Source: **Check one**	Annual Household Income:	Expected Payment Source: **Check One**
☐ None	*Approximate or exact numeric amount and include Alaska PFD's if applicable*	☐ Aetna
☐ Tribal Assistance Programs		☐ AK Native Health Care
☐ Alaska Native Corp Dividends		☐ Blue Cross/Blue Shield
☐ Alimony		☐ CIGNA
☐ Alaska PFD		☐ Client Self Pay
☐ Child Support		☐ HMO
☐ Employment		☐ Indian Health Services
☐ Interest & Other		☐ Medicaid
☐ Other		☐ Medicare
☐ Public Assistance/Welfare Pay		☐ No Charge
☐ Parent's Income		☐ Other Government Grant
☐ Spouse/Significant Other Income		☐ Other Native Health Care
☐ Retirement/Surv/Disability Pension		☐ Other Private
☐ Social Security Disability (SSDI)		☐ Other Public
☐ SSI		☐ Sliding Scale; client partial payment
☐ SSI/SSDI Never		☐ Sliding Scale, No Charge
☐ SSI/SSDI Previous		
☐ Unemployment Compensation		

Household Composition: **Check One**	Living Arrangement: **Check One**
❒ Client Lives alone ❒ Lives with Adolescents ❒ Lives with Children ❒ Lives with Non-relatives ❒ Lives with Relatives ❒ Lives with Significant Other(s) ❒ Significant Other & Children	❒ Assisted Living Facility ❒ Correction/Detention Facility ❒ Crisis Residence ❒ Foster Care ❒ Group Home ❒ Halfway House ❒ Homeless ❒ Hospital for Non-psychiatric purposes ❒ Hospital for psychiatric purposes ❒ Nursing home ❒ Private Residence w/out supportive services ❒ Private residence w/supportive services ❒ Residential Treatment ❒ Shelter ❒ Therapeutic Foster Care ❒ Transitional Housing
Marital Status: **Check one** ❒ Never Married-single ❒ Married ❒ Cohabitating ❒ Separated ❒ Divorced ❒ Widowed	Living in Home: **Answer all** Number of people living with client: #____ Number of children in household: #____ Number of children in Residential Setting: #____ Number of children in Residential Setting receiving services: #____

Number of Days Abstinent (no use of alcohol, Marijuana, or illegal drugs) in Last 30 Days: _____

Do You Currently Use Tobacco: **Check one**

____ Cigarettes ___Cigars/Pipes ___Combo ___Smokeless Tobacco ___No

Number of Arrests in **past 30** days: #_____

ALASKA FAMILY SERVICES

BEHAVIORAL HEALTH TREATMENT CENTER

TELEPHONE: (907) 376-4000*FAX: (907) 373-1135

PROOF OF INCOME CHECKLIST

If you come in to sign up for a treatment program you must provide proof of your household gross income at your financial appointment. Your financial contract must be completed before you begin treatment.

Ultimately you, the client, are responsible for payment of all services.

- If you have **INSURANCE** please bring your insurance ID card, or insurance form with patient portion completed and signed. We will gladly bill your insurance. If your insurance does not cover any portion of your costs you will then become eligible for the sliding fee scale. You may want to call your insurance company or look in your policy to determine if your insurance covers the treatment you are about to begin.
- If you are covered by **MEDICAID OR DENALI KID CARE** please bring in your sticker, coupon, or card covering the current month. If Medicaid does not cover any portion of your costs you will then become eligible for the sliding fee scale. You will then become responsible for payment.

If you DO NOT have Insurance, Medicaid, or Denali Kid Care you must bring your most recent TAX RETURN, W-2, and 1099 (if applicable) And any of the following that apply:

- **LAST TWO CHECK STUBS (IF MARRIED SPOUSES ALSO)**
- **UNEMPLOYMENT**
- **WORKMANS COMPENSATION**
- **SOCIAL SECURITY INCOME**
- **RETIREMENT PENSION**
- **DISABILITY INCOME**
- **PUBLIC ASSISTANCE**
- **NATIVE CORPORATION DIVIDENDS**

If you do not provide adequate proof of income you will be charged at our customary full rate.

I acknowledge that I have received a copy of this form.

_____

Client Name

_____ _____

Client Signature Date