

CPH Behavioral Health

245 North Binkley St. Suite 202, Soldotna, AK 99669
Intake office: (907) 714-4521 Fax Number: (907) 260-4063

ATTENTION

New tobacco free policy for Behavioral Health Department locations, including the Behavioral Health Intake Office, Serenity House, Care Transitions and Diamond Willow buildings.

As of June 1st, 2017, the Behavioral Health department took an important step in supporting the health of individuals with substance addictions by adopting a tobacco free policy to protect the rights of clients, employees and visitors to breathe clean air. Individuals with a substance addictions smoke at rates two to four times higher than the general population and experience increased mortality and morbidity rates related to smoking. Recent research indicates that quitting smoking while in recovery can increase the chance of long term sobriety by 25%. Additionally, a large proportion of employees in substance abuse treatment facilities are smokers and therefore are less likely to discuss the benefits of tobacco cessation with clients during treatment. The commonality of smoking in this population and community exposes many individuals to secondhand smoke. On average, tobacco free workplace policies effectively reduce secondhand smoke exposure by 72%.

The overall goal of tobacco free policy on our campus is to protect the health of our clients, employees and visitors while reducing health care costs and increasing employee productivity. This is an important step in protecting the health of individuals who are heavily impacted by smoking related illness and exposed to dangerous secondhand smoke. The policy includes **NO** E-cigarettes, vapes, cigarettes, loose or chewing tobacco and cigars.

For more information on and help with quitting tobacco products, please speak with nursing staff, your medical provider, or contact the Alaska Tobacco Quit Line at 1-800-QUIT-NOW (1-800-784-8669) 24 hours a day, 7 days a week. Alaska Tobacco Quit Line free services include telephone coaching, free nicotine replacement therapy, self-guided materials, a secure website, information for those concerned about a tobacco user, referrals and expanded services for pregnant and nursing women.

I have read and understand NO TOBACCO POLCY.

Client signature: _____

Date: _____

Staff witness signature: _____

(Original copy to clients chart, second copy for client records)

INTAKE APPLICATION PACKET

Instructions: Please answer each question as completely as possible. If a question does not apply, write N/A.
Information provided is confidential and will be used to help determine appropriate services and payment options.

1. APPLICANT INFORMATION

Full Legal Name:	Date Completed:
Preferred Name / Nickname:	Nickname / Maiden / Other Names Used:
Date of Birth:	Age:
Place of Birth (City / State / Country):	Social Security Number (if required):
Current Phone Number:	Email Address:

Current Physical Address:

City:	State:	ZIP Code:
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Current Mailing Address (if different from physical address):

City:	State:	ZIP Code:
Current Legal Marital Status:	Spouse / Partner Name (optional):	

2. IDENTITY AND BACKGROUND

Sex Assigned at Birth:	Gender Identity (optional):
Race (optional):	Ethnicity (optional):
Primary Language:	Interpreter Needed? ☐ Yes ☐ No

Cultural, spiritual, religious, or community considerations important to your care:

3. REFERRAL AND PAYMENT SOURCE

Who referred you to CPH Behavioral Health?

Have you received services from CPH Behavioral Health before? ☐ Yes ☐ No ☐ Unsure

Insurance or payment source (check all that apply): ☐ Medicaid ☐ Medicare ☐ Private Insurance
☐ VA / TRICARE ☐ Self-Pay ☐ Grant ☐ Other

4. INSURANCE COVERAGE

Do you currently have health insurance? ☐ Yes ☐ No ☐ Unsure

Primary Insurance Company Name:	Primary Insurance Phone Number:
Primary Insurance Company Address:	City / State / ZIP:
Primary Policy Holder:	Policy Holder Date of Birth:
Primary Policy Number:	Primary Group Number:

Secondary insurance (complete if applicable):

Secondary Insurance Company Name:	Secondary Insurance Phone Number:
Secondary Insurance Company Address:	City / State / ZIP:
Secondary Policy Holder:	Policy Holder Date of Birth:
Secondary Policy Number:	Secondary Group Number:

5. EMERGENCY CONTACTS

Name	Relationship	Phone	Address
Primary Emergency Contact Name:		Emergency Contact Phone Number:	

Emergency Contact Address:	City / State / ZIP:
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6. MEDICAL HISTORY

Current Health Care Provider:	Provider Phone Number:
Date Last Seen:	ER Visits During the Past 12 Months:

Medication allergies (list medication and reaction):

Current medical conditions or health concerns:

MEDICAL HISTORY CONTINUED

Non-Treatment Substance-Related Hospitalizations in the Past 6 Months:	Prior Mental Health Treatment Admissions:
Prior Mental Health Hospitalizations:	Prior Substance Use Treatment Admissions:

7. CURRENT HOUSEHOLD AND SOCIAL HISTORY

Applicant lives with (check one): ☐ Relatives ☐ Children ☐ Non-Relatives ☐ Significant Other ☐ Alone ☐ Significant Other and Children ☐ Other

Current living arrangement (check one): ☐ Private Residence Without Supportive Services ☐ Supportive Housing ☐ Residential Program ☐ Homeless ☐ Other

Current marital status (check one): ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Cohabiting

If other living arrangement, please specify:

List children/minors in the home (name or initials, age, and relationship to applicant):

Describe your current social situation, relationships, and available support system:

Are you currently experiencing housing instability or homelessness? ☐ Yes ☐ No

If yes, please explain:

Do you feel safe in your current home and relationships? ☐ Yes ☐ No ☐ Unsure

Are you a caregiver for another person? ☐ Yes ☐ No

Current transportation needs or barriers:

8. EDUCATION AND EMPLOYMENT

Highest Grade Completed:	Diploma / Degree / Certificate:
Current Employment Status:	Employer:
Job Title / Occupation:	Length of Employment:

Learning needs, literacy concerns, or accommodations that may help you participate in services:

9. CURRENT FINANCIAL STATUS AND BASIC NEEDS

Current sources of income (check all that apply): ☐ Employment ☐ SSI ☐ SSDI ☐ VA Benefits
☐ Retirement ☐ Public Assistance ☐ Child Support ☐ None ☐ Other

Approximate Current Monthly Household Income:	Yearly Income for the Most Recent Year:
Primary Income Source:	Receiving Disability Benefits? ☐ Yes ☐ No

Are you currently able to meet your basic needs? ☐ Yes ☐ No ☐ Sometimes

Check any basic needs with which you need assistance: ☐ Food ☐ Housing ☐ Utilities ☐ Clothing
☐ Transportation ☐ Medical Care ☐ Medication ☐ Childcare ☐ Safety ☐ Other

Please describe current financial concerns or urgent basic-needs assistance requested:

10. MILITARY SERVICE

Have you ever served in the U.S. Armed Forces, National Guard, or Reserves? ☐ Yes ☐ No

Branch of Service:	Dates of Service:
Discharge Status:	Combat / Deployment History (optional):

Eligible for or Receiving VA Services? ☐ Yes ☐ No ☐ Unsure	VA Facility / Provider:
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Military-service experiences or needs you would like the treatment team to be aware of:

11. LEGAL STATUS AND HISTORY

Have you had any legal issues during the past 12 months? ☐ Yes ☐ No

If yes, describe the charge, court, date, and current status:

Present legal status (check all that apply): ☐ None ☐ Pending Charges ☐ Probation ☐ Parole ☐ Pretrial Supervision ☐ Court-Ordered Treatment ☐ Protective Order ☐ Other

Number of Arrests in the Past 30 Days:	Nights Spent in Jail in the Past 30 Days:
Drug-Related Arrests in the Past 30 Days:	Crimes Committed in the Past 30 Days:
Awaiting Charges, Trial, or Sentencing? ☐ Yes ☐ No	Currently on Probation or Parole? ☐ Yes ☐ No
Probation / Parole Officer:	Officer Phone:
Attorney / Public Defender:	Attorney Phone:
Next Court Date:	Court Location / Case Number:

Past legal history or legal obligations that may affect treatment attendance or planning:

12. SERVICE NEEDS AND ADDITIONAL INFORMATION

What services are you requesting or interested in? ☐ Mental Health ☐ Substance Use ☐ Medication Management ☐ Peer Support ☐ Case Management ☐ Crisis Services ☐ Other

Briefly describe the primary reason you are seeking services now:

What do you hope to gain from treatment or services?

Are there barriers that may affect your ability to participate in services? ☐ Yes ☐ No

If yes, please describe (work schedule, childcare, transportation, accessibility, technology, or other):

Is there anything else you would like CPH Behavioral Health to know?

13. APPLICANT ACKNOWLEDGMENT

I certify that the information provided in this application is true and complete to the best of my knowledge. I understand that completing this application does not guarantee admission or establish a provider-patient relationship. CPH Behavioral Health may contact me using the preferences listed in this packet to coordinate screening, eligibility, scheduling, or services.

Applicant Signature:	Date:
Parent / Guardian Signature (if applicable):	Date:
Staff Receiving Application:	Date / Time Received:

14. FOR OFFICE USE ONLY

Date Contacted:	Contacted By:
Screening Date:	Screened By:
Program / Level of Care Referred To:	Appointment Date / Time:
Disposition:	Follow-Up Needed By: