TANANA CHIEFS CONFERENCE HEALTH SERVICES

Behavioral Health Services

Chief Peter John Tribal Building

122 First Ave, Suite 600

Fairbanks, AK 99701

(907) 459-3800 Fax: 459-3835

Toll Free in Alaska 1-800-478-6822 ext. 3800

To whom it may concern

Thank you for your interest in the Tanana Chiefs Conference (TCC) Old Minto Family Recovery Camp (OMFRC) office located on the 4th floor of the Chief Peter John Tribal Building (CPJTB). The first step to determine if you are eligible for services is to complete the attached application and submit it in person at TCC 4th floor, mail it to; **TCC OMFRC 122 First Avenue Suite 600 Fairbanks, Alaska 99701**, or Fax it to **(907) 459-3835**. When you send a fax call and let us know you are sending a fax and call again to make sure we received everything you faxed. If there are any adults wishing to attend camp with you they must also complete an application.

Once our office receives your application a Behavioral Heath Consultant will contact you to do a screening. **It is very important that you provide a phone number you can be reached to do this screening and continue the process to enter into OMFRC.** After the screening process is done you will be added to the waitlist to receive an assessment if you already do not have one. It is your responsibility to turn in an outside assessment. Once your assessment is received the Clinical Supervisor will review your assessment to determine if OMFRC will be an appropriate placement for you. If not we will assist you in finding an appropriate treatment for you.

After your assessment is approved for services at OMFRC we will need each of the following as soon as possible.

- **Criminal History** is required for all persons over 18 who will be attending the program. OMFRC requires the criminal history to be acquired from the Alaska State Troopers Office and there is a $20 dollar fee for each request. **Note: Any individual (client or family member) convicted of a sexual offense or with a long history of violence are not admitted into OMFRC and will be referred to alternative programs.**
- **Physical Exam** (Note: a physical is required for all members of the family attending the program). The form is available on the web site or you will be given a form to be completed and signed by a Doctor or a Physician Assistant (PA). (It cannot be done by a community Health Aid.)

It is important to understand that if you or family members have a medical or dental condition that need treatment, admission to OMFRC will be delayed until medical clearance is received. This is due to the high cost, weather and available transportation to and from camp.

The information you provide is necessary for us to determine placement, recommended treatment and to provide a safe environment for our clients and their families. If you have further questions or need assistance with the application, please call our office at 1- 800-478-6822 or 452-8251 extension 3097.

ITEMS NEEDED PRIOR TO ENTERING OMFRC–in order of priority.

1. **OMFRC Application**
2. **Drug/Alcohol Assessment or a Comprehensive Assessment**–the Alaska Screening Tool will determine which assessment is needed–must be done within the past 3 months.
3. **Current Criminal History from Alaska State Troopers office** (for adults 18 years and older.)–you will need two forms of ID and $20.00 to get an official copy.
   - Items 1, 2 and 3 are needed as soon as possible to determine eligibility.
4. **Current Physical Exam**–within the past 3 months
   - Step 4 is required for ALL family members who plan to attend.

*If you reside outside the Fairbanks area: we will need your travel arrangements to and from Fairbanks and Housing information.

Keep in touch with the Intake Counselor at the Old Minto Family Recovery Camp at least once a week!
We need to know that you are interested and motivated so that we can take care of Intake Paperwork and confirm bed space. If you do not contact us, we will assume you are not interested.
All applicants that are accepted for treatment (from Fairbanks) will be enrolled in pre-treatment and expected to actively participate. Lack of participation could result in losing your bed space.

PLEASE TAKE CARE OF ALL YOUR COURT, PERSONAL, LEGAL, FINANCIAL, AND FAMILY OBLIGATIONS BEFORE YOU GO TO OLD MINTO FAMILY RECOVERY CAMP.

We will provide ◊ all meals ◊ laundry soap ◊ work gloves ◊ insect repellent ◊ tools for working ◊ hand soap ◊ Coleman lamps/candles ◊ wood/woodstoves

The Old Minto Family Recovery Camp is in a traditional camp setting
and therefore has *no* electricity and *no* running water.
Wood stoves are used to heat the cabins and Coleman lamps are used for lights.
Please do not bring any unnecessary items, as you will be traveling to the camp by a small plane in the winter or by a boat in the summer. **There are NO stores in Old Minto. **

Please let your family and friends know to send your **mail** to the office at:

Tanana Chiefs Conference-OMFRC
"Client name"
122 First Avenue, Suite 600
Fairbanks, AK 99701

YOU ARE ALLOWED ONE PHONE CALL AT THE END OF THE 2ND WEEK.
CELL PHONES, LAPTOPS, DVD PLAYERS ARE NOT ALLOWED AT THE CAMP!

WE DO NOT ALLOW DIRECT PHONE CALLS TO THE CAMP—WE WILL TAKE MESSAGES AND FORWARD THEM TO THE COUSELORS AT THE CAMP.

WHAT THE CLIENT MUST BRING

- **Sleeping bags, bedding, pillows, towels** for all family members. Bring flip flops to use in the Steam House.
- **Clothes and shoes** appropriate for the weather and travel. (One week of clothing per family member) space on the airplane is limited when traveling during the winter. We recommend that you bring warm gear at all times of the year as it can be cold traveling in open boat during the summer especially have rain gear during the summer.
- **Personal Hygiene Products**: Tooth brush, toothpaste, shampoo/conditioner, feminine products, soap, shaving items, non-alcoholic mouth wash, Q-tips, etc.
- **Diapers, wipes, baby food, formula for infants (In case of bad weather–PLEASE bring a 40 day supply of baby food, diapers, etc.)**
- **Medication - (In case of bad weather–PLEASE bring a 40 day supply of medication.)**
- **Cigarettes/Chew** (TO LAST 40 DAYS)
- **Stamps and envelopes-** Please have your own supply. We do not provide these items AND due to **confidentiality** we will not call family and friends to pick up envelopes.
- **You are welcome to bring your own supplies for:** beading, knitting, carving, and sewing.
- **Native food:** including dry meat, dry fish, berries, etc —— optional
- **You can bring Healthy snacks for your Kids**: no candy.

■ WE DO NOT ALLOW

- SODA AND JUNK FOOD AT CAMP, ie candy, chips, etc.
- Aerosols or any items containing alcohol, including hairspray
- Cameras, iPods/music player, Laptops, PSP's, CD's, Cellphones
- Clothing with alcohol, drug, weapon, sexual words and or pictures. Clothing with excessive holes, tears, rips, (is skin tight, or reveling, tops; low-cut or cropped tops, are not allowed).

►We do not allow VICTOR (unemployment) calls during treatment.◄

In the event that you need a personal item at camp, you can write to your family and friends and let them know that if they drop your things off at the front desk or have it mailed, it can go to the camp on the next available trip.

REMEMBER—there is limited space available and you are responsible to pack all your gear to and from the boat and airplane.

OMFRC STAFF will not shop for the clients during their time off.

Tanana Chiefs Conference Behavioral Health

OLD MINTO FAMILY RECOVERY CAMP
Application for Enrollment

PLEASE FILL OUT THE FOLLOWING INFORMATION AS **COMPLETELY** AND **ACCURATELY** AS POSSIBLE.

Name of Applicant: _____ Date of Application: _____/_____/_____
First Middle Last

Name of Person Completing or Assisting in Application (list self if no-one) _____
First Last Agency or Relationship

Date of Birth of Applicant: _____/_____/_____ Social Security # _____

Is Applicant? ☐ Male Driver's License # _____
☐ Female- Pregnant? __Yes- # months_____
__No
__Not sure

Applicant's ethnic or racial identification: ☐ Alaskan Native/American Indian
Please also indicate group/tribe ___Aleut ___Haida ___Eskimo ___Athabascan ___Tlingit ___Yupik ___Tsimshian ___Inupiat _____other:_____

☐ Caucasian/White
☐ African American
☐ Asian/Pacific Islander
☐ Other _____

A staff person will be in contact with you for further information and answer any questions you may have. Please provide information on how you can be contacted.

Home Address:_____

Mailing Address:_____ City/State:_____ Zip Code_____

Phone Number: Home:_____ Work:_____ Contact: _____

E-mail address _____

Other addresses and phone numbers you may be reached through:

Address	Phone #	Description (relatives, shelter, program)

Maiden(s) name or other names you may be known as: _____

What is your home village (where most of your family is originally from)? _____

Who are your biological parents? _____

How did you hear about the program? _____

Who recommended you to treatment? (Included agency, address, contact person & phone number)

Agency Name:_____Contact Person:_____

Address:_____Phone:_____

Are you currently involved with the legal system? ☐ No ☐ Yes, describe how and why

_____

_____

_____

Are you being **mandated/required or recommended by**: (check all that apply)

__Court, __FASAP __Probation/Parole __Tribal Court __OCS __Employer __Family __Other _____

Have you ever been convicted of a violent or sexual crime?

- ☐ No
- ☐ Yes ➔ How many times? _____
  - ➔ What was/were the crime/s? _____
    - (include to what degree)

Are you currently receiving services from any other agency ___ No ___Yes (please list agencies)

First Agency

Name:_____ Address:_____

Contact person:_____ Phone Number:_____

Second Agency

Name:_____ Address:_____

Contact person:_____ Phone Number:_____

If you need more space please add an additional page

Have you ever been to residential treatment before? ___ No ___Yes➔

Was it: OMFRC _____ other _____

Why do you want to be in this program (what do you hope to get out of it)?

- # Times _____
- Dates: _____
- Did you complete? _____

_____

_____

What are your drugs of choice (what you most typically drink or use) and when last used:
(Please note that alcohol is a drug)

1st Choice		2nd Choice		3rd Choice	
Drug	**Last used**	**Drug**	**Last used**	**Drug**	**Last used**

Are you an injection drug user? ☐ Yes ☐ No

Do you have travel arrangements to get to and from treatment? Yes _____ No _____

Are you currently involved in a committed relationship?

- ☐ No
- ☐ Yes → ☐ Married
  ☐ Living together

→ Will your partner be attending the program also?

- ☐ Yes - Name_____
- ☐ No

How many children do you have? _____

Please list the names, gender, birth date, and your relationship to the children ***who will attend*** the program with you (if you need extra space, please write on the back).

Name	Gender	Birth date	Relationship (e.g. Natural, adopted, or foster child)
	M F		
	M F		
	M F		
	M F		
	M F		
	M F		

Do you or any of the family members which may attend have any special needs or considerations we will need to know about to accommodate you?

	Who is experiencing the problem	**Please describe**
Medical		
Disability		
Legal		
Work		
Social		

What is the highest grade of education you have completed? _____

What is your primary language?

☐ English → → → →

How well do you ***read and write*** English (circle one)
Very well Good Fair Difficult

☐ Other _____ →

Do you require an interpreter for English? _____
How well do you ***read and write*** English (circle one)
Very well Good Fair Difficult

We look forward to meeting you. You will be notified once your application has been reviewed. If you have .questions, please feel free to contact us for assistance. Thank you.

_____ _____ _____

Printed Customer Name Date Customer Signature

Tanana Chiefs Conference, Behavioral Health

OLD MINTO FAMILY RECOVERY CAMP
Medical History & Physical Screening

Name _____ DOB: _____ Date _____

Old Minto Family Recovery Camp is an Alcohol and Drug treatment program operated by Tanana Chiefs Conference in Fairbanks, Alaska. The program setting is isolated, rural, and accessible only by small plane and boat and treatment is expected to take five weeks. (NOTE: A Medivac is not possible out of Old Minto, so consider that when doing the physical.) A condition of admission is that clients be able to fully participate in all activities, which include hauling water, cutting and lifting wood, Subsistence Activities, etc. All clients are required to obtain a health screening to ensure that there are no medical conditions or severe withdrawal potential that would interfere with treatment and leave the client at risk for complications.

FILLED OUT BY A HEALTH CARE PROVIDERS

Please check if the client has ever had any of the following and explain "Yes" answers on the lines below:

Yes	No		Yes	No	
☐	☐	Major Illnesses	☐	☐	Seizures or feinting episodes
☐	☐	Allergies (food, drug, other)	☐	☐	Migraine or recurrent headaches
☐	☐	Chronic medications	☐	☐	Anxiety or panic attacks
☐	☐	Heart illness – CAD, Angina, CHF	☐	☐	Depression or mental health illness
☐	☐	Heart palpitations, pacemaker, etc.	☐	☐	Blurred vision or difficulty seeing
☐	☐	Diabetes – medications, insulin	☐	☐	Eye disease / major vision issues
☐	☐	Asthma or lung disease	☐	☐	Ear disease / hearing / dizziness
☐	☐	Joint/muscle/back illness – limiting activity	☐	☐	Tired/fatigue – limiting activity
☐	☐	Stomach problems – pain, nausea, etc.	☐	☐	Chronic or recurrent skin disease
☐	☐	Bowel issues – diarrhea, constipation, etc.	☐	☐	Bleeding gums or teeth problems
☐	☐	Liver, gallbladder, pancreas disease	☐	☐	Kidney, bladder, prostate disease
☐	☐	Uterine/pelvic/menstrual problems	☐	☐	Active hernia
☐	☐	Other: _____	☐	☐	Other: _____

Please explain any 'Yes' responses:

_____

_____

_____

_____

(Please use back of page if needed for this or other questions)

Please review hospitalizations, operations, or Emergency room visits (for conditions that might be at risk while at Old Minto:

_____

_____

_____

Is the client currently receiving medical care from elsewhere (ANMC, other hospitals, other providers?)
__No __Yes, Why? _____

_____

_____

Contact details if needed: Name: _____
Address: _____ Phone: _____

FEMALES - Date of last period _____ Are periods irregular, difficult, painful, heavy? _____
Pregnant? ____ No ____ Yes ____Unsure? Explain _____ Pregnancy Test _____
Contraception or hormones that will be needed while at Old Minto? _____

Does the client currently have any special dietary requirements? __No __Yes Describe: _____

_____

Medications:
Is the client currently taking any **prescription medications** that will be needed while at Old Minto? ___No ___Yes
*(All medications are locked in a central cabin and dispensed to patients. All medications need to be dispensed for at least 45 days... refills very difficult. And **opiate based medications are not allowed at camp**. If indicated, please prescribe an alternative),*

Medication	Dosing	For what Condition	45-day Supply?
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No

Are any of the medications possibly "mind altering?" (benzodiazepines, anti-psychotics, lithium, etc). Discuss potential issues:
_____
_____

Will the client be taking any **over-the-counter products**? __No __Yes Medication and what for: _____
_____

NOTE: As an optional part of treatment patients may take vitamin supplements for physical detoxification, including high dose of B vitamins. Would use of vitamins conflict with any of the patients medical conditions or medications? __No __Yes

Mental Health:
Is the client currently depressed, anxious, or having suicidal thought? Or thoughts of hurting someone else? ____ No ____ Yes
Does the client have a history of suicide attempts or violent behavior towards others, family, or self? ____ No _____ Yes
Explain: _____
_____
Does the examiner feel the client is ___ Low ___ Medium ___ High risk of harm to ___ Self ___Others?

Substance Abuse:
Is the client an IV drug user? ___No ___Yes. Last used _____ What drug _____ With whom? _____
Is the client currently experiencing signs and symptoms of withdrawal – please check the following:
None ☐ Nausea & Vomiting ☐ Tremor ☐ Sweats ☐ Tactile Disturbances ☐ Anxiety ☐
Agitation ☐ Auditory Disturbances ☐ Headache ☐ Orientation ☐ Visual Disturbances ☐
Does the client have a history of withdrawal complications? ___ No ____ Yes Explain: _____
_____

Please check current immunizations: (check if current)
☐Flu Shot ☐Tetanus Shot ☐ Other _____

Please review history and patient for TB. Do you feel there signs or symptoms suggesting active TB? ___ No ___ Yes
Explain: _____

Are there any additional studies or lab tests needed before a recommendation is made? ___ No ___ Yes. Explain: _____
_____

Based on your exam and review, are there concerns regarding the client's ability to fully and safely participate in the treatment program and activities at Old Minto Camp for 45 days in a remote and isolated location?_____
_____
_____
_____

Based on findings of Medical Evaluation, the client:
☐ Is recommended for Old Minto Family Recovery Camp.
☐ Is not recommended for Old Minto Family Recovery Camp.

Signature of Physician, Nurse Practitioner or Physician Assistant **Contact Number** **Date**

_____
Stamp or printed name of Provide

TANANA CHIEFS CONFERENCE HEALTH SERVICES

Behavioral Health Services

Chief Peter John Tribal Building

122 First Ave, Suite 400

Fairbanks, AK 99701

(907) 459-3800 Fax: 459-3835

Toll Free in Alaska 1-800-478-6822 ext. 3800

Release of Information is required from you for us to be able to talk with a family member in case they need to get a message to you in camp. You will also need a Release of Information for each agency that you may be working with or will want information on compliance, letter of completion, discharge summary and other information they may need form you about treatment and for OMFRC to exchange information with those agencies. Below is a list of agencies you may need a Release of Information for.

1. Anchorage Alcohol and Safety Action Program (AASAP)
2. Fairbanks Alcohol and Safety Action Program (FASAP)
3. Alcohol and Safety Action Program from your community
4. Public Defender or Lawyer
5. Office of Children Services (OCS)
6. Probation Officer
7. Tribal Court
8. Tribal or City offices for purpose of providing transportation.
9. Employer
10. Counselor, Behavioral Health Aid and health provider outside of the TCC Behavioral Health service region.

Make sure you tell the staff that is helping you fill out this application packet that you need a Release of Information to be filled out. For the Release of Information to be a valid release all sections need to be filled out, initialed, signed by client and by a staff member working with you.

TANANA CHIEFS CONFERENCE BEHAVIORAL HEALTH

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Ph (907) 451-6682 ext 3254 Fax (907) 459-3810

Instructions: Fill out form in its entirety. If any section is incomplete, this form may be invalid and the request may not be processed.

Printed Name of Client:	Previous Names, If Applicable:
HRN:	
Date of Birth:	Daytime Telephone Number:

I authorize the use/disclosure of health information about the above named patient as described below:

The information is to be disclosed by:	**And is to be provided to:**
Name of Facility:	**Name of Person/Organization/Facility**
Address	
City/State	
Fax #	

Date of Service/s: From: _____ To: _____

Consumer ***must*** initial the specific confidential information:

____Discharge Summary ____Psychiatric Evaluations/Assessments ____Substance Abuse Evaluations/Assessments

____Behavioral Health Records ____Treatment Plan ____All Records ___Other: _____

The purpose or need for this disclosure is:

□ Further Medical Care □ Legal □ Disability Determination □ Personal Use/Request of Individual □ Benefits/Insurance

□ Other (*Specify*) _____

The information may be transmitted via (consumer ***must*** initial each approved communication method)

_____ fax _____ verbal _____electronically (***required*** to complete duty to warn) _____hard copy

I understand that:

- My health information is protected by federal regulations governing Confidentiality of Alcohol and Drug Abuse Consumer Records (42 CFR Part 2; and/or HIPAA, 45 CFR) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. If I am receiving Part 2 services, TCC may condition my treatment on whether I elect to sign an authorization for payment. If I am not receiving Part 2 services, I understand my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for services.
- I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. Submit written revocation to TCC Health Information Management 1717 West Cowles Street, Fairbanks, AK 99701. If not so revoked, this consent automatically expires on: (*specify*)_____
- For substance abuse treatment records that are covered by 42 CFR Part 2, Federal law prohibit the recipient of these records from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse participant. For all other medical records covered only by HIPAA information disclosed pursuant to this authorization might be redisclosed by the recipient and is no longer protected by HIPAA rules.

I further acknowledge that the information to be release has been explained to me and certify that this consent is given of my own free will.

Signature of Client	Printed Name of Client	Date
Signature of Parent/Guardian (if required)	Printed Name of Parent/Guardian	Date
Signature of Staff Witness	Printed Name of Staff Witness	Date

For TCC's Use:

Date Received: _____

□ Fees explained if needed: _____

□ Verification of Identity and Authority_____

□ Identification: _____

□ Information sent by: _____

Preferred Method of Communication: Duty to Warn

Please use this form to let us know of the method you prefer we use in communicating with you. You have the right to request to receive communications about your protected health information from us by alternative means and we will accommodate reasonable request/s.

Name of Client: _____

Today's Date: _____

Date of Birth: _____

You do not need to tell us why you are making this request.

You may change your mind at any time and we will provide you with another copy of this form to request modification of your preferred method of communication. **If You Prefer Email, Telephone/Text Messages, Mail and/or Fax** You may request that we communicate with you by email, telephone/text message, mail and/or fax. We will contact you using your preferred method whenever possible. We must warn you there is some level of risk that protected health information transmitted by unencrypted email and/or unsecured phone and/or fax could be intercepted or read by an unauthorized person. In light of this warning, if you still prefer that we communicate with you by unencrypted email and/or unsecured phone and/or fax we will agree to your request. We are not responsible for unauthorized access of your protected health information while in transmission or for safeguarding information that has been delivered to you.

I request you communicate with me by:

1. **Telephone**

Call my Home Phone- Number_____

- *(Please select a box)*
  - ☐ This is my preferred method of communication and is okay to leave a detailed message.
  - ☐ This is my preferred method of communication, but do not leave a detailed message.

Call my Cell Phone- Number _____

- *(Please select a box)*
  - ☐ This is my preferred method of communication and is okay to leave a detailed message.
  - ☐ This is my preferred method of communication, but do not leave a detailed message.

2. **Text Message:**

Preferred Text Message-Number: _____

3. **Email:**

Preferred Email Address: _____

4. **Fax:**

Preferred Fax Number: _____

I further acknowledge that this consent is given on my own free will.

Signature of Client	Printed Name of Client	Date
Signature of Parent/Guardian (if required)	Printed Name of Parent/Guardian	Date

For TCC's Use:

Date Received: _____

□ Fees explained if needed: _____

□ Verification of Identity and Authority_____

□ Identification: _____

□ Information sent by: _____

CHECK LIST FOR REGISTRATION PACKETS

Please make sure to provide all supporting documents as we are unable to process registrations without them.

THE FOLLOWING DOCUMENTS ARE REQUIRED:

_____ Certificate of Indian Blood (CIB) and/or Tribal Card (must have blood quantum listed on it). Ensure the copy is PHOTO QUALITY and EXPANDED to 190%.

_____ Birth Certificate. Copied at standard size.

_____ State ID or Driver's License. Ensure the copy is PHOTO QUALITY and EXPANDED to 190%.

_____ All private insurance (s) that you may have. If a minor please provide all parents insurance (s). Ensure the copy is PHOTO QUALITY and EXPANDED to 190%.

_____ Chief Andrew Isaac Health Center, Consent for Treatment of a Minor Form, is required if anyone other than a parent is to bring in the (child patient) for treatment.

_____ Additional documentation requested: Social Security Card. Copied at PHOTO QUALITY and EXPANDED to 190%.

Please completely fill out all fields in the registration packet. If an area of the registration packet does not apply to you, note it by marking N/A in the blank space. Please ensure signatures and initials are provided on all pages that require them for acknowledgements and authorizations.

Please print, or check the correct box.

OFFICE USE ONLY
☐New ☐Pending
☐Established/Update ☐Ineligible
☐Active ☐Direct
☐CHS/Direct

PATIENT INFORMATION:

Last Name:_____ First Name:_____ Middle Name:_____ Suffix:_____

Address 1:_____ DOB:____/____/____ Age:_____

Address 2:_____ SSN:____-_____-____ Gender:_____

City:_____ State_____ Zip:_____

Home Phone:(____)_____ Work Phone: (____)_____ Other Phone: (____)_____

Current Community:_____ Email:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Is the patient:

☐ Aleut ☐ Eskimo ☐ Alaska Native ☐ Native American

Corporation/Tribal Membership:_____

Blood Quantum: (How much Alaska Native/Native American are you?) ☐ 1/8 ☐ ¼ ☐ ½ ☐ ¾ ☐ full

Race/Ethnicity/Heritage: ☐ Asian ☐ Black/African American ☐ Hispanic ☐ Other
☐ Native Hawaiian ☐ Other Pacific Islander ☐ White

Commissioned Officer Dependent of Commissioned Officer Civil Service PHS Employee Other (Student, Volunteer)

Employment Status (Choose one):

☐ FT/PT Student ☐ FT Employed ☐ PT Employed ☐ Unemployed
☐ Self Employed ☐ Retired ☐ Active Military

Employer:_____ Occupation:_____

Address:_____ City:_____ State_____ Zip:_____

Phone:(____)_____ Type of Business:_____

Migrant/Seasonal	Homeless	Interpreter Needed
Yes No	Yes No	Yes No
(If yes, provide temporary address)		(If yes, alert Cust. Serv. If available and requested)

Other Information: (circle all that apply)

Tribal Adoption: Yes No Foster Parent: Yes No Guardianship: Yes No

Court Order: Yes No Durable Power of Attorney: Yes No Other:_____

Guarantor Information (Makes decisions for the patient) Relationship to patient:_____

Last Name:_____ First Name:_____ Middle Name:_____ Suffix:_____

Address 1:_____ DOB:____/____/____ Age:_____

Address 2:_____ SSN:____-_____-____ Gender:_____

City:_____ State_____ Zip:_____ Home Phone:(____)_____

Employer:_____ Work Phone: (____)_____

Please print, or check the correct box.

OFFICE USE ONLY

☐New ☐Pending
☐Established/Update ☐Ineligible
☐Active ☐Direct
☐CHS/Direct

#1 PRIMARY INSURANCE INFORMATION (Please provide clerk with the insurance card)

Insurance Company:_____ Phone: (_____)_____

Address:_____ City:_____ State_____ Zip:_____

Policy Holder:_____ Relationship to Patient:_____

Policy Holder DOB:_____/_____/_____ Policy Holder Gender____ Policy Holder Employer:_____

Policy #:_____ Group #:_____ Policy Holder SSN:_____

Policy Holder Address:_____ Phone: (_____)_____

Additional Information:_____

#2 SECONDARY INSURANCE INFORMATION (Please provide clerk with the insurance card)

Insurance Company:_____ Phone: (_____)_____

Address:_____ City:_____ State_____ Zip:_____

Policy Holder:_____ Relationship to Patient:_____

Policy Holder DOB:_____/_____/_____ Policy Holder Gender____ Policy Holder Employer:_____

Policy #:_____ Group #:_____ Policy Holder SSN:_____

Policy Holder Address:_____ Phone: (_____)_____

Additional Information:_____

Does the patient have Medicaid? Yes No
(if yes, please provide clerk with your coupons)

Does the patient have Denali Kid Care? Yes No

Does the patient have Medicare? Yes NO
(If yes, please provide clerk with your card)

Is the patient a Veteran? Yes No (If yes, please provide clerk with your fee service card)

Is this a service related injury and/or is it pre-authorized by VA?

#1 EMERGENCY CONTACT/NEXT OF KIN Relationship to Patient:_____

Last Name:_____ First Name:_____ Middle Name:_____ Suffix:_____

Address 1:_____ DOB:____/____/____ Age:_____

Address 2:_____ SSN:____-_____-____ Gender:_____

City:_____ State_____ Zip:_____ Home Phone:(____)_____

Employer:_____ Work Phone: (____)_____

#2 EMERGENCY CONTACT/NEXT OF KIN Relationship to Patient:_____

Last Name:_____ First Name:_____ Middle Name:_____ Suffix:_____

Address 1:_____ DOB:____/____/____ Age:_____

Address 2:_____ SSN:____-_____-____ Gender:_____

City:_____ State_____ Zip:_____ Home Phone:(____)_____

Employer:_____ Work Phone: (____)_____

Patient/Parent/Guardian's Signature_____ Date:_____

Printed Name:_____

PLEASE COMPLETE BOTH PAGES OF THIS FORM

New Patient Consent and Signature for Treatment

I am signing as the: ☐ Patient ☐ Patient Representative (mark status below)

☐ Parent ☐ Spouse ☐ Guardian

☐ Power of Attorney ☐ Next of Kin ☐ Other

Address: (If not signing as the patient): _____

_____

_____

_____

Home phone: (If not signing as the patient): _____

I am an adult or an emancipated minor with legal capacity. If I am a patient's representative I am properly exercising my authority, and will make available copies of my documents if requested. I consent to all necessary steps taken for examination, diagnosis and treatment. If at any time I have questions about my examination, diagnosis or treatment I will not proceed until the questions have been answered so I am fully informed. If surgical or invasive procedures are recommended I may be asked to sign additional consents after being fully informed of the potential risks and benefits.

I understand that giving medical providers, community health aides, and nurses all relevant information is critical to proper diagnosis and treatment. I understand complete compliance with my providers' instructions is critical to the success of any treatment prescribed.

I have read and do understand the above information.

Signed: _____ Date: _____

Printed Name: _____

Preferred Method of Communication: Duty to Warn

Please use this form to let us know of the method you prefer we use in communicating with you. You have the right to request to receive communications about your protected health information from us by alternative means and we will accommodate reasonable request/s.

Name of Client: _____

Today's Date: _____

Date of Birth: _____

You do not need to tell us why you are making this request.

You may change your mind at any time and we will provide you with another copy of this form to request modification of your preferred method of communication. **If You Prefer Email, Telephone/Text Messages, Mail and/or Fax** You may request that we communicate with you by **email, telephone/text message, mail and/or fax. We will contact you using your preferred method whenever possible**. We must warn you there is some level of risk that protected health information transmitted by unencrypted email and/or unsecured phone and/or fax could be intercepted or read by an unauthorized person. In light of this warning, if you still prefer that we communicate with you by unencrypted email and/or unsecured phone and/or fax we will agree to your request. We are not responsible for unauthorized access of your protected health information while in transmission or for safeguarding information that has been delivered to you.

I request you communicate with me by:

5. **Telephone**

Call my Home Phone- Number_____

- *(Please select a box)*

☐ This is my preferred method of communication and is okay to leave a detailed message.

☐ This is my preferred method of communication, but do not leave a detailed message.

Call my Cell Phone- Number _____

- *(Please select a box)*

☐ This is my preferred method of communication and is okay to leave a detailed message.

☐ This is my preferred method of communication, but do not leave a detailed message.

6. **Text Message:**

Preferred Text Message-Number: _____

7. **Email:**

Preferred Email Address: _____

8. **Fax:**

Preferred Fax Number: _____

I further acknowledge that this consent is given on my own free will.

_____

Signature of Client | Printed Name of Client | Date

_____

Signature of Parent/Guardian (if required) | Printed Name of Parent/Guardian | Date

For TCC's Use:

Date Received: _____

☐ Verification of Identity and Authority_____

☐ Identification: _____

Please initial each section and sign at the bottom

_____Patient Receipt for Notice of Privacy Protection

I have received a copy of the Tanana Chiefs Conference Notice of Privacy Protection to keep. I understand this form is mandated by federal law and that in order to treat any patient, Tanana Chiefs Conference will have to gather, store and use Protected Health Information ("PHI"), and that PHI is subject to special federal legal protections. I give my consent to Tanana Chiefs Conference to gather, store and use PHI for treatment, billing and health care operational purposes.
If I have any questions on this notice, I will contact the patient advocate at Tanana Chiefs Conference, at (800) 478-6682 extension 3143.

_____Consent for Use and Disclosure of Medical Information

TCC Health Services may use or disclose medical information about me (1) for my treatment, (2) to apply for payment from insurance companies or government programs, and (3) for operation of TCC Health Services Department. For example, I understand that the information on this form can be shared with Fairbanks Memorial Hospital, and that TCC may release alcohol and drug treatment information about me under 42 CFR Part 2. I authorize assignment of benefits and payment directly to TCC. I have reviewed, understand and have a copy of TCC's Notice of Privacy Practices.

_____Patient Receipt of Payment Policy

I have received a copy of the Tanana Chiefs Conference Community Health Center payment policy. I authorize Tanana Chiefs Conference to release information to my designated insurance carrier for the purpose of receiving payment. I further authorize the payment of benefits to be made directly to Tanana Chiefs Conference on my behalf. I understand a patient is responsible for all charges incurred, subject to contract and program rules, regardless of my insurance status. If it becomes necessary to send this account to collections, the patient will be responsible for all additional charges.

_____Permission to Release Information

I_____authorize Tanana Chiefs Conference to release Protected Health Information, including clinical and financial information, to the following: (please provide persons name and relationship to the patient)

I am signing as the:	☐ Patient	☐ Patient Representative (mark status below)
☐ Parent	☐ Spouse	☐ Guardian
☐ Power of Attorney	☐ Next of Kin	☐ Other

Signed:_____Date:_____

Printed Name:_____

Chief Andrew Isaac Health Center
Health Resources Screening Form

If you have or qualify for Medicaid, Veteran Status, Denali Kid Care, Medicare, Health Insurance and/or Workers Compensation, you can help us build a strong Alaska Native health system for you, your family and future generations…

Total # of people living in the household including yourself? _____

- Of those how many are **your dependents** and are under 18? _____

Please **circle** or **write** in $ _____ the amount closest to your **Monthly Gross** (before taxes) Household income.

$1,200	**$1,400**	**$1,600**	**$1,800**	**$2,000**	**$2,200**	**$2,400**	**$2,600**	**$2,800**	**$3,000**	**$3,200**	**$3,400**
$3,600	**$3,800**	**$4,000**	**$4,200**	**$4,400**	**$4,600**	**$4,800**	**$5,000**	**$5,200**	**$5,400**	**$5,600**	**$5,800**
$6,000	**$6,200**	**$6,400**	**$6,600**	**$6,800**	**$7,000**	**$7,200**	**$7,400**	**$7,600**	**$7,800**	**$8,000**	**$8,200**

Are you a Veteran?	Yes	☐	No	☐
If yes have you signed up for VA Health Benefits?	Yes	☐	No	☐
Are you Pregnant?	Yes	☐	No	☐
Do you have Medicaid/Denali Kid Care?	Yes	☐	No	☐
Do you have Medicare?	Yes	☐	No	☐
Do you have Private Insurance?	Yes	☐	No	☐
Are you disabled?	Yes	☐	No	☐
If yes did you apply for disability?	Yes	☐	No	☐

THANK YOU FOR PROVIDING THIS INFORMATION

All responses will be kept confidential

Alternate Resource Use Only

Program: _____

T-Ship: _____

Initials/Date: _____

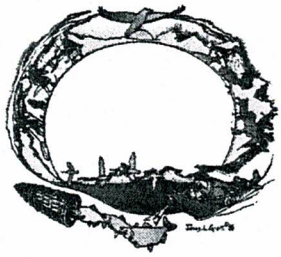
Clinic/Department:

Family Medicine Specialty Registration

Chart #

1. _____

09/2015



TANANA CHIEFS CONFERENCE
CHIEF ANDREW ISAAC HEALTH CENTER

CONSENT FOR TREATMENT OF A MINOR

This authorizes: Last Name:_____, First Name: _____, MI:____

(This individual must be at least 18 years of age.)

To give consent for medical or surgical treatment for our child/children: (Names & Birthdates)

Last Name:_____, First Name: _____, MI_____

Date of Birth:_____/_____/_____

Last Name:_____, First Name: _____, MI_____

Date of Birth:_____/_____/_____

Last Name:_____, First Name: _____, MI_____

Date of Birth:_____/_____/_____

The consent for treatment of a minor is used in the event that neither parent/guardian is available at the time treatment is needed for the minor (s). This consent will remain in effect until:___/___/___ (not to exceed one year). The authorized adult (must) be prepared to verify his/her identity.

Signature:_____

(Parent/Legal Guardian)

Signature:_____

(Witness)

Parent/Guardian physical address:_____, City:_____

State:_____, Zip:_____ Home Phone#:_____-_____-_____

Employer:_____, Work Phone#: _____-_____-_____

Health Insurance Company:_____, ID#_____

Insured Social Security Number:_____-_____-_____. Group#:_____

Authorized Adult home address:_____, City:_____

State:_____, Zip:_____ Home Phone#:_____-_____-_____

Chronic Illnesses or Allergies:_____

Date of Last Tetanus Shot: _____-_____-_____, _____

Regular Doctor/Clinic:_____

Other Information:_____