APPLICATION FOR SERVICES

(Print Clearly)

Name: First: _____ Last: _____ DOB: _____ Age: _____

SSN: _____ Gender: Male Female Cell Phone: _____

Physical Address: _____

Mailing Address: _____ Message Phone: _____

Emergency Contact: _____Relationship: _____
Contact Phone: _____

Who referred you here? **(Please complete a Release of Information for each referring agency.)**

- ☐ ASAP
- ☐ OCS
- ☐ DVR
- ☐ TVR
- ☐ VA
- ☐ Anchorage Community Mental Health
- ☐ Alaska Mental Health Trust
- ☐ Shelter: _____
- ☐ Treatment Center: _____
- ☐ Other: _____

What services do you need?

- ☐ Adult Pubic Assistance
- ☐ Food Stamps
- ☐ General Assistance
- ☐ Disability Benefits
- ☐ Medicaid
- ☐ Medicare
- ☐ Mental Health Counseling
- ☐ Low Income Housing: _____
- ☐ Medical Assistance: _____
- ☐ Bus Pass
- ☐ Clothing
- ☐ Furniture

What is your race?

- ☐ American Indian
- ☐ Alaska Native
- ☐ Inupiaq
- ☐ Athabascan
- ☐ Yup'ik/Cup'ik
- ☐ Tlingit/Haida
- ☐ Tsimshian
- ☐ Aleut
- ☐ Haida
- ☐ Tsimshian
- ☐ Asian
- ☐ Black/African-American
- ☐ Caucasian
- ☐ Native Hawaiian/Pacific Islander
- ☐ Spanish
- ☐ Other: _____

What is your ethnicity?

- ☐ Not Spanish/Hispanic/Latino
- ☐ Hispanic
- ☐ Latino/a
- ☐ Mexican-American
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Dominican

Corporation: _____ Shareholder ☐ Descendent ☐ Tribe/Village_____

English Fluency (Circle one): Excellent Good Moderate Poor Interpreter Needed? Yes ☐ No ☐

What is your current living situation?

- ☐ Homeless: Camping
- ☐ Homeless: Staying w/family or friends
- ☐ Homeless: Hotel
- ☐ Homeless: Shelter
- ☐ Homeless: Living in Car
- ☐ Halfway House
- ☐ Private Residence w/o Support Services
- ☐ Private Residence with Support Services
- ☐ Transitional Home
- ☐ Nursing Home
- ☐ Group Home
- ☐ Residential Treatment

Within the past year, have you stayed at the Anchorage Safety Center (Sleep off center)? ____ Yes ____ No.

Have you applied for housing? Yes ☐ No ☐ If yes, where did you apply?_____

Waitlist #: _____

Who do you live with?

- ☐ Live Alone
- ☐ Live with non-relative
- ☐ Live with significant other
- ☐ Live with children, How many children & ages: _____
- ☐ Live with relative
- ☐ Live with non-relative

What is your veteran status?

- ☐ Never in Military
- ☐ Retired
- ☐ Vietnam
- ☐ Afghan War
- ☐ Active Duty
- ☐ Combat
- ☐ Gulf War
- ☐ Veteran
- ☐ National Guard Reserve
- ☐ Dependent
- ☐ Iraq War
- ☐ Other: _____

What is your education background?

- ☐ H.S. Diploma Year: _____
- ☐ G.E.D. Year: _____
- ☐ Vocational Education Year: _____
- ☐ Some College Year(s) _____
- ☐ College Degree Year _____
- ☐ Other: _____

What is your employment status?

- ☐ Unemployed & not looking for work
- ☐ Unemployed & looking for work
- ☐ Employed Full-time
- ☐ Employed Part-time
- ☐ Seasonal Employment
- ☐ Day Jobs

Annual Income: $_____ Current Job:_____Desired Job: _____

Employer Name: _____ Supervisor: _____

Address: _____ Phone:_____

Work Schedule: (Circle) Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Time: _____.

Insurance Provider: _____Insurance ID#: _____

What is your health status?

- ☐ Excellent
- ☐ Good
- ☐ Moderate
- ☐ Fair
- ☐ Poor

Female, are you pregnant? ___ Yes ___No If yes, when is your due date? _____

Have you ever been tested for HIV/AIDS? Yes ☐ No ☐ If "No", would you like to be referred to get tested? Yes ☐ No ☐

Have you ever been tested for TB? ☐ Yes ☐ No

Have you ever been physically, verbally, emotionally, or sexually abused? Yes ☐ No ☐
Please Explain: _____

Have you ever been diagnosed with a physical or mental health disability? Please explain in detail:
_____
_____
_____

Are you able to work or be fully engaged in substance abuse treatment if recommended? Yes N☐ ☐
If no, please explain: _____

Identify previous substance abuse treatment programs the applicant has participated in:

Year	Program Name	City/State	Length	Completed
				Yes/ No
				Yes /No
				Yes/ No

How many times during the past 5 years has the applicant detoxed in either a detox center or a hospital? _____What medical complications have the applicant experienced while detoxing?
_____
_____

What is your substance use history?

Have you ever-injected drugs? Yes ☐ No ☐ Date of last AOD (Alcohol or Drugs) use: _____

Are you currently participating in an opioid replacement therapy program? Yes ☐ No ☐
With whom? _____

Do you use tobacco? ☐ Yes ☐ No If yes what type: _____cigarettes _____cigars other_____

Number of Prior Substance Use Treatment Admissions: _____
Number of non-treatment Substance hospitalizations in the past six months? _____
Number of Prior Mental Health Treatment Admissions? _____
Number of times that you have participated in a Self-Help group in the last 30 days? _____
In the space provided, please write a brief description of:

1) The progression of your substance use-

2) The consequences of your substance use-

What is your criminal history?

Describe current legal status: (circle all that apply)

180 day commitment	90 day commitment	30 day commitment
Case Pending	Community Sentencing	Deferred Prosecution
Deferred Sentence	Emergency Commitment	Incarcerated
Informal Probation	No Involvement	Probation/Parole-
length_____		
Protective Custody	Office of Children's Services	Court Order for Treatment

Number of Arrests in the last 30 days: _____

Do you have a Domestic Violence Protective Order in place? ☐ Yes ☐ No

Are you currently safe? Yes ☐ No ☐

SUBSTANCE USE INFORMATION:

Primary substance: _____

Frequency of use: daily weekly 1-3 times/month

Age of first use: _____

Method of use: Inhalation IV injection Nasal Oral/smoking

Secondary substance: _____

Frequency of use: daily weekly 1-3 times/month

Age of first use: _____

Method of use: Inhalation IV injection Nasal Oral/smoking

Tertiary substance: _____

Frequency of use: daily weekly 1-3 times/month

Age of first use: _____

Method of use: Inhalation IV injection Nasal Oral/smoking

Does the applicant currently use tobacco products? Yes / No

DUAL DIAGNOSIS:

Does the applicant have an Axis I (DSM-5) mental illness? Yes / No

If YES, What is the diagnosis? _____

Identify the current medications taken to stabilize the mental illness: _____

Who currently provides the applicant's psychiatric care?

Name: _____ Phone: _____

Is the applicant eligible for SSI/SSDI benefits? Yes / No

Is he/she currently receiving these benefits? Yes / No

Is the applicant receiving Interim Assistance? Yes / No

If applicable, include your Medicaid # _____

ACKNOWLEDGEMENT:

I certify that all information contained in this application is true and correct to the best of my knowledge. I understand, have read, or heard read to me the "Rights and Responsibilities". I understand that payment is required before services are rendered and if I can't make payment(s), I will be referred to an agency that will determine eligibility to authorize payment for services. I understand that I will be placed on the waitlist until payment is received at which time, I will be contacted to resume services which I am applying for.

_____

Print Name

_____ _____

Participant Signature Date

FOR OFFICE USE ONLY

Interview/Intake Appt. Date: _____ Time: _____ Assigned Assessor: _____