IT IS IN THE SHELTER OF EACH OTHER THAT THE PEOPLE LIVE.

Irish Proverb

Community Connections
Children's Mental Health
Request for Services

Dear Parent/Guardian:

Children's Mental Health has highly trained counselors and staff who will meet with you to discuss concerns you have about your child's behaviors and emotions. Our staff can provide service in the places which work best for you and your child either the office, your home, or your child's school for troubling behaviors and feelings.

After providing us with some written information and giving it to the front desk it will be date stamped and a Supervisor will contact you within two business days. This first contact will be to confirm that your enrollment packet has been received and discuss with you the next steps in the enrollment process. Please complete the forms to the best of your ability. We rely on the information in order to contact you. If you would like some help completing the forms call Community Connections and ask to speak with a Service Coordinator in Children's Mental Health. **Please understand that your child is not considered a client of Community Connections until he/she has had an assessment with a counselor and the counselor determines that services are appropriate for your child.**

Each week enrollment packets are reviewed by the counselors and we attempt to have families meet with a counselor within two weeks of turning in the packet. During the last year we have had longer wait times due to many families asking for our services. We will discuss wait times with you in the initial phone call.

Please know that if you have any questions or concerns about this process we are available to speak with you Monday through Friday from 8 am to 5 pm.

I acknowledge that my child is not considered a client of Community Connections until he/she has been assessed by a clinician and the clinician determines mental health services are appropriate for my child.

Signature:_____

Date:_____

721 Stedman St.
Ketchikan, AK 99901
Tel: (907) 225-7825
Fax: (907) 225-1541

P.O. Box 420
Craig, AK 99921
Tel: (907) 826-3891
Fax: (907) 826-3892

CLIENT INFORMATION

Patient Name: _____ Social Security Number: _____-_____-_____

Date of Birth: _____/_____/_____ Sex: M / F (Circle one)

Address:_____
(Street) (City/State/Zip)

Home Phone: (_____) _____-_____ E-mail Address: _____

Parent/Guardian:_____

Employer Name: _____Employer Phone Number: (_____) _____

Employer Address: _____
(Street) (City/State/Zip)

How did you hear about our services? _____

School Attending: _____Grade:_____

P**erson responsible for bill or parent (Complete only if different from client)**
Guarantor Name: _____ Social Security Number: _____ - _____ - _____
Relationship to Patient: (please check): ( ) self, ( ) spouse, or ( ) parent Date of Birth: _____/_____/_____
Address: _____ Phone Number: _____
Employer Name: _____ Employer Phone Number: (___) _____
Employer Address: _____
(Street) (City)
Who to call for an emergency:
Name: _____ Address:_____
Home Phone: (__) _____ - _____ Work Phone: (___) _____-_____ Relationship: _____

PRIMARY INSURANCE INFORMATION
Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F
SECONDARY INSURANCE INFORMATION
Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Community Connections. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____

CLIENT INFORMATION PART 2

Ethnicity (Circle ONE):		
Not Spanish/Latino Mexican	Chicano/Other Hispanic	Cuban
Hispanic-specific origin not specified	Mexican American	Puerto Rican
Spanish/Hispanic Latino	Unknown	

Race (Circle ALL THAT APPLY):			
Aleut	American Indian	Asian	Athabascan
Black/African American	Caucasian	Haida	Inupiat
Native Hawaiian	Other Alaska Native	Pacific Islander	Tlingit
Tsimshian	Yupik	Other	Unknown

Annual Household Income (Circle ONE):			
$0-$999	$1,000-$4,999	$5,000-$9,999	$10,000-$19,999
$20,000-$29,999	$30,000-$39,999	$40,000-$49,999	$50,000 and above

Is ANYONE in the family a VETERAN?_____

Three Strengths of My Child:

1. _____
2. _____
3. _____

Here is a list of some things that parents/people can be concerned about. Please mark anything you would like to speak with a counselor about (Check ALL THAT APPLY):

	Major events in child's life in the last year		Trouble with friends, or being social
	Angry or defiant		Worries, seems stressed, lonely
	Highly active and difficult to manage		Talks about hurting self or others
	Moody, easily frustrated, sad		Trouble being successful in school
	Using alcohol or drugs		Trouble doing what I ask
	Major health concerns		Destructive or violent

CLIENT INFORMATION PART 3

Please describe the most urgent concerns you have for your child and rate the seriousness of the issue on the following scale:

0= Not significant 1= Once in a while 2= Moderate 3= Severe

1. _____ 0 1 2 3
2. _____ 0 1 2 3
3. _____ 0 1 2 3
4. _____ 0 1 2 3

What else is important for us to know about your child and family?

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