



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)

Gender: \_\_\_\_\_ Sexual Orientation: \_\_\_\_\_ Gender Expression: \_\_\_\_\_

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: \_\_\_\_\_

## Person 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

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

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

| <b>Annual Household Income (Circle ONE):</b> |                   |                   |                    |
|--|-------------------|-------------------|--------------------|
| \$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):

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

