



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 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: _____

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

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	Athabaskan
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):

<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

Concerns of Risk to Self or Others Please check all that apply

<input type="checkbox"/> Risk to self , talks about harming self	<input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Has a history of harming themselves	<input type="checkbox"/> Has a plan for suicide, means and accessibility
<input type="checkbox"/> At risk of self- mutilation (eg. cutting)	<input type="checkbox"/> Has history of attempts of suicide
<input type="checkbox"/> Risk to others, Physical aggression	
<input type="checkbox"/> Risk to other, verbal aggression	

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?

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Adverse Childhood Experiences Questionnaire (ACE-Q) Child

Children 12 years and younger: To be completed by Parent/Caregiver

Today's Date: _____

Child's Name: _____ Date of birth: _____

Your Name: _____ Relationship to Child: _____

Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's therapist in assessing their health and determining guidance. Please read the statements below. Count the number of statements that apply to your child and write the total number in the box provided.

Please DO NOT mark or indicate which specific statements apply to your child.

1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box.

Section 1. At any point since your child was born...

- Your child's parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt
- Someone touched your child's private parts or asked your child to touch their private parts in a sexual way
- More than once, your child went without food, clothing, a place to live, or had no one to protect her/him
- Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- Your child lived with someone who had a problem with drinking or using drugs
- Your child often felt unsupported, unloved and/or unprotected

2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number in the box.

Section 2. At any point since your child was born...

- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/his primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child often saw or heard violence in the neighborhood or in her/his school neighborhood
- Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion

Adverse Childhood Experiences Questionnaire (ACE-Q) Teen Self-Report

Teen 13+ years old: To be completed by Youth

Today's Date: _____

Your Name: _____ Date of birth: _____

Many children experience stressful life events that can affect their health and development. The results from this questionnaire will assist your therapist in assessing your health and determining guidance. Please read the statements below. Count the number of statements that apply to you and write the total number in the box provided.

Please DO NOT mark or indicate which specific statements apply to you.

1) Of the statements in section 1, HOW MANY apply to you? Write the total number in the box.

Section 1. *At any point since you were born...*

- Your parents or guardians were separated or divorced
- You lived with a household member who served time in jail or prison
- You lived with a household member who was depressed, mentally ill or attempted suicide
- You saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put you down in a way that scared you OR a household member acted in a way that made you afraid that you might be physically hurt
- Someone touched your private parts or asked you to touch their private parts in a sexual way that was unwanted, against your will, or made you feel uncomfortable
- More than once, you went without food, clothing, a place to live, or had no one to protect you
- Someone pushed, grabbed, slapped or threw something at you OR you were hit so hard that you were injured or had marks
- You lived with someone who had a problem with drinking or using drugs
- You often felt unsupported, unloved and/or unprotected

2) Of the statements in section 2, HOW MANY apply to you? Write the total number in the box.

Section 2. *At any point since you were born...*

- You have been in foster care
- You have experienced harassment or bullying at school
- You have lived with a parent or guardian who died
- You have been separated from your primary caregiver through deportation or immigration
- You have had a serious medical procedure or life threatening illness
- You have often seen or heard violence in the neighborhood or in your school neighborhood
- You have been detained, arrested or incarcerated
- You have often been treated badly because of race, sexual orientation, place of birth, disability or religion
- You have experienced verbal or physical abuse or threats from a romantic partner (i.e. boyfriend or girlfriend)



**Community Connections
Children's Mental Health
Affirmation of Authority to Consent to Treatment**

721 Stedman Street
Ketchikan, Alaska 99901

PO Box 420
Craig, Alaska 99921

Parent/Guardian: _____ Child's Name _____

Date of Birth: _____ Phone Number: _____

Address: _____

I, _____ affirm that I have the ability based on the custody order in place for
_____ (child) to enroll them in mental health services such as counseling, case
management, behavioral support services, or psychiatry, without the consent of any other individuals. I am
making this affirmation based on my understanding of my parental rights and I am aware that there may be
legal consequences to misrepresenting my rights. I understand that I should consult with an attorney or other
appropriate source of legal advice if I have any uncertainty or require clarification about my authority in this
decision **before** consenting to treatment.

X _____
Signature of person giving permission Relationship Date

Signature of Witness Date

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

The Federal rules restrict any use of the information to criminally investigate for prosecution of the consumer. Community Connections will not exchange any information from any other person/agency to any other person/agency, and will only release with permission, information generated by Community Connections, its staff or contractors.



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OF EACH OTHER THAT
THE PEOPLE LIVE.

IRISH PROVERB

AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

Regarding: _____ Date: _____
(Individual's Name)

Also Known As: _____ Date of Birth: _____

I authorize Community Connections

To (check all that apply)

☐ X ☐ Receive and use the following protected information, and/or

☐ X ☐ Disclose the following protected information generated by Community Connections to:

Ketchikan Gateway Borough School District

(Name of person/organization to exchange information)

Check the Specific description/type of information:

☒ Assessment ☒ IEP/IFSP ☒ Progress Notes ☒ Eligibility ☒ Financial
☒ Medical Information ☒ Psychiatric Assessment ☒ Treatment Planning

☒ Other Application for Community Connections

This protected information is being used or disclosed for the following purposes:

Facilitation for intake and/or continued services

This authorization will be valid through the entire treatment period with Community Connections unless revoked by customer in writing.

I understand this authorization is voluntary and may be revoked at any time by signing the revocation section on the back of this release, or by notifying the individual(s) or organization releasing this information in writing; the revocation will not have any effect on any prior actions taken. I understand that I may receive a copy of this authorization and view and/or copy the information described on this authorization if requested.

Customer's Signature _____ Date _____

Parent/Legal Representative's Signature _____ Date _____

Witness Signature _____ Date _____

NOTE: This authorization was revoked on : _____ (see reverse or attached revocation)
(Date)

Recipient Information: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if held by another party 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 patient.

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Fax: (907) 826-3892

REVOCATION SECTION

I do hereby request that this authorization to release the information of:

_____ described on the reverse side of this form,
(Printed name of customer)

be rescinded, effective _____. I understand that any action taken on this
(Date)

authorization prior to the rescind date is legal and binding.

Signature of Customer

Date

Parent/Guardian Signature

Date

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I authorize Community Connections

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☐ X ☐ Disclose the following protected information generated by Community Connections to:

(Name of person/organization to exchange information)

Check the Specific description/type of information:

☒ Assessment ☒ IEP/IFSP ☒ Progress Notes ☒ Eligibility ☒ Financial
☒ Medical Information ☒ Psychiatric Assessment ☒ Treatment Planning

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Parent/Legal Representative's Signature Date

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Date

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