Denali Family Services Referral Information

Outline of Services

Denali Family Services is a non-profit agency that provides mental health services for SED youth and their families. If your family qualifies, we can offer a wide range of services which include:

- Mental Health Assessments
- Case Management Services
- Individual and Group Skill Development
- Individual, Family and Group Psychotherapies
- In-school Support
- Therapeutic Foster Care (TFC/MTFC)
- Home Based Support
- Little Steps Pre-School (for ages 3-5 years)
- Psychiatric Evaluations and Medication Management

In order to be eligible for services, you would need to answer 'yes' to the following questions:

1. Is the child or youth under 21 years of age?
2. For the past 6 months, has your child been in danger of leaving his or her home or school setting due to his or her behavior or mental status or
3. During the past 6 months has your child been in a psychiatric hospital, residential treatment center, or foster care setting due to his or her behavior or mental status?

You must answer 'no' to the following question:

1. Can the child's behavior or condition be explained by a non-mental health disability or other medical condition?

Referral for Services

If your answers to these questions indicate that your child may qualify for services, please contact the Intake Coordinator at (907) 222-2347 to begin the referral process. Please fill out our confidential application which provides us with the applicant's current information and the type of service being applied for. In order for us to make the most informed decision regarding eligibility we ask that you include specific records with your application. If you cannot provide these records, please make sure to fill out the DFS release(s) of information that will allow us to access them from the youth's previous service providers (please make sure that releases have witness signatures).

Referrals are staffed weekly through an Intake Committee in order to determine if applicants are eligible for services. A complete mental health assessment will be needed to make a final determination. If your family does not qualify for services with DFS, we will provide you with an alternate referral source.

Thank you for your interest in our services and we look forward to working with you!

Office Use Only
Intake Committee Review
Date_______________
ͥAccept ͥRefer Out

Denali Family Services

CONFIDENTIAL APPLICATION

Return Application to:
Intake Coordinator
Denali Family Services
1251 Muldoon Rd, Suite 116
Anchorage, AK 99504
Phone: 907-222-2347
Fax: 907-222-2397

Referred By (Name): ______________________________ **Legal Guardian?** Yes☐ No☐

Agency (if applicable): ______________________________ **Referral Date**: ____________

Contact Information:
Phone: ________________
Fax: ________________
How did you hear about us?
____

Service Needed (please check one):
☐ Wraparound Services ☐ Wraparound, Valley
☐ Therapeutic Foster Care ☐ Therapeutic Foster Care, Valley
☐ Little Steps Pre-School

Applicant Information

Last Name:		**First Name:**	
Birth Date:	**Age:**	**SSN:**	**Gender:** ☐ M ☐ F
School:	**Grade:**	**Education Plan (IEP):** Yes☐ No☐	**Ethnicity:**

Current Placement: ☐ Home ☐ Hospital ☐ RTC ☐ Shelter ☐ Foster Home ☐ Other
Name of Hospital, RTC or Shelter :______________________________
Or Youth currently resides with:______________________________
Address:______________________________ Phone: ________________

Guardian 1:________________	**Guardian 2:** ________________
Phone: ________________	**Phone:** ________________
Address:________________	**Address:**________________

Most Current Psychiatric Diagnosis	**Code**
Axis I: ________________	( )
Axis II: ________________	( )
Axis III: ________________	( )
Axis IV: ________________	( )
Axis V: ________________	( )
Date of diagnosis: ________________	
Diagnosed by: ________________	

Insurance/Medicaid Information:

Medicaid/Denali Kid Care: Yes☐ No☐

If Yes, Include Number and Resource Code:

____

Private: Yes☐ No☐

If Yes, include Insurance Name and Number:

____

Insurance Telephone: ________________

Please include the following information (if applicable):

☐ **Release of Information Form(s)** (***Required for all applicants***)

☐ Custody Document (must be *legal*)

☐ Psychological and/or Psychiatric Evaluations

☐ Discharge Summaries from Previous Placements and/or Treatment Plan Reviews

☐ Placement History (ex. Foster Homes, Hospitals, Residential Treatment, Relatives, etc.)

Behavioral Information Questionnaire

Client Name:________________________________ Date:______________

Please tell us why you are seeking counseling (check as many as necessary)

- ☐ Drug or alcohol use
- ☐ Aggressive behaviors (fighting, hitting, kicking)
- ☐ Argues, talks back, defiant
- ☐ Mood swings
- ☐ Depressive symptoms
- ☐ Family difficulties
- ☐ Legal difficulties
- ☐ Academic difficulties
- ☐ Social setting difficulties
- ☐ Hyperactivity
- ☐ Suicidal (thought or attempt)
- ☐ Homicidal (thought or attempt)
- ☐ Difficulty making/keeping friends
- ☐ Employment problems
- ☐ Parenting skills
- ☐ Anger management
- ☐ Grief or loss
- ☐ Relationship conflicts
- ☐ Hallucinations/Delusions
- ☐ Anxiety
- ☐ Other:
- ☐ Other:

Please describe briefly when the problem(s) began:

____
____
____
____
____

How would you describe the problem(s) now?

____
____
____
____
____

Please rate the following on a scale of 1 to 10, with 1 being awful and 10 being wonderful (1 2 3 4 5 6 7 8 9 10)

How were you feeling about the problem(s) at the time you called?_______

How are you feeling about the problem(s) right now?_______

How confident are you that counseling will help you resolve the issue(s)?_______

Thank you for taking the time to complete this questionnaire.

If you have any questions or need any assistance with this, please call the Intake Coordinator at 222-2347.

Release of Information

I _________________________ authorize the release of clinical information regarding_______________________:

From/to Denali Family Services from/to: ____
(Specify Agency or Individual)

___ Clinical Summary
___ Continuing Care Plan
___ Medical/Dental Aftercare
___ Intake Assessment
___ Psychiatric Review(s)
___ Psychological Assessment(s)
___ Substance Abuse Assessments
___ Clinical and Laboratory Results
___ Consultations
___ Discharge Summary
___ Immunization Records
___ Medical History/Physical Exam
___ Special Education Records
___ Verbal exchange of all information to aid in assessing and/or treating client
___ Physician Orders
___ Progress Notes
___ Psychiatric Assessment(s)
___ Treatment Plan & Need Sheets
___ Treatment Plan Review(s)
___ UA Results
___ Other:____

This information is being released/ requested for the following purpose: ____ Legal Request ____ Further Treatment ____ Insurance Claim ____ Other (specify): ____

PROHIBITION ON REDISCLOSURE: *This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations restrict any use of this information to investigate or prosecute any alcohol or drug abuse patient.*
Disclosure of patient information is permitted with the patient's written consent; however, disclosures to central registries and in connection with criminal justice referrals must meet the following specific regulations: (42 CFR 2.32 and 2.33). This information disseminated from Denali Family Services.

This information may be used for continuation of care. I understand this authorization will expire on __________________________ (if no date entered, this release will expire 90 days from date signed), or ***6 MONTHS FOLLOWING THE DATE OF DISCHARGE FROM ANYDENALI FAMILY SERVICES PROGRAM***, revocation of custody or guardianship, or upon written revocation, whichever comes first. This authorization may be revoked prior to the expiration, but not retroactively. Photostatic and/or facsimile copies of this authorization will be considered as valid as the original.

I acknowledge that the information to be released is protected by Federal law and may include information regarding:
drug/alcohol abuse_______ sexually transmitted diseases______ HIV____ Hepatitis B_____

My initials above and signature below authorizes the mutual exchange of this information. If I am involved in Child in Need of Aid proceedings, I am waiving the privileges provided by Child in Need of Aid Rule 9 only with regards to the party named above. If I am a child over the age of twelve that is involved in Child in Need of Aid proceedings, I have had the opportunity to consult with my guardian ad litem or attorney.

____ ________________________
Client *Date*

____ ________________________
Guardian Ad Litem for Child under 12 involved in CINA proceedings *Date*

____ ________________________
Parent *Date*

____ ________________________
Guardian/Placing Worker/Legal Representative *Date*

____ ________________________
Witness *Date*

Social Security Number:_________________________	Date of Birth: ___________________________