Aleutian Pribilof Islands Association Patient Registration

Anchorage (907) 276-2700 **Anchorage Behavioral Health** (907) 222-9764
Atka (907) 839-2232 **Nikolski** (907) 576-2204 **St. George** (907) 859-2254
Unalaska Primary Care (907) 581-2742 **Unalaska Behavioral Health** (907) 581-2751

CLEAR FORM

Patient/Client Information

First Name: Middle: Last:

Date of Birth: SSN: Gender: ☐Male ☐ Female Non-Binary Identify As:

Address: City: State & Zip:

Please check preferred number for contact:

☐Home Phone: ☐Cell Phone: ☐Work Phone:

Can APIA leave a confidential voice message? ☐Yes ☐ No Ok to send appt reminders by text?☐

Email: Internet Access?☐ Yes ☐No Ok to send email?☐ (Emails are not encrypted)

Number of People that live with you: ___ Number of Children under 18 in Household:_____

Marital Status: (check one) Never Married-Single Married Cohabitating Divorced Separated Widowed

Reason you are seeking Behavioral Health services today:

Additional Parent/Guardian Information (Responsible Party) ☐Same as Patient

First Name: Middle: Last:

Address: City: State & Zip:

Please check preferred number for contact:

☐Home Phone:_____ ☐Cell Phone: _____ ☐Work Phone:_____

Email: Date of Birth: Employer:

Tribal Affiliation/Ethnicity/ Language

Tribal/Native Corporation: Tribal Enrollment #

CIB: ☐Yes ☐ No

CIB Card in Medical Record? ☐Yes ☐No

Ethnicity: ☐Not Spanish/Hispanic/ Latino ☐ Spanish/Hispanic/ Latino ☐Unknown ☐Decline ☐Puerto Rican ☐Cuban ☐ Mexican American

Race (check all that apply): ☐Alaska Native: ☐American Indian: ☐Black/African American ☐Native Hawaiian ☐Pacific Islander ☐White ☐Asian ☐Other ☐Don't know ☐Decline

Primary Language if not English: ☐ Uuangam Tunuu ☐ Spanish ☐Russian ☐Tagalog ☐Other:_____

Translator/Interpreter Required: ☐Yes ☐No

Employment

Employment Status:

☐Active Military Duty ☐Full Time ☐Part Time ☐Disabled ☐Retired ☐Student

☐Subsistence or Seasonal ☐Unemployed looking for work ☐Unemployed ☐Homemaker

Employer:		
Address:	City:	State & Zip:

Primary Income Source: (check one)

Employment Public Assistance/Welfare Pay Alaska PFD Parent's Income Child Support

___Social Security Disability (SSDI) Social Security Supplemental Security Inc (SSI)

Spouse/Significant Other's Income Unemployment Compensation Self-Employment Other____________

Education/Housing

Education: (check one)

High School Diploma GED Vocational Training Special Ed Bachelor's Degree (BA,BS)

Graduate Work (no degree) Master's Degree Doctorate/Professional degree Post-Secondary 2yrs(include AA degree)

No Schooling Other____________

If K-11, What is the last grade you completed?______________________ Currently attending grade school? Yes No

Living Arrangement: (check one)

Private Residence(House, Apt, Condo, Trailer, etc) Someone Else's Private Residents(House, Apt, Condo Trailer, etc)

Private Residence with Supportive Services Assisted Living Facility Corrections/Detention Facility Foster Care

Group Home Halfway House Homeless Nursing Home Shelter Other___________________

How do you feel about your living conditions?

Very Dissatisfied Dissatisfied Neither Satisfied Very Satisfied Don't know

Health and Treatment Information

If Female, Are you pregnant? Yes No Unsure

Are you an IV Drug User? Yes No

Date of last physical exam?___

Have you ever been in the hospital or residential treatment for substance abuse? Yes No

Have you been in the hospital in the last 6 months for medical problems caused by substance abuse? Yes No

How many inpatient mental health hospitalizations have you had? (If none, enter 0) ___

Legal History: Number of Arrests in the past 30 days (If none, enter "0") ___

Emergency Contact Information

Emergency Contact:		Relationship:
Address:	City:	State & Zip:
Home Phone:	Cell Phone:	Email :

Next of Kin ☐ **Same as Emergency Contact**	
Next of Kin:	Relationship:
Address:	State and Zip:
Home Phone:	Email:

Insurance Information (Please Provide your ID card)

Please list **ALL** members (people) in the household.
(spouse, child, foster child, grandparent, aunt, uncle, etc.)

Full Name	Relationship	Age

Total Annual Household Income Estimate:

This information will help us screen if you are eligible to apply for the APIA Sliding Fee/Discount Schedule.

☐Under $15,000 ☐$15,000-$30,000 ☐$31,000 -$41,000 ☐$42,000-$52,000 ☐$53,000-$63,000
☐$64,000-$74,000 ☐$75,000-$85,000 ☐$86,000-$96,000 ☐$97,000-107,000 ☐Above $108,000

Medicare: ☐Yes ☐No ☐Primary ☐Secondary Effective: Exp Date: #:
Medicaid: ☐Yes ☐No ☐Primary ☐Secondary Effective: Exp Date: #:
Denali Kid: ☐Yes ☐No ☐Primary ☐Secondary Effective: Exp Date: #:

Private Insurance: ☐Yes☐ No (please provide your ID card)	Insurance Company:	
Policy Holder:	Policy #:	Group #:
Other Insurance:	Policy #:	Group #:
Veteran: ☐Yes ☐ No	VA Benefits: ☐Yes ☐No	Service Branch:
Service Entry Date:	Service Exit Date:	Vietnam Service Indicated? ☐Yes ☐No

☐I DO NOT have any other insurance coverage from any other source other than the above mentioned

Self Pay/Guarantor:		Relationship:
DOB:	Phone:	Address:
City:	State/ Zip:	Effective Date:

Referral Information

☐Self-Referral ☐Family/Relative ☐Friend ☐Behavioral Health Provider ☐ Medical Provider ☐Court

☐Clergy ☐School ☐Social Services ☐SCF ☐OCS ☐Other:

Medical Referral: Would you like to be contacted by the Medical RN? Yes No
Or a referral for a physical exam? Yes No

Advance Care Planning

I have an Advance Health Care Directive, also known as a living will, Durable Power of Attorney, POLST or Comfort One:
☐Yes ☐No ☐Pt Less than 18 yrs. ☐Unable to Access: Reason_____

I have a Psychiatric Advance Directive: ☐Yes ☐No ☐Pt Less than 18 yrs. ☐Unable to Access: Reason_____

If yes, is your Advance Health Care Directive on file? ☐Yes ☐No Last date reviewed:_____

If no, would you like information regarding Advance Health Care Directives? ☐Yes ☐No

Consent

Consent: I hereby certify that all information provided is true and correct to the best of my knowledge and I give my consent for APIA to administer–assessments and/or–treatments to perform behavioral health or medical services. APIA operates as an integrated health system and may refer patients as necessary.

I ____________________________(printed name) authorize APIA Behavioral Health Providers to disclose general mental health, housing, drug or alcohol use information to APIA staff for the purpose of program evaluation and grant reporting. I understand I may be contacted to complete a questionnaire over the telephone or by email. I understand that I may revoke this authorization at any time preventing future use. Unless I revoke my consent earlier, this consent will expire automatically one year from active services at APIA.

Assignment of Medical Insurance Benefits: I hereby agree to full responsibility for all expenses incurred by or on account of this patient and assign to APIA, Inc. any and all insurance benefits due to me to the full extent of my financial obligation and said providers. This is certification and authorization is valid until otherwise revoking in writing.

I consent to full financial responsibility for services rendered at APIA, Inc.

Signed: ____ Date: ___________________________

Guardian: ____ Date: ___________________________

Release of Confidential Information (ROI) on file? ☐Yes ☐No