Alaska Crossings Application Process

Step 1: Preliminary Screening

Submit the following by fax, email or postal mail **as early as three months prior to your preferred admission date.**

Once we are within a month of the admission date, an intake coordinator will call you to update the forms by phone and send them on to clinical and medical staff for review.

Preliminary Screening Forms!

Fill out all forms thoroughly and completely.

Releases of Information!

If there are other people that Alaska Crossings may need to communicate with (such as therapists, schools, step-parents, etc.), fill out a separate authorization for the release of protected health information form for each individual or agency.

Previous Clinical History!

If the youth is currently receiving services from another agency, or has received services in the past, our clinician may need to review records before proceeding with the interview. Records requests can sometimes take several weeks, so if you already have any documentation from other agencies (such an assessment or discharge summary) it is best to send it to us directly.

Have Questions?

Contact our intake coordinators Monday-Friday 8:00am-5:00pm by phone or by email!

Please note that final acceptance into the program is not determined until all three steps are complete.

We will temporarily secure an admission date once our clinician and medical staff have determined that Alaska Crossings would be an appropriate program for the youth. It is your responsibility to provide all information and documentation requested by the intake coordinator so that this determination can be made.

Step 2: Assessment Interview

Once it has been determined that Alaska Crossings would be an appropriate program for the youth, you and the youth will speak with an Alaska Crossings clinician by phone. The clinician may also speak with other individuals or agencies involved in the youth's care.

Step 3: Admissions Packet

Once the clinician has clinically approved the youth for participation in Alaska Crossings, an intake coordinator will contact you to ask you a few brief questions. The intake coordinator will then fill out the Alaska Crossings Admissions Packet for you and will send it to you by fax or secure email. You and the youth will review the forms and sign/date all signature lines. You may also be asked to submit proof of insurance and/or immunization records at this time.

If at any time in the process a clinician or medical control officer determines that Alaska Crossings is not an appropriate program for the youth, you will be given recommendations for alternative services.

AICS Alaska Crossings
PO Box 1231, Wrangell, AK 99929
Phone: 907-874-2371, Toll Free Phone: 866-550-2371, Fax: 866-223-0888
intake@alaskacrossings.org, www.alaskacrossings.org

CLIENT INFORMATION SHEET

YOUTH IDENTIFYING DATA

Name *(First Middle Last):* _____ Other Names: _____ ☐ M ☐ F

DOB: _____ **Age:** _____ **SSN:** _____ Race/Ethnicity: _____

Hair: _____ Eyes: _____ Height: _____ * Weight: _____ Shoe Size: _____

* Minimum weight required for participation in the Alaska Crossings program is 90 lbs

CUSTODY INFORMATION

Who has legal custody of the youth?

Name: _____ DOB: _____

Relationship: _____

Mailing Address: _____

Address *City* *State* *Zip*

Street Address: _____

Address *City* *State* *Zip*

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Employer: _____

Email Address:

Is custody shared?

☐Yes ☐No

If yes, fill out this section:

Name: _____ DOB: _____

Relationship: _____

Mailing Address: _____

Address *City* *State* *Zip*

Street Address : _____

Address *City* *State* *Zip*

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Employer: _____

Email Address:

Date custody expires, or date of next custody hearing (*if applicable*)**:**

CONTACT INFORMATION

Who is currently the preferred contact person for this youth? _____

If not listed as guardian above…

Relationship: _____ Phone: _____

Location:

With whom is the youth currently living?

_____

If not listed as guardian above…

Relationship: _____ Phone: _____

Location:

Can we leave messages identifying ourselves as Alaska Crossings?

☐Yes If yes, list phone number(s):

☐No If no, how do you prefer that we contact you?

EMERGENCY CONTACTS

Individuals to contact *if the guardian cannot be reached*

Emergency Contact 1	Name:	Relationship:	
	Cell Phone:	Home Phone:	Work Phone:
Emergency Contact 2	Name:	Relationship:	
	Cell Phone:	Home Phone:	Work Phone:

FAMILY INFORMATION

Please list the family members and other persons living in the youth's home:

Name	Relationship to Youth	Age

Biological Mother

Name: _____ Age (current): _____ Age When Youth Was Born: _____

Current marital status: ☐Married ☐ Divorced ☐Single ☐ Partnered ☐Widowed

Location (if not listed on previous page):

Biological Father

Name: _____ Age (current): _____ Age When Youth Was Born: _____

Current marital status: ☐Married ☐ Divorced ☐Single ☐ Partnered ☐Widowed

Location ((if not listed on previous page):

Is the youth adopted? ☐Yes ☐No If yes, does the youth know? ☐Yes ☐ No

BEHAVIORAL HEALTH INFORMATION

Person filling out form: **Relationship to youth:** **Date:**

How does the youth feel about attending Alaska Crossings?

OR... ☐ The youth does not know about Alaska Crossings at this time

PROBLEMS AND GOALS

What are the three biggest problems you would like the youth to work on, improve or resolve?	1)
	2)
	3)
What are the 3 biggest goals, desires or wishes the youth has for him/herself?	1)
	2)
	3)

SUBSTANCE USE

IN THE LAST 4 MONTHS, which of the following has the youth used/abused?

☐ Alcohol ☐ Marijuana ☐ Cigarettes ☐ Chewing tobacco ☐ Hallucinogens (i.e. mushrooms)

☐ Cocaine ☐ Inhalants ☐ Methamphetamines ☐ Intravenous (IV) drugs ☐ Spice ☐ Bath salts

☐ Prescription medication (not prescribed to him/her) If so, what? _____

☐ Over-the-counter (OTC) medicine (with intent to get high) If so, what? _____

☐ **NONE OF THESE**

ACADEMICS

Current (or most recent) School Status

☐ Good grades ☐ Average grades ☐ Poor grades

☐ Frequently absent/truant ☐ Suspended or expelled ☐ Has an IEP

What is the youth's IQ? _____ If untested/unknown:

☐ Probably above average

☐ Probably near average

☐ Probably below average

What school does the youth attend? _____ **Current Grade** _____

School Contact (name and title):

DIAGNOSIS

Please check if the youth has been diagnosed with the following:

☐ Attention Deficit/Hyperactivity Disorder ☐ Oppositional Defiant Disorder ☐ Depression

☐ Post-traumatic Stress Disorder (PTSD) ☐ Reactive Attachment Disorder ☐ Anxiety disorder (panic, social phobia, etc.)

☐ Eating Disorder ☐ Bipolar Disorder ☐ Asperger's Disorder

☐ Developmental delay or disorder ☐ Autism ☐ Prenatal exposure to substances or Fetal Alcohol Spectrum Disorder

☐ NONE OF THESE

Check the boxes that most closely describe the youth's

BEHAVIORS, EMOTIONS, SYMPTOMS

		(past)	(current)			
	Never	More than 4 months ago	1 or 2 times in the last 4 months	1+ times a month	1+ times a week	Daily
1. Verbal outbursts (i.e. yelling, swearing)	☐	☐	☐	☐	☐	☐
2. Threatens to harm others (verbal)	☐	☐	☐	☐	☐	☐
3. Threatens to harm self	☐	☐	☐	☐	☐	☐
4. Shoplifts or steals from non-family	☐	☐	☐	☐	☐	☐
5. Still affected by past traumatic events	☐	☐	☐	☐	☐	☐
6. Unreasonably fearful, anxious or nervous	☐	☐	☐	☐	☐	☐
7. Seems depressed, hopeless, apathetic	☐	☐	☐	☐	☐	☐
8. Talks about death or wishing to not be alive	☐	☐	☐	☐	☐	☐
9. Overeats, or refuses to eat	☐	☐	☐	☐	☐	☐
10. Struggling with sexuality	☐	☐	☐	☐	☐	☐
FOR QUESTIONS 11–18, PLEASE PROVIDE SPECIFIC EXAMPLES OR DETAILED INFORMATION						
11. Harms others (physical)	☐	☐	☐	☐	☐	☐
Please describe:						
12. Premeditated violence	☐	☐	☐	☐	☐	☐
Please describe:						
13. Harms self (non-suicidal)	☐	☐	☐	☐	☐	☐
Please describe:						
14. Suicide attempt	☐	☐	☐	☐	☐	☐
Please describe:						
15. Damages property	☐	☐	☐	☐	☐	☐
Please describe:						
16. Behaves sexually inappropriately toward others	☐	☐	☐	☐	☐	☐
Please describe:						
17. Hears voices/sees things others do not	☐	☐	☐	☐	☐	☐
Please describe:						
18. Intoxicated by alcohol or drugs	☐	☐	☐	☐	☐	☐
Please describe:						

SERVICES

CURRENTLY what type of behavioral health care is the youth receiving?

- ☐ None
- ☐ Outpatient therapy……. Organization and/or Provider: _____
- ☐ Outpatient Psychiatry… Organization and/or Provider: _____
- ☐ Residential…….. Facility and Provider: _____
- ☐ Inpatient hospital …… Facility: _____ Reason for Admission: _____
- ☐ Other…….. Describe:

Does the youth have involvement with the **Office of Children's Services** ☐Yes ☐ No If yes, name of social worker:

Does the youth have involvement with the **Division of Juvenile Justice?** ☐Yes ☐ No If yes, name of probation office and reason for involvement:

IN THE PAST, has the youth ever received outpatient therapy, been in residential treatment or hospitalized for mental/behavioral health reasons? ☐ Yes ☐ No If yes…

When	Agency/Facility	Reason for Admission	Reason for Discharge

If for any reason the youth is not able to attend Alaska Crossings, what other treatment or placement(s) will you consider and/or pursue?

MEDICAL SCREENING FORM

Name of Youth:	**Date Completed:**
When did the youth last see a doctor?	**Reason?**

MEDICATIONS

Please list all medications taken by the youth

☐ No medications

Medication:	Dosage:	Dosage time(s):	How long on this medication?	Date medication or dosage last changed:

ALLERGIES

☐ No Known Allergies

	Allergen	Type of Reaction
To medication:		
To food:		
To environmental allergens:		

Does the youth have an epi-pen? ☐ Yes ☐ No

DOES THE YOUTH EXPERIENCE….

	How often?	Other Details:
☐ Enuresis or bedwetting		
☐ Constipation		
☐ Problems with bowel control		
☐ Migraine headaches		
☐ Seizures		
☐ **NO, NONE OF THE ABOVE**		

In the last MONTH…				
	Was a doctor seen for it?	Currently resolved	Ongoing	Details:
☐ Severe headaches	☐No ☐Yes: When?	☐	☐	
☐ Sore throat or ear pain	☐No ☐Yes: When?	☐	☐	
☐ Productive cough (phlegm, blood, etc.)	☐No ☐Yes: When?	☐	☐	
☐ Fever	☐No ☐Yes: When?	☐	☐	
☐ Diarrhea, nausea, or vomiting	☐No ☐Yes: When?	☐	☐	
☐ Abdominal pain	☐No ☐Yes: When?	☐	☐	
☐ Injury of any body part with pain or swelling	☐No ☐Yes: When?	☐	☐	
☐ Signs of alcohol/drug withdrawal (tremors, hallucinations, etc.)	☐No ☐Yes: When?	☐	☐	
☐ Rashes or skin infections	☐No ☐Yes: When?	☐	☐	
☐ Dental pain or abscess	☐No ☐Yes: When?	☐	☐	
☐ Scabies	☐No ☐Yes: When?	☐	☐	
☐ Head lice	☐No ☐Yes: When?	☐	☐	
☐ Ringworm	☐No ☐Yes: When?	☐	☐	
☐ Pin worms in stool	☐No ☐Yes: When?	☐	☐	
☐ **NONE OF THE ABOVE in the last month**				

In the last YEAR…				
	Was a doctor seen for it?	Currently resolved	Ongoing	Details:
☐ Unexplained weight loss or weight gain	☐No ☐Yes: When?	☐	☐	
☐ Fainting episodes	☐No ☐Yes: When?	☐	☐	
☐ Chest pain with or without activity	☐No ☐Yes: When?	☐	☐	
☐ Heart palpitations or racing pulse	☐No ☐Yes: When?	☐	☐	
☐ Breathing difficulties	☐No ☐Yes: When?	☐	☐	
☐ Bladder problems ☐ Painful urination ☐ increased frequency of urination ☐ Mucous, discharge or odors	☐No ☐Yes: When?	☐	☐	
☐ Fatigue with mild exertion	☐No ☐Yes: When?	☐	☐	
☐ Blurred vision/dizziness (while sober)	☐No ☐Yes: When?	☐	☐	
☐ Black bowel movements (appear to contain blood)	☐No ☐Yes: When?	☐	☐	
☐ **NONE OF THE ABOVE in the last year**				

ADDITIONAL HEALTH QUESTIONS

Has a medical provider said the youth has any of the following?

	Explain (other details):
☐ Diabetes	
☐ Thyroid disease	
☐ Rheumatoid arthritis	
☐ Heart murmur	
☐ HIV/AIDS	
☐ Hepatitis B or C	
☐ TB (tuberculosis)	
☐ Another chronic medical condition	If so, what?
☐ A hernia	If so, repaired? ☐No ☐Yes When?
☐ **NO, NONE OF THE ABOVE**	

Does the youth suffer from asthma?	☐Yes ☐No	If yes, ever been hospitalized for it?	☐Yes ☐No	If yes, when?
Has the youth ever used a nebulizer?	☐Yes ☐No	If yes, when?		
Is the youth sexually active?	☐Yes ☐No	If yes, type of protection used?		

For female participants... ☐ Regular menses (periods)? Date of last normal menses: _____

☐ Pain with menses ☐ Abnormal vaginal discharge or odor ☐ History of ovarian cysts

PREVIOUS HOSPITALIZATIONS (overnight)

Approximate date & year	Reason

PREVIOUS SURGERIES

Approximate date & year	Reason

PREVIOUS FRACTURES (broken bones)

Approximate date & year	Body Part

ACKNOWLEDGEMENTS

Alaska Crossings programs require participants to carry 40 pounds each, up to 10 miles at a time, over rough and challenging terrain, as well as paddle for up to several hours at a time.

☐ There are no medical or physical issues that I know of which would affect his/her participation in these activities.