



## Tanana Chiefs Conference

Behavioral Health Services

*Old Minto Family Recovery Camp*

122 First Avenue, Suite 302

Fairbanks, AK 99701

(907) 452-8251 ext 3144 Fax: 459-3835

Toll Free in Alaska, 1-800-478-7822

To Whom It May Concern:

Thank you for your interest in services at Tanana Chiefs Conference, Old Minto Family Recovery Camp. Attached is our application, the first step in the application process, from which initial eligibility or referral to more appropriate services is determined.

All potential clients and any additional adults wishing to attend camp must complete this form in its entirety to be considered for acceptance into services at OMFRC. Please fill it out as neatly as possible, illegible or incomplete information will result in delays in processing, as we will need to contact you to clarify any gaps. Completed forms can be returned by fax: **459-3835** or in person or by mail to **OMFRC 122 First Avenue, Third Floor, Fairbanks, Alaska 99701**. Please be sure to provide thorough and reliable contact information so we can contact you to continue the intake process.

Once the form is received in our offices it will be reviewed for eligibility. Someone will contact you within a week of receipt to let you know if you have been approved for services and placed on the waitlist.

*If approved* you will be scheduled for a full Behavioral Health Assessment. We will need each of the following as soon as possible:

- **Physical Exam** (Note: a physical is required for all members of the family attending the program). During the Assessment process you will be given a form to be completed by a Health Care Provider.
- **Results of a current** (within the past year) **PPD** test: (for all members of the family attending the program). For any positive results we will need a doctor's medical clearance prior to entering the program.
- **Dental Exam** (each family member attending treatment is required to see a dentist within 3 months of admission).

*It is important to understand that if clients or family members have a medical or dental condition that cannot be treated they may not be admitted to OMFRC until it is cleared. If the condition develops at camp you may need to be medically discharged due to the high cost of transportation back and forth to the camp.*

- **Criminal Record** (a criminal history is required for all persons over 18 going to the camp). Copies of criminal history can be picked up from the Alaska State Troopers Office. *There is a \$20 charge for each request for each criminal history.* **Note: Any individual (client or family member) convicted of a sexual offense or with a long history of violence are not admitted into OMFRC and will be referred to alternative programs.**
- **Mental Health Assessment** -if a person has been diagnosed with a disorder or self reports symptoms that indicate a possible mental health condition, an assessment by a mental health professional will be required. Additionally if there are any mental health concerns indicated for children who will be attending the program with their parents, they must be screened by a mental health specialist also.

The information required is necessary for us to complete accurate assessments, determine treatment needs and placement, and to provide a safe environment for our clients and their families. If you have further concerns or questions or need assistance in completing the application, please call our office at 800-478-6822 ext. 3144 within Alaska or 452-8251 ext. 3144 in Fairbanks.

Sincerely,

Laverne Alexander  
Clinical Supervisor  
Old Minto Family Recovery Camp.



How did you hear about the program? \_\_\_\_\_

Who recommended you to treatment? (Included agency, address, contact person & phone number)

Name: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Are you being **mandated/required or recommended by:** (check all that apply)

Court,  FASAP  Probation/Parole  Tribal Court  OCS  Employer  Family  Other \_\_\_\_\_

Are you currently receiving services from any other agency  No  Yes (please list agencies)

**First Agency**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Contact person: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Second Agency**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Contact person: \_\_\_\_\_

Phone Number: \_\_\_\_\_

*If you need more space please add an additional page*

Have you ever been to residential treatment before?  No  Yes →

Was it : OMFRC \_\_\_\_\_ Other \_\_\_\_\_

Why do you want to be in this program (what do you hope to get out of it)?

<input type="checkbox"/> # Times _____
<input type="checkbox"/> Dates: _____
<input type="checkbox"/> Did you complete? _____

\_\_\_\_\_  
\_\_\_\_\_

Please list your drugs of choice and when last used: please note that alcohol is a drug

1 <sup>st</sup> Choice		2 <sup>nd</sup> Choice		3 <sup>rd</sup> Choice	
Drug	Last used	Drug	Last used	Drug	Last used

Are you an injection drug user?  Yes  No

Are you currently involved with the legal system?  No  Yes-> Describe how and why \_\_\_\_\_

Have you ever been convicted of a violent or sexual crime?

No

Yes → How many times?

→ What was/were the crime/s? \_\_\_\_\_ (include to what degree)

Are you currently involved in a committed relationship?

- No
- Yes →
  - Married
  - Living together

→ Will your partner be attending the program also?

- Yes -> Name \_\_\_\_\_
- No

How many children do you have? \_\_\_\_\_

Please list the names, gender, birth date, and your relationship to the children ***who may attend*** the program with you (if you need extra space, please write on the back).

Name	Gender	Birth date	Relationship (e.g. Natural, adopted, or foster child)
	M F		
	M F		
	M F		
	M F		
	M F		
	M F		

Do you or any of the family members which may attend have any special needs or considerations we will need to know about to accommodate you?

	Who is experiencing the problem	Please describe
Medical		
Disability		
Legal		
Work		
Social		

What is the highest grade of education you have completed? \_\_\_\_\_

What is your primary language?

- English → → → →
- Other \_\_\_\_\_ →

How well do you <b><i>read and write</i></b> English (circle one) Very well    Good    Fair    Difficult
---

Do you require an interpreter for English? _____ How well do you <b><i>read and write</i></b> English (circle one) Very well    Good    Fair    Difficult
---

Do you have travel arrangements to get to and from treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

Client Name: \_\_\_\_\_

Date: \_\_\_\_\_

Staff: \_\_\_\_\_

## Alaska Screening Tool

Please circle your answer to the following questions **based on your activities over the past 12 months.**

1. Have you gotten into trouble at home, at school or in the community, because of your drinking, using drugs or inhalants?  
Yes    No
2. Have you missed school or work because of using alcohol, drugs or inhalants?  
Yes    No
3. In the past year have you ever had 6 or more drinks at any one time?  
Yes    No
4. Have you done harmful or risky things when you were high?  
Yes    No
5. Do you think you might have a problem with your drinking, drug or inhalant use?  
Yes    No
6. When using alcohol, drugs or inhalants have you done things without thinking, and wished you had not done them later?  
Yes    No
7. Do you miss family activities, after school activities, community events, traditional ceremonies, potlatches, or feasts because of using alcohol, drugs or inhalants?  
Yes    No
8. Does anyone close to you worry or complain about your using alcohol, drugs or inhalants?  
Yes    No
9. Have you lost a friend or hurt a loved one because of your using alcohol, drugs or inhalants?  
Yes    No
10. Do you use alcohol, drugs or inhalants to make you feel normal?  
Yes    No
11. Does it make you mad if someone tells you that you drink or use drugs or inhalants too much?  
Yes    No
12. Do you feel guilty about your alcohol, drug or inhalant use?  
Yes    No
13. Do you or other people worry about the amount of money or time you spend at Bingo, pull-tabs or other gambling activities?  
Yes    No
14. Did your mother ever consume alcohol?  
Yes    No
15. If yes, did she continue to drink during her pregnancy with you?  
Yes    No

**SECTION II** --Please circle your answer to these questions based on the past 12 months.

- |   |            |           |
|---|------------|-----------|
| 1. Do you often have difficulty sitting still and paying attention at school, work or social settings?  | <b>Yes</b> | <b>No</b> |
| 2. Do disturbing thoughts that you can't get rid of come into your mind?  | <b>Yes</b> | <b>No</b> |
| 3. Do you ever hear voices or see things that other people tell you they don't see or hear?   | <b>Yes</b> | <b>No</b> |
| 4. Do you spend time thinking about hurting or killing yourself or anyone else?   | <b>Yes</b> | <b>No</b> |
| 5. Have you tried to hurt yourself or commit suicide?   | <b>Yes</b> | <b>No</b> |
| 6. Do you think people are out to get you and you have to watch your step?  | <b>Yes</b> | <b>No</b> |
| 7. Do you often find yourself in situations where your heart pounds and you feel anxious and want to get away?  | <b>Yes</b> | <b>No</b> |
| 8. Do you sometimes have so much energy that your thoughts come quickly, you jump from one activity to another, you feel like you don't need sleep and like you can do anything?  | <b>Yes</b> | <b>No</b> |
| 9. Have you destroyed property or set a fire that caused damage?  | <b>Yes</b> | <b>No</b> |
| 10. Do you feel trapped, lonely, confused, lost or hopeless about your future?  | <b>Yes</b> | <b>No</b> |
| 11. Do you feel dissatisfied with your life and relationships?  | <b>Yes</b> | <b>No</b> |
| 12. Do you have nightmares, flashbacks or unpleasant thoughts because of a terrible event like rape, domestic violence, incest/unwanted touching, warfare, a bad accident, fights, being or seeing someone shot or stabbed, knowing or seeing someone who has committed suicide, fire, or natural disasters like earthquake or flood? | <b>Yes</b> | <b>No</b> |
| -----   |            |           |
| 13. Do you have difficulty sleeping or eating?  | <b>Yes</b> | <b>No</b> |
| 14. Have you physically harmed or threatened to harm an animal or person on purpose?  | <b>Yes</b> | <b>No</b> |
| 15. Have you lost interest or pleasure in school, work, friends, activities or other things that you once cared about?  | <b>Yes</b> | <b>No</b> |
| 16. Do you feel angry and think about doing things that you know are wrong?   | <b>Yes</b> | <b>No</b> |
| 17. Do you often get into trouble because of breaking the rules?  | <b>Yes</b> | <b>No</b> |
| 18. Do you sometimes feel afraid, panicky, nervous or scared?   | <b>Yes</b> | <b>No</b> |
| 19. Do you feel sad or depressed much of the time?  | <b>Yes</b> | <b>No</b> |
| 20. Do you spend a lot of time thinking about your weight or how much you eat?  | <b>Yes</b> | <b>No</b> |

**SECTION III--** Please circle and fill-in your answer to the following questions based on events in your lifetime.

1. Have you ever had a blow to the head that was severe enough to make you lose consciousness? Circle one: **Yes No**  
 If "Yes", when did it occur? \_\_\_\_\_ Please Describe \_\_\_\_\_  
 If "Yes", how long were you unconscious? Circle One: **N/A Seconds Minutes Hours Days Weeks Months**
2. Have you ever had a blow to the head that was severe enough to cause a concussion? Circle One: **Yes No**  
 If "Yes", when did it occur? \_\_\_\_\_ Please Describe \_\_\_\_\_  
 If "Yes", how long were you unconscious? Circle One: **N/A Seconds Minutes Hours Days Weeks Months**
3. Did you receive treatment for the head injury? Circle One: **N/A Yes No**
4. If you had a blow to the head that caused unconsciousness or a concussion, was there a permanent change in any of the following?

*Circle all that apply (SKIP if no head injury -- "No" to question 1 and 2):*

Physical Abilities	<b>Yes</b>	<b>No</b>
Ability to care for yourself	<b>Yes</b>	<b>No</b>
Speech	<b>Yes</b>	<b>No</b>
Hearing, vision, or other senses	<b>Yes</b>	<b>No</b>
Memory	<b>Yes</b>	<b>No</b>
Ability to concentrate	<b>Yes</b>	<b>No</b>
Mood	<b>Yes</b>	<b>No</b>
Temper	<b>Yes</b>	<b>No</b>
Relationships with others	<b>Yes</b>	<b>No</b>
Ability to work, or do school work	<b>Yes</b>	<b>No</b>
Use of alcohol or other drugs	<b>Yes</b>	<b>No</b>

5. Did you receive treatment for any of the things that changed after the head injury?  
 Circle One: **N/A—no head injury Yes No**

**For Office Use Only**

Section I results	<input type="checkbox"/> negative	<input type="checkbox"/> positive	→Follow-up_____
Section II results	<input type="checkbox"/> negative	<input type="checkbox"/> positive	→Follow-up_____
Need FASD Assessment?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→Follow-up_____
Potential DD?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→Follow-up_____
Evidence of TBI?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→Follow-up_____

Follow-up Details or Notes\*

**AKAIMS OPTIONS FOR THIS SECTION:**

**\*PLEASE NOTE WHAT STEPS HAVE BEEN TAKEN**

In-house assessment	Referral Created
Inappropriate for intervention	Not necessary in Clinicians judgement
Provided resource info to client	N/A