TANANA CHIEFS CONFERENCE HEALTH SERVICES

Behavioral Health Services

Chief Peter John Tribal Building

122 First Ave, Suite 600
Fairbanks, AK 99701
(907) 459-3800 Fax: 459-3835
Toll Free in Alaska 1-800-478-6822 ext. 3800

To whom it may concern

Thank you for your interest in the Tanana Chiefs Conference (TCC) Old Minto Family Recovery Camp (OMFRC) office located on the 4th floor of the Chief Peter John Tribal Building (CPJTB). The first step to determine if you are eligible for services is to complete the attached application and submit it in person at TCC 4th floor, mail it to; **TCC OMFRC 122 First Avenue Suite 600 Fairbanks, Alaska 99701**, or Fax it to **(907) 459-3835**. When you send a fax call and let us know you are sending a fax and call again to make sure we received everything you faxed. If there are any adults wishing to attend camp with you they must also complete an application.

Once our office receives your application a Behavioral Heath Consultant will contact you to do a screening. **It is very important that you provide a phone number you can be reached to do this screening and continue the process to enter into OMFRC.** After the screening process is done you will be added to the waitlist to receive an assessment if you already do not have one. It is your responsibility to turn in an outside assessment. Once your assessment is received the Clinical Supervisor will review your assessment to determine if OMFRC will be an appropriate placement for you. If not we will assist you in finding an appropriate treatment for you.

After your assessment is approved for services at OMFRC we will need each of the following as soon as possible.

- **Criminal History** is required for all persons over 18 who will be attending the program. OMFRC requires the criminal history to be acquired from the Alaska State Troopers Office and there is a $20 dollar fee for each request. **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.**
- **Physical Exam** (Note: a physical is required for all members of the family attending the program). The form is available on the web site or you will be given a form to be completed and signed by a Doctor or a Physician Assistant (PA). (It cannot be done by a community Health Aid.)

It is important to understand that if you or family members have a medical or dental condition that need treatment, admission to OMFRC will be delayed until medical clearance is received. This is due to the high cost, weather and available transportation to and from camp.

The information you provide is necessary for us to determine placement, recommended treatment and to provide a safe environment for our clients and their families. If you have further questions or need assistance with the application, please call our office at 1- 800-478-6822 or 452-8251 extension 3097.

ITEMS NEEDED PRIOR TO ENTERING OMFRC–in order of priority.

1. OMFRC Application
2. **Drug/Alcohol Assessment or a Comprehensive Assessment**–the Alaska Screening Tool will determine which assessment is needed–must be done within the past 3 months.
3. **Current Criminal History from Alaska State Troopers office** (for adults 18 years and older.)–you will need two forms of ID and $20.00 to get an official copy.
   - Items 1, 2 and 3 are needed as soon as possible to determine eligibility.
4. **Current Physical Exam–**within the past 3 months
   - Step 4 is required for ALL family members who plan to attend.

*If you reside outside the Fairbanks area: we will need your travel arrangements to and from Fairbanks and Housing information.

Keep in touch with the Intake Counselor at the Old Minto Family Recovery Camp at least once a week!
We need to know that you are interested and motivated so that we can take care of Intake Paperwork and confirm bed space. If you do not contact us, we will assume you are not interested.
All applicants that are accepted for treatment (from Fairbanks) will be enrolled in pre-treatment and expected to actively participate. Lack of participation could result in losing your bed space.

PLEASE TAKE CARE OF ALL YOUR COURT, PERSONAL, LEGAL, FINANCIAL, AND FAMILY OBLIGATIONS BEFORE YOU GO TO OLD MINTO FAMILY RECOVERY CAMP.

We will provide ◊ all meals ◊ laundry soap ◊ work gloves ◊ insect repellent ◊ tools for working ◊ hand soap ◊ Coleman lamps/candles ◊ wood/woodstoves

The Old Minto Family Recovery Camp is in a traditional camp setting
and therefore has *no* electricity and *no* running water.
Wood stoves are used to heat the cabins and Coleman lamps are used for lights.
Please do not bring any unnecessary items, as you will be traveling to the camp by a small plane in the winter or by a boat in the summer. **There are NO stores in Old Minto. **

Please let your family and friends know to send your **mail** to the office at:

Tanana Chiefs Conference-OMFRC
"Client name"
122 First Avenue, Suite 600
Fairbanks, AK 99701

YOU ARE ALLOWED ONE PHONE CALL AT THE END OF THE 2ND WEEK.
CELL PHONES, LAPTOPS, DVD PLAYERS ARE NOT ALLOWED AT THE CAMP!

WE DO NOT ALLOW DIRECT PHONE CALLS TO THE CAMP—WE WILL TAKE MESSAGES AND FORWARD THEM TO THE COUSELORS AT THE CAMP.

WHAT THE CLIENT MUST BRING

- **Sleeping bags, bedding, pillows, towels** for all family members. Bring flip flops to use in the Steam House.
- **Clothes and shoes** appropriate for the weather and travel. (One week of clothing per family member) space on the airplane is limited when traveling during the winter. We recommend that you bring warm gear at all times of the year as it can be cold traveling in open boat during the summer especially have rain gear during the summer.
- **Personal Hygiene Products**: Tooth brush, toothpaste, shampoo/conditioner, feminine products, soap, shaving items, non-alcoholic mouth wash, Q-tips, etc.
- **Diapers, wipes, baby food, formula for infants (In case of bad weather–PLEASE bring a 40 day supply of baby food, diapers, etc.)**
- **Medication - (In case of bad weather–PLEASE bring a 40 day supply of medication.)**
- **Cigarettes/Chew** (TO LAST 40 DAYS)
- **Stamps and envelopes-** Please have your own supply. We do not provide these items AND due to **confidentiality** we will not call family and friends to pick up envelopes.
- **You are welcome to bring your own supplies for:** beading, knitting, carving, and sewing.
- **Native food:** including dry meat, dry fish, berries, etc — optional
- **You can bring Healthy snacks for your Kids**: no candy.

■ WE DO NOT ALLOW

- SODA AND JUNK FOOD AT CAMP, ie candy, chips, etc.
- Aerosols or any items containing alcohol, including hairspray
- Cameras, iPods/music player, Laptops, PSP's, CD's, Cellphones
- Clothing with alcohol, drug, weapon, sexual words and or pictures. Clothing with excessive holes, tears, rips, (is skin tight, or reveling, tops; low-cut or cropped tops, are not allowed).

►We do not allow VICTOR (unemployment) calls during treatment.◄

In the event that you need a personal item at camp, you can write to your family and friends and let them know that if they drop your things off at the front desk or have it mailed, it can go to the camp on the next available trip.

REMEMBER—there is limited space available and you are responsible to pack all your gear to and from the boat and airplane.

OMFRC STAFF will not shop for the clients during their time off.

Tanana Chiefs Conference Behavioral Health

OLD MINTO FAMILY RECOVERY CAMP
Application for Enrollment

PLEASE FILL OUT THE FOLLOWING INFORMATION AS **COMPLETELY** AND **ACCURATELY** AS POSSIBLE.

Name of Applicant: _____ Date of Application: _____/_____/_____
First Middle Last

Name of Person Completing or Assisting in Application (list self if no-one) _____
First Last Agency or Relationship

Date of Birth of Applicant: _____/_____/_____ Social Security # _____

Is Applicant? ☐ Male Driver's License # _____
☐ Female- Pregnant? __Yes- # months_____
__ No
__ Not sure

Applicant's ethnic or racial identification: ☐ Alaskan Native/American Indian
Please also indicate group/tribe ___Aleut ___Haida ___Eskimo ___Athabascan ___Tlingit ___Yupik ___Tsimshian ___Inupiat _____other:_____
☐ Caucasian/White
☐ African American
☐ Asian/Pacific Islander
☐ Other _____

A staff person will be in contact with you for further information and answer any questions you may have. Please provide information on how you can be contacted.

Home Address:_____

Mailing Address:_____ City/State:_____ Zip Code_____

Phone Number: Home:_____ Work:_____ Contact: _____

E-mail address _____

Other addresses and phone numbers you may be reached through:

Address	**Phone #**	**Description (relatives, shelter, program)**

Maiden(s) name or other names you may be known as: _____

What is your home village (where most of your family is originally from)? _____

Who are your biological parents? _____

How did you hear about the program? _____

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

Agency Name:_____Contact Person:_____

Address:_____Phone:_____

Are you currently involved with the legal system? ☐ No ☐ Yes, describe how and why

_____

_____

_____

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

__Court, __FASAP __Probation/Parole __Tribal Court __OCS __Employer __Family __Other _____

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 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 _____

- # Times _____
- Dates: _____
- Did you complete? _____

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

_____

_____

What are your drugs of choice (what you most typically drink or use) and when last used:
(Please note that alcohol is a drug)

1st Choice		2nd Choice		3rd Choice	
Drug	**Last used**	**Drug**	**Last used**	**Drug**	**Last used**

Are you an injection drug user? ☐ Yes ☐ No

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

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 will 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 your primary language?

☐ English ➔ ➔ ➔ ➔

How well do you ***read and write*** English (circle one)
Very well Good Fair Difficult

☐ Other _____ ➔

Do you require an interpreter for English? _____
How well do you ***read and write*** English (circle one)
Very well Good Fair Difficult

We look forward to meeting you. You will be notified once your application has been reviewed. If you have .questions, please feel free to contact us for assistance. Thank you.

_____ _____ _____

Printed Customer Name Date Customer Signature

Tanana Chiefs Conference, Behavioral Health

OLD MINTO FAMILY RECOVERY CAMP
Medical History & Physical Screening

Name _____DOB:_____Date _____

Old Minto Family Recovery Camp is an Alcohol and Drug treatment program operated by Tanana Chiefs Conference in Fairbanks, Alaska. The program setting is isolated, rural, and accessible only by small plane and boat and treatment is expected to take five weeks. (NOTE: A Medivac is not possible out of Old Minto, so consider that when doing the physical.) A condition of admission is that clients be able to fully participate in all activities, which include hauling water, cutting and lifting wood, Subsistence Activities, etc. All clients are required to obtain a health screening to ensure that there are no medical conditions or severe withdrawal potential that would interfere with treatment and leave the client at risk for complications.

FILLED OUT BY A HEALTH CARE PROVIDERS

Can this client performs 4 METS of activity (equivalent to climbing 2 flights of stairs) without chest pain or shortness of breath?
____ Yes ___ No
Does this client have a chronic condition which is likely to deteriorate in the next 6 weeks causing them to be unsafe in a remote setting? ____ Yes ___ No
Does this client have evidence of an acute or rapidly changing condition which will need active management in the next 6 weeks?
___ Yes ___ No

- If yes, is this a condition which is likely to resolve with treatment, allowing admission to Old Minto after acute treatment?
___ Yes ___ No
- If yes, when should the client follow-up for a repeat Medical History and Physical Screening appointment?

Date:_____

Is the client actively followed by a specialty clinic? ___ Yes ___ No
Is yes, do they have follow-up appts scheduled or due in the next 6 weeks? ___ Yes ___ No

Please explain any treatment or appointments recommended PRIOR to clearance for Old Minto:
_____
_____
_____
_____

(Please use additional page if needed for this or other questions)

FEMALES - Date of last period _____ Are periods irregular, difficult, painful, heavy? _____
Pregnant? ____ No ____ Yes ____Unsure? Explain _____ Pregnancy Test _____
Contraception or hormones that will be needed while at Old Minto? _____

Medications:
Is the client currently taking any **prescription medications** that will be needed while at Old Minto? ___No ___Yes
(*All medications are locked in a central cabin and dispensed to patients. All medications need to be dispensed for at least 45 days… refills very difficult. And **opiate based medications are not allowed at camp**. If indicated, please prescribe an alternative),*

Medication	Dosing	For what Condition	45-day Supply?
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No

Are any of the medications possibly "mind altering?" (benzodiazepines, anti-psychotics, lithium, etc). Discuss potential issues:
_____
_____

Will the client be taking any **over-the-counter products**? __No __Yes Medication and what for: _____

_____

NOTE: As an optional part of treatment patients may take vitamin supplements for physical detoxification, including high dose of B vitamins. Would use of vitamins conflict with any of the patients medical conditions or medications? __No __Yes

Does the client currently have any special dietary requirements? __No __Yes Describe: _____

_____

Mental Health:

Is the client currently depressed, anxious, or having suicidal thought? Or thoughts of hurting someone else? ____ No ____ Yes

Does the client have a history of suicide attempts or violent behavior towards others, family, or self? ____ No _____ Yes

Explain: _____

_____

Does the examiner feel the client is ___ Low ___ Medium ___ High risk of harm to ___ Self ___Others?

Substance Abuse:

Is the client an IV drug user? ___No ___ Yes. Last used _____ What drug _____ With whom? _____

Is the client currently experiencing signs and symptoms of withdrawal – please check the following:

None ☐ Nausea & Vomiting ☐ Tremor ☐ Sweats ☐ Tactile Disturbances ☐ Anxiety ☐

Agitation ☐ Auditory Disturbances ☐ Headache ☐ Orientation ☐ Visual Disturbances ☐

Does the client have a history of withdrawal complications? ___ No ____ Yes Explain: _____

_____

Please check current immunizations: (check if current)

☐ Flu Shot ☐ Tetanus Shot ☐ Other _____

Please review history and patient for TB. Do you feel there signs or symptoms suggesting active TB? ___ No ___ Yes
Explain: _____

Are there any additional studies or lab tests needed before a recommendation is made? ___ No ___ Yes. Explain: _____

_____

Based on your exam and review, are there concerns regarding the client's ability to fully and safely participate in the treatment program and activities at Old Minto Camp for 45 days in a remote and isolated location?_____

_____

_____

_____

Based on findings of Medical Evaluation, the client:

☐ Is recommended for Old Minto Family Recovery Camp.
☐ Is not recommended for Old Minto Family Recovery Camp.

Signature of Physician, Nurse Practitioner or Physician Assistant **Contact Number** **Date**

_____

Stamp or printed name of Provide

TANANA CHIEFS CONFERENCE HEALTH SERVICES

Behavioral Health Services

Chief Peter John Tribal Building

122 First Ave, Suite 400

Fairbanks, AK 99701

(907) 459-3800 Fax: 459-3835

Toll Free in Alaska 1-800-478-6822 ext. 3800

Release of Information is required from you for us to be able to talk with a family member in case they need to get a message to you in camp. You will also need a Release of Information for each agency that you may be working with or will want information on compliance, letter of completion, discharge summary and other information they may need form you about treatment and for OMFRC to exchange information with those agencies. Below is a list of agencies you may need a Release of Information for.

1. Anchorage Alcohol and Safety Action Program (AASAP)
2. Fairbanks Alcohol and Safety Action Program (FASAP)
3. Alcohol and Safety Action Program from your community
4. Public Defender or Lawyer
5. Office of Children Services (OCS)
6. Probation Officer
7. Tribal Court
8. Tribal or City offices for purpose of providing transportation.
9. Employer
10. Counselor, Behavioral Health Aid and health provider outside of the TCC Behavioral Health service region.

Make sure you tell the staff that is helping you fill out this application packet that you need a Release of Information to be filled out. For the Release of Information to be a valid release all sections need to be filled out, initialed, signed by client and by a staff member working with you.

Tanana Chiefs Conference Behavioral Health Division
122 First Avenue, Suite 400, Fairbanks, AK 99701 Telephone (907) 459-3800 Fax (907) 459-3810

BEHAVIORAL HEALTH AUTHORIZATION FOR RELEASE OF INFORMATION

Each section of the form must be completed; missing information will result in delays in processing and may be invalid.

Check Box for ROI type: □ Individual □ Third Party Payer □ Treating Provider Recipient □ Non-Treating Provider (Must list name(s) of person(s) to receive information) Specific name of the person to which the disclosure is to be made: _____

PATIENT INFORMATION:
Patient Name: _____ Birth Date: _____ Medical Record # (if known): _____
Address: _____ City/ State/ Zip: _____

I Hereby Authorize TCC Behavioral Health Division to Disclose Information TO:
Name of Facility/ Organization/ Individual: _____
Address: _____ City/ State/ ZIP: _____
Phone Number: _____ FAX: _____

I Hereby Authorize TCC Behavioral Health Division to Request Information FROM:
Name of Facility/ Organization/ Individual: _____
Address: _____ City/ State/ Zip: _____
Phone Number: _____ FAX: _____

□ Dates of treatment: FROM: _____ TO: _____

□ Purpose or need for information being requested:
Further Treatment: _____ Legal Proceedings:_____ Insurance Claim: _____ Other (specify): _____

□ Type of Information to be used or disclosed:
_____ Acknowledge presence in treatment/attendance _____Diagnosis _____ Discharge Summary, status _____ Lab Reports
_____ Treatment Plan _____ Assessment/ Evaluation _____ Program compliance _____ Billing statements Other: _____

□ I authorize the release of information relating to: (Please **initial** which will be disclosed)
_____ Substance Use Disorder Information _____ Psychiatric/Psychological Treatment _____ AIDS, HIV, ARC/Medical

□ This information may be transmitted via: (please **initial** each approved communication method)
_____ Fax _____ Verbal _____ Electronically (**Required** to complete duty to warn) _____Hard copy

Unless revoked, this authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire 180 days from the date of signing.

I understand that my substance use disorder treatment records are protected under the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and cannot be disclosed without my written consent unless otherwise provided for by those laws. I understand that the only personal representatives authorized to consent on behalf of a substance use disorder patient are legal guardians appointed by a court due to the patient's incompetency. 42 C.F.R. § 2.15(a), and that other personal representatives or powers-of-attorney are not so authorized. I understand that a minor patient's consent to disclosure is *always* required, even if parental consent is also required, except that legal guardians who have been court-appointed on behalf of a minor due to incompetency (but not due to minor age) may sign on a minor patient's behalf. I understand that I may revoke this authorization in writing at any time by notifying TCC, except to the extent that TCC has already used or disclosed information in reliance on my authorization. I understand that TCC must provide me with a copy of this authorization. I understand that I might be denied services if I refuse to consent to a disclosure for purposes of TCC's treatment, payment, or health care operations, and that I will not be denied services if I refuse to consent to a disclosure for other purposes. I understand that 42 C.F.R. Part 2 prohibits the recipient of these recipient from redisclosing them to others, except with my consent, or in compliance with Part 2's rules, and accordingly, TCC will provide recipients with the following written statement: This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is *NOT* sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

By my signature below, I certify that I have been given sufficient time to read this authorization, ask questions, and understand it:

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Legal Guardian (Where Required or Authorized to Consent on Behalf of the Patient) Date

_____ _____
Printed name of Parent or Legal Guardian (if applicable) Relationship to Patient

_____ _____
Signature of Witness Date

Tanana Chiefs Conference
PATIENT E-MAIL AUTHORIZATION FORM
AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

I authorize TCC to communicate my protected health information through e-mail, voicemail, or text message at the following:

☐ E-mail address: _____

By completing this authorization form, I understand and agree that:

- TCC will send a test email confirmation to the email address you provided. Please confirm that the email is active and accurate by responding to the test email with your name and date of birth. If TCC does not receive a reply within 5 business days, your records will automatically be mailed to the address you provided above. TCC will include "CONFIDENTAL" in the subject line of any e-mail, use a subject description that is as discrete as possible, and include a confidentiality statement in the body of the e-mail.

- The risks with using these methods of communication include, but are not limited to:
  - Messages may be sent to the wrong recipient or left at the wrong number; or
  - PHI sent to my e-mail account or accessed through an electronic device could be hacked, or otherwise inappropriately accessed if left unattended or lost.

- TCC cannot control or ensure the security of my PHI after it is sent via e-mail.

- I hold TCC harmless from any liability for sending my PHI by voicemail, e-mail or text message to the address or phone number listed above, including where my PHI is intercepted or inappropriately accessed due to hacking or failure to secure my accounts and electronic devices.

- I may revoke this authorization in writing at any time.

By my signature below, I certify that I have been given sufficient time to read this authorization, ask questions, and understand it:

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Legal Guardian (Where Required or Authorized to Consent on Behalf of the Patient) Date

_____ _____
Printed name of Parent or Legal Guardian (if applicable) Relationship to Patient

_____ _____
Signature of Witness Date

For TCC's Use Only: Date Received: _____ Description of Identity Verification: _____ Charges ($): _____

Name/Title of Staff Member Processing Request: _____ Date of Response/Completion: _____.

(Revised September 2019)

TANANA CHIEFS CONFERENCE
New Patient Registration Checklist

Please make sure to provide all supporting documents as we are unable to process registrations without them.

THE FOLLOWING DOCUMENTS ARE REQUIRED:

_____ **Certificate of Indian Blood (CIB) and/or Tribal Card** (must have blood quantum listed on it). Ensure the copy is PHOTO QUAILITY and EXPANDED to 190%.

_____ **Birth Certificate.** Copied at standard size.

_____ **Government issued photo ID.** Ensure the copy is PHOTO QUAILITY and EXPANDED to 190%.

_____ **All private insurance(s)** that you may have. If a minor please provide all parents insurance(s). Ensure the copy is PHOTO QUAILITY and EXPANDED to 190%.

_____ **Consent for Treatment of a Minor form,** is required if anyone other than a parent is to bring in the (child patient) for treatment.

_____ Completed **Registration** form to include **Screening form**

_____ Sliding Fee Scale Application – **NON-BENEFICIARIES ONLY (VILLAGE BASED)**

Please completely fill out all fields in the registration packet. If an area of the registration packet does not apply to you, note it by marking N/A in the blank space. Please ensure signatures and initials are provided on all pages that require them for acknowledgements and authorizations. Fax completed packet to registration at (907) 459-3860.

TANANA CHIEFS CONFERENCE

New Patient Registration

Page 1

PATIENT INFORMATION: (Please Print)

Last Name: _____ First Name: _____ Middle Name: _____ Suffix: _____

Previous Name (last,first): _____ Mother's maiden Name _____

Legal Sex: _____ DOB: ___/___/___ SSN: ___-___-_____

Address : _____

City: _____ State: _____ Zip: _____ Home Phone: (___) ___-_____.

Mobile phone: (___) ___-_____ Consent to text: yes no Work Phone: (___) ___-_____.

Email Address : _____ No Email

Contact preference: email home phone mobile phone

Language Preference: English / Other: _____ Interpreter Needed: yes no

Race: (circle all that apply) Alaska Native / American Indian Asian Black/African America

Native Hawaiian Other Pacific Islander White Other _____.

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Marital Status: Single Married Divorced Separated Widowed

Sexual Orientation: Lesbian Gay or Homosexual Bisexual Other:

Don't Know Choose not to disclose

Gender Identitity : Male / Female / Transgender Female to Male / Transgender Male to Female

Gender non-conforming / Other: / Choose not to disclose

Assigned Sex at Birth: Male Female Choose not to disclose Unknown

Preferred Pronoun: he/him she/her they/them

Agricultural Worker	**Homeless**	**Veteran?**
Yes No	Yes No	Yes No

Corporation/Tribal Membership: _____ Enrollment Number: _____.

Blood Quantum: (How much Alaskan Native/American Indian are you?) 1/8 1/4 1/2 3/4 Full Other _____

Internet Access: yes No Current Community: _____.

EMERGENCY CONTACT _____ Relationship to Patient: _____

Last Name: _____ First Name: _____ Middle Name: _____ Suffix: _____

Home Phone: (___) ___-_____ Mobile Phone: (___) ___-_____

NEXT OF KIN _____ Relationship to Patient: _____

Last Name: _____ First Name: _____ Middle Name: _____ Suffix: _____

Home Phone: (___) ___-_____ Mobile Phone: (___) ___-_____

TANANA CHIEFS CONFERENCE

New Patient Registration

Employment Status (choose one)

FT/PT Student FT Employed PT Employed Unemployed Self Employed Retired Active Military

Employer: _____ **Occupation:** _____.

Address: _____ City: _____ State: _____ Zip: _____.

Phone: ( ) - _____ Type of Business: _____.

Guarantor Information (makes decisions for the patient) Relationship to Patient: _____

Last Name: _____ First Name: _____ Middle Name: _____ Suffix: _____.

Address : _____ DOB: __/__/__

City: _____ State: _____ Zip: _____ Phone: ( ) - _____.

#1 PRIMARY INSURANCE INFORMATION (Please provide staff the insurance card)

Insurance Company: _____ Phone: ( ) - _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Holder DOB: __/__/__ Policy Holder Gender: _____.Policy Holder Employer: _____

Policy #: _____. Group #: _____ Policy Holder SSN: ___-___-____

Policy Holder Address: _____ Phone: ( ) - _____

Additional Information : _____

#2 SECONDARY INSURANCE INFORMATION (Please provide clerk the insurance card)

Insurance Company: _____ Phone: ( ) - _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Holder DOB: __/__/__ Policy Holder Gender: _____.Policy Holder Employer: _____

Policy #: _____. Group #: _____ Policy Holder SSN: ___-___-____

Policy Holder Address: _____ Phone: ( ) - _____

Additional Information : _____

Does the patient have Medicaid?	**Does the patient have Denali Kid Care?**	**Does the patient have Medicare?**
Yes No	Yes No	Yes No

Is this a work related injury	Is this a service related injury and/or is it pre-authorized by VA?
Yes No	Yes No

Commissioned Officer Dependent of Commissioned Officer Civil Service PHS Employee Other (Student, Volunteer)

Patient / Guardian Signature: _____ Date: _____

Patient / Guardian Printed Name: _____

Tanana Chiefs Conference

New Patient Consent and Signature for Treatment

I am signing as the: ☐Patient ☐Patient Representative (*mark status below)*

☐ Parent ☐ Spouse ☐ Guardian

☐ Power of Attorney ☐ Next of Kin ☐ Other

Address: (If not signing as the Patient): _____

_____

_____

_____

Home phone: (If not signing as the Patient): _____

I am an adult or an emancipated minor with legal capacity. If I am a patient's representative I am properly exercising my authority, and will make available copies of my documents if requested.

I consent to all necessary steps taken for examination, diagnosis and treatment. If at any time I have questions about my examination, diagnosis or treatment I will not proceed until the questions have been answered so I am fully informed. If surgical or invasive procedures are recommended I may be asked to sign additional consents after being fully informed of the potential risks and benefits.

I understand that giving medical providers, community health aides, Behavioral Health Consultants and nurses all relevant information is critical to proper diagnosis and treatment.

I understand complete compliance with my provider's instructions is critical to the success of any treatment prescribed.

I have read and do understand the above information.

Signed: _____ Printed Name: _____

Date: _____

Preferred Method of Communication: Duty to Warn

Please use this form to let us know of the method you prefer we use in communicating with you. You have the right to request to receive communications about your protected health information from us by alternative means and we will accommodate reasonable request/s.

Name of Client: _____

Today's Date: _____

Date of Birth: _____

You do not need to tell us why you are making this request.

You may change your mind at any time and we will provide you with another copy of this form to request modification of your preferred method of communication. **If You Prefer Email, Telephone/Text Messages, Mail and/or Fax** You may request that we communicate with you by email, telephone/text message, mail and/or fax. We will contact you using your preferred method whenever possible. We must warn you there is some level of risk that protected health information transmitted by unencrypted email and/or unsecured phone and/or fax could be intercepted or read by an unauthorized person. In light of this warning, if you still prefer that we communicate with you by unencrypted email and/or unsecured phone and/or fax we will agree to your request. We are not responsible for unauthorized access of your protected health information while in transmission or for safeguarding information that has been delivered to you.

I request you communicate with me by:

1. **Telephone**

Call my Home Phone- Number_____

- *(Please select a box)*
  - ☐ This is my preferred method of communication and is okay to leave a detailed message.
  - ☐ This is my preferred method of communication, but do not leave a detailed message.

Call my Cell Phone- Number _____

- *(Please select a box)*
  - ☐ This is my preferred method of communication and is okay to leave a detailed message.
  - ☐ This is my preferred method of communication, but do not leave a detailed message.

2. **Text Message:**

Preferred Text Message-Number: _____

3. **Email:**

Preferred Email Address: _____

TCC will send a test email confirmation to the email address you provided. Please confirm that the email is active and accurate by responding to the test email with your name and date of birth. If TCC does not receive a reply within 5 business days, your records will automatically be mailed to the address you provide here:

Mailing Address:_____

_____

_____

4. **Fax:**

Preferred Fax Number: _____

I further acknowledge that this consent is given on my own free will.

_____

Signature of Client | Name of Client

_____

Signature of Parent/Guardian (if required) | Printed Name of Parent/Guardian | Date

For TCC's Use:

Date Received:_____

☐ Verification of Identity and Authority_____

☐ Identification: _____

Date Revised: 10/08/2018

Annual Acknowledgement and Authorizations

Patients printed name:_____ Date:_____

Please initial each section and sign at the bottom.

_____Patient Receipt for Notice of Privacy Protection

I have received a copy of the Tanana Chiefs Conference (TCC) Notice of Privacy Protection to keep. I understand this form is mandated by federal law and that in order to treat any patient, Tanana Chiefs Conference will have to gather, store and use Protected Health Information ("PHI"), and that PHI is subject to special federal legal protections. I give my consent to Tanana Chiefs Conference to gather, store and use PHI for treatment, billing and health care operational purposes.
If I have any questions on this notice, I will contact the patient advocate at Tanana Chiefs Conference, at (800) 478-6682 extension 3143.

_____Consent for Use and Disclosure of Medical Information

TCC Health Services may use or disclose medical information about me (1) for my treatment, (2) to apply for payment from insurance companies or government programs, and (3) for operation of TCC Health Services Department. For example, I understand that the information on this form can be shared with Fairbanks Memorial Hospital, and that TCC may release alcohol and drug treatment information about me under 42 CFR Part 2. I authorize assignment of benefits and payment directly to TCC. I have reviewed, understand and have a copy of TCC's Notice of Privacy Practices.

_____Patient Receipt of Payment Policy

I have received a copy of the Tanana Chiefs Conference Community Health Center payment policy. I authorize Tanana Chiefs Conference to release information to my designated insurance carrier for the purpose of receiving payment. I further authorize the payment of benefits to be made directly to Tanana Chiefs Conference on my behalf. I understand a patient is responsible for all charges incurred, subject to contract and program rules, regardless of my insurance status. If it becomes necessary to send this account to collections, the patient will be responsible for all additional charges.

_____Emergency Contact

Authorized person(s): _____

Relationship to me, the patient:_____ Phone Number: ___ - ___ - _____

*This is person is only to be contacted in the case of an *emergency* ***not for other disclosures***. To have someone *authorized* to *know about/make appointments etc. a* **Medical Release of Information (ROI) Form** must be filled out and sent to *TCC Medical Records*.

I am signing as the: ☐ Patient ☐ Patient Representative (*mark status below)*

☐ Parent ☐ Spouse ☐ Guardian
☐ Power of Attorney ☐ Next of Kin ☐ Other

Patient / Guardian Signature: _____ Date: _____

Patient / Guardian Printed Name: _____

SS 3/25/22

Tanana Chiefs Conference

Attn: Health Information Management
1717 West Cowles St
Fairbanks, AK 99701
907-451-6682

Consent Form For ePrescribe Program

ePrescribe Program

ePrescribing is a way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- Formulary and benefit transactions - Gives the health care provider information about which drugs are covered by your drug benefit plan.
- Fill status notification - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- Medication history transactions - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

Consent

By signing this consent form you are agreeing that your provider at Tanana Chiefs Conference may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Tanana Chiefs Conference to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____Print Patient Name _____Patient Chart/DOB

_____Signature of Patient/Guardian

_____Relationship to Patient _____Date

TANANA CHIEFS CONFERENCE
TRIBAL MEMBER AND BENEFICIARY ENGAGEMENT

TCC is committed to provide tribal members and staff with timely information about TCC services, current events and issues that impact Interior Alaska Native people.

If you would like up to date communication please provide relevant information:

First Name:

Last Name:

I have read and understand by providing my personal contact information, I give TCC permission to communicate with me about TCC services, promotions, current events and issues that impact Interior Alaska Native people. This permission will remain in effect until withdrawn in writing.

Signed: _____

Date:_____

Printed Name: _____