PO'AILANI, INC.
CONTINUUM OF CARE

SCREENING FORM

74 KIHAPAI STREET
KAILUA, HAWAII 96734

TELEPHONE (808) 262-2799
FAX (808) 262-0970

Referral Source	**Date**
Name/Title	**Telephone**

Funding Source (circle appropriate source)

Adult Mental Health (Authorization must be obtained)	**Alcohol Drug Abuse Division**
Adult Probation Department	**Community Care Services**
Veteran's Administration	**Other (Manage Care)**

Applicant's Data – Descriptor Information (Please Complete Entire Form)

Name _____ Date of Birth _____

Address _____

Telephone _____Social Security No. _____ Gender: M F Transgender

Has a psychiatrist diagnosed the applicant? Y _____ N _____

Is applicant currently under the care of a psychiatrist? Y _____ N _____

Name of Attending Psychiatrist _____Telephone _____

Has the applicant ever been in the State Hospital? Y _____ N _____

Has the applicant ever been affiliated with any Hawaii State Mental Health Clinic?
Y _____ N _____

Reason for Referral ((**Presenting Problems**)

_____

_____

Does the applicant have a history of any of the following? **Must Be Answered**

Forensics Status – Legal Encumberance Y _____ N _____

Violent/Assaultive behavior Y _____ N _____

Suicidal thoughts/attempts Y _____ N _____

Arson or child molestation Y _____ N _____

If yes, please describe _____

_____

Does the applicant have a history of sexual and/or physical abuse? Y _____ N _____

If yes, please have applicant describe _____

_____

Does the applicant want to address issues of abuse while in treatment with Po'ailani, Inc?
Y _____ N _____

Current Medications (minimum 2 weeks supply of medication required for admission)

Name	Frequency	Purpose	Last Dose	Effects

Is the applicant adherent with medication regime? Y _____ N _____

Is s/he capable of administering his/her own medication? Y _____ N _____

Has the applicant consistently taken medication for the last two weeks? Y _____ N _____

Does the applicant have any dental and/or medical problems that will require medical attention and treatment with narcotic medication (i.e., painkillers)? Y _____ N _____

NOTE: Prior approval for admission required from the Medical Director for an individual taking controlled substances.

Any chance that the applicant could be pregnant? Y _____ N _____

If yes, please describe _____

Previous Psychiatric Treatment History (Begin with last episode)

Has the applicant been hospitalized for psychiatric care in the past 12 months for treatment of major mental illness?

Y _____ N _____

If yes, please indicate below.

	Treatment Episode	Treatment Episode	Treatment Episode
When			
Where			
Length of Stay			
Modality			
Outcome			
What Led to the Relapse			
Difference This Time			

List additional psychiatric treatment events on separate sheet.

Previous Substance Abuse Treatment History (Begin with last episode)

Has the applicant been in treatment for substance abuse/dependency? Y _____ N _____

If yes, please indicate below.

	Treatment Episode	Treatment Episode	Treatment Episode
When			
Where			
Length of Stay			
Modality			
Outcome			
What Led to the Relapse			
Difference This Time			

List additional substance abuse treatment events on separate sheet

Substance Abuse History

Is there a history of IV Drug Use? Y _____ N _____

Substance Used			
Route of Administration			
Date of Last Use			
History of Overdose			
Withdrawal Symptoms			
Frequency of Use			
# of Years Used			
Age of Onset			

If the applicant has support from family, friends, and/or significant other, please provide name and contact number of individual(s) in support of applicant.

Name of Support Person — Contact Telephone Number

_____ _____

_____ _____

Financial Resources

NOTE: All participants are responsible for the following:

- **Residential Treatment Monthly Program Fees $325.00**
- **Residential Treatment Monthly Food Contribution $300.00**
- **Group Housing Monthly Rent (2 to an apartment) $450.00**
- **Clean and Sober Housing Monthly Rent (3 to an apartment) $300.00**
- **Group Housing Monthly Food Independent Purchases**

Does the applicant currently have money to pay the program fee and/or rent? Y _____ N _____

If so, how much money will the applicant have at the time of admission into treatment or entry into group housing? _____ _____

Does the applicant currently have resources to contribute to the purchase of food or to independently purchase food to care for basic needs? Y _____ N _____

If yes, specifically indicate the available resources that the applicant will have at the time of admission into treatment or entry into group housing _____

What is the source of the applicant's monthly income (if any)? Please include all entitlements such as food stamps _____

Does the consumer exceed three hundred percent of the poverty level for Hawaii? Y _____ N _____

AMHD REFERRALS ONLY

NOTE: Po'ailani, Inc. requires that case managers put in requests for CRF funds with the DIVISION to provide financial support for applicants that do not have money, food, etc. to initially cover program fees, rent, food and other essential personal items prior to admission into residential treatment or entry into group housing. Please complete below if applicable.

Case Manager Name	Agency	Office Telephone	Alternate Telephone	CRF Request Date	Person Notified

Health Benefit Resources

If applicant has Quest health care benefits with managed care, circle the appropriate response below.

CCS **HMSA** **KAISER** **ALOHA CARE**

HEALTH PLAN NUMBER _____

If applicant has other health care benefits, circle the appropriate response below.
MEDICARE **MEDICAID** **HEALTH PLAN NUMBER _____**

Vocational Educational History and Interest

Has the applicant completed high school? Y _____ N _____

Does the applicant have a GED? Y _____ N _____

If the answer to the above questions is no, is the applicant interested in obtaining a GED?
Y _____ N _____
Is the applicant interested in participating in any type of educational program? Y _____ N _____

If yes, what are the interests the applicant? _____

Has the applicant been employed in the past (30) days? Y _____ N _____

Last Month/Year of employment _____ Last Employer _____

Is the applicant interested in participating or returning to work? Y _____ N _____

If yes, what are the work interests of the applicant? _____

Criminal Justice History

Is the applicant presently incarcerated? Y _____ N _____

If the applicant was previously incarcerated, please complete the following:

CHARGE	MONTH/YEAR	FACILITY	LENGTH INCARCERATED

What is the applicant's current legal status with the criminal justice system?

_____

_____

DSM – V Diagnosis

AXIS I	AXIS II	AXIS III	AXIS IV	AXIS V (Current)	(Past)

NOTE: Po'ailani, Inc. requires a copy of a current psychiatric evaluation and/or discharge summary. Please forward copy to the Intake Specialist for consideration of admission into treatment.

AMHD REFERRALS ONLY

Po'ailani, Inc. requires a master treatment service plan (MTSP) from case managers for consumers to enter group housing.

PO'AILANI'S USE ONLY **Client Name/ID:_____**

ASAM PLACEMENT CRITERIA

Placement Decision			
Key Placement Dimensions (ASAM)	**Severity Profile (note) H M L**		
1. Acute Intoxication and/or Withdrawal Potential			
2. Biomedical Conditions and Problems			
3. Emotional/Behavioral Conditions and Problems			
4. Treatment Acceptance/Resistance			
5. Relapse Potential/Recidivism			
6. Recovery Environment/Family Support			
6a. Legal			

APPROPRIATE PLACEMENT **(Complete Sections Below)**

ADMISSION DATE	TREATMENT MODALITY			HOUSING LEVEL	
	RES	DAY	OPS	24–HR	8/16-HR

INAPPROPRIATE/INELIGIBLE **(Complete Sections Below)**

REFERRAL DATE	REASON FOR INELIGIBILITY

REFERRAL INFORMATION

Staff Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Revised 08/15/12, 5,20,13