PO'AILANI, INC.
CONTINUUM OF CARE

SCREENING FORM

970 N. KALAHEO AVE. #A102
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 Encumbrance 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 regimen/taking medications consistently as prescribed?
Y _____ N _____

Is he/she 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			

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 (Residential? Outpatient?)			
Outcome			
What Led to the Relapse			
Difference This Time			

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 and fill out a consent form. **If not already included with your application, please contact the Intake Department if you need additional consent forms.**

Name of Support Person — Contact Telephone Number

_____ _____

_____ _____

Financial Resources

NOTE: All participants are responsible for the following:

- **Residential Treatment Monthly Rent $350.00**
- **Residential Treatment Monthly Food Contribution $350.00**

Does the applicant currently have money to pay the rent and/or food contribution?
Y_____ N_____

If so, how much money will the applicant have at the time of admission into treatment?

_____

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

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. 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.

HMSA **KAISER** **OHANA HEALTH PLAN** **UNITED HEALTH CARE** **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?

_____

_____

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**

Residential	Day	IOP	Outpatient	Modified OP	AC

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, 7,24,13, 11,7,16