Behavioral Health Services Pre-Service Application

3100 S Cushman Street Fairbanks, AK 99701 (907) 452-6251

Please check the program(s) in which you are interested:

☐Assessment ☐ Ralph Perdue Center Residential ☐ Women and Children's Center Residential ☐ SOAP Basic Center (Youth Shelter)
☐ SOAP (Youth - Street Outreach and Advocacy) ☐ Preparing Future Leaders Outpatient (16-26) ☐ Healing the Hurts Outpatient (0-18)
☐ Family Wellness Outpatient (Adults with children ages 0-8) ☐Infant/Early Child Mental Health (0-6) ☐ Suicide Prevention/Postvention
☐ Ralph Perdue Center Outpatient/Intensive Outpatient ☐ Community Opioid Intervention Services ☐ Pathways to Recovery (Meth Outpatient)

Please respond as accurately and completely as possible to the following questions.
Your responses will be used to understand your specific needs and the types of services you require.

Today's Date: ___/___/___ Consumer's DOB: ___/___/___ Consumer's Race/Ethnicity:_________________________

Consumer's Name: First: ____________________ Preferred: ________________Middle Initial: ____ Last Name: _______________________

Sex assigned at Birth (**F**emale/**M**ale) : _____Gender Identity (Man/Woman/Boy/Girl/Cis/Trans/Two Spirit/Non-Binary/Other): ___________ Gender Pronouns: __________

Mailing Address: ___________________________________City_____________________ State _________ Zip__________________

Home Phone#:____________________Cell Phone#:___________________ Email:____

Resident Address: ____

Referred By (Contact Person) ____

From (Agency) _____________________________________ Location____

Referral Phone#:___________________________________ Referral: Fax#:____

Is there a guardian or conservator? Yes or No **(please circle one)** If yes, contact name and phone number _________________________

Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good? Number of days: ____

Are you currently experiencing difficulties or problems in the following areas of your life and/or the lives of others who are important to you? [Please check all that apply]

[ ] Physical health, and/or other illnesses that affect daily life
[ ] Mental health, such as depression, trauma, anxiety, or suicidal thoughts
[ ] Family life, such as relationships with partner, spouse, and/or children
[ ] Housing, such as availability, affordability, quality, and/or stability
[ ] Transportation to and from school, work, and other important places
[ ] Social relationships with friends, neighbors, and important others outside of family
[ ] Substance use/abuse (what is your drug of choice? ________________________)
[ ] Legal problems, whether criminal or civil
[ ] Work or employment
[ ] Finances, adequate income
[ ] School and education
[ ] Personal safety

Of the difficulties or problems checked above, please circle the one of greatest concern to you?

State of Alaska Division of Behavioral Health requires all applications to be prioritized

Have you (and/or your child) experienced a violent traumatic event such as child abuse and neglect, sexual violence and/or suicide? ___

For Women: Are you Pregnant? Yes or No **(please circle one)** If yes, how many months? ___________________________________
If your children will join you in treatment: what are the ages ____

Are you an Injection Drug User? Yes or No **(please circle one)**

What are your living arrangements? Own/Rent, Living with Family/Friends, Shelter or Other **(please circle one)**

Please describe if living arrangements are other: ____

Are you a court referral? Yes or No **(please circle one)** If yes, who referred you? ____

Do you have any restraining orders in effect? Yes or No **(please circle one)** If yes, against whom___________________________

Treatment Experiences: Have you received treatment at one of Fairbanks Native Associations programs in the past? Yes or No

---

____Date____/____/_____
Signature of Consumer

Consumers under the age of 18

As the parent or legal guardian, _____________________ (print name) give consent for ______________________(child's name) to discuss treatment options available with Child, Youth and Young Adult Services

Parent or Legal Guardian Signature____Date_____/____/_____
By signing this form you are stating that the information contained within this application is true and accurate to your best knowledge.