The Arc
of Anchorage

2211 Arca Drive
Anchorage, Alaska 99508

T (907) 277-6677
F (907) 272-2161
E-mail: info@thearcofanchorage.org
www.thearcofanchorage.org

Date, Month, Day, Year

{Name of person}
{mailing address}
{city, state, zip code}

Dear {Mr., Ms., Sir, or Ma'am};

Thank you for your interest in services with The Arc of Anchorage.

The following instructions and checklist will assist you through the first steps toward involvement with The Arc of Anchorage's team. At this time we need to verify eligibility for Developmental Disability Services. This is done with a letter from The State of Alaska, Department of Health and Social Services, Division of Senior and Disability Services (SDS).

STEP 1: If you do not already have a letter of eligibility from The Division of Senior and Disability Services or you are not sure if you have completed the Developmental Disability Determination Application, please contact your local Short Term Assistance and Referral Coordinator. A current list can be found at: http://dhss.alaska.gov/dsds/Documents/grantservices/PDFs/STAR_Roster.pdf
STEP 2: Complete The Arc of Anchorage's Intake Application. This form can be found on our website at https://thearcofanchorage.org/our-services/intake-application/, or via email if requested.
STEP 3: Forms needed with signatures:

- The Arc of Anchorage's Intake Application.
- Release of Information Form for each individual, entity or provider that The Arc of Anchorage will need to communicate with regarding prior services/treatment records (please do not return signed Release of Information Forms that are not completely filled out).
- As many of the items listed on the checklist located on page 2 of this correspondence.

STEP 4: You can drop these items off at our front desk, fax the documents to me at 907-272-2161 or contact me at 907-777-0113 for an Intake Appointment.

Please contact me with questions or concerns regarding this process.

I look forward to meeting with you.

Respectfully,

Mona Murphy
CLS Case Manager/Intake Coordinator
Direct phone: (907) 777-0113
Agency Fax: (907) 272-2161
mmurphy@thearcofanchorage.org

The following items will help The Arc of Anchorage process the Applicant's Intake Application faster.

Please send the documents directly to Mona Murphy via fax at 907-272-2161 or mail/drop off at 2211 Arca Drive, Anchorage, AK 99508

☐ Letter of Eligibility from The Division of Senior and Disability Services

☐ Current copy of the Developmental Disabilities Registration and Review Form

☐ Current copy of the Plan of Care for Waivers (ISW, IDD, CCMS) and a copy of the ICAP, Level of Care and Appointment of Care Coordinator

☐ Current Behavioral Health Treatment Plan with corresponding Assessment

☐ Special Education - Evaluation Summary and Eligibility Review and/or Individualized Education Plan

☐ Miscellaneous Documents (*Required Documents, as applicable)
- Birth Certificate
- Social Security Card
- Medicaid Card
- Driver's License or State ID Card
- Certificate of Degree of Indian or Alaska Native Blood (CDIB Card)

☐ Proof of Guardianship (as applies, documents must be signed by a judge).
- Power of Attorney
- Court Ordered Guardianship
- Conservatorship or Payee Representative
- Custody Agreement
- Divorced Guardian's Request Custody Order
- Foster Care Papers
- Authorized Representative
- Condition of probation/parole

☐ Current or Prior Medical Records and/or Evaluations
- Neuropsychological Evaluation
- Psychological Evaluation
- Functional Assessments
- Mental Health Assessments
- School Individualized Education Plan (IEP)
- Occupational/Physical/Speech Therapy Evaluations, Progress Notes & Recommendations.
- Diagnosing Records of Mental Illness
- Diagnosing Records of Developmental Disability
- Verification of Diagnosis
- Rx Medication List
- Any Other Current Treatment Plans, Evaluations, or Recommendations from a Medical Professional

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APPLICANT'S PERSONAL INFO:

NOT info on Guardians, Parent, or Legal Reps

LEGAL LAST NAME:	
LEGAL FIRST NAME:	
MIDDLE INITIAL:	
DOB:	
CITY & STATE OF BIRTH:	
GENDER:	☐Male ☐Female ☐Other _____ ☐ Male to female transgender ☐ Female to male transgender
ADL OR STATE ID #:	
CONTACT NAME:	
CELL PHONE #: Best # to reach Applicant. State who # belongs to if not Applicant.	
EMAIL Address:	
PREFERRED CONTACT: Please choose one	☐Email ☐Phone ☐USPS
CARE COORDINATOR OR OTHER PERSON ASSISTING YOU:	First & Last Name _____ ☐Care Coordinator ☐Referral Source ☐Other_____ Phone Number _____
ARE YOU CURRENTLY RECEIVING SERVICES FROM OTHER PROVIDERS: Provider Names & Service Types	
HAVE YOU APPLIED FOR SERVICES WITH OTHER PROVIDERS: Provider Names & Service Types	
PHYSICAL ADDRESS: Applicants Address	
MAILING ADDRESS: Applicants Address	
ETHNICITY:	
PRIMARY LANGUAGE:	
ENGLISH FLUENCY: Please Choose One	☐Excellent ☐Good ☐Moderate ☐Poor
CITIZENSHIP:	☐US Citizen ☐Certificate of Naturalization ☐Certificate of Citizenship ☐Other _____
HEALTH INSURANCE: Answer Each Question	1. Health Insurance provided through guardian: ☐Yes ☐No 2. Primary Insurance:_____

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	3. Policy #:_____ 4. Group Name:_____ 5. Group Member:_____ 6. Insurance Address:_____ 7. City, State, Zip:_____ 8. Policy Holder:_____
APPLICANT HAS MEDICAID, DENALI KID CARE OR TERFA COVERAGE?	☐Medicaid Number: _____ ☐ISW ☐IDD ☐CCMC ☐MH Medicaid ☐Private Pay ☐Other _____ ☐Denali Kid Care ☐Terfa
APPLICANT HAS MEDICARE COVERAGE?	☐Yes - Medicare Number:_____ ☐No
APPLICANT RECEIVES ANY OTHER MEDICAL ASSISTANCE?	☐APA ☐SSI ☐Other: _____
ANTICIPATE CURRENT MEDICAL ASSISTANCE ELIGIBILITY TO END IN NEAR FUTURE?	If yes, Explain.
MEDICAL INFO:	1. Primary Care Physician:_____ 2. Date of Last Physical:_____ 3. Neurologist Name:_____ 4. Date of Last Psychological Evaluation:_____ 5. Dentist Name:_____ 6. Date of Last Exam:_____ 7. OTHER:_____
DIAGNOSTIC INFO:	1. Provide Name of ALL Diagnosis (past/present): 2. Age or Date of 1st Diagnosis: 3. Last time Reassessed:
LIST OF CURRENT MEDICATIONS:	Name: Dose: Frequency: Name: Dose: Frequency: Name: Dose: Frequency: Name: Dose: Frequency:
ALLERGIES: Please list all types of allergies - food allergies, environmental allergies, medication allergies, etc.	Allergy: Allergic Reaction: Allergy Allergic Reaction: Allergy Allergic Reaction: Allergy Allergic Reaction:

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Intake Application

Services being requested - please check all that may apply:	☐Case Management ☐Family Home Habilitation ☐ Group Home ☐ Supported Living ☐ In-Home Supports ☐Day Habilitation ☐Supported Employment ☐ Respite ☐ Nursing Oversight ☐Other: _____ ☐ Behavioral Health Services ☐Pharmacologic Management ☐Therapeutic Behavioral Health Services ☐Comprehensive Community Support Services ☐Psychotherapy
How did you hear about The Arc?	
Read and initial each of the following statements:	_____ I certify, under penalty of perjury, that the information on this application is a true and complete statement of the facts according to my best knowledge and belief. _____ I also understand that Al may be asked to provide proof of any information given on this application. _____ I understand that if this information substantially changes or services are no longer needed, I am required to notify The Arc of Anchorage. _____ I further understand that I am committed to participating in the service planning, including meetings, and service delivery.
Signatures:	_____ _____ Signature of Applicant Requesting Services (required for individuals over the age of 14) Date _____ _____ Signature of Referral Source Date _____ _____ Signature of Legal Representative Date _____ _____ Signature of Staff Member Date

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Release of Information

2211 Arca Drive, Anchorage, Alaska 99508
Phone: (907) 277-6677 • Fax: (907) 272 2161 • TTY: (907) 277-3345

Name of Individual whose information is to be released:	Individual's Date of Birth and Medicaid Number
Name of Parent/Legal Guardian, if applicable: (required for minors):	Individual's Contact Information (or legal representative, if applicable):

I authorize The Arc of Anchorage to: ☒ **RELEASE INFORMATION TO** and/or ☐ **OBTAIN INFORMATION FROM**

Individual/Entity/Provider: _____

Address: _____ City/State/Zip Code: _____

Main Phone Number: _____ Fax Number: _____

How would you like to receive these records: ☐ Fax ☐ Mail ☐ Walk In/Pick Up

Description of Specific Information to be disclosed and/or obtained: (please check all that apply)

	Intake Assessment		Neuropsychological Assessment		Service Plans & Reviews
	Education Records		Psychiatric/Psychological Assessment		Discharge/Transfer Summaries
	Service Notes (ISP Data)		Medication Lists		Complete Health Record
	Immunization Records		Pharmacological Management Notes		Other:
	Guardianship/Legal Rep Documents		Laboratory/Radiology Reports		Other:

(Optional) Record Dates authorized to be released (From): ___ (To) : ___

Specific purpose of this release of information (please check the best description):

☑ Coordination of Care/Treatment ☐ Legal Use ☐ Personal Use ☐ Emergency Contact ☐ Other: ___

I authorize the release of the following sensitive information below: (check all that apply)

☐ HIV/AIDS ☐ Drug/Alcohol Treatment and/or Diagnosis ☐ Mental Health Treatment and/or Diagnosis

I authorize The Arc of Anchorage and its administrative, program and clinical staff to use this information and/or disclose this protected health information. If the records pertain to alcohol and/or drug treatment, I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2. I understand that records pertaining to medical information and/or mental health services records are covered by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my consent unless otherwise provided for in the regulations. I understand that I may revoke this consent, in writing, at any time except to the extent that action has already been taken in reliance on it, and that in any event this consent expires automatically as follows: I understand that The Arc of Anchorage may not condition my treatment on whether I sign a consent form, but that in certain limited instances I may be denied treatment if I do not sign a consent form.

Expiration Date or Event: ___ (Unless otherwise specified, the authorization will expire one year from signature date)

_____ _____
Individual's Signature Signature Date

_____ _____
Parent/Guardian/Authorized Representative Signature Date

REVOCATION SECTION

This section should NOT be completed when the authorization is initially signed.

This section should ONLY be completed IF the individual wishes to revoke authorization. I hereby request that this authorization to release information be revoked: effective on my date of signature below:

Signature of Individual/Guardian: _____

Signature Date: _____