ADOLESCENT SBIRT

# Teen Health Screen

Patient Name: ______________________ Screening Date: __________

We ask all our teen patients annually about alcohol, tobacco and mood because these factors can affect your health. Tobacco products include cigarettes, cigars, chewing tobacco, vaping and betel nut. Please ask us if you have any questions. Your answers on this form will remain confidential.

## SECTION A – S2BI

| In the **PAST YEAR**, have you used: | Never | Once or Twice | Monthly | Weekly |
|---|---|---|---|---|
| Tobacco | ☐ | ☐ | ☐ | ☐ |
| Alcohol | ☐ | ☐ | ☐ | ☐ |
| Marijuana | ☐ | ☐ | ☐ | ☐ |

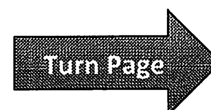
If you answered "Never" to all questions above, you can skip to Section B question #1 and turn the page. Otherwise, please continue answering all questions below.

| | Never | Once or Twice | Monthly | Weekly |
|---|---|---|---|---|
| Prescription drugs that were not prescribed for you: (such as pain medication or Adderall) | ☐ | ☐ | ☐ | ☐ |
| Illegal drugs: (such as cocaine or ecstasy) | ☐ | ☐ | ☐ | ☐ |
| Inhalants: (such as nitrous oxide) | ☐ | ☐ | ☐ | ☐ |
| Herbs or synthetic drugs: (such as salvia, "K2", or bath salts) | ☐ | ☐ | ☐ | ☐ |

## SECTION B - CRAFFT

| | | |
|---|---|---|
| 1. Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs? | ☐NO | ☐YES |
| 2. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in? | ☐NO | ☐YES |
| 3. Do you ever use alcohol or drugs while you are by yourself, or alone? | ☐NO | ☐YES |
| 4. Do you ever forget things you did while using alcohol or drugs? | ☐NO | ☐YES |
| 5. Do your family or friends ever tell you that you should cut down on your drinking or drug use? | ☐NO | ☐YES |
| 6. Have you ever gotten into trouble while you were using alcohol or drugs? | ☐NO | ☐YES |

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|



## SECTION C – PHQ-9 Modified for Teens

| How often have you been bothered by each of the following symptoms during the past **TWO WEEKS**? | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things? | ☐ | ☐ | ☐ | ☐ |
| 2. Feeling down, depressed, irritable, or hopeless? | ☐ | ☐ | ☐ | ☐ |
| 3. Trouble falling asleep, staying asleep, or sleeping too much? | ☐ | ☐ | ☐ | ☐ |
| 4. Feeling tired, or having little energy? | ☐ | ☐ | ☐ | ☐ |
| 5. Poor appetite, weight loss, or overeating? | ☐ | ☐ | ☐ | ☐ |
| 6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down? | ☐ | ☐ | ☐ | ☐ |
| 7. Trouble concentrating on things like school work, reading, or watching TV? | ☐ | ☐ | ☐ | ☐ |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual? | ☐ | ☐ | ☐ | ☐ |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way? | ☐ | ☐ | ☐ | ☐ |
| | 0 | 1 | 2 | 3 |

| | | |
|---|---|---|
| In the **PAST YEAR** have you felt depressed or sad most days, even if you felt okay sometimes? | ☐NO | ☐YES |

| If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people? | Not difficult at all ☐ | Somewhat difficult ☐ | Very difficult ☐ | Extremely difficult ☐ |
|---|---|---|---|---|

| | | |
|---|---|---|
| Has there been a time in the past month when you have had serious thoughts about ending your life? | ☐NO | ☐YES |

| | | |
|---|---|---|
| Have you **EVER**, in your **WHOLE LIFE**, tried to kill yourself or made a suicide attempt? | ☐NO | ☐YES |

| CRAFFT | N | ʎ | S2BI | N | O | W | M | PHQ-9 Mod | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | F |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | SD |

Materials provided by the American Academy of Pediatrics Hawai'i Chapter the Ka Huliau Project. Teen Health Screen Tool developed by SBIRTOregon consists of the S2BI, CRAFFT, and the PHQ-9 modified for teens. The S2BI was developed at Boston Children's Hospital with suport from the National Institute of Drug Abuse, The CRAFFT was developed by the Center for Adolescent Substance Abuse Research (CeASAR) at Boston Children's Hospital. The depression screen was modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)

# Integrated Care Referral Form

| REFERRAL SOURCE INFORMATION | | Date | |
|---|---|---|---|
| **Referring MD** | | **Phone** | |
| **Address** | | **Fax** | |
| **City** | | **Zip** | |

| PATIENT INFORMATION | | Urgency | |
|---|---|---|---|
| **Name** | | **DOB** | |
| **Parent or Guardian Name** | | **Last Visit Date** | |
| **Address** | | **Fax** | |
| **City** | | **Zip** | |
| **Primary Language** | ☐ English ☐ Other:<br>☐ Interpreter needed | ☐ Male ☐ Female | |

| REFERRAL INFORMATION | | | Phone | |
|---|---|---|---|---|
| **Name** | | | **Fax** | |
| **Reason for Referral** | **+Screen**<br>☐ Alcohol<br>☐ Tobacco<br>☐ Drug<br>☐ Violence<br>☐ Depression<br>☐ Anxiety<br>☐ Other | ☐ AUDIT (Alcohol Use Disorders Identification Test)<br>☐ CAGE (Cut down, Annoy, Guilty, Eye-opener)<br>☐ CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble)<br>☐ DAST (Drug Abuse Screening Test)<br>☐ PHQ-A (Patient Health Questionniare for Adolescents)<br>☐ PHQ-9 (Patient Health Questionniare 9)<br>☐ PHQ-4 (Patient Health Questionniare 4)<br>☐ S2BI<br>☐ 5P's (Parents, Peers, Partner, Past, Present, Violence, Depression, Smoking) | | |
| **Comments:** | | | | |

## FOLLOW UP

**I have instructed my patient to schedule an appointment. To facilitate communication please provide a consult report regarding the following:**

- ☐ Completion of evaluation
- ☐ Follow-up arranged or provided
- ☐ Appointment not made/kept
- ☐ Adds or changes to medication
- ☐ Termination of treatment
- ☐ Other care needed

| ☐ This request does not require consent.<br>This is not a request for psychotherapy notes. | ☐ This request requires consent.<br>The 42 CFR Part 2 and HIPAA compliant consent form is attached. |
|---|---|

Referring Physician Signature ____________________ Date ________

# CONSENT INFORMATION

I, ________________________________________ authorize

**FULL PRINTED NAME OF CONSENTING PERSON OR PERSONS**

**NAME OF PROVIDER OR PROGRAM MAKING DISCLOSURE**

to disclose to ______________________________________

**REFERRING PROVIDER**

the following information: ______________________________________

The purpose of this disclosure authorized herein is to coordinate services and treatment planning from a referral to treatment.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

**SPECIFICATION OF THE DATE, EVENT, OR CONDITION UPON WHICH THIS CONSENT EXPIRES**

**DATE** **SIGNATURE OF PATIENT**

**SIGNATURE OF PERSON SIGNING FORM IF NOT PATIENT**

**DESCRIBE AUTHORITY TO SIGN ON BEHALF OF PATIENTS**

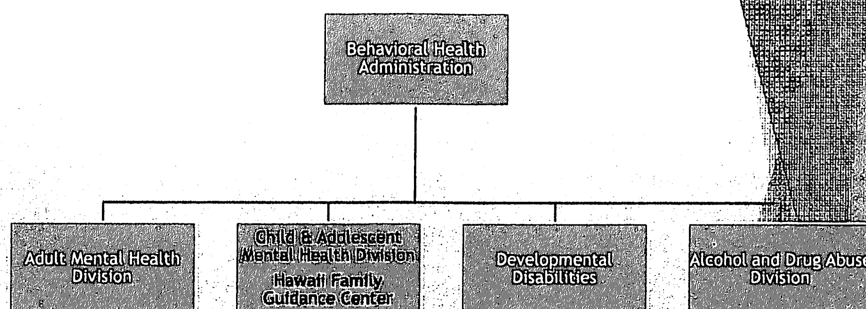
Materials provided by the American Academy of Pediatrics Hawai'i Chapter the Ka Huliau Project. Tool developed in partnership with Aloha United Way and the Omidyar 'Ohana Fund at the Hawai'i Community Foundation through the Hawai'i Prenatal SBIRT Project of the Hilopa'a Family to Family Health Information Center Hawai'i, March 2016.

# Child and Adolescent Mental Health Division

How to access child and adolescent mental health services?

Rachelle Agrigado - East HI FGC Center Chief

## Hawaii State Department of Health



# EAST HAWAII FAMILY GUIDANCE CENTER

**Our vision: HAPPY KEIKI, HEALTHY OHANA, HELPFUL COMMUNITY**

*Our mission is to malama keiki and 'ohana by providing quality care coordination and mental health services that support them every step of the way.*

## What do we do?

- The Hawaii Family Guidance Center (HFGC) provides intensive mental health services and care coordination for the Child and Adolescent Mental Health Division (CAMHD) of the Department of Health (DOH).
- CAMHD provides services ranging from intensive case management and outpatient therapy to transitional foster placement and hospital-based residential treatment. Our clients typically struggle with behavioral and/or emotional difficulties in multiple settings(at school, at home, in the community, with peers) and may have problems with substance use, suicidal ideation and/or psychosis

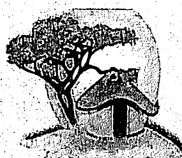
## Who is eligible?

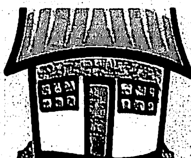
A child, youth or adolescent who meets the following:

- Is 3 through 20 years of age; and
- Has Hawaii QUEST or Medicaid Fee-For-Service insurance and/or is IDEA identified ; and
- Has significant problems with different areas of life such as home and school; and
- Has a qualifying ICD10 diagnosis

* Note - Assessments and other information provided will be used to determine the extent of a child's emotional and behavioral needs.

## What are the services?





**Outpatient services**
- Intensive In-Home Therapy
- Multi-Systemic Therapy
- Functional Family Therapy
- CBI - Comprehensive Behavioral Intervention
- Independent Living Skills
- Tele-psychiatry
- Parent Partner

**Out of home services**
- Transitional Family Homes
- Therapeutic Respite Homes
- Community Based Residential
- Hospital Based Residential

**Crisis Services**
- Crisis Mobile Outreach
- Therapeutic Crisis Homes

# Access to Mental Health Services

IDEA
Individuals with Disabilities Act

| Educationally Supportive Services (ES) | Support for Emotional and Behavioral Development (SEBD) | Juvenile Justice Involvement via Office of Youth Services |
| --- | --- | --- |

# APPLICATIONS

Family Application For CAMHD Services

Department of Education

# Who we are:

**CSS 1 – Hilo Care Coordinators**

Charmaine Alameda - Supervisor
Darianne Piagentini-Godoy
Jamie-Lee Keliikuli
Kailoa Harmon
Samson Kela
Vacant

**CSS 2 – Hilo/Puna Care Coordinators**

Terry Michels - Supervisor
Kim DeLima
Kuulei Galloway
Rachel Oili
Robyn Vincent
Sharra Dancel
Zachary Montizor

**CSS 3 – Puna/Ka'u Care Coordinators**

Rachelle Agrigado - Center Chief
Allan Sebastian
Christine Keanu
David Catrvalho
Jasmine Kaahanui
Thayne Sweat

# Questions?

Mental Health... is not a destination but a process. It's about how you drive, not where you're going."
~ Noam Shpancer

# State of Hawaii

**Department of Health**
**Child & Adolescent Mental Health Division**
3627 Kilauea Avenue, Room 101
Honolulu, Hawaii 96816
(808) 733-9333

## Family Application for CAMHD Services Instructions

**Families:** Please complete as much of the Family Application for CAMHD Services form as you can. In addition, please make sure that you have read through and signed the consent forms. Once you have completed the forms, please send them in to the Family Guidance Center nearest to you. If you run into trouble filling out the form and need assistance, feel free to call your local Family Guidance Center for help.

**Referring Agencies:** Please complete the last two sections, Agency Contact Information and Authorization for Use or Disclosure of Protected Health Information.

**Department of Education:** Please use this form for Medicaid referrals. For ES/IDEA referrals, please use the Department of Education ES/IDEA Referral packet.

### CAMHD Family Guidance Centers

### Hawaii

**Hawaii FGC - Hilo**
88 Kanoelehua Ave, Suite A-204
Hilo, Hawaii 96720
Phone: (808) 933-0610
Fax: (808) 933-0558

**Hawaii FGC - Kona**
81-980 Halekii Street, Room 101
Kealakekua, Hawaii 96750
Phone: (808) 322-1534
Fax: (808) 322-1547

**Hawaii FGC - Waimea**
65-1230 Mamalahoa Highway,
Suite A-11
Kamuela, Hawaii 96743
Phone: (808) 887-8100
Fax: (808) 887-8113

### Kauai

**Kauai FGC**
3-3204 Kuhio Highway, Room 104
Lihue, Hawaii 96766
Phone: (808) 274-3883
Fax: (808) 274-3889

### Maui

**Maui FGC - Wailuku**
270 Waiehu Beach Road, Suite 213
Wailuku, Hawaii 96793
Phone: (808) 243-1252
Fax: (808) 243-1254

**Maui FGC - Lahaina**
1830 Honoapiilani Highway
Lahaina, Hawaii 96761
Phone: (808) 662-4045
Fax: (808) 661-5450

### Lanai

**Maui FGC - Lanai**
c/o Lahaina Office
1830 Honoapiilani Hwy.
Lahaina, Hawaii 96761
Phone: (808) 662-4045
Fax: (808) 661-5450

### Molokai

**Maui FGC - Molokai**
65 Makaena Place
Kaunakakai, Hawaii 96748
Phone: (808) 553-7878
Fax: (808) 553-7874

### Oahu

**Central Oahu FGC - Pearl City**
860 Fourth Street, 2nd Floor
Pearl City, Hawaii 96782
Phone: (808) 453-5900
Fax: (808) 453-5940

**Central Oahu FGC - Kaneohe**
45-691 Keaahala Road
Kaneohe, Hawaii 96744
Phone: (808) 233-3770
Fax: (808) 233-5659

**Honolulu FGC**
3627 Kilauea Avenue, Room 401
Honolulu, Hawaii 96816
Phone: (808) 733-9393
Fax: (808) 733-9377

**Leeward Oahu FGC**
601 Kamokila Boulevard,
Room 355
Kapolei, Hawaii 96707
Phone: (808) 692-7700
Fax: (808) 692-7712



Revised April 12, 2017

## Family Application for CAMHD Services

### Youth Information

Name: ______________________ Date of Birth: ___/___/_____

Preferred Name: ______________________ Gender: ○ Male ○ Female

School: ______________ Grade: _____ Gender Identity: __________

Primary MedQUEST Insurance Plan: ○ AlohaCare ○ OHANA ○ HMSA ○ UHA ○ Kaiser

○ None ○ Other: ______________ Insurance ID#: ______________

Secondary Insurance: ○ AlohaCare ○ OHANA ○ HMSA ○ UHA ○ Kaiser ○ TriCare

○ None ○ Other: ______________ Insurance ID#: ______________

SSN: ______________ Primary Care Provider: ______________

Who does your child live with? ○ Parents ○ Relatives ○ Foster Family ○ Other: __________

How did you hear about our services? ☐ DOH Website ☐ School ☐ Primary Care Provider

☐ Brochure ☐ Child Welfare Service ☐ Therapist ☐ Probation Officer

☐ Other: ______________________

Youth's Preferred Language: ______________________

### Background Questions

Has your child been evaluated for emotional or behavioral reasons before?

○ Yes ○ No ○ I don't know

Why is your family seeking mental health services? ______________________

______________________________________________

**Primary Legal Guardian Information**

Name: ______________________________

Guardian's Preferred Language: ______________________________

Primary Phone Number: ______________ Secondary Phone Number: ______________

Relationship to Youth: ○ Mother ○ Father ○ Grandparent ○ Aunt or Uncle

○ Foster Parent ○ CWS Social Worker ○ OYS Administrator ○ Other: ______________

I have the legal right to sign consents for this youth: ○ Yes ○ No

Email: ______________________________

Mailing Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

Home Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

**Additional Guardian Information** *Please complete if there is an additional caregiver.*

Name: ______________________________

Guardian's Preferred Language: ______________________________

Primary Phone Number: ______________ Secondary Phone Number: ______________

Relationship to Youth: ○ Mother ○ Father ○ Grandparent ○ Aunt or Uncle

○ Foster Parent ○ CWS Social Worker ○ OYS Administrator ○ Other: ______________

I have the legal right to sign consents for this youth: ○ Yes ○ No

Email: ______________________________

Mailing Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

Home Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

*I attest that the information given is complete and correct, and that I have the legal right to sign consents for this youth.*

*I hereby consent to the evaluation of my child for the purpose of determining eligibility, and agree to CAMHD program enrollment, and agree that CAMHD may obtain information about my child with the understanding that it cannot be disclosed to others without my further approval, except the agency that has referred you and completed this packet, unless permitted by Federal or State law. I also understand that this consent expires in one year.*

Parent or Legal Guardian's Signature: ______________________________ Date: ___/___/_____

**Agency Contact Information**

*To be completed by referring agency only. If there is none, leave blank.*
*If a state agency is making this referral the agency must complete this section, and the "Authorization for Use or Disclosure of Protected Health Information (PHI)" at the end of this packet as appropriate.*

Agency: ○ CWS ○ OYS ○ DHS ○ PO ○ DOE ○ Other: ______________________________

Referral Program Type: ○ MedQUEST/SEBD ○ DOE/IDEA ○ OYS/MOA ○ PK Only

Form completed by: ☐ Agency Contact ☐ Guardian ☐ Youth Case Worker

☐ Other: ______________________________

Name: ______________________________ Phone Number: ______________

Email: ______________________________

Mailing Address: ______________________________

City: ________________ State: __________ Zip Code: __________

Relationship to Youth: ○ Foster Parent ○ CWS Social Worker ○ DOE/SBBH

○ Parole Officer ○ Probation Officer ○ OYS Administrator

○ Other: ______________________________

Title: ______________________________

HYCF Intake Date: ___/___/_____ HYCF Projected End Date: ___/___/_____

Parole Start Date: ___/___/_____ Parole Projected End Date: ___/___/_____

Probation Start Date: ___/___/_____ Probation Projected End Date: ___/___/_____

CWS Status: ____________________

CWS Start Date: ___/___/_____ Projected CWS End Date: ___/___/_____

I have the legal right to sign consents for this youth: ○ Yes ○ No

Reason for Referral: ______________________________

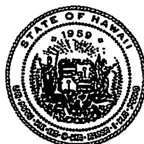
______________________________

______________________________

List of social, emotional, and behavioral health needs: ______________________________

______________________________

______________________________



# Child and Adolescent Mental Health Division (CAMHD)
# Authorization to Jointly Disclose Protected Health Information (PHI)

**Individual Whose Protected Health Information is Being Disclosed**

| First Name: | Last Name: |
|---|---|
| Address: | Birth Date: |
| **FROM: Child and Adolescent Mental Health Division** 3627 Kilauea Avenue, Room 101, Honolulu HI 96816 | **TO: All Parties Identified Below** |
| **FROM: All Parties Identified Below** | **TO: Child and Adolescent Mental Health Division** 3627 Kilauea Avenue, Room 101, Honolulu HI 96816 |

*Please initial all agencies your information may be disclosed with.*

**Department of Health**
- ___ Developmental Disabilities Division
- ___ Early Intervention Section
- ___ Alcohol and Drug Abuse Division

**Juvenile Client Services Branch**
- ___ Oahu – First Circuit
- ___ Maui – Second Circuit
- ___ Hawaii – Third Circuit
- ___ Kauai – Fifth Circuit

**University of Hawaii**
- ___ Psychology (First Episode Psychosis /Eval/CCBT)
- ___ Psychiatry (Telepsych/Eval)

**Department of Education**
- ___ Honolulu District
- ___ Central District
- ___ Leeward District
- ___ Windward District
- ___ Hawaii District
- ___ Kauai District
- ___ Maui District

**Department of Human Services**
- ___ Child Welfare Services Branch
- ___ Office of Youth Services
- ___ Med-QUEST Division

___ **Other:**
___ **Other:**

**Providers**
- ___ Alaka`i Na Keiki
- ___ Aloha House
- ___ Benchmark Behavioral Health Services
- ___ Bobby Benson Center (BBC)
- ___ Care Hawaii, Inc.
- ___ Catholic Charities Hawaii (CCH)
- ___ Child & Family Service
- ___ Hale Kipa Inc.
- ___ Hale `Opio Kauai, Inc.
- ___ Hawaii Behavioral Health (HBH)
- ___ Marimed Foundation
- ___ Maui Youth & Family Services
- ___ Parents and Children Together (PACT)
- ___ Queen's Family Treatment Center (QFTC)
- ___ Sutter Health Pacific dba Kahi Mohala Behavioral Hospital
- ___ Waianae Coast Community Mental Health Center

I authorize that the following Protected Health Information be disclosed: **Any and all information relevant to mental health care coordination, treatment planning, access to resources, assessments and supports. This includes but is not limited to:**

- **Clinical Management Plan; Coordinated Service Plans; Mental Health related assessments and evaluations**
- **Provider mental health treatment plans and progress reports**
- **Court hearings, reports and orders**
- **Individualized Educational Plans and Department of Education (DOE) health-related documents**
- **Functional Behavioral Assessments and Behavioral Support Plans**
- **Mental Health-related medical records**
- **Department of Human Services (DHS)**
- **Type of Records:**
- **Other:**

Initial here if your authorization includes the disclosure of Substance Abuse Treatment information: ______ (initials)

The Protected Health Information is being disclosed for the following **Purpose: To help identify the client's needs and strengths, assist in developing treatment recommendations, assist in screening of eligibility for services and to provide care coordination of intensive mental health services.**

This authorization will be in force and effect until: **Six (6) Months after Termination of Services.** At that time, this authorization to disclose this protected health information expires.

I understand that I have the **right to revoke this authorization, in writing,** at any time by sending such written notification to the Department of Health. I understand that a revocation is not effective to the extent that the Department has relied on the disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. However, I understand that information related to education (FERPA 34, CFR Part 99), alcohol or drug treatment services (42 CFR Part 2) may not be disclosed or re-disclosed without my authorization.

The Entity or Person(s) receiving this information will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The disclosure requested under this authorization will result in direct or indirect remuneration to the Department from a Third Party.

| Individual or Personal Representative Signature: | Date: |
|---|---|
| Print Name of Individual or Personal Representative: | Description of Personal Representative's Authority: |

Revised: 12/08/2016

## Names and Addresses

### Department of Health

- ☐ **Developmental Disabilities Division**
  1250 Punchbowl Street, Suite 423, Honolulu HI 96813
- ☐ **Early Intervention Section**
  1350 South King Street Suite 200 Honolulu, Hawaii 96814
- ☐ **Alcohol and Drug Abuse Division**
  601 Kamokila Boulevard, Suite 360, Kapolei HI 96707

### Juvenile Client Services Branch, Judiciary

- ☐ **Oahu – First Circuit**
  4675 Kapolei Parkway, Kapolei HI 96707-3272
- ☐ **Maui – Second Circuit**
  2145 Main Street, Wailuku HI 96793-1679
- ☐ **Hawaii – Third Circuit**
  777 Kilauea Avenue, Hilo HI 96720-4212
- ☐ **Kauai – Fifth Circuit**
  3970 Kaana Street, Lihue HI 96766

### University of Hawaii

- ☐ **Department of Psychology**
  The Center for Cognitive Behavior Therapy (CCBT)
  2444 Dole Street, Krauss Hall 101, Honolulu, HI 96822
- ☐ **Department of Psychiatry**
  1356 Lusitana Street, 4th Floor, Honolulu, HI 96813

### Department of Education

- ☐ **Honolulu District**
  4967 Kilauea Avenue, Honolulu HI 96816
- ☐ **Central District**
  1122 Mapunapuna Street, Suite 200, Honolulu Hi 96819
- ☐ **Leeward District**
  601 Kamòkila Boulevard, Suite 418, Kapolei, HI 96707
- ☐ **Windward District**
  46-169 Kamehameha Highway, Kaneohe HI 96744
- ☐ **Hawaii District**
  75 Aupuni St. Room 203, Hilo HI 96720-4253
- ☐ **Kauai District**
  3060 Eiwa Street, Suite 305, Lihue, HI 96766
- ☐ **Maui District**
  54 High St, 4th Floor, Wailuku HI 96793

### Department of Human Services

- ☐ **Child Welfare Services Branch**
  420 Waiakamilo Road, Honolulu HI 96817
- ☐ **Office of Youth Services**
  42-470 Kalanianaole Highway, Kailua HI 96734
- ☐ **Med-QUEST Division**
  601 Kamokila Blvd, Room 518, Kapolei, HI 96707

### Providers

- ☐ **Alaka`i Na Keiki**
  1100 Alakea St, Honolulu, HI 96813
- ☐ **Aloha House**
  200 Ike Dr, Makawao, HI 96768
- ☐ **Benchmark Behavioral Health Services**
  2501 Waimano Home Rd, Pearl City, HI 96782
- ☐ **Bobby Benson Center (BBC)**
  56-660 Kamehameha Highway Kahuku, HI 96731
- ☐ **Care Hawaii, Inc.**
  875 Waimanu St, Honolulu, HI 96813
- ☐ **Catholic Charities Hawaii (CCH)**
  1822 Keeaumoku Street Honolulu, HI 96822
- ☐ **Child & Family Service**
  91-1841 Fort Weaver Road Ewa Beach, HI 96706
- ☐ **Hale Kipa Inc.**
  615 Pi'ikoi Street, Suite 203 Honolulu, HI 96814
- ☐ **Hale `Opio Kauai, Inc.**
  2959 Umi St # 300, Lihue, HI 96766
- ☐ **Hawaii Behavioral Health (HBH)**
  210 Ward Avenue #219 Honolulu, HI 96814
- ☐ **Marimed Foundation**
  45-021 Likeke Place Kaneohe, HI 96744
- ☐ **Maui Youth & Family Services**
  200 Ike Dr, Makawao, HI 96768
- ☐ **Parents and Children Together (PACT)**
  1485 Linapuni Street, Suite 105 Honolulu, HI 96819
- ☐ **Queen's Family Treatment Center (QFTC)**
  1301 Punchbowl Street Honolulu, HI 96813
- ☐ **Sutter Health Pacific dba Kahi Mohala Behavioral Hospital**
  91-2301 Fort Weaver Road Ewa Beach, HI 96706
- ☐ **Waianae Coast Community Mental Health Center**
  86-226 Farrington Highway Waianae, HI 96792

### Other

- ☐
- ☐
- ☐

**Youth Name:**

**Youth CR# (if known):**

# Adolescent Substance Use Provider Listing

October 2016

| ISLAND | PROVIDER | FAX NUMBER | COMMUNITY-BASED | SCHOOL-BASED |
|---|---|---|---|---|
| **O'ahu** | Alcoholic Rehabilitation Services of Hawai'i, INC. dba Hina Mauka | (808) 236-2626 | ● | ● |
| | CARE Hawai'i, Inc. | (808) 791-6198 | ● | |
| | Child and Family Services | (808) 681-6353 | ● | ● |
| | Coalition for a Drug Free Hawai'i | (808) 545-2686 | | ● |
| | Young Men's Christian Association (YMCA) of Honolulu | (808) 842-7736 | | ● |
| **Hawai'i** | Big Island Substance Abuse Council | (808) 887-0508 | ● | ● |
| **Kaua'i** | Alcoholic Rehabilitation Services of Hawai'i, INC. dba Hina Mauka | (808) 245-8040 | ● | ● |
| **Moloka'i** | Hale Ho'okupa'a | (808) 553-5474 | | ● |
| **Maui and Lāna'i** | Maui Youth and Family Services, INC. | (808) 579-8426 | ● | ● |
| | Ohana Makamae, INC. | (808) 248-7099 | | ● |

| **Substance Abuse Treatment Providers** | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Area Served | Fax Number | Funding | | | | | | | | | | | <18y | ≥18y |
| | | ADAD | AlohaCare | HMSA QI | 'Ohana | HMAA | HMSA | United | UHA | TRICARE | VA | Self-Pay | | |
| **HONOLULU – OAHU** | | | | | | | | | | | | | | |
| The Queen's Medical Center: Day Treatment Services | (808) 547-4574 | ● | ● | ● | ● | ● | ● | ● | ● | ● | | ● | ● | ● |
| Care Hawaii | (808) 791-6198 | ● | ● | ● | ● | ● | ● | ● | ● | ● | | | ● | ● |
| Care Hawaii Adolescent IOP | (808) 791-6198 | ● | ● | ● | ● | ● | ● | ● | ● | ● | | | ● | |

Materials provided by the American Academy of Pediatrics Hawai'i Chapter the Ka Huliau Project.
Materials developed by the University of Hawai'i Department of Psychiatry with support from the Hawai'i Department of Health, Preventive Health and Health Services Block Grant

| **Substance Abuse Treatment Providers** | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Area Served | Fax Number | Funding | | | | | | | | | | | <18y | ≥18y |
| | | ADAD | AlohaCare | HMSA QI | 'Ohana | HMAA | HMSA | United | UHA | TRICARE | VA | Self-Pay | | |
| Salvation Army Addiction Treatment Services | | ● | ● | ● | | ● | ● | ● | ● | | | ● | | ● |
| Salvation Army Family Treatment Services | (808) 734-7470 | ● | ● | ● | | ● | ● | ● | ● | | | | ● | ● |
| Waikiki Health Center: PATH Clinic | (808) 683-7058 | | ● | ● | ● | ● | ● | ● | ● | | | | ● | ● |
| Ku Aloha Ola Mau | (808) 538-0474 | ● | ● | ● | ● | ● | ● | ● | | | | | | ● |
| Sand Island Treatment Center | (808) 841-5232 | | ● | ● | ● | ● | ● | ● | | | | | | ● |
| Kokua Kalihi Valley Comprehensive Family Services | (808) 848-0979 | ● | ● | ● | ● | ● | ● | ● | | | | | ● | ● |
| Women's Way | | ● | ● | ● | | | ● | | | | | ● | ● | ● |
| YMCA Kalihi | (808) 842-7736 | ● | | | | | | | | | | | ● | |
| Oxford House | | ● | | | | | | | | | | ● | | ● |
| CHAMP Clinic (Comprehensive Health and Attitude Mangement) | (808) 426-4519 | | ● | ● | ● | ● | ● | ● | ● | | | | | ● |
| Mckenna Recovery Center: Ke Ala Pono | | | | ● | | ● | ● | | | | | | | ● |
| Freedom Recovery Services | (808) 591-0590 | | | ● | | | ● | | | | | | | ● |
| Real World Recovery | (808) 947-2231 | | | ● | | | ● | | | | | | ● | ● |
| **CENTRAL – OAHU** | | | | | | | | | | | | | | |
| Action With Aloha | (808) 484-4489 | ● | ● | ● | ● | ● | ● | ● | ● | | | | | ● |
| Ho'oko Counseling Center | | | | ● | | ● | ● | ● | ● | ● | | | ● | ● |
| Army Substance Abuse Program (ASAP) | (808) 433-8701 | | | | | | | | | ● | ● | | ● | ● |
| Naval Health: Makalapa Clinic | | | | | | | | | | ● | ● | | | ● |
| Tripler Army Medical Center Addictions Medicine IOP Program | (808) 433-1829 | | | | | | | | | ● | ● | | ● | |

| Substance Abuse Treatment Providers | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Area Served | Fax Number | Funding | | | | | | | | | | | <18y | ≥18y |
| | | ADAD | AlohaCare | HMSA QI | 'Ohana | HMAA | HMSA | United | UHA | TRICARE | VA | Self-Pay | | |
| VA Pacific Islands Health Care System Substance Use Disorder Program | | | | | | | | | | ● | ● | | | |
| Adolescent Substance Abuse Counseling Service (ASACS) | (808) 655-6934 | | | | | | | | | ● | | | ● | |
| **WINDWARD – OAHU** | | | | | | | | | | | | | | |
| Po'ailani | (808) 263-3508 | ● | ● | ● | ● | ● | ● | ● | ● | | | ● | ● | ● |
| Hina Mauka Recovery Center | (808) 236-2626 | ● | ● | | ● | ● | ● | ● | ● | ● | | ● | ● | ● |
| Hina Mauka: Kaneohe Teen CARE Program | | ● | | | | | | | | | | | ● | |
| Hawaii Counseling & Education Center | 1 (877) 831-4232 | | ● | | ● | ● | ● | ● | ● | ● | | | ● | ● |
| Bobby Benson Center | (808) 293-7196 | ● | ● | ● | ● | ● | ● | ● | ● | | | ● | ● | |
| North Shore Mental Health: Ohana Access to Recovery Program | | ● | ● | ● | ● | ● | ● | | ● | ● | | | ● | ● |
| Substance Abuse Counseling Center, Marine Corps Base Hawaii (SACC) | (808) 257-3810 | | | | | | | | | ● | | | | ● |
| **LEEWARD – OAHU** | | | | | | | | | | | | | | |
| Child & Family Service | (808) 681-6363 | ● | ● | ● | | ● | ● | ● | ● | | | ● | ● | ● |
| Ho'omau Ke Ola | (808) 696-3661 | ● | ● | ● | ● | ● | ● | ● | ● | | | ● | | |
| Waianae Coast Comprehensive Health Center: Malama Recovery Services | | ● | ● | ● | ● | ● | ● | ● | ● | | | ● | ● | ● |
| Women In Need | (808) 486-1997 | ● | ● | ● | ● | | ● | | | | | | | |
| Hina Mauka: Waianae Teen CARE Program | | ● | | | | | | | | | | | ● | |

| Substance Abuse Treatment Providers | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Area Served | Fax Number | Funding | | | | | | | | | | | <18y | ≥18y |
| | | ADAD | AlohaCare | HMSA QI | 'Ohana | HMAA | HMSA | United | UHA | TRICARE | VA | Self-Pay | | |
| Hina Mauka: Waipahu Teen CARE Program | | ● | | | | | | | | | | | | |
| Kahi Mohala Behavioral Health Center | (808) 677-2574 | | ● | ● | ● | ● | ● | ● | ● | ● | | ● | ● | |
| Waianae Coast Community Mental Health Center: Hale Na'au Pono | | | ● | ● | ● | ● | ● | ● | | | | | | ● |
| Integrated Counseling & Psychotherapy | | | | | | ● | | | | | | | | ● |
| United States Veterans Initative, INC | (808) 682-9006 | | | | | | | | | ● | ● | | | ● |
| Waianae Civic Center Homeless Transitional Facility | (808) 682-6711 | | | | | | | | | | ● | | ● | ● |