

CLIENT REGISTRATION

For registering clients of clinicians (1) in programs that received Attorney General funds under Kentucky Kids Recovery Program, and (2) clinicians who received AHARTT-sponsored training in Functional Family Therapy or Cognitive Behavior Therapy

**NOVEMBER 2014 RELEASE
FEBRUARY 2015 UPDATE**

The paper version of the KY Kids Recovery Program (KKRP) and AHARTT client registration is for educational purposes only. Use the online data collection program by logging in to the secure client information system at: <https://ukcdar.uky.edu/kykids>

If you must complete the interview on paper (i.e., internet is down, meeting with youth away from computer access), please enter the information into the online data collection program **within 7 days** of the interview date to maintain validity of data.

This information is used to count the number of clients your program/you serve through the KKRP funds or AHARTT-sponsored training.

In order to register this client we will need some basic information. Please choose from the options below.

1. Please select the reason you are registering the client in the system:
 - 2 = I (the clinician) has received AHARTT-sponsored training in Functional Family Therapy (FFT) or Cognitive Behavioral Therapy (CBT) and will be using one of these therapies with this client.
 - 1 = This client is being served through funds from the Kentucky Kids Recovery Program (through special funding from the Kentucky Attorney General's Office)
 - 3 = Both of the above apply to this client

2. Is your program part of a CMHC? 0 = No (**Skip to #3**) 1 = Yes

2a. What is the CMHC region for this treatment program? (*Please skip to #3 if your program is the collaborative effort between The Ridge and bluegrass.org*)

- 1 = Four Rivers
- 2 = Pennyroyal
- 3 = RiverValley
- 4 = LifeSkills
- 5 = Communicare
- 6 = Seven Counties
- 7 = NorthKey
- 8 = Comprehend
- 10 = Pathways
- 11 = Mountain
- 12 = Kentucky River
- 13 = Cumberland River
- 14 = Adanta
- 15 = Bluegrass

3. (*If the program is not one of the CMHC programs*) Please select the name of the program in which the client is receiving treatment:

- 1 = Boys and Girls Haven
- 2 = Children's Home of Northern Kentucky
- 3 = KVC Behavioral Health Care Kentucky
- 4 = Maryhurst
- 5 = Methodist Home of Kentucky
- 6 = Necco
- 7 = Our Lady of Peace
- 8 = Ramey Estep Homes
- 9 = Rivendell Behavioral Health Hospital
- 10 = Specialized Alternatives for Family and Youth of Kentucky (SAFY)
- 11 = The Ridge Behavioral Health System & bluegrass.org
- 12 = University of Kentucky Department of Psychiatry Model Clinic
- 12 = WestCare
- 13 = Other program, please specify: _____

When entering your site on AKTOS you will now use Site ID instead of I-SATS number. If you do not know your Site ID or do not see your site listed, select the closest match (i.e., main office, physical location where you attend meetings, where your paycheck is issued).

(You will need to fill out the site code only if your program is part of a CMHC)

4. What is the site ID or site code for this treatment program?

Site ID: _____

To track clients accurately and to allow us to contact program staff if we have questions, please enter the contact information for the clinician or admitting staff person.

5. Admitting clinician's or staff person's name: _____

6. Email address of the admitting clinician or staff member: _____

7. Work phone number of admitting clinician/staff member: (_____) _____ - _____

Please enter information about the client so we can register him/her in the system. All client information is confidential (with identifiers stored separately from survey data), is encrypted (or scrambled) such that only those with a specific key can read them, and can only be accessed by authorized staff.

8. Client's name: First _____ Middle _____ Last _____

9. What is the client's date of birth? ____/____/____

10. What is the client's social security number? ____-____-____

11. *(If the client is a KY Kids Recovery Program client)* Please indicate the type of services the client is receiving at your program:

- 1 = Prevention, universal (education for all)
- 2 = Prevention, selected (education with individuals with risk factors)
- 3 = Prevention, indicated or targeted (information and referral with high-risk individuals)
- 4 = Early intervention
- 5 = Treatment
- 6 = Assessment only (i.e., other program may provide treatment if warranted)

12. **Date of entry into this prevention/treatment episode/assessment** [Date the client began receiving prevention or early intervention services OR Date the client was admitted into this treatment episode OR Date of the assessment]: _____MM/_____DD/_____YYYY

Note: In the web data collection survey, you will be asked to verify the intake interview date.

13. *(Skip if the client is receiving prevention, intervention, or assessment only services)* What type of admission is the client to your program?

- 1 = Readmission
- 2 = New admission
- 3 = Continuing client but will receive a new type of service/therapy

14. What type of medical insurance does the client have? **Select one.**

- 1 = No medical insurance
- 2 = Insurance through family member's employer
- 3 = Insurance through Health Exchange
- 4 = Other private insurance (self-employed)
- 5 = Medicaid (Medical card, Passport)
- 6 = Medicare
- 7 = VA/Champus/Tricare
- 8 = Other: Specify _____

15. Will insurance cover any part of this prevention/assessment/treatment episode?

- 0 = No
- 1 = Yes
- 2 = Don't know

16. Client Information	
a. City in which the client resides	
b. County in which the client resides	
c. State in which the client resides	1 = KY 2 = OH 3 = WV 4 = VA 5 = TN 6 = MO 7 = IN 8 = Other, please specify: _____
d. Client's zip code	