

Applicant Please KEEP THIS PAGE

SOME OF THE THINGS THAT CAN MAKE AN INDIVIDUAL INELIGIBLE FOR MEDICATION ASSISTED TREATMENT:

1. Disruptive and/or disrespectful behavior, violence or threats of violence in the clinic, on the clinic property, or at another treatment facility
2. Misuse of benzodiazepines or alcohol
3. Unresolved legal issues
4. Inability to meet the diagnosis for Opioid Dependence
5. Inability to attend daily dosing and weekly counseling in an outpatient level of care
6. Medical, legal, or mental health issues that preclude full participation in treatment

IMAT POLICY AND PROCEDURES SECTION V. INTAKE REQUIREMENTS AND PROCESS

Admission Criteria: Applicants must satisfy the following criteria:

- a) Consumer must provide proof that they are 18 years or older;

Sufficient verification of current physiological dependence on opioid drug(s) (includes urine screen for opioids, physiological manifestations of opioid abstinence syndrome, physical evidence) or eligibility according to specific exceptions as outlined in federal regulations; and

- b) Documentation of 1-year addiction. Addiction history documents may include:
 - Medical Records
 - Note from physician
 - Emergency Room Records
 - Medical clinic records
 - Verification of previous substance abuse treatment (for opiate addiction)
 - Pharmacy Records
 - Department of Corrections records or pre-sentence reports
 - Letters or affidavit form presented in person by individuals who can verify that individuals use and the length of time they have been addicted (parent, spouse, adult child, and, if absolutely nothing else is available, a letter from an IMAT consumer willing to sign his/her name).

Interior Medication Assisted Treatment Client Intake Packet Your responses are protected by federal confidentiality laws and are not discussed or released without your consent in writing. <i>Please let us know if you need help answering the questions.</i>	A fee of \$120 or a Medicaid card/number will be due when the assessment appointment is made. If this is a barrier to making the appointment, please talk to the counselor to determine if a payment plan is feasible.															
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Client Profile Date: _____ <table style="width: 100%;"> <tr> <td style="width: 50%;">First, Middle, and Last Name</td> <td style="width: 50%;">Maiden Name</td> </tr> </table> Alternate Names _____ Sex: ☐ Female ☐ Male Gender identity: _____ Sexual orientation: _____ (straight, lgbtq+, etc.) Date of birth: ____/____/____ Age: ____ Social Security Number: _____ Primary phone: _____ Secondary phone: _____ Medicaid number: _____ Home address: _____ City, State, Zip Code Mail/billing address: _____ City, State, Zip Code		First, Middle, and Last Name	Maiden Name													
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Community of Origin (city, town or village you currently reside) _____																

Special Needs

☐ None ☐ Developmentally disabled ☐ Major difficulty in ambulation or nonambulation
☐ Moderate-severe medical problems ☐ Organically based problem ☐ Severe hearing loss/Deaf
☐ Traumatic brain injury ☐ Visual impairment/Blind ☐ Other: _____

Need for Assistive Technology? _____

English Fluency ☐ Excellent ☐ Good ☐ Moderate ☐ Poor ☐ Not at all

Primary Language ☐ English ☐ Other (Specify): _____

Interpreter Needed ☐ Yes ☐ No

Education ☐ HS diploma ☐ Highest completed grade ☐ AA Degree ☐ BA/BS Degree
☐ GED ☐ Vocational training (beyond high school) ☐ Master's Degree

Veteran Status ☐ Never in Military ☐ Reserves/Nat Guard: Combat
☐ Other (specify): _____ ☐ Reserves/Nat Guard: Noncombat

Citizenship ☐ United States ☐ Other (specify): _____

Emergency Contacts *(Must list at least one person in case of emergency)*

1. _____ Can we contact? ☐ Yes ☐ No
First, Middle, and Last Name Relation Consent on file? ☐ Yes ☐ No

Home address: _____
City, State, Zip Code

Primary phone: _____ Secondary phone: _____

2. _____ Can we contact? ☐ Yes ☐ No
First, Middle, and Last Name Relation Consent on file? ☐ Yes ☐ No

Home address: _____
City, State, Zip Code

Primary phone: _____ Secondary phone: _____

3. _____ Can we contact? ☐ Yes ☐ No
First, Middle, and Last Name Relation Consent on file? ☐ Yes ☐ No

Home address: _____
City, State, Zip Code

Primary phone: _____ Secondary phone: _____

Who referred you to our agency? ☐ Self ☐ Other: specific agency or name _____

Why are you seeking services at our agency? _____

In your own words, what problem(s) would you like our agency to help with?

Have you ever received services from our agency? ☐ Yes ☐ No

If yes, what type of services, when and what type of services did you receive?

Are you currently receiving mental health and/or substance abuse treatment services from any other agency?

☐ Yes ☐ No

If yes, which agency and what type of services?

Do you have family and friends in town who know you have addiction problems? ☐ Yes ☐ No

If yes, are you in regular contact? ☐ Yes ☐ No

Do you have someone nearby to talk to about problems when they occur? ☐ Yes ☐ No

Do you participate in social activities with friends or family? ☐ Yes ☐ No

Spiritual beliefs? _____

Hobbies? _____

Medical Status

If female, are you pregnant? __ Yes __ No __ Unknown

If yes, when is your due date? _____

Do you inject drugs? __ Yes __ No

If yes, when was the last time you injected drugs? _____

How many times have you been admitted into any program(s) for substance abuse treatment? _____

List programs: _____

How many days in the past 30 have you attended a self-help group like AA or NA? _____

Do you use tobacco? __ Yes __ No

If yes, what type do you use? __ Cigarette __ Electronic (vape) __ Cigar/Pipes __ Combination __ Smokeless Tobacco

How would you rank your overall health? __ Excellent __ Very good __ Good __ Fair __ Poor __ Unsure

List any allergies:

Are you prescribed any medications? __ Yes __ No

If yes, please list medication and reason:

Do you have any mental health conditions? __ Yes __ No

If yes, please describe:

How many non-treatment substance abuse related **hospitalizations** have you had in the past 6 months? _____

How many times have you been admitted into any program(s) for **mental health** treatment? _____

How many times have you been **hospitalized for mental health** treatment? _____

How many months since your last discharge? _____

Drug Use In order, list your preferred drugs and how frequently you use them:

Drug	How often used? Multiple times daily, daily, weekly, etc...	How long have you been using?	How used? Smoke, snort, IV, etc.

Financial Information

- | | | |
|--|---|---|
| ☐ Employed full-time | ☐ Employed part-time | |
| ☐ Disabled | ☐ Homemaker | ☐ Unemployed: Looking for work |
| ☐ Retired | ☐ Student | ☐ Unemployed Not seeking work |
| ☐ In the Armed Forces | ☐ Resident/Inmate | ☐ Unemployed: Subsistence lifestyle |
| ☐ Not seeking work | ☐ Other | ☐ Seasonal employment: in-season |
| | | ☐ Seasonal employment: out-of-season |
| | | ☐ Not in work/labor force (other): _____ |

If employed, who is your employer? _____

Occupation: _____

Within the last 6 months, how many months have you been employed? _____

What is your annual household income? \$ _____

What is your primary source of income? Please select one

- | | | |
|---|---|---|
| ☐ None | ☐ Interest and Other | ☐ Self Employment |
| ☐ AK Native Corp Dividends | ☐ Public Assistance/Welfare Pay | ☐ Supplemental Security Ins |
| ☐ Alimony | ☐ Parent's Income | ☐ Spouse or significant other's income |
| ☐ Alaska PFD | ☐ Retirement, Survivor, Disability Pension | ☐ Social Security |
| ☐ Child Support | ☐ Railroad Retirement | ☐ Unemployment Compensation |
| ☐ Employment | ☐ Social Security Disability | ☐ Tribal Assistance Programs |
| ☐ Other | | |

Other income sources? Select all that apply

- | | | |
|---|---|---|
| ☐ None | ☐ Interest and Other | ☐ Self Employment |
| ☐ AK Native Corp Dividends | ☐ Public Assistance/Welfare Pay | ☐ Supplemental Security Ins |
| ☐ Alimony | ☐ Parent's Income | ☐ Spouse or significant other's income |
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| ☐ Child Support | ☐ Railroad Retirement | ☐ Unemployment Compensation |
| ☐ Employment | ☐ Social Security Disability | ☐ Tribal Assistance Programs |
| ☐ Other | | |

How do you plan to pay for treatment services?

☐ AK Native Health Care	☐ Indian Health Services	☐ Other Native Health Grant
☐ Blue Cross/Blue Shield	☐ Medicaid	☐ Other private
☐ CIGNA	☐ Medicare	☐ Other public care
☐ HMO	☐ Other government grant	☐ Self pay

What type of insurance do you have?

☐ Blue Cross/Blue Shield	☐ Medicare Conditionally Primary	☐ Personal Payment Cash – No Insurance
☐ Commercial	☐ Medicare Part B	☐ Supplemental Policy
☐ Group Policy	☐ Medicaid	☐ VA Insurance
☐ HMO	☐ Medicare Primary	☐ Other: _____
☐ Individual Policy	☐ Other Government Service	
☐ Long Term Policy	☐ Other Public Insurance	
☐ Litigation	☐ Other Private Insurance	

What is your marital status?

☐ Cohabiting	☐ Never married/single	☐ Widowed	☐ Divorced
☐ Separated	☐ Married		

Household Composition Select the description that best describes your household composition:

☐ Live alone	☐ with non-relatives	☐ with relatives	☐ with adolescents
☐ with children	☐ with significant other	☐ Other: _____	

Number of people in your household? _____**Number of children in your household?** _____ **Number of children not in your custody?** _____**Select description that best describes your living arrangement:**

☐ Assisted living facility	☐ Homeless	☐ Residential treatment
☐ Correction/Detention facility	☐ Hospital for non-psych	☐ Recovery housing
☐ Crisis residence	☐ Hospital for psych	☐ Shelter
☐ Foster care	☐ Nursing home	☐ Transitional housing
☐ Group Home	☐ Private residence without supportive services	☐ Therapeutic foster care
☐ Halfway house	☐ Private residence with supportive services	☐ Other: _____

Legal Status

Have you ever been arrested? __ Yes __ No

Arrests in the last 12 months? _____

Arrests in your lifetime? _____

Currently on probation/parole? _____

Incarcerated in the last 90 days? _____

Legal History

__ 30 day commitment

__ Court order juveniles

__ 90 day commitment

__ Court order mental health

__ 180 day commitment

__ Deferred prosecution

__ Incarcerated-Sentenced

__ Deferred sentence

__ Incarcerated-Unsentenced

__ Emergency commitment

__ Case pending

__ Informal probation

__ Community sentencing

__ Office of children's services custody

__ Court order for observation/evaluation

__ Protective custody

__ Court order for alcohol treatment/prevention

__ Title 12- not guilty by reason of insanity

__ Court order for drug treatment/prevention

IMAT Staff:

Applicant appears to meet DSM-5-TR Diagnosis for F11.20 Opioid Use Disorder?

__ Yes __ No

Staff Signature

Name: _____ Date: _____

1. Have you ever felt that you ought to Cut down on your drinking or drug use?

- | | |
|---------------------------|-------------------------------|
| ☐ Yes | ☐ Drugs |
| ☐ No | ☐ Alcohol |

2. Have people Annoyed you by criticizing your drinking or drug use?

- | | |
|---------------------------|-------------------------------|
| ☐ Yes | ☐ Drugs |
| ☐ No | ☐ Alcohol |

3. Have you ever felt bad or Guilty about your drinking or drug use?

- | | |
|---------------------------|-------------------------------|
| ☐ Yes | ☐ Drugs |
| ☐ No | ☐ Alcohol |

4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?

- | | |
|---------------------------|-------------------------------|
| ☐ Yes | ☐ Drugs |
| ☐ No | ☐ Alcohol |

Over the last 2 weeks, how often have you been bothered by the following problems?

5. Little interest or pleasure in doing things

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

6. Feeling down, depressed or hopeless

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

7. Feeling nervous, anxious or on edge

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

8. Not being able to stop or control worrying

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

IAA's Interior Medication Assisted Treatment

710 3rd Ave Fairbanks, AK 99709

907-452-4222

Informed Consent

COUNSELING is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained addiction counselor who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your counselor is available to support you throughout the counseling process.

Providers: Brenda Henze-Nelson, LPC, MAC, CDCII

Adie Callahan, LPC, CDCII

Lindsey Grennan, LPC, CDCII

Phelicia Wazny, MEd, CDCII

Chanci Davis, LMSW

Dominique Devore-Mosinski, MSW

CONFIDENTIALITY:

This consent is authorizing IAA to provide services to you. All interactions with IAA, including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential and protected under HIPAA as well as 42CFR Part 2 and 45CFR Parts 160 & 164, and cannot be disclosed without your written consent unless provided for in the regulations. Your consent may be revoked at any time except to the extent that action has been taken in reliance on it.

EXCEPTIONS TO CONFIDENTIALITY:

- The counseling staff works as a team. Your counselor will consult with the Clinical Supervisor and other counseling staff to provide the best possible care. These consultations are for professional and training purposes.
- If there is evidence of clear and imminent danger of harm to self and/or others, a counselor is legally required to report this information to the authorities responsible for ensuring safety.
- If IAA staff learn of, or strongly suspect, physical or sexual abuse or neglect of any person under 18 years of age must report this information to child protection services.
- A court order, issued by a judge, may require the IAA staff to release information contained in records and/or require a counselor to testify in a court hearing.

Costs of services are subsidized by State of Alaska Division of Behavioral Health grant. We do accept Medicaid, some private insurance, and have a sliding fee scale for those who meet qualifications.

We appreciate prompt arrival for appointments. Please notify us at 907-452-4222 if you will be late. Twenty-four-hour notice of cancellation allows us to use the time for others.

I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a client at IAA.

Signature of Client

Date

Interior AIDS Association
Interior Medication Assisted Treatment

710 3rd Avenue

Mailing: PO Box 71248, Fairbanks, AK 99707-1248
907.452.4222 Fax: 907.452.8176

Consent For Release of Consumer Information

Purpose of this form: To obtain approval from the consumer to bill medical insurance companies, including Medicaid for covered substance abuse treatment services and to exchange information required to obtain third party payment.

1. Consumer Name: _____ ID# _____ Date of Birth: _____
2. Current Mailing Address: _____
3. Phone: _____ Social Security # _____
4. Single ☐ Married ☐ Other ☐
5. Medicaid – Do you currently have Medicaid coverage? Yes No (circle one)
(a) Medicaid # _____ (Attach copy of card or printout)
6. Other Insurance:
(A) Primary Insured: _____ SS# _____ DOB: _____
(B) Consumer Name: _____
(C) Employer Name: _____ Group # _____
(D) Insurance Company Name: _____ Policy # _____
Phone # _____ (Please provide a copy of insurance card front and back)

Insurance Companies, including Medicaid, will be billed for treatment at IMAT at standard program rates. Consumers are responsible for paying deductibles and copayments according to their insurance policies. Consumers are responsible for communicating any changes in insurance coverage to the Executive Director.

I hereby authorize insurance benefits to be paid directly to the Interior AIDS Association, Interior Medication Assisted Treatment (IMAT) for services provided to me by IMAT. I also authorize IMAT to release to the appropriate insurance company or Medicaid (Division of Medical Assistance and their billing contractor (Conduent) any information required to process this claim (including information relating to drug abuse disorders).

I also authorize the Interior AIDS Association to release information necessary to facilitate direct billing by laboratories for test that are necessary for my treatment at IMAT.

Signature of Consumer Date

IMAT Telehealth Consent and Safety Plan

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my counselor supports use of telehealth consultation.
2. My counselor explained to me how the technology that will be used to affect such a consultation will not be the same as a direct client/counselor visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my counselor or I can discontinue the telehealth consult/visit if it is felt that the connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
6. I understand that the appointment will be conducted through the use of a 42 CFR and HIPPA compliant interactive video, audio, and telecommunications technology. Facetime and social media app communication platforms are not 42 CFR and HIPPA compliant and therefore unable to be utilized for telehealth.
7. I understand my counselor will provide me with a secure link for visual telehealth appointments.

CONSENT TO USE THE TELEHEALTH BY RINGCENTRAL SERVICE

1. Telehealth by RingCentral is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:
2. Telehealth by RingCentral is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
3. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither RingCentral nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
4. The Telehealth by RingCentral Service facilitates video/audio conferencing and is not responsible for the delivery of any healthcare, medical advice or care.
5. I do not assume that my provider has access to any or all of the technical information in the Telehealth by RingCentral Service – or that such information is current, accurate or up-to-date. I will not rely on my counselor to have any of this information in the Telehealth by RingCentral Service.
6. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

7. Clients must be fully clothed and presentable as if they were in an office setting.
8. Clients may not be using or under the influence of any type of substance such as alcohol or cannabis during the appointment.
9. Clients may not be in the presence of other people or in public spaces that may violate 42 CFR or HIPAA, their confidentiality or privacy. The only exception is if the client is having a preplanned conjoined family or couple session.
10. Clients may not be driving or operating any machinery or engaging in frequent distractionsthat will reduce the therapeutic focus of the session.

EMERGENCY PROCEDURES SPECIFIC TO TELEHEALTH SERVICES

CRISIS RESOURCES

If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:

Call your local crisis resources (see list below)

Call 911 for immediate emergency care or your community's emergency room department

Call 988 for the Suicide & Crisis Lifeline

Text HOME to 741741 from anywhere in the United States, anytime to connect with a volunteer crisis counselor

Call the Alaska Careline Crisis Intervention Line 1-877-266-4357

If in the Fairbanks area, Contact the Fairbanks Community Behavioral Health Center On-Call Service at 907-371-1300 **SAFETY PLAN**

There are additional procedures that we need to have in place specific to Telehealth services. These are for your safety in case of an emergency and are as follows:

If you are having suicidal or homicidal thoughts, experiencing new or worsening unmanageable psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and Telehealth services are not appropriate.

I require an Emergency Contact Person (ECP) who I may contact on your behalf in a lifethreatening emergency only. Please enter this person's name and contact information below.

Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

*Please list your Emergency Contact Person here

Name: _____

Phone: _____

*Please select the hospital nearest to you:

_____ Fairbanks Memorial Hospital (907) 452-8181

_____ Chief Andrew Isaac Health Center (907) 451-6682

_____ Bassett Army Community Hospital (907) 361-5172 _____

Other:

* Please list your nearest emergency services:

_____ Fairbanks Police Department (907)450-6500

_____ Alaska State Troopers (907) 451-5100 _____

North Pole Police Department (907) 488-6902

_____ Other:

By signing this form, I certify:

That I have read or had this form read and/or had this form explained to me. That I fully understand its contents including the risks and benefits of the procedure(s).

That I agree to adhere to the above safety plan.

That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature of Client

Date

BY SIGNING I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.