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. Positive urinalysis for benzodiazepines or alcohol
3. Unresolved legal issues
4. Inability to meet the diagnosis for Opioid Dependence
5. Inability to meet the criteria for an outpatient level of care
6. Medical, legal, or mental health issues that preclude full participation in treatment
Medication Assisted Treatment
Client Intake Packet
Please let us know if you need help completing this packet.

Preferred Medication
- Methadone
- Suboxone
- Vivitrol

A fee of $120 or a Medicaid sticker will be due when the assessment appointment is made. If this is a barrier to making the assessment appointment, please talk to the counselor to determine if a payment plan is feasible.

Client Profile

First name ___________________________ Maiden name ___________________________
Middle name ___________________________ Provider client ID ___________________________
Last name ___________________________ Alternate name(s) ___________________________

Gender
- □ Female
- □ Male

Alternate name(s) ___________________________

Date of birth _______/_______/_______________ Age ____________

Home phone _______________ Fax _______________

Social Security Number ___________________________

Work phone _______________ Other phone _______________

Driver’s license number ___________________________ State ______

Cell phone ___________________________

Medicaid number ___________________________

Email address __________________________________

Home street address __________________________________________________________________

City ____________________________ State _____ Zip ____________

Mailing/Billing address ________________________________________________________________

City ____________________________ State _____ Zip ____________

Race
- □ Aleut
- □ American Indian
- □ Asian
- □ Athabascan (Other than American Indian)
- □ Black/African American
- □ Caucasian
- □ Haida
- □ Inupiat
- □ Native Hawaiian
- □ Other Alaska Native
- □ Pacific Islander
- □ Tlingit
- □ Tsimshian
- □ Yupik
- □ Other (Specify) ___________________________

Ethnicity
- □ Not Spanish/Hispanic/Latino Mexican
- □ Chicano/Other Hispanic
- □ Cuban
- □ Puerto Rican
- □ Mexican American
- □ Spanish/Hispanic Latino
- □ Hispanic (specific origin not specified)

Community of Origin (city, town, or village where you currently reside) __________________________________

Special needs
- □ None
- □ Developmentally disabled
- □ Major Diff. in ambulatory or nonambulation
- □ Moderate to severe medical problems
- □ Organically based problem
- □ Severe hearing loss/Deaf
- □ Traumatic Brain Injury (TBI)
- □ Visual Impairment/Blind
- □ Other ___________________________
### English fluency

- [ ] Excellent
- [ ] Good
- [ ] Moderate
- [ ] Poor
- [ ] Not at all

### Primary language

- [ ] English
- [ ] Other (specify) ___________

### Interpreter needed

- [ ] Yes
- [ ] No

### Education

- [ ] Highest completed grade ________
- [ ] HS diploma
- [ ] GED
- [ ] AA degree
- [ ] Voc. training (beyond HS)
- [ ] BA/BS degree
- [ ] Master’s

### Veteran Status

- [ ] Rsrvs/Nat Guard: Combat
- [ ] Never in Military
- [ ] Rsrvs/Nat Guard: Noncombat
- [ ] Other (specify) ___________

### Citizenship

- [ ] United States
- [ ] Other (specify) ___________________________

### Collateral or Emergency Contacts (must list at least one person in case of emergency)

1. First name ________________________________ Last name ________________________________ Relation ____________________________
   
   Address ___________________________________________________________________________________________
   
   Home phone __________________ Work phone __________________ Cell phone __________________ Other ________________
   
   Can we contact? [ ] Yes [ ] No  Consent on file? [ ] Yes [ ] No

2. First name ________________________________ Last name ________________________________ Relation ____________________________
   
   Address ___________________________________________________________________________________________
   
   Home phone __________________ Work phone __________________ Cell phone __________________ Other ________________
   
   Can we contact? [ ] Yes [ ] No  Consent on file? [ ] Yes [ ] No

3. First name ________________________________ Last name ________________________________ Relation ____________________________
   
   Address ___________________________________________________________________________________________
   
   Home phone __________________ Work phone __________________ Cell phone __________________ Other ________________
   
   Can we contact? [ ] Yes [ ] No  Consent on file? [ ] Yes [ ] No

Who referred you to our agency (specific agency or name of person) ____________________________________________________________________________________

Why are you seeking services at our agency? ____________________________________________________________________________________________________________
In your own words, what problem(s) would you like our agency to help you with?
______________________________________________________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________________________________________________
Have you ever received services from our agency?  □ Yes  □ No  If yes, 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
**Medical Status (Admission Profile)**

If female, are you pregnant?  □ Yes  □ No  □ Unknown  
If yes, what is your due date? ____________________________

Are you an injection drug user?  □ 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 would you rank your overall health?  □ Excellent  □ Very Good  □ Good  □ Fair  □ Poor  □ Unsure

Do you have any mental health problems?  □ 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? _______

Do you use tobacco?  □ Yes  □ No  
If yes, what type do you use?  □ Cigarette  □ Cigars/Pipes  □ Combination  □ Smokeless Tobacco

List, in order, your drugs of choice (be specific) and how frequently you use them:

<table>
<thead>
<tr>
<th>Drug</th>
<th>How often used</th>
<th>How long you have been using</th>
<th>How used</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Financial Information** *(Admission Profile)*

Select the description that describes your employment status.

<table>
<thead>
<tr>
<th>Description</th>
<th>□</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabled</td>
<td>□</td>
</tr>
<tr>
<td>Not seeking work</td>
<td>□</td>
</tr>
<tr>
<td>Student</td>
<td>□</td>
</tr>
<tr>
<td>Employed full-time</td>
<td>□</td>
</tr>
<tr>
<td>Employed part-time</td>
<td>□</td>
</tr>
<tr>
<td>Retired</td>
<td>□</td>
</tr>
<tr>
<td>Homemaker</td>
<td>□</td>
</tr>
<tr>
<td>In the Armed Forces</td>
<td>□</td>
</tr>
<tr>
<td>Resident/Inmate</td>
<td>□</td>
</tr>
<tr>
<td>Seasonal employment: In-season</td>
<td>□</td>
</tr>
<tr>
<td>Seasonal employment: Out-of-season</td>
<td>□</td>
</tr>
<tr>
<td>Unemployed: Not seeking work</td>
<td>□</td>
</tr>
<tr>
<td>Unemployed: Subsistence lifestyle</td>
<td>□</td>
</tr>
<tr>
<td>Unemployed: Looking for work</td>
<td>□</td>
</tr>
<tr>
<td>Unknown</td>
<td>□</td>
</tr>
<tr>
<td>Other</td>
<td>□</td>
</tr>
<tr>
<td>Not in labor force; Other</td>
<td>□</td>
</tr>
</tbody>
</table>

If employed, who is your employer?  
______________________________________________________________________________________________________________________________

Occupation ____________________________  
Within the last 6 months, how many months have you been employed?  _____________

What is your household income?  

| Income Level | □ 0-999 | □ 1,000-4,999 | □ 5,000-9,999 | □ 10,000-19,999 | □ 20,000-29,999 | □ 30,000-39,999 | □ 40,000-49,999 | □ 50,000+
|--------------|---------|---------------|---------------|----------------|----------------|----------------|----------------|----------------|

What is your primary source of income? Please select one.

<table>
<thead>
<tr>
<th>Source</th>
<th>□</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK Native Corp.</td>
<td>□</td>
</tr>
<tr>
<td>Interest/Dividends</td>
<td>□</td>
</tr>
<tr>
<td>Railroad retirement</td>
<td>□</td>
</tr>
<tr>
<td>Spouse/Significant other’s income</td>
<td>□</td>
</tr>
<tr>
<td>Retirement, Survivor, Disability Pension</td>
<td>□</td>
</tr>
<tr>
<td>Alaska PFD</td>
<td>□</td>
</tr>
<tr>
<td>Alimony</td>
<td>□</td>
</tr>
<tr>
<td>Child Support</td>
<td>□</td>
</tr>
<tr>
<td>Employment</td>
<td>□</td>
</tr>
<tr>
<td>Parent’s income</td>
<td>□</td>
</tr>
<tr>
<td>Public Assist./Welfare</td>
<td>□</td>
</tr>
<tr>
<td>Self-employment</td>
<td>□</td>
</tr>
<tr>
<td>Social Security</td>
<td>□</td>
</tr>
<tr>
<td>Social Security Disability (SSDI)</td>
<td>□</td>
</tr>
<tr>
<td>Supplemental Security Inc (SSI)</td>
<td>□</td>
</tr>
<tr>
<td>Unemployment Comp</td>
<td>□</td>
</tr>
<tr>
<td>Other</td>
<td>□</td>
</tr>
<tr>
<td>Unknown</td>
<td>□</td>
</tr>
<tr>
<td>None</td>
<td>□</td>
</tr>
</tbody>
</table>

How do you plan to pay for treatment services?

<table>
<thead>
<tr>
<th>Service Provider</th>
<th>□</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK Native Health</td>
<td>□</td>
</tr>
<tr>
<td>HMO</td>
<td>□</td>
</tr>
<tr>
<td>Blue Cross/Blue Shield</td>
<td>□</td>
</tr>
<tr>
<td>Self pay</td>
<td>□</td>
</tr>
<tr>
<td>Other public care</td>
<td>□</td>
</tr>
<tr>
<td>Indian Health Services</td>
<td>□</td>
</tr>
<tr>
<td>CIGNA</td>
<td>□</td>
</tr>
<tr>
<td>Medicaid</td>
<td>□</td>
</tr>
<tr>
<td>Medicare</td>
<td>□</td>
</tr>
<tr>
<td>Other private</td>
<td>□</td>
</tr>
<tr>
<td>Other private insurance</td>
<td>□</td>
</tr>
<tr>
<td>Other government grant</td>
<td>□</td>
</tr>
</tbody>
</table>

What type of insurance do you have?

<table>
<thead>
<tr>
<th>Type of Insurance</th>
<th>□</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auto Insurance</td>
<td>□</td>
</tr>
<tr>
<td>Litigation</td>
<td>□</td>
</tr>
<tr>
<td>Medicare primary</td>
<td>□</td>
</tr>
<tr>
<td>Commercial</td>
<td>□</td>
</tr>
<tr>
<td>Other</td>
<td>□</td>
</tr>
<tr>
<td>Individual policy</td>
<td>□</td>
</tr>
<tr>
<td>Long term policy</td>
<td>□</td>
</tr>
<tr>
<td>Medigap Part B</td>
<td>□</td>
</tr>
<tr>
<td>Supplemental Policy</td>
<td>□</td>
</tr>
<tr>
<td>Group policy</td>
<td>□</td>
</tr>
<tr>
<td>Medicaid</td>
<td>□</td>
</tr>
<tr>
<td>VA Insurance</td>
<td>□</td>
</tr>
<tr>
<td>HMO</td>
<td>□</td>
</tr>
<tr>
<td>Medicare Conditionally Primary</td>
<td>□</td>
</tr>
<tr>
<td>Medicare Part B</td>
<td>□</td>
</tr>
<tr>
<td>Other private insurance</td>
<td>□</td>
</tr>
<tr>
<td>Other Public Insurance</td>
<td>□</td>
</tr>
<tr>
<td>Personal payment (cash, no insurance)</td>
<td>□</td>
</tr>
</tbody>
</table>

Do you have any of the following as other income sources? Please check all that apply.

<table>
<thead>
<tr>
<th>Income Source</th>
<th>□</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK Native Corp.</td>
<td>□</td>
</tr>
<tr>
<td>Interest and other</td>
<td>□</td>
</tr>
<tr>
<td>Railroad retirement</td>
<td>□</td>
</tr>
<tr>
<td>Dividends</td>
<td>□</td>
</tr>
<tr>
<td>Other</td>
<td>□</td>
</tr>
<tr>
<td>None</td>
<td>□</td>
</tr>
<tr>
<td>Alaska PFD</td>
<td>□</td>
</tr>
<tr>
<td>Alimony</td>
<td>□</td>
</tr>
<tr>
<td>Employment</td>
<td>□</td>
</tr>
<tr>
<td>Self Employment</td>
<td>□</td>
</tr>
<tr>
<td>Child Support</td>
<td>□</td>
</tr>
<tr>
<td>Unknown</td>
<td>□</td>
</tr>
<tr>
<td>Social Security</td>
<td>□</td>
</tr>
<tr>
<td>Unemployment compensation</td>
<td>□</td>
</tr>
<tr>
<td>Parent’s income</td>
<td>□</td>
</tr>
<tr>
<td>Supplemental Security Inc (SSI)</td>
<td>□</td>
</tr>
<tr>
<td>Public Assistance/Welfare Pay</td>
<td>□</td>
</tr>
<tr>
<td>Social Security Disability(SSDI)</td>
<td>□</td>
</tr>
<tr>
<td>Spouse’s or Significant other’s income</td>
<td>□</td>
</tr>
<tr>
<td>Retirement, Survivor, Disability Pension</td>
<td>□</td>
</tr>
</tbody>
</table>
### Household Composition
Select the description that best describes your household composition.

- [ ] Live alone
- [ ] w/non-relatives
- [ ] w/adolescents
- [ ] w/relatives
- [ ] w/children
- [ ] w/significant other
- [ ] Other

What is your marital status?
- [ ] Cohabitating
- [ ] Never married/single
- [ ] Widowed
- [ ] Divorced
- [ ] Separated
- [ ] Married

Select description that best describes your living arrangement.

- [ ] Adult foster care
- [ ] Alone
- [ ] Assisted living home
- [ ] Child/Adolescent foster care
- [ ] Correctional halfway house
- [ ] Group home
- [ ] Juvenile detention
- [ ] Homeless
- [ ] Nursing home
- [ ] Hospital for psychiatric purposes
- [ ] Hospital for non-psychiatric purposes
- [ ] Jail/Correctional facility
- [ ] Other
- [ ] Private residence w/supports
- [ ] Private residence w/o supports
- [ ] Residential treatment
- [ ] Shelter
- [ ] In-household w/non-related persons
- [ ] In-household w/relatives
- [ ] Substance abuse halfway house
- [ ] Transitional housing

How many people live with you? _____ How many children live with you in a residential setting? _____
How many children are in your household? _____ Of the children who live with you in a residential setting, how many are currently receiving services? _____

Do any of the following live with you? Please select all that apply.

- [ ] Aunt(s)
- [ ] Brother(s)
- [ ] Daughter(s)
- [ ] Father
- [ ] Guardian
- [ ] Grandfather
- [ ] Grandmother
- [ ] Mother
- [ ] Other relatives
- [ ] Son(s)
- [ ] Stepfather
- [ ] Sister(s)
- [ ] Stepmother
- [ ] Significant others
- [ ] Spouse
- [ ] Uncle(s)
- [ ] Unrelated

If you have resided in a Controlled Environment in the last 30 days, please select the description that best fits that environment.

- [ ] Alcohol/Drug treatment
- [ ] Jail
- [ ] Medical treatment
- [ ] Psychiatric treatment
- [ ] Other __________________________

### Legal History
Please select the description that best describes your legal status.

- [ ] 180 day commitment
- [ ] 30 day commitment
- [ ] 90 day commitment
- [ ] Case pending
- [ ] Community sentencing
- [ ] Court ordered for observation and evaluation
- [ ] Court ordered for alcohol treatment
- [ ] Court ordered for juveniles (INT); DJJ custody
- [ ] Court ordered juveniles (INT); parents retain custody
- [ ] Deferred sentence
- [ ] Emergency commitment
- [ ] Furlough/Rehabilitation leave
- [ ] Incarcerated
- [ ] In case
- [ ] Office of Children's Services custody
- [ ] Probation/Parole
- [ ] Protective custody
- [ ] Title 12-Not guilty by reason of insanity (NGRI, GBMI)
- [ ] Deferred prosecution
- [ ] None/No involvement

Have you ever been arrested? [ ] Yes [ ] No
If yes, how many times have you been arrested in your life? _____ How many of those arrests took place in the last 12 months? _____

Applicant appears to meet DSM-5 Diagnosis for F11.20 Opioid Use Disorder? [ ] Yes [ ] No

______________________________
IMAT Staff Signature
IMAT Policy and Procedures Section V.  Intake Requirements and Process

A. Admission procedures for consumers who request medication assisted treatment at IAA

Applicants must satisfy the following criteria:

1) Consumer must provide proof that he/she is 18 years or older. (Detoxification services may be available to individuals under 18 with a waiver from the State Methadone Authority and Center for Substance Abuse Treatment, Division of Pharmacologic Therapies (CSAT/DPT).

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

3) Documentation of more than 1 year addiction. Addiction history documents may include:
   - Medical records
   - Note from physician
   - Emergency room records
   - Medical clinical records
   - Verification of previous substance abuse treatment (for opiate addiction)
   - Pharmacy records
   - Division of Corrections records or pre-sentence reports
   - Notarized letters from 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 a IMAT consumer willing to sign his/her name).
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 # __________ (Please provide a copy of insurance card front and back)
       Phone # __________________

Insurance Companies, including Medicaid, will be billed for IMAT treatment 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 IAA to release to the appropriate insurance company or Medicaid (Division of Medical Assistance and First Health Services Corporation) 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

__________________________________    __________________________________
Signature of Witness                                  Date