4) Transfer Patients

a) Medication maintenance consumers enrolled in programs other than IMAT may request approval for transfer to and enrollment in IMAT. Individuals requesting approval for transfer must work with their home program to insure that all appropriate records are copied and sent to IMAT for review. *The transfer application process begins when the consumer's home program contacts IMAT.* Documentation forwarded to IMAT should include admission documents including verification of addiction, physical and health history.

1) Recent assessment, diagnosis, summary and treatment recommendations.
2) Dosing and other medication records for previous 60 days.
3) Current Treatment Plan 4) Courtesy dosing request for 30 days

b) Transfer patients will be required to dose on-site for the first 60 days following admission to IMAT. **Limited** exceptions to the 60 day period may be approved to facilitate employment. Transfer patients who have previously qualified for take-home privileges may request a return to the previously approved dosing schedule following 60 days of MMT at IMAT, but under no circumstances is a return to the previous take-home schedule guaranteed. Criteria for evaluating a return to the previous schedule include: adjustment to new program (attendance, urinalysis, cooperation, and communication), ability to support self and/or family in new community, completion of required activities or tasks.

c) IMAT may deny approval of a transfer when, in the best judgment of the clinical staff, the transfer is not in the best interest of the consumer or because IMAT cannot meet the needs of the consumer at the time.

Documentation should be faxed to 907-452-8176

IMAT Courtesy Dosing Check-In Procedures

Call 452-4222 ext. 100 and give your name to the receptionist to be checked into the dosing queue. She will let you know when it is your turn to come into the building to dose.

Present a valid form of identification.

Pay courtesy dosing fee: **$20 per day/ $120 per week/ $450 per month. Discounts are only available when paid in advance in full. Fees must be paid in full, in cash or by money order prior to arrival or prior to dosing. Fees may be paid daily.**

Courtesy dosing is limited to 30 days.

IMAT requires a face mask to be worn upon entry and during dosing within the building. Please also adhere to 6ft social distancing when necessary.

Dosing Hours

Monday – Friday	7:00am – 9:30am
Saturday and Sunday	8:00am – 10:00am
Holidays	8:30am – 9:30am

- Dosing ends promptly and door will be shut.
- Do not Call and ask the nurse to stay late.
- Only call for dire emergency such as major power outage or you are in the Hospital

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
Interior AIDS Association's Interior Medication Assisted Treatment

I, _____ authorize the **IAA's Interior**
(patient's name)

Medication Assisted Treatment to exchange with _____the

following information: (**please initial** that you understand the following info could be communicated):

_____My name and other personal identifying information
_____My status as a patient in alcohol and/or drug treatment
_____Attendance and compliance with treatments
_____Recommendations for further treatment services
_____Discharge plan/summaries to include discharge dates and status
_____Name of agency where I received treatment
_____Assessment/evaluation results
_____Other, must be specific_____

The purpose of this exchange, authorized by this consent, is to provide information to facilitate continuing substance abuse education/treatment OR _____.

THIS RELEASE EXPIRES ON _____
Date (no longer than 90 days from signature)

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, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F.R. Pts 160 &164 and **cannot be disclosed without my written consent unless otherwise provided for in the regulations**. I 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 in 90 days. I understand that if I choose to revoke this consent the revocation must be in writing.

I understand that generally the IMAT may not condition my treatment on whether I sign this consent form, but in certain limited circumstances I may be denied treatment and/or services if I do not sign the consent form.

Information will be shared by: _____phone _____fax _____US Mail _____email
(Consumer must initial)

_____ _____
Consumer signature Date

_____ _____
Parent, guardian, or WITNESS signature Date

REVOKE CONSENT

_____ _____
Consumer signature Date

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 Date _____

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 ☐F air ☐ 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:

Drug	How often used	How long you have been using	How used

Financial Information (Admission Profile)

Select the description that describes your employment status.

☐ Disabled ☐ Not seeking work ☐ Student ☐ Employed full-time ☐ Employed part-time ☐ Retired ☐ Homemaker
☐ In the Armed Forces ☐ Resident/Inmate ☐ Seasonal employment: In-season ☐ Seasonal employment: Out-of-season
☐ Unemployed: Not seeking work ☐ Unemployed: Subsistence lifestyle ☐ Unemployed: Looking for work
☐ Unknown ☐ Other _____ ☐ Not in 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 household income? ☐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.

☐ AK Native Corp. ☐ Interest/Dividends ☐ Railroad retirement ☐ Spouse/Significant other's income ☐ Retirement, Survivor, Disability Pension
☐ Alaska PFD ☐ Alimony ☐ Child Support ☐ Employment ☐ Parent's income
☐ Public Assist./Welfare ☐ Self-employment ☐ Social Security ☐ Social Security Disability (SSDI) ☐ Supplemental Security Inc (SSI)
☐ Unemployment Comp ☐ Other_____ ☐ Unknown ☐ None

How do you plan to pay for treatment services?

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

What type of insurance do you have?

☐ Auto Insurance ☐ Litigation ☐ Medicare primary ☐Commercial ☐ Other _____
☐ Individual policy ☐ Long term policy ☐ Medigap Part B ☐ Supplemental Policy ☐ Group policy
☐ Medicaid ☐ VA Insurance ☐ HMO ☐ Medicare Conditionally Primary
☐ Medicare Part B ☐ Other private insurance ☐ Other Public Insurance ☐ Personal payment (cash, no insurance)

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

☐ AK Native Corp. ☐ Interest and other ☐ Railroad retirement ☐ Dividends ☐ Other ☐ None ☐ Alaska PFD ☐ Alimony
☐ Employment ☐ Self Employment ☐ Child Support ☐ Unknown ☐ Social Security ☐ Unemployment compensation
☐ Parent's income ☐ Supplemental Security Inc. (SSI) ☐ Public Assistance/Welfare Pay ☐ Social Security Disability(SSDI)
☐Spouse's or Significant other's income ☐ Retirement, Survivor, Disability Pension

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 ☐ Court order for observation and evaluation ☐ Deferred sentence ☐ Office of Children's Services custody
☐ 30 day commitment ☐ Court ordered for alcohol treatment ☐ Emergency commitment ☐ Probation/Parole
☐ 90 day commitment ☐ Court ordered for juveniles (INT); DJJ custody ☐ Furlough/Rehabilitation leave ☐ Protective custody
☐ Case pending ☐ Court ordered juveniles (INT); parents retain custody ☐ Incarcerated
☐ Community sentencing ☐ 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).

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 # _____ (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