Interior Mediation Assisted Treatment Referral

To: Interior Medication Assisted Treatment
Fax: 907-452-8176

Date of Referral:_____

Referring Agency:_____

Staff Name: _____ Phone Number: _____

Eligibility Criteria

- 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, and documentation of 1-year addiction.
- Daily attendance to on-site dosing

Ineligibility Considerations

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

Referring Agency to attach:

☐ Release of Information

☐ IMAT Client Intake Packet

☐ Most Recent Assessment/OUD Diagnosis

_____ _____

Referring Provider Signature Date

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 useand 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.
Please let us know if you need help answering the questions.

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.*

Preferred medication:

__ Methadone

__ Suboxone

__ Vivitrol

Non-medication services:

__ Individual Counseling

__ Group Counseling

__ Intensive Outpatient Services (9+hours per week)

Client Profile

Date: _____

_____ _____
First, Middle, and Last Name Maiden Name

_____
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

Race

__ Aleut __ American Indian __ Asian __ Athabascan __ Black/African American

__ Caucasian __ Haida __ Inupiat __ Native Hawaiian __ Other Alaska Native

__ Pacific Islander __ Tlingit __ Tsimshian __ Yupik __ Other

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 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 <u>at least one</u> 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
__ Retired
__ Student
__ In the Armed Forces
__ Resident/Inmate
__ Not seeking work
__ Other
__ Unemployed: Looking for work
__ Unemployed Not seeking work
__ Unemployed: Subsistence lifestyle
__ 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
__ Alaska PFD
__ Retirement, Survivor, Disability Pension
__ Social Security
__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
__ Blue Cross/Blue Shield
__ CIGNA
__ HMO
__ Indian Health Services
__ Medicaid
__ Medicare
__Other government grant
__ Other Native Health Grant
__ Other private
__ Other public care
__ Self pay

What type of insurance do you have?

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

What is your marital status?

__ Cohabitating
__ 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
__Correction/Detention facility
__Crisis residence
__Foster care
__Group Home
__ Halfway house
__ Homeless
__ Hospital for non-psych
__ Hospital for psych
__ Nursing home
__ Private residence without supportive services
__ Private residence with supportive services
__ Residential treatment
__ Recovery housing
__ Shelter
__ Transitional housing
__Therapeutic foster care
__ 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

__ 90 day commitment

__ 180 day commitment

__ Incarcerated-Sentenced

__ Incarcerated-Unsentenced

__ Case pending

__ Community sentencing

__ Court order for observation/evaluation

__ Court order for alcohol treatment/prevention

__ Court order for drug treatment/prevention

__ Court order juveniles

__ Court order mental health

__ Deferred prosecution

__ Deferred sentence

__ Emergency commitment

__ Informal probation

__ Office of children's services custody

__Protective custody

__Title 12- not guilty by reason of insanity

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
   - ○ No
   - ○ Drugs
   - ○ Alcohol
2. **Have people Annoyed you by criticizing your drinking or drug use?**
   - ○ Yes
   - ○ No
   - ○ Drugs
   - ○ Alcohol
3. **Have you ever felt bad or Guilty about your drinking or drug use?**
   - ○ Yes
   - ○ No
   - ○ Drugs
   - ○ 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
   - ○ No
   - ○ Drugs
   - ○ 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
Leslie Fails, 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-todate. 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.