

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	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Moderate
	<input type="checkbox"/> Poor	<input type="checkbox"/> Not at all	
Primary language	<input type="checkbox"/> English	<input type="checkbox"/> Other (specify) _____	
Interpreter needed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Education	<input type="checkbox"/> Highest completed grade _____	<input type="checkbox"/> HS diploma
	<input type="checkbox"/> GED	<input type="checkbox"/> AA degree
	<input type="checkbox"/> BA/BS degree	<input type="checkbox"/> Voc. training (beyond HS)
		<input type="checkbox"/> Master's
Veteran Status	<input type="checkbox"/> Rsrvs/Nat Guard: Combat	<input type="checkbox"/> Never in Military
	<input type="checkbox"/> Rsrvs/Nat Guard: Noncombat	<input type="checkbox"/> Other (specify) _____
Citizenship	<input type="checkbox"/> United States	<input type="checkbox"/> 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:

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? Cohabiting 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).

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Interior Medication Assisted Treatment
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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