Outpatient & Residential Intake Packet

DEMOGRAPHICS- PAGE 1 OF 4

Please Circle the Program(s) You Are Interested in Accessing:

Assessment Center AWFP Outpatient Akeela Outpatient Therapeutic Court

Akeela House Stepping Stones Akeela Mental Health KAR House

Transitional Housing—Ketchikan Transitional Housing—Anchorage Gateway Center for Human Services

Therapeutic Foster Care

Last Name: ______________________________ **First Name:** ______________________________

Middle Name: ______________________________ **Maiden Name:** ______________________________

Date of Birth: ____________________ **Age:** ________ **Gender:** ________________

Social Security Number: ______/______/______ **Driver's License Number:** _________________ **State:** __________

Are you on Medicaid? (Circle) Yes No **Medicaid Number:** ___________________

If No, What Insurance? _____________________________________

Insurance ID # ________________________ **Group #**____________________

Ethnicity: (Circle One)

Not Spanish/Hispanic/Latino/Mexican Spanish/Hispanic/Latino Puerto Rican Cuban

Hispanic- Specific origin not specified Mexican Chicano/Other Hispanic Not Specified

Race: (Please circle all that apply)

Aleut American Indian Asian Athabascan Black/African American

Caucasian Haida Inupiat Native Hawaiian Other Alaska Native Pacific Islander

Tlingit Tsimshian Yupik Other: ____________________________

Veteran Status: (Circle One)

Never in Military Not Applicable Vietnam Era Vet – Combat Reserves/National Guard – Combat

Vietnam Era Vet – Non-Combat Reserves/National Guard – Non-Combat Gulf War Vet – Combat

Veteran – Other Eras Gulf War Vet – Non-Combat Retired/Former Military – Combat

Afghan War Vet – Combat Retired/Former Military – Non-Combat on Active Duty – Combat

Military Dependent on Active Duty – Non-Combat Other: ____________________________

DEMOGRAPHICS- PAGE 2 OF 4

Mailing Address: ____

City: _________________________ **State:** _______________ **Zip:** ____________________

Physical Address (if different): ____

Email Address: ____

Can we leave a message at this phone? (Circle)

Home Phone: _____________________________ Yes No

Cell Phone: _______________________________ Yes No

Work Phone: ______________________________ Yes No

Other Contact Phone: _____________________________ Yes No

Type of other Contact: ___________________________

(Please specify what kind of other contact phone this is: e.g., cell phone, friends, SO's, etc.)

Emergency Contact Name: ____

Relationship: _______________________ **Phone:** ____________________________

Referral Source: ____ **Completed ROI?** Yes No

English Fluency: (Circle One) Excellent Good Moderate Poor None

Interpreter Needed? (Circle) Yes No **Primary Language:** _______________

Do you receive your care at the Alaska Native Medical Center? Yes No

If no, list where: ____

Presenting Problem(s) (in your own words): Examples: substance abuse, mental health concerns, DUI/OUI, felony probation, etc.

____

If female, are you pregnant? Yes No **Due Date:** _______________

Have you ever injected drugs? Yes No **Date of last use:** ________________

Are you participating in Opioid Replacement Therapy? Yes No **Agency/Doctor:** _________________

Treatment History: ____

Number of prior Substance Use Disorder Treatment Admissions: ______________________________________

Number of Non-TX SA related hospitalization in past 6 months: _______________________________________

Number of times you have participated in a Self-Help group in the last 30 days: _________________________

DEMOGRAPHICS- PAGE 3 OF 4

Education: (Circle) HS Diploma GED BA/BS Degree AA Degree Master's Degree

Highest Grade Completed: ___________________________________

Vocational Training: ____

Employment Status: (Circle one)
Employed Full Time Employed Part Time Retired Student Disabled Homemaker

Not in Labor Force-Inmate Not in Labor Force-Not Seeking Work Not in Labor Force-Subsistence

Seasonal-In Season Seasonal- Out of Season Unemployed-Seeking Work

Unemployed-not Seeking Work Other: _______________________________

Please identify your primary source of income: (Circle One)
Non-Tribal Assistance Program AK Native Corporation Dividend

Public Assistance/Welfare Alimony Alaska PFD Child Support Parent's Income

Employment Interest and Other Social Security Disability Self Employed

Railroad Retirement Unemployment Compensation Spouse/Significant other

Retirement/Survivor/Disability Pension Supplemental Security Insurance

Other: ____________________________

Annual Household Income: (Circle One)
$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 $50,000-59,999 $60,000+

Please identify your primary payment source: (Circle One)
Aetna Moda Health BlueCross/Blue Shields CIGNA AK Native Health Care

Other government grant Other Native Health Care HMO Indian Health Services

Sliding scale- no charge Sliding scale- charge Sliding scale- client partial payment Unknown

Other Private Other public Workman's compensation Client self-pay Medicaid Medicare

Health Insurance Provider: ____

Living Arrangements: (Check One)
Assisted Living Correction Detention Facility Crisis Residence Foster Care

Group Home Halfway House Homeless Shelter

Residential Treatment Therapeutic Foster Care Transitional Housing Unknown

Private Residence with Supportive Services Private Residence without supportive services

Hospital for Psychiatric Purposes Nursing Home Other ___________________________

DEMOGRAPHICS- PAGE 4 OF 4

Marital Status: (Circle One) Single Married Cohabitating Separated Divorced Widowed

Number of Children living with client: ____________

Legal Status: (Circle One)

None/No Involvement	180 Day Commitment	90 Day Commitment	30 Day Commitment
Case Pending	Community Sentencing	Deferred Prosecution	Informal Probation
Emergency Commitment	Incarcerated	Office of Children's Services	Probation/Parole

Court Ordered for Observation and Evaluation

Court Ordered for Mental Health Treatment

Court Ordered Juvenile (INT) Parents Retain Custody

Court Ordered Juvenile (INT), DJJ Custody

Court Ordered for Alcohol Treatment

Title 12-Not Guilty by Reason of Insanity

Number of Arrests in the past 30 days: ______________

Client Signature at Intake: ____ **Date:** _________________

For Referring Agency to Complete: Priority Admission Criteria: Check all that apply:

Pregnant Woman _________

Injection Drug User (IV Drug User) _________

On DOC Furlough _________

Imminent danger to self or others and has continuous or multiple prior substance abuse treatment placements _________

Have co-occurring mental health and substance use disorder diagnoses _________

Referrals from:

Alcohol Safety Action Program (ASAP) _________

Therapeutic Courts _________

Alaska Psychiatric Institute (API) _________

MENTAL HEALTH EMERGENCY PROCEDURE

If a mental health emergency crisis situation should arise and I am unable to reach my Akeela treatment team, I understand that I have an option to ask for help by calling:

- Providence Alaska Medical Center Crisis Line
    - **(907) 563-3200** 24 hours/7 days per week
- Ketchikan Cares Crisis Line
    - **(907) 225-2273** - 24 hours/7 days per week
- National Suicide Prevention Lifeline
    - **988** - 24 hours/7 days per week (alternate National number (800) 273-8255)

If I am not clear as to what type of emergency I am having, I have been informed I should call **911** immediately.

I understand that I am releasing my own confidential information when I call the hotline.

____ ____________________

Client Signature Date

Reviewed with the client by:

____ ____________________

Akeela Staff Signature Date

AKEELA

For your Safety, the following information will be kept in a secure area, accessible only to staff members, while you are attending group.

All information must be current in case of an emergency. Please complete the following:

I, ____, hereby give my consent to be given emergency medical treatment in the event of an accident, injury, or illness.

I hereby release the Akeela, Inc. and its representatives from any liability rising from an emergency in which it is deemed necessary to pursue medical treatment.

In Case of an emergency Akeela, Inc. may contact:

1. ______________________________ ______________________________
   Name/Relationship Contact #

2. ______________________________ ______________________________
   Name/Relationship Contact #

Drug/Allergies: ____

Medications: ____

Other medical conditions: ____

____

Insurance Information/Policy Number: ____
Medicaid Number: ____

Is there an Advance Directive in place**?** **Yes** ☐ **No** ☐
If Advance Directive obtain copy and place in chart and give to emergency personnel.

By signing below, I authorize the above information to appropriate medical personnel.

____ ________________________
Client Signature Date

Reviewed with the client by:

______________________________________ ___________________
Akeela Staff Signature Date

CLIENT RIGHTS

1. Each client's rights are to be respected by Akeela, Inc. and its staff.
2. A client has the right to get information supplied and explained in a manner understood.
3. A client has the right to be a part of the decision making and planning of treatment, care, or services.
4. A client has the right to give or withhold permission for recordings, films, pictures, videos, or other images of him/her to be taken or released for purposes other than their care.
5. A client's rights to be protected during research, investigation and clinical trials are to be respected by Akeela, Inc. and its staff.
6. A client has the right to receive information on the staff providing care, treatment or services, such as qualifications, gender, education, experience.
7. A client has the right to be free from neglect, exploitation, and verbal, mental, physical and sexual abuse.
8. A client has the right to be in an environment that preserves dignity and contributes to a positive self-image.
9. A client continues to have the right of all citizenship privileges including non-discrimination in receiving services.
10. A client has the right to access protective and advocacy services.
11. Akeela, Inc. protects the rights of those served who work for or on behalf of Akeela.
12. Akeela, Inc. staff will inform each client of their responsibilities related to their care, treatment or services.
13. A client has the right to participate in formulating, evaluating and periodically reviewing their individualized written treatment plan, including requesting specific forms of treatment, being informed why requested forms of treatment are not made available, refusing specific forms of treatment that are offered, and being informed of prognosis.
14. A client has the right to review their treatment file with a staff member, at a reasonable time.
15. A client has the right to be informed by the prescribing physician of the name, purpose and possible side effects of any medication prescribed as part of their treatment.
16. A client has the right to request a written summary of treatment at time of discharge: that summary must include discharge and transition plans.
17. A client has the right for all their information to be maintained confidentially and the right to give prior written approval for the release of identifiable information.

- Except for clients in State of Alaska Department of Corrections (DOC) programs, as per DOC regulations, policies and procedures.

If you believe your rights have been violated, please contact:

- YOUR Akeela Counselor / Clinician, Program Manager or Director.
- You can always call Akeela Quality Improvement at 1-800-478-7738.
- You can also contact the Alaska Division of Behavioral Health, The Disability Law Center, or other organizations of your choosing.

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective September 1, 2020 and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

1. We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
2. We are required to abide by the terms of this Notice currently in effect.
3. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are several situations in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment, and health care operations requires you to sign an Authorization. Certain disclosures are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure. We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our agency once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination, or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities and arranging for legal and auditing functions.

Health Information Exchange Organization: Federal and state laws permit us to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share your health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of your health records; decreasing the time needed to access your information; aggregating and comparing your information for quality improvement purposes and such other purposes as may be permitted by law. You can **opt-in** for participation in this database.

There are certain circumstances under which we may use or disclose your health information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law- enforcement activities, judicial and administrative proceeding and in the event of death.

We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law enforcement official's information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We may contact you from time-to-time to provide appointment reminders or information about treatment. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others. Specifically, there are eight reasons when we can disclose the minimum necessary client information:

1.To qualified business associates with a business associate agreement in place	2. To State or Federal auditors or in the process of research
3. To medical providers in a medical emergency	4. To report child abuse or neglect
5. To other Akeela, Inc. personal	6.To report a crime committed on Akeela's premises or against Akeela's personnel
7. Suicidal or homicidal threats or attempts	8. As allowed by an authorizing court order

You have certain rights regarding your health information, as follows:

You may request that we restrict the uses and disclosures of your health record information for treatment, payment, and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to the above noticed exceptions, disclosures of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiles in anticipation of or for use in civil, criminal, or administrative action or proceeding to which your access is restricted by law. We may charge a reasonable fee for providing a copy of your health records or a summary of those records at your request, which includes the cost of copying, postage, and preparation of an explanation or summary of the information.

All requests for inspection, copying and/or amending information in your health records and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment, and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you at your request.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer at Akeela, Inc. or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site: http://www.hhs.gov/ocr/hipaa

ALL QUESTIONS CONCERNING THIS NOTICE OR REQUESTS MADE PURSUANT TO IT SHOULD BE ADDRESSED TO:

AKEELA, INC.

ATTN: PRIVACY OFFICER,

360 W. BENSON BLVD. SUITE 300,

ANCHORAGE, AK 99503

(907)565-1200

ACKNOWLEDGEMENT OF CLIENT RIGHTS & CLIENT PRIVACY PRACTICES

The undersigned person acknowledges receiving a copy of Akeela Inc. "Client Rights" and "Notice of Privacy Practices" and has had the opportunity to have my questions answered. A signature below signifies my receipt.

______________________________	____________________
Client Name (Printed)	Date
______________________________	____________________
Client Signature	Date

Reviewed with the client by:

______________________________	____________________
Akeela Staff Signature	Date

REFUND POLICY

- Akeela does not provide refunds for any monies paid. **NO EXCEPTIONS.**

- Akeela does not perform assessments on individuals under the influence
    - of drugs and/or alcohol. If you arrive and are under the influence, your
    - appointment may be re-scheduled but there will be no refund tendered.

- This includes pre-paid assessments. It is ***your*** responsibility to follow
    - through with appointments.

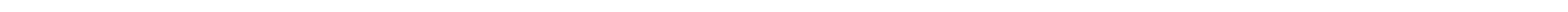
- There is a $30.00 missed appointment fee if the appointment is cancelled
    - or re-scheduled within 24 hours or if you do not show or call in for your
    - appointment. This fee will be payable when you arrive for your assessment.

- If you have any questions or concerns, please contact Shannon Pritchett,
    - Chief Financial Officer, (CFO) at 907-565-1232.

My signature below signifies that I have read and understand Akeela's Refund Policy.

____

Client Signature Date



Reviewed with the client by:

__________________________________ _________________

Akeela Staff Signature Date

TREATMENT PROGRAMS FINANCIAL INFORMATION AND RELEASE

DATE: ________________________

LAST NAME: ___________________________________FIRST NAME: ____

EMPLOYER/SCHOOL: ____________________________OCCUPATION: ____

PRIMARY INSURANCE (INCLUDING MEDICAID)(COPY OF INSURANCE CARD, FRONT AND BACK) REQUIRED:

PERSON RESPONSIBLE FOR ACCOUNT: ____

LAST NAME FIRST NAME MIDDLE INITIAL

RELATIONSHIP TO PATIENT: _________________DATE OF BIRTH: ________________SSN: _______________________

ADDRESS IF DIFFERENT THAN PATIENT'S: ____

CITY: ____STATE: _____________________ZIP CODE: _____________

PHONE NUMBER: ____

INSURANCE COMPANY: ____

MEMBER ID #: _________________________________GROUP #: _____________________________________

SECONDARY INSURANCE (INCLUDING MEDICAID)(COPY OF INSURANCE CARD, FRONT AND BACK) REQUIRED:

IS PATIENT COVERED BY ADDITIONAL INSURANCE: □ YES □ NO

SUBSCRIBER'S NAME: ____

LAST NAME FIRST NAME MIDDLE INITIAL

RELATIONSHIP TO PATIENT: _________________DATE OF BIRTH: ____________________SSN: ______________________

ADDRESS IF DIFFERENT THAN PATIENT'S: ____

CITY: _________________________________STATE: __________________________ZIP CODE: ______________________

PHONE NUMBER: ____

INSURANCE COMPANY: ____

MEMBER ID #: _________________________________GROUP #: ____

I authorize the individual below to contact Akeela on my behalf regarding financial payments only. Copy of signed ROI must be on file.

NAME: ________________________________PHONE NUMBER: ___________________RELATIONSHIP: _______________

____ _________________________

Signature of Client Date

TREATMENT PROGRAMS FINANCIAL INFORMATION AND RELEASE

ASSIGNMENT

I certify that I and/or my dependent(s) have insurance coverage with ___________________________________
and _________________________________therefore assign directly to Akeela, Inc., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

RELEASE OF INFORMATION:

The following specific information: Required documentation and information for payment of service provision invoices for care received from Admission to Discharge

The purpose of the release of this information is: Payment of Invoices for services rendered.

I understand that the information in my health record may include information relating to behavioral or mental health services and/or treatment for alcohol and drug abuse. It may also include information to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). Exchange of information ensures continuity of care between providers. By not sharing information, my health care could be compromised.

I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that I may revoke this authorization at any time by notifying the individual(s) or organization releasing this information in writing, but if I do, it will not have any effect on actions taken on this authorization before my revocation was received. I understand that the individuals(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (If applicable) or eligibility for benefits on whether I provide this authorization, but that in certain limited circumstances, I may be denied treatment if I do not sign a consent form. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential.

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”), 45 CRF pts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time, except to the extent that action has been taken based upon it, and that in any event this consent expires automatically as of 12 months post discharge.

By my signature below I indicate that I have read this document, or have had it read to me, that I fully understand its meaning, that I have consented to its terms knowingly and voluntarily, and that I have not been under any undue duress or influence of alcohol or drugs in making this agreement.

______________________________ ______________________________
Signature of Client or Personal Representative | Date

______________________________ ______________________________
Printed Name of Personal Representative | Description of Personal Representative’s Authority

______________________________ ______________________________
Signature of Staff | Date

RECIPIENT INFORMATION: “This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.”

REVOCATION OF RELEASE:

I revoke the authorization to release information to ____________________and/or ______________health insurance companies, effective: ___________________________(date).

______________________________ ______________________________
Signature of Client or Personal Representative | Date

______________________________ ______________________________
Printed Name of Personal Representative | Description of Personal Representative’s Authority

____
Signature of Staff

Revised 03/12/2021

AKEELA, Inc

Behavioral Health Services Fee Schedule - Effective 07/01/2022

Client's Full Legal Name: ______________________ Client's **DOB:** ______________________

AU clients are responsible for full payment of services provided to them by Akeela, Inc at the time service is provided.

Screening/Assessments (Sliding Fee Scale does not apply)				
Assessment Screening Tool	$ 50.00	per assessment	No SFS	Included In **Assessment price**
Integrated MH / SU Intake Assessment	$ 630.00 •	per session	No SFS •	$100 Discount when paid in full al lime of service
Alcohol/ Drug Assessment	$ 340.00 •	per session	No SFS •	$100 Discount when paid in full al **lime** of service
Mental Health Intake Assessment	$ 550.00 •	per session	No SFS •	$100 Discount when paid in full at tme of service
Psychiatric Assessments - By MD, PA ,ANP only	$ 650.00	per session	NoSFS	
Clinic **Services• Mental Health**				
Individual/ Family Psychotherapy	$ 160.00	per hour		
Group Psychotherapy	$ 80.00	per hour		
Multi-Family Psychotherapy	$ 120.00	per hour		
Crisis intervention / Stabilization	$ 150.00	per hour		
Pharmacologic Management	$ 180.00	per occurrence	NoSFS	
Rehab Services - Substance Use				
Individual/ Family Services	$ 120.00	per hour		
Group Services	$ 80.00	per hour		
Case Management	$ 120.00	per hour		
Treatment Plan Development / Review	$ 140.00	per occurrence		
Residential Services (Sliding Fee Scale does not apply)				
Akeela House	$ 18.25	per Bed/day	Submission of Quest Card Required Full	
Stepping Stones	$ 20.50	per Bed/day	Unit	
Stepping Stones	$ 10.25	per Bed/day	Shared Unit	
Kar House	$ 30.00	per Bed/day	Submission of Quest Card Required Full	
Transitional Housing	$ 1,000.00	Per Month	Unit	
Transitional Housing	$ 500.00	Per Month	Shared Unit	
Other Services (Sliding Fee Scale does not applyl				
No Show Fee	$ 30.00	per occurrence	No SFS	
ADIS Class	$ 150.00	per 3 day class	No SFS	

Slldlng Fee Scale discounts available to self-pay clients that qualify.

Proof of Income, along with completed and signed Sliding Fee Scale paperwork, is required to receive a Sliding Fee Scale discount. All clients will be billed at a 100•;. fee for services provided to them until financial documentation is reviewed and approved by billing department staff. Sliding Fee Scale discounts are available to self-pay clients only and will take effect as of the first day of the month in which acceptable proof of income is received.

As a courtesy, Akeela will bill and collect from all other sources of insurance first before billing the client for the balance. Proof of valid insurance required prior to billing of Insurance. This Includes all private Insurance as well as Denali Care/Denali Kid Care (Medicaid. Akeela is not in network with any private insurance companies. Insurance coverage and/or payment depends on each individual policy and is not guaranteed.

Clients must bring In their insurance card if they wish to have Akeela bill their insurance. Denali Care/Denali Kid Care (Medicaid) Is Insurance. Insurance will only be billed providing all required paperwork Is completed and signed. Insurance billing will begin as of the first day of the month in which proof of valid insurance is received.

I have received a copy of the above Fee Schedule and agree to the above rates and terms:

_______________________	_______________________	_______________
Client. Parent or Guardian Signature	*Parent or Guardian Name*	*Date*

I hereby assign any benefits payable for services provided to me, by Akeela, Inc., be remitted to Akeela, Inc.

AKEELA, Inc

Behavioral Health Services Sliding Fee Reference - Effective 07/01/2022

Client's Full Legal Name:________________________________

Approved Sliding Fee Scale (SFS): ________________________ Effective Date (See SFS): __________________

Sliding Fee Scale - Please note unit increments aDDIY									
		Cost Per Unit							
Service	*Units*	*100¾*	*90¾*	*80¾*	*70¾*	*60¾*	*50¾*	*40¾*	*30¾*
Screening/Assessments (Sliding Fee Scale does not apply)									
Assessment Screeninq Tool	aqency admit	$ 50.00	NoSFS	**Included** in **Assessment price**					
Inteqrated MH / SU Intake Assessment	loer session	$ 630.00	No SFS	$100 Discount aoolies when oaid in full at lime of service					
Alcohol / Drug Assessment	per session	$ 340.00	No SFS	$100 Discount applies when paid in full at lime of service					
Mental Health Intake Assessment	'per session	$ 550.00	NoSFS	$100 Discount applies when paid in full at time of service					
Psychiatric Assessments - By MD, PA ,ANP onlv	per session	$ 650.00	NoSFS						
Clinic Services - Mental Health									
Individual / Family Psychotherapy	oer hour	$ 160.00	$ 144.00	$ 128.00	$ 112.00	$ 96.00	$ 80.00	$ 64.00	$ 48.00
Group Psychotherapy	:per hour	$ 80.00	$ 72.00	$ 64.00	$ 56.00	$ 48.00	$ 40.00	$ 32.00	$ 24.00
Multi-Family Psychotherapy	per hour	$ 120.00	$ 108.00	$ 96.00	$ 84.00	$ 72.00	$ 60.00	$ 48.00	$ 36.00
Crisis Intervention	oer hour	$ 150.00	$ 135.00	$ 120.00	$ 105.00	$ 90.00	$ 75.00	$ 60.00	$ 45.00
Pharmacologic Management	per occurrence	$ 180.00	No SFS						
Rehab Services • Substance Use									
Individual / Family Services	,per hour	$ 120.00	$ 108.00	$ 96.00	$ 84.00	$ 72.00	$ 60.00	$ 48.00	$ 36.00
Group Services	1oer hour	$ 80.00	$ 72.00	$ 64.00	$ 56.00	$ 48.00	$ 40.00	$ 32.00	$ 24.00
Case Management	:oer hour	$ 120.00	$ 108.00	$ 96.00	$ 84.00	$ 72.00	$ 60.00	$ 48.00	$ 36.00
Treatment Plan Development/ Review	'per occurrence	$ 140.00	$ 126.00	$112.00	$ 98.00	$ 84.00	$ 70.00	$ 56.00	$ 42.00
Other Services (Sliding Fee Scale does not apply)									
No Show Fee	per occurrence	$ 30.00	No SFS						
ADIS Class	per 3 day class	$ 150.00	No SFS						

______________________________ ______________

Client, Parent or Guardian Signature *Date*

______________________________ ______________

Staff Signature *Date*

______________________________ ______________

Billing Department Signature *Date*

Revision Date: 07/10/2022

SECTION 2: RESIDENTIAL PROGRAMS ONLY

Akeela, Inc. Residential Treatment Programs

MEMORANDUM – Intake Introduction

TO: All Referral Professionals

Thank you for your interest in Akeela, Inc. Residential Treatment Programs

A completed packet is to include all documents listed on the **INTAKE CHECKLIST** (page 46).

Please fax or email completed packets to your designated Akeela, Inc. Residential Treatment Program. A list of Akeela, Inc. Residential Treatment Programs and their contact information can be found on the **INTAKE CHECKLIST**.

There are more applications than available beds for treatment. A wait list is maintained for applicants who are approved for admission until beds are available. (See below for information on priority admission criteria.)

Akeela, Inc. Residential Treatment Program's admission policies include Priority Admission Criteria. Applicants who meet any of the Priority Admission Criteria will have priority over other individuals on the Wait List (per State of Alaska Wait List Protocol). Please see page 4 of the Demographics forms for the complete list of criteria.

It is long-standing policy for Akeela, Inc. Residential Treatment Programs that persons with criminal charges that have not yet been adjudicated (pre-sentence) are ineligible for admission.

Please inform the applicant that submitting the application package does not mean acceptance into an Akeela, Inc. Residential Treatment Program. After submitting a completed packet, an interview with the Intake Coordinator of the designated Akeela, Inc. Residential Treatment Program may be required, the interview may be either in person or by telephone. The admission process includes treatment team review of completed intake packets.

Also please inform the applicant that after submitting a completed Intake packet, the applicant will need to have contact with the Intake Coordinator of the designated Akeela, Inc. Residential Treatment Program. If the applicant does not have a phone or a reliable contact phone number, the applicant will take the initiative to contact the Intake Coordinator at Akeela House on a regular basis. If you require further information, please contact the Intake Coordinator of the designated Akeela, Inc. Residential Treatment Program at the information provided on the **INTAKE CHECKLIST**.

Akeela, Inc. Residential Treatment Programs

INTAKE CHECKLIST

A completed intake packet is to include the following 5 items:

☐ 1) Demographics (Page 5-8)

☐ 2) Medical Clearance, TB, Medication Self-Administration Form (Page 47-49)
All forms must to be filled out by a Health Care Provider. Medication self-administration form must be completed prior to admission; Medical and TB forms preferred completion within past 30 days, mandatory completion within 2 days of program admission (Upon program approval).

☐ 3) Behavioral Health Assessment
Assessment must be completed within past six months. Comprehensive Biopsychosocial Substance Abuse assessment to include DSM--5 and ASAM-3rd edition diagnoses with treatment recommendations requiring level 3.5 level of care. If an assessment has not already been completed, you may call Akeela, Inc. Assessment Center at (907) 433-7080 to schedule one.

☐ 4) Releases of Information (ROI) (Page 20)
Include a separate signed ROI for each of the parties involved in the applicant's case, i.e., physician, attorney, parole officer, counselor, OCS, etc. A separate ROI is required for each person and each agency that requires communication from the program and client.

☐ 5) If on probation or parole, please provide a copy of the Presentence Report.

☐ 6) Children's Profile – **Stepping Stones Only** (Page 50-53)

Once the above items are completed, you may fax or email the completed paperwork to the designated Akeela, Inc. Residential Treatment Program. Each Residential Treatment Program's contact information is below:

☐ **Akeela House**: *Phone* (907) 561-5266; *Fax* (907) 562-5041
Email AkeelaHouseIntake@akeela.org

☐ **Stepping Stones**: *Phone* (907) 569-0097; *Fax* (907) 569-0098
Email Stepping StonesIntake@akeela.org

☐ **KAR House**: *Phone* (907) 225-3510; *Fax* (907) 225-3514
Email KARHouseIntake@akeela.org

Medical Clearance Form

PATIENT NAME (please print): ________________________________ DATE OF BIRTH: _________________

The following medical information form must be completed by a health care provider in order to participate in Akeela, Inc. Residential Treatment.

Does this patient require detoxification prior to entering treatment? □ NO □ YES

Does this patient have any physical impairments/limitations? □ NO □ YES
If YES, please explain:

____

____

Does this patient have any communicable diseases? □ NO □ YES
If YES, please explain:

____

____

If applicable, is this patient pregnant? □ NO □ YES - _________________________________

PHYSICAL EXAMINATION

SYSTEMS	NORMAL	ABNORMAL
Abdomen		
Cardiovascular		
Extremities		
Genitals		
Lungs		
Neck/Thyroid		
Neurological		
Skin		
Vital Signs		

TB CLEARANCE

Skin Test:
Administered Date: _______________
Read Date: ________________

Results: ______mm Negative / Positive

X- RAY:
Results: ____________________________

This patient has been medically evaluated and cleared to participate in residential treatment which may include groups and other activities up to 8 or more hours per day. □ NO □ YES
If NO, please explain:

____

____

Medical Clearance Form

Is this patient in psychiatric crisis? □ NO □ YES
If YES, please explain:

____

____

Has this patient reported any recent suicidal ideation or homicidal ideation? □ NO □ YES
If YES, please explain:

____

____

Does this patient have a regular Primary Care Provider? □ NO □ YES
If YES, please list:

____

____

Does this patient have a regular Mental Health Provider? □ NO □ YES
If YES, please list:

____

____

______________________________ ______________________________
Signature of Physician / PA / ANP Date

Name of Clinic: ______________________________

Clinic Office Phone Number: ______________________________

Date: ____________________

Medical Clearance for Self-Administration of Medication

MEDICATION LIST FOR CLIENT

Name of Medication	Prescribed By	Dosage	Route

If the patient is prescribed addictive or narcotic medications are there non-narcotic alternatives? □ NO □ YES

If YES, please list:

____

____

RE: Medical Clearance for Self-Administration of Medication

1. The person listed below is requesting substance use disorder treatment at a residential treatment program of Akeela, Inc. The residential treatment program does not administer medications, but instead safely stores medications so that clients can then take their own medication (self-administration) as prescribed by their prescriber.
2. In keeping with regulations by the State of Alaska, persons entering residential treatment in which clients take their own medication require a medical clearance from a physician, PA or ANP that states the client is capable of self-administration of medication prescribed.
3. If you have questions, please call specific Akeela House Program Manager at

(907) 569-0097. Or please call Akeela Chief Clinical Officer at 907-565-1200.

Name of Client: ____

DOB: ____

The person named above is capable of self-administration of medication prescribed.

______________________________________ ____________________

Signature of Physician / PA / ANP Date:

Name of Clinic: ___________________________________

Clinic Office Phone Number: _____________________________

Date: ____________________

CHILDREN PROFILE – ONE PER CHILD

(Stepping Stones Only)

Date: ______________________________

Child Full Name (including any native names): ____

____

Date of Birth: ___________ Age: ___________ Gender: Female Male Other__________

Mother's Name: _________________________ Father's Name: _________________________

Parent's Status (circle one): Married Divorced Separated Remarried

Please provide any instructions regarding your custody arrangements as they affect your child while at the Stepping Stones Children's program: ____

____

____

Please provide names and ages of siblings:

1 ____________________________________ 3 ____________________________________

2 ____________________________________ 4 ____________________________________

Has your child ever lived with a foster family or similar situation? ☐ No ☐ Yes

If Yes, please briefly describe: who, when, and for how long:

____

____

OCS Caseworker Name and Location: ____

Developmental and Health History

Did you use drugs or alcohol while pregnant with your child? ☐ No ☐ Yes

If Yes, please describe: what, how long, how often, and intensity of use:

____

____

Has your child received a developmental assessment? ☐ No ☐ Yes

If Yes, please comment on its finding (a copy may be required): ___________________________________

____

CHILDREN PROFILE – ONE PER CHILD

(Stepping Stones Only)

Physical/Mental Disabilities or Limitations: ______________________________

____

____

Primary Physician Name and Location: ______________________________

____

Other Treatment Provider (mental health therapist, physical therapist, etc.):

____

____

Please list any other known health or medical problems including special needs or developmental delays:

____

____

Education History

Has your child been in a care facility before? ☐ No ☐ Yes

If yes, for how long? ____________________

How did your child do there? ______________________________

____

____

Did you or your child experience any problem there? ☐ No ☐ Yes

If yes, please describe: ______________________________

____

____

Is your child in public school? ☐ No ☐ Yes

If yes, what is the name of the school? ______________________________

What grade is your child in? ____________________

Teacher's Name? ______________________________

Does your child participate in any after school or extra-curricular activities? ☐ No ☐ Yes

If yes, please list them here: ______________________________

____

Toilet and Napping Habits

Is your child fully potty trained? ☐ No ☐ Yes.

If no, does he/she/they use: ☐ Diapers ☐ Pull-ups

Does your child need pull-ups or diapers at night or at nap time? ☐ No ☐ Yes

Can we depend on your child to tell us when they need to go to the bathroom? ☐ No ☐ Yes

Any special words your child uses? ☐ No ☐ Yes

If yes, please list them here: ______________________________

____

____

Are there any special naptime instructions? ☐ No ☐ Yes

If yes, please describe: ______________________________

____

____

Normal bed time? ________Awaken? ________Normal nap time? ________ Bedtime Buddy? ________

Does your child have a special sleeping routine (song, story, etc.)? ☐ No ☐ Yes

If yes, please describe: ______________________________

____

____

Personality Profile

How would you describe your child's normal disposition? ______________________________

____

____

Does he/she/they have any specific fears or phobias? ☐ No ☐ Yes

If yes, please describe: ______________________________

____

____

CHILDREN PROFILE – ONE PER CHILD

(Stepping Stones Only)

What means of discipline do you find most effective? ____

____

____

Describe the experience your child has had playing with other children: ______________________________

____

____

What language(s) are spoken at home? ____

What is your child's nature? Friendly Shy Aggressive Other: _______________

What frustrates your child, or makes them angry? ____

____

____

What is the best way to communicate with your child? ____

____

____

How do you comfort your child? ____

____

____

Is there anything out of the ordinary that might help us in understanding and working with your child more effectively (newborn, divorce, death, new step-parents, moves, etc.)? __________________________________

____

____

What areas of special attention would you like us to focus on this year? ______________________________

____

____

What are some of your child's favorite things (toys, food, games, etc.)? ______________________________

____

____

Is there anything else you would like us to know about your child? __________________________________

____

____

Akeela, Inc. Residential Treatment Programs

PLEASE REVIEW THE FOLLOWING GUIDELINES WITH THE APPLICANT:

- To be admitted into the program, you must be well enough to participate in the program. If you arrive under the influence of alcohol or other drugs, or in withdrawal requiring clinical intervention, you will be referred to an appropriate detoxification setting before treatment.
- Akeela, Inc. Residential Treatment Programs are not responsible for your transportation or any other personal costs you may incur (e.g., approved medications) while in treatment.
- Please bring required medications. Medications must be in the original prescription bottle with the original prescribed information and may not be mixed in with other medications.
- Treatment fees will be determined using a sliding fee scale appropriate to the client's income and family status utilizing the federal poverty guidelines.

I agree that the information provided by me in development of the Behavioral Health assessment, history and physical, and other intake paperwork is true and accurate to the best of my knowledge.

I have signed an enclosed Release of Information to obtain further information that is necessary to determine my suitability for treatment and/or to confirm I will be reporting for treatment at my designated Akeela, Inc. Residential Treatment Program as scheduled.

I have also signed a Release of Information, which authorizes my physician to release to my designated Akeela, Inc. Residential Treatment Programs, medical information which is required to assess my suitability for acceptance and admittance into the residential treatment program.

Other Releases of Information may also be required from other agencies (DOC, Courts, OCS, etc.) should also be signed for a comprehensive understanding of your appropriateness for our program.

I have read and agree to the enclosed "Resident Information and Responsibilities."

Applicant's Signature______________________________Date_______________

Akeela, Inc. Residential Treatment Programs

Resident Information and Responsibilities:

- Akeela, Inc. Residential Treatment Programs are long-term residential treatment facilities that work with those who suffer from addiction. Each facility has varying bed space. Each client is required to apply for cash assistance, TANF, food stamps, daycare assistance and Medicaid. These benefits assist in covering the costs of living expenses and treatment costs. The average length of stay for a client is 12 months.

- The treatment program can run from 9 to 18 months, seven days a week, and our professional clinical treatment staff will guide your care for this time period.

- All program materials, including paper and pens will be provided.

- Any medications, prescription or otherwise, not authorized for use will be confiscated and disposed.

- Total abstinence, free from all mood altering substances, except for prescribed medications.

- Please wear comfortable and appropriate clothing with no alcohol or drug logos, no revealing blouses or shirts. Socks and shoes must be worn at all times. No sleeveless or tank tops may be worn. No open toed shoes are to be worn in groups and out of apartment. During business hours, no sweats or shorts may be worn.

- **NO** shampoos, mouthwash, hairspray, or other items containing that contain alcohol are permitted.

- There is **no parking** available. Please do not bring a vehicle.

- Akeela, Inc. Residential Treatment Programs are **non-smoking/tobacco free environment**. No tobacco products are allowed on the premises. Vapes and e-cigarettes are also not allowed. Smoking cessation programs are available such as QuitLine and QuitLine calls can be arranged.

- Supported phone calls are available for client use after completing orientation. Staff will pass on messages to resident. If you wish for your family to be able to reach you in case of emergency, a staff member can provide you with a phone number to give to them.

- From the day of admission, a blackout period of 14-days exists to assist the client with program orientation, including handbook and orientation packet reading with support of peers in the therapeutic community. During the 14-days of blackout, only business calls (OCS, Attorney, PO, etc.) and calls and visits with your children are permitted. Staff may support visits and phone calls.

- We believe and encourage the involvement of supportive family and friends. **After** Orientation, visitors are welcome after completing one visitation orientation group and having one meeting with the client and the primary counselor