Maniilaq Association/Behavioral Health Services Intake and Admission Form

Client Profile

Name (First Middle Last):	**Maiden or Other Name:**	**Preferred Name:**
Social Security Number:	**Medicaid Number:**	**DOB:** **Age:**
Mailing Address: **City:** **State:** **Zip:** **Email Address:**		**Phone #(s):** **Are we able to leave a message at this number:** ☐ **Yes** ☐ **No**
For Youth Clients Only: Parent/Guardian Name	**Collateral Contacts (Name, Phone #, Address) (Probation Officer, Attorney, OCS CS, etc.):**	

Preferred Delivery of Treatment: ☐ In Person ☐ Telehealth (video or phone) ☐ No Preference

Presenting Problem:

(Please number your top 3 in the order of importance)
****REQUIRED QUESTION****

_____Problems related to historical trauma
_____Grief/Loss
_____Thought Disorder
_____Alcohol and Drugs
_____Alcohol
_____Drugs
_____Suicide Attempt/Threat
_____Child Abuse Survivor/Victim
_____Sexual Abuse Survivor/Victim
_____Eating Disorder
_____Psychological/Emotional
_____Depression
_____Social/Interpersonal
_____Marital
_____Coping with Daily Roles/Activities
_____ ASAP (Alcohol Safety Action Program)
_____Medical/Somatic
_____Runaway Behavior
_____Financial
_____Poverty
_____Child Abuse Perpetrator
_____Sexual Abuse Perpetrator
_____Family (non-marital)
_____Legal
_____DV-IP/BIP (Domestic Violence – Intimate Partner Violence/ Batter's Intervention Program
_____Domestic Violence Survivor/Victim
_____Other (Please specify):

What challenges are you experiencing that brings you in for services (presenting concerns)?
****REQUIRED QUESTION****

I am seeking services because...

Referral Source

☐ Self- Referred ☐ Internal Referral MHC : Provider _____
☐ External Referral (please specify):
☐ CAC (Children's Advocacy Center) ☐ School ☐ OCS (Office of Child Services)
☐ ASAP (Alcohol Safety Action Program) ☐ Division of Juvenile Justice (DJJ)
☐ DV-IP/BIP (Domestic Violence Intimate Partner/Batter's Intervention Program)
☐ Other (Please Specify

Gender:

☐ Male ☐ Female Becoming Male ☐ Male Becoming Female
☐ Female ☐ Transgender Male ☐ Transgender Female
☐ Decline to Answer ☐ Two-spirit/Gender Fluid ☐ Non-binary/Non-Conforming

Ethnicity:

☐ Not Spanish/Hispanic/Latino/Mexican ☐ Puerto Rican ☐ Hispanic – Origin NOS
☐ Spanish/Hispanic/Latino ☐ Cuban ☐ Chicano/Other Hispanic
☐ Hispanic – Origin Unspecified ☐ Mexican

Communities:	☐Kotzebue ☐Kivalina ☐Ambler ☐Buckland ☐Noatak ☐Noorvik ☐Kiana ☐Deering ☐Point Hope ☐Shungnak ☐Kobuk ☐Selawik ☐Other_____
Race:	☐Not Collected ☐Aleut ☐Native Hawaiian ☐Tsimshian ☐Caucasian ☐Asian ☐Pacific Islander ☐Black/African American American ☐Indian ☐Haida ☐Tlingit ☐Other Alaska Native Athabascan ☐Yupik ☐Inupiat ☐Other (specify): _____
Special Needs:	☐None ☐Autism ☐Intellectual Developmental Disability ☐Major Difficulty in Ambulating (mobility) ☐Moderate to Severe Medical Problems ☐Non-Ambulation ☐New Immigrant ☐ FASD (Fetal Alcohol Syndrome) ☐TBI (Traumatic Brain Injury) ☐Hearing Impaired or Deaf ☐Visual Impairment or Blind ☐Acquired Brain Injury ☐Other:_____
Sexual Orientation:	☐Decline to Answer ☐Asexual ☐Bi-Sexual ☐Heterosexual/Straight ☐Homosexual/Lesbian/Gay ☐Pansexual ☐Queer ☐Questioning ☐Another identity: _____
English Fluency:	☐Excellent ☐Good ☐Moderate ☐Poor ☐Not at All
Education:	☐No Schooling ☐Bachelor's Degree ☐Post-Secondary 1 Year ☐Current Student ☐Graduate Work ☐Post-Secondary 2 Years (AA Degree) ☐GED ☐Master's Degree ☐Post-Secondary 3 Years ☐HS Diploma ☐Doctorate Degree ☐Post-Secondary 4+ Years (No Degree) ☐Special Education ☐Vocational Training
Highest Grade Completed:	**Number of Days Absent in the Past Month:**
Veteran Status:	☐Never in Military ☐Retired from Military ☐Military Dependent ☐Retired from Military; No Combat ☐On Active Duty; Combat ☐Vietnam Era Veteran; Combat ☐On Active Duty; No Combat ☐Vietnam Era Veteran; No Combat ☐Iraq War Veteran; Combat ☐In Reserves/National Guard; Combat ☐Afghan War Veteran; Combat ☐In Reserves/National Guard; No Combat ☐Separated, Non-Combat, Honorable Discharge ☐Separated, Non-Combat, Other Than Honorable Discharge

Intake Information

If Female, Are You pregnant?	☐Yes	☐No	Due Date?
Are You an Injection Drug User?	☐Yes	☐No	Last Injected?

Admission Information

How many times have you been admitted for substance use treatment?	
How much substance use related hospitalizations have you had in the past six months?	
How many times have you been admitted for mental health treatment?	
How many times have you been hospitalized for mental health treatment?	
Do you take medication (psychotropic) for a mental health related problem?	

Revised 5/4/2026

Rank your overall health:	☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor

Number of times you have attended a self-help program in the 30 days preceding the date of admission to treatment services. Includes attendance at AA, NA, and other self-help/mutual support groups focused on recovery from substance abuse and dependence:

☐ No attendance in the past month ☐ 1-3 times in the last month ☐ 4-7 times in the last month
☐ 8-15 times in the last month ☐ 16-30 times in the last month ☐ frequency unknown

Financial Information

Employment Status:

☐ Employed Full-Time ☐ Student ☐ Not in Labor Force, Other
☐ Employed Part-Time ☐ Retired ☐ Seasonal, In Season
☐ Disabled ☐ Unemployed, Looking ☐ Seasonal, Out of Season
☐ Unemployed, Subsistence Lifestyle ☐ Unemployed, Not Looking ☐ Not Seeking Work
☐ In the Armed Forces ☐ Homemaker ☐ Resident/Inmate
☐ Other_____

Occupation:

☐ Accommodation/Food Service ☐ Health Care and Social Assistance
☐ Agriculture/Forestry/Fishing ☐ Information
☐ Arts, Entertainment, Recreation ☐ Management of Companies/Enterprises
☐ Construction ☐ Manufacturing
☐ Utilities ☐ Mining, Quarrying, Oil and Gas Extraction
☐ Educational Services ☐ Other Services except Public Administration
☐ Finance and Insurance ☐ Retail Trade
☐ Government ☐ Administrative/Support Services
☐ Real Estate, Rental/Leasing ☐ Professional, Scientific, Technical Services
☐ Transportation and Warehousing ☐ Self-Employed
☐ Wholesale Trade ☐ None
☐ Other (Please specify): _____

Estimated Annual Household Income:

Primary Income Source:

☐ None ☐ Parent's Income ☐ SSI
☐ AK Native Dividend ☐ Railroad Retirement ☐ SSI/SSDI Never
☐ AK PFD ☐ Unemployed Compensation ☐ SSI/SSDI Previous
☐ Alimony ☐ Self-Employment ☐ Social Security
☐ Child Support ☐ Tribal Assistance Program ☐ SSDI
☐ Employment ☐ Spouse/Significant Other's Income ☐ Interest and Other
☐ Public Assistance/Welfare ☐ Retired, Survivor, or Disability Pension ☐ Other_____

Expected Payment Source:	☐ Aetna	☐ HIS	☐ Other Native Health Care
	☐ HMO	☐ Medicaid	☐ Other Private
	☐ Blue Cross/Shield	☐ Medicare	☐ Sliding Fee Scale, Self-Pay
	☐ Cigna	☐ No Charge	☐ Sliding Fee Scale, no Charge
	☐ AK Native Health Care	☐ Other Government Grant	☐ VA Insurance
	☐ HMO	☐ Individual Policy	☐ Personal Payment (cash)
	☐ IHS	☐ Other_____	

Household Composition

Marital Status:	☐ Cohabitating	☐ Married	☐ Separated
	☐ Divorced	☐ Single (never married)	☐ Widowed
Household Composition:	☐ Lives Alone	☐ Lives with Relatives	☐ Lives with Non-Relatives
	☐ Lives with Children	☐ Lives with Adolescents	☐ Lives with Significant other
	☐ Other	☐ Lives with Significant Others and Children	
Living Arrangement:	☐ Private Residence without Supportive Services	☐ Private Residence with Supportive Services	
	☐ Assisted Living Facility	☐ Group Home	☐ Correctional Facility
	☐ Foster Care	☐ Hospital (non-psychiatric)	☐ Halfway House
	☐ Homeless	☐ Hospital (psychiatric)	☐ Therapeutic Foster Care
	☐ Nursing Home	☐ Transitional Housing	☐ Crisis Residence
	☐ Residential Treatment	☐ Shelter	☐ Other_____

Number of children in a residential setting		Number of people living with client	
Number of children in residential setting receiving services		Number of children in household	

Legal History

Legal Status:	☐ Court Ordered, Mental Health	☐ Court Ordered, DJJ Custody	☐ Court Ordered, parent's custody
	☐ 90 Day Commitment	☐ Incarcerated	☐ Informal Probation
	☐ 30 Day Commitment	☐ 180 Day Commitment	☐ None/No Involvement
	☐ Case Pending	☐ Deferred Prosecution	☐ OCS Custody
	☐ Comm. Sentencing	☐ Deferred Sentence	☐ Probation/Parole
	☐ Court Ordered Evaluation	☐ Emer. Commitment	☐ Protective Custody
	☐ Court Ordered, Substance Abuse	☐ Furlough/Rehab Leave	
	☐ Title 12, Not Guilty by Reason of Insanity		

Number of arrests in the last 30 days:	

By signing below, I certify all information is true and correct to the best of my knowledge.

Client Printed Name	**Client Signature**	**Date**
Guardian Printed Name	**Guardian Signature**	**Date**
BHS Staff Printed Name	**BHS Staff Signature**	**Date**

MANIILAQ BEHAVIORAL HEALTH SERVICES

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Maniilaq Behavioral Health Services (MBHS) is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples:
   a. For *Treatment* - Physician-to-Physician communication of patient information for the purposes of continuity of care.
   b. For payment - *Submission of claims and requested medical records information to applicable third party insurance.*
   c. For health care operations - *Conducting quality assessment and improvement activities.*
2. MBHS is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization.
3. Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization.
4. MBHS may contact the individual by SMS text message via the Zoom platform for non-clinical communications.
   a. With the individual's written consent, MBHS may send text messages related to appointment reminders, rescheduling, and general wellness outreach. These messages will never include clinical content.
   b. Message frequency varies. Message & data rates may apply. Text HELP for help. Reply STOP to opt out.
   c. No mobile information will be shared with third parties/affiliates for marketing/promotional purposes. All other categories exclude text messaging originator opt-in data and consent; this information will not be shared with any third parties.
5. MBHS intends to engage in one or more of the following activities:
   a. MBHS may contact the individual to provide appointment reminders of information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.
   b. A group health plan, or a health insurance issuer or HMO with respect to a group health plan, may disclose protected health *information* to the sponsor of the plan.
6. The individual has the following rights regarding protected health information:
   a. The right to request restrictions on certain uses and disclosures of protected health information. MBHS is not required to agree to a requested restriction, however.
   b. The right to receive confidential communications of protected health information, as applicable.
   c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
   d. The right to amend protected health information, as provided in the Privacy Regulation.
   e. The right to receive an accounting of disclosures of protected health information.
   f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.

This Notice is first in effect on April 14, 2003. Updated 6/5/2025, 06/24/2025, 6/4/2026, 6/26/26, 7/3/26

NOTICE OF PRIVACY PRACTICES
(CONTINUED)

7. MBHS is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.
8. MBHS is required to abide by the terms of the Notice currently in effect.
9. MBHS reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.
10. MBHS will provide individuals or patients with a revised Notice by posting the revision on MBHS' corporate website and publishing the revision in MBHS' corporate bi-monthly newsletter. A copy of the revision will also be supplied at the next patient encounter after the revision becomes effective.
11. Individuals may bring concerns to MBHS and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated.
12. MBHS' contact person for matters relating to complaints is:

    Chief Compliance Officer
    P.O. Box 256, 733 2nd Avenue, Kotzebue, AK 99752
    Phone: (907) 442-7608

Client Rights/Responsibilities Notification and Grievance Procedure

YOU HAVE THE RIGHT TO:

1. Request and receive information about your counselor's professional capabilities including licensure, certification education, training, experience, specializations, and/or limitations.
2. Be treated respectfully.
3. Ask questions about your services/treatment.
4. Participate in the development of your treatment plan and selection of services provided.
5. Request information about your progress in treatment.
6. A safe treatment environment free from physical, emotional, and/or sexual abuse.
7. Confidentiality except for specific reasons to include:
    a. Suspected and/or disclosed abuse/neglect of a child, elder, or individual with a developmental disability.
    b. You are in danger of harming yourself.
    c. You threaten to harm another person(s).
    d. You have become gravely disabled.
    e. *Pursuant* to an agreement with a qualified service organization/business associate for research, audit, and/or evaluation.
    f. To report a crime committed against staff and/or the program.
    g. To medical personnel in a medical emergency.
    h. As allowed by an authorizing court order.
    i. Among behavioral health staff for the purpose of clinical and quality review.
8. Refuse treatment except during an emergency situation or as permitted under law in the case of a person committed by a court for treatment.
9. Not participate in experimentation without informed, voluntary, written consent, the right to appropriate protections associated with such participation and the right to revoke such consent an anytime.
10. Refuse photographic, audio, and/or video recordings of your sessions/treatment.
11. Request in writing and receive a copy of your treatment records.
12. Be in the least restrictive level of services.
13. File grievances with respect to inappropriate treatment and to have such grievance considered in a fair, timely, and impartial procedure.
14. Receive a second opinion with regards to your treatment recommendations.

CLIENT'S RESPONSBILITIES:

1. You are responsible for following the policies of the clinic.
2. You are responsible to treat staff and fellow patients in a respectful cordial manner in which their rights are not violated.
3. You are responsible to provide accurate information about yourself.

WHAT TO DO IF YOU BELIEVE YOUR RIGHTS HAVE BEEN VIOLATED:

Informal grievance: Clients are asked to make a good-faith attempt to resolve problems at the lowest level possible without resorting to the formal grievance procedure. An informal grievance is to be submitted in writing and/or verbally to staff within three (3) working days from the date of the dispute or concern. Staff is expected to determine as promptly as possible the cause for the concern while making every effort to resolve said complaint informally. Staff shall conduct any necessary and/or appropriate investigation and inform the grievant of a decision based upon a fair consideration of all the facts within five (5) working days after the receipt of said grievance. The staff will issue a written memo to the grievant stating how the complaint was processed and resolved. If the grievant is dissatisfied after making a good faith effort to resolve the problem with the informal process, the grievant may next qualify to have the concern addressed through a formal process.

Formal Grievance: A formal grievance may be submitted in writing after an informal grievance failed to resolve the Client's concern using the following steps:

1. The grievant has three (3) working days from the date that the informal decision was made to submit a written request for a formal grievance to the staff supervisor. The supervisor or designee will issue a written decision regarding the grievance within five (5) working days of receipt. Copies of the decision will be forwarded to the aggrieved, the staff, and the Clinical Compliance Officer.
2. If the aggrieved is dissatisfied with the decision at step one, the aggrieved may submit a written appeal to the Clinical Compliance Officer. The appeal must be filed within five (5) working days after the receipt of the decision in step one.
3. If the aggrieved is dissatisfied with the decision at step two, they may submit a written appeal to the Deputy Director. The appeal must be filed in writing within five (5) working days after receipt of the decision from step two. The Deputy Director will conduct such investigation as is deemed appropriate. In addition, the Deputy Director will schedule and hold a conference with the aggrieved and any other necessary parties within five (5) working days after receipt of the appeal to step three. The Deputy Director will issue a written decision after five (5) working days form the conclusion of the conference. A copy of said decision will be forwarded to the aggrieved, the staff, the program supervisor, clinical compliance office and to the director.
4. If the aggrieved continues to feel dissatisfied after step three, they may request in writing a step four hearing with the Director. An appeal must be submitted in writing by five (5) working days after receipt of the decision from step three. Within five (5) working days after receipt of the written request for a Step Four, the Director will schedule a hearing. Within five (5) working days after the hearing, a written decision will be submitted to all concerned parties. This decision shall be final and binding. If the aggrieved Client continues to maintain their dissatisfaction with the entire grievance process, they have the right to contact The State of Alaska Department of Health and Social Services: Behavioral Health Unit (DHSS BH) for technical assistance and/or for review of the aforementioned grievance process. At this level, the DHSS BH will take and action deemed prudent or necessary to assist the Client and/or the agency.

Exceptions to the Steps Process:

If the aggrieved Client's grievance involves abuse, neglect, unnecessary seclusion, illicit restraint, sexual assault/abuse, bodily injury and/or life threatening behaviors, the aggrieved maintains the right to have said grievance immediately addressed by the Behavioral Health Director or designee.

Maniilaq Behavioral Health Services

Advance Directives Information

As a consumer of health care, including behavioral health care, you have the right to be informed about and take part in deciding what treatment you receive and/or do not receive. You also have the right to ***say in advance*** *what kind of treatment you want or do not want in special, serious psychiatric conditions; this right is called an* ***Advance Directive and/or a Durable Power of Attorney.***

What is an Advance Directive? An **Advance Directive** is a written statement telling your doctor, psychiatrist, or mental health provider that you do not want to receive certain medication, certain procedures, or see certain providers. You may also offer information about which medications work for you under these circumstances, which doctor/provider you want to see (within reason), what techniques or interventions work best to lessen the crisis and who you would like to make clinical decisions for you if these directives are insufficient or fail (see **Durable Power of Attorney).**

This is called a **"Living Will"** because it takes effect while you are still living. Your **Living Will** takes effect when your condition is determined **and** you become unable to make your own decision.

It is **your** responsibility to give a copy of your **Advance Directive** to your physician, psychiatrist, or mental health provider. Once a health care provider receives a copy of your **Advance Directive**, it becomes part of your permanent medical record at that hospital or clinic. If you leave the State of Alaska, you may need to complete a new **Advance Directive** in the new state to meet that state's laws (a health care facility can assist you with this new document).

What is a Durable Power of Attorney for Health Care?

You may know how a **Power of Attorney** is used; this legal document is used to give someone else the authority to act on your behalf in certain matters. In this same way, a **Durable Power of Attorney for Health Care** allows for someone else to make health care decisions on your behalf.

The "durable" part of this power of attorney means that you want the power of attorney to continue to be valid and in force even if you become unable to make decisions because of mental or physical problems which happen **after** you sign the document.

In this document, you are able to name a person or persons to have your power of attorney, to make decisions for you if you are unable. You should choose someone that you trust and who knows about what you would want if you become disabled and cannot speak for yourself. If you choose several people to act on your behalf, you must make certain that the people make the decisions **together, not separately**.

A **Durable Power of Attorney for Health Care** authorizes your representative/s to see and let others see any medical information about you. Your representative/s can consent or refuse to consent to medical care or relief from your pain. Your representative/s **cannot** authorize stopping life-sustaining procedures unless you have stated this power in your document. Your representative/s must take all necessary steps to make sure that your wishes (as expressed in your **Advance Directive and Durable Power of Attorney for Health Care)** are followed.

How are my mental health decisions followed in a Durable Power of Attorney for Health Care?

You may choose to allow your representative/s to determine what is best for your mental health care **or** you may fill out the section for mental health treatment on the document.

You may also strike any wording that you do not want. **You must be considered "competent" at the time the document is completed.**

The instructions that you include in this document will be followed **only** if a court, two physicians that include a psychiatrist, or a physician and a professional mental health clinician believe that you are not competent and cannot make treatment decisions.

May I change my mind or decide not to have an Advance Directive or Durable Power of Attorney for Health Care?

You may revoke or change the powers you grant in the power of attorney and the Advance Directive at **any time**. You may make this change in **any way** that you are able to communicate. The change is only effective once you or someone you have told communicates your wishes to your health care provider. Once the health care provider becomes aware of the change, the change or revocation becomes a part of your permanent medical record at that facility.

When you enter the health care service and are given information about **Advance Directives,** you do not have to complete the documents. Your care will not be affected if you do not sign.

If you would like to have an **Advance Directive** you can contact Maniilaq Counseling and Recovery Center/ Social Services at 907-443-4541 to assist you in obtaining one. If you have an **Advance Directive**, please bring a copy of the document to your next visit or appointment at the health care service. This will allow your decisions to become part of your medical record in that facility or service. If you have lost your **Advance Directive,** the health care provider will make every effort to help you find a copy of your document.

This Notice is first in effect on April 14, 2003. Updated 6/5/2025, 06/24/2025, 6/4/2026, 6/26/26, 7/3/26

MANIILAQ BEHAVIORAL HEALTH SERVICES

CONSENT FOR TREATMENT

I understand that Maniilaq Behavioral Health Services (MBHS) providers are here to assist me in my care. I also understand that making change requires work and commitment on my part. Further, I recognize my lack of participation and/or nonattendance impacts providers' ability to serve myself or others. Therefore, I commit to attend appointments and following through with my treatment plan.

I understand my access to treatment may be limited if I do not keep my commitment to my care. I understand if I skip an appointment without informing MBHS in advance; my provider(s) may close my file, after a minimum of 3 to 4 attempts to contact due no active treatment, due to lack of involvement in my care.

I understand as a condition to my receiving treatment and/or services from MBHS may use or disclose my personally identified health information for treatment and/or services, to obtain payment for the treatment/services provided, and as necessary for the operations of MBHS. These uses and disclosures are more fully explained in the Notice of Privacy Practices I will be receiving and which I have had the opportunity to review.

I understand the privacy practices described in the Notice may change over time, and I have a right to obtain any revised Notice of Privacy Practices. If I have not been provided a copy of any revisions I may obtain one by contacting my intake coordinator, clinician, case manager, medical provider, or the Privacy Officer or designee to make such a request. Providers for Behavioral Health Services may be contacted at **(907)442-7640.**

I understand that if I seek psychiatric medication management services, my visits will be accessible to medical providers and pharmacists of MBHS and Alaska Native Medical Center (ANMC). The purpose of this is to provide quality health services and to promote wellness through continuity of care.

I understand that my care may involve collaboration and consultation between the MBHS team and the Integrated Care team to support coordination of services and ensure continuity of care.

I also understand I have the right to request MBHS to restrict how my health information is used or disclosed.

MBHS does not have to agree to my request for the restriction, but if MBHS does agree, MBHS is bound to abide by the restriction as agreed.

Finally, I understand I have the right to revoke/withdraw this consent, in writing, at any time. My revocation/withdrawal will be effective except to the extent MBHS has already taken action in reliance on my consent for use or disclosure of my health information. Future treatment may be discontinued if I withdraw my consent unless state or federal law requires MBHS to provide such services (i.e. crisis/emergency).

_____ I have received a copy of the Notice of Privacy Practices and consent to the use and disclosure of information as explained in the Notice of Privacy Practices.
Initial

_____ I understand that for Psychiatric medication management services, only, my visits will be accessible to medical providers and pharmacists of Maniilaq Behavioral Health Services and Alaska Native Medical Center (ANMC).
Initial

_____ I have received a copy of the Behavioral Health Client Handbook which contains my Rights and Responsibilities, Grievance Procedure, Exceptions to Confidentiality, Orientation of Services and Safety Expectations.
Initial

_____ I have received an information sheet about my right to an Advance Directive (If client is over 18 years old).
Initial

I hereby authorize MBHS to provide services as are mutually agreed upon by myself or parent/legal guardian and the Behavioral Health Services staff.

Client Printed Name	**Client Signature**	**Date**
Guardian Printed Name	**Guardian Signature**	**Date**
BHS Staff Printed Name	**BHS Staff Signature**	**Date**

This Notice is first in effect on April 14, 2003. Updated 6/5/2025, 06/24/2025, 6/4/2026, 6/26/26, 7/3/26

Financial Policy for Non-Beneficiary Patients

Welcome to Maniilaq Health Services. We look forward to assisting you with your healthcare needs.

Maniilaq Health Services is a non-profit corporation whose primary mission is to serve Alaska Natives and Native Americans of the Northwest Alaska region. Federal laws and regulations of Indian Health Services (IHS) also permit Maniilaq Health Center to provide services for persons who are not IHS beneficiaries, but require us to charge and collect for services rendered.

Please read our financial policy below and sign confirming you have read and understand your financial obligations as it pertains to Maniilaq Health Services.

• I understand it is my responsibility to provide current, accurate billing information at the time of check-in and to notify Maniilaq Health Services promptly of any changes in this information.

• I understand it is my responsibility to know my co-pay, co-insurance and/or deductible benefits prior to services being rendered. My insurance plan benefit booklet and/or a representative from my insurance carrier can assist me in obtaining this information.

• I hereby authorize the payment of medical benefits for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.

• I hereby authorize the release of the minimum necessary medical information as required to complete and process my insurance claims, consistent with applicable federal privacy laws (HIPPA).

• I understand if I present an insufficient funds (NSF) check for payment on my account, I will be charged a $30.00 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, money order, cashier's check, or credit card.

• I understand I will be billed for any amounts due by me and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance adjudication, sent no less than 30 days apart.

• I further understand that if I have not made payment after the second statement being mailed, my account may be referred to an outside collection agency if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts. I understand I have the right to request an itemized statement of charges at any time by contacting the billing office.

• I understand that if I have a question or dispute regarding my bill, I may contact Maniilaq Health Services billing office at 907-442-7238 within 30 days of receiving a statement to request a review prior to any collection action

If you have any questions regarding our billing and financial policies, please contact Maniilaq Health Services billing office at 907-442-7238 and we will gladly assist you.

Printed Name of Patient or Responsible Party	Date
Signature of Patient or Responsible Party	Relationship to Patient

Revised June 2026 by MHC Revenue Cycle

This Notice is first in effect on April 14, 2003. Updated 6/5/2025, 06/24/2025, 6/4/2026, 6/26/26, 7/3/26

Informed Consent for Telemedicine Services

INTRODUCTION

Telemedicine involves the use of electronic communications to enable healthcare providers at Maniilaq Association to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up, test screening and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output from medical devices

Electronic systems used will protect the confidentiality of patient identification and data and will include measures to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain at home or clinic while the physician provides service through a telemedicine visit.
- More efficient medical evaluation and management.
- Safety precaution for patients during public health emergencies.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s).
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. Connecting with your provider from your home or a public area could cause a breach of patient confidentiality that is beyond the control of your provider.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

Informed Consent for Telemedicine Services

I Attest to and Understand the Following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. Alternatives have been explained to my satisfaction.
4. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners within Maniilaq.
5. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
6. I attest that I am located in the state of Alaska and will be present in the state of Alaska during all telehealth encounters with Maniilaq healthcare providers.
7. I understand that telemedicine visits will be billed in the usual manner to my insurance, if applicable.

Patient Consent to the Use of Telemedicine

I understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

Client Printed Name	**Client Signature**	**Date**
Guardian Printed Name	**Guardian Signature**	**Date**
BHS Staff Printed Name	**BHS Staff Signature**	**Date**

This Notice is first in effect on April 14, 2003. Updated 6/5/2025, 06/24/2025, 6/4/2026, 6/26/26, 7/3/26

Informed Consent for SMS Text Messaging Via Zoom

Purpose

Maniilaq Behavioral Health Services (MBHS) is offering clients the option to receive non- clinical communication via SMS (text messaging) using the Zoom platform. These messages are intended to improve communication and client engagement related to administrative and appointment-related matters only.

What You Will Receive

If you consent, you may receive the following types of messages:

- Appointment reminders
- Scheduling changes or confirmations
- Notices regarding office closures or rescheduling
- General wellness check-ins or non-clinical updates

Note: Clinical information (i.e., diagnoses, treatment plans, test results) will not be sent via SMS under any circumstances.

Message and Data Use Disclosure

By signing this form and providing your mobile number:

- You **authorize** Maniilaq BHS to send you text messages through Zoom.
- You may receive messages from the following **Maniilaq BHS staff** based on your care team or service type:
    - 907-921-4201
    - 907-202-8367
    - 907-206-7384
    - 907-531-4173
    - 907-531-4171
    - 907-531-4179
- Message frequency varies. Message & data rates may apply. Text **HELP** for help. Reply **STOP** to opt out.
- You may revoke this consent at any time by notifying Maniilaq BHS in writing or verbally.

Data Privacy Statement

Your privacy is important to us. Maniilaq Association complies with all state and federal privacy laws, including HIPAA and 42 CFR Part 2.

No mobile information will be shared with third parties/affiliates for marketing/promotional purposes. All other categories exclude text messaging originator opt-in data and consent; this information will not be shared with any third parties.

Informed Consent for SMS Text Messaging Via Zoom

Client Consent and Acknowledgment

Please complete the section below:

Client Printed Name: _____

Date of Birth: _____

Mobile Phone Number: _____

Please **initial** each statement below:

_____I consent to receive SMS (text) messages from Maniilaq BHS at the number above for the purposes stated in this form.

_____I understand that I can opt out at any time by replying STOP.

_____I acknowledge that I have reviewed and understand the privacy statement provided above

By providing a telephone number and submitting this form, you are consenting to be contacted by SMS text message. Message & data rates may apply. You can reply STOP to opt-out of further messaging.

For Staff Use Only

☐ Consent reviewed and signed by client/guardian
☐ Consent uploaded into AKAIMS
☐ Client informed of STOP opt-out instructions

Client Printed Name	**Client Signature**	**Date**
Guardian Printed Name	**Guardian Signature**	**Date**
BHS Staff Printed Name	**BHS Staff Signature**	**Date**

MANIILAQ
ASSOCIATION

CLIENT HANDBOOK ACKNOWLEDGMENT

This form serves as acknowledgment that you have been provided a Client Handbook and oriented to the important information within is such as information about our programs, services, policies, procedures, and your rights and responsibilities as a client.

By signing below, you acknowledge the following:

Please initial each statement.

_____ I have received a copy of the Client Handbook.

_____ I understand that the handbook contains important information regarding the services available to me, program expectations, client rights and responsibilities, confidentiality, grievance procedures, and other agency policies.

_____ I have had the opportunity to ask questions about the information contained in the handbook, and my questions have been answered to my satisfaction.

_____ I understand that I am responsible for reading the handbook and following the policies and expectations outlined within it.

_____ I understand that if I have questions in the future or need another copy of the handbook, I may request one at any time.

_____ I understand that receiving the handbook does not create a contractual agreement and that agency policies, procedures, and practices may be updated as needed. I understand I will be informed of significant changes that affect my services or rights.

I acknowledge that I have received the Client Handbook and understand the information outlined above.

Client Name: _____ **Client Signature:** _____ **Date:** _____

Parent/Legal Guardian (if applicable): _____

Relationship to Client: _____ **Signature:** _____ **Date:** _____

Staff Verification

I certify that I provided the Client Handbook to the client (and/or parent/legal guardian), reviewed its contents, and offered the opportunity to ask questions.

Staff Name: _____ **Date:** _____

Maniilaq Behavioral Health Services

CLIENT HANDBOOK



We are honored to be part of your journey toward wellness, recovery, and personal growth. Our team is committed to providing compassionate, respectful, and culturally responsive services that support your unique strengths, goals, and needs. We believe that recovery is possible and that every individual deserves to be treated with dignity and respect.

This handbook provides important information to orient you about our services, your rights and responsibilities, confidentiality, and other resources available to support your care. If you have any questions, please do not hesitate to ask a member of our team. We look forward to working with you.

Maniilaq Behavioral Health Services

CLIENT HANDBOOK

Maniilaq Behavioral Health Services (MBHS) is an outpatient mental health and substance use treatment provider.

Our hours of operation are Monday Friday from 8:00AM-5:00PM. Services are provided in person and via telehealth (video or phone).
The address to The Wellness Center is 346 Tundra Way and the address to The Ferguson Building is 733 Second Avenue
The mailing address for Maniilaq Association is P.O. Box 256 Kotzebue, Alaska 99752

We provide the following services:

- Psychiatric Emergency Services
- Services for High-Risk Children in Early Childhood and/or Youth with Serious Emotional Disturbance and their Family
- Outpatient Treatment for Adults with Serious Mental Illness
- Opioid Treatment Services
- Youth and Family Outpatient Substance Use Disorder Treatment
- Women and Children Outpatient Substance Use Disorder Treatment
- Adult Substance Use Disorder Treatment
- Outpatient Treatment for Individuals Experiencing Emotional Disturbances

MBHS serves Kotzebue, AK and 10 other villages in the Northwest Arctic Borough as well as the village of Point Hope. This area is home to the largest concentration of Iñupiat people in the world.

This booklet is designed to orient you with basic information about our treatment services. If you have any questions about MBHS or your participation here, please discuss them with your primary counselor, or other MBHS staff.

We are honored to serve you!

This Notice is first in effect on April 14, 2003. Updated 6/5/2025, 06/24/2025, 6/4/2026, 7/1/2026, 8/3/26

MANIILAQ BEHAVIORAL HEALTH SERVICES' COMMITMENT TO CLIENTS:

- Provide Quality Behavioral Health Services to address mental health and substance use disorders
- Challenge old thinking about addiction and everyday life
- Connect you with your culture and spiritual self to the best of our ability
- Educate with new skills for your mental health and sobriety
- Evaluate your treatment progress
- Help you to look at life a different way
- Promote the importance of your safety
- As a part of our safety measures, we do not involve in restraining or secluding clients, but we do utilize safe de-escalation practices called Ukuru to manage escalated situations

AVAILABLE SERVICES:

- Case Management
- Counseling/Psychotherapy for Individuals / Families / Group
- Behavioral Health Assessments
- Recipient Support Services
- Skills Building for Individuals / Families / Group
- Substance Use Assessment
- Psychiatric Evaluation
- Medication Management
- Referrals for Psychological Testing
- Emergency Services / Crisis Intervention / Stabilization
- Services that are needed but not provided by MBHS are referred to the appropriate Service Provider/Program

CONFIDENTIALITY OF SERVICES:

At Maniilaq Behavioral Health Services, we are committed to treating and using protected health information about you responsibly. Each time you visit MBHS or any of the village clinics, a record of your visit is made. Although your health record is the physical property of MBHS, the information belongs to you.

All services and written information are confidential as mandated by federal and state laws and by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.

Charts will not be released without client's written consent, except in the following circumstances:

- *Information from charts is requested through a valid court order or subpoena naming a specific individual.*
- *Child abuse or elder abuse is identified or suspected.*
- *The client is in a state of medical emergency that necessitates disclosure of information to medical personnel.*
- *If the client threatens to harm someone, the intended victim and the police will be notified.*

To learn more about your rights and how MBHS protects your privacy, review the full Privacy Statement that will be given to you during the admission process. Please discuss your questions or concerns with a MBHS staff member at any time.

FREQUENTLY ASKED QUESTIONS:

What rights do I have to receive services?

Services at MBHS are available without regard to age, sex, gender identity, sexual orientation, race, creed, color, ancestry, national origin, disability, familial status, or marital status. Each individual has the right to request or refuse treatment without penalty of loss of service. If MBHS is unable to provide a needed service you will be referred to an appropriate treatment facility. Any information regarding the referral process will be discussed on an individual basis. A complete copy of the policy regarding client rights is posted in all facility waiting areas.

What does treatment look like?

When you come to your first appointment, your treatment provider will work with you to determine the focus of treatment based upon your presenting problems, needs, strengths, abilities, skills, and interests. Your assessment will guide what types of care and services are available. You and your treatment team will create a treatment plan. Once the plan has been developed counseling services will begin. You are always welcome to provide feedback and update your treatment plan anytime to your treatment team.

Will the agency staff respect my cultural and linguistic background?

It is the policy of MBHS to provide services that are culturally competent. If a translator is needed, it can be requested and we will attempt to provide one for you.

Will my family be involved in my services?

MBHS believes that support from "family" (as defined by the client) is very beneficial to treatment. If the client chooses, the client's support system will be encouraged to participate in treatment. The client will meet with their counselor to determine who will be included.

How can I give feedback on the quality of services received?

MBHS invites you to provide feedback regarding the quality of care using the Client Status Review (CSR) form that is administered at admission and every 90 days thereafter while in treatment and a final CSR form is administered at discharge. You may also contact the agency at 907 442-7640 to give feedback directly. MBHS also sends out client surveys in which we encourage you to submit feedback to help improve services.

What is the procedure for expressing a grievance or complaint?

MBHS has an established policy and procedure for handling client complaints and grievances. All clients should receive this information at the time of the first appointment. If you did not receive this information, please notify the front desk and this information will be provided to you. You may also contact the agency directly to express a grievance or complaint.

What responsibilities do I have as a client?

- Provide information necessary to complete an appropriate clinical and financial assessment and ensure proper treatment
- Work with treatment team to develop an individual treatment plan and follow the agreed upon course of action
- Sign releases and other paperwork necessary for continuation of care
- Treat other clients and staff in a respectful manner
- Refrain from bringing alcohol, drugs, or weapons onto agency property
- Tobacco (smoking and smokeless types) are confined to designated areas
- Notify agency (counselor/therapist or front office staff) of intention to discontinue services
- Arrive on time for appointments; or, if unable to keep an appointment, call 24 hours in advance or as soon as possible to cancel.

Who is responsible for the security of my vehicle while it's parked on Maniilaq's property?

It is the policy of Maniilaq Health Center that any non-Center owned vehicle on the property is the responsibility of the owner of the lost, stolen, or damaged vehicle. Parking at any Maniilaq Association facility is at the vehicle owner's risk.

What is my financial responsibility for treatment?

MBHS accepts Medicaid, Medicare, most commercial insurance plans, and Indian Health Service (IHS) beneficiaries. We will bill your insurance or other eligible payer sources for covered services. If you do not have insurance coverage or are not eligible for IHS benefits, you may be responsible for paying for services and may receive a bill. If you are concerned about your ability to pay for services, you may request to speak with a Financial Counselor to discuss available financial assistance options, including eligibility for a sliding fee scale. A schedule of self-pay fees is available upon request. If you need assistance applying for Medicaid or understanding your coverage options, please contact a Financial Counselor or ask your provider for assistance. To help ensure accurate billing, it is your responsibility to provide current insurance information and present your insurance card or beneficiary card at the time of service. We also encourage you to contact your insurance company before your appointment to verify your behavioral health benefits and coverage. If you have questions about billing, insurance, or financial assistance, please let us know and we will help connect you with the appropriate resources.

What are the rates for services?

The AK Department of Health, Division of Behavioral Health, issues Rate Charts to inform organizations of the Medicaid rates. Rate charts do not cover all services reimbursed by Medicaid, but offer rates for the majority of the services we provide. This handbook will provide clients with the most up to date Medicaid Service Rates.

Alaska Department of Health, Division of Behavioral Health
Chart of Behavioral Health Reform 1115 Medicaid Services Rates
Effective July 1, 2026

Procedure Codes / Modifiers	Substance Use Disorder (SUD) Provider Service Description	Unit	Rate
H0007-V1	Outpatient Services ASAM 1.0 – Individual	15 minutes	$32.01
H0007-HQ-HA-V1	Outpatient Services ASAM – Group (Adolescent)	15 minutes	$11.39
H0007-HQ-HB-V1	Outpatient Services ASAM – Group (Adult)	15 minutes	$11.39
H0015-V1	Intensive Outpatient Services ASAM 2.1 – Individual	15 minutes	$38.85
H0015-HQ-V1	Intensive Outpatient Services ASAM 2.1 – Group	15 minutes	$13.89
H0035-V1	Partial Hospitalization Program ASAM 2.5	Daily	$714.11
H2036-HA-V1	SUD Clinically Managed Low-Intensity Residential ASAM 3.1 (Adolescent)	Daily	$437.72
H2036-HF-V1	SUD Clinically Managed Low-Intensity Residential ASAM 3.1 (Adult)	Daily	$437.72
H0047-HF-V1	SUD Clinically Managed Population Specific High-Intensity Residential ASAM 3.3 (Adult)	Daily	$749.31
H0047-HA-V1-TF	SUD Clinically Managed Medium-Intensity Residential ASAM 3.5 (Adolescent)	Daily	$607.47
H0047-TG-V1	SUD Clinically Managed Medium-Intensity Residential ASAM 3.5 (Adult)	Daily	$607.47
H0009-TF-HA-V1	Medically Monitored High Intensity Inpatient ASAM 3.7 (Adolescent)	Daily	$1,108.46
H0009-TF-V1	Medically Monitored High Intensity Inpatient ASAM 3.7 (Adult)	Daily	$1,108.46
H0009-TG-V1	Medically Managed Intensive Inpatient ASAM 4.0	Daily	$1,694.06
H0014-V1	Ambulatory Withdrawal Management	15 minutes	$38.83
H0010-V1	Clinically Managed Residential Withdrawal Management ASAM 3.2 WM	Daily	$354.28
H0010-TG-V1	Medically Monitored Inpatient Withdrawal Management ASAM 3.7 WM	Daily	$1,108.46
H0011-V1	Medically Managed Intensive Inpatient Withdrawal Management ASAM 4.0 WM	Daily	$1,694.06
H2021-V1	Community Recovery Support Services (CRSS) – Individual	15 minutes	$27.20
H2021-HQ-V1	Community Recovery Support Services (CRSS) – Group	15 minutes	$9.76
H0047-V1	SUD Care Coordination	Monthly	$327.61
H0023-V1	Intensive Case Management Services (ICM)	15 minutes	$30.65
H0038-V1	Peer-Based Crisis Services (PBCS)	15 minutes	$22.34
S9484-V1	23-Hour Crisis Observation and Stabilization (COS)	Hourly	$126.89
T2034-V1	Mobile Outreach and Crisis Response (MOCR) Services	Per Call Out	$191.80
H2011-TS-V1	MOCR Crisis Service Follow-Up	15 minutes	$22.34
S9485-V1	Crisis Residential and Stabilization Services (CSS)	Daily	$982.82
T1007-V1	Treatment Plan Development or Review	Per Assessment	$198.70

Alaska Department of Health, Division of Behavioral Health
Chart of Behavioral Health Reform 1115 Medicaid Services Rates
Effective July 1, 2026

Procedure Codes & Modifiers	Behavioral Health Provider (BHP) Service Description	Unit	Rate
H1011-V2	Home-Based Family Treatment HBFT Level 1	15 minutes	$36.47
H1011-TF-V2	Home-Based Family Treatment HBFT Level 2	15 minutes	$36.47
H1011-TG-V2	Home-Based Family Treatment HBFT Level 3	15 minutes	$36.47
H2020-V2	Therapeutic Treatment Homes (TTH)	Daily	$321.77
T2033-V2	Children's Residential Treatment CRT Level 1	Daily	$579.90
T2033-TF-V2	Children's Residential Treatment CRT Level 2	Daily	$656.97
H0023-V2	Intensive Case Management (ICM)	15 minutes	$30.65
H2021-V2	Community Recovery Support Services (CRSS) – Individual	15 minutes	$27.20
H2021-HQ-V2	Community Recovery Support Services (CRSS) – Group	15 minutes	$9.76
H0039-V2	Assertive Community Treatment (ACT) Services	15 minutes	$33.45
H0015-V2	Intensive Outpatient Services (IOP) – Individual	15 minutes	$38.85
H0015-HQ-V2	Intensive Outpatient Services (IOP) – Group	15 minutes	$13.89
H0035-V2	Partial Hospitalization Program (PHP)	Daily	$714.11
T2016-V2	Adult Mental Health Residential Services (AMHR) Level 1	Daily	$656.97
T2016-TG-V2	Adult Mental Health Residential Services (AMHR) Level 2	Daily	$579.90
H0038-V2	Peer-Based Crisis Services (PBCS)	15 minutes	$22.34
S9484-V2	23-Hour Crisis Observation and Stabilization (COS)	Hourly	$126.89
T2034-V2	Mobile Outreach and Crisis Response (MOCR) Services	Per Call Out	$191.80
H2011-TS-V2	MOCR Crisis Service Follow-Up	15 minutes	$22.34
S9485-V2	Crisis Residential and Stabilization Services (CSS)	Daily	$982.82
T1007-V2	Treatment Plan Development or Review	Per Assessment	$198.70

Alaska Department of Health, Division of Behavioral Health
Chart of Community Behavioral Health and Mental Health Physician Clinic Medicaid Covered Services Rates
Effective July 1, 2026

Procedure Code / Modifier	Service Description	Duration/Unit	Rate
T1023*¥	Behavioral Health Screen	1 screening	$149.40
H0001	Alcohol and/or Drug Assessment	1 assessment	$391.58
H0031*¥	Mental Health Intake Assessment	1 assessment	$537.79
H0031-HH*¥	Integrated Mental Health & Substance Use Intake Assessment	1 assessment	$618.46
90791*	Psychiatric Assessment - Diagnostic Evaluation	1 assessment	$705.09
96136-HO*	Psychological Testing	30 minutes	$83.28
96137-HO*	Psychological Testing	30 minutes	$83.28
96130-HO*	Psychological Testing	60 minutes	$166.71
96131-HO*	Psychological Testing	60 minutes	$166.71
96136-HP*	Neuropsychological Testing	30 minutes	$97.87
96137-HP*	Neuropsychological Testing	30 minutes	$97.87
96132-HP*	Neuropsychological Testing	60 minutes	$195.71
96133-HP*	Neuropsychological Testing	60 minutes	$195.71
90832*¥	Psychotherapy, Individual	16-37 minutes	$80.29
90834*¥	Psychotherapy, Individual	38-52 minutes	$120.45
90837*¥	Psychotherapy, Individual	53-60 minutes	$160.59
90846*¥	Psychotherapy, Family (w/o patient present)	60 minutes	$168.93
90846-U7*¥	Psychotherapy, Family (w/o patient present)	30 minutes	$84.46
90847*¥	Psychotherapy, Family (with patient present)	60 minutes	$164.11
90847-U7*¥	Psychotherapy, Family (with patient present)	30 minutes	$81.95
90849*¥	Psychotherapy, Multi-family group	60 minutes	$65.66
90849-U7*¥	Psychotherapy, Multi-family group	30 minutes	$32.81
90853*¥	Psychotherapy, Group	60 minutes	$64.24
90853-U7*¥	Psychotherapy, Group	30 minutes	$32.11

Alaska Department of Health, Division of Behavioral Health
Chart of Community Behavioral Health and Mental Health Physician Clinic Medicaid Covered Services Rates
Effective July 1, 2026

Procedure Code / Modifier	Service Description	Duration/Unit	Rate
H2010*	Comprehensive Medication Services	1 visit	$178.43
S9484*	Short-term Crisis Intervention Service	1 hour	$157.84
S9484-U6*	Short-term Crisis Intervention Service	15 minutes	$39.46
H2011	Short-term Crisis Stabilization Service	15 minutes	$36.88
T1016	Case Management	15 minutes	$34.73
H2019	Therapeutic BH Services - Individual	15 minutes	$31.51
H2019-HQ	Therapeutic BH Services - Group	15 minutes	$14.79
H2019-HR	Therapeutic BH Services - Family (with patient present)	15 minutes	$31.51
H2019-HS	Therapeutic BH Services - Family (w/o) patient present)	15 minutes	$31.51
H0038-HR	Peer Support Services - Family (with patient present)	15 minutes	$31.65
H0038-HS	Peer Support Services - Family (w/o patient present)	15 minutes	$31.65
H0038	Peer Support Services - Individual	15 minutes	$31.65
H2012	Day Treatment for Children (combined mental health & school district resources)	1 hour	$53.78
T1007	Treatment Plan Review for Methadone Recipient	1 review	$131.37
H0033	Oral Medication Administration, direct observation; on premises	1 day	$121.09
H0033-HK	Oral Medication Administration, direct observation; off premises	1 day	$134.99
H0020	Methadone Administration and/or service	administration episode	$45.43
H0014	Ambulatory Detoxification	15 minutes	$60.17
H0010	Clinically Managed Detoxification	1 day	$374.60
H0011	Medically Managed Detoxification	1 day	$598.45
H0002	Medical Evaluation for Recipient NOT Receiving Methadone Treatment	1 evaluation	$673.75
H0002-HF	Medical Evaluation for Recipient Receiving Methadone Treatment	1 evaluation	$673.75
99408*¥	Screening, Brief Intervention, and Referral for Treatment (SBIRT)	15-to-30-minute episode	$59.90

Who do I contact if I have more questions?

Questions about services	⋙ Your Provider
Clinical concerns	⋙ Clinical Supervisor, call BHS main number (907) 442-7646 to inquire who that is for your provider
Complaints or grievances	⋙ Behavioral Health Director or Deputy Director, call BHS main number
Billing questions	⋙ Financial Services, call patient Health Benefits Specialist at (907) 442-7137

MISSED APPOINTMENTS:

- We understand that in some cases, you will miss your appointment due to emergencies.
- Please notify the office at least 24 hours in advance or as soon as you are aware that you will be unable to keep your appointment.
- All appointments will be rescheduled.
- When there is significant non-engagement, we will reach out via phone and contact letters to inform you if you at risk of having your episode of care ended.

LENGTH OF PROGRAM:

All outpatient services are individualized for each client. There are groups that are time limited; however, the overall treatment is based on client needs and progress towards treatment goals. The treatment progress is discussed with the client and the counselor on a regular basis.

CLIENT ADMISSION PROCESS:

Admission to MBHS is designed to make you and your goals part of the process. To begin providing services, MBHS staff will assist you to complete a

- Intake Packet
- Consent Forms

- Patient Rights & Confidentiality forms
- Advance Directives
- Release of Information

Once the initial paperwork is completed, a counselor will determine the type of assessment that will be the most beneficial in addressing your behavioral health needs.

Assessment Types include:

- Integrated Assessment (mental health and substance use)
- Mental Health Assessment
- Substance Use Assessment

You will be asked to complete a Client Status Review form. The information is used in the assessment process to assist in treatment planning. You will also be provided with copies of information regarding Infectious Diseases as well. We provide this to all clients as a way to inform and educate on the importance of knowing health and safety measures.

Once the assessment is completed, you will meet with your counselor to develop a treatment plan that is based on the goals that you set.

The treatment plan contains a list of the problems that were identified during the assessment and you and your counselor will decide the order in which to address these problems.

You and your counselor will define the steps that you will take to achieve your goals you wish to work on.

The entire assessment process is in place to ensure that you are provided with the opportunity to be an active participant in your treatment. Active participation includes sharing thoughts and feelings and discussing your personal motivation for change.

Your counselor will provide guidance, activities, and service delivery to assist you in achieving the goals on your treatment plan.

SERVICE PROGRAMS:

- Outpatient Mental Health – provided by Master's level trained Itinerant Therapists, Clinical Associates, and Behavioral Health Aides (BHA)
- Outpatient Substance Use treatment – provided Chemical Dependency Counselors and Behavioral Health Aides.
- Tele-psychiatry – provided by Psychiatric professionals.

For medication services you can expect the following to occur:

- All clients receiving psychiatric services at MBHS are assigned a Mental Health Itinerant Therapist as well.
- 90 day renewals of treatment plan and Client Status Review will be arranged with your therapist
- Your Medication Management Appointment will be scheduled by your case manager
- You will be linked via video to your psychiatrist
- Your case manager will make sure that the pharmacy receives your prescriptions from your psychiatrist

SAFETY AND EMERGENCY INFORMATION:

EMERGENCY EXITS

All MBHS facilities are equipped with clearly marked emergency exits. Exit routes are identified by illuminated exit signs and posted evacuation maps. Clients, visitors, and staff should familiarize themselves with the nearest exits upon entering the facility. In the event of an emergency or evacuation, individuals should follow staff instructions and proceed to the designated assembly area identified for that location.

FIRE SUPPRESSION EQUIPMENT

Fire extinguishers, alarm systems, and other fire suppression equipment are strategically located throughout each MBHS facility and are maintained in accordance with applicable safety regulations. Emergency response procedures are available at each site and may be reviewed upon request.

FIRST AID SUPPLIES

First aid kits are maintained in accessible locations throughout each MBHS facility. Staff are trained on the location of first aid supplies and emergency response procedures.

QUESTIONS OR SAFETY CONCERNS

Individuals who have questions regarding emergency procedures, safety equipment, evacuation routes, or other safety concerns should notify an MBHS staff member. Safety concerns may also be directed to the Office Manager, Clinical Supervisor, Behavioral Health Directors, Program Manager, or other designated supervisor.

EMERGENCY PREPAREDNESS

MBHS regularly reviews emergency preparedness procedures and conducts safety training to promote a safe environment for clients, visitors, and staff.

INFECTIOUS DISEASE INFORMATION & WHY WE PROVIDE THIS INFORMATION:

Individuals receiving behavioral health and substance use services may be at increased risk for certain infectious diseases and health conditions. Providing education helps clients make informed decisions about their health, understand available screening and prevention options, and access appropriate medical care when needed. This provided information attached is intended to increase awareness and encourage clients to speak with their behavioral health provider and/or primary care provider if there are any questions or would like additional information about screening, testing, or treatment.

For Your Infomation

INFECTIOUS DISEASES & BEHAVIORAL HEALTH

Important Health Screenings You Should Know About

Many infectious diseases and health conditions can affect a person's physical health, mental health, recovery, and overall well-being. Some conditions may go undiagnosed because symptoms are mild or may not appear right away.

WHY DOES THIS MATTER?

Research shows that individuals experiencing mental health concerns or substance use disorders may be at increased risk for certain infectious diseases due to factors such as:

- Sharing needles or injection equipment
- Unprotected sexual activity
- Limited access to healthcare
- Homelessness or unstable housing
- Co-occurring medical conditions

UNTREATED INFECTIONS CAN IMPACT YOUR:

- Depression and anxiety
- Fatigue and low energy
- Difficulty concentrating
- Memory problems
- Increased stress
- Challenges with recovery and treatment participation

REGULAR SCREENING AND EARLY TREATMENT CAN IMPROVE BOTH PHYSICAL AND BEHAVIORAL HEALTH OUTCOMES.

HEPATITIS C (HCV)



WHAT IS IT?
A virus that affects the liver and can cause serious liver damage over time.

HOW IS IT SPREAD?
- Sharing needles or injection equipment
- Contact with infected blood
- Less commonly through sexual contact

SIGNS
- Fatigue
- Joint pain
- Nausea
- Yellowing of the skin or eyes (jaundice)
- Many people have no symptoms

PREVENTION
- Do not share needles
- or drug-use equipment
- Practice safer sex
- Avoid contact with another person's blood

TREATMENT
Highly effective medications can cure most cases of Hepatitis C.

IF LEFT UNTREATED
- Liver disease
- Cirrhosis
- Liver failure
- Liver cancer

SYPHILIS



WHAT IS IT?
A sexually transmitted infection (STI) caused by bacteria.

HOW IS IT SPREAD?
- Sexual contact with an infected person
- During pregnancy from mother to baby

SIGNS
- Painless sore
- Rash
- Fever
- Swollen lymph nodes
- Symptoms may disappear even when infection remains

PREVENTION
- Practice safer sex
- Regular STI testing
- Early treatment

TREATMENT
Antibiotics prescribed by a healthcare provider.

IF LEFT UNTREATED
- Brain and nervous system damage
- Heart problems
- Blindness
- Serious complications during pregnancy

HIV/AIDS



WHAT IS IT?
Human Immunodeficiency Virus (HIV) attacks the immune system. AIDS is the most advanced stage of HIV.

HOW IS IT SPREAD?
- Sexual contact
- Sharing needles
- Blood exposure
- From parent to baby during pregnancy, birth, or breastfeeding

SIGNS
- Flu-like symptoms
- Fatigue
- Weight loss
- Frequent infections
- Many people may not know they are infected

PREVENTION
- Practice safer sex
- Do not share needles
- Regular testing
- Preventive medications (PrEP)

TREATMENT
Antiretroviral medications help people live long, healthy lives.

IF LEFT UNTREATED
- Severe immune system damage
- Serious infections
- Increased risk of certain cancers
- Progression to AIDS

TUBERCULOSIS (TB)



WHAT IS IT?
A bacterial infection that usually affects the lungs.

HOW IS IT SPREAD?
Through the air when a person with active TB coughs, sneezes, or speaks.

SIGNS
- Persistent cough
- Fever
- Night sweats
- Weight loss
- Fatigue

PREVENTION
- Early screening and testing
- Follow medical recommendations
- Good ventilation and infection-control practices

TREATMENT
Prescription medications taken over several months.

IF LEFT UNTREATED
- Serious lung damage
- Spread of infection to others
- Severe illness and death

FASD (FETAL ALCOHOL SPECTRUM DISORDERS)



WHAT IS IT?
A group of lifelong conditions that can occur when alcohol is used during pregnancy.

HOW IS IT SPREAD?
FASD is not contagious. It occurs when alcohol exposure affects a developing baby before birth.

SIGNS
- Learning difficulties
- Memory problems
- Attention and concentration challenges
- Difficulty with decision-making and impulse control
- Behavioral and social difficulties

PREVENTION
No amount of alcohol is considered safe during pregnancy.

TREATMENT
There is no cure, but early identification and supportive services can improve outcomes.

IF LEFT UNTREATED
- Ongoing challenges with school, work, relationships, and daily living skills
- Increased risk of mental health and substance use concerns

PROTECT YOUR HEALTH

Early screening and treatment can improve your health, support recovery, and help prevent serious complications.

Screen | Treat | Support | Thrive

ASK YOUR BEHAVIORAL HEALTH PROVIDER ABOUT:

- Hepatitis C screening
- HIV testing
- Syphilis testing
- Tuberculosis (TB) screening
- FASD resources and support services
- Other infectious disease education and prevention resources
- Referrals to medical providers for testing and treatment

Taking care of your physical health is an important part of taking care of your mental health and recovery.

This information is for educational purposes only and is not a substitute for professional medical advice.
Talk with your healthcare provider about any concerns or questions you may have.