NeighborWorks® ALASKA

***Referral Application for***

***Permanent Supportive Housing***

***Program Contact: Laura Cox, Program Manager***

***Office: (907) 677-8472 Fax: (907) 677-8453***

***2515 A Street, Anchorage, Alaska, 99503***

| | *Program Applicant* | *All Household members (use separate sheet if more than 1 other household member)* | *Information* |
|---|---|---|---|
| *Last Name:* | | | *Case Manager* |
| *First Name :* | | | |
| *Middle Name:* | | | *CM Contact Number* |
| *Soc. Sec. Number:* | | | |
| *Birth Date* | | | *Emergency Contact* |
| *Mailing Address :* | | | |
| | | | *Emergency Contact #* |
| | | | |
| *Residence Address:* | | | *Family Status* |
| | | | *Single* ☐ |
| | | | *Married* ☐ |
| *Phone:* | *Day:* | *Home:* | *Partner* ☐ |
| | *Alternate:* | *Message:* | *# of Children* |

*Please list any other agencies providing services to the applicant such as Assets, Akeela, Four Directions, The ARC, Volunteers of America Alaska, Cook Inlet Tribal Council, etc. Please include a contact name and phone number*

_____

_____

EQUAL HOUSING OPPORTUNITY

## *INCOME INFORMATION*

*List all the income you and each person in your household receives on the following chart.*

| *SOURCE* , | *NAME* | *AMOUNT PER MONTH* |
|---|---|---|
| *Supplemental Security Income (SSI)* | | |
| *Social Security Disability Income (SSDI)* | | |
| *Social Security* | | |
| *General Public Assistance* | | |
| *Interim Public Assistance* | | |
| *ATAP - Alaska Temporary Assistance Program* | | |
| *Child Support* | | |
| *Veterans Benefits* | | |
| *Veterans Health Care* | | |
| *Employment Income* | | |
| *Unemployment Benefits* | | |
| *No Financial Resources* | | |
| *Medicare Yes/No* | | |
| *Medicaid Yes/No* | | |
| *Food Stamps Yes/No* | | |
| *Alaska Permanent Fund* | | |
| *Native Corporation Dividends* | | |
| *Other (please specify)* | | |

___ *Guardian* ___ *Conservator* ___ *Payee*

*Please provide Name/ Agency/Contact # of above:*

_____

## *ASSET INFORMATION*

*List assets of all household members including checking accounts, savings accounts, IRAs, CDs, real estate, stocks, bonds, recreational vehicles, boats, and fishing permits, including the value of each.*

***Checking Account -- Bank or Credit Union**:*

*Bank:*_____ *Account #*_____ *Amt. $*_____

*Address:*_____

***Savings Account – Bank or Credit Union***

*Bank:*_____ *Account #*_____ *Amt. $*_____

*Address:*_____

*Stocks & Bonds (Value)* *Amount $*_____

*IRA/CD (Value)* *Amount $*_____

*Real Estate (Value)* *Amount $*_____

*Other (Value)* *Amount $*_____

*(hr/wk/mo/yr)*

## *CHILD CARE EXPENSES*

*Do you receive Child Care Assistance? YES*___ *NO*___ *Assistance Amount:*_____
*Child Care Expense (Out of Pocket): Amount $*_____ *(hr/wk/mo/yr)*

*Name and Address of Child Care Provider:* _____

_____

*Phone number of Child Care Provider:* _____

## *CLIENT INFORMATION*

*Check all that applies. Applicant must meet the criteria below:*

***Disability**: What is the applicants verified disability category?*

*a.☐ Mental illness*
*b.☐ Alcohol abuse*
*c.☐ Drug abuse*
*d.☐ HIVIAIDS & related diseases*
*e.☐ Developmental Disability*
*f.☐ Physical Disability*

Describe any history of physical, mental health, or substance use treatment:

_____
_____
_____
_____
_____
_____
_____

***Homeless**: What was the applicant's prior living situation in the week prior to application?*

*a.☐ Non-housing (streets, car, camp, etc.)*
*b.☐ Emergency shelter*
*c.☐ Transitional housing for homeless*
*d.☐ Psychiatric facility**
*e.☐ Substance abuse treatment facility**
*f.☐ Hospital**
*g.☐ Jail/prison **

**** Is exiting an institution where (s) he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution***

***Duration of Homelessness**:*

*☐ <1 day* *☐ 1-30 days* *☐ 31-180 days* *☐ 181-365 days*
*☐ 366-730 days* *☐ >730 day*

***TAY-VISPDAT Score: _____***

***Reason for referral to this particular Permanent Supportive Housing Program**:_____*

_____
_____
_____
_____

***Describe the applicant's current living situation***. *Use the back of this page or attach a separate sheet if needed. Please provide the appropriate verification documents as described on the Applicant Check List.*

**Describe applicants perceived strengths, limitations, needs, and hobbies.**

**Describe any problems the applicant might be struggling with**. Legal, *Mental health or unmanageable feelings, history of abuse or trauma, substance use, and/or family or relationship problems. Attach additional pages if necessary*.

**Describe any history of substance use and/or suicidal or homicidal attempts/ideation.**

_____

_____

_____

***List previous residences for the past two years.***

*Address:* _____

*From:* _____ *To:* _____

*Address:* _____

*From:* _____ *To:* _____

*The following demographic information is requested for statistical purposes only.*

***Ethnicity/Race:***

a. ☐ *American Indian/Alaska Native*
b. ☐ *Asian*
c. ☐ *Black/African American*
d. ☐ *Native Hawaiian/Pacific Island*
e. ☐ *White*
f. ☐ *American Indian/Alaska Native & White*
g. ☐ *Asian & White*
h. ☐ *Black/African American*
i. ☐ *American Indian/Alaska Native*
j. ☐ *Other Multi-Racial*

*Hispanic/Latino:* *Yes* ☐ *No* ☐ *Veteran:* *Yes* ☐ *No* ☐ *Sex:* *Male* ☐ *Female* ☐ *Transgender* ☐

*I hereby give my permission for NeighborWorks Alaska to verify any information they may need to determine my eligibility for housing and for continued occupancy in the Sponsor-based rental assistance program. I fully understand this waiver covers future, as well as current verification from State and Federal Agencies. NeighborWorks Alaska is hereby given my permission to request information from all other available sources.*

*The above information is true and correct. I hereby authorize NeighborWorks Alaska to check references and verify information contained in this application.*

_____
*Applicant Name*

_____ _____
*Applicant Signature* *Date*

_____
*Referring Agency Representative Name/Title*

_____ _____
*Referring Agency Representative Signature* *Date*

EQUAL HOUSING OPPORTUNITY

## *SUPPORTIVE HOUSING PROGRAMS -- APPLICANT PROFILE*

*Please provide a brief narrative describing the applicant with regards to the following areas. This information is being requested because in instances where we have had problems with tenants that resulted in evictions, it is these areas that have been the causes of the problems. Please use additional pages if necessary.*

1. *Please describe the applicant's relationships to persons who may cause problems for them or victimize them, (i.e. drug dealers, domestic violence, etc.) and evaluate the potential for victimization on a scale of 1 to 5 with 5 being the greatest risk.*

| | | | | | | |
|---|---|---|---|---|---|---|
| *Least risk for Victimization* | *1* ☐ | *2* ☐ | *3* ☐ | *4* ☐ | *5* ☐ | *Greatest risk for Victimization* |

2. *Please describe the ability of the applicant to set boundaries, apply appropriate refusal skills, and set limits for themselves and others with regard to allowing other people free access to his/her apartment. Evaluate the applicant's ability in this regard on a scale of 1 to 5 with 1 being the highest ability to set boundaries, etc.*

| | | | | | | |
|---|---|---|---|---|---|---|
| *Excellent Boundaries/ Refusal skills* | *1* ☐ | *2* ☐ | *3* ☐ | *4* ☐ | *5* ☐ | *Minimal Boundaries Poor refusal skills* |

3. *Please describe the applicant's level of treatment compliance and engagement. Evaluate the applicant's ability in this regard on a scale of 1 to 5 with 1 being the highest quality of compliance and 5 being the lowest quality of compliance.*

| | | | | | | |
|---|---|---|---|---|---|---|
| *High level of Compliance* | *1* ☐ | *2* ☐ | *3* ☐ | *4* ☐ | *5* ☐ | *Non-Compliant* |

*Please fill out the following form and also describe on the back of this page the applicant's history with regard to substance use and legal history, specifically if the applicant is currently using substances or is presently on probation/parole.*

***Treatment History:***

*# of Emergency Room Visits in the last 90 days: _____*

*# of Emergency Room Visits in the last 12 months: _____*

| ***Mental Health*** | ***Alcohol & Drug Treatment*** | ***Legal History*** |
|---|---|---|
| ____ *No Treatment History* | ____ *No Treatment History* | ____ *Past Probation/Parole* |
| ____ *Outpatient Only* | ____ *Outpatient Only* | ____ *Present Probation/Parole* |
| ____ *<3 Psychiatric Hospitalizations* | ____ *<3 In-Patient Admits* | ____ *# Jail Sentences* |
| ____ *>3 Psychiatric Hospitalizations* | ____ *>3 In-Patient Admits* | ____ *Felony History* |

***Volunteers of America Alaska***

***PERMANENT SUPPORTIVE HOUSING PROGRAM***

***APPLICANT CHECKLIST***

*The following information must be provided in order for the application to be processed.*

☐ *Completed and signed application*

☐ *Verification of disability from a physician or other licensed professional (if applicable).*

☐ *Verification of income (letter from payee, conservator, SSI/APA printout, notarized statement from applicant, pay check receipt, W-2 form)*

☐ *All applicable ROIs such as Permanent Fund Dividend, OPA, SSI, NeighborWorks etc. A current ROI will be required with the new Landlord when the tenant moves into their apartment.*

☐ *Completed Assessment Packet to include all applicable ROIs such as Permanent Fund Dividend, OPA, SSI, NeighborWorks etc. A current ROI will be required with the new Landlord when the tenant moves into their apartment.*

EMERGENCY AND BILLING INFORMATION

***HAVE YOU CALLED YOUR INSURANCE COMPANY TO PRE-AUTHORIZE THE ASSESSMENT?*** ***Y*** ☐ ***N*** ☐

DATE_____ REFERRED BY_____ CLIENT #_____

**CLIENT INFORMATION:**

NAME_____ GENDER: M_____ F_____

ADDRESS_____ CITY_____

STATE_____ ZIP CODE_____ HOME PHONE_____

BIRTH DATE____/____/_____ SS#_____-_____-_____ CELL PHONE_____

GUARDIAN AT TIME OF ASSESSMENT_____

*** List any of the above phone numbers where you do not want messages left*_____

**PARENT INFORMATION:**

NAME_____ HOME PHONE_____

ADDRESS (if different from client)_____ CELL PHONE_____

_____ WORK PHONE_____

BIRTH DATE____/____/_____ SS#_____-_____-_____ EMAIL (optional)_____

RELATIONSHIP TO CLIENT: Mother☐ Father☐ Step☐ Other (explain)_____

FAMILY INCOME: _____ # IN HOUSEHOLD: _____

*** List any of the above phone numbers where you do not want messages left*_____

**OTHER PARENT INFORMATION:**

NAME_____ HOME PHONE_____

ADDRESS (if different from client)_____ CELL PHONE_____

_____ WORK PHONE_____

BIRTH DATE____/____/_____ SS#_____-_____-_____ EMAIL (optional)_____

RELATIONSHIP TO CLIENT: Mother☐ Father☐ Step☐ Other (explain)_____

*** List any of the above phone numbers where you do not want messages left*_____

**INSURANCE INFORMATION:**

PRIMARY INSURANCE_____ ID#_____

NAME OF POLICYHOLDER_____ GROUP#_____

RELATIONSHIP TO CLIENT: Mother☐ Father☐ Step☐ Other (explain)_____

☐ CHECK HERE IF INSURANCE CARD GIVEN TO VOA TO COPY FRONT AND BACK

**OR** PROVIDE: INSURANCE PHONE_____

CLAIM ADDRESS_____

SECONDARY INSURANCE_____ ID#_____

NAME OF POLICYHOLDER_____ GROUP#_____

RELATIONSHIP TO CLIENT: Mother☐ Father☐ Step☐ Other (explain)_____

☐ CHECK HERE IF INSURANCE CARD GIVEN TO VOA TO COPY FRONT AND BACK

**OR** PROVIDE: INSURANCE PHONE_____

**EMERGENCY HEALTH INFORMATION:**

PREFERRED HOSPITAL_____ ALLERGIES_____HEIGHT_____ WEIGHT_____

PRIMARY CARE PHYSICIAN: ☐ YES/NO ☐ IF YES, NAME_____

ADDREESS_____PHONE_____

REVIEWED BY_____

*Rev 3/2015*

(Volunteers of America Alaska representative)

Volunteers of America
Alaska

509 W 3rd Ave #103
Anchorage, AK 99501-2236
Phone: 907-279-9634, Fax 907-276-5489

# ASSESSMENT
# AUTHORIZATION OF MEDICAL BENEFITS AND FINANCIAL RESPONSIBILITY

I authorize Volunteers of America Alaska to submit claims to my health plan or insurance company, from the onset of treatment, on my behalf and in the name of the patient named below. I assign to Volunteers of America Alaska insurance benefits otherwise payable to me. This authorization shall remain in effect until revoked.

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Volunteers of America Alaska for any charges not covered by health care benefits. I am responsible for the entire bill or balance of the bill as determined by Volunteers of America Alaska and/or my health plan or insurance company if the submitted claims or any part of them are denied for payment as not medically necessary or non-covered. It is my responsibility to notify Volunteers of America Alaska of any changes in my health care coverage.

**I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for services received.**

I also understand that I may apply for a sliding fee discount on any patient balance by providing Volunteers of America Alaska with either of the income documents listed at the bottom of this page.

| | |
|---|---|
| _____ | _____ |
| Patient name – PRINTED | Parent/guardian name – PRINTED |
| _____ | _____ |
| Patient signature | Parent/guardian signature |
| _____ | _____ |
| Date | Date |

Documents acceptable for sliding fee evaluation are:

1. Tax return **AND** number living in household *OR*
2. Pay stubs for most recent 2 consecutive months **AND** number living in household

Documentation must be for both (if applicable) parents/guardians

# VOLUNTEERS OF AMERICA, ALASKA INC.
# CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

**Date of Authorization: _____**

**I, _____ / _____**
**Client Name** **Date of Birth**
**authorize Volunteers of America-Alaska (Assist/ARCH) and the following insurance company(s):**

**(Client MUST initial all categories that apply)**

| | |
|---|---|
| | **Denali Kid Care/Medicaid/Xerox/Qualis Health/Denali Care** |
| | **Aetna** |
| | **Blue Cross** |
| | **ODS/Moda** |
| | **Tricare/UMVS** |
| | **Value Options** |
| | **Other (Must Indicate):** |

**To communicate with and disclose to one another the following information verbally, written, and/or facsimile:**

**_____ (Client Must initial) access to my client records from Volunteers of America, Alaska to obtain the following information:**

- **My name and other personal identifying information**
- **Any assessment evaluation results and history**
- **Date of admission/interpretive summary**
- **Date of transition/discharge and transition/discharge summary**
- **Progress note(s)**
- **Diagnosis**
- **Treatment plan**
- **Progress report(s) and compliance**
- **Toxicology results**
- **Continuing care plan**
- **Treatment recommendations**

**_____ (Client Must initial) all records held by Volunteers of America, Alaska from the onset of treatment.**

**The disclosure of the information in this consent is for the purpose of:**

**_____ (Client Must initial) to process medical claims, eligibility, benefits, pre-certification and /or utilization reviews.**

**_____ (Client MUST initial) I understand that the information to be disclosed includes information pertaining to drug/alcohol abuse, treatment and rehabilitation.**

**I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45C.F.R., Parts 160 and 164, cannot be disclosed without my written consent unless otherwise provided in 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 in reliance on it, and that in any event this consent expires automatically as follows:**
**_____.**
**(MUST have specification of the date, event, or condition upon which this consent expires)**

**I understand that generally Volunteers of America, Alaska may not condition my treatment on whether or not I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.**

| | | | |
|---|---|---|---|
| **Signature of Client:** | | **Date:** | |
| **Witness:** | | **Signature of Parent/ Legal Guardian:** | |

# VOLUNTEERS OF AMERICA, ALASKA INC.
# CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

**Date of Authorization: _____**

**I, _____ / _____**
**Client Name** **Date of Birth**

**authorize:**

**Volunteers of America-Alaska (Assist/ARCH)**
**509 W. 3rd Ave., Suite 103**
**Anchorage, AK 99501**
**Phone: (907) 279-9634**
**Fax: (907) 276-5489**

**to be an Authorized Representative on my behalf and can request information on behalf of my household from**

| | | | |
|---|---|---|---|
| **Name of Agency and/or Person:** | **Alaska Department of Public Assistance** | **Home/Business Phone:** | **(907)269-6529** |
| **Address:** | | **Fax:** | **(907)269-0986** |
| | | | |

**To communicate with and disclose to one another the following information verbally, written, and/or facsimile:**

**_____ (Client Must initial) Permission for Volunteers of America, Alaska to obtain the following information:**

- **My name and other personal identifying information**
- **Obtain Medicaid/DenaliCare eligibility status for benefits**
- **Obtain Medicaid/DenaliCare application status for benefits**
- **Obtain Medicaid/DenaliCare certification through date for benefits**

**_____ (Client Must initial) all records held by Volunteers of America-Alaska from the onset of treatment.**

**The disclosure of the information in this consent is for the purpose of:**

**_____ (Client Must initial) to process medical claims, eligibility, and benefits.**

**_____ (Client Must initial) I understand that the information to be disclosed includes information pertaining to application or eligibility status and that Volunteers of America-Alaska may be signing on my behalf.**

**I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45C.F.R., Parts 160 and 164, cannot be disclosed without my written consent unless otherwise provided in 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 in reliance on it, and that in any event this consent expires automatically as follows:**
**_____.**
**(MUST have specification of the date, event, or condition upon which this consent expires)**

**I understand that generally Volunteers of America, Alaska may not condition my treatment on whether or not I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.**

**By signing, you allow Volunteers of America-Alaska (Assist/ARCH) to act as an Authorized Representative for you on matters related to the official information about your status of application of benefits, certification through dates, or other information pertaining to benefits status including signing your application on your behalf.**

| | | | |
|---|---|---|---|
| **Signature of Client:** | | **Date:** | |
| **Witness:** | | **Signature of Parent/Legal Guardian:** | |

# VOLUNTEERS OF AMERICA, ALASKA INC.
# CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

**Date of Authorization: _____**

**I, _____ / _____**
**Client Name Date of Birth**
**authorize Volunteers of America-Alaska (Assist/ARCH) and**

| | | | |
|---|---|---|---|
| **Name of Agency and/or Person:** | **NeighborWorks Alaska** | **Home/Business Phone:** | **6778490** |
| **Address:** | **2515 A Street** | **Cell Phone:** | |
| | **Anchorage, AK 99503** | **Fax:** | |
| | | | |

**To communicate with and disclose to one another the following information verbally, written, and/or facsimile: (Client MUST initial each category that applies).**

| | | | |
|---|---|---|---|
| | **My name and other personal identifying information** | | **Treatment plan** |
| | **Initial assessment evaluation results and history** | | **Progress report(s) and compliance** |
| | **Date of admission/interpretive summary** | | **Toxicology results** |
| | **Date of transition/discharge and transition/discharge summary** | | **Continuing care plan** |
| | **Significant information for screening and treatment** | | **Medical emergencies** |
| | **Attendance in Treatment Only** | | **Other:** |

**The disclosure of the information in this consent is for the purpose of:**
**(Client MUST initial category that applies)**

| | | | |
|---|---|---|---|
| | **Continued treatment** | | **Personal use** |
| | **Legal** | | **Parental participation in treatment** |
| | **Other (Must indicate):** | | |

**I understand that the information to be disclosed includes information pertaining to drug/alcohol abuse, treatment and rehabilitation. _____ (Client MUST initial)**

**I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45C.F.R., Parts 160 and 164, cannot be disclosed without my written consent unless otherwise provided in 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 in reliance on it, and that in any event this consent expires automatically as follows: _____.**
**(MUST have specification of the date, event, or condition upon which this consent expires)**

**I understand that generally Volunteers of America, Alaska may not condition my treatment on whether or not I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.**

| | | | |
|---|---|---|---|
| **Signature of Client:** | | **Date:** | |
| **Witness:** | | **Signature of Parent/Legal Guardian:** | |

# VOLUNTEERS OF AMERICA, ALASKA INC.
# CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

**Date of Authorization: _____**

**I, _____ / _____**
**Client Name Date of Birth**
**authorize Volunteers of America-Alaska (Assist/ARCH) and**

| | | | |
|---|---|---|---|
| **Name of Agency and/or Person:** | | **Home/Business Phone:** | |
| **Address:** | | **Cell Phone:** | |
| | | **Fax:** | |
| | | | |

**To communicate with and disclose to one another the following information verbally, written, and/or facsimile: (Client MUST initial each category that applies).**

| | | | |
|---|---|---|---|
| | **My name and other personal identifying information** | | **Treatment plan** |
| | **Initial assessment evaluation results and history** | | **Progress report(s) and compliance** |
| | **Date of admission/interpretive summary** | | **Toxicology results** |
| | **Date of transition/discharge and transition/discharge summary** | | **Continuing care plan** |
| | **Significant information for screening and treatment** | | **Medical emergencies** |
| | **Attendance in Treatment Only** | | **Other:** |

**The disclosure of the information in this consent is for the purpose of:**
**(Client MUST initial category that applies)**

| | | | |
|---|---|---|---|
| | **Continued treatment** | | **Personal use** |
| | **Legal** | | **Parental participation in treatment** |
| | **Other (Must indicate):** | | |

**I understand that the information to be disclosed includes information pertaining to drug/alcohol abuse, treatment and rehabilitation. _____ (Client MUST initial)**

**I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45C.F.R., Parts 160 and 164, cannot be disclosed without my written consent unless otherwise provided in 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 in reliance on it, and that in any event this consent expires automatically as follows:**
**_____.**
**(MUST have specification of the date, event, or condition upon which this consent expires)**

**I understand that generally Volunteers of America, Alaska may not condition my treatment on whether or not I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.**

| | | | |
|---|---|---|---|
| **Signature of Client:** | | **Date:** | |
| **Witness:** | | **Signature of Parent/Legal Guardian:** | |

Volunteers of America®
Alaska

Notice of Privacy Practices
Acknowledgement of Receipt
Effective April 14, 2003

PLEASE REVIEW CAREFULLY.

The Notice of Privacy Practices describes how Volunteers of America Alaska may use or disclose your protected health information. The example in this Notice is not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by Volunteers of America Alaska. A volunteer of America Alaska is required to give you a copy of our Notice of Privacy Practices.

I hereby acknowledge that I received a copy of Volunteers of America Alaska's Notice of Privacy Practices.

ACKNOWLEDGEMENT OF CONFIDENTIALITY REGULATIONS

ARCH, ASSIST, PRIME for Life under 21, Prevention, RSVP, CMCA and Restorative Justice

The undersigned hereby acknowledges and agrees to abide by the Federal Regulations governing the Confidentiality of Alcohol and Drug Abuse Client Records (42 C.F.R., Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (45 C.F.R., Parts 160 and 164). These regulations prohibit the disclosure or re-disclosure of protected health information in such a way as to compromise the confidentiality and privacy of current program clients, of former program clients, or of those applying for, or otherwise seeking client status. This prohibition includes any disclosure of any protected health information, which may identify an individual, not just alcohol or drug related information.

The undersigned specifically acknowledges and agrees to the following prohibition.

This information has been disclosed to you from records protected by Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 C.F.R., Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R., Parts 160 and 164. The Federal Regulations prohibit you from making any further disclosure of this information without specific written consent from the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2, and HIPAA. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

**By signing below, you are acknowledging that you have received a copy of the Notice of Privacy Practices and that you have an understanding of the Confidentiality Regulations.**

_____
Printed Name of Person Receiving Services

_____ _____
Signature of Person Receiving Services Date

_____ _____
Signature of Legal Guardian Date

_____ _____
Signature of Witness (staff) Date

**VOLUNTEERS OF AMERICA ALASKA, INC.**
**NOTICE OF PRIVACY PRACTICES**
**Original Effective April 14, 2003; Current Version Effective March 12, 2013**

---

**THIS NOTICE DESCRIBES HOW MEDICAL AND DRUG AND ALCOHOL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Information regarding your health care, including payment for health care, is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, and the Substance Abuse Confidentiality Law, 42 C.F.R. Part 2 (Confidentiality Law).

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It describes how Volunteers of America Alaska, Inc. may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside the Volunteers of America Alaska, Inc. system except when the release is required or authorized by law or regulation.

Under HIPAA and the Confidentiality Law, Volunteers of America Alaska, Inc. may not say to a person outside Volunteers of America Alaska, Inc. that you attend the ARCH or Assist programs, nor may Volunteers of America Alaska, Inc. disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected health information except as permitted by federal law.

**Use or Disclosure for Treatment.** Volunteers of America Alaska, Inc. may use your information internally for treatment purposes, in accordance with state and federal law. For example, one staff member may disclose health information to another staff member to coordinate your care. Use and disclosure outside of Volunteers of America Alaska, Inc. will not be permitted without your written consent, except as described in this Notice or otherwise permitted under all applicable privacy laws.

**Use or Disclosure for Payment.** Volunteers of America Alaska, Inc. must obtain your written consent before it can disclose information about you for payment purposes. (A consent under the Confidentiality Law is generally the same as an authorization under HIPAA. For the purposes of this Notice, the term "consent" will be used to describe both.) For example, Volunteers of America Alaska, Inc. must obtain your written consent before it can disclose information to your health insurer in order to be paid for services rendered. Generally, you must also sign a written consent before Volunteers of America Alaska, Inc. can share your health care information for treatment purposes or for health care operations.

**Use or Disclosure for Health Care Operations.** Volunteers of America Alaska, Inc. may use your information internally for health care operations, in accordance with state and federal law. For example, information about your treatment may be disclosed to a staff member to follow up on a customer service complaint that you file against another staff member. Uses and disclosures for these purposes will be limited to the minimum necessary to achieve the operational purpose.

Volunteers of America Alaska, Inc. is required to obtain your written consent before it can sell information about you or disclose information about you for marketing purposes. Volunteers of America Alaska, Inc. must obtain your written consent before disclosing any of your psychotherapy records.

If Volunteers of America Alaska, Inc. intends to contact its clients for fundraising purposes you will be informed of that intent and of your right to opt out of receiving such communication.

If Volunteers of America Alaska, Inc. intends to send you communications concerning treatment alternatives or other health-related products or services, or intends to conduct notifications for which the program receives financial remuneration in exchange for making the communication, you will be informed of that intent and of your right to opt out of receiving such communication.

**ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE**
You will be asked to provide a signed acknowledgement of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights.

**HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION**
The following are examples for which the federal law permits Volunteers of America Alaska, Inc. to use and disclose your protected health information without your written permission:

**Pursuant To an Agreement with a Qualified Service Organization/Business Associate**. Volunteers of America Alaska, Inc. may disclose your protected health information without your consent to obtain legal or financial services, or to another medical facility to provide health care to you, as long as there is a qualified service organization/business associate agreement in place.

**For Audits or Evaluations**. Volunteers of America Alaska, Inc. may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

**For Research.** Volunteers of America Alaska, Inc. may disclose your protected health information to researchers, when authorized by law, if their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

**To Report Criminal Activity.** Volunteers of America Alaska, Inc. may disclose your protected health information to law enforcement if a crime has been committed on Volunteers of America Alaska, Inc.'s premises or against Volunteers of America Alaska, Inc. personnel.

**To Report Suspected Child Abuse or Neglect.** Volunteers of America Alaska, Inc. may disclose your protected health information to an appropriate authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**As Allowed by a Court Order**. Volunteers of America Alaska, Inc. may disclose your protected health information in the course of any judicial or administrative proceeding, in response to a court order issued by a judge in accordance with federal and state laws.

**To Medical Personnel in a Medical Emergency.** Volunteers of America Alaska, Inc. will disclose your protected health information to appropriate medical personnel in a medical emergency.

Before Volunteers of America Alaska, Inc. can use or disclose protected health information about you in a manner that is not described above, it must first obtain your specific written consent allowing us to make the disclosure. Any such written consent may be revoked by you in writing, except for information already disclosed in reliance on the consent and if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a

claim under the policy or the policy itself. This consent must contain the signature of both the minor and the legal guardian.

**YOUR PRIVACY RIGHTS**

**Under HIPAA you have the right to inspect and copy your own health care information.** This means you may inspect and obtain a copy of your protected health information and billing records maintained by Volunteers of America Alaska, Inc., except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal, or administrative proceeding or in other limited circumstances. You must make your request in writing. In the event that Volunteers of America Alaska, Inc. holds your records in an electronic health record, you will have a right to an electronic copy of your health care information. If you request a copy of the information, we may charge a fee for the costs or copying, mailing, or other supplies associated with your request.

In limited circumstance, Volunteers of America Alaska, Inc. may deny your request to see or get copies of your records. If you are denied access to your protected health information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. Volunteers of America Alaska, Inc. will comply with the outcome of the review.

**Under HIPAA, you have the right to request restrictions on certain uses and disclosures of your protected health information**. This means you may ask Volunteers of America Alaska, Inc. not to use or disclose any part of your protected health information for the purposes of treatment, payment, or health care operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply.

Volunteers of America Alaska, Inc. is not required to agree to any restriction you request, except in the case of eligible requests for restrictions on information provided to your insurer for services paid for out of pocket. If Volunteers of America Alaska, Inc. believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If Volunteers of America Alaska, Inc. does agree to the requested restriction, we are bound by that agreement and may not use or disclose any protected health information, which you have restricted, except as necessary in a medical emergency.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location**. Volunteers of America of Alaska, Inc. will accommodate such requests that are reasonable and will not request an explanation from you.

**Under HIPAA, you have the right, with some exceptions, to amend your protected health care information.** This means you may request an amendment of your protected health information maintained in Volunteers of America Alaska, Inc.'s records. In certain cases, Volunteers of America Alaska, Inc. may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of your disagreement with us, and we may prepare a rebuttal to your statement. We will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information**. This right applies to disclosures for purposes other than treatment, payment, or health care operations as described in this Notice of Privacy Practices. It excludes disclosures Volunteers of America Alaska, Inc. may have made to you, to family members or friends involved in your care, or for notification purposes. Your request must be in writing.

Volunteers of America Alaska, Inc. is not required to account for disclosures prior to April 14, 2003, or for any period longer than six years prior to your request.

**You have the right to receive a paper copy of this notice**. You may obtain a copy of our Notice of Privacy Practices by calling the Volunteers of America of Alaska, Inc. office at (907) 279-9634 and request a copy be mailed to you, or by asking for a copy at your next appointment.

**OUR DUTIES TO YOU REGARDING YOUR PROTECTED HEALTH INFORMATION**

"Protected health information" is individually identifiable health information. This information includes demographics that may identify you, and relates to your past, present, or future physical or mental health or condition and related health care services. Volunteers of America Alaska, Inc. is required by law to do the following:

- Protect the privacy of your health information.
- Give you a copy of this Notice of our legal responsibilities and duties and privacy practices related to the use and disclosure of your protected health information.
- Abide by the terms of the Notice of Privacy Practices currently in effect.
- Communicate any changes in the Notice to you.
- Notify affected individuals following a breach of unsecured health information.

We reserve the right to change the terms of this Notice. We reserve the right to make the revised and changed Notice effective for all protected health information Volunteers of America Alaska, Inc. already has about you as well as any information we create or receive in the future.

**COMPLAINTS AND REPORTING VIOLATIONS**

Under HIPAA, if you feel your privacy rights have been violated, you may file a complaint with Volunteers of America Alaska, Inc. at the address listed below or the Secretary of the United States Department of Health and Human Services, Office of Civil Rights at the address listed below. You will not be retaliated against for filing such a complaint.

Violation of the Confidentiality Law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.

CONTACT

To file a complaint with Volunteers of America Alaska, Inc. or for further information regarding this Notice of Privacy Practices, contact:

Elaine Dahlgren, Privacy Officer
Volunteers of America Alaska, Inc.
509 W. 3rd Ave, Suite 103
Anchorage, AK 99501
(907) 279-9636

To file a complaint with the Secretary of the United States Department of Health and Human Services, contact:

Office for Civil Rights
Medical Privacy, Complaint Division
U.S. Department of Health and Human Services
200 Independence Avenue, SW, HHH Building, Room 509H
Washington, DC 20201