Missoula Indian Center
Bldg. 33 Fort Missoula Road
Missoula, MT 59804
Tel 406.829.9515 Fax. 406.829.9519

To: Persons seeking treatment at the Missoula Indian Center
Re: Missoula Indian Center policies on smudging and medical marijuana

Smudging: It is the mission of the Missoula Indian Center Behavioral Health program to promote and foster the health, education and general welfare of Native American people in Missoula, Montana and the surrounding areas.

We believe that healing practices and spirituality contribute to the health and wellbeing of American Indians and Alaskan Natives. We use smudging and prayer when starting ceremonies, meetings and group gatherings. We invite you to join in the smudging, whether you are Native American, or not. You may choose to participate, or not. If you wish you may use this time to enter into a prayer traditional of your religion. We strive to respect all cultures and their differing ceremonies and traditions.

Medical Marijuana: It is the policy of the Missoula Indian Center to admit individuals who are seeking treatment for their alcohol and/or drug addictive disorders. Persons who are users of medical marijuana will be admitted with the following conditions:

1. The person does not attend counseling sessions while under the influence of marijuana.
2. The person adopts as a treatment goal to become marijuana free.

We have given this policy great consideration. We understand that people will have conflicting views regarding this policy. However, we stand by our decision.

By signing below you acknowledge that you have read and agree to adhere to the policies stated on this page.

Client Acknowledgement: ____Date

Intake Coordinator: ____Date

PROGRESS NOTES

Client Name______________________________________

Date Dimension

Missoula Indian Center
Building #33 Fort Missoula Road,
Missoula, MT. 59808
(406) 721-2700

PATIENT RIGHTS STATEMENT MISSOULA INDIAN CENTER CHEMICAL DEPENDENCY PROGRAM

The Missoula Indian Center applies The Patient Rights Policy to all past and present patients. Under no circumstances will anyone be refused because of race, creed, color, or sex. Nor will anyone be refused services because of inability to pay. Nor will the fact that person discontinued treatment in the past, against program advice, be a factor that causes refusal of services. However staff may refer such persons to another more appropriate level of care.

The patient has the right to know names of all personnel involved in conducting his/her care. The patient has the right to know and clearly understand the diagnosis, treatment, prognosis, and other significant information related to his/her care.

All patients will be treated without regard to physical or mental disability, unless such disability makes treatment offered by the facility non-beneficial or hazardous.

The Missoula Indian Center will provide reasonable opportunity for patients to practice the religion of his/her choice, alone or in private, insofar as such religious practices does no infringe upon the rights and treatment of others or the Treatment Program. The client also has the right to be excused from any religious practices.

No patient will be subject by Program staff to Physical abuse, psychological abuse, sexual abuse, corporal punishment, or other forms of abuse administer against their will.

The Missoula Indian Center provides services for men and women, which reflects an awareness of the special needs of each gender.

The patient has the right to make complaints in writing to the Missoula Indian Center Clinical Coordinator. The client will receive reply to the status of his/her complaint. He/she has the right to know what rules and regulations apply to his/her conduct as a patient.

Patient Signature ______________________________ Date ______________________

Witness ___________________________________ Date ______________________

Missoula Indian Center
Building #33 Fort Missoula Road,
Missoula, MT. 59808
(406) 721-2700

NOTICE OF PATIENT REGARDING CONFIDENTIALITY OF CHEMICAL DEPENDENCY RECORDS

The confidentiality of your identity and records as a chemical dependency patient is protected both by Missoula Indian Center program policies and by Federal Law (Sec.42 U.S.C 290ddee-3 and 42 C.F.R. Part 2). Generally, program personnel cannot acknowledge to outsiders that you are a patient, or disclose your condition or other personal information, without your written consent or a court order.

There are EXCEPTIONS, all agency Chemical Dependency Personnel will have access to your records as necessary to run the program and agency. Others who participate in the program will meet you and know you are in treatment. Agencies and organizations, which provide services to the agency, regulate the agency or the program, or pay for program or agency services to the agency, with their written agreement to protect confidentiality. In medical emergencies other staff members or the Food and Drug Administration may receive your records or information as necessary to respond to the emergency.

Also, law requires certain disclosures. Suspected abuse/neglect of children must be reported under State law. Law enforcement officials or others may be notified if you commit or threaten to commit a crime on personal premises. These reports may reveal information about your presence or status in the chemical dependency program.

Violation of Federal regulations is a crime, and may be reported to appropriate authorities in accordance with the regulations. Protecting your confidentiality is a priority for the Missoula Indian Center. Any concerns you have in that regard should be discussed with your Counselor or the Clinical Coordinator.

Minors requesting information and referrals or chemical dependency evaluations will be confidential. However, if treatment services are requested, parental consent is required and all releases of information require written consent from the minor patient and parent or guardian.

BY SIGNING BELOW, I ACKOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS INFORMATION.

Patient Signature ____ Date _____________________

Missoula Indian Center
Building #33 Fort Missoula Road,
Missoula, MT. 59808
(406) 721-2700

Acknowledge of Receipt of MIC/I.H.S Notice of Privacy Practices

I herby acknowledge receipt of the Missoula Indian Center/I.H.S. Notice of Privacy Practices at:

Signature of Patient ________________________ Date ___________

Signature of Patient Representative Date

(State relationship to Patient)

Or Witness (if signature is by thumb print or mark)

Signature and Title of MIC Employee ________________________ Date ___________

For Patients Unable to Acknowledge Receipt

I certify that the patient was unable to acknowledge receipt of the MIC/I.H.S. Notice of Practices because:

Signature of MIC Staff Date

CLIENT FEE AGREEMENT

The Missoula Indian Center receives support from Indian Health Services, State and County tax dollars which makes it possible for this agency to offer services at rates much lower than those of private counselors and health centers. However, research indicates that clients who pay for their treatment are more likely to benefit from their investment in their treatment. Therefore payment is required of all clients who are above 100% of the Federal Poverty Guidelines. Anybody below 100% will be referred to make application for Medicaid if not already on Medicaid. Nobody will be turned away for inability to pay.

Fees are based according to the schedule developed by the Missoula Indian Center Chemical Dependency Program for the appropriate level of services. Please let MIC staff know if your financial situation changes so adjustments can be made to your fee.

Rates are as follows: Sliding Fee Scale %:______________________ Initial

- Chemical Dependency Evaluation and Assessments:______________ ______
  MIP Flat Rate ($100 1st MIP/ $125 2nd+ MIP): ___________________ ______
- Individual rate per hour: _________________________________ ______
  Group rate per hour: _______________________________________ ______

Payments for Evaluations/assessments and MIP's are expected at time of service. Once your counselor has documented the services provided your monthly statement should be mailed to you so you can make a payment after each session.

Initial

______ * I further understand that failures to make payments described herein are my responsibility.

______ * I understand that any account more than 30 days past due will result in my treatment suspension until my account is brought up to date.

______ * I also understand that I will be referred back to referral source for non-compliance of my treatment agreement.

______ * I also wave my legal rights to confidentiality, for the purpose of collection if account is turned over to collection bureau.

______ * Further, I agree to pay all cost, court, collection fees and reasonable attorney fees.

Signature: _________________________________. Date: __________________________

Witness: _________________________________. Date: __________________________

Montana Department of Public Health & Human Services
Substance Abuse Management System

CLIENT INFORMATION FORM

Program #	2	2	4		Facility	0	0	1	

Social Security Number (SSN)										
Birth Date:										
Last Name										
First name:				Middle Name:						

ADIS ID										

DETAILS

General Demographics

ETHNICITY *(Please select one)*

- *Cuban*
- ☐ *Mexican*
- ☐ *Non-Hispanic*
- ☐ *Other Hispanic*
- ☐ *Puerto Rican*

TRIBE *(Please select one)*

☐ *Assininboine*	☐ *Gros Ventre*	☐ *Piegan*
☐ *Blackfeet*	☐ *Kootenai*	☐ *Salish*
☐ *Blood*	☐ *Little Shell*	☐ *Shoshone*
☐ *Chippewa*	☐ *Nez Perce*	☐ *Sioux*
☐ *Chippewa Cree*	☐ *Northern Cheyenne*	☐ *Tribe Unknown*
☐ *Crow*	☐ *Not Domiciled*	☐ *Turtle Mountain*
☐ *Flathead*	☐ *Other Tribe*	☐ *Yankton Tribal Affiliation*

RACE *(Select all that apply)*

- ☐ *White*
- ☐ *American Indian (other than Alaska Native)*
- ☐ *Asian*
- ☐ *Black/African American*
- ☐ *Native Hawaiian or other Pacific Islander*

Other Demographics

Level of Education			Veteran: ☐ Yes ☐ No

Gender: ☐ *Male* ☐ *Female*

Marital Status:

- ☐ *Divorced*
- ☐ *Never Married (including annulled)*
- ☐ *Life Partner*
- ☐ *Separated*
- ☐ *Married (including common law)*
- ☐ *Widowed*

Montana Department of Public Health & Human Services
Substance Abuse Management System

CLIENT INFORMATION FORM

Name:					Account #:				
Program #	2	2	4		Facility	0	0	1	

CONTACT	
Phone Numbers	
Home:	Ext:
Work:	Ext:
Message:	Ext:
Contact Person:	
Relation:	
Phone:	Ext:

ADDRESS				
(Please select one)	☐ Mailing	☐ Physical	☐ Third Party	☐ History
Address:				
City:				
State:				
Zip Code:				
County Name: MISSOULA				
Country:				

ADDRESS				
(Please select one)	☐ Mailing	☐ Physical	☐ Third Party	☐ History
Address:				
City:				
State:				
Zip Code:				
County Name:				
Country:				

Montana Department of Family Health & Human Services
Substance Abuse Management System

ADMISSION FORM

Name:					Account #:				
Program #	2	2	4		Facility	0	0	1	

DEMOGRAPHICS

3. Admission Date *(mmddyyyy)*															
5. Case Number															
10. County of Residence	3	2													

13. Living Arrangement *(check one)*

☐ *Homeless* ☐ *Dependent Living* ☐ *Independent Living*

14. Employment Status *(check one)*

☐ *Employed Full Time* ☐ *Employed Part Time* ☐ *Public Assistance Benefits Depleted*
☐ *Unemployed* ☐ *Not in Labor Force*

15. Detailed Not in Labor Force *(check one)*

☐ *Homemaker* ☐ *Student* ☐ *Retired*
☐ *Disabled* ☐ *Inmate* ☐ *Other*

17a. Has the client participated in a self-help group, support group (e.g., AA, NA, etc.) in the last 30 days? ☐ *Yes* ☐ *No*

17b. Attendance in the last 30 days? ☐ None ☐ 1-3 times in past month ☐ 4-7 times in past month ☐ 8-15 times in past month ☐ 16-30 times in past month ☐ Some

TREATMENT AND REFERRAL

18. Days Waiting to Enter Treatment:			

Is client waiting for a higher level of care *(check one)*: ☐ *Yes* ☐ *No*

19. Number of Prior CD Treatment Episodes			

20. Admission Status *(check one)*:

☐ *Voluntary* ☐ *Forced Voluntary* ☐ *Involuntary (commitment)* ☐ *Court Order*

21. IV Usage *(check one)*:

☐ *Never* ☐ *Not in the last 12 months but since 1978*
☐ *During the last 12 months* ☐ *Not since 1978 but before 1978*

22. Is the Client Adversely affected by his/her gambling? *(check one)*: ☐ *Yes* ☐ *No*

23. Agency Referral Source *(Write Description)*			
24. Program Referral Source *(Use Program Table)*			

25. Detailed Criminal Justice Referral *(check one)*

☐ *State/Federal Court* ☐ *Diversionary Program*
☐ *Other Court* ☐ *Prison*
☐ *Probation/Parole* ☐ *DUI/DWI*
☐ *Other Recognized Legal Entity* ☐ *Other*

26. Number of arrests in the last 30 days	0	0

ADMISSION FORM

Name:					Account #:			
Program #					Facility			

FINANCIAL / ELIGIBILITY

27. Household Income from all sources *(Annual)*

☐ Client refused to give income related information.

28. Pay Frequency *(check one)*

☐ *Weekly* ☐ *Every Two Weeks* ☐ *Bi-Monthly*
☐ *Monthly* ☐ *Annually* ☐ *Day Labor*

29. Including yourself, how many dependents are in your household?

30. Primary Source of Income *(check one)*

☐ *Salary* ☐ *Public Assistance* ☐ *Retirement/Pension*
☐ *Disability* ☐ *Other* ☐ *None*

31. Primary Source of Payment *(check one)*

☐ *Medicaid* ☐ *Other Government Pay*
☐ *Worker's Comp* ☐ *Other Health Insurance*
☐ *No Charge* ☐ *Other*
☐ S*elf-Pay* ☐ *BCBS*
☐ *Medicare* ☐ *Unknown*

32. Health Insurance *(check one)*

☐ *Blue Cross/Blue Shield* ☐ *Other Private Insurance* ☐ *Medicare*
☐ *Medicaid* ☐ *IHS* ☐ *None*
☐ *Insurance Benefits Depleted* ☐ *CHIP* ☐ *ATR*

INTERIM SERVICES

TB Services
☐ *Referral for Testing* ☐ *Counseling and Education*

Pregnant Women
☐ *Referral for Testing* ☐ *Counseling and Education*

IV Drug User
☐ *Referral for Testing* ☐ *Counseling and Education*

CRITICAL POPULATIONS

Check All That Apply

☐ *a. DUI Offender*
☐ *b. Receiving Food Stamps*
☐ *c. Receiving Medicaid*
☐ *d. Receiving AFDC*
☐ *e. Receiving SSI**
☐ *f. IV Drug User**
☐ *g. Protective Services Case*
☐ *h. Probation*
☐ *i. On Parole*
☐ *j. On Pre-Release*
☐ *k. Other Incarcerated Person*
☐ *l. Pregnant Woman**
☐ *m. Woman w/Dependents** ☐ # staying/CBR
☐ *n. Homeless**
☐ *o. Mandatory Monitoring*
☐ *p. Receiving SSDI**
☐ *q. Infected AIDS**

Montana Department of Public Health & Human Services
Substance Abuse Management System

CLIENT INSURANCE FORM

Name:					Account #:				
Program #	2	2	4		Facility	0	0	1	

Account Opened Date *(mmddyyyy)*									
Company:									
Group Name:									
Group Number:									
Member Number:									
Begin Date *(mmddyyyy)*									
End Date *(mmddyyyy)*									
Status ☐ *Active* ☐ *Cancelled*									
Comments:									

Montana Department of Public Health & Human Services
Substance Abuse Management System

CLIENT ELIGIBILITY INFORMATION FORM

Name:					Account #:				
Program #	2	2	4		Facility	0	0	1	

Information Date *(mmddyyyy)*									
Number of People in Household	0								
Household Income from All Sources *(Monthly)*						.	0	0	
☐ Client refused to give income related information.									

Information Date *(mmddyyyy)*									
Number of People in Household	0								
Household Income from All Sources *(Monthly)*						.			
☐ Client refused to give income related information.									

Information Date *(mmddyyyy)*									
Number of People in Household									
Household Income from All Sources *(Monthly)*						.			
☐ Client refused to give income related information.									

Information Date *(mmddyyyy)*									
Number of People in Household									
Household Income from All Sources *(Monthly)*						.			
☐ Client refused to give income related information.									

Information Date *(mmddyyyy)*									
Number of People in Household									
Household Income from All Sources *(Monthly)*						.			
☐ Client refused to give income related information.									

Information Date *(mmddyyyy)*									
Number of People in Household									
Household Income from All Sources *(Monthly)*						.			
☐ Client refused to give income related information.									

Montana Department of Public Health & Human Services
Substance Abuse Management System

CLIENT DRUG MATRIX FORM

Name:					Account #:				
Program #	2	2	4		Facility	0	0	1	

X *Admission* ☐ *Discharge*

Drug Matrix (Primary)			
Primary Drug of Choice:			
Drug Details:			
Frequency of Use: ☐ *No Use in Past Month* ☐ *1-2 Times Per Week* ☐ *Daily* ☐ *1-3 Times in Past Month* ☐ *3-6 Times Per Week*			
Age of First Use *(in years)*			
Usual Route of Administration: ☐ *Oral* ☐ *Inhalation* ☐ *Other* ☐ *Smoking* ☐ *Injection*			
Route Details:			

Drug Matrix (Secondary)			
Secondary Drug of Choice:			
Drug Details:			
Frequency of Use: ☐ *No Use in Past Month* ☐ *1-2 Times Per Week* ☐ *Daily* ☐ *1-3 Times in Past Month* ☐ *3-6 Times Per Week*			
Age of First Use *(in years)*			
Usual Route of Administration: ☐ *Oral* ☐ *Inhalation* ☐ *Other* ☐ *Smoking* ☐ *Injection*			
Route Details:			

Montana Department of Public Health & Human Services
Substance Abuse Management System

CLIENT DRUG MATRIX FORM

Name:					Account #:				
Program #	2	2	4		Facility	0	0	1	

Drug Matrix (Tertiary)
Tertiary Drug of Choice:
Drug Details:
Frequency of Use: ☐ *No Use in Past Month* ☐ *1-2 Times Per Week* ☐ *Daily* ☐ *1-3 Times in Past Month* ☐ *3-6 Times Per Week*
Age of First Use *(in years)*
Usual Route of Administration: ☐ *Oral* ☐ *Inhalation* ☐ *Other* ☐ *Smoking* ☐ *Injection*
Route Details:

Statement

Missoula Indian Center
Chemical Dependency Program

Client Name: ________________________________ **Phone:** ______________________________

Address: ______________________ **City:** MSLA __________ **ST:** MT **Zip:** 5980

ID#: ____________________ **Billing Type:** ___________________ **Placement** ________________

BH	Billed	SAMS	Date	Units	Description Codes	Attendance	Theme

Description Codes

(Use these codes for state)
B = Bundled (i.e. Evaluation takes 1,2 or 3 sessions only enter one time on billing sheet, enter 1)
P = Per Visit (i.e. No matter how long the session 1,2, or 3 hours only enter 1 on sheet, minimum of 45 min.)
U = 15 Minute Units (i.e. Enter 1unit per each 15 minutes, 1 hour = units.)
B = Bundled (i.e. Evaluation takes 1,2 or 3 sessions only enter one time on billing sheet, enter 1)
H = 1 hour

90846 Family Therapy w/o Pat (P)
90847 Family Therapy w Pat (P)
90849 Family Group Multi-Family (P)
H0004 Individual Therapy (U)
H2035 Group Counseling (H)
T1016 Liaison/Case Management (U)
H0001 Complete Evaluation (B)

CD0788 Group Monitoring Probation/Parole (P)
CD0787 Individual Monitoring Probation/Parole (P)
CD0792 Unexcused Absence (P)
90801 Co-Psyc Interview (First Interview appointment)
90804 Co-Psyc individual (20-30 min session)
90806 Co-Psyc (individual (45-50 min session)
90853 Co-Psyc Group (45-50 min sessions)
CC Co-Psyc case management

MISSOULA INDIAN CENTER
Bldg. # 33, Ft. Missoula Rd.
Missoula, Mt 59804
Telephone (406) 721-2700 Fax (Fax) (406) 829-9518

Per Hour = (H)
Per visit = Service (S)
Per unit = 15 Min (U)

	X	Y	Z	
Individual - U (H0004)	$75.00	$55.12	$19.88	X = Full Rate
Group - H (H2035)	$30.00	$19.29	$10.71	Y = State Rate
Case Man - U (T1016)	$50.00	$38.00	$12.00	
Ind.Monitoring - S (CD0787)	$50.00	$0.00	$50.00	
Grp Monitoring -S (CD0788)	$30.00	$0.00	$30.00	
Evaluation - S (H0001)	$450.00	$275.39	$174.61	

	ANNUAL FAMILY INCOME					**CHARGE RATE**
	1	2	3	4	5	
(0%-50%)	Less 6,230	Less 8,380	Less 10.530	Less 12,680	Less 14,830	10%
(51%-!00%)	6,230 - 12,460	8,380 - 16,760	10,530 - 21,060	12,680 - 25,360	14,830 - 29,660	20%
(101%-150%)	12,460 -18,690	16,760 - 25,140	21,060 - 31,590	25,360 -38,040	29,660 - 44,490	40%
(151%-200%)	18,690 - 24,920	25,140 - 33,520	31,590 -42,120	38,040 - 50,720	44,490 - 59,320	60%
(201%-225%)	24,920 - 28,038	33,520 - 37,720	42,120 -47,385	50,720 - 57,060	59,320 - 66,735	160%
(226%-250%)	28,038 - 31,150	37,720 - 41,900	47,385 - 52,680	57,060 - 63,400	66,735 - 74,150	200%
(251%-275%)	31,150 - 34,256	41,900 - 46,090	52,680 - 57,945	63,400 - 69,740	74,150 - 81,569	230%
(OVER 275%)	Full Cost	Full Cost	Full Cost	Full Cost	Full Cost	

CHARGE RATE			**INDIVIDUAL RATE**	**GROUP RATE**
10% =	(0%-50%)	POVERTY	$.50 per unit = $ 2.00 per hr	$ 1.07 per hour
20% =	(51%-!00%)	POVERTY	$.99 per unit = $ 3.96 per hr	$ 2.14 per hour
40% =	(101%-150%)	POVERTY	$ 1.99 per unit = $ 7.96 per hr	$ 4.28 per hour
60% =	(151%-200%)	POVERTY	$ 2.98 per unit =$ 11.92 per hr	$ 6.43 per hour
160% =	(201%-225%)	POVERTY	$ 7.95 per unit =$ 31.80per hr	$ 17.14 per hour
205% =	(226%-250%)	POVERTY	$ 10.19 per unit =$ 40.76 per hr	$ 21.96 per hour
230% =	(251%-275%)	POVERTY	$ 11.43 per unit = 45.72 per hr	$ 24.63 per hour
(OVER 275%)	Full Cost		$ 18.75 per unit = 75.00 per hr	$ 30.00 per hour