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THE MENTAL HEALTH TREATMENT ASSISTANCE PROGRAM

The purpose of this manual is to provide guidance in understanding and implementing the statutes and regulations dealing with the Division of Behavioral Health (DBH) Mental Health Treatment Assistance Program.

Beginning in the late 1970s, the Designated Evaluation and Treatment (DET) Program provided funding on a fee-for-service basis to local community hospitals and specialty hospitals. This funding covered psychiatric inpatient care to certain persons, enabling them to receive care close to home and family. The population initially served by the program was anyone who did not have the means to pay the bill for hospital and related services. The budget, while limited, enabled the program to compensate hospitals for psychiatric inpatient care provided to "indigent" persons, without any further restrictions.

Growth in the program and increases in hospital rates pushed program costs beyond the available budget, and the first restriction was imposed. The program policy was changed to provide payment only for persons who were under civil commitment. A task force, appointed to resolve payment issues, recommended that the hospitals be paid at the Medicaid rate.

During the 21st session of the Alaska State Legislature, Senate Bill 97 became law. It created the Mental Health Treatment Assistance Program (AS 47.31.005 – 47.31.100) and directed the department to adopt regulations to implement the program (after consulting with the Alaska Mental Health Trust Authority).

The Mental Health Treatment Assistance Program applies only to persons who have received evaluation or treatment at a designated evaluation or treatment facility that is not a state-operated hospital and who meet additional eligibility criteria. The program establishes:

- Eligibility criteria for assistance
- The process for applying for assistance
- How decisions about eligibility are determined
- Information about eligible services and rates
- How payment for services is made
- The appeal process

The Designated Evaluation and Treatment (DET) Program has become a vital part of the necessary array of community services that must be in place before the Alaska Psychiatric Institute can assume its role as the tertiary care facility for Alaska. The program relies on a sound interrelated relationship between DBH-funded Community Mental Health Centers (CMHC), approved Guard Escort Providers, State and local Police, emergency medical responders, DET hospitals and the Alaska Psychiatric Institute (API).

Community Mental Health Center

A CMHC must provide emergency evaluation services that include diagnosis (DSM-IV-TR) classification, for persons being considered for involuntary commitment under AS 47.30.700 – 47.30.915. This service is to include both court-ordered screening investigations and evaluations for commitment to DET facilities or to API. Twenty-four-hour inpatient psychiatric treatment for both voluntary and involuntary patients should be considered as
close to the patient’s home as possible. For involuntary patients, this service must include a written cooperative agreement with the API or other state-designated inpatient psychiatric facility. (AS 47.30.530, AS 47.30.540)

To ensure coordination and continuity of services, CMHC's must enter into a written agreement with each evaluation or treatment facility designated under 7 AAC 72 that refers patients to the center after discharge, and the state-operated hospital (API) that refers patients to the center after discharge. An agreement must state that the center will, after being notified by the facility or hospital of a patient’s discharge, schedule an appointment at the center with the patient for clinical services within one week after the patient’s discharge, and medication management services before depletion of any psychotropic medication dispensed or prescribed to the patient upon discharge, and that, whenever possible, medication management services are to include a psychiatric evaluation. (AS 47.30.530, 47.30.540, 47.30.660, 47.31.090)

Approved Guard Escort/AST/Police

Guard Escort services require prior authorization by the CMHC for transportation to and from a hospital. API admission medical staff must be contacted by the CMHC/DET facility to ensure that the admission is appropriate for API. Only after these arrangements have been confirmed can transportation arrangements be made and Guard services contacted for the transportation of the patient.

Documentation authorizing the transport will include a copy of the Ex-Parté, Peace Officer Authorization (POA), or other involuntary commitment order, as well as a guard escort authorization form completed by the CMHC.

Ambulance transports will be approved in only very limited situations and are rarely related to admissions covered under this program.
SUMMARY OF PROGRAM STANDARDS
FOR DET HOSPITALS

This manual summarizes the statutory and regulatory requirements and therefore, it is important to become familiar with the complete statutes and regulations discussed. The full text of both is included in the manual for easy reference. The summary includes footnotes to assist you in locating the appropriate statute or regulation.

<table>
<thead>
<tr>
<th>Eligibility for assistance¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>A patient is eligible for financial assistance if:</td>
</tr>
<tr>
<td>• The patient does not have the financial resources to pay for, or significantly contribute to the payment of charges resulting from an inpatient stay at a psychiatric facility;</td>
</tr>
<tr>
<td>• The patient has no medical insurance coverage or third party payor that provides coverage for evaluation or treatment provided under the civil commitment statutes;²</td>
</tr>
<tr>
<td>• The patient has been admitted for inpatient evaluation or treatment at a designated evaluation or treatment facility after either an involuntary commitment or a voluntary admission, if the patient meets the involuntary commitment criteria; and</td>
</tr>
<tr>
<td>• The patient’s gross monthly household income does not exceed 185 percent of the federal poverty guideline for the calendar month in which service was provided [this includes all earned or unearned income from any source of a member of the patient's household.³]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient’s Proof of Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proof of gross monthly household income may be in the form of paycheck stubs, tax records, unemployment check stubs, a signed statement from an employer, or any other document that shows evidence of income for the month during which a patient received care provided by a designated facility.⁴</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Third-Party Payors⁵</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Bureau of Indian Affairs and the Indian Health Service are not considered to be third-party payors.</td>
</tr>
<tr>
<td>A private insurance company is not considered to be a third-party payor if there is proof that the company does not cover mental health inpatient treatment or that the maximum benefit level has been reached.</td>
</tr>
</tbody>
</table>

¹ AS 47.31.010
² AS 47.30
³ AS 47.31.100
⁴ 7 AAC 72.530
⁵ 7 AAC 72.530
To be eligible for financial assistance, a patient must meet the involuntary commitment criteria even if the patient is under a voluntary commitment (Voluntary in Lieu – VIL). A patient must go through a professionally conducted screening investigation and be determined to be mentally ill and either gravely disabled, or to present a likelihood of serious harm to self or others. "Gravely disabled" is a condition in which a person, as a result of a serious mental illness, (A) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if action by another is not taken; or (B) will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person's previous ability to function independently."

A specific diagnosis is not a condition for admission to an inpatient setting. However, a specified diagnosis within the range of 290 through 301.9, 309.81, or 311, is required to be documented at the time of discharge from inpatient services.

Involuntary admission commitment status supersedes admission criteria until the consumer can be evaluated and the involuntary status is removed or expires.

Admission Criteria:

- The consumer must have a diagnosed or suspected mental illness. Mental illness as defined in AS 47.30.915 (12): “means an organic, mental, or emotional impairment that has substantial adverse effects on an individual’s ability to exercise conscious control of the individual’s actions or ability to perceive reality or to reason or understand; mental retardation, epilepsy, drug addiction, and alcoholism do not per se, constitute mental illness, although persons suffering from these conditions may also be suffering from mental illness;” and defined as a psychiatric disorder identified with appropriate DSM IV codes on all applicable axes, I-V.

- Criteria A, B or C must be met:

(A) The consumer is likely to cause serious harm to themselves or others as defined in AS 47.30.915(10): means a person who

(1) poses a substantial risk of bodily harm to self as manifested by recent behavior causing, attempting, or threatening self-harm; or

(2) poses substantial risk of harm to others as manifested by recent behavior causing or attempting threatening harm, and is likely in the near future to
cause physical injury, physical abuse, or substantial property damage to another person; or

(3) manifests a current intent to carry out plans of serious harm to that person’s self or another.”

(B) And/or is “gravely disabled” as defined in AS 47.30.915 (7): “means a condition in which a person as a result of mental illness:

(1) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness or death highly probable if care by another is not taken; or

(2) will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person’s previous ability to function independently.”

(C) Cannot be served in a less restrictive treatment alternative within the community.

**Continued Stay Criteria:**

This type of service provides planned, comprehensive assessment or treatment involving close daily psychiatric supervision and 24-hour medical supervision. Treatment should be in the least restrictive type of service consistent with the person’s need and therefore should not be instituted unless there is documentation of a failure to respond to or professional judgment of an inability to be safely managed in a less restrictive type of service.

Criteria **A** or **B** must be met

A. The admission criteria must continue to be met, or

B. The current treatment plan requires inpatient care. Any one of the following aspects must be met.
   1. Acute symptoms of the disorder(s), which caused the admission, still remain, and the consumer’s safety would be compromised if a lower level of care is utilized;
   2. New problems have developed that require continued inpatient care to re-stabilize, consolidate treatment gains and integrate the consumer back into the community; or

**Expected Response:**

The patient’s behaviors and symptoms, which were identified as reasons for admission, can be effectively treated by medically indicated treatment available in this setting. The treatment can reasonably be expected to improve or stabilize the patient’s condition so that this type of service will no longer be needed.
The Utilization Review (UR) certifies eligibility under commitment criteria and medical necessity for treatment. The UR does not guarantee payment, and any final claims determination will be made after the bill is received and reviewed against all eligibility requirements. Medical necessity without meeting commitment criteria is not reimbursable under the DET Program. Eligibility and medical necessity will be established from the utilization reviews on cases requiring more than 4 days of hospitalization. Determination to use DET funding for payment beyond the fourth day of hospitalization will require further evaluation by the DET reviewer.

1. Prior to the end of the fourth day of hospitalization, the facility will make an initial determination if the patient qualifies for DET funding per the DET admission criteria. Final determination can be made later based on updated information related to the patient’s finances, pending insurance coverage, and other potential resources for hospitalization payment. Involuntary admission commitment status supersedes admission criteria until the consumer can be evaluated and the involuntary status is removed or expires.

2. Should the facility determine that the patient requires more than four complete days of hospitalization; i.e., four nights past midnight and appears to be a candidate for DET funding per lack of resources, the facility will complete a utilization review with the DET reviewer.

3. The utilization review must be completed no later than close of business on the fourth day of hospitalization, and prior to the fourth completed night past midnight. Should deadline for review fall on a weekend or holiday, it can be deferred to the next business day.
   a. Exceptions for extending the telephonic first review beyond the fourth day of hospitalization can be made if the patient is too psychotic or non-compliant due to mental illness to give permission for the facility to complete utilization reviews with the DET reviewer.

Should the facility fail to review by the close of business on the fourth day of hospitalization excluding weekends or holidays, the facility must send a copy of these pertinent components of the patient record to the DET reviewer: psychiatric evaluation, all progress notes, medical orders, treatment plan, and discharge summary. The clinical documents will be reviewed by the DET reviewer.

4. DBH recognizes that facilities may be treating very non-compliant patients who may resist allowing the utilization review process. Should the patient be discharged before the fourth night past midnight and the patient met involuntary commitment criteria, a utilization review with the DET reviewer is not required.
DET Utilization Review Process

Initial Reviews:

1. The hospital utilization reviewer will call the State DET reviewer and either speak with the reviewer or leave clinical information on a secure voice mail system.

2. Required clinical information for the initial review:
   a. Demographics
   b. Circumstances under which the patient was admitted; i.e., Ex Parté, POA, other involuntary commitment order.
   c. 5 Axis Diagnosis
   d. Reasons why the person requires hospitalization. Reasons for continued hospitalization beyond the fourth night.
   e. Physician’s Certification that patient meets involuntary commitment criteria at admission and current symptoms and specific behaviors that support continued hospitalization.
   f. Past and present medications (if known). Planned course of medication for this hospitalization.
   g. Pertinent personal history
      • Past psychiatric history
      • Present psychiatric care
      • Present support systems
      • Pertinent past trauma
   h. Estimated length of stay and discharge plan

Continued Stay/Concurrent Reviews:

The DBH DET reviewer will give initial certification of inpatient days. When those days expire and the patient is still requiring inpatient care, the facility calls for a concurrent review for an additional re-certification or extended stay.

1. Required information for a concurrent review.
   a. Reasons for continued hospitalization and current mental status
   b. Medications changes
   c. Diagnostic changes
   d. Treatment plan changes
   e. Estimated length of stay and discharge plan

Denials:

When agreement on certified days cannot be made between the facility and the DET reviewer, the DET reviewer can move to deny further certification of treatment days. The DET reviewer cannot deny treatment. Only a designated DET psychiatrist can deny treatment. The DET reviewer will refer the case to the DET consulting psychiatrist for resolution or possible denial of certification. Once denied, the facility can appeal by either an expedited appeal or a closed case appeal.
1. Expedited appeals. The facility MD has two (2) business days to attempt to complete the appeal with the DET psychiatrist via telephone. The facility MD will plead the case for additional hospitalization. Even if the patient is discharged, this review may be used to finalize the certification and resolve any outstanding days of non-certification.

2. Closed case appeal. The facility sends a copy of the psychiatric evaluation, all progress notes, medical orders, treatment plan, and discharge summary to the DET reviewer after the patient is discharged. The DET Reviewer will reconsider their initial denial. If the DET Reviewer upon reconsideration continues to deny the requested days, then the appeal shall advance to the DBH Quality Improvement Manager. The DBH Quality Improvement manager will render the final level of appeal by reviewing the closed case materials, DET MD review notes, and the DET UR notes as well as possible consultation with the facility. This is the final level of appeal. The facility has 60 days to send the chart records once the patient is discharged. Resolution of the case by DBH must be completed within 45 days, upon receipt of the chart.

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**Duties of the treating physician**

For a patient admitted after an involuntary commitment or a voluntary admission chosen after the patient’s physician certifies that the patient meets the involuntary commitment criteria (VIL), the treating physician shall:

(1) using a form supplied by the department, certify upon admission that the patient meets the involuntary commitment criteria; if the patient thereafter transfers to voluntary admission status, the treating physician shall certify whether the patient continues to meet the involuntary commitment criteria;

(2) make a daily notation on each patient’s case chart regarding whether the patient continues to meet the involuntary commitment criteria;

(3) after the initial 72-hour evaluation period, certify, with the Designated Evaluation and Treatment (DET) utilization reviewer, whether the patient continues to meet the involuntary commitment criteria.

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**Federal Poverty Level Guidelines Determination**

Proof of gross monthly household income may be in the form of paycheck stubs, tax records, unemployment check stubs, a signed statement from an employer, or any other document that shows evidence of income for the month during which a patient received care provided by a designated facility [this includes all earned or unearned income from any source of a member of the patient's household].

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8 7 AAC 72.520(e)
9 AS 47.30.700 – 47.30.915
10 AS 47.31.100
Chart for Calculating Federal Poverty Level

Use the following chart to determine if a patient’s gross monthly household income, as reported on the application form, exceeds 185 percent of the federal poverty guideline for Alaska, for the calendar month in which services were provided.

<table>
<thead>
<tr>
<th>Number in Household</th>
<th>Monthly Income Below</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$1,969</td>
</tr>
<tr>
<td>2</td>
<td>$2,640</td>
</tr>
<tr>
<td>3</td>
<td>$3,310</td>
</tr>
<tr>
<td>4</td>
<td>$3,981</td>
</tr>
<tr>
<td>5</td>
<td>$4,652</td>
</tr>
<tr>
<td>6</td>
<td>$5,322</td>
</tr>
<tr>
<td>7</td>
<td>$5,993</td>
</tr>
<tr>
<td>8</td>
<td>$6,664</td>
</tr>
<tr>
<td>Each Additional Person</td>
<td>$671</td>
</tr>
</tbody>
</table>

*Poverty standards are adjusted annually

Eligible Services

The statute directs the department to identify the type and level of services for which assistance is available. The following are considered eligible services if the services were directly related to a patient’s mental health condition that resulted in eligibility for financial assistance:

1. emergency room costs
2. staff physician services, if those services are not already included in the facility’s daily rate
3. physician services, if those services require the action of a physician who is not a member of the designated facility’s staff
4. physician court time costs for participation in a commitment hearing
5. medical costs, if related to the evaluation, diagnosis, and treatment of a patient’s mental illness
6. room and board costs related to the evaluation, diagnosis, and treatment of a patient’s mental illness
7. laboratory costs that are required for all patients entering a facility and laboratory costs related to mental health evaluation, diagnosis, and treatment
8. medication costs related to mental health diagnosis and treatment

11 AS 47.31.025 and 7 AAC 72.520
(9) transportation costs that are not covered by AS 47.30.870 or AS 47.30.905 (certain transportation and related costs are reimbursed by the department under the civil commitment statutes12)

(10) other services related to the admission being billed, as determined by the division on a case-by-case basis

| Designated Evaluation and Treatment and Disproportionate Share Hospital (DET/DSH) Eligible Services |

A Designated Evaluation and Treatment (DET) Hospital, having served a disproportionate share of low-income patients with special needs, qualifies for Medicaid disproportionate share incentive payments for hospitals (DSH) described in 7 AAC 43.687. A hospital agrees that it will provide a negotiated and specific number of encounters (inpatient days) to persons otherwise eligible under 7 AAC 72.190 through 7 AAC 72.210. The following services are inclusive of a DET/DSH agreement daily rate with the Division of Behavioral Health (DBH):

(1) emergency room costs,

(2) staff physician services, if those services are not already included in the facility’s daily rate

(3) physician services, if those services require the action of a physician who is not a member of the designated facility’s staff

(4) medical costs, if related to the evaluation, diagnosis, and treatment of a patient’s mental illness

(5) room and board costs related to the evaluation, diagnosis, and treatment of a patient’s mental illness

(6) laboratory costs that are required for all patients entering a facility and laboratory costs related to mental health evaluation, diagnosis, and treatment

(7) medication costs related to mental health diagnosis and treatment

(8) other services related to the admission being billed, as determined by the division on a case-by-case basis

For DET/DSH inpatient days covered under this agreement in excess of the negotiated agreement, the Division will reimburse the DET hospital at the Medicaid daily rate in effect at the time the service was rendered and 100% of billed charges for physician services provided, upon receipt of all reports and information requested to carry out the provisions of 7 AAC 43.687.

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12 AS 47.30.870; AS 47.30.905
The department will not reimburse for

(1) physician time spent performing administrative or supervisory duties; this exclusion does not include time spent participating in a commitment hearing

(2) facility costs for space, overhead, supplies, or equipment

(3) local ambulance service, unless there is also a need for emergency medical care, and only when directly related to the patient’s mental condition; or ambulance service is necessary to meet the requirements of EMTALA

(4) the co-pay portion of a third-party reimbursement

(5) any transportation or other expense to be paid by the court system for civil commitment proceedings

(6) any service that is not directly related to the patient’s mental condition

Time Periods That Will Be Covered

Up To Seven Days -- The division will reimburse a designated evaluation facility for no more than seven days for evaluation and crisis stabilization or for transition to community-based services if the division utilization reviewer determines the amount of time is clinically appropriate and

(1) the patient continues under, or has transferred to, voluntary commitment and the treating physician has certified, on a form supplied by the department, that the patient meets the involuntary commitment criteria; or

(2) the court has extended the time for evaluation and treatment for a patient who continues to meet the involuntary commitment criteria.

Up To 40 Days -- The division will reimburse a designated treatment facility for no more than 40 days for evaluation, treatment, and crisis stabilization or for transition to community-based services if the division utilization reviewer determines the amount of time is clinically appropriate and:

(1) the patient continues under, or has transferred to, voluntary commitment and the treating physician has certified, on a form supplied by the department, that the patient meets the involuntary commitment criteria.

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13 AS 47.31.025 and 7 AAC 75.520(d)
14 7 AAC 75.520(b) and (c)
15 See AS 47.30.700 – 47.30.915
16 See AS 47.30.700 – 47.30.915
17 See AS 47.30.700 – 47.30.915
(2) the court has extended the time for evaluation and treatment for a patient who continues to meet the involuntary commitment criteria;\textsuperscript{18} or

(3) the patient is authorized to remain at the facility under the civil commitment statutes.\textsuperscript{19}

\begin{center}
\begin{tabular}{|l|}
\hline
\textbf{Application by Patient or Patient’s Representative\textsuperscript{20}}
\hline
\end{tabular}
\end{center}

To receive financial assistance, an eligible patient or that patient's legal representative must apply in writing on a form provided by the department.\textsuperscript{21}

A patient must apply for assistance within 180 days after the date of discharge.\textsuperscript{22}

The application must include:

- a copy of the hospital bill

- completed physician’s certification regarding voluntary or involuntary admission

- proof of gross monthly household income; this proof may be in the form of paycheck stubs, tax records, unemployment check stubs, a signed statement from an employer, or any other document that shows evidence of income for the month during which a patient received care provided by a designated facility

- insurance coverage information; the Bureau of Indian Affairs and the Indian Health Service are not considered to be third-party payors; a private insurance company is not considered to be a third-party payor if there is proof that the company does not cover mental health inpatient treatment or that the maximum benefit level has been reached.

\begin{center}
\begin{tabular}{|l|}
\hline
\textbf{Application by facility\textsuperscript{23}}
\hline
\end{tabular}
\end{center}

If no arrangements for payment have been made within 150 days after the date of discharge, the administrator (or designee) of an evaluation or treatment facility may apply on a patient’s behalf, using a form provided by the department.

A good faith effort is required by the facility to determine that

- the patient is eligible for assistance but has failed to apply, or lacks the mental capacity to apply for assistance

- there is no third-party payor responsible for payment

The application must be made on a form supplied by the department that includes

- a copy of the invoice for the services for which financial assistance is sought

\textsuperscript{18} See AS 47.30.700 – 47.30.915
\textsuperscript{19} See AS 47.30.745(g)
\textsuperscript{20} 7 AAC 72.530
\textsuperscript{21} AS 47.31.015
\textsuperscript{22} AS 47.31.015
\textsuperscript{23} AS 47.31.015(b) and 7 AAC 72.530
• a completed physician’s certification that the patient lacks mental capacity to apply for benefits

• completed physician’s certification regarding involuntary or voluntary (VIL) admission

• certification that a good faith effort as described above was made

• information regarding the patient’s gross monthly household income and possible third-party payors

**Important Note:** If the patient is also being treated for alcohol or drug abuse in a facility that receives federal assistance as described in 42 C.F.R. Part 2, the facility cannot supply certain confidential records to the Division. It will be necessary for Division staff to visit the facility in person, after 10 days notice, to review the confidential records needed to complete a review.

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**Requirement to release records and other information**

A patient who applies or is considered to have applied for assistance under this chapter, the patient's spouse, the patient's parent if the patient is under 18 years of age, or a person in the patient's household shall release records and information to the department necessary to verify eligibility for the assistance. If the records and information are not provided, the department may issue an administrative order imposing full liability for the patient's cost of care and treatment to the evaluation facility or designated treatment facility.

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**Decision on Eligibility**

The department will review all information submitted with the application and will, if necessary, review records at the facility to verify that the patient meets the eligibility requirements and that each service for which financial assistance is sought is an eligible service.

The department will issue its written decision regarding a patient’s eligibility within 30 days after receiving a complete application. The department will send the decision to the patient or the patient's legal representative and to the facility.

If the patient is eligible for financial assistance, payment will be made directly to the facility for all eligible services provided to the patient.

If the patient is found ineligible, the notice must contain the reason for the denial and an explanation of the patient's right to an administrative appeal of the denial under AS 47.31.035.

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24 AS 47.31.015(c) and (d)
25 AS 47.31.020 and 7 AAC 72.540
The statute limits reimbursement to the Medicaid rate and directs the department to establish this in regulation. The department established the rate as the Medicaid rate that is set by regulation and in effect for the facility at the time the service was rendered, prior to year-end review (usually referred to as year-end conformance adjustment).

Payment

Payment will be made directly to the facility.

By endorsing the check, the facility certifies that the claim for which the check is payment is true and accurate unless written notice of an error is sent to the department by the facility within 30 days.

If the facility receives payment from a patient or a third-party payor after being reimbursed by the division under this chapter, the administrator shall return the money to the division.

26 AS 47.31.025
27 7 AAC 43.660 – 7 AAC 43.709 in accordance with AS 47.07.070
28 7 AAC 72.510
29 AS 47.31.030
30 7 AAC 72.530(c)
FORMS FOR DET FACILITY DESIGNATION

APPLICATION FOR FACILITY DESIGNATION UNDER AS 47.30 AND 7 AAC 72
CERTIFICATION OF COMPLIANCE
ANNUAL REPORT REGARDING FACILITY DESIGNATION UNDER AS 47.30 AND 7 AAC 72
QUARTERLY REPORT OF PATIENT INFORMATION

FORMS FOR THE MENTAL HEALTH TREATMENT ASSISTANCE PROGRAM

PHYSICIAN’S CERTIFICATION REGARDING VOLUNTARY OR INVOLUNTARY ADMISSION
APPLICATION FOR ASSISTANCE
PHYSICIAN’S CERTIFICATION THAT PATIENT LACKS MENTAL CAPACITY TO APPLY FOR BENEFITS
APPLICATION FOR REIMBURSEMENT OF SERVICES
DHSS DETERMINATION OF ELIGIBILITY CHECKLIST
DET INPATIENT UTILIZATION REVIEW CERTIFICATION LOG

TRANSPORTATION FORMS

GUARD ESCORT AUTHORIZATION
SECURE TRANSPORT AND ESCORT SERVICES DUTY LOG
INDIVIDUAL TRANSPORT INVOICE
MONTHLY CONSUMER SUMMARY

STATUTES AND REGULATIONS FOR THE MENTAL HEALTH TREATMENT ASSISTANCE PROGRAM

ALASKA STATUTES CHAPTER 47.30
ALASKA STATUTES CHAPTER 47.31
COMMUNITY MENTAL HEALTH SERVICES 7 AAC 71
CIVIL COMMITMENT 7 AAC 71
INPATIENT STANDARDS

NOTE:
The Department will provide hard copy of these forms for your use upon request or you may obtain electronic copies at the Department’s website: http://www.hss.state.ak.us/dbh/
APPLICATION FOR FACILITY DESIGNATION UNDER AS 47.30 AND 7 AAC 72

☐ Applying for designation as a Designated Evaluation Facility

☐ Applying for designation as a Designated Evaluation and Treatment Facility

Hospital Name

Street Address

Mailing Address

Telephone/Facsimile

Administrator’s Name and Official Title

Checklist of required attachments:

☐ a copy of the hospital’s current license or accreditation AND, AS APPLICABLE:

☐ if a general acute care hospital is operating under a provisional license issued under 7 AAC 12.610, a written report of the nature of any violation and of the efforts to achieve compliance

☐ for a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, a copy of the most recent accreditation report

☐ for a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, a written report of the nature of any Type I deficiency described in the report, and of the efforts to achieve compliance

☐ a completed Certification of Compliance form

☐ a copy of the table of contents for the hospital’s policies and procedures

I hereby apply for designation by the department and certify that the information submitted with this application is accurate.

Date: ____________________________  Administrator’s Signature: ________________________________

Public notice regarding this application must be published within 10 working days after this application is submitted to the department, as described in 7 AAC 72.020(d).
CERTIFICATION OF COMPLIANCE

☐ Applying for designation or continued designation as a Designated Evaluation Facility

☐ Applying for designation or continued designation as a Designated Evaluation and Treatment Facility

Hospital Name
Street Address
Mailing Address
Telephone/Facsimile
Administrator’s Name and Official Title

As required by 7 AAC 72.015, 7 AAC 72.020, and 7 AAC 72.050, I hereby certify that this facility is in compliance with applicable statutes and regulations as follows:

Check all that apply:

☐ The above-named facility is a general acute care hospital licensed under AS 18.20.020 and 7 AAC 12.610, and is in compliance with the applicable provisions of (1) 7 AAC 12 adopted by reference in 7 AAC 72.012, (2) AS 47.30.660 – 47.30.915, and (3) 7 AAC 72.

☐ The above-named facility is a hospital that is accredited by the Joint Commission on Accreditation of Healthcare Organizations, and is in compliance with the applicable provisions of (1) 7 AAC 72, (2) AS 47.30.660 – 47.30.915, and (3) standards and procedures substantially similar to those adopted by reference in 7 AAC 72.012.

☐ The above-named facility has been granted a waiver of a requirement of 7 AAC 72 (under 7 AAC 72.030). The required report setting out the status of attempts to meet the schedule of compliance is attached.

Date: Administrator’s Signature:
ANNUAL REPORT REGARDING FACILITY DESIGNATION
UNDER AS 47.30 AND 7 AAC 72

(DUE ON OR BEFORE JUNE 30 EACH YEAR)

☐ Applying for continued designation as a Designated Evaluation Facility

☐ Applying for continued designation as a Designated Evaluation and Treatment Facility

Hospital Name
Street Address
Mailing Address
Telephone/Facsimile
Administrator’s Name and Official Title

Checklist of required attachments:

☐ a copy of the hospital’s current license or accreditation AND, AS APPLICABLE:

☐ if a general acute care hospital is operating under a provisional license issued under 7 AAC 12.610, a written report of the nature of any violation and of the efforts to achieve compliance

☐ for a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, a copy of the most recent accreditation report

☐ for a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, a written report of the nature of any Type I deficiency described in the report, and of the efforts to achieve compliance

☐ a completed Certification of Compliance form

☐ a list of any policies or procedures that have been updated during the previous year

☐ a copy of the updated table of contents for the hospital’s policies and procedures

☐ a copy of each written agreement required under 7 AAC 72.110

OR  ☐ all written agreements previously submitted are still in effect

The purpose of this annual report is to continue operation as a designated facility. I hereby certify that the information submitted with this annual report is accurate.

Date:                        Administrator’s Signature:
QUARTERLY REPORT OF PATIENT INFORMATION
(DUE WITHIN 60 DAYS AFTER THE END OF EACH CALENDAR QUARTER)

Hospital Name

Street Address

Mailing Address

Telephone/Facsimile

Administrator’s Name and Official Title

As required by 7 AAC 72.155, the following information is provided to the department regarding patients admitted to this facility during the quarter being reported who were found to be suffering from a mental illness and who posed a danger to self or others, or who were gravely disabled, as determined by each patient’s treating physician or psychiatrist.

<table>
<thead>
<tr>
<th>Patient Information Required</th>
<th>First Quarter</th>
<th>Second Quarter</th>
<th>Third Quarter</th>
<th>Fourth Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients admitted voluntarily</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of patients admitted voluntarily in lieu</td>
<td></td>
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<td></td>
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<tr>
<td>Number of patients admitted involuntarily</td>
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<tr>
<td>Number of patients admitted who had insurance or self-pay coverage that was billed</td>
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<tr>
<td>Average length of stay for all patients admitted during the quarter, whether voluntary, voluntarily in lieu or involuntary</td>
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<tr>
<td>Number of patients who were readmitted during the quarter</td>
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</table>

One form may be used to report all quarters in one year, using a photocopy from the previous quarter(s), but an original signature is required for the quarter being reported.

I hereby certify that the information submitted with this report is accurate.

Date: Administrator’s Signature:

Date: Administrator’s Signature:

Date: Administrator’s Signature:

Date: Administrator’s Signature:
The Mental Health Treatment Assistance Program (see AS 47.31.005 - 47.31.100 and 7 AAC 72.500 – 7 AAC 72.540 for details) is designed for persons who have received mental health inpatient evaluation or treatment at a designated evaluation facility or a designated treatment facility that is not a state operated hospital.

### Patient Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<tbody>
<tr>
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<thead>
<tr>
<th>Mailing Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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</table>

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Message Phone</th>
<th>Social Security Number</th>
<th>Contact person (optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

### Hospital Information

<table>
<thead>
<tr>
<th>Name of Hospital</th>
<th>Date Admitted</th>
<th>Date Discharged</th>
<th>Amount Owed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Please provide a copy of your hospital bill and a copy of the fully-completed Physician’s Certification Regarding Voluntary or Involuntary Admission

### Household Information

Please complete the following for all other people in your household. Household means each person who lives with you and is either related to you or has legal responsibility for you (parents, spouse, children or another adult who is legally responsible for your bills).

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Relationship to You</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
Monthly Income Information
Please list **ALL MONTHLY** income received by people in your household. This includes, but is not limited to wages, tips, self-employment income, dividends and interest (but not the Permanent Fund Dividend), Native corporation payments, Social Security, SSI, and child support. **Provide proof for each income source.**

<table>
<thead>
<tr>
<th>Name or Person working or receiving income</th>
<th>Source of Income</th>
<th>Relationship to You</th>
<th>Gross Monthly Income</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Insurance Information

1. Are you covered by health insurance (personal or provided by an employer)? ☐ Yes ☐ No

If yes, you must provide proof that inpatient mental health care is not covered or that you have reached your coverage limit for this service. Otherwise, you are not eligible for financial assistance.

2. Has Medicaid or Medicare paid for any portion of your bill? ☐ Yes ☐ No

If yes, you are not eligible for financial assistance.

Statement of Truth
I certify that the statements made on this application are true and complete to the best of my knowledge.

__________________________________  ______________
Signature of Applicant     Date

**OR**

__________________________________  _______________
Signature of authorized representative   Date

Please review your application very carefully and be sure that all required information has been included. Attach proof of each source of income. If you are self-employed, you may send your most recent federal income tax form. If you are not sure what to send, or if you have questions regarding this application, see the attachment with answers to frequently asked questions or call our toll free number 1-800-465-4828.
AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of information requested by the Department of Health and Social Services, Division of Behavioral Health or its agents. The requested information will be used solely in the administration of the Mental Health Treatment Assistance Program and will not be released to any other person or agency outside the Department of Health and Social Services. This release of information shall be in effect while I am an applicant or recipient of this assistance, and for any later investigations regarding my eligibility for assistance.

A REPRODUCTION OF THIS RELEASE IS AS VALID AS THE ORIGINAL.

Date Signed

Your Signature  Printed Name

Signature of Parent or Legal Guardian  Printed Name

Signature of Witness if signed with an “X”  Printed Name of Witness
Answers to Frequently Asked Questions

Q. What type of proof of monthly income is required?
A. You may submit paycheck stubs, tax records if you are self-employed, a signed statement from your employer, an unemployment check stub, or any other document that shows evidence of your income for the month during which you received care in the hospital.

Q. What happens if my hospitalization runs into the next calendar month?
A. Your eligibility is determined on the basis of the month in which you are admitted to the hospital.

Q. Do I have to show the value of my home, car or other assets?
A. No – this program does not consider assets as part of your monthly income.

Q. Do I have to declare my PFD as income?
A. No – This is exempt under AS 43.23.085.

Q. Do I have to declare Native corporation dividends?
A. Yes, unless the Legislature changes the definition of gross monthly income in AS 47.31.100.

Q. What if I am covered by Indian Health Services?
A. You may still be eligible for the Mental Health Treatment Assistance Program.

Q. What if I have private health insurance?
A. To be eligible for this assistance, you must show proof that your private insurance company does not cover mental health inpatient treatment, or that you have reached the maximum benefit level paid by your insurance. This assistance program is the payer of last resort.

Q. Is there a deadline for application?
A. YES, you must apply no later than 180 days after the day you are discharged from the hospital.

Q. What if I disagree with the determination?
A. You have the right to appeal the decision. A copy of the appeals process will be provided to you.
MENTAL HEALTH TREATMENT ASSISTANCE PROGRAM
ADMINISTRATOR’S CERTIFICATION
THAT PATIENT FAILED TO APPLY FOR BENEFITS

[NOTE: If this patient is also being treated for alcohol or drug abuse and the facility is receiving federal financial assistance as defined in 42 C.F.R. 2.12(b), the patient must sign the release required under 42 C.F.R. Subpart C, section 2.31 before information protected under 42 C.F.R. Part 2 may be released.]

Patient Name
Treating Facility
Patient Case Number
Admitting or Treating Physician
Dates Services Provided

The patient, the patient’s spouse, or the patient’s parent (if the patient is under age 18) has failed within 150 days after date of discharge from this facility to make arrangements to pay for services rendered.

This is to certify that the above-named patient failed to apply for benefits under AS 47.31.

_________________________  ____________________________
Date  Administrator’s Signature

A copy of this certification must be attached to application for financial assistance submitted by the facility
MENTAL HEALTH TREATMENT ASSISTANCE PROGRAM
PHYSICIAN'S CERTIFICATION
THAT PATIENT LACKS MENTAL CAPACITY TO APPLY FOR BENEFITS

[NOTE: If this patient is also being treated for alcohol or drug abuse and the facility is receiving federal financial assistance as defined in 42 C.F.R. 2.12(b), the patient must sign the release required under 42 C.F.R. Subpart C, section 2.31 before information protected under 42 C.F.R. Part 2 may be released.]

Patient Name

Treating Facility

Patient Case Number

Admitting or Treating Physician

Dates Services Provided

This is to certify that the above-named patient lacks the mental capacity to apply for benefits under AS 47.31.

__________________  _____________________________________________
Date  Admitting or Treating Physician

A copy of this certification must be attached to application for financial assistance submitted by the facility
MENTAL HEALTH TREATMENT ASSISTANCE PROGRAM
PHYSICIAN’S CERTIFICATION REGARDING
VOLUNTARY-IN-LIEU OR INVOLUNTARY ADMISSION

[NOTE: If this patient is also being treated for alcohol or drug abuse and the facility is receiving federal financial assistance as defined in 42 C.F.R. 2.12(b), the patient must sign the release required under 42 C.F.R. Subpart C, section 2.31 before information protected under 42 C.F.R. Part 2 may be released.]

<table>
<thead>
<tr>
<th>Patient Name</th>
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<tbody>
<tr>
<td>Treating Facility</td>
</tr>
<tr>
<td>Patient Case Number</td>
</tr>
<tr>
<td>Admitting or Treating Physician</td>
</tr>
<tr>
<td>Dates Services Provided</td>
</tr>
</tbody>
</table>

- □ Voluntary-In-Lieu  □ Involuntary admission

If applicable, date patient accepted voluntary admission after voluntary in lieu or involuntary admission.
Date:

This is to certify that the above-named client has been admitted for treatment and that this person is suffering from a mental illness and meets the criteria for involuntary commitment set out in AS 47.30.700 – 47.30.915.

As required by Alaska Statute (AS 47.30.675), the client has received documents that were explained and that set out the client’s rights under AS 47.30.825 – 47.30.865. I affirm that, with or without the patient’s agreement to accept voluntary treatment, the patient is mentally ill and is likely to cause harm to self or others; and/or that the patient is gravely disabled; and/or that the evaluation staff has considered but has not found that there are any less restrictive alternatives available that would adequately protect the patient or others; and/or, with respect to the patient being gravely disabled, that the patient’s mental condition could be improved by a course of continued in-hospital treatment; and/or that the patient has accepted voluntary commitment; and/or that the patient has been advised of the need for, but has not accepted voluntary treatment, and request that a court of jurisdiction commit the client to treatment for a period of time not to exceed 30 days.

Admitting or Treating
Date:  Time:  Physicians’ Signature:

WEEKLY UPDATES
(To be completed at the end of each week during which the patient is treated)

This is to certify that, with or without the patient’s agreement to accept voluntary treatment, the above-named patient continues to meet the criteria for involuntary commitment set out in AS 47.30.700 – 47.30.915.

<table>
<thead>
<tr>
<th>Treating Physician’s Signature</th>
<th>Date</th>
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Notes: State regulations (7 AAC 72) require a daily notation on the patient’s case chart establishing that the patient continues to meet the criteria described in this form.

A copy of this form must be placed in the patient’s hospital file for auditing purposes.
MENTAL HEALTH TREATMENT ASSISTANCE PROGRAM
APPLICATION FOR REIMBURSEMENT OF SERVICES

[NOTE: If this patient is also being treated for alcohol or drug abuse and the facility is receiving federal financial assistance as defined in 42 C.F.R. 2.12(b), the patient must sign the release required under 42 C.F.R. Subpart C, section 2.31 before any information that is protected under 42 C.F.R. Part 2 may be released.]

<table>
<thead>
<tr>
<th>Hospital Name</th>
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<tr>
<td>Street Address</td>
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<tr>
<td>Mailing Address</td>
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<tr>
<td>Telephone/Facsimile</td>
<td></td>
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<tr>
<td>Administrator’s Name and Official Title</td>
<td></td>
</tr>
<tr>
<td>Patient’s Name and Mailing Address</td>
<td></td>
</tr>
<tr>
<td>Patient Number</td>
<td></td>
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<tr>
<td>Dates Service Provided</td>
<td></td>
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</tbody>
</table>

**ADMINISTRATOR'S CERTIFICATION**

As required by AS 47.31.015(b) and 7 AAC 72.530(b), this is to certify to the Department of Health and Social Services, Division of Behavioral Health, the following regarding the mental health hospitalization of the above-named patient under AS 47.30.700 - 47.30.710.

[Check each box to verify requirement has been met]

- A good faith effort has been made to determine that this patient meets the eligibility requirements of AS 47.31.010.

- A good faith effort has been made to determine possible financial resources for the payment of the attached bill relating to hospitalization or transportation and there is no third-party payor or other financial resources available to reimburse our facility for services rendered to this patient.

- The patient, the patient’s spouse, or the patient’s parent (if the patient is under age 18) has failed within 150 days after date of discharge from this facility to make arrangements to pay for services rendered.

- The patient lacks the mental capacity to apply for benefits under AS 47.31 (physician’s certification is enclosed)

- A fully-completed Physician’s Certification Regarding Voluntary in Lieu or Involuntary Admission is in the patient’s file

The bill, in the amount of $ ____________________________ is therefore being submitted to the Division of Behavioral Health for consideration for payment as the payor of last resort.

I hereby certify that the information provided in this application is accurate.

**Date:** ____________________________  
**Administrator’s Signature:** ____________________________

**A copy of this application is to be placed in the patient’s hospital file for auditing purposes**
MENTAL HEALTH TREATMENT ASSISTANCE PROGRAM
DHSS DETERMINATION OF ELIGIBILITY CHECKLIST

Patient Name
DET Facility Name
Dates Service Provided

CHECKLIST FOR APPLICATION

Needed by DHSS for Eligibility Determination:

☐ APPLICATION FOR REIMBURSEMENT OF SERVICES
☐ ORIGINAL UB 92 and/or HCFA-1500
☐ HOSPITAL BILL BREAK DOWN
☐ PHYSICIAN’S CERTIFICATION REGARDING VOLUNTARY IN LIEU OR INVOLUNTARY ADMISSION
☐ CERTIFICATION OF NEED
☐ RECERTIFICATION OF NEED (FOR MORE THAN 4 DAY INPATIENT STAY)
☐ UTILIZATION REVIEW LOG (FOR MORE THAN 4 DAY INPATIENT STAY)

AND

☐ MENTAL HEALTH TREATMENT ASSISTANCE PROGRAM APPLICATION FOR ASSISTANCE
☐ INCOME INFORMATION (Proof of gross monthly household income)
☐ AUTHORIZATION FOR RELEASE OF INFORMATION

OR

☐ ADMINISTRATOR’S CERTIFICATION THAT PATIENT FAILED TO APPLY FOR BENEFITS

OR

☐ PHYSICIAN’S CERTIFICATION THAT PATIENT LACKS MENTAL CAPACITY TO APPLY FOR BENEFITS

AND

☐ PROOF OF INSURANCE DENIAL (IF APPLICABLE)
☐ EMERGENCY ROOM SUMMARY
☐ PSYCHIATRIC EVALUATION SUMMARY
☐ DISCHARGE SUMMARY
☐ COURT ORDER, EX-PARTÉ OR PEACE OFFICER / MENTAL HEALTH PROFESSIONAL APPLICATION FOR EXAMINATION
☐ DHSS DETERMINATION OF ELIGIBILITY CHECKLIST
**DET Inpatient Utilization Review Certification Log**

<table>
<thead>
<tr>
<th>Facility</th>
<th>Facility UR Reviewer</th>
</tr>
</thead>
<tbody>
<tr>
<td>UR Fax</td>
<td></td>
</tr>
<tr>
<td>Patient Name</td>
<td>Social Security #</td>
</tr>
<tr>
<td>Admission Date</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Certification</th>
<th>Number of Days Certified</th>
<th>Last Authorized Day</th>
<th>DBH UR Reviewer</th>
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**Discharge Date:**

**Comments:**
CMHC or FAMILY ESCORT AUTHORIZATION to API, DET HOSPITAL
Or OTHER HOSPITAL APPROVED BY the DBH/API

Consumer Name

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

Date of Birth

<table>
<thead>
<tr>
<th>Social Security Number</th>
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</thead>
</table>

Instruction for use: When a CMHC staff person or a family member is approved by the CMHC to escort a person under an involuntary commitment order to API, DET Hospital, or Other Hospital approved by DBH/API, the following criteria must be met. Check appropriate boxes.

☐ Order Completed  ☐ Signed Ex Parté, Order for Evaluation or POA order attached.

Judge who approved order:

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

And

☐ API approvals obtained to transport and admit to API

Name of API medical staff that approved admission

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

Or

☐ DET medical staff approval to transport to DET hospital and admission to DET hospital

Name of DET medical staff that approved admission

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

Or

☐ Other Hospital authorized by API physician

Name of Physician from Hospital who approved admission

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

Name and Address of Other Hospital Approved

Address

JUSTIFICATION: (Completed by CMHC staff as reported by API staff if an Other Hospital is required.)
ADDITIONAL INFORMATION REQUIRED AS APPLICABLE

Is consumer medically cleared through ER?  ☐ Yes  ☐ No
Does consumer have history of violence?  ☐ Yes  ☐ No
Is consumer violent at this time?  ☐ Yes  ☐ No

METHOD OF TRANSPORT

☐ Ground
☐ Airfare (Scheduled)
☐ Airfare (Charter)

AUTHORIZATION/JUSTIFICATION (Completed by CMHC Staff if chartered aircraft is required.)

☐ Per Diem
Beginning date and hour of transport ____________________________
Ending date and hour of transport ____________________________
Attach Hotel and cab receipts if applicable ____________________________

Distribution of Authorization:
1.  DBH DET Billing Coordinator with all necessary items to complete billing.
2.  Local CMHC Files

CMHC staff completing form: (Print)__________________________________________

Agency:___________________________________________________________________

Signature: ____________________________ Date: ____________________________
INSTRUCTIONS FOR COMPLETING THE CMHC or FAMILY ESCORT AUTHORIZATION TO API, DET HOSPITAL or OTHER HOSPITAL

- Consumer Name, Date, Time, Date of Birth, and Social Security Number. Complete information for consumer whom you are requesting transport.

- Justification—CMHC Staff or Family Member Transport/Escort
  Family escorts will be used when a professional judges that the situation will be safe and therapeutic. Mixing guard escorts with family escorts may increase management problems.

  The types of transport to be used are Ground, Commercial Transport, or Charter Transport. CMHC will make every effort to use ground or commercial transportation whenever possible unless CMHC indicates the consumer’s behavior will need a charter, or when the schedule and seat availability does not meet the CMHC’s need to get the consumer to API, DET Hospital or other hospital.

  Authorization – describe the reason the consumer needed to be transported by chartered aircraft.

- Per Diem
  CMHC staff and family members will be reimbursed for per diem expenses directly related to escort. Reimbursement will be for only those items listed on attachment #1.

- Other Approved Hospitals
  Other Approved hospitals will only be considered for reimbursement by DBH when the API admission screening officer or medical staff determines that an admission to API would be inappropriate. Escort similar to transportation to API after an alternate hospital is authorized by API/DBH staff and after receiving approval from the receiving hospital. Documentation of involuntary commitment is still required. Any other arrangements require prior authorization from API/DBH.

- Distribution of Authorization
  Copies of the authorizations for transport must be provided to:
  1. DBH DET Billing Coordinator with all necessary items to complete billing.
  2. Local CMHC Files
GUARD ESCORT AUTHORIZATION to API, DET HOSPITAL
Or OTHER HOSPITAL APPROVED BY API/DBH
(To be completed by Authorized Requesting Agency.)

Consumer Name

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

Date of Birth

Social Security Number

Instruction for use: When a person under an involuntary commitment order is being escorted by an approved guard service to API, DET Hospital, or Other Hospital approved by the API/DBH, the following criteria must be met.

Check appropriate boxes.

☐ Order Completed ☐ Signed Ex Parté, Order for Evaluation or POA order attached.

Judge who approved order:

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

And

☐ API approvals obtained to transport and admit to API
Name of API medical staff that approved admission

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

Or

☐ DET medical staff approval to transport to DET hospital and admission to DET hospital
Name of DET medical staff that approved admission

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

Or

☐ Other Hospital authorized by API physician
Name of Physician from Hospital who approved admission

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
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</table>

Name and Address of Other Hospital Approved

Address

JUSTIFICATION: (Completed by CMHC staff as reported by API staff if an Other Hospital is required.)
ADDITIONAL INFORMATION REQUIRED AS APPLICABLE

Is consumer medically cleared through ER?  □ Yes  □ No
Does consumer have history of violence?  □ Yes  □ No
Is consumer violent at this time?  □ Yes  □ No

METHOD OF TRANSPORT

☐ Ground
☐ Airfare (Scheduled)
☐ Airfare (Charter)

AUTHORIZATION/JUSTIFICATION (Completed by CMHC Staff if chartered aircraft is required)

____________________________
____________________________

ADDITIONAL GUARD

☐ Additional Guard requested

AUTHORIZATION/JUSTIFICATION: (Completed by CMHC staff if an additional guard is required)

____________________________
____________________________

GENDER REQUIREMENT

☐ Same gender escort required  □ Escort gender requirement waived

AUTHORIZATION/JUSTIFICATION: (Completed by CMHC staff if Escort gender is waived)

____________________________
____________________________

Contact Person and Guard Service Used

Date  Time

Distribution of Authorization:
1. Guard Service when consumer is picked up
2. Local CMHC Files

CMHC staff completing form: (Print)
Agency: (Print)

Signature:  Date:
INSTRUCTIONS FOR COMPLETING THE GUARD ESCORT AUTHORIZATION TO API, DET HOSPITAL or OTHER HOSPITAL

- Consumer Name, Date, Time, Date of Birth and Social Security Number. Complete information for consumer whom you are requesting transport.

- Call Guard Transport Service
  Call Guard Transport Services to let them know a transport is needed, the pick up site, and degree of urgency. Leave your contact number as they will have to call you back about airline schedules and personnel requirements.

- Airfare (commercial): Airfare (charter):
  Type of airfare transport to be used. Guard Service will use commercial airfare whenever possible unless you indicate the consumer’s behavior will require a charter, or when the airline schedule and seat availability does not meet the CMHCs’ need to get the consumer to API.

Authorization – describe the reason the consumer needed to be transported by chartered aircraft.

- Additional Guard
  If the consumer to be transported needs an extra guard due to his/her behavior and/or condition, you must explain the situation to the Guard Service and mutually decide on the use of an additional guard. A second guard should be an exception. If an additional guard is indicated due to behavior, you should consider the security of the setting where that consumer is being held and whether transport by the Troopers may be required. If both these options are reviewed and transport with the Guard Service is still the indicated option, then authorize extra support.

Authorization – describe the reason the additional guard was required.

- Other Approved Hospitals
  DBH will approve transport to Other Approved hospitals only when an API admission screening officer or medical staff determines that admission to API would be inappropriate. Contact a Guard Service for escort similar to transportation to API after an alternate hospital is authorized by API/DBH staff and after receiving approval from the receiving hospital. Documentation of involuntary commitment is still required. Any other arrangements require prior authorization from DBH/API.

- Distribution of Authorization
  Send copies of the authorizations for transport to
  1. Guard Service
  2. Local CMHC Files
AST or POLICE ESCORT AUTHORIZATION to API, DET HOSPITAL
Or OTHER HOSPITAL APPROVED BY DBH/API

<table>
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<tr>
<th>Consumer Name</th>
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<tr>
<td>Date</td>
<td>Time</td>
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<tr>
<td>Date of Birth</td>
<td>Social Security Number</td>
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</table>

Instruction for use: **When using an AST or Police to escort an individual to API, DET Hospital, or Other Hospital approved by the API/DBH under an involuntary commitment, the following criteria must be met.**

**Check appropriate boxes.**
- [ ] Order Completed
- [ ] Signed Ex Parté, Order for Evaluation or POA order attached.

Judge who approved order:

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
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</table>

And
- [ ] API approvals obtained to transport and admit to API

Name of API medical staff that approved admission

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

Or
- [ ] DET medical staff approval to transport to DET hospital and admission to DET hospital

Name of DET medical staff that approved admission

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

Or
- [ ] Other Hospital authorized by API physician

Name of Physician from Hospital who approved admission

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
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</table>

Name and Address of Other Hospital Approved

<table>
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<tr>
<th>Address</th>
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</thead>
</table>

**JUSTIFICATION:** (Completed by CMHC staff as reported by API staff if an Other Hospital is required.)

---

Alaska DHSS DET Manual - 57 - February 2005
Revised 2/2/07
ADDITIONAL INFORMATION REQUIRED AS APPLICABLE

Is consumer medically cleared through ER? □ Yes □ No
Does consumer have history of violence? □ Yes □ No
Is consumer violent at this time? □ Yes □ No

METHODOF TRANSPORT

☐ Ground
☐ Airfare (Scheduled)
☐ Airfare (Charter)

AUTHORIZATION/JUSTIFICATION (Completed by CMHC Staff if chartered aircraft is required.)

☐ Additional Guard. Justification required for decision to request an additional guard,

AUTHORIZATION/JUSTIFICATION: (Completed by CMHC staff if an additional guard is required.)

☐ Per Diem
Beginning date and hour of transport
Ending date and hour of transport
Attach Hotel and cab receipts if applicable

Contact Person

Date Time

Distribution of Authorization:
1. AST or POLICE
2. Local CMHC Files

CMHCstaff completing form: (Print)
Agency: (Print)

Signature: Date:
INSTRUCTIONS FOR COMPLETING THE AST or POLICE ESCORT AUTHORIZATION TO API, DET HOSPITAL or OTHER HOSPITAL

• Consumer Name, Date, Time, Date of Birth and Social Security Number
  Complete information for consumer whom you are requesting transport.

• Call AST or POLICE Transport Service
  Call nearest detachment of Alaska State Troopers to let them know an escort is needed, the pick up site, and degree of urgency. Leave your contact number as they will have to call you back to clarify personnel requirements and airline schedules. Alternatively, a similar call can be made to the local police. Leave your contact number as they will have to call you back about airline schedules and personnel requirements.

• Airfare (commercial): Airfare (charter):
  Type of airfare transport to be used. Alaska State Troopers or Local Police will try to use commercial airfare whenever possible unless you indicate the consumer’s behavior will need a charter, or the airline schedule and seat availability does not comply with your need to get the consumer to API.

  Authorization – describe the reason the consumer needed to be transported by chartered aircraft.

• Additional Guard
  If the consumer to be transported needs an extra guard due to their behavior and/or condition you must explain the situation to the Alaska State Troopers or Local Police and mutually decide on the use of an additional guard. A second guard should be an exception.

  Authorization – describe the reason the additional guard was required.

• API or DET Hospitals
  API, DET, and Other Hospitals must each approve their own admissions before arranging to transport to those hospitals. Once approval is obtained from those hospitals to transport to API or a DET Hospital, contact a Guard Service to arrange for the transport and escort of the consumer to the receiving hospital.

• DET Hospital or Other Approved Hospital
  An Other Approved Hospital will only be considered by the DBH if it is determined by API admission screening officer or medical staff that an admission to API would be inappropriate. Only after API/DBH staff authorizes an Other Hospital and approval from the receiving hospital is confirmed would it be appropriate to contact a Guard Service to arrange for transport and escort of the consumer. Documentation of involuntary commitment is still required. Any other arrangements require prior authorization from the API/DBH.

• Per Diem
  The trooper or police officer providing escort will be provided per diem expenses directly related to transport. The per diem would include meals, ground transportation, and lodging at State rates if the, transport cannot be completed the same day. If applicable, the Troopers or police must fax the receipts to the DBH DET Billing Officer.

• Distribution of Authorization
  Copies of the authorizations for transport must be provided to
  1. AST or Local Police
  2. Local CMHC Files
### Individual Transport Invoice

**Division of Behavioral Health**

**DET Transport Billing**

PO Box 110620  
Juneau, AK 99811

(907) 465-3370 fax (907) 465-2185

### Client Information

**Client Name**

**Client DOB**

**Client SS#**

**Transport From**

**Transport To**

### Date Description of Service Number of Charges Total

<table>
<thead>
<tr>
<th>Date</th>
<th>Description of Service</th>
<th>Number of Charges</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Airfare - Client - One Way or Round Trip</td>
<td></td>
<td>$ -</td>
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<td></td>
<td>Airfare - Escort - Round Trip</td>
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<td></td>
<td>Cab/Ferry/Shuttle Fare - Total of all Fares</td>
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<tr>
<td></td>
<td>Lodging - Cost for each night</td>
<td></td>
<td>$ -</td>
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<tr>
<td></td>
<td>Meal - Breakfast - State Rate</td>
<td>$ 9.00</td>
<td>$ -</td>
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<tr>
<td></td>
<td>Meal - Lunch - State Rate</td>
<td>$ 11.00</td>
<td>$ -</td>
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<td></td>
<td>Meal - Dinner - State Rate</td>
<td>$ 22.00</td>
<td>$ -</td>
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<td>Mileage - State Rate</td>
<td>$ 0.485</td>
<td>$ -</td>
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<tr>
<td></td>
<td>Airfare - Client - Return Home</td>
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<td>$ -</td>
</tr>
</tbody>
</table>

**Total Charges**

$ -

### Transport Notes

- Ex-Parte, Court Order or POA
- Travel Authorization
- Receipts for Expenses
- Copy of Airline Tickets/Charter Inv.
MONTHLY CONSUMER SUMMARY

<table>
<thead>
<tr>
<th>Date of Transport</th>
<th>Consumer Name</th>
<th>Consumer DOB</th>
<th>Consumer SS#</th>
<th>Total Charges</th>
</tr>
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<tbody>
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Please ensure legible and complete documents are attached to this statement.

Total $ -
Secure Transport and Escort Services Duty Log

ESCORTING OFFICER INFORMATION:

<table>
<thead>
<tr>
<th>Name(s):</th>
<th>Date:</th>
<th>Time:</th>
<th>Client Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Location:</td>
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<tr>
<td>Ending Location:</td>
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<td>Starting Location:</td>
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<tr>
<td>Ending Location:</td>
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<tr>
<td>Escorting Officer’s Total Time for Transport:</td>
<td>Hours</td>
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RERAINT USE:
Please document all use of restraints and provide a justification that includes the circumstances under which they are used, the type of restraint, the duration of the restraint, and the patient's response. (NOTE: If a patient refuses to be restrained and is determined to be a danger to self/others, transport by a Peace Officer will be utilized to ensure the patient's safety.)

______________________________________________________________

COMMENTS:

______________________________________________________________

SUBJECT INFORMATION:

<table>
<thead>
<tr>
<th>Name:</th>
<th>DOB:</th>
<th>SS#</th>
<th>Gender:</th>
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<tbody>
<tr>
<td>Mental Health Transportation:</td>
<td>Adult</td>
<td>Juvenile</td>
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<tr>
<td>Transported From:</td>
<td>Date:</td>
<td>Time:</td>
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<tr>
<td>Transported To:</td>
<td>Date:</td>
<td>Time:</td>
<td></td>
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</tbody>
</table>

Signature of Escort Date
<table>
<thead>
<tr>
<th>ESCORT'S NAME</th>
<th>CONSUMER'S NAME</th>
<th>REFFERING CMHC</th>
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<th>ADDRESS, CITY, STATE, ZIP</th>
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<th>ADDRESS, CITY, STATE, ZIP</th>
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<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>LOCATION</th>
<th>ODOMETER READING</th>
<th>TOTAL MILES</th>
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I certify that I used this company vehicle on State of Alaska business. Vehicle License Number _________________________ Total miles _________________________

Escort's Signature: _________________________

Mileage Allowance: $0.485

Reimbursement Due: $
Chapter 47.30. MENTAL HEALTH

Article 01. MENTAL HEALTH TRUST AUTHORITY

Sec. 47.30.010. [Repealed, Sec. 7 ch 84 SLA 1981].
Repealed or Renumbered

Sec. 47.30.011. Alaska Mental Health Trust Authority.
(a) The Alaska Mental Health Trust Authority is established as a public corporation of the state within the Department of Revenue.
(b) The purpose of the authority is to ensure an integrated comprehensive mental health program and to administer the office of the long term care ombudsman established in AS 47.62.010.
(c) The authority
(1) shall, as provided in AS 37.14.009, administer the trust established under the Alaska Mental Health Enabling Act of 1956;
(2) may sue and be sued;
(3) may retain the services of independent counsel when, in the judgment of the authority's board of trustees, independent counsel is needed;
(4) shall insure or indemnify and protect the board, a member of the board, or an agent or employee of the authority against financial loss and expense, including reasonable legal fees and costs, arising out of a claim, demand, suit, or judgment by reason of alleged negligence, alleged violation of civil rights, or alleged wrongful act resulting in death or bodily injury to a person or accidental damage to or destruction of property if the board member, agent, or employee, at the time of the occurrence, was acting under the direction of the authority within the course or scope of the duties of the board member, agent, or employee;
(5) shall exercise the powers granted to it under AS 37.14.041, subject to the limitations imposed by AS 37.14.045; and
(6) shall administer the office of the long term care ombudsman established in AS 47.62.010.
(d) The provisions of AS 44.62.330 - 44.62.630 do not apply to the Alaska Mental Health Trust Authority.

Sec. 47.30.016. Membership of the board.
(a) The authority shall be governed by its board of trustees.
(b) The board consists of seven members appointed by the governor and confirmed by the legislature. The members appointed under this subsection shall be appointed
(1) based upon their ability in financial management and investment, in land management, or in services for the beneficiaries of the trust;
(2) after the governor has considered a list of persons prepared by a panel of six persons who are beneficiaries, or who are the guardians, family members, or representatives of beneficiaries; the panel shall consist of
(A) one person selected by the Alaska Mental Health Board established by AS 47.30.661;
(B) one person selected by the Governor's Council on Disabilities and Special Education;
(C) one person selected by the Advisory Board on Alcoholism and Drug Abuse established by AS 44.29.100;
(D) one person selected by the Alaska Commission on Aging established by AS 44.21.200;
(E) one person selected by the Alaska Native Health Board; and
(F) one person selected by the authority.
(c) A member of the board appointed by the governor under (b) of this section may not
(1) be an officer or employee of the state; or
(2) within the preceding two years or during the member's term of office have an interest in,
 served on the governing board of, or been employed by an organization that has received,
during that same period, money from the mental health trust settlement income account under
a grant or contract for services.
(d) A quorum of the board is four members.
(e) A member of the board is entitled to
(1) an honorarium of $200 for each day or any part of a day spent at a meeting of the
 board, at a meeting of a subcommittee of the board, or as a representative of the board; and
 (2) per diem and travel expenses authorized for boards and commissions under AS 39.20.180.

Sec. 47.30.020. [Repealed, Sec. 7 ch 84 SLA 1981].
Repealed or Renumbered

Sec. 47.30.021. Term of office, vacancies, and removal.
(a) The members of the board serve staggered five-year terms. A member shall continue
to serve until the member's successor is appointed and confirmed.
(b) A vacancy occurring in the membership of the board shall be filled within 60 days by
appointment of the governor for the unexpired portion of the vacated term.
(c) The governor may remove a member of the board only for cause, including
incompetence, neglect of duty, misconduct in office, poor attendance, or lack of contribution
to the board's work. A member being removed for cause shall be given a copy of the charges
and afforded an opportunity to publicly present a defense in person or by counsel upon not
less than 10 days' written notice. If a member is removed for cause, the governor shall file
with the lieutenant governor a complete statement of all charges made against the member
and the governor's findings based on the charges, together with a complete record of the
proceedings. The removal of a member for cause constitutes a final administrative order. A
member seeking to appeal the governor's removal of a member for cause under this
subsection shall file a notice of appeal with the superior court under AS 44.62.560.
(d) Except for a trustee who has served two consecutive five-year terms, a member of
the board may be reappointed. A member of the board who has served two consecutive five-
year terms is not eligible for reappointment to the board until one year has intervened.

Sec. 47.30.026. Officers and staff.
(a) The board shall annually elect a presiding officer and other officers it considers
necessary from among its membership.
(b) The board shall employ a chief executive officer who shall be selected by the board.
The chief executive officer shall be compensated at no less than range 26 of the pay plan for
state employees under AS 39.27.011(a). The chief executive officer may
(1) hire additional employees;
(2) appoint hearing officers to perform the responsibilities set out in AS 47.30.031
(b)(5); and
(3) contract for the services of consultants and others.
(e) The chief executive officer is directly responsible to the board.
(d) The chief executive officer and employees hired under this section are in the exempt service under AS 39.25.110.

Sec. 47.30.030. [Repealed, Sec. 7 ch 84 SLA 1981].
Repealed or Renumbered

Sec. 47.30.031. Regulations.
(a) The board shall adopt regulations under AS 44.62 (Administrative Procedure Act) consistent with state law and the fiduciary responsibilities imposed by law on members of boards of directors of corporations having trust responsibilities.
(b) The regulations shall address, but are not limited to,
(1) the requirements of AS 47.30.056(h) and (j);
(2) [Repealed, Sec. 39 ch 5 FSSLA 1994].
(3) procedures by which an aggrieved person or group who believe they have not received services that should be provided from the trust may apply to the authority for redress;
(4) provisions that allow and encourage entities providing trust funded services to integrate those services with other community human services funded by other sources;
(5) administrative adjudication procedures, including but not limited to
(A) the acceptance of applications under (4) of this subsection;
(B) investigations;
(C) hearings; and
(D) the issuance of administrative orders, as necessary;
(6) provisions that establish a process for long-range planning for expenditures from the mental health trust settlement income account; and
(7) criteria for determining the nature and extent of necessary services and related expenses to be funded by the trust.

Sec. 47.30.036. Duties of the board.
The board shall
(1) preserve and protect the trust corpus under AS 37.14.009;
(2) coordinate with other state agencies involved with programs affecting persons in need of mental health services;
(3) review and consider the recommendations submitted under AS 44.21.230(a)(10), AS 44.29.140(2), AS 47.30.666(6), and AS 47.80.090(13);
(4) adopt bylaws governing its meetings, selection of officers, proceedings, and other aspects of board procedure;
(5) make an annual written report of its activities to the governor and the public and notify the legislature that the report is available; and
(6) fulfill its obligations under AS 47.30.046.

Sec. 47.30.040. [Repealed, Sec. 7 ch 84 SLA 1981].
Repealed or Renumbered

Sec. 47.30.041. Board advisors.
The commissioners of health and social services, natural resources, and revenue, or their respective designees, are advisors to the board.

Sec. 47.30.046. Budget recommendations; reports.
(a) The board shall annually, not later than September 15, submit to the governor and the Legislative Budget and Audit Committee a budget for the next fiscal year and a proposed plan of implementation based on the integrated comprehensive mental health program plan prepared under AS 47.30.660(a)(1). The budget must include the authority's determination of the amount

(1) recommended for expenditure from the general fund during the next fiscal year to meet the operating and capital expenses of the integrated comprehensive mental health program;

(2) in the mental health trust settlement income account, if any, that is not reasonably necessary to meet the projected operating and capital expenses of the integrated comprehensive mental health program that may be transferred into the general fund; and

(3) of the expenditures the authority intends to make under AS 37.14.041 and 37.14.045, including the specific purposes and amounts of any grants or contracts as part of the state's integrated comprehensive mental health program.

(b) When the authority submits its proposed budget under (a) of this section, the authority shall also provide a report to the Legislative Budget and Audit Committee, the governor, the Office of Management and Budget, the commissioner of health and social services, and all entities providing services with money in the mental health trust settlement income account, and shall make it available to the public. The report must describe at least the following:

(1) the assets, earnings, and expenditures of the trust as of the end of the preceding fiscal year;

(2) comparisons of the trust's assets, earnings, and expenditures with the prior five fiscal years;

(3) projections of the trust's assets, earnings, and expenditures for the next five fiscal years;

(4) the authority's budget recommendations submitted under (a) of this section, and its reasons for making those recommendations;

(5) the authority's guidelines for the establishment of services; the provision of services shall be based on the principle that services paid for from the trust are provided to recipients as close to the recipient's home and family as practical with due consideration of demographics, mental health service requirements, use of mental health services, economic feasibility, and capital expenditures required for provision of minimum levels of service;

(6) forecasts of the number of persons needing services;

(7) projections of the resources required to provide the necessary services and facilities; and

(8) reviews of the status of the integrated comprehensive mental health program, including evaluation of program goals, objectives, targets and timelines, and overall effectiveness.

Sec. 47.30.050. [Repealed, Sec. 7 ch 84 SLA 1981].
Repealed or Renumbered

Sec. 47.30.051. Submissions requiring use of trust money.
An agency or entity proposing an expenditure of money by the trust shall present its proposal to the authority under regulations adopted under AS 47.30.031.

Sec. 47.30.056. Use of money in the mental health trust settlement income account.
(a) The money in the mental health trust settlement income account established in AS 37.14.036 shall be used as provided in AS 37.14.041, including to
(1) provide an integrated comprehensive mental health program as required by this section;
(2) meet the authority's annual administrative expenses; and
(3) offset the effect of inflation on the mental health trust fund.
(b) Expenditures under (a)(1) of this section shall provide for a reasonable level of necessary services to
(1) the mentally ill;
(2) the mentally defective and retarded;
(3) chronic alcoholics suffering from psychoses;
(4) senile people who as a result of their senility suffer major mental illness; and
(5) other persons needing mental health services, as the legislature may determine.
(c) The integrated comprehensive mental health program for which expenditures are made under this section
(1) shall give priority in service delivery to persons who, as a result of a mental disorder or of a disorder identified in (b) of this section;
   (A) may require or are at risk of hospitalization; or
   (B) experience such major impairment of self-care, self-direction, or social and economic functioning that they require continuing or intensive services;
 (2) may, at the discretion of the board, include services to persons who are not included under (b) or (c)(1) of this section.
(d) In (b)(1) of this section, "the mentally ill" includes persons with the following mental disorders:
   (1) schizophrenia;
   (2) delusional (paranoid) disorder;
   (3) mood disorders;
   (4) anxiety disorders;
   (5) somatoform disorders;
   (6) organic mental disorders;
   (7) personality disorders;
   (8) dissociative disorders;
   (9) other psychotic or severe and persistent mental disorders manifested by behavioral changes and symptoms of comparable severity to those manifested by persons with mental disorders listed in this subsection; and
   (10) persons who have been diagnosed by a licensed psychologist, psychiatrist, or physician licensed to practice medicine in the state and, as a result of the diagnosis, have been determined to have a childhood disorder manifested by behaviors or symptoms suggesting risk of developing a mental disorder listed in this subsection.
(e) In (b)(2) of this section, "the mentally defective and retarded" includes persons with the following neurologic or mental disorders:
   (1) cerebral palsy;
   (2) epilepsy;
   (3) mental retardation;
   (4) autistic disorder;
   (5) severe organic brain impairment;
   (6) significant developmental delay during early childhood indicating risk of developing a disorder listed in this subsection;
   (7) other severe and persistent mental disorders manifested by behaviors and symptoms similar to those manifested by persons with disorders listed in this subsection.
(f) In (b)(3) of this section, "chronic alcoholics suffering from psychoses" includes persons with the following disorders:
(1) alcohol withdrawal delirium (delirium tremens);
(2) alcohol hallucinosis;
(3) alcohol amnestic disorder;
(4) dementia associated with alcoholism;
(5) alcohol-induced organic mental disorder;
(6) alcoholic depressive disorder;
(7) other severe and persistent disorders associated with a history of prolonged or excessive drinking or episodes of drinking out of control and manifested by behavioral changes and symptoms similar to those manifested by persons with disorders listed in this subsection.

(g) In (b)(4) of this section, "senile people who as a result of their senility suffer major mental illness" includes persons with the following mental disorders:
   (1) primary degenerative dementia of the Alzheimer type;
   (2) multi-infarct dementia;
   (3) senile dementia;
   (4) presenile dementia;
   (5) other severe and persistent mental disorders manifested by behaviors and symptoms similar to those manifested by persons with disorders listed in this subsection.

(h) The authority shall adopt regulations defining the disorders identified in this section to reflect revisions in the diagnostic nomenclature of the health professions serving the beneficiaries of the trust. The authority shall review and revise the regulations as necessary. Regulations adopted under this subsection must be in the long term best interest of the trust and of persons with disorders equivalent to those identified in (b) and (c) of this section.

(i) In this section, "an integrated comprehensive mental health program"
   (1) means public health programs and services that, on December 16, 1994, are separately recognizable and administered, without regard to the administrative unit directly responsible for the delivery of the service; among the services included are services for the mentally ill, community mental health services, services for the developmentally disabled, alcoholism services, and services for children, youth, adults, and seniors with mental disorders;
   (2) includes, at a minimum, each of the following services as appropriate:
      (A) emergency services on a 24-hour basis;
      (B) screening examination and evaluation services required to complete the involuntary commitment process under AS 47.30.700 - 47.30.815;
      (C) inpatient care;
      (D) crisis stabilization services, which may include:
         (i) active community outreach;
         (ii) in-hospital contact;
         (iii) mobile crisis teams of mental health professionals;
         (iv) crisis beds to provide a short term residential program for persons experiencing an acute episode of mental illness that requires temporary removal from a home environment;
      (E) treatment services, which may include
         (i) diagnosis, testing, and evaluation of medical needs;
         (ii) medication monitoring;
         (iii) physical examinations;
         (iv) dispensing psychotropic and other medication;
         (v) detoxification;
         (vi) individual or group therapy;
         (vii) aftercare;
      (F) case management, which may include
(i) evaluation of needs;
(ii) development of individualized treatment plans;
(iii) enhancement of access to available resources and programs;
(iv) development of interagency contacts and family involvement;
(v) advocacy;
(G) daily structure and support, which may include
(i) daily living skills training;
(ii) socialization activities;
(iii) recreation;
(iv) transportation;
(v) day care services;
(vi) client and care provider education and support services;
(H) residential services, which may include
(i) crisis or respite care;
(ii) board and care;
(iii) foster care, group homes, halfway houses, or supervised apartments;
(iv) intermediate care facilities;
(v) long-term care facilities;
(vi) in-home care;
(I) vocational services, which may include
(i) prevocational services;
(ii) work adjustment;
(iii) supported work;
(iv) sheltered work;
(v) training in which participants achieve useful work experience;
(J) outpatient screening, diagnosis, and treatment services, including individual, family,
and group psychotherapy, counseling, and referral;
(K) prevention and education services, including consultation with organizations,
providers, and the public; and
(L) administrative services, including appropriate operating expenses of state agencies
and other service providers.

(j) The authority shall adopt regulations regarding the services described in (i) of this
section to reflect advances in the appropriate professions. The authority shall review and
revise the regulations as necessary. Regulations adopted under this subsection must be in the
long term best interest of the mental health trust.

Sec. 47.30.060. [Repealed, Sec. 7 ch 84 SLA 1981].
Repealed or Renumbered

Sec. 47.30.061. Definitions.
In AS 47.30.011 - 47.30.061,
(1) "authority" means the Alaska Mental Health Trust Authority established by AS
47.30.011;
(2) "board" means the board of trustees of the authority;
(3) "trust" means the trust established by the Alaska Mental Health Enabling Act of

Sec. 47.30.070. - 47.30.170 [Repealed, Sec. 7 ch 84 SLA 1981].
Repealed or Renumbered
Sec. 47.30.180. [Renumbered as AS 47.30.880].
Repealed or Renumbered

Sec. 47.30.190 - 47.30.340 [Repealed, Sec. 7 ch 84 SLA 1981].
Repealed or Renumbered
Sec. 47.30.350. Powers and duties of department.
(a) The department shall
   (1) develop and submit to the Surgeon General of the United States Public Health Service a comprehensive program for the constructing and equipping of hospitals and other facilities for the examination, observation, care, and treatment of the mentally ill;
   (2) develop and submit to the Surgeon General plans and specifications for the constructing and equipping of the hospitals and other facilities;
   (3) construct and equip the hospitals and other facilities in accordance with the program, plans, and specifications approved by the Surgeon General; construction and equipping under this paragraph is governed by AS 36.30 (State Procurement Code);
   (4) cooperate, coordinate, and contract, wherever indicated and desirable, with other state boards, departments and agencies, and agencies of the United States in the construction program, and hire necessary personnel and enter into contracts with private individuals and companies, to the end that the hospitals and other facilities are constructed in the most economical and expeditious manner; contracting and construction under this section are governed by AS 36.30 (State Procurement Code).
(b) An action, agreement, or transaction taken or entered before April 3, 1957, by the Mental Health Authority consistent with AS 47.30.350 - 47.30.400 is affirmed and ratified.

Sec. 47.30.360. Acceptance of funds.
The department may accept on behalf of the state and deposit separate and apart from other public funds grants from the federal government or gifts or contributions from other sources to assist in carrying out the purposes of AS 47.30.350 - 47.30.400 and may expend the funds for those purposes.

Sec. 47.30.370. Review by legislative budget and audit committee.
Before implementation, the programs, plans and actions of the department made under AS 47.30.350, except for the proposed geographic location of the mental health hospital, shall be reviewed by the legislative budget and audit committee. The review and findings of the budget and audit committee shall be made public.

Sec. 47.30.380. Appropriation authorized.
Funds to carry out AS 47.30.350 - 47.30.400 shall be set out in the appropriation bill authorizing the operating and capital expenditures of the state's integrated comprehensive mental health program under AS 37.14.003(a) and submitted to the legislature under AS 37.07.020(a)(1).

Sec. 47.30.390. Acquisition of existing mental health care facilities.
The department may acquire existing facilities for mental health care.

Sec. 47.30.400. Purpose of AS 47.30.350 - 47.30.400.
The purpose of AS 47.30.350 - 47.30.400 is to provide for the constructing and equipping of hospitals and other facilities in this state needed for carrying out a comprehensive mental health program, to accept the benefits of 42 U.S.C. 274, and to authorize the department to take action necessary to accomplish these purposes.
Article 03. UNIFORM ACT FOR THE EXTRADITION OF PERSONS OF UNSOUND MIND

Sec. 47.30.410. Persons subject to extradition.
A person alleged to be of unsound mind found in this state, who has fled from another state, shall, on demand of the executive authority of the state from which the person fled, be delivered up to be removed to the state where, at the time of the flight the person

(1) was under detention by law in a hospital, asylum or other institution for the insane as a person of unsound mind;

(2) had been determined by legal proceedings to be of unsound mind, the finding being unreversed and in full force and effect, and the control of the person having been acquired by a court of competent jurisdiction of the state from which the person fled; or

(3) was subject to detention in that state, which was then the person's legal domicile (personal service of process having been made) based on legal proceedings there pending to have the person declared of unsound mind.

Sec. 47.30.420. Extradition proceedings.
If the executive authority of a state demands of the executive authority of this state a fugitive under AS 47.30.410 and produces a copy of the commitment decree or other judicial process and proceedings, certified as authentic by the governor or chief magistrate of the state from which the person so charged has fled, with an affidavit made before a proper officer showing the person to be a fugitive, the executive authority of this state shall have the fugitive apprehended and secured, if found in this state, and have immediate notice of the apprehension given to the executive authority making the demand, or to the agent of that authority appointed to receive the fugitive, and have the fugitive delivered to the agent when the agent appears. If no agent appears within 30 days from the time of the apprehension the fugitive may be discharged. All costs and expenses incurred in the apprehending, securing, maintaining and transmitting the fugitive to the state making the demand shall be paid by that state. An agent so appointed who receives the fugitive into custody is empowered to transmit the fugitive to the state from which the fugitive fled. The executive authority of this state may, on the application of a person interested, demand the return to this state of a fugitive under AS 47.30.410 - 47.30.460.

Sec. 47.30.430. Time to commence proceedings.
All proceedings under AS 47.30.410 - 47.30.460 shall be begun within one year after the flight referred to in AS 47.30.410.

Sec. 47.30.440. Interpretation and construction.
AS 47.30.410 - 47.30.460 shall be so interpreted and construed as to effectuate its general purpose to make uniform the law of those states that enact it.

Sec. 47.30.450. Definitions.
In AS 47.30.410 - 47.30.460

(1) "executive authority," "governor," and "chief magistrate," respectively, as applied to a request to return a person under AS 47.30.410 - 47.30.460 to or from the District of Columbia, include a justice of the supreme court of the District of Columbia and other authority;

(2) "flight" and "fled" mean a voluntary or involuntary departure from the jurisdiction of the court where the proceedings mentioned in AS 47.30.410 - 47.30.460 have been instituted and are still pending, with the effect of avoiding, impeding, or delaying the action of the court in which the proceedings have been instituted or are pending, or a voluntary or
involuntary departure from the state where the person demanded then was, if the person then
was under detention by law as a person of unsound mind and subject to detention;
(3) "state" includes states, territories, districts, and insular and other possessions of the
United States.

Sec. 47.30.460. Short title.
AS 47.30.410 - 47.30.460 may be cited as the Uniform Act for the Extradition of Persons of
Unsound Mind.

Article 04. ALCOHOLICS

Sec. 47.30.470. Powers and duties of department.
The department shall:
(1)ascertain and keep current a list of all institutions in the state that have available
facilities for the care and treatment of alcoholics and drug abusers;
(2)encourage the development and advancement of standards of treatment of alcoholics
and drug abusers in institutions;
(3) promote and encourage educational activities to make the public aware of the effects
of intemperate use of alcoholic beverages and drugs, and promote and encourage the
education of the general public about scientific facts regarding alcoholism and drug abuse;
(4) identify and utilize whatever facilities and services are available or can be made
available through community organization for carrying out the purposes of this section,
including identification and utilization for detoxification of under-utilized hospital beds;
(5) engage in research and educational activities that will aid in the understanding of
alcoholism and drug abuse and in the treatment of alcoholics and drug abusers;
(6) administer a community grant-in-aid program for alcoholism and drug abuse;
(7) submit an annual report concerning alcoholism and drug abuse in the state and the
grant-in-aid program within 10 days after the convening of the legislature in each regular
session;
(8) prepare that part of the plan for the integrated comprehensive mental health program
under AS 47.30.056 that relates to the services and facilities that are necessary for the care
and treatment of persons identified as chronic alcoholics suffering from psychoses, as
defined in AS 47.30.056(b)(3) and (f); in preparing the plan of services for persons identified
in this paragraph, the department shall coordinate with the Alaska Mental Health Trust
Authority and the Advisory Board on Alcoholism and Drug Abuse;
(9) use money awarded to the department by grant or contract from the mental health
trust settlement income account established under AS 37.14.036 and appropriated from the
general fund to provide the necessary services identified in (8) of this section and in
accordance with AS 47.30.056.

Sec. 47.30.475. Grant-in-aid program.
(a) A nonprofit corporation, a city or borough government, or other political subdivision
of the state, or a combination of these, is eligible for grant-in-aid funds under this section.
Applications shall be sent to the department.
(b) Money available under this section shall be awarded by the department to applicants
on the basis of community need, but only after consideration of comment and advice of the
Advisory Board on Alcoholism and Drug Abuse. In awarding grants, the department shall
further consider the amount of money that is available for all applications and whether an
application would contribute to the wise development of a comprehensive program of
alcoholic and drug abuse rehabilitation and prevention.
(c) Grants shall be awarded in a ratio of 90 percent state money to 10 percent community money for the costs of providing staff and limited improvement, renovation, or new construction of facilities for alcohol or drug detoxification, rehabilitation, or "half-way house" care. The department may waive all or part of the requirement that state money be matched by community money if the department finds that community money is unavailable and waiver of the requirement is in the best interests of the state. A grant for improving, renovating, or constructing may not exceed $50,000 except when there is a lack of applicants for available money and then only with the approval of the Advisory Board on Alcoholism and Drug Abuse. The department is not required to award all money available under this program, or the full percentages specified in this subsection, when another source of money is available or could reasonably be made available to the applicant.

(d) Money used by the applicant to qualify for state money may be from any source other than the state. The cost of developing an application is not reimbursable from the grant. The value of real property to be used directly in conjunction with the grant may be used in calculating the required amount of community money, as allowed by regulations of the department.

(e) A grant may not be awarded under this section unless the application includes a plan that provides for

1. the expenditure of grant money for education and other preventative measures, or the treatment of alcoholics and drug abusers;
2. the reception of advice and comment from a local advisory board, or, if a local advisory board cannot be formed because the area is sparsely populated, from the governing bodies of private nonprofit health organizations, regarding the design, implementation, and evaluation of the plan and action to be taken;
3. goals, expressed in quantifiable terms that express the intended effect of the assistance provided under the plan upon the number of individuals needing or utilizing that assistance;
4. [Repealed, Sec. 21 ch 6 SLA 1993].

(f) The department shall monitor the implementation of the plan required under (e) of this section, and shall terminate payment of grant money if the plan is not implemented or approval of the program as a public or private treatment program under AS 47.37.140 is not granted within one year of the award of the grant, or is suspended, revoked, limited, or restricted. Modification of the plan required by (e) of this section shall be approved by the department before implementation of the modification.

(g) The department shall provide management training for persons administering a program receiving grant money under this section.

(h) If the department determines, after the award of a grant under (c) of this section, that the community is capable of bearing a greater portion of the cost of a program than originally determined, the department may

1. reduce the award by that portion of the cost of a program that the department subsequently determined the community could bear; or
2. terminate payment of the grant entirely.

Sec. 47.30.477. Grant-in-aid program regulations.
The department shall adopt regulations implementing AS 47.30.475. The regulations must provide for the method of application, the time for consideration of applications, the processing of applications, the type of record keeping, the requirements for reporting the progress and statistics regarding the program, and the notification of the applicant as to the action taken on the application. The department shall also establish the necessary forms of application and may adopt other regulations considered necessary to meet the requirements
of health and safety and the orderly administration of the grant-in-aid program. The regulations must include reporting requirements that will permit an evaluation of the success of the program.

Sec. 47.30.480. Judicial notice.
The superior courts of this state may take judicial notice of the fact that an alcoholic is suffering from an illness and is in need of proper medical, advisory, or rehabilitative treatment.

Sec. 47.30.490. Acceptance of funds.
The department may accept on behalf of the state and deposit, apart from other public funds, grants from the federal government or gifts or contributions from other sources to assist in carrying out the purposes of AS 47.30.470.

Sec. 47.30.500. Definitions.
In AS 47.30.470 - 47.30.490
(1) "alcoholism" means a condition related to alcohol and concerns a physical compulsion which exists, coupled with a mental obsession;
(2) "costs of improvement, renovation, or new construction of facilities" includes, in addition to costs directly related to the project, the sum total of all costs of financing and carrying out the project; these include, but are not limited to, the costs of all necessary studies, surveys, plans and specifications, architectural, engineering or other special services, acquisition of real property, site preparation and development, purchase, construction, reconstruction and improvement of real property, and the acquisition of machinery and equipment as may be necessary in connection with the project; an allocable portion of the administrative and operating expenses of the grantee; the cost of financing the project, including interest on bonds issued to finance the project; and the cost of other items, including any indemnity and surety bonds and premiums on insurance, legal fees, fees and expenses of trustees, depositaries, financial advisors, and paying agents for the bonds issued as the issuer considers necessary;
(3) "department" means the Department of Health and Social Services;
(4) [Repealed, Sec. 33 ch 23 SLA 1995].

Article 05. COMMUNITY MENTAL HEALTH SERVICES ACT

Sec. 47.30.520. Legislative purpose.
It is the purpose of the Community Mental Health Services Act to
(1) provide a range of community based inpatient, outpatient, and support services for persons with mental disorders;
(2) assist communities in planning, organizing, and financing community mental health services through locally developed, administered, and controlled community mental health programs;
(3) better develop and use resources at both state and local levels;
(4) develop and implement plans for comprehensive mental health services based on demonstrated need on a regional basis;
(5) improve the effectiveness of existing mental health services;
(6) integrate state-operated and community mental health programs into a unified mental health system;
(7) ensure that consumers, families, and representatives of communities within mental health planning regions can participate in planning for, determining the need for, and allocating mental health resources;

(8) provide a means of allocating money available for state mental health services according to community needs;

(9) encourage the full use of all existing public or private agencies, facilities, personnel, and funds to accomplish these objectives; and

(10) prevent unnecessary duplication and fragmentation of services and expenditures.

Sec. 47.30.523. Community mental health program policy and principles.

(a) It is the policy of the state that

(1) the community mental health program provide a comprehensive and integrated system of community based facilities, supports, and mental health services including child and adolescent screening and diagnosis, inpatient, outpatient, prevention, consultation, and education services;

(2) persons most in need of community mental health services receive appropriate services as provided under AS 47.30.056;

(3) the community mental health program be coordinated, to the maximum extent possible, with the programs established under AS 47.37, AS 47.65, AS 47.80, and other programs affecting the well being of persons in need of mental health services.

(b) Community mental health program service delivery principles include the principles that persons

(1) have ready and prompt access to necessary screening, diagnosis, and treatment;

(2) receiving community mental health services be informed of their rights, including their rights to confidentiality and to treatment with dignity;

(3) be provided community mental health services by staff and programs that reflect the culture, linguistic, and other social characteristics of their community and that incorporate multidisciplinary professional staff to meet client functional levels and diagnostic and treatment needs;

(4) in need of community mental health services, and their families, be encouraged to participate in formulating, delivering, and evaluating treatment and rehabilitation;

(5) in need of community mental health services be provided treatment and rehabilitation services designed to minimize institutionalization and maximize individual potential;

(6) be treated in the least restrictive alternative environment consistent with their treatment needs, enabling the person to live as normally as possible;

(7) be provided necessary treatment as close to the person's home as possible;

(8) be informed of and allowed to participate in planning their own treatment as much as possible.

Sec. 47.30.530. Duties of department.

(a) The department shall administer the provisions of AS 47.30.520 - 47.30.620 and shall

(1) define and develop standards for various levels and qualities of mental health care;

(2) provide fiscal and professional technical assistance in planning, organizing, developing, implementing, and administering local mental health services;

(3) develop budgets and receive and distribute state appropriations and funds in accordance with the provisions of AS 47.30.520 - 47.30.620;

(4) establish standards of education and experience for professional, technical, and administrative personnel employed in community mental health services;
(5) assist the community in establishing the organization and operation of community mental health services;

(6) develop a standardized system for measuring and reporting to the department the types, quantities, and quality of services; and develop a cost accounting system that will demonstrate the cost of various levels and qualities of care;

(7) provide each local community planning and services delivery entity with statistics, reports, and other data relevant to development of indices indicating the need for mental health services, or relevant to evaluating the effectiveness of existing services;

(8) review each local community plan and require each plan to include
   (A) an affirmative showing that the most effective and economic use will be made of all available public and private resources in the community including careful consideration of the most effective and economic alternative forms and patterns of services;
   (B) a five-year projection of needs, services, and resources; and
   (C) adequate provisions for review and evaluation of services provided in the local community;

(9) adopt regulations and establish priorities, after consultation with local communities affected and in conjunction with the Alaska Mental Health Board, that are necessary to carry out the purposes of AS 47.30.520 - 47.30.620.

(b) In performing its duties under (a) of this section, the department shall coordinate with the Alaska Mental Health Trust Authority established in AS 47.30.011.

Sec. 47.30.540. Eligible local community entities.

(a) A city or borough government or other political subdivision of the state, a nonprofit corporation, or a combination of these, is eligible to receive funds and administer local programs under AS 47.30.520 - 47.30.620. In order to ensure equitable access to funds and programs through the state, the department shall determine appropriate geographical areas to be served by local programs in consultation with representatives of the geographical areas in question.

(b) An entity designated by the department to receive money under AS 47.30.520 - 47.30.620 shall ensure a broad base of community support as evidenced by a governing board reasonably representative of the professional, civic, and citizen groups in the community and including persons with mental disorders or family members of persons with mental disorders. No more than two members, or 40 percent of the membership, whichever is greater, may be providers of services under the program. In order to receive money under AS 47.30.520 - 47.30.620, a local community entity shall agree

1) to give priority to mental health programs and services consistent with the priorities set out in AS 47.30.056 and that provide the maximum services for the least expenditure of money from the mental health trust settlement income account;

2) to furnish services through a qualified staff meeting reasonable standards of experience and training;

3) to conform to a state cost accounting system showing the true cost of services rendered, collect fees for services according to a schedule based on an analysis of reasonable ability to pay, and provide that a person may not be refused services because of inability to pay for those services;

4) to maintain adequate clinical and administrative records and furnish periodic reports to the department;

5) to furnish the authority and the department an annual report of the preceding fiscal year, including an evaluation of the effectiveness of the previous year's programs and their costs;
(6) to furnish the authority and the department satisfactory needs assessments for the population and area it serves and an annual update of a long-range planning and budget statement that describes program goals for the coming year, the steps and resources necessary to implement the goals, the projected means by which these resources will be secured, and the procedures necessary to evaluate the program;

(7) to furnish the department with confidential and other information about recipients of services paid for, in whole or part, under AS 47.30.520 - 47.30.620 and comply with regulations of the department regarding the submission of this information; and

(8) to notify the department immediately of emergency situations involving recipients of services paid for, in whole or in part, under AS 47.30.520 - 47.30.620 and comply with regulations of the department regarding this notification; for purposes of this paragraph, "emergency situations" include the disappearance, injury, or death of a recipient.

(c) Members of local governing boards may be reimbursed for necessary travel expenses incurred in the organization and operation of local programs as may be determined by the department.

Sec. 47.30.545. Populations to be served.
The entities designated by the department to receive money under AS 47.30.540(b) shall provide one or more of the services that are set out in AS 47.30.056(i) to persons identified in AS 47.30.056.

Sec. 47.30.546. Services for mentally and emotionally disturbed. [Repealed, Sec. 49 ch 66 SLA 1991].

Repealed or Renumbered

Sec. 47.30.547. Standards for community mental health services.
An entity that provides community mental health services shall

(1) make services available at times and locations that enable residents of the entity's service area to obtain services readily;

(2) ensure each client's right to confidentiality and treatment with dignity;

(3) establish staffing patterns of qualified and trained personnel that reflect the cultural, linguistic, and other social characteristics of the community and that incorporate multidisciplinary professional staff to meet client functional levels and diagnostic and treatment needs;

(4) promote client and family participation in formulating, delivering, and evaluating treatment and rehabilitation;

(5) design screening, diagnosis, treatment, and rehabilitation services to maximize individual potential and to minimize institutionalization; and

(6) provide services in the least restrictive setting, enabling the person receiving the services to live as normally as possible.

Sec. 47.30.550. Cost sharing formula; limitations.

(a) In a district designated by the department as a poverty area, the department may fund not more than 90 percent of the eligible costs of the community mental health services to be furnished under an entity's approved plan.

(b) In a district that has not been designated by the department as a poverty area, the department may fund not more than 75 percent of the eligible costs of the community mental health services to be furnished under an entity's approved plan.

(c) Notwithstanding (a) and (b) of this section, if the department determines that sufficient funds from other sources are unavailable, then the department shall fund the percent of the eligible costs that is necessary in order to ensure that services for chronically
mentally ill adults and severely mentally ill children, and other community mental health services to be furnished under an entity's approved plan are made available by the entity. Funding under this subsection is subject to the availability of legislative appropriations for the purpose.

(d) Income earned by an entity through a community mental health project funded under AS 47.30.520 - 47.30.620 shall be used to augment or enhance the entity's mental health services.

(e) In (a) and (b) of this section, "poverty area" means a census district in which at least 15 percent of the population, based upon the most recent census date, falls under 125 percent of the United States Department of Health and Human Services' Poverty Income Guidelines for Alaska, as reported in the Federal Register.

Sec. 47.30.560. Funds for local programs.
The contracts for services provided for in AS 47.30.520 - 47.30.620 shall be reviewed, revised if necessary, and approved at the expiration of each contract year. A contract shall be approved if the department finds that the community entity has complied with its plan, AS 47.30.520 - 47.30.620, and any applicable regulations adopted by the department. Expenditures for the purchase of services shall be made in accordance with the approved contract, budgets, and program projections.

Sec. 47.30.570. Eligible costs; maintenance of local effort.
The department shall adopt regulations specifying the types of services and program costs eligible for state participation. These regulations must include

1. a provision excluding capital expenditures as eligible costs; and
2. a requirement that the community entity contractor or applicant agrees as a condition of contract approval that it will not supplant existing local fund support of community mental health services with funds received under AS 47.30.520 - 47.30.620 and that it will continue local funding support of community mental health services, in any year in which it contracts with the department, at a level that is at least equal to the local funding support in the previous year.

Sec. 47.30.580. Comprehensive services.
Plans and regulations adopted under AS 47.30.520 - 47.30.620 must allow local programs sufficient administrative and program flexibility so that local community mental health programs may be joined with other programs such as mental retardation programs, drug abuse programs, alcoholism programs and comprehensive mental health services programs.

Sec. 47.30.590. Patient rights and the confidential nature of records and information.

(a) The department shall adopt regulations to assure patient rights and to safeguard the confidential nature of records and information about the recipients of services provided under this chapter. The regulations must require that entities identified in AS 47.30.540(b) develop and include in any plan submitted for approval adequate provisions for safeguarding confidential information. The regulations must provide for disclosure of confidential information to parents or guardians, to mental health professionals providing services to a recipient, and to other appropriate service agencies when it is in the defined best interests of the patient.

(b) Notwithstanding (a) of this section, the department is authorized to review, obtain, and copy confidential and other records and information about the clients of services requested or furnished under AS 47.30.520 - 47.30.620 to evaluate compliance with those statutes. The department may obtain the records and information regarding clients from the
client or directly from an entity designated by the department under AS 47.30.520 - 47.30.620 that furnished those services. Records obtained by the department under this subsection are medical records, shall be handled confidentially, and are exempt from public inspection and copying under AS 40.25.110 - 40.25.120.

Sec. 47.30.600. Applicability to existing programs. [Repealed, Sec. 6 ch 47 SLA 1987]. Repealed or Renumbered

Sec. 47.30.605. Mental Health Advisory Council. [Repealed, Sec. 13 ch 48 SLA 1987]. Repealed or Renumbered

Sec. 47.30.610. Definitions.
In AS 47.30.520 - 47.30.610,
(1) "authority" means the Alaska Mental Health Trust Authority established in AS 47.30.011;
(2) "department" means the Department of Health and Social Services;
(3) "persons with mental disorders" means persons with disorders currently included within nationally accepted diagnostic systems of the mental health professions;
(4) "trust" has the meaning given in AS 47.30.061.

Sec. 47.30.620. Short title.
AS 47.30.520 - 47.30.620 may be cited as the Community Mental Health Services Act.

Article 06. STATE MENTAL HEALTH POLICY

Sec. 47.30.655. Purpose of major revision.
The purpose of the 1981 major revision of Alaska civil commitment statutes (AS 47.30.660 and 47.30.670 - 47.30.915) is to more adequately protect the legal rights of persons suffering from mental illness. The legislature has attempted to balance the individual's constitutional right to physical liberty and the state's interest in protecting society from persons who are dangerous to others and protecting persons who are dangerous to themselves by providing due process safeguards at all stages of commitment proceedings. In addition, the following principles of modern mental health care have guided this revision:
(1) that persons be given every reasonable opportunity to accept voluntary treatment before involvement with the judicial system;
(2) that persons be treated in the least restrictive alternative environment consistent with their treatment needs;
(3) that treatment occur as promptly as possible and as close to the individual's home as possible;
(4) that a system of mental health community facilities and supports be available;
(5) that patients be informed of their rights and be informed of and allowed to participate in their treatment program as much as possible;
(6) that persons who are mentally ill but not dangerous to others be committed only if there is a reasonable expectation of improving their mental condition.

Sec. 47.30.660. Powers and duties of department.
(a) The department shall
(1) prepare, and periodically revise and amend, a plan for an integrated comprehensive mental health program, as that term is defined by AS 47.30.056(i); the preparation of the plan and any revision or amendment of it shall
   (A) be made in conjunction with the Alaska Mental Health Trust Authority;
   (B) be coordinated with federal, state, regional, local, and private entities involved in mental health services;
(2) in planning expenditures from the mental health trust settlement income account, conform to the regulations adopted by the Alaska Mental Health Trust Authority under AS 47.30.031(b)(6); and
(3) implement an integrated comprehensive system of care that, within the limits of money appropriated for that purpose and using grants and contracts that are to be paid for from the mental health trust settlement income account, meets the service needs of the beneficiaries of the trust established under the Alaska Mental Health Enabling Act of 1956, as determined by the plan.
(b) The department, in fulfilling its duties under this section and through its division of mental health and developmental disabilities, shall
   (1) administer a comprehensive program of services for persons with mental disorders, for the prevention of mental illness, and for the care and treatment of persons with mental disorders, including inpatient and outpatient care and treatment and the procurement of services of specialists or other persons on a contractual or other basis;
   (2) take the actions and undertake the obligations that are necessary to participate in federal grants-in-aid programs and accept federal or other financial aid from whatever sources for the study, prevention, examination, care, and treatment of persons with mental disorders;
   (3) administer AS 47.30.660 - 47.30.915;
   (4) designate, operate, and maintain treatment facilities equipped and qualified to provide inpatient and outpatient care and treatment for persons with mental disorders;
   (5) provide for the placement of patients with mental disorders in designated treatment facilities;
   (6) enter into arrangements with governmental agencies for the care or treatment of persons with mental disorders in facilities of the governmental agencies in the state or in another state;
   (7) enter into contracts with treatment facilities for the custody and care or treatment of persons with mental disorders; contracts under this paragraph are governed by AS 36.30 (State Procurement Code);
   (8) enter into contracts, which incorporate safeguards consistent with AS 47.30.660 - 47.30.915 and the preservation of the civil rights of the patients with another state for the custody and care or treatment of patients previously committed from this state under 48 U.S.C. 46 et seq., and P.L. 84-830, 70 Stat. 709;
   (9) prescribe the form of applications, records, reports, request for release, and consents to medical or psychological treatment required by AS 47.30.660 -47.30.915;
   (10) require reports from the head of a treatment facility concerning the care of patients;
   (11) visit each treatment facility at least annually to review methods of care or treatment for patients;
   (12) investigate complaints made by a patient or an interested party on behalf of a patient;
   (13) delegate upon mutual agreement to another officer or agency of it, or a political subdivision of the state, or a treatment facility designated, any of the duties and powers imposed upon it by AS 47.30.660 - 47.30.915;
(14) after consultation with the Alaska Mental Health Trust Authority, adopt regulations to implement the provisions of AS 47.30.660 - 47.30.915;
(15) provide technical assistance and training to providers of mental health services; and
(16) set standards under which each designated treatment facility shall provide programs to meet patients' medical, psychological, social, vocational, educational, and recreational needs.

Article 07. ALASKA MENTAL HEALTH BOARD

Sec. 47.30.661. Alaska Mental Health Board.
The Alaska Mental Health Board is established. For budgetary purposes, the board is located within the department. The board is the state planning and coordinating agency for the purposes of federal and state laws relating to the mental health program of the state. The purpose of the board is to assist the state in ensuring an integrated comprehensive mental health program.

Sec. 47.30.662. Composition.
(a) The board consists of not fewer than 12 nor more than 16 members appointed by the governor, with due regard for the demographics of the state and balanced geographic representation of the state. The membership and committees of the board shall fulfill the requirements of P.L. 99-660, as amended.
(b) Not less than one-half of the members shall be persons with a mental disorder identified in AS 47.30.056(b)(1) or members of their families.
(c) The board members
(1) shall include the director of the division of mental health and developmental disabilities in the department; and
(2) may include representatives of the principal state agencies with respect to education, vocational rehabilitation, criminal justice, housing, social services, medical assistance, substance abuse, and aging.
(d) Board members appointed under (c) of this section may not vote on matters before the board.
(e) The board members shall include at least two licensed mental health professionals who represent public and private providers of mental health services and at least one member who is admitted to practice law in the state. Members appointed under this subsection may also be family members identified under (b) of this section.

Sec. 47.30.663. Term of office.
(a) Board members serve staggered terms of three years.
(b) A vacancy occurring in the membership of the board shall be filled by appointment of the governor for the unexpired portion of the vacated term.
(c) Members may be removed only for cause, including, but not limited to, poor attendance or lack of contribution to the board's work.

Sec. 47.30.664. Officers and staff.
(a) The board, by a majority of its membership, shall annually elect a chair and other officers it considers necessary from among its membership.
(b) The board shall have a paid staff provided by the department, including, but not limited to, an executive director who shall be selected by the board. The executive director is in the partially exempt service and may hire additional employees in the classified service of
the state. The department shall provide for the assignment of personnel to the board to ensure the board has the capacity to fulfill its responsibilities. The executive director of the board shall be directly responsible to the board in the performance of the director's duties.

Sec. 47.30.665. Bylaws.
The board, on approval of a majority of its membership and consistent with state law, shall adopt and amend bylaws governing its composition, proceedings, and other activities consistent with state law and including, but not limited to, provisions concerning a quorum to transact board business and other aspects of procedure, frequency and location of meetings, and establishment, functions, and membership of committees.

Sec. 47.30.666. Duties of the board.
The board is the state planning and coordinating body for the purpose of federal and state laws relating to mental health services for persons with mental disorders identified in AS 47.30.056(b)(1). On behalf of those persons, the board shall

(1) prepare and maintain a comprehensive plan of treatment and rehabilitation services;
(2) propose an annual implementation plan consistent with the comprehensive plan and with due regard for the findings from evaluation of existing programs;
(3) provide a public forum for the discussion of issues related to the mental health services for which the board has planning and coordinating responsibility;
(4) advocate the needs of persons with mental disorders before the governor, executive agencies, the legislature, and the public;
(5) advise the legislature, the governor, the Alaska Mental Health Trust Authority, and other state agencies in matters affecting persons with mental disorders, including, but not limited to,
   (A) development of necessary services for diagnosis, treatment, and rehabilitation;
   (B) evaluation of the effectiveness of programs in the state for diagnosis, treatment, and rehabilitation;
   (C) legal processes that affect screening, diagnosis, treatment, and rehabilitation;
   (6) provide to the Alaska Mental Health Trust Authority for its review and consideration recommendations concerning the integrated comprehensive mental health program for those persons who are described in AS 47.30.056(b)(1) and the use of money in the mental health trust settlement income account in a manner consistent with regulations adopted under AS 47.30.031; and
   (7) submit periodic reports regarding its planning, evaluation, advocacy, and other activities.

Sec. 47.30.667. Compensation, per diem, and expenses.
The board members appointed under AS 47.30.662(b) and (e) are not entitled to a salary, but are entitled to per diem, reimbursement for travel, and other expenses authorized by law for boards and commissions under AS 39.20.180.
Sec. 47.30.669. Definition.
In AS 47.30.661 - 47.30.669, "board" means the Alaska Mental Health Board established in AS 47.30.661.

Article 08. VOLUNTARY ADMISSION FOR TREATMENT

Sec. 47.30.670. Standards for voluntary admission.
A person 18 years of age or older may be voluntarily admitted to a treatment facility if the person is suffering from mental illness and voluntarily signs the admission papers.
Sec. 47.30.675. Notice of rights.
(a) Upon the application of a person for voluntary admission, or at the time a person admitted under AS 47.30.690 reaches the age of 18, the person shall be given a copy of the following documents which shall be explained as necessary:
   (1) notice of rights as set out in AS 47.30.825 - 47.30.865 and an explanation of any document served upon the person; and
   (2) notice that should the person desire to leave at a time when the treatment facility determines that the person is mentally ill and as a result is likely to cause serious harm to self or others or is gravely disabled, the facility could initiate commitment proceedings against the person.
(b) If an applicant for voluntary admission does not understand English, the explanation shall be given in a language the applicant understands.

Sec. 47.30.680. Discharge of voluntary patients.
A patient who no longer meets the standards established in AS 47.30.670 shall be discharged from the treatment facility.

Sec. 47.30.685. Request to leave; evaluation; 48-hour hold for commitment.
A voluntary patient who is 18 years of age or older and who desires to leave a treatment facility shall submit to the facility a request to leave on a form provided by the facility. When the investigation is completed, the patient shall be evaluated immediately in writing and discharged immediately or given written notice that involuntary commitment proceedings will be initiated against the patient. The treatment facility may detain the patient for no more than 48 hours after receipt of the patient's request to leave in order to initiate involuntary commitment proceedings.

Sec. 47.30.690. Admission of minors under 18 years of age.
(a) A minor under the age of 18 may be admitted for 30 days of evaluation, diagnosis, and treatment at a designated treatment facility if the minor's parent or guardian signs the admission papers and if, in the opinion of the professional person in charge,
   (1) the minor is gravely disabled or is suffering from mental illness and as a result is likely to cause serious harm to the minor or others;
   (2) there is no less restrictive alternative available for the minor's treatment; and
   (3) there is reason to believe that the minor's mental condition could be improved by the course of treatment or would deteriorate further if untreated.
(b) A guardian ad litem for a minor admitted under this section shall be appointed under AS 25.24.310 to monitor the best interests of the minor as soon as possible after the minor's admission. If the guardian ad litem finds that placement is not appropriate, the guardian ad litem may request that an attorney be appointed under AS 25.24.310 to represent the minor. The attorney may request a hearing on behalf of the minor during the 30-day admittance.
(c) The minor may be released by the treatment facility at any time if the professional person in charge or the minor's designated mental health professional determines the minor would no longer benefit from continued treatment and the minor is not dangerous. The minor's parents or guardian must be notified by the facility of the contemplated release.

Sec. 47.30.693. Notice to parent or guardian or minor.
When a minor under 18 years of age is detained at or admitted or committed to a treatment facility, the facility shall inform the parent or guardian of the location of the minor as soon as possible after the arrival of the minor at the facility.
Sec. 47.30.695. Notice of request for release of minors under 18 years of age from detention and commitment.
The parent or guardian of a minor who is less than 18 years of age may file a notice to withdraw the minor from the facility. On receipt of the notice, the facility may

(1) discharge the minor to the custody of the parent or guardian; or
(2) if, in the opinion of the treating physician, release of the minor would be seriously detrimental to the minor's health, the treating physician may

(A) discharge the minor to the custody of the parent or guardian after advising the parent or guardian that this action is against medical advice and after receiving a written acknowledgement of the advice; or
(B) refuse to discharge the minor, initiate involuntary commitment proceedings, and continue to hold the minor until a court order under AS 47.30.700 has been issued; or
(3) if, in the opinion of the treating physician, the minor is likely to cause serious harm to self or others and there is reason to believe the release could place the minor in imminent danger, the treating physician shall refuse to discharge the minor, and shall initiate involuntary commitment proceedings and continue to hold the minor until a court order under AS 47.30.700 has been issued.

Article 09. INVOLUNTARY ADMISSION FOR TREATMENT

Sec. 47.30.700. Initiation of involuntary commitment procedures.
(a) Upon petition of any adult, a judge shall immediately conduct a screening investigation or direct a local mental health professional employed by the department or by a local mental health program that receives money from the department under AS 47.30.520 - 47.30.620 or another mental health professional designated by the judge, to conduct a screening investigation of the person alleged to be mentally ill and, as a result of that condition, alleged to be gravely disabled or to present a likelihood of serious harm to self or others. Within 48 hours after the completion of the screening investigation, a judge may issue an ex parte order orally or in writing, stating that there is probable cause to believe the respondent is mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others. The court shall provide findings on which the conclusion is based, appoint an attorney to represent the respondent, and may direct that a peace officer take the respondent into custody and deliver the respondent to the nearest appropriate facility for emergency examination or treatment. The ex parte order shall be provided to the respondent and made a part of the respondent's clinical record. The court shall confirm an oral order in writing within 24 hours after it is issued.

(b) The petition required in (a) of this section must allege that the respondent is reasonably believed to present a likelihood of serious harm to self or others or is gravely disabled as a result of mental illness and must specify the factual information on which that belief is based including the names and addresses of all persons known to the petitioner who have knowledge of those facts through personal observation.

Sec. 47.30.705. Emergency detention for evaluation.
A peace officer, a psychiatrist or physician who is licensed to practice in this state or employed by the federal government, or a clinical psychologist licensed by the state Board of Psychologist and Psychological Associate Examiners who has probable cause to believe that a person is gravely disabled or is suffering from mental illness and is likely to cause serious harm to self or others of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS 47.30.700, may cause the
person to be taken into custody and delivered to the nearest evaluation facility. A person taken into custody for emergency evaluation may not be placed in a jail or other correctional facility except for protective custody purposes and only while awaiting transportation to a treatment facility. The peace officer or mental health professional shall complete an application for examination of the person in custody and be interviewed by a mental health professional at the facility.

Sec. 47.30.710. Examination.
(a) A respondent who is delivered under AS 47.30.700 - 47.30.705 to an evaluation facility for emergency examination and treatment shall be examined and evaluated as to mental and physical condition by a mental health professional and by a physician within 24 hours after arrival at the facility.
(b) If the mental health professional who performs the emergency examination has reason to believe that the respondent is (1) mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others, and (2) is in need of care or treatment, the mental health professional may hospitalize the respondent, or arrange for hospitalization, on an emergency basis. If a judicial order has not been obtained under AS 47.30.700, the mental health professional shall apply for an ex parte order authorizing hospitalization for evaluation.

Sec. 47.30.715. Acceptance of order.
When a facility receives a proper order for evaluation, it shall accept the order and the respondent for an evaluation period not to exceed 72 hours. The facility shall promptly notify the court of the date and time of the respondent's arrival. The court shall set a date, time and place for a 30-day commitment hearing, to be held if needed within 72 hours after the respondent's arrival, and the court shall notify the facility, the respondent, the respondent's attorney, and the prosecuting attorney of the hearing arrangements. Evaluation personnel, when used, shall similarly notify the court of the date and time when they first met with the respondent.

Sec. 47.30.720. Release before expiration of 72-hour period.
If at any time in the course of the 72-hour period the mental health professionals conducting the evaluation determine that the respondent does not meet the standards for commitment specified in AS 47.30.700, the respondent shall be discharged from the facility or the place of evaluation by evaluation personnel and the petitioner and the court so notified.

Sec. 47.30.725. Commitment proceeding rights; notification.
(a) When a respondent is detained for evaluation under AS 47.30.660 - 47.30.915, the respondent shall be immediately notified orally and in writing of the rights under this section. Notification must be in a language understood by the respondent. The respondent's guardian, if any, and if the respondent requests, an adult designated by the respondent, shall also be notified of the respondent's rights under this section.
(b) Unless a respondent is released or voluntarily admitted for treatment within 72 hours of arrival at the facility or, if the respondent is evaluated by evaluation personnel, within 72 hours from the beginning of the respondent's meeting with evaluation personnel, the respondent is entitled to a court hearing to be set for not later than the end of that 72-hour period to determine whether there is cause for detention after the 72 hours have expired for up to an additional 30 days on the grounds that the respondent is mentally ill, and as a result
presents a likelihood of serious harm to the respondent or others, or is gravely disabled. The facility or evaluation personnel shall give notice to the court of the releases and voluntary admissions under AS 47.30.700 - 47.30.815.

(c) The respondent has a right to communicate immediately, at the department's expense, with the respondent's guardian, if any, or an adult designated by the respondent and the attorney designated in the ex parte order, or an attorney of the respondent's choice.

(d) The respondent has the right to be represented by an attorney, to present evidence, and to cross-examine witnesses who testify against the respondent at the hearing.

(e) The respondent has the right to be free of the effects of medication and other forms of treatment to the maximum extent possible before the 30-day commitment hearing; however, the facility or evaluation personnel may treat the respondent with medication under prescription by a licensed physician or by a less restrictive alternative of the respondent's preference if, in the opinion of a licensed physician in the case of medication, or of a mental health professional in the case of alternative treatment, the treatment is necessary to

1) prevent bodily harm to the respondent or others;
2) prevent such deterioration of the respondent's mental condition that subsequent treatment might not enable the respondent to recover; or
3) allow the respondent to prepare for and participate in the proceedings.

(f) A respondent, if represented by counsel, may waive, orally or in writing, the 72-hour time limit on the 30-day commitment hearing and have the hearing set for a date no more than seven calendar days after arrival at the facility. The respondent's counsel shall immediately notify the court of the waiver.

Sec. 47.30.730. Procedure for 30-day commitment; petition for commitment.

(a) In the course of the 72-hour evaluation period, a petition for commitment to a treatment facility may be filed in court. The petition must be signed by two mental health professionals who have examined the respondent, one of whom is a physician. The petition must

1) allege that the respondent is mentally ill and as a result is likely to cause harm to self or others or is gravely disabled;
2) allege that the evaluation staff has considered but has not found that there are any less restrictive alternatives available that would adequately protect the respondent or others; or, if a less restrictive involuntary form of treatment is sought, specify the treatment and the basis for supporting it;
3) allege with respect to a gravely disabled respondent that there is reason to believe that the respondent's mental condition could be improved by the course of treatment sought;
4) allege that a specified treatment facility or less restrictive alternative that is appropriate to the respondent's condition has agreed to accept the respondent;
5) allege that the respondent has been advised of the need for, but has not accepted, voluntary treatment, and request that the court commit the respondent to the specified treatment facility or less restrictive alternative for a period not to exceed 30 days;
6) list the prospective witnesses who will testify in support of commitment or involuntary treatment; and
7) list the facts and specific behavior of the respondent supporting the allegation in (1) of this subsection.

(b) A copy of the petition shall be served on the respondent, the respondent's attorney, and the respondent's guardian, if any, before the 30-day commitment hearing.

Sec. 47.30.735. 30-day commitment.
(a) Upon receipt of a proper petition for commitment, the court shall hold a hearing at the date and time previously specified according to procedures set out in AS 47.30.715.

(b) The hearing shall be conducted in a physical setting least likely to have a harmful effect on the mental or physical health of the respondent, within practical limits. At the hearing, in addition to other rights specified in AS 47.30.660 - 47.30.915, the respondent has the right

(1) to be present at the hearing; this right may be waived only with the respondent's informed consent; if the respondent is incapable of giving informed consent, the respondent may be excluded from the hearing only if the court, after hearing, finds that the incapacity exists and that there is a substantial likelihood that the respondent's presence at the hearing would be severely injurious to the respondent's mental or physical health;

(2) to view and copy all petitions and reports in the court file of the respondent's case;

(3) to have the hearing open or closed to the public as the respondent elects;

(4) to have the rules of evidence and civil procedure applied so as to provide for the informal but efficient presentation of evidence;

(5) to have an interpreter if the respondent does not understand English;

(6) to present evidence on the respondent's behalf;

(7) to cross-examine witnesses who testify against the respondent;

(8) to remain silent;

(9) to call experts and other witnesses to testify on the respondent's behalf.

(c) At the conclusion of the hearing the court may commit the respondent to a treatment facility for not more than 30 days if it finds, by clear and convincing evidence, that the respondent is mentally ill and as a result is likely to cause harm to the respondent or others or is gravely disabled.

(d) If the court finds that there is a viable less restrictive alternative available and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment for not more than 30 days if the program accepts the respondent.

(e) The court shall specifically state to the respondent, and give the respondent written notice, that if commitment or other involuntary treatment beyond the 30 days is to be sought, the respondent has the right to a full hearing or jury trial.

Sec. 47.30.740. Procedure for 90-day commitment following 30-day commitment.

(a) At any time during the respondent's 30-day commitment, the professional person in charge, or that person's professional designee, may file with the court a petition for a 90-day commitment of that respondent. The petition must include all material required under AS 47.30.730(a) except that references to "30 days" shall be read as "90 days"; and

(1) allege that the respondent has attempted to inflict or has inflicted serious bodily harm upon the respondent or another since the respondent's acceptance for evaluation, or that the respondent was committed initially as a result of conduct in which the respondent attempted or inflicted serious bodily harm upon the respondent or another, or that the respondent continues to be gravely disabled, or that the respondent demonstrates a current intent to carry out plans of serious harm to the respondent or another;

(2) allege that the respondent has received appropriate and adequate care and treatment during the respondent's 30-day commitment;

(3) be verified by the professional person in charge, or that person's professional designee, during the 30-day commitment.

(b) The court shall have copies of the petition for 90-day commitment served upon the respondent, the respondent's attorney, and the respondent's guardian, if any. The petition for 90-day commitment and proofs of service shall be filed with the clerk of the court, and a date
for hearing shall be set, by the end of the next judicial day, for not later than five judicial
days from the date of filing of the petition. The clerk shall notify the respondent, the
respondent's attorney, and the petitioner of the hearing date at least three judicial days in
advance of the hearing.

(c) Findings of fact relating to the respondent's behavior made at a 30-day commitment
hearing under AS 47.30.735 shall be admitted as evidence and may not be rebutted except
that newly discovered evidence may be used for the purpose of rebutting the findings.

Sec. 47.30.745. 90-day commitment hearing rights.

(a) A respondent subject to a petition for 90-day commitment has, in addition to the
rights specified elsewhere in this chapter, or otherwise applicable, the rights enumerated in
this section. Written notice of these rights shall be served on the respondent and the
respondent's attorney and guardian, if any, and may be served on an adult designated by the
respondent at the time the petition for 90-day commitment is served. An attempt shall be
made by oral explanation to ensure that the respondent understands the rights enumerated in
the notice. If the respondent does not understand English, the explanation shall be given in a
language the respondent understands.

(b) Unless the respondent is released or is admitted voluntarily following the filing of a
petition and before the hearing, the respondent is entitled to a judicial hearing within five
judicial days of the filing of the petition as set out in AS 47.30.740(b) to determine if the
respondent is mentally ill and as a result is likely to cause harm to self or others, or if the
respondent is gravely disabled. If the respondent is admitted voluntarily following the filing
of the petition, the voluntary admission constitutes a waiver of any hearing rights under AS
47.30.740 or under AS 47.30.685. If at any time during the respondent's voluntary admission
under this subsection, the respondent submits to the facility a written request to leave, the
professional person in charge may file with the court a petition for a 180-day commitment of
the respondent under AS 47.30.770. The 180-day commitment hearing shall be scheduled for
a date not later than 90 days after the respondent's voluntary admission.

(c) The respondent is entitled to a jury trial upon request filed with the court if the
request is made at least two judicial days before the hearing. If the respondent requests a jury
trial, the hearing may be continued for no more than 10 calendar days. The jury shall consist
of six persons.

(d) If a jury trial is not requested, the court may still continue the hearing at the
respondent's request for no more than 10 calendar days.

(e) The respondent has a right to retain an independent licensed physician or other
mental health professional to examine the respondent and to testify on the respondent's
behalf. Upon request by an indigent respondent, the court shall appoint an independent
licensed physician or other mental health professional to examine the respondent and testify
on the respondent's behalf. The court shall consider an indigent respondent's request for a
specific physician or mental health professional. A motion for the appointment may be filed
in court at any reasonable time before the hearing and shall be acted upon promptly.
Reasonable fees and expenses for expert examiners shall be determined by the rules of court.

(f) The proceeding shall in all respects be in accord with constitutional guarantees of due
process and, except as otherwise specifically provided in AS 47.30.700 - 47.30.915, the rules
of evidence and procedure in civil proceedings.

(g) Until the court issues a final decision, the respondent shall continue to be treated at
the treatment facility unless the petition for 90-day commitment is withdrawn. If a decision
has not been made within 20 days of filing of the petition, not including extensions of time
due to jury trial or other requests by the respondent, the respondent shall be released.
Sec. 47.30.750. Conduct of hearing.
The hearing under AS 47.30.745 shall be conducted in the same manner, and with the same rights for the respondent, as set out in AS 47.30.735(b).

Sec. 47.30.755. Court order.
(a) After the hearing and within the time limit specified in AS 47.30.745, the court may commit the respondent to a treatment facility for no more than 90 days if the court or jury finds by clear and convincing evidence that the respondent is mentally ill and as a result is likely to cause harm to self or others, or is gravely disabled.
(b) If the court finds that there is a less restrictive alternative available and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment after acceptance by the program of the respondent for a period not to exceed 90 days.

Sec. 47.30.760. Placement at closest facility.
Treatment shall always be available at a state-operated hospital; however, if space is available and upon acceptance by another treatment facility, a respondent who is committed by the court shall be placed by the department at the designated treatment facility closest to the respondent's home unless the court finds that
(1) another treatment facility in the state has a program more suited to the respondent's condition, and this interest outweighs the desirability of the respondent being closer to home;
(2) another treatment facility in the state is closer to the respondent's friends or relatives who could benefit the respondent through their visits and communications; or
(3) the respondent wants to be further removed from home, and the mental health professionals who sought the respondent's commitment concur in the desirability of removed placement.

Sec. 47.30.765. Appeal.
The respondent has the right to an appeal from an order of involuntary commitment. The court shall inform the respondent of this right.

Sec. 47.30.770. Additional 180-day commitment.
(a) The respondent shall be released from involuntary treatment at the expiration of 90 days unless the professional person in charge files a petition for a 180-day commitment conforming to the requirements of AS 47.30.740(a) except that all references to "30-day commitment" shall be read as "the previous 90-day commitment" and all references to "90-day commitment" shall be read as "180-day commitment".
(b) The procedures for service of the petition, notification of rights, and judicial hearing shall be as set out in AS 47.30.740 - 47.30.750. If the court or jury finds by clear and convincing evidence that the grounds for 90-day commitment as set out in AS 47.30.755 are present, the court may order the respondent committed for an additional treatment period not to exceed 180 days from the date on which the first 90-day treatment period would have expired.
(c) Successive 180-day commitments are permissible on the same ground and under the same procedures as the original 180-day commitment. An order of commitment may not exceed 180 days.
(d) Findings of fact relating to the respondent's behavior made at a 30-day commitment hearing under AS 47.30.735, a 90-day commitment hearing under AS 47.30.750, or a previous 180-day commitment hearing under this section shall be admitted as evidence and
may not be rebutted except that newly discovered evidence may be used for the purpose of rebutting the findings.

**Sec. 47.30.772. Medication and treatment.**
An evaluation facility or designated treatment facility may administer medication or other treatment to an involuntarily committed patient only in a manner that is consistent with the provisions of AS 47.30.825 - 47.30.865.

**Sec. 47.30.775. Commitment of minors.**
The provisions of AS 47.30.700 - 47.30.815 apply to minors. However, all notices required to be served on the respondent in AS 47.30.700 - 47.30.815 shall also be served on the parent or guardian of a respondent who is a minor, and parents or guardians of a minor respondent shall be notified that they may appear as parties in any commitment proceeding concerning the minor and that as parties they are entitled to retain their own attorney or have the office of public advocacy appointed for them by the court. A minor respondent has the same rights to waiver and informed consent as an adult respondent under AS 47.30.660 - 47.30.915; however, the minor shall be represented by counsel in waiver and consent proceedings.

**Sec. 47.30.780. Early discharge.**
The professional person in charge shall at any time discharge a respondent on the ground that the respondent is no longer gravely disabled or likely to cause serious harm as a result of mental illness. A certificate to this effect shall be sent to the court which shall enter an order officially terminating the involuntary commitment.

**Sec. 47.30.785. Authorized absences.**
A respondent undergoing involuntary treatment on an inpatient basis under AS 47.30.700 - 47.30.815 may be authorized to be absent from the treatment facility during times specified by the professional person in charge, or that person's professional designee, when an authorization to be absent is in the best interests of the respondent and the respondent is not likely to cause harm to self or others.

**Sec. 47.30.790. Unauthorized absences: return to facility; required notice.**
When a respondent undergoing involuntary treatment on an inpatient basis is absent from the treatment facility without, or in excess of, authorization under AS 47.30.785, the professional person in charge, or that person's professional designee, may contact the appropriate peace officers who shall take the respondent into custody and return the respondent to the treatment facility. If it is determined by the professional person in charge to be necessary, a member of the treatment facility staff shall accompany the peace officers when they take the respondent into custody. In addition, the family or guardian of the patient and any person known to have been threatened by the patient shall be notified of the patient's unauthorized absence immediately upon its discovery.

**Sec. 47.30.795. Involuntary outpatient care for committed persons.**
(a) A respondent who was originally committed to involuntary inpatient care under AS 47.30.700 - 47.30.915 may be released before the expiration of the commitment period if a provider of outpatient care accepts the respondent for specified outpatient treatment for a period of time not to exceed the duration of the commitment, and if the professional person in charge, or that person's professional designee, finds that

(1) it is not necessary to treat the respondent as an inpatient to prevent the respondent from harming self or others; and
(2) there is reason to believe that the respondent's mental condition would improve as a result of the outpatient treatment.

(b) A copy of the conditions for early release shall be given to the respondent and the respondent's attorney and guardian, if any, the provider of outpatient care, and the court.

(c) If during the commitment period the provider of outpatient care determines that the respondent can no longer be treated on an outpatient basis because the respondent is likely to cause harm to self or others or is gravely disabled, the provider shall give the respondent oral and written notice that the respondent must return to the treatment facility within 24 hours, with copies to the respondent's attorney and guardian, if any, the court, and the inpatient treatment facility. If the respondent fails to arrive at the treatment facility within 24 hours after receiving the notice, the professional person in charge may contact the appropriate peace officers who shall take the respondent into custody and transport the respondent to the facility. If it is determined by the professional person in charge to be necessary, a member of the treatment facility staff shall accompany the peace officers when they take the respondent into custody.

(d) If the provider of outpatient care determines that the respondent will require continued outpatient care after the expiration of the commitment period, the provider may initiate further commitment proceedings as if the provider were the professional person in charge, and the provisions of AS 47.30.660 - 47.30.915 apply, except that provisions relating to inpatient treatment shall be read as applicable to outpatient treatment.

Sec. 47.30.800. Conversion of involuntary outpatient treatment to inpatient commitment.

(a) A respondent ordered by the court under the provisions of AS 47.30.700 - 47.30.915 to receive involuntary outpatient treatment may be required to undergo inpatient treatment when the provider of outpatient care finds that (1) the respondent is mentally ill and is likely to cause serious harm to self or others or is still gravely disabled; (2) the respondent's behavior since the hearing resulting in court-ordered treatment indicates that the respondent now needs inpatient treatment to protect self or others; (3) there is reason to believe that the respondent's mental condition will improve as a result of inpatient treatment; and (4) there is an inpatient facility appropriate to the respondent's need which will accept the respondent as a patient. Treatment for these respondents shall be available at state-operated hospitals at all times.

(b) Upon making the findings specified in (a) of this section, the provisions of AS 47.30.795(c) relating to notice and AS 47.30.745 relating to hearing apply.

Sec. 47.30.803. Conversion from involuntary to voluntary status.

A patient subject to involuntary hospitalization under AS 47.30.705, 47.30.735, or AS 47.30.755 may at any time convert to voluntary status if the responsible physician agrees that

(1) the patient is an appropriate patient for voluntary hospitalization; and

(2) the conversion is made in good faith.

Sec. 47.30.805. Computing periods of time.

(a) Except as provided in (b) of this section,

(1) computations of a 72-hour evaluation period under AS 47.30.715 or a 48-hour detention period under AS 47.30.685 do not include Saturdays, Sundays, legal holidays, or any period of time necessary to transport the respondent to the treatment facility;

(2) a 30-day commitment period expires at the end of the 30th day after the 72 hours following initial acceptance;
(3) a 90-day commitment period expires at the end of the 90th day after the expiration of a 30-day period of treatment;
(4) a 180-day commitment period expires at the end of the 180th day, after the expiration of a 90-day period of treatment or previous 180-day period, whichever is applicable.

(b) When a respondent has failed to appear or been absent through the respondent's own actions contrary to any order properly made or entered under AS 47.30.660 - 47.30.915, the relevant commitment period shall be extended for a period of time equal to the respondent's absence if written notice of absence is promptly provided to the respondent's attorney and guardian, if there is one, and if, within 24 hours after the respondent has returned to the evaluation or treatment facility, written notice of the corresponding extension and the reason for it is given to the respondent and the respondent's attorney and guardian, if any, and to the court.

Sec. 47.30.810. Habeas corpus not limited.
Nothing in AS 47.30.660 - 47.30.915 may be construed as limiting a person's right to a writ of habeas corpus.

Sec. 47.30.815. Limitation of liability; bad faith application a felony.
(a) A person acting in good faith upon either actual knowledge or reliable information who makes application for evaluation or treatment of another person under AS 47.30.700 - 47.30.915 is not subject to civil or criminal liability.
(b) The following persons may not be held civilly or criminally liable for detaining a person under AS 47.30.700 - 47.30.915 or for releasing a person under AS 47.30.700 - 47.30.915 at or before the end of the period for which the person was admitted or committed for evaluation or treatment if the persons have performed their duties in good faith and without gross negligence:
   (1) an officer of a public or private agency;
   (2) the superintendent, the professional person in charge, the professional designee of the professional person in charge, and the attending staff of a public or private agency;
   (3) a public official performing functions necessary to the administration of AS 47.30.700 - 47.30.915;
   (4) a peace officer or mental health professional responsible for detaining or transporting a person under AS 47.30.700 - 47.30.915.
(c) A person who wilfully initiates an involuntary commitment procedure under AS 47.30.700 without having good cause to believe that the other person is suffering from a mental illness and as a result is gravely disabled or likely to cause serious harm to self or others, is guilty of a felony.

Article 10. PATIENT RIGHTS

Sec. 47.30.817. Advance health care directives.
A health care provider or a health care institution may not require or prohibit the execution or revocation of an advance health care directive as a condition for admission, discharge, or providing health care. In this section, "advance health care directive," "health care institution," and "health care provider" have the meanings given in AS 13.52.390.

Sec. 47.30.825. Patient medical rights.
(a) A patient who is receiving services under AS 47.30.660 - 47.30.915 has the rights described in this section.
(b) The patient and the following persons, at the request of the patient, are entitled to participate in formulating the patient's individualized treatment plan and to participate in the evaluation process as much as possible, at minimum to the extent of requesting specific forms of therapy, inquiring why specific therapies are or are not included in the treatment program, and being informed as to the patient's present medical and psychological condition and prognosis: (1) the patient's counsel, (2) the patient's guardian, (3) a mental health professional previously engaged in the patient's care outside of the evaluation facility or designated treatment facility, (4) a representative of the patient's choice, (5) a person designated as the patient's attorney-in-fact with regard to mental health treatment decisions under AS 13.26.332 - 13.26.358, AS 47.30.950 - 47.30.980, or other power-of-attorney, and (6) the adult designated under AS 47.30.725. The mental health care professionals may not withhold any of the information described in this subsection from the patient or from others if the patient has signed a waiver of confidentiality or has designated the person who would receive the information as an attorney-in-fact with regard to mental health treatment.

(c) A patient who is capable of giving informed consent has the right to give and withhold consent to medication and treatment in all situations that do not involve a crisis or impending crisis as described in AS 47.30.838(a)(1). A facility shall follow the procedures required under AS 47.30.836 - 47.30.839 before administering psychotropic medication.

(d) A locked quiet room, or other form of physical restraint, may not be used, except as provided in this subsection, unless a patient is likely to physically harm self or others unless restrained. The form of restraint used shall be that which is in the patient's best interest and which constitutes the least restrictive alternative available. When practicable, the patient shall be consulted as to the patient's preference among forms of adequate, medically advisable restraints including medication, and that preference shall be honored. Nothing in this section is intended to limit the right of staff to use a quiet room at the patient's request or with the patient's knowing concurrence when considered in the best interests of the patient. Patients placed in a quiet room or other physical restraint shall be checked at least every 15 minutes or more often if good medical practice so indicates. Patients in a quiet room must be visited by a staff member at least once every hour and must be given adequate food and drink and access to bathroom facilities. At no time may a patient be kept in a quiet room or other form of physical restraint against the patient's will longer than necessary to accomplish the purposes set out in this subsection. All uses of a quiet room or other restraint shall be recorded in the patient's medical record, the information including but not limited to the reasons for its use, the duration of use, and the name of the authorizing staff member.

(e) [Repealed, Sec. 12 ch 109 SLA 1992].

(f) A patient capable of giving informed consent has the absolute right to accept or refuse electroconvulsive therapy or aversive conditioning. A patient who lacks substantial capacity to make this decision may not be given this therapy or conditioning without a court order unless the patient expressly authorized that particular form of treatment in a declaration properly executed under AS 47.30.950 - 47.30.980 or has authorized an attorney-in-fact to make this decision and the attorney-in-fact consents to the treatment on behalf of the patient.

(g) In no event may treatment include psychosurgery, lobotomy, or other comparable form of treatment without specific informed consent of the patient, including a minor unless the minor is clearly too young or disabled to give an informed consent in which case the consent of the minor's legal guardian is required. In addition, this treatment may not be given without a court order after hearing compatible with full due process.

(h) When, in the written opinion of a patient's attending physician, a true medical emergency exists and a surgical operation is necessary to save the life, physical health, eyesight, hearing or member of the patient, the professional person in charge, or that person's professional designee, may give consent to the surgical operation if time will not permit
obtaining the consent of the proper relatives or guardian or appropriate judicial authority. However, an operation may not be authorized if the patient is not a minor and knowingly withholds consent on religious grounds.

(i) A patient upon discharge shall be given a discharge plan specifying the kinds and amount of care and treatment the patient should have after discharge and such other steps as the patient might take to benefit the patient's mental health after leaving the facility. The patient shall have the right to participate, as far as practicable, in formulating the patient's discharge plan. A copy of the plan shall be given to the patient, the patient's guardian, an adult designated in accordance with AS 47.30.725, the court if appropriate, and any follow-up agencies.

Sec. 47.30.830. Prohibition of experimental treatments.

(a) Experimental treatments involving any significant risk of physical or psychological harm may not be administered to a patient.

(b) If the personnel of an evaluation or treatment facility are uncertain as to whether a proposed treatment is experimental or is experimental as applied to a particular patient or would involve a significant risk of mental or physical harm to the patient, the matter may be referred to the commissioner for a determination. The patient, the patient's attorney and guardian, if any, and an adult designated by the patient, shall, simultaneously with the referral to the commissioner, be provided with copies of all the documents by which the referral is made and shall have the opportunity to provide evidence to the commissioner on the question.

(c) A determination by the commissioner that a treatment is experimental and entails significant risks of mental or physical harm is binding upon all persons involved in the administration of treatment to a patient.

Sec. 47.30.833. Nutritional evaluation; right to proper diet.

(a) A treatment facility shall conduct a nutritional evaluation of a person admitted or committed to a treatment facility for evaluation or treatment, whether the person is a voluntary or involuntary patient. The evaluation shall be conducted within the first week after the patient is admitted or committed.

(b) Notwithstanding (a) of this section, a treatment facility is not required to conduct a nutritional evaluation of a patient who is released within 72 hours of arrival.

(c) A patient has the right to a nutritionally sound and medically appropriate diet. After conducting the nutritional evaluation required under (a) of this section, the treatment facility shall take appropriate steps to correct the patient's nutritional deficiencies.

Sec. 47.30.835. Civil rights not impaired.

(a) A person may not deny to a person who is undergoing evaluation or treatment under AS 47.30.660 - 47.30.915 a civil right, including but not limited to, the right to free exercise of religion and the right to dispose of property, sue and be sued, enter into contractual relationships, and vote. A person who violates this subsection commits the crime of interference with constitutional rights under AS 11.76.110.

(b) Court-ordered evaluation or treatment under AS 47.30.660 - 47.30.915 is not a determination of legal incapacity under AS 13.26.005 - 13.26.330.

Sec. 47.30.836. Psychotropic medication in nonemergencies.

An evaluation facility or designated treatment facility may not administer psychotropic medication to a patient in a situation that does not involve a crisis under AS 47.30.838(a)(1) unless the patient
(1) has the capacity to give informed consent to the medication, as described in AS 47.30.837, and gives that consent; the facility shall document the consent in the patient's medical chart;

(2) authorized the use of psychotropic medication in a declaration properly executed under AS 47.30.950 - 47.30.980 or authorized an attorney-in-fact to consent to the use of psychotropic medication for the patient and the attorney-in-fact does consent; or

(3) is determined by a court to lack the capacity to give informed consent to the medication and the court approves use of the medication under AS 47.30.839.

Sec. 47.30.837. Informed consent.
(a) A patient has the capacity to give informed consent for purposes of AS 47.30.836 if the patient is competent to make mental health or medical treatment decisions and the consent is voluntary and informed.

(b) When seeking a patient's informed consent under this section, the evaluation facility or designated treatment facility shall give the patient information that is necessary for informed consent in a manner that ensures maximum possible comprehension by the patient.

(c) If an evaluation facility or designated treatment facility has provided to the patient the information necessary for the patient's consent to be informed and the patient voluntarily consents, the facility may administer psychotropic medication to the patient unless the facility has reason to believe that the patient is not competent to make medical or mental health treatment decisions. If the facility has reason to believe that the patient is not competent to make medical or mental health treatment decisions and the facility wishes to administer psychotropic medication to the patient, the facility shall follow the procedures of AS 47.30.839.

(d) In this section,

(1) "competent" means that the patient

(A) has the capacity to assimilate relevant facts and to appreciate and understand the patient's situation with regard to those facts, including the information described in (2) of this subsection;

(B) appreciates that the patient has a mental disorder or impairment, if the evidence so indicates; denial of a significantly disabling disorder or impairment, when faced with substantial evidence of its existence, constitutes evidence that the patient lacks the capability to make mental health treatment decisions;

(C) has the capacity to participate in treatment decisions by means of a rational thought process; and

(D) is able to articulate reasonable objections to using the offered medication;

(2) "informed" means that the evaluation facility or designated treatment facility has given the patient all information that is material to the patient's decision to give or withhold consent, including

(A) an explanation of the patient's diagnosis and prognosis, or their predominant symptoms, with and without the medication;

(B) information about the proposed medication, its purpose, the method of its administration, the recommended ranges of dosages, possible side effects and benefits, ways to treat side effects, and risks of other conditions, such as tardive dyskinesia;

(C) a review of the patient's history, including medication history and previous side effects from medication;

(D) an explanation of interactions with other drugs, including over-the-counter drugs, street drugs, and alcohol;

(E) information about alternative treatments and their risks, side effects, and benefits, including the risks of nontreatment; and
(F) a statement describing the patient's right to give or withhold consent to the administration of psychotropic medications in nonemergency situations, the procedure for withdrawing consent, and notification that a court may override the patient's refusal;

(3) "voluntary" means having genuine freedom of choice; a choice may be encouraged and remain voluntary, but consent obtained by using force, threats, or direct or indirect coercion is not voluntary.

Sec. 47.30.838. Psychotropic medication in emergencies.

(a) Except as provided in (c) and (d) of this section, an evaluation facility or designated treatment facility may administer psychotropic medication to a patient without the patient's informed consent, regardless of whether the patient is capable of giving informed consent, only if

(1) there is a crisis situation, or an impending crisis situation, that requires immediate use of the medication to preserve the life of, or prevent significant physical harm to, the patient or another person, as determined by a licensed physician or a registered nurse; the behavior or condition of the patient giving rise to a crisis under this paragraph and the staff's response to the behavior or condition must be documented in the patient's medical record; the documentation must include an explanation of alternative responses to the crisis that were considered or attempted by the staff and why those responses were not sufficient; and

(2) the medication is ordered by a licensed physician; the order

(A) may be written or oral and may be received by telephone, facsimile machine, or in person;

(B) may include an initial dosage and may authorize additional, as needed, doses; if additional, as needed, doses are authorized, the order must specify the medication, the quantity of each authorized dose, the method of administering the medication, the maximum frequency of administration, the specific conditions under which the medication may be given, and the maximum amount of medication that may be administered to the patient in a 24-hour period;

(C) is valid for only 24 hours and may be renewed by a physician for a total of 72 hours, including the initial 24 hours, only after a personal assessment of the patient's status and a determination that there is still a crisis situation as described in (1) of this subsection; upon renewal of an order under this subparagraph, the facts supporting the renewal shall be written into the patient's medical record.

(b) When a patient is no longer in the crisis situation that lead to the use of psychotropic medication without consent under (a) of this section, an appropriate health care professional shall discuss the crisis with the patient, including precursors to the crisis, in order to increase the patient's and the professional's understanding of the episode and to discuss prevention of future crises. The professional shall seek and consider the patient's recommendations for managing potential future crises.

(c) If crisis situations as described in (a)(1) of this section occur repeatedly, or if it appears that they may occur repeatedly, the evaluation facility or designated treatment facility may administer psychotropic medication during no more than three crisis periods without the patient's informed consent only with court approval under AS 47.30.839.

(d) An evaluation facility or designated treatment facility may administer psychotropic medication to a patient without the patient's informed consent if the patient is unable to give informed consent but has authorized the use of psychotropic medication in a declaration properly executed under AS 47.30.950 - 47.30.980 or has authorized an attorney-in-fact to consent to this form of treatment for the patient and the attorney-in-fact does consent.

Sec. 47.30.839. Court-ordered administration of medication.
(a) An evaluation facility or designated treatment facility may use the procedures described in this section to obtain court approval of administration of psychotropic medication if

(1) there have been, or it appears that there will be, repeated crisis situations as described in AS 47.30.838(a)(1) and the facility wishes to use psychotropic medication in future crisis situations; or

(2) the facility wishes to use psychotropic medication in a noncrisis situation and has reason to believe the patient is incapable of giving informed consent.

(b) An evaluation facility or designated treatment facility may seek court approval for administration of psychotropic medication to a patient by filing a petition with the court, requesting a hearing on the capacity of the person to give informed consent.

(c) A patient who is the subject of a petition under (b) of this section is entitled to an attorney to represent the patient at the hearing. If the patient cannot afford an attorney, the court shall direct the Public Defender Agency to provide an attorney. The court may, upon request of the patient's attorney, direct the office of public advocacy to provide a guardian ad litem for the patient.

(d) Upon the filing of a petition under (b) of this section, the court shall direct the office of public advocacy to provide a visitor to assist the court in investigating the issue of whether the patient has the capacity to give or withhold informed consent to the administration of psychotropic medication. The visitor shall gather pertinent information and present it to the court in written or oral form at the hearing. The information must include documentation of the following:

(1) the patient's responses to a capacity assessment instrument administered at the request of the visitor;

(2) any expressed wishes of the patient regarding medication, including wishes that may have been expressed in a power of attorney, a living will, or oral statements of the patient, including conversations with relatives and friends that are significant persons in the patient's life as those conversations are remembered by the relatives and friends; oral statements of the patient should be accompanied by a description of the circumstances under which the patient made the statements, when possible.

(e) Within 72 hours after the filing of a petition under (b) of this section, the court shall hold a hearing to determine the patient's capacity to give or withhold informed consent as described in AS 47.30.837 and the patient's capacity to give or withhold informed consent at the time of previously expressed wishes regarding medication if previously expressed wishes are documented under (d)(2) of this section. The court shall consider all evidence presented at the hearing, including evidence presented by the guardian ad litem, the petitioner, the visitor, and the patient. The patient's attorney may cross-examine any witness, including the guardian ad litem and the visitor.

(f) If the court determines that the patient is competent to provide informed consent, the court shall order the facility to honor the patient's decision about the use of psychotropic medication.

(g) If the court determines that the patient is not competent to provide informed consent and, by clear and convincing evidence, was not competent to provide informed consent at the time of previously expressed wishes documented under (d)(2) of this section, the court shall approve the facility's proposed use of psychotropic medication. The court's approval under this subsection applies to the patient's initial period of commitment if the decision is made during that time period. If the decision is made during a period for which the initial commitment has been extended, the court's approval under this subsection applies to the period for which commitment is extended.
(h) If an evaluation facility or designated treatment facility wishes to continue the use of psychotropic medication without the patient's consent during a period of commitment that occurs after the period in which the court's approval was obtained, the facility shall file a request to continue the medication when it files the petition to continue the patient's commitment. The court that determines whether commitment shall continue shall also determine whether the patient continues to lack the capacity to give or withhold informed consent by following the procedures described in (b) - (e) of this section. The reports prepared for a previous hearing under (e) of this section are admissible in the hearing held for purposes of this subsection, except that they must be updated by the visitor and the guardian ad litem.

(i) If a patient for whom a court has approved medication under this section regains competency at any time during the period of the patient's commitment and gives informed consent to the continuation of medication, the evaluation facility or designated treatment facility shall document the patient's consent in the patient's file in writing.

Sec. 47.30.840. Right to privacy and personal possessions.

(a) A person undergoing evaluation or treatment under AS 47.30.660 - 47.30.915 may not be photographed without the person's consent and that of the person's guardian if a minor, except that the person may be photographed upon admission to a facility for identification and for administrative purposes of the facility; all photographs shall be confidential and may only be released by the facility to the patient or the patient's designee unless a court orders otherwise;  
(b) The patient's rights under (a)(4), (5), (7) and (9) of this section may be suspended temporarily, following the initial evaluation period, if the professional person in charge of the patient determines that granting the patient those rights will pose a threat to the safety or well-being of the patient or others.
Sec. 47.30.845. Confidential records.
Information and records obtained in the course of a screening investigation, evaluation, examination, or treatment are confidential and are not public records, except as the requirements of a hearing under AS 47.30.660 - 47.30.915 may necessitate a different procedure. Information and records may be copied and disclosed under regulations established by the department only to
(1) a physician or a provider of health, mental health, or social and welfare services involved in caring for, treating, or rehabilitating the patient;
(2) the patient or an individual to whom the patient has given written consent to have information disclosed;
(3) a person authorized by a court order;
(4) a person doing research or maintaining health statistics if the anonymity of the patient is assured and the facility recognizes the project as a bona fide research or statistical undertaking;
(5) the Department of Corrections in a case in which a prisoner confined to the state prison is a patient in the state hospital on authorized transfer either by voluntary admission or by court order;
(6) a governmental or law enforcement agency when necessary to secure the return of a patient who is on unauthorized absence from a facility where the patient was undergoing evaluation or treatment;
(7) a law enforcement agency when there is substantiated concern over imminent danger to the community by a presumed mentally ill person;
(8) the department in a case in which services provided under AS 47.30.660 - 47.30.915 are paid for, in whole or in part, by the department or in which a person has applied for or has received assistance from the department for those services.

Sec. 47.30.847. Patients' grievance procedures.
(a) A patient has the right to bring grievances about the patient's treatment, care, or rights to an impartial body within an evaluation facility or designated treatment facility.
(b) An evaluation facility and a designated treatment facility shall have a formal grievance procedure for patient grievances brought under (a) of this section. The facility shall inform each patient of the existence and contents of the grievance procedure.
(c) An evaluation facility and a designated treatment facility shall have a designated staff member who is trained in mental health consumer advocacy who will serve as an advocate, upon a patient's request, to assist the patient in bringing grievances or pursuing other redress for complaints concerning care, treatment, and rights.

Sec. 47.30.850. Expunging or sealing records.
Following the discharge of a respondent from a treatment facility or the issuance of a court order denying a petition for commitment, the respondent may at any time move to have all court records pertaining to the proceedings expunged on condition that the respondent file a full release of all claims of whatever nature arising out of the proceedings and the statements and actions of persons and facilities in connection with the proceedings. Upon the filing of the motion and full release, the court shall order the court records either expunged or sealed, whichever the court considers appropriate under the circumstances.

Sec. 47.30.855. Posting of rights.
The rights set out in AS 47.30.825 - 47.30.855 shall be prominently posted in all treatment facilities in places accessible to all patients. A patient who does not understand English shall have the patient rights explained in a language the patient understands.
Sec. 47.30.860. Notices in languages other than English.
When practicable all documents and notices required by AS 47.30.660 - 47.30.915 to be served on a respondent, or on the respondent's parents, guardian or adult designee, shall be explained in a language the person understands if the respondent is not competent in English.

Sec. 47.30.865. Discrimination prohibited.
(a) The fact that a person is or has been evaluated or treated for mental illness may not be a basis for discrimination in
   (1) seeking employment;
   (2) resuming or continuing professional practice or previous occupation;
   (3) obtaining or retaining housing;
   (4) obtaining or retaining licenses or permits, including but not limited to a motor vehicle license, motor vehicle operator's and chauffeur's license, and a professional or occupational license.
   (b) Applications for positions, licenses, and housing may not contain requests for information concerning evaluation or treatment experiences.
   (c) A person may not aid, abet, incite, compel, or coerce the doing of an act forbidden under this section or attempt to do so.
Article 11. MISCELLANEOUS PROVISIONS

Sec. 47.30.870. Transportation.
When a person is to be involuntarily committed to a facility, the department shall arrange, and is authorized to pay for, the person's necessary transportation to the designated facility accompanied by appropriate persons and if necessary by a peace officer. The department shall pay return transportation of a person, the person's escorts, and if necessary a peace officer, after a determination that the person is not committable, at the end of a commitment period, or at the end of a voluntary stay at a treatment facility following an evaluation conducted in accordance with AS 47.30.715. When advisable, one or more relatives or friends shall be permitted to accompany the person. The department may pay necessary travel, housing, and meal expenses incurred by one relative or friend in accompanying the person if the department determines that the person's best interests require that the person be accompanied by the relative or friend and the relative or friend is indigent.

Sec. 47.30.875. Nonresident patients.
(a) The admission papers of a person who is admitted to a treatment facility under AS 47.30.660 - 47.30.915 must include a statement as to the person's residence. The department may return a patient who is not a resident of the state to the state of the person's residence with court approval if the person has been committed. If the state in which the person has residence does not accept the person as a patient, the person shall be treated as a resident of this state under the provisions of AS 47.30.660 - 47.30.915.

(b) To facilitate the return of nonresident patients the department may enter into a reciprocal agreement or compact with another state providing for the prompt return under appropriate supervision of residents of that state who are mentally ill. A mentally ill resident of this state who has been placed in a facility outside this state may be admitted with the approval of the department to a treatment facility in the state designated by the department. The department may enter into reciprocal agreements or contracts with another state providing for custody, care or treatment, or return of mentally ill residents of this state by the other state and for the custody and care or treatment of mentally ill residents of that state by this state on a reimbursable basis. A resident of this state who has been committed in another state and is returned in accordance with this section shall, within 72 hours of admission to the designated facility, be examined. After examination the mental health professional in charge shall release the person or shall petition for involuntary commitment as prescribed in AS 47.30.740.

(c) In taking action under (a) and (b) of this section, consideration shall be given to the best interests of the patient, particularly to the relationship of the patient to the patient's family, legal guardian, or friends to maintain relationships and encourage visits beneficial to the patient.

Sec. 47.30.880. Interstate Compact on Mental Health ratified.
This state ratifies and adopts by reference "The Interstate Compact on Mental Health" consisting of 14 articles approved on September 30, 1955, by the Northeast State Governments Conference on Mental Health. The department is designated as compact administrator with full power to carry out the purpose of the compact and to adopt all necessary regulations to implement the compact.

Sec. 47.30.885. Rights outside state.
Nothing in AS 47.30.660 - 47.30.915 alters or impairs the application or availability to a patient, while hospitalized in another state under contractual arrangements entered in
accordance with AS 47.30.660 - 47.30.915, of the rights, remedies, or safeguards provided by
the laws of this state.

Sec. 47.30.890. Provision for personal needs upon discharge.
The department shall ensure that
(1) a patient is not discharged from a treatment facility without suitable clothing; and
(2) a discharged indigent patient is furnished
(A) suitable transportation to the patient's permanent residence in this state or to another
suitable place at the discretion of the department; and
(B) a reasonable amount of money to meet the patient's immediate needs.

Sec. 47.30.895. Disposition of personal property and unclaimed money.
(a) Those unclaimed articles of personal property that are covered by AS 34.45.110 -
34.45.260 and the unclaimed money in the custody of a treatment facility that belong to a
patient who dies before discharge, or to a patient who leaves the hospital without authority, if
unclaimed by the patient or the legal heirs or representatives of the patient within one year
after the patient's death or departure, shall be disposed of in accordance with AS 34.45.110 -
34.45.780, and the other articles of the patient's personal property shall be disposed of in the
manner prescribed by the department and the proceeds deposited in the general fund.
(b) If a mentally ill individual has died in a foreign facility and the department desires to
recover the patient's personal property under this section, the commissioner or the
commissioner's designated representative may secure the property and for that purpose only
is designated the decedent's administrator. Property so recovered shall be disposed of as
provided by law.

Sec. 47.30.900. Disposition of money and personal property subject to claim.
The department shall make diligent inquiry in every instance after departure without
authority or death of a patient, to ascertain the whereabouts of the patient or that of the
patient's legal heirs or representatives, and shall turn over to the proper person the money or
articles of personal property in the custody of the facility to the credit of the patient. Claims
to the money or articles of personal property, including claims by the state, may be presented
to the department at any time. If a claim other than by the state is established by clear and
convincing evidence more than one year after the death or departure without authority of a
patient, it shall be certified to the legislature for consideration and the legislature may pay the
claim.

Sec. 47.30.905. Fees and expenses for judicial proceedings.
(a) The witnesses, expert witnesses, and the jury in commitment proceedings under AS
47.30.660 - 47.30.915 are entitled to the fees, compensation, and mileage established by the
administrative rules of court for other jurors and witnesses. Compensation, mileage, fees,
transportation expenses for a respondent, and other expenses arising from evaluation and
commitment proceedings shall be audited and allowed by the superior court of the judicial
district in which the proceedings are held. To the extent that services of a peace officer are
used to carry out the provisions of AS 47.30.660 - 47.30.915, the officer is entitled to fees
and actual expenses from the same source and in the same manner as for the officer's other
official duties.
(b) An attorney appointed for a person under AS 47.30.660 - 47.30.915 shall be
compensated for services as follows:
(1) the person for whom an attorney is appointed shall, if the person is financially able under standards as to financial capability and indigency set by the court, pay the costs of the legal services;
(2) if the person is indigent under those standards, the costs of the services shall be paid by the state.

Sec. 47.30.910. Liability for expense of placement in a facility.
(a) A patient, the patient's spouse, or the patient's parent if the patient is under 18 years of age shall pay the charges for the care, transportation, and treatment of the patient when the patient is hospitalized under AS 47.30.670 - 47.30.915 at a state-operated facility, an evaluation facility, or a designated treatment facility providing services under AS 47.30.670 - 47.30.915. The patient, the patient's spouse, or the patient's parent if the patient is under 18 years of age shall make arrangements with a state-operated facility, an evaluation facility, or a designated treatment facility for payment of charges, including providing income information necessary to determine eligibility for benefits under AS 47.31. Charges assessed for services provided under AS 47.30.670 - 47.30.915 when a patient is hospitalized at a state-operated facility may not exceed the actual cost of care and treatment. The department may, when assessing charges for services provided at a state-operated facility, consider the ability to pay of a patient, a patient's spouse, or a patient's parent if the patient is under 18 years of age. In order to impose liability for a patient's cost of care at a state-operated facility, the department shall issue an order for payment within six months after the date on which the charge was incurred. The order remains in effect unless modified by subsequent court order or department order. The department may not impose liability for a patient's cost of care at a state-operated facility if the patient would otherwise meet the eligibility criteria, other than location of service, in AS 47.31.010.
(b) The department, the evaluation facility, or a designated treatment facility shall make reasonable efforts to determine whether the patient, the patient's spouse, or the patient's parent if the patient is under 18 years of age has a third-party payor or has the available means to substantially contribute to the payment of charges, or whether the patient is eligible for assistance under AS 47.31.
(c) If a patient is hospitalized at a state-operated facility and the patient, the patient's spouse, or the patient's parent if the patient is under 18 years of age fails to provide to the department information necessary to determine whether there is a third-party payor or available means to substantially contribute to the payment of charges, or whether the patient would, if not hospitalized at a state-operated facility, be eligible for assistance under AS 47.31, the department may issue an administrative order imposing full liability for the patient's actual cost of care on the patient, the patient's spouse, or the patient's parent if the patient is under 18 years of age. The order remains in effect unless modified by subsequent court order or department order.
(d) If a person who is hospitalized under AS 47.30.670 - 47.30.915 at an evaluation facility or a designated treatment facility cannot pay or substantially contribute to the payment of charges described under this section, the patient may apply for assistance under AS 47.31.
(e) The department may charge or accept money or property from a person for the care or treatment of a patient at a state-operated facility.
(f) Money paid by the patient or on the patient's behalf to the department under this section shall be deposited in the general fund.

Sec. 47.30.915. Definitions.
In AS 47.30.660 - 47.30.915
(1) "commissioner" means the commissioner of health and social services;
(2) "court" means a superior court of the state;
(3) "department" means the Department of Health and Social Services;
(4) "designated treatment facility" or "treatment facility" means a hospital, clinic, institution, center, or other health care facility that has been designated by the department for the treatment or rehabilitation of mentally ill persons under AS 47.30.670 - 47.30.915 but does not include correctional institutions;
(5) "evaluation facility" means a health care facility that has been designated or is operated by the department to perform the evaluations described in AS 47.30.660 - 47.30.915, or a medical facility licensed under AS 18.20.020 or operated by the federal government;
(6) "evaluation personnel" means mental health professionals designated by the department to conduct evaluations as prescribed in AS 47.30.660 - 47.30.915 who conduct evaluations in places in which no staffed evaluation facility exists;
(7) "gravely disabled" means a condition in which a person as a result of mental illness
   (A) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken; or
   (B) will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person's previous ability to function independently;
(8) "inpatient treatment" means care and treatment rendered inside or on the premises of a treatment facility, or a part or unit of a treatment facility, for a continual period of 24 hours or longer;
(9) "least restrictive alternative" means mental health treatment facilities and conditions of treatment that are
   (A) no more harsh, hazardous, or intrusive than necessary to achieve the treatment objectives of the patient; and
   (B) involve no restrictions on physical movement nor supervised residence or inpatient care except as reasonably necessary for the administration of treatment or the protection of the patient or others from physical injury;
(10) "likely to cause serious harm" means a person who
   (A) poses a substantial risk of bodily harm to that person's self, as manifested by recent behavior causing, attempting, or threatening that harm;
   (B) poses a substantial risk of harm to others as manifested by recent behavior causing, attempting, or threatening harm, and is likely in the near future to cause physical injury, physical abuse, or substantial property damage to another person; or
   (C) manifests a current intent to carry out plans of serious harm to that person's self or another;
(11) "mental health professional" means a psychiatrist or physician who is licensed by the State Medical Board to practice in this state or is employed by the federal government; a clinical psychologist licensed by the state Board of Psychologist and Psychological Associate Examiners; a psychological associate trained in clinical psychology and licensed by the Board of Psychologist and Psychological Associate Examiners; a registered nurse with a master's degree in psychiatric nursing, licensed by the State Board of Nursing; a marital and family therapist licensed by the Board of Marital and Family Therapy; a professional counselor licensed by the Board of Professional Counselors; a clinical social worker licensed by the Board of Social Work Examiners; and a person who
   (A) has a master's degree in the field of mental health;
(B) has at least 12 months of post-masters working experience in the field of mental illness; and

(C) is working under the supervision of a type of licensee listed in this paragraph;

(12) "mental illness" means an organic, mental, or emotional impairment that has substantial adverse effects on an individual's ability to exercise conscious control of the individual's actions or ability to perceive reality or to reason or understand; mental retardation, epilepsy, drug addiction, and alcoholism do not per se constitute mental illness, although persons suffering from these conditions may also be suffering from mental illness;

(13) "peace officer" includes a state police officer, municipal or other local police officer, state, municipal, or other local health officer, public health nurse, United States marshal or deputy United States marshal, or a person authorized by the court;

(14) "persons with mental disorders" has the meaning given in AS 47.30.610.

(15) "professional person in charge" means the senior mental health professional at a facility or that person's designee; in the absence of a mental health professional it means the chief of staff or a physician designated by the chief of staff;

(16) "provider of outpatient care" means a mental health professional or hospital, clinic, institution, center, or other health care facility designated by the department to accept for treatment patients who are ordered to undergo involuntary outpatient treatment by the court or who are released early from inpatient commitments on condition that they undergo outpatient treatment;

(17) "screening investigation" means the investigation and review of facts that have been alleged to warrant emergency examination or treatment, including interviews with the persons making the allegations, any other significant witnesses who can readily be contacted for interviews, and, if possible, the respondent, and an investigation and evaluation of the reliability and credibility of persons providing information or making allegations;

(18) "state" means a state of the United States, the District of Columbia, the territories and possessions of the United States, and the Commonwealth of Puerto Rico, and, with the approval of the United States Congress, Canada.

Article 12. PERSONAL DECLARATION OF PREFERENCE FOR MENTAL HEALTH TREATMENT

Sec. 47.30.950. Declaration.

(a) An adult of sound mind may make a declaration of preferences or instructions regarding mental health treatment. The preferences or instructions may include consent to or refusal of mental health treatment.

(b) A declaration for mental health treatment continues in effect for three years or until revoked, whichever is sooner. The authority of a named attorney-in-fact and an alternative attorney-in-fact named in the declaration continues in effect as long as the declaration appointing the attorney-in-fact is in effect or until the attorney-in-fact has withdrawn. If a declaration for mental health treatment has been invoked and is in effect at the expiration of three years after its execution, the declaration remains effective until the principal is no longer incapable.

Sec. 47.30.952. Designation of attorney-in-fact.

(a) A declaration may designate a competent adult to act as attorney-in-fact to make decisions about mental health treatment. An alternative attorney-in-fact may also be designated to act as attorney-in-fact if the original designee is unable or unwilling to act at any time. An attorney-in-fact who has accepted the appointment in writing may make
decisions about mental health treatment on behalf of the principal only when the principal is incapable. The decisions must be consistent with desires the principal has expressed in the declaration.

(b) The following may not serve as attorney-in-fact:

1. the attending physician or mental health service provider, or an employee of the physician or provider, if the physician, provider, or employee is unrelated to the principal by blood, marriage, or adoption;

2. an owner, operator, or employee of a health care facility in which the principal is a patient or resident if the owner, operator, or employee is unrelated to the principal by blood, marriage, or adoption.

(c) An attorney-in-fact may withdraw by giving notice to the principal. If a principal is incapable, the attorney-in-fact may withdraw by giving notice to the attending physician or provider. The attending physician or provider shall note the withdrawal as part of the principal's medical record. A person who has withdrawn under the provisions of this subsection may rescind the withdrawal by executing an acceptance after the date of the withdrawal. The acceptance must be in the same form as provided by AS 47.30.970 for accepting an appointment. A person who rescinds a withdrawal shall give notice to the principal if the principal is capable or to the principal's health care provider if the principal is incapable.

(d) The designation of an attorney-in-fact under this section supersedes a previous or subsequent designation of an attorney-in-fact regarding mental health treatment unless otherwise specifically provided in the declaration executed under AS 47.30.950 - 47.30.980 or in the document that designates the other attorney-in-fact.

Sec. 47.30.954. Signature; witnesses.

(a) A declaration is effective only if it is signed by the principal and two competent adult witnesses. The witnesses must attest that the principal is personally known to them, signed the declaration in their presence, appears to be of sound mind, and is not under duress, fraud, or undue influence.

(b) The following may not serve as a witness to the signing of a declaration:

1. the attending physician or mental health service provider or a relative of the physician or provider;

2. an owner, operator, or relative of an owner or operator of a health care facility in which the principal is a patient or resident; or

3. a person related to the principal by blood, marriage, or adoption.

Sec. 47.30.956. Operation of declaration.

(a) A declaration becomes operative when it is delivered to the principal's physician or other mental health treatment provider and remains valid until revoked or expired. The physician or provider shall act in accordance with an operative declaration when the principal has been found to be incapable. The physician or provider shall continue to obtain the principal's informed consent to all mental health treatment decisions if the principal is capable of providing informed consent or refusal.

(b) Upon being presented with a declaration, a physician or other provider shall make the declaration a part of the principal's medical record. When acting under authority of a declaration, a physician or provider shall comply with it to the fullest extent possible, consistent with reasonable medical practice, the availability of treatments requested, and applicable law. If the physician or other provider is unwilling at any time to comply with the declaration, the physician or provider may withdraw from providing treatment consistent with the exercise of independent medical judgment and shall promptly notify the principal and the attorney-in-fact and document the notification in the principal's medical record.
Sec. 47.30.958. Powers of attorney-in-fact.
   (a) The attorney-in-fact does not have authority to make mental health treatment decisions unless the principal is incapable.
   (b) The attorney-in-fact is not, as a result of acting in that capacity, personally liable for the cost of treatment provided to the principal.
   (c) Except to the extent the right is limited by the declaration or any federal law, an attorney-in-fact has the same right as the principal to receive information regarding the proposed mental health treatment and to receive, review, and consent to disclosure of medical records relating to that treatment. This right of access does not waive any evidentiary privilege.
   (d) In exercising authority under the declaration, the attorney-in-fact has a duty to act consistently with the desires of the principal as expressed in the declaration. If the principal's desires are not expressed in the declaration and not otherwise known by the attorney-in-fact, the attorney-in-fact has a duty to act in what the attorney-in-fact in good faith believes to be the best interests of the principal.
   (e) An attorney-in-fact is not subject to criminal prosecution, civil liability, or professional disciplinary action for an action taken in good faith under a declaration for mental health treatment.

Sec. 47.30.960. Limitations.
A person may not be required to execute or to refrain from executing a declaration as a criterion for insurance, as a condition for receiving mental or physical health services, or as a condition of discharge from a health care facility.

Sec. 47.30.962. Actions contrary to declaration.
The physician or provider may subject the principal to mental health treatment in a manner contrary to the principal's wishes as expressed in a declaration for mental health treatment only
   (1) if the principal is committed to a treatment facility under this chapter and treatment is authorized in compliance with AS 47.30.825 - 47.30.865; or
   (2) in cases of emergency endangering life or health.

Sec. 47.30.964. Relation to other statutes.
A declaration does not limit any authority provided in this chapter either to take a person into custody or to admit, retain, or treat a person in a health care facility.

Sec. 47.30.966. Revocation.
A declaration may be revoked in whole or in part at any time by the principal if the principal is not incapable. A revocation is effective when a capable principal communicates the revocation to the attending physician or other provider. The attending physician or other provider shall note the revocation as part of the principal's medical record.

Sec. 47.30.968. Limited immunity.
A physician or provider who administers or does not administer mental health treatment according to and in good faith reliance upon the validity of a declaration is not subject to criminal prosecution, civil liability, or professional disciplinary action resulting from a subsequent finding of a declaration's invalidity.

Sec. 47.30.970. Form of declaration.
A declaration for mental health treatment shall be in substantially the following form:

DECLARATION FOR MENTAL HEALTH TREATMENT

I, ________________________, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by a court, two physicians that include a psychiatrist, or one physician and a professional mental health clinician, that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. 'Mental health treatment' means electroconvulsive treatment, treatment of mental illness with psychotropic medication, and admission to and retention in a health care facility for a period up to 17 days.

I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

PSYCHOTROPIC MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows:

I consent to the administration of the following medications:

I do not consent to the administration of the following medications:

Conditions or limitations: ____________________________________________________________.

ELECTROCONVULSIVE TREATMENT

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding electroconvulsive treatment are as follows:

I consent to the administration of electroconvulsive treatment.

I do not consent to the administration of electroconvulsive treatment.

Conditions or limitations: ____________________________________________________________.

ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding admission to and retention in a health care facility for mental health treatment are as follows:

I consent to being admitted to a health care facility for mental health treatment for up to ________ days.

I do not consent to being admitted to a health care facility for mental health treatment.

This directive cannot, by law, provide consent to retain me in a facility for more than 17 days.

Conditions or limitations: ____________________________________________________________.

ADDITIONAL PREFERENCES OR INSTRUCTIONS

__________________________________________________________

Conditions or limitations: ____________________________________________________________.

ATTORNEY-IN-FACT

I appoint:
NAME ______________________________________________________________
ADDRESS ___________________________________________________________
TELEPHONE NO. _______________________________________________________
to act as my attorney-in-fact to make decisions regarding my mental health treatment if Iecome incapable of giving or withholding informed consent for that treatment.
If the person named above refuses or is unable to act on my behalf, or if I revoke that
person's authority to act as my attorney-in-fact, I authorize the following person to act as my
attorney-in-fact:
NAME ______________________________________________________________
ADDRESS ___________________________________________________________
TELEPHONE NO. _______________________________________________________
My attorney-in-fact is authorized to make decisions that are consistent with the wishes I have
expressed in this declaration or, if not expressed, as are otherwise known to my attorney-in-
fact. If my wishes are not expressed and are not otherwise known by my attorney-in-fact, my
attorney-in-fact is to act in what my attorney-in-fact believes to be my best interests.

OTHER DOCUMENTS
_______ I have executed a general power-of-attorney or a power-of-attorney under AS
13.26 that includes the power to make decisions regarding health care services for myself. I
authorize the attorney-in-fact appointed under this declaration and the attorney-in-fact
appointed under a general power-of-attorney under AS 13.26 to serve
_______ jointly with consent of each other as to my mental health treatment;
_______ separately without each other's consent as to my mental health treatment.
_______ I have not executed a general power-of-attorney or a power-of-attorney under AS
13.26 that includes the power to make decisions regarding health care services for myself.

(Signature of Declarant/Date)

________________________________
(Address)

(Telephone Number)

AFFIRMATION OF WITNESSES
We affirm that the principal is personally known to us, that the principal signed or
acknowledged the principal's signature on this declaration for mental health treatment in our
presence, that the principal appears to be of sound mind and not under duress, fraud, or
undue influence, and that neither of us is a person appointed as an attorney-in-fact by this
document; the principal's attending physician or mental health service provider or a relative
of the physician or provider; the owner, operator, or relative of an owner or operator of a
facility in which the principal is a patient or resident; or a person related to the principal by
blood, marriage, or adoption.
Witnessed By:

(Signature of Witness/Date) (Printed Name of Witness)

________________________________
(Address)

(Telephone Number)

(Signature of Witness/Date) (Printed Name of Witness)

(Address)
ACCEPTANCE OF APPOINTMENT AS ATTORNEY-IN-FACT

I accept this appointment and agree to serve as attorney-in-fact to make decisions about mental health treatment for the principal. I understand that I have a duty to act in a manner consistent with the desires of the principal as expressed in this appointment. I understand that this document gives me authority to make decisions about mental health treatment only while the principal is incapable as determined by a court, two physicians that include a psychiatrist, or one physician and a professional mental health clinician. I understand that the principal may revoke this declaration in whole or in part at any time and in any manner when the principal is not incapable.

(Signature of Attorney-in-fact/Date) (Printed name)

(Address)

(Telephone Number)

(Signature of Alternate Attorney-in-fact/Date) (Printed name)

(Address)

(Telephone Number)

NOTICE TO PERSON MAKING A DECLARATION FOR MENTAL HEALTH TREATMENT

This is an important legal document. It creates a declaration for mental health treatment. Before signing this document, you should know these important facts:

1. This document allows you to make decisions in advance about three types of mental health treatment: psychotropic medication, electroconvulsive therapy, and short-term (up to 17 days) admission to a treatment facility. The instructions that you include in this declaration 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 incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments.

2. You may also appoint a person as your attorney-in-fact to make these treatment decisions for you if you become incapable. The person you appoint has a duty to act consistent with your desires as stated in this document or, if your desires are not stated or otherwise made known to the attorney-in-fact, to act in a manner consistent with what the person in good faith believes to be in your best interest. For the appointment to be effective, the person you appoint must accept the appointment in writing. The person also has the right to withdraw from acting as your attorney-in-fact at any time.

3. This document will continue in effect for a period of three years unless you become incapable of participating in mental health treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapable.

4. You have the right to revoke this document in whole or in part at any time you have not been determined to be incapable. YOU MAY NOT REVOKE THIS DECLARATION WHEN YOU ARE CONSIDERED INCAPABLE BY A COURT, TWO PHYSICIANS THAT INCLUDE A PSYCHIATRIST, OR A PHYSICIAN AND A PROFESSIONAL MENTAL HEALTH CLINICIAN. A revocation is effective when it is communicated to your attending physician or other provider.
(5) If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This declaration will not be valid unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

Sec. 47.30.972. Penalty.
It is a class A misdemeanor for a person without authorization of the principal to knowingly alter, forge, conceal, or destroy a declaration executed under AS 47.30.950 - 47.30.980, the reinstatement or revocation of a declaration executed under AS 47.30.950 - 47.30.980, or any other evidence or document reflecting the principal's desires and interests with the intent or effect of affecting a mental health care decision. In this section, "knowingly" has the meaning given in AS 11.81.900(a).

Sec. 47.30.980. Definitions.
In AS 47.30.950 - 47.30.980,
(1) "attending physician" means the licensed physician who has primary responsibility for the care and treatment of the declarant;
(2) "attorney-in-fact" means an adult properly appointed under AS 47.30.950 - 47.30.980 to make mental health treatment decisions for a principal under a declaration for mental health treatment and also means an alternative attorney-in-fact;
(3) "facility" means a
(A) designated treatment facility, as defined in AS 47.30.915;
(B) nursing home; or
(C) assisted living home licensed under AS 47.33;
(4) "incapable" means that, in the opinion of the court in a guardianship proceeding under AS 13.26, in the opinion of two physicians that include a psychiatrist, or in the opinion of a physician and a professional mental health clinician, a person's ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that the person currently lacks the capacity to make mental health treatment decisions;
(5) "mental health treatment" means electroconvulsive treatment, treatment with psychotropic medication, and admission to and retention in a facility for a period not to exceed 17 days;
(6) "professional mental health clinician" means a person having at least a master's degree in psychology, social work, counseling, child guidance, or nursing with specialization or experience in mental health; if employed by a mental health physician clinic, a "professional mental health clinician" must also be licensed to practice in the state in which service is being provided or be a clinical member in good standing of the American Association for Marriage and Family Therapy, and be working in the clinician's field of expertise; in this paragraph, "mental health physician clinic" means a clinic, operated by one or more psychiatrists, that exclusively or primarily provides mental health services furnished by a psychiatrist or by one or more licensed psychologists, licensed psychological associates, licensed clinical social workers, licensed nurse practitioners, licensed psychiatric nursing clinical specialists, or clinical members in good standing of the American Association for Marriage and Family Therapy, who are working in their field of expertise under the direct supervision of a psychiatrist.
Chapter 47.31. MENTAL HEALTH TREATMENT ASSISTANCE PROGRAM

Sec. 47.31.005. Applicability.
This chapter applies only to those patients who have received evaluation or treatment at an evaluation facility or a designated treatment facility that is not a state-operated hospital.

Sec. 47.31.010. Eligibility for assistance.
(a) The department shall provide financial assistance under this chapter to a patient who
(1) does not have the available means to pay or substantially contribute to the payment of charges assessed by a facility;
(2) has no other third party to pay for the evaluation or treatment provided under AS 47.30; and
(3) meets the criteria in this chapter.
(b) To be eligible for assistance under this chapter, a patient must have
(1) been admitted for inpatient evaluation or treatment at an evaluation facility or a designated treatment facility other than a state-operated hospital after either
(A) an involuntary commitment under AS 47.30.700 - 47.30.915; or
(B) a voluntary admission chosen by the patient after a determination by the patient's treating physician that the patient meets the involuntary commitment criteria in AS 47.30.700 - 47.30.915 and that involuntary commitment proceedings would be initiated if the patient did not choose to be admitted voluntarily; and
(2) a gross monthly household income that does not exceed 185 percent of the federal poverty guideline for this state for the calendar month in which service was provided.

Sec. 47.31.015. Application for assistance.
(a) To receive assistance under this chapter, a patient or a patient's legal representative must apply in writing on a form provided by the department. A patient must apply for assistance within 180 days after the date of discharge from the facility.
(b) A patient is considered to have applied for assistance under (a) of this section if the evaluation facility or designated treatment facility notifies the department on a form provided by the department that there is good cause to believe that the patient would be eligible for assistance under this chapter and
(1) the patient, the patient's spouse, or the patient's parent if the patient is under 18 years of age failed within 150 days after the date of discharge from the facility to make arrangements to pay the evaluation facility or designated treatment facility; or
(2) the patient lacks the mental capacity to apply for benefits under this chapter.
(c) A patient who applies or is considered to have applied for assistance under this chapter, the patient's spouse, the patient's parent if the patient is under 18 years of age, or a person in the patient's household shall release records and information to the department necessary to verify eligibility for the assistance.
(d) If a patient, the patient's spouse, the patient's parent if the patient is under 18 years of age, or a person in the patient's household fails to provide records and information to the department necessary to verify eligibility, the department may issue an administrative order imposing full liability for the patient's cost of care and treatment to the evaluation facility or designated treatment facility.

Sec. 47.31.020. Decision on eligibility.
(a) Within 30 days after receiving a complete application, the department shall give notice in writing of an eligibility determination to the patient or the patient's legal
representative. If the patient is found ineligible, the notice must contain the reason for the denial and an explanation of the patient's right to an administrative appeal of the denial.

(b) The department shall provide a copy of the notice of eligibility or ineligibility to the facility at which the patient was treated.

Sec. 47.31.025. Eligible services; rates.
The department shall identify the type and level of services for which assistance is available under this chapter. An evaluation facility or a designated treatment facility shall be reimbursed at a rate established by the department that is equivalent to the Medicaid rate for that facility at the time service was rendered as determined under AS 47.07.070.

Sec. 47.31.030. Payment.
If the department determines that a patient is eligible for assistance under this chapter, the department shall provide for payment of assistance directly to the facility. By endorsing the check received from the department or authorizing the endorsement by the facility's agent, the facility certifies that the claim for which the check is payment is true and accurate unless written notice of an error is sent to the department by the facility within 30 days after the date the check is presented by the facility for payment.

Sec. 47.31.032. Access to records and information by the department.
The department is authorized to review, obtain, and copy confidential and other records and information about the patients who were eligible for or were provided financial assistance under this chapter to evaluate compliance with this chapter. The department may obtain the records and information from the patient or directly from the evaluation facility or the designated treatment facility. Records obtained by the department under this section are medical records, shall be handled confidentially, and are exempt from public inspection and copying under AS 40.25.110 - 40.25.120.

Sec. 47.31.035. Appeals.
(a) A patient or the patient's legal representative may appeal a denial of assistance by sending written notice of objection to the department within 30 days after the date of the notice of denial. The written notice of objection must include an explanation of the reasons for the objection and may include documentation supporting the objection. AS 44.62 (Administrative Procedure Act) does not apply to the appeal.

(b) The commissioner or the commissioner's designee shall review the notice of objection and issue a decision within 90 days after its receipt. The commissioner or the commissioner's designee may request additional information on the appeal from either the patient, the evaluation facility or designated treatment facility, or department staff. A request for additional information suspends the time period for the appeal until the department determines that the additional information has been received. If more than 180 days have passed from the date of submission of a notice of appeal and the additional information requested by the commissioner or the commissioner's designee has not been received from a patient, the evaluation facility, the designated treatment facility, or the department, the appeal shall be considered denied.

(c) The decision on the appeal under (b) of this section, including an appeal denied for failure to submit additional information, is a final agency decision and may be appealed to the superior court under the Alaska Rules of Appellate Procedure.

Sec. 47.31.090. Regulations.
The department shall, after consultation with the Alaska Mental Health Trust Authority, adopt regulations to interpret or implement this chapter.

Sec. 47.31.100. Definitions.
In this chapter, unless the context otherwise requires,
(1) "commissioner" means the commissioner of health and social services;
(2) "department" means the Department of Health and Social Services;
(3) "designated treatment facility" has the meaning given in AS 47.30.915;
(4) "evaluation facility" means a health care facility that has been designated by the department to perform the evaluations described in AS 47.30.670 - 47.30.915, including a facility licensed under AS 18.20.020 or operated by the federal government;
(5) "gross monthly household income" means all earned or unearned income from any source of a member of the patient's household;
(6) "household" means a patient and each person
(A) residing with the patient; and
(B) related to the patient by marriage or other legal relationship giving rise to a duty of support and maintenance;
(7) "mental illness" has the meaning given in AS 47.30.915.
CHAPTER 71. COMMUNITY MENTAL HEALTH SERVICES.

Article
1. Scope. (7 AAC 71.010 - 7 AAC 71.010)
2. Contracts for Services. (7 AAC 71.020 - 7 AAC 71.045)
3. Standards for Operation of a Community Mental Health Center. (7 AAC 71.100 - 7 AAC 71.165)
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Article 1
Scope

Section
10. Applicability.

7 AAC 71.010. Applicability
(a) 7 AAC 71 applies to a community mental health center receiving financial assistance under AS 47.30.520 - 47.30.620, the Community Mental Health Services Act.
(b) A nonprofit corporation or political subdivision that receives financial assistance under AS 47.30.520 - 47.30.620 and subcontracts with agencies or individuals to deliver mental health services must ensure that the agencies actually delivering the services comply with 7 AAC 71.

History: Eff. 9/1/82, Register 83
Authority: AS 47.30.530
AS 47.30.540

Article 2
Contracts for Services

Section
20. Application process.
25. Geographic planning areas.
30. Governing boards and advisory boards.
35. Execution of contract.
40. Coordination and non-duplication of services.
45. Capital expenditures.

7 AAC 71.020. Application process
(a) Application for financial assistance under AS 47.30.520 - 47.30.620 must be made on a form provided by the department.
(b) The department may assist an applicant in preparing the application and in complying with the requirements of this chapter 7 AAC 71.

History: Eff. 9/1/82, Register 83; am 6/24/2004, Register 170
Authority: AS 47.30.530
AS 47.30.540
7 AAC 71.025. Geographic planning areas
(a) The department will maintain a list of geographic planning areas and the communities within each area. A community mental health center receiving financial assistance, or an applicant for financial assistance under AS 47.30.520 - AS 47.30.620 within a geographic planning area, shall serve the entire area. Centers or applicants that are unable to provide services to the entire geographical planning area must submit to the department their reasons for proposing to serve only part of the geographical planning area. Department review and approval of these reasons is required before financial assistance will be awarded.
(b) An organization applying for financial assistance under AS 47.30.520 - 47.30.620 shall, whenever possible, propose to provide services throughout an entire geographic planning area. If two or more organizations are each proposing to serve only a part of the planning area, the department, upon receipt of the organizations' letters of intent under 7 AAC 78.060, will notify each applicant of the intent of other applicants to serve a part of the same planning area. The affected applicants shall either develop a single areawide services application or document attempts to do so.
(c) An applicant shall submit a separate application for each geographic planning area for which financial assistance is sought.
History: Eff. 9/1/82, Register 83; am 6/24/2004, Register 170
Authority: AS 47.30.530
AS 47.30.540

7 AAC 71.030. Governing boards and advisory boards
(a) A community mental health center receiving financial assistance under AS 47.30.520 - 47.30.620 must be governed by a board selected in accordance with the following criteria, except as provided for in (b) of this section:
(1) A governing board must be composed of at least five members who reside in the area served by the mental health center.
(2) A majority of the board members may not be providers of direct health care services or have been providers of direct health care services for the 12 months before appointment. No more than two members or 40 percent of the membership, whichever is greater, may be providers of direct health care services.
(3) As much as practicable, a governing board must be representative of the geographic planning area, including representatives of the
(A) major racial and linguistic groups; and
(B) various economic groups.
(4) A representative of a particular subgroup or class of members need not be an actual member of the subgroup or class if the representative is designated by an organization composed primarily of members of the subgroup or class.
(5) No employee of a grantee may be a member of the grantee's governing board.
(b) A native corporation, municipality, or other nonprofit entity that receives financial assistance under AS 47.30.520 - 47.30.620 which has an existing governing board must (1) appoint and be advised by an advisory board; or
(2) if services are offered by a subcontractor, the subcontractor must either have its own board as specified in (a) of this section or be directed by the contractor's advisory board.
(c) Each advisory board must meet the requirements of representation in (a) of this section.
An advisory board must participate in program planning, development and evaluation, and must advise the governing board with respect to policy, administration procedures, and other areas of community mental health.

(d) A governing board must select a program director or subcontractor. If an advisory board is required by (b) of this section, the selection and discharge of a project director is subject to the approval of the advisory board.

History: Eff. 9/1/82, Register 83
Authority: AS 47.30.530
AS 47.30.540

7 AAC 71.035. Execution of contract
(a) The department will distribute financial assistance under AS 47.30.520 - 47.30.620 to a local community entity whose application is approved under 7 AAC 71.110 only after the community entity enters into a written contract with the department.
(b) The contract must contain a written provision assuring that money made available under AS 47.30.520 - 47.30.620 will not supplant existing local funding support of community mental health services.
(c) If the contractor is, or is affiliated with, a political subdivision of the state, the contract must provide that local support of community mental health services will be continued at a level at least equal to that of the previous grant year.

History: Eff. 9/1/82, Register 83; am 6/24/2004, Register 170
Authority: AS 47.30.520
AS 47.30.530
AS 47.30.540
AS 47.30.550
AS 47.30.560
AS 47.30.570

7 AAC 71.040. Coordination and non-duplication of services
An applicant or contractor receiving financial assistance under AS 47.30.520 - 47.30.620 must work with other programs or entities in its service area providing the same category or scope of services to assure that service delivery is coordinated with other programs in order to minimize duplication of services and best meet the needs of the service area population. An applicant must document these attempts in the application for financial assistance.

History: Eff. 9/1/82, Register 83
Authority: AS 47.30.530
AS 47.30.570

7 AAC 71.045. Capital expenditures
Capital expenditures by contractors may not be paid, in whole or in part, by financial assistance provided under AS 47.30.520 - 47.30.620.

History: Eff. 9/1/82, Register 83
Authority: AS 47.30.530
AS 47.30.570

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Article 3
Standards for Operation of a Community Mental Health Center

Section
100. Organization and administration.
105. Policy and procedures manual.
110. Fiscal administration.
115. Personnel administration.
120. Program evaluation.
125. Quality assurance.
130. Plan of services.
135. Types of services and populations to be served.
140. Availability and accessibility of services.
145. Coordination and continuity of services.
150. Center facility.
155. Client records.
160. Records retention.
162. Closure of center; records.
165. Waiver of requirements.

7 AAC 71.100. Organization and administration
A community mental health center must provide the department with
(1) a table of organization that identifies and describes all operating units of the program,
defines the roles and responsibilities of all center staff, delineates the interrelationship of the
governing body, advisory board, program director, and all center administrative and service
staff, and that is reviewed and updated annually; and
(2) the name, address, and telephone number of the individual or entity ultimately
responsible for operation of the center and the name and address of each member of its
governing and advisory boards.
History: Eff. 9/1/82, Register 83; am 6/24/2004, Register 170
Authority: AS 47.30.530
AS 47.30.540

7 AAC 71.105. Policy and procedures manual
(a) A center must have a policy and procedures manual that is approved by the governing
board. It must be reviewed annually and revised as necessary.
(b) Provisions in the policy and procedures manual must be consistent internally and with
applicable department and division policies and procedures.
(c) Written policies and procedures must be maintained in the following areas:
(1) fiscal administration, including provisions required under 7 AAC 71.110;
(2) personnel administration, including provisions required under 7 AAC 71.115;
(3) evaluation and research procedures, including provisions of 7 AAC 71.120;
(4) quality assurance and utilization review procedures, including provisions of 7 AAC
71.125;
(5) provisions for service delivery to the physically handicapped, including provisions of 7
AAC 71.135;
(6) procedures for serving major language and cultural population subgroups, including
provisions of 7 AAC 71.135;
(7) procedures for 24-hour availability of services according to
7 AAC 71.135;
(8) procedure to ensure coordination and continuity of services to clients, including
provisions of 7 AAC 71.140;
(9) procedures for ensuring privacy in facilities, including provisions of 7 AAC 71.150;
(10) client records, including provisions required under 7 AAC 71.155 - 7 AAC 71.160;
(11) rights of clients, including provisions of 7 AAC 71.200 - 7 AAC 71.220; and
(12) a plan for management of pharmaceuticals stored in the center.

History: Eff. 9/1/82, Register 83
Authority: AS 47.30.530
AS 47.30.540

7 AAC 71.110. Fiscal administration
To maximize revenues and to ensure proper fiscal management, a center must
(1) prepare and maintain a formal budget;
(2) maintain fiscal records and provide to the department fiscal reports at least quarterly on
forms provided by the department;
(3) provide for an audit at least once every two years;
(4) develop a sliding fee scale based on an analysis of reasonable ability to pay; and
(5) establish procedures within the limits set by 7 AAC 71.140(g) to maximize collection of
fees from service recipients and third-party insurers.

History: Eff. 9/1/82, Register 83; am 6/24/2004; Register 170
Authority: AS 47.30.530
AS 47.30.540

7 AAC 71.115. Personnel administration
(a) A center must have written and functioning policies and procedures to ensure consistency
in personnel administration and staff competency in carrying out assigned tasks. These
policies and procedures must include
(1) job descriptions for paid and volunteer staff members, including for each position
   (A) a description of the duties, specific tasks and responsibilities;
   (B) the salary range;
   (C) a statement of minimum qualifications describing necessary training, experience, and
      other qualifications such as licensure; and
   (D) the position title of the immediate supervisor of the position;
(2) provision for yearly written evaluations of all staff;
(3) procedures for recruitment and screening of job applicants;
(4) a description of the center's salary structure, including salary ranges and the method of
determining salary increases; and
(5) a requirement that tasks which are restricted by law to specific disciplines will be
   performed only by qualified individuals.
(b) Changes in or exceptions to written job descriptions that materially alter the scope of the
program are subject to prior department approval.
(c) A written job description for a program director is subject to department approval. A
program director must be an experienced mental health professional with at least a master's
degree in a mental health field.
(d) A center must develop a staff training plan and provide or arrange for supervised practical
experience, education, or training to increase the skill level of center staff. This staff training
must include a least 30 hours of instruction each year. The training may be offered in the
form of formalized education, case supervision, staff conferences, or other appropriate
educational activities in the area of mental health and mental health administration.

History: Eff. 9/1/82, Register 83; am 6/24/2004, Register 170
Authority: AS 47.30.530
AS 47.30.540
7 AAC 71.120. Program evaluation
(a) A center must develop procedures necessary to evaluate the program and must conduct an evaluation annually.
(b) The evaluation must include
(1) information about demographic characteristics and diagnostic categories of clients served;
(2) computation of the time spent in each program area such as administration, direct client services, and consultation;
(3) assessment of community and client reaction to services, which may include questionnaires, surveys, or board reports; and
(4) the center's evaluation of the degree of achievement of the annual plan.
History: Eff. 9/1/82, Register 83
Authority: AS 47.30.530

7 AAC 71.125. Quality assurance
(a) A center must have systematic procedures for the review of the quality of care and the use of services and facilities.
(b) There must be a written description of current quality assurance procedures that is reviewed and revised annually.
(c) At least two utilization reviews must be completed each year as described in 7 AAC 71.155(g).
History: Eff. 9/1/82, Register 83
Authority: AS 47.30.530

7 AAC 71.130. Plan of services
A center must have a written plan of services which
(1) the center staff reviews annually and revises as necessary to reflect changing community needs;
(2) includes the center's annual goals, the steps and resources necessary to implement the goals;
(3) includes a review of compliance with or reasons for exceptions to relevant regional and state planning documents; and
(4) includes a five-year plan for development and delivery of mental health services to the service area.
History: Eff. 9/1/82, Register 83
Authority: AS 47.30.530
AS 47.30.540

7 AAC 71.135. Types of services and populations to be served
(a) A center must serve, to the extent that mental health services are not available to them from other providers, the following populations in prioritized order:
(1) acutely disturbed persons;
(2) chronically, severely disturbed persons;
(3) children and adolescents;
(4) other persons or agencies requiring direct mental health intervention; and
(5) other persons or agencies requiring nondirect mental health services such as consultation or education.
(b) A center must provide the following services to the above listed populations in prioritized order:
(1) evaluation services, including
(A) diagnosis using a classification in Diagnostic and Statistical Manual of Mental Disorders, 4th edition, 2000 (DSM-IV-TR), adopted by reference, or International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM), adopted by reference; and

(B) evaluations for persons being considered for involuntary commitment under AS 47.30.700 - 47.30.915; this service is to include both court-ordered screening investigations and evaluations for commitment, if the necessary facilities and personnel are available; and

(2) treatment services, both voluntary and involuntary, which emphasize a brief therapy and crisis intervention model, including

(A) 24-hour inpatient psychiatric treatment for both voluntary and involuntary patients as close to the patient's home as possible; for involuntary patients, this service must include a written cooperative agreement with the Alaska Psychiatric Institute or other state-designated inpatient psychiatric facility; and

(B) outpatient care, including

(i) 24-hour direct emergency services for crisis intervention;
(ii) individual counseling/psychotherapy;
(iii) group counseling/psychotherapy;
(iv) case management and supportive care for chronic patients;
(v) referral services to other agencies; and
(vi) consultation and education services.

(3) The services required by (b) of this section may be provided either

(A) directly by the center; or

(B) by another provider through a contract with the center.

History: Eff. 9/1/82, Register 83; am 6/24/2004, Register 170

Authority: AS 47.30.530

AS 47.30.540

Editor's note: A copy of both publications adopted by reference in 7 AAC 71.135(b) (1)(A), Diagnostic and Statistical Manual of Mental Disorders, 4th edition, 2000 (DSM-IV-TR), and International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM), may be reviewed at the department's division of behavioral health. Diagnostic and Statistical Manual of Mental Disorders, 4th edition, 2000 (DSM-IV-TR), may be obtained from the American Medical Association at 800-621-8355. International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM), may be obtained from the American Psychiatric Association at 1400 K Street N.W., Washington, D.C. 20015.

7 AAC 71.140. Availability and accessibility of services

(a) A center must make services available at times and locations which enable service area residents to use services.

(b) A center must

(1) have written procedures indicating how residents will have access to 24-hour mental health emergency services;

(2) provide regular services on evenings and weekends if the need for such services is determined by the local governing board; and

(3) include in its yearly plan provisions for serving those persons who cannot come to the center.

(c) Methods of obtaining services must be made known to other human services agencies and to area residents.

(d) Center services must be listed in the public telephone directory.

(e) If center services are not accessible to physically handicapped individuals, alternative means for these individuals to receive services must be included in the yearly plan.
(f) A center must establish procedures to make services available to clients in the languages of the major subgroups within the service area.
(g) A center may not deny services to any person because of inability to pay.

History: Eff. 9/1/82, Register 83
Authority: AS 47.30.530
AS 47.30.540

7 AAC 71.145. Coordination and continuity of services
(a) A center must
(1) have written procedures to ensure coordination and continuity of services to clients;
(2) document coordination of services within the center and between community agencies and the center through such mechanisms as referral agreements and case conferences;
(3) identify, initiate, and document working relationships with all in-patient facilities servicing the service area, to ensure that area residents have access to follow-up services; and
(4) document procedures for case management.
(b) To ensure coordination and continuity of services under (a) of this section, the center must enter into a written agreement with each
(1) evaluation or treatment facility designated under 7 AAC 72 that refers patients to the center after discharge; and
(2) state-operated hospital that refers patients to the center after discharge.
(c) An agreement under (b) of this section must state that the center will, after being notified by the facility or hospital of a patient's discharge, schedule an appointment at the center with the patient for
(1) clinical services within one week after the patient's discharge; and
(2) medication management services before depletion of any psychotropic medication dispensed or prescribed to the patient upon discharge, and that, whenever possible, medication management services are to include a psychiatric evaluation.
(d) If a single-point-of-entry psychiatric emergency facility is located in the area served by a center, the center shall, at a minimum, have in place with that facility a memorandum of understanding that includes terms identical to those required under (c) of this section.

History: Eff. 9/1/82, Register 83; am 3/16/2001, Register 157
Authority: AS 47.30.530
AS 47.30.540
AS 47.30.660
AS 47.31.090

7 AAC 71.150. Center facility
A center must
(1) provide space for confidential interviews; and
(2) comply with applicable state and local fire, health and safety ordinances, regulations, and statutes.

History: Eff. 9/1/82, Register 83
Authority: AS 47.30.530
AS 47.30.540

7 AAC 71.155. Client records
(a) A center must maintain an organized record system that contains client information, including information required on the admission and discharge forms provided by the department.
(b) A client record must contain documentation of the initial and continued assessment of the client including:

1. a description and evaluation of the present problem as seen by the client;
2. a mental status assessment;
3. health status and current medication;
4. developmental, social, and referral information; and
5. a diagnostic formulation of the client's problems.

(c) A client record must contain an identifiable, current treatment plan which includes:

1. the goals of the service provided by the center;
2. a description of the services to be provided and the frequency and estimated duration of these services; and
3. copies of referrals to other individuals or agencies to meet these service goals when referrals are necessary.

(d) A client record must contain descriptive progress notes including all diagnostic and treatment services rendered and their results.

(e) A client record must be dated and signed by the person completing it.

(f) A client record must contain a closing summary at termination of service which must include the reason for termination, a summary of the course and results of treatment, and any follow-up plans or referral information.

(g) A center must provide for at least semi-annual utilization review of client records to determine that the records contain sufficient documentation to meet the requirements of this section.

(h) A center must submit information to the department as required by 7 AAC 85.

(i) Subject to the other provisions of this subsection, a center may satisfy the recordkeeping requirements of this section for records that contain behavioral health information through electronic records that meet the applicable requirements of 7 AAC 85. Notwithstanding the requirements of this section, a center may be required to retain paper or paper-based copies of documents that are required under other state or federal law for audit or other purposes. For purposes of this subsection, "behavioral health information" means information regarding behavioral health services, including:

1. emergency services, including detoxification and acute psychiatric hospitalization; and
2. prevention, intervention, and treatment services in the areas of mental health and of alcohol abuse and other addictions, including ongoing care and supportive services; and
3. "paper-based copies" means documents stored on microfilm or microfiche, in tagged image file format (TIFF), portable document file (PDF) format, or in another format that allows for the efficient storage of documents.

History: Eff. 9/1/82, Register 83; am 11/29/97, Register 144; am 6/24/2004, Register 170; am 9/23/2004, Register 171
Authority: AS 18.23.100
AS 47.30.530
AS 47.30.540

7 AAC 71.160. Records retention
(a) Administrative records of a center must be retained in accordance with department grant regulation 7 AAC 78.250.
(b) Client records of the center must be retained for seven years following the discharge of the client. However, the records of a client under 19 years of age must be kept until at least two years after the client reaches age 19 or until seven years after the discharge of the client, whichever is later.
7 AAC 71.162. Closure of center; records
If a center that is awarded a grant under 7 AAC 78 or 7 AAC 81 closes or ceases to exist as a service provider, the center's records, including client records, are subject to the requirements of 7 AAC 78.255 or 7 AAC 81.185, as applicable.

7 AAC 71.165. Waiver of requirements
(a) The commissioner of the department will, in his discretion, waive a requirement of 7 AAC 71.100 - 7 AAC 71.165, if a center establishes an alternative method of satisfying the requirement.
(b) Application for waiver must be made in writing to the department and must include
(1) a statement of the requirement for which a waiver is requested;
(2) an explanation of the reasons why the requirement cannot be satisfied; and
(3) a description of the alternative method proposed to satisfy the requirement for which the waiver is requested.
(c) The department will answer all requests for waivers in writing.

7 AAC 71.200. Legal rights
A person receiving treatment at a community mental health center which receives financial assistance under AS 47.30.520 - 47.30.620 has the same legal rights and responsibilities guaranteed to all persons by the Constitution and statutes of the United States and the State of Alaska.

7 AAC 71.205. Informed consent
(a) A center must obtain written, informed consent from a client for
(1) experimental treatments;
(2) nonstandard treatment; and
(3) participation in education or demonstration programs such as the use of audio-visual equipment and one-way mirrors.
(b) All experimental or nonstandard treatment procedures must be documented in the client's record.

History: Eff. 9/1/82, Register 83
Authority: AS 47.30.530
AS 47.30.590

7 AAC 71.210. Bill of client rights
(a) A center must prepare a "bill of client's rights," including all rights in this section, which must be prominently posted in places of treatment.
(b) The "bill of client's rights" must contain the following information:
1. A client is entitled to participate in formulating, evaluating, and periodically reviewing his or her individualized written treatment plan, including requesting specific forms of therapy, being informed why requested forms of therapy are not made available, refusing specific forms of therapy that are offered, and being informed of treatment prognosis;
2. A client has the right to review with a staff member, at a reasonable time, the client's treatment record; however, information confidential to other individuals may not be reviewed by the client;
3. A client will be informed by the prescribing physician of the name, purpose, and possible side effects of medication prescribed as part of the client's treatment plan at the center;
4. A client may request a copy of the treatment summary which should include follow-up plans;
5. A client has a right to confidential treatment of all information pertaining to the client and the right of prior written approval for the release of identifiable information.

History: Eff. 9/1/82, Register 83
Authority: AS 47.30.530
AS 47.30.590

7 AAC 71.215. Confidentiality
(a) All records and information about a client must be kept confidential by the center except as provided in (b) of this section unless the center obtains an authorization for release of information from the patient or a legally designated representative of the patient.
(b) Information regarding a client may be released without consent only to
1. A person authorized by court order;
2. A designated hospital to which a client is involuntarily committed;
3. Direct service health or mental health personnel if a medical or psychological emergency arises;
4. Mental health professionals designated by the department to conduct program analysis or on-site reviews;
5. Center-authorized researches, if provision is made to preserve anonymity in the reported results;
6. Insurance, medical assistance, or other programs to the extent necessary for a client to make a claim, or for a claim to be made on behalf of a client;
7. Other persons to whom disclosure is required by law; and
8. The department under 7 AAC 78, 7 AAC 81, or 7 AAC 85, as applicable.
(c) Records and information regarding a client may be released to an individual to whom the client or the client's parent, guardian, or other legally designated representative has given written consent for the disclosure. The consent must include
1. Client's name;
2. First and last dates of authorization;
(3) information to be released;
(4) recipient of information; and
(5) signature of client or other legally designated representative.
(d) Only the minimum identifiable client information necessary to the intended purpose may be released.
(e) A center must
(1) develop a plan for safeguarding confidential information and submit that plan to the department as part of the annual plan for services; and
(2) maintain all information that it is required to submit to the department under 7 AAC 78, 7 AAC 81, or 7 AAC 85 as required by 7 AAC 78.250, 7 AAC 81.180, or 7 AAC 85.400, as applicable.
(f) If a center closes or ceases to exist as a service provider, it must comply with 7 AAC 78.255 or 7 AAC 81.185, as applicable.
History: Eff. 9/1/82, Register 83; am 11/29/97, Register 144; am 6/24/2004, Register 170; am 9/23/2004, Register 171
Authority: AS 47.30.530
AS 47.30.540
AS 47.30.590

7 AAC 71.220. Grievance procedures
A center must establish a grievance procedure by which a client may seek redress of grievances. A copy of the grievance procedure must be filed with the department and posted at the center.
History: Eff. 9/1/82, Register 83
Authority: AS 47.30.530
AS 47.30.590

7 AAC 71.300. Definitions
Repealed.
History: Eff. 9/1/82, Register 83; repealed 11/29/97, Register 144

Article 5
Management Information System for Mental Health Programs

Section
400. (Repealed).
405. (Repealed).
410. (Repealed).
415. (Repealed).
420. (Repealed).
425. (Repealed).
430. (Repealed).
435. (Repealed).
440. (Repealed).
449. (Repealed).

Editor's note: The substance of the regulations in this article has been relocated to 7 AAC 85.

7 AAC 71.400. Management Information System for mental health programs; required submission of data
Repealed.
History: Eff. 11/29/97, Register 144; repealed 9/23/2004, Register 171

7 AAC 71.405. Submission of data by providers
Repealed.
History: Eff. 11/29/97, Register 144; repealed 9/23/2004, Register 171

7 AAC 71.410. Obligation to submit accurate and complete data
Repealed.
History: Eff. 11/29/97, Register 144; repealed 9/23/2004, Register 171

7 AAC 71.415. Transmission of data
Repealed.
History: Eff. 11/29/97, Register 144; repealed 9/23/2004, Register 171

7 AAC 71.420. Confidential information
Repealed.
History: Eff. 11/29/97, Register 144; repealed 9/23/2004, Register 171

7 AAC 71.425. Use and disclosure of data and information
Repealed.
History: Eff. 11/29/97, Register 144; repealed 9/23/2004, Register 171

7 AAC 71.430. Access to system computer records
Repealed.
History: Eff. 11/29/97, Register 144; repealed 9/23/2004, Register 171

7 AAC 71.435. System record retention
Repealed.
History: Eff. 11/29/97, Register 144; repealed 9/23/2004, Register 171

7 AAC 71.440. Security of data
Repealed.
History: Eff. 11/29/97, Register 144; repealed 9/23/2004, Register 171

7 AAC 71.449. Definitions for 7 AAC 71.400 - 7 AAC 71.449
Repealed.
History: Eff. 11/29/97, Register 144; repealed 9/23/2004, Register 171

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Article 6
General Provisions

Section
990. Definitions.

7 AAC 71.990. Definitions
In this chapter,
(1) "center" means a mental health center operated with financial assistance provided under AS 47.30.520 - 47.30.620 (Community Mental Health Service Act) or any service provided by a subcontractor with financial assistance provided under AS 47.30.520 - 47.30.620;
(2) "contractor" means
(A) a city or borough government or other political subdivision of the state;
(B) a nonprofit corporation; or
(C) a combination of persons identified in (A) and (B) of this paragraph who have entered into an agreement with the department to provide community mental health services provided for in 7 AAC 71.010;
(3) "department" means the Department of Health and Social Services;
(4) "geographic planning area" means the locality designated by the department in A Shared Vision II, A Strategic Plan for Mental Health Services in Alaska, 1999-2003, adopted by reference.
(5) "mental health professional" means a person who
(A) has at least a master's degree in psychology or social work, or in a related field; and
(B) is appropriately credentialed through education, training, and experience to carry out the person's professional duties as set out in the person's job description;
(6) "service area" means the geographic area described by an applicant or contractor and approved by the department as the area for which services will be or are being provided;
(7) "working day" means a day other than Saturday, Sunday, or a state holiday.
History: Eff. 11/29/97, Register 144; am 6/24/2004, Register 170
Authority: AS 47.30.530
AS 47.30.540
Editor's note: A copy of A Shared Vision II, A Strategic Plan for Mental Health Services in Alaska, 1999-2003, adopted by reference in 7 AAC 71.990(4), may be reviewed at the Alaska state Library or the department's division of behavioral health.
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF BEHAVIORAL HEALTH

7 AAC 72
CIVIL COMMITMENT
CHAPTER 72. CIVIL COMMITMENT.

Article
1. Scope and Applicability. (7 AAC 72.010 - 7 AAC 72.010)
2. Designation of Facilities. (7 AAC 72.012 - 7 AAC 72.070)
3. Requirements for Designated Facilities. (7 AAC 72.080 - 7 AAC 72.210)
5. Procedures for Evaluations. (7 AAC 72.270 - 7 AAC 72.290)
6. Procedures for Designation of Evaluation Personnel. (7 AAC 72.300 - 7 AAC 72.350)
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9. Appeals. (7 AAC 72.410 - 7 AAC 72.440)
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11. General Provisions. (7 AAC 72.900)

Article 1
Scope and Applicability

Section
10. Scope of chapter.

7 AAC 72.010. Scope of chapter
The provisions of
(1) 7 AAC 72.020 - 7 AAC 72.290 apply to facilities submitting applications for designation
by the department as an evaluation facility or as a treatment facility for purposes of providing
services to persons subject to voluntary or involuntary admission for mental health or
psychiatric evaluation or treatment under AS 47.30.660 - 47.30.915, including persons
eligible for financial assistance under AS 47.31;
(2) 7 AAC 72.300 - 7 AAC 72.390 apply to mental health professionals who submit
applications for designation by the department as evaluation personnel for purposes of
evaluating persons subject to voluntary or involuntary admission for treatment under AS
47.30.660 - 47.30.915, including persons eligible for financial assistance under AS 47.31;
(3) 7 AAC 72.410 - 7 AAC 72.440 apply to a facility or mental health professional seeking to
appeal a department decision under this chapter; and
(4) 7 AAC 72.500 - 7 AAC 72.540 apply to persons who are eligible for financial assistance
under AS 47.31 and to facilities providing services to those persons.
History: Eff. 3/30/85, Register 93; am 3/16/2001, Register 157
Authority: AS 47.30.660
AS 47.31.025
AS 47.31.090
Editor's note: Words and phrases used in this chapter are defined at 7 AAC 72.900.
Article 2
Designation of Facilities

Section
15. General requirements for designation.
17. Function of a designated facility.
20. Application for facility designation.
30. Waiver of requirements.
40. Decision on application for designation.
50. Annual report regarding facility designation.
60. Reconsideration.
70. Revocation of designation.

7 AAC 72.012. Adoption by reference
(a) For the purposes of AS 47.30.660 - 47.30.915 and this chapter, the following provisions of 7 AAC 12, as amended through February 13, 2001 are adopted by reference and are applicable to a facility that seeks designation under this chapter as an (1) evaluation facility:
(A) 7 AAC 12.105(a) (Services Required from General Acute Care Hospitals);
(B) 7 AAC 12.110 (Medical Staff);
(C) 7 AAC 12.610 (Licensure);
(D) 7 AAC 12.660 (Personnel);
(E) 7 AAC 12.670 (Nursing Service);
(F) 7 AAC 12.680 (Pharmaceutical Service);
(G) 7 AAC 12.700 (Social Work Service);
(H) 7 AAC 12.770 (Medical Record Service);
(I) 7 AAC 12.790 - 7 AAC 12.850 (Laboratory Service Requirements);
(J) 7 AAC 12.860 (Risk Management);
(K) 7 AAC 12.890 (Patients' or Residents' Rights);
(L) 7 AAC 12.910 (Contracts); or
(2) evaluation and treatment facility:
(A) each provision adopted by reference in (1) of this subsection;
(B) 7 AAC 12.160 (Psychiatric Service);
(C) 7 AAC 12.215 (Psychiatric Hospitals);
(D) 7 AAC 12.710 (Occupational Therapy Service);
(b) This section does not affect a facility's obligation to comply with the licensing requirements of 7 AAC 12.

History: Eff. 3/16/2001, Register 157
Authority: AS 47.30.660
AS 47.31.025
AS 47.31.090

7 AAC 72.015. General requirements for designation
(a) The department will approve only the following facilities under this chapter and AS 47.30.660 - 47.30.915 to operate as designated evaluation or treatment facilities:
(1) a general acute care hospital that
(A) is licensed under AS 18.20.020 and 7 AAC 12.610; and
(B) certifies to the department that the hospital is in compliance with the applicable provisions of
(i) AS 47.30.660 - 47.30.915; and
(ii) this chapter, including provisions of 7 AAC 12 that are adopted by reference in 7 AAC 72.012;
(2) a facility that
(A) is exempt from state licensure but is accredited by the Joint Commission on Accreditation of Healthcare Organizations; and
(B) certifies to the department that the facility is in compliance with the applicable provisions of
(i) AS 47.30.660 - 47.30.915;
(ii) this chapter; and
(iii) standards and procedures that are substantially similar to those applicable to general acute care hospitals, set out in 7 AAC 72.012.
(b) For the purposes of this chapter, a facility designated as a treatment facility is also a designated evaluation facility.

History: Eff. 3/16/2001, Register 157
Authority: AS 47.30.660
AS 47.31.025
AS 47.31.090

Editor's note: Information about the Joint Commission on Accreditation of Healthcare Organizations may be obtained from that organization at One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181; telephone (630) 792-5000.

7 AAC 72.017. Function of a designated facility
(a) A designated evaluation facility may
(1) conduct emergency examinations and treatment under AS 47.30.700 (a) and 47.30.710, including a mental health evaluation;
(2) detain patients for no more than 72 hours for evaluation and treatment under AS 47.30.715; and
(3) provide crisis stabilization.
(b) A designated treatment facility may provide mental health treatment services during the 30-day commitment period under AS 47.30.735 and any additional time allowed under AS 47.30.745 (g).
(c) The director of the Alaska Psychiatric Institute (API) shall provide case consultation services to a designated evaluation or treatment facility regarding crisis stabilization, treatment techniques, and short-term treatment approaches as alternatives to transferring a patient to API, and shall assist in determining whether a patient needs long-term treatment at API.

History: Eff. 3/16/2001, Register 157
Authority: AS 47.30.660
AS 47.31.025
AS 47.31.090

7 AAC 72.020. Application for facility designation
(a) The administrator of a facility described in 7 AAC 72.015(a) may apply for designation of that facility as an evaluation facility or as a treatment facility under this chapter. The administrator shall apply for designation on a form supplied by the department. The form must be accompanied by the following:
(1) for a general acute care hospital described in 7 AAC 72.015(a) (1),
(A) a copy of the hospital's current license; however, if the hospital is operating under a provisional license issued under 7 AAC 12.610, the administrator shall also provide a written report of the nature of each violation and of the efforts to achieve compliance;
(B) the certification of compliance described in 7 AAC 72.015(a) (1)(B), on a form supplied by the department; and
(C) a copy of the table of contents for the hospital's policies and procedures, prepared as described in (b) of this section; the complete policies and procedures must be available for department review, and a copy of any specific procedure must be provided if requested by the department;
(2) for a facility described in 7 AAC 72.015(a) (2),
(A) a copy of the facility's current accreditation;
(B) the certification of compliance described in 7 AAC 72.015(a) (2)(B), on a form supplied by the department;
(C) a copy of the most recent accreditation report issued by the Joint Commission on Accreditation of Healthcare Organizations; if the report describes a Type I deficiency, the administrator shall provide a written report of the nature of each Type I deficiency and of the efforts to achieve compliance; and
(D) a copy of the table of contents for the facility's policies and procedures, prepared as described in (b) of this section; the complete policies and procedures must be available for department review, and a copy of any specific procedure must be provided if requested by the department.
(b) The administrator of a designated facility shall develop, and amend as necessary, written policies and procedures that cover
(1) personnel administration;
(2) fiscal administration;
(3) patient records;
(4) patient rights, consistent with 7 AAC 12.890 and AS 47.30.825 - 47.30.865;
(5) language and cultural relevance of services;
(6) coordination and continuity of services;
(7) services for physically handicapped patients;
(8) management of pharmaceuticals;
(9) quality assurance procedures;
(10) program evaluation procedures;
(11) ongoing inservice training; and
(12) interdisciplinary services for patients with an alcohol or drug problem or a developmental disability, including planning for treatment before and after discharge.
(c) The department may provide technical assistance to applicants.
(d) Within 10 working days after applying under (a) of this section, the administrator of a facility seeking designation as an evaluation or treatment facility shall publish, at the facility's expense, a public notice of the application at least one time in at least one newspaper of general circulation in the area served by the facility. The public notice must include the following text: "The [insert name of facility], located at [insert address], is requesting the Department of Health and Social Services to designate this facility as a [insert "designated evaluation facility" or "designated evaluation and treatment facility", as appropriate] for purposes of providing services to persons subject to voluntary or involuntary admission for mental health or psychiatric evaluation or treatment. Any person may submit written comments to the department regarding this request so that the department receives them by [insert a date at least 20 days after the date that the notice is published in the newspaper]. Please send comments to: Department of Health and Social Services, [insert the appropriate department office and address]. If you would like a copy of the application
materials, please write to the above address or contact the department by telephone at [insert telephone number]. If you are a person with a disability who may need a special accommodation in order to comment, please contact the department at the number listed above, before [insert a date at least 10 days after the date that the notice is published in the newspaper]."

(e) An administrator who has a public notice published under (d) of this section shall obtain an original publisher's affidavit of publication and shall submit it so that the department receives it within 10 days after publication of the public notice.

History: Eff. 3/30/85, Register 93; am 3/16/2001, Register 157; am 6/24/2004, Register 170
Authority: AS 47.30.660

Editor's note: The department information to be inserted in the public notice text under 7 AAC 72.020(d) is as follows: (1) appropriate department office: Division of Behavioral Health; (2) department address: P.O. Box 110620, Juneau, AK 99811-0620; and (3) department telephone number: (907) 465-3370.

7 AAC 72.030. Waiver of requirements
(a) Upon request by a facility administrator, the commissioner or the commissioner's designee will waive a provision of this chapter if the administrator
(1) provides an alternative method that reasonably assures, to the satisfaction of the commissioner or the commissioner's designee, the same level of protection and treatment that the provision sought to be waived affords the patient; and
(2) demonstrates, to the satisfaction of the commissioner or the commissioner's designee, that the waiver does not result in a violation of a requirement of AS 47.30.660 - 47.30.915 or 7 AAC 12.

(b) A request for a waiver from a provision of this chapter must be in writing and must
(1) identify the provision for which a waiver is sought;
(2) explain the reasons why the facility cannot comply with the provision;
(3) describe the alternative method proposed to satisfy the requirement in (a)(1) of this section; and
(4) describe the facility's plan for complying with the provision, including a time schedule for compliance.
(c) The department will rescind a waiver granted under this section if the department determines that the facility in not in compliance with (a)(1) and (2) of this section.

History: Eff. 3/30/85, Register 93; am 3/16/2001, Register 157
Authority: AS 47.30.660

7 AAC 72.040. Decision on application for designation
(a) Within 60 days after receipt of a written application for designation under 7 AAC 72.020(a), after review of any additional information requested under (b) of this section, after review of any public comment received under 7 AAC 72.020(d), and based on the department's determination as to whether the facility complies with 7 AAC 72.015, the department will, in writing, either
(1) approve the application, with modifications or conditions as necessary, make a decision on any request for a waiver submitted under 7 AAC 72.030, and designate the facility as an evaluation facility or as a treatment facility; or
(2) deny the application and specify the reasons for denial.
(b) If the department requires additional information to make a decision under this section, the department will request that information in writing and advise the applicant that the 60-day review period will be suspended until the information is received.
(c) If the department denies an application under this section, the administrator may request reconsideration of that decision under 7 AAC 72.060.

History: Eff. 3/30/85, Register 93; am 3/16/2001, Register 157
Authority: AS 47.30.660

7 AAC 72.050. Annual report regarding facility designation

(a) On or before June 30 of each year, the administrator of a designated facility shall submit to the department, on a form supplied by the department, the following:
(1) for a general acute care hospital described in 7 AAC 72.015(a) (1),
   (A) a copy of the hospital's current license; however, if the hospital is operating under a provisional license issued under 7 AAC 12.610, the administrator also shall provide a written report of the nature of each violation and of the efforts to achieve compliance;
   (B) the certification of compliance described in 7 AAC 72.015(a) (1)(B), on a form supplied by the department; however, if a waiver has been granted under 7 AAC 72.030, the administrator shall also submit a report setting out the status of the attempts to meet the schedule of compliance required by 7 AAC 72.030(b) (4);
   (C) a list of any policies and procedures described in 7 AAC 72.020(b) that have been updated during the previous year and a copy of the current table of contents for the policies and procedures; and
   (D) a copy of each written agreement prepared under 7 AAC 72.110 or a certification attesting that each written agreement already submitted to the department is still in effect;
(2) for a facility described in 7 AAC 72.015(a) (2),
   (A) a copy of the facility's current accreditation;
   (B) the certification of compliance described in 7 AAC 72.015(a) (2)(B), on a form supplied by the department; however, if a waiver has been granted under 7 AAC 72.030, the administrator shall also submit a report setting out the status of the attempts to meet the schedule of compliance required by 7 AAC 72.030(b) (4);
   (C) a copy of the most recent accreditation report issued by the Joint Commission on Accreditation of Health Care Organizations; if the report describes a Type I deficiency, the administrator shall provide a written report of the nature of each Type 1 deficiency and of the efforts to achieve compliance;
   (D) a list of any policies and procedures described in 7 AAC 72.020(b) that have been updated during the previous year and a copy of the current table of contents for the policies and procedures; and
   (E) a copy of each written agreement prepared under 7 AAC 72.110 or a certification attesting that each written agreement already submitted to the department is still in effect.
(b) The department will review the information submitted under this section and will advise the administrator in writing that the department finds the facility to be in compliance with this chapter, unless the department finds that the facility no longer meets the requirements for designation set out in 7 AAC 72.105. If the department finds that the facility no longer (1) meets the requirements, for designation, including a violation of any requirement referred to in 7 AAC 72.012, the department will notify the administrator in writing under 7 AAC 72.070; or
(2) complies with the conditions of any waiver issued under 7 AAC 72.030, the department will rescind the waiver under 7 AAC 72.030(c).

History: Eff. 3/30/85, Register 93; am 3/16/2001, Register 157
Authority: AS 47.30.660

7 AAC 72.060. Reconsideration
The administrator may, within 30 days after receiving the department's decision under 7 AAC 72.040, request reconsideration of the decision. In the request for reconsideration, the administrator may include any additional materials and information that support facility designation and that are relevant to the department's decision. Within 30 days after receipt of a request for reconsideration, after review of any additional material and information submitted, and based on the department's determination as to whether the facility complies with 7 AAC 72.015, the department will
(1) approve the application, with modifications or conditions as necessary; or
(2) reaffirm the decision made under 7 AAC 72.040.

History: Eff. 3/30/85, Register 93; am 3/16/2001, Register 157
Authority: AS 47.30.660

7 AAC 72.070. Revocation of designation
(a) Based on the department's review of a facility's performance under this chapter, including a review of information provided by the facility or by an interested person under (e) of this section, the department will revoke the facility's designation if the department determines that the facility does not substantially comply with
(1) the applicable requirements of AS 47.30.660 - 47.30.915; or
(2) the applicable requirements of this chapter, including a provision of 7 AAC 12 that is adopted by reference in 7 AAC 72.012.
(b) Except as provided in (c) of this section, and at least 30 days before the effective date of the revocation, the department will notify the administrator of the department's determination and of the department's intent to revoke the facility's designation.
(c) If the department determines that immediate revocation of a facility's designation is necessary to protect the public from a substantial and immediate threat to health or safety, the department will notify the administrator of the department's determination and that the facility's designation has been immediately revoked.
(d) The department will issue a notice under this section in writing, will specify the basis for revocation in the notice, and will state in the notice that the administrator may appeal the decision under 7 AAC 72.410 - 7 AAC 72.440. The department will hand-deliver the notice to an authorized agent of the facility or will mail the notice to the last known address of the facility's authorized agent. For the purpose of starting the 30-day period in (b) of this section, or triggering immediate revocation under (c) of this section, notice is effective upon personal delivery of the notice or on the third day after the department mails the notice, whichever occurs first. For the purposes of this subsection, the department mails a notice if the department sends that notice through the United States mail, a courier-type delivery service, a facsimile, or a telegram.
(e) An interested person may submit a request to the department, asking that the department revoke a facility's designation, and clearly stating how the facility has failed to comply with an applicable provision of AS 47.30.660 - 47.30.915 or this chapter, including a provision of 7 AAC 12 that is adopted by reference in 7 AAC 72.012. Within 14 days after receiving a request under this subsection, the department will send the interested person and the administrator of the facility written notification as to whether the department will perform a review under (a) of this section.

History: Eff. 3/30/85, Register 93; am 3/16/2001, Register 157; am 6/24/2004, Register 170
Authority: AS 47.30.660

Article 3
Requirements for Designated Facilities
7 AAC 72.080. General requirements for a designated facility
In addition to complying with this chapter, including any applicable requirements of 7 AAC 12 that are adopted by reference in 7 AAC 72.012, the administrator shall ensure that
(1) staff members receive training to develop appropriate interactions with patients;
(2) properly trained and qualified staff handle the protection, security, and observation of patients;
(3) children under 18 years of age do not share a room with adults;
(4) discharge plans are initiated early in the evaluation or treatment process and that the facility provides stabilization, establishes diagnoses, and initiates care with the goal of permitting the patient's early return to the community for followup care; discharge planning at an evaluation facility includes determining whether a patient should be released or transferred to a treatment facility, and whether the patient needs medication;
(5) treatment is individualized; as necessary, the administrator shall hire or contract with staff to deliver necessary specialized care;
(6) subject to the disclosure restrictions of 42 C.F.R. Part 2, for a patient who is also receiving treatment for alcohol or drug abuse at a facility that receives federal financial assistance as described in 42 C.F.R. Part 2, the local community mental health center or other after-care agency is notified within 48 hours if a client from that center or agency, or an unassigned patient, is admitted for care, after obtaining a release for this notification from the patient; and
(7) a determination is made as to whether a patient is a candidate for placement and monitoring in the community's local crisis respite program and, if that is the case, ensure that the patient is placed in that program as soon as possible.

History: Eff. 3/30/85, Register 93; am 3/16/2001, Register 157
Authority: AS 47.30.660

7 AAC 72.085. Determination regarding declarations for mental health treatment
The staff at a designated facility shall make a reasonable effort to determine whether a patient committed under AS 47.30 has made a declaration of preferences or instructions regarding mental health treatment under AS 47.30.950 - 47.30.980 by consulting the patient,
the patient's health care provider, the patient's spouse or parent, a person in the patient's household, or a person designated by the patient.

History: Eff. 3/16/2001, Register 157
Authority: AS 47.30.660

7 AAC 72.090. Qualified personnel
Repealed.
History: Eff. 3/30/85, Register 93; repealed 3/16/2001, Register 157

7 AAC 72.100. Personnel administration
Repealed.
History: Eff. 3/30/85, Register 93; repealed 3/16/2001, Register 157

7 AAC 72.110. Written agreements
(a) The administrator shall enter into a written agreement with each community mental health center served by the facility to provide for coordination and continuity of services related to the admission and discharge of patients receiving inpatient psychiatric care.
(b) An agreement under (a) of this section must state that the center, after being notified by the facility of a patient's discharge from the facility, will schedule an appointment at the center with the patient for
(1) clinical services within one week after a patient's discharge from the facility; and
(2) medication management services before depletion of any psychotropic medication dispensed or prescribed for a patient upon discharge, and that, whenever possible, medication management services are to include a psychiatric evaluation.
(c) If a single-point-of-entry psychiatric emergency facility is located in the area served by a designated facility, the designated facility shall, at a minimum, have in place with that other facility a memorandum of understanding that includes terms identical to those required under (b) of this section.
History: Eff. 3/30/85, Register 93; am 3/16/2001, Register 157
Authority: AS 47.30.660

7 AAC 72.120. Availability of services
Repealed.
History: Eff. 3/30/85, Register 93; repealed 3/16/2001, Register 157

7 AAC 72.130. Environment
Repealed.
History: Eff. 3/30/85, Register 93; repealed 3/16/2001, Register 157

7 AAC 72.140. Patient rights
Repealed.
History: Eff. 3/30/85, Register 93; repealed 3/16/2001, Register 157

7 AAC 72.150. Patient records
(a) In addition to complying with 7 AAC 12.770, as adopted by reference in 7 AAC 72.012, for each patient, a facility shall maintain a clinical record with forms that document the facility's use of the emergency examination or the evaluation procedure set out in 7 AAC 72.220 - 7 AAC 72.260.
(b) The facility shall safeguard patient records, including electronic records, against loss, defacement, tampering, and use by unauthorized persons. Information from patient records,
including electronic records, may be released only in accordance with AS 47.30.845 and (c) of this section.
(c) For a patient being treated for alcohol or drug abuse in a facility that receives federal assistance as described in 42 C.F.R. 2.12(b), the facility may disclose information from that patient's records only as allowed under 42 C.F.R. Part 2, including use of the consent form required under 42 C.F.R. 2.31.
(d) Patient records that are required to be submitted to the department are subject to the applicable requirements of 7 AAC 85.
History: Eff. 3/30/85, Register 93; am 3/16/2001, Register 157; am 9/23/2004, Register 171 Authority: AS 47.30.660
AS 47.30.845

7 AAC 72.155. Quarterly report of patient information
Within 60 days after the end of each calendar quarter, the administrator shall submit to the department, on a form supplied by the department, the following information regarding patients admitted to the facility during the previous quarter who were found to be suffering from a mental illness and who posed a danger to self or others, or who were gravely disabled, as determined by each patient's treating physician or psychiatrist:
(1) the number of patients admitted voluntarily;
(2) the number of patients admitted involuntarily;
(3) the number of patients admitted who had insurance or self-pay coverage that was billed;
(4) the average length of stay for all patients admitted during the quarter, whether voluntary or involuntary;
(5) the number of patients who were readmitted during the quarter.
History: Eff. 3/16/2001, Register 157; am 6/24/2004, Register 170 Authority: AS 47.30.660

7 AAC 72.160. Quality assurance plan
Repealed.
History: Eff. 3/30/85, Register 93; repealed 3/16/2001, Register 157

7 AAC 72.165. Transfer of patients between designated facilities
An already committed patient may not be transferred from a designated evaluation or treatment facility to another designated facility or to a state-operated hospital, unless
(1) a mental health professional
(A) determines that the transfer is in the best treatment interests of the patient;
(B) obtains, before the transfer, certification from the patient's attending physician that the patient is medically stable; and
(C) contacts authorized admitting personnel at the receiving facility or hospital, and explains why the patient's mental condition or behavior necessitates transfer to another facility or hospital; and
(2) the administrator of the facility proposing the transfer obtains, before the transfer, permission from the administrator at the receiving facility or hospital to transfer the patient.
History: Eff. 3/16/2001, Register 157 Authority: AS 47.30.660
Editor's note: The subject matter of 7 AAC 72.165 was formerly located at 7 AAC 72.400. The history note for 7 AAC 72.165 does not reflect the history of the earlier section.

7 AAC 72.170. Evaluation
Repealed.
Article 4

Procedures for Emergency Examinations

Section
220. Scope of 7 AAC 72.230 - 7 AAC 72.260.
230. Emergency examinations.
240. Physician and mental health professional.
250. Physical examination.
260. Mental health evaluation.

7 AAC 72.220. Scope of 7 AAC 72.230 - 7 AAC 72.260
The requirements of 7 AAC 72.230 - 7 AAC 72.260 apply to all facilities, whether licensed under 7 AAC 12.100 or otherwise designated under this chapter.
History: Eff. 3/30/85, Register 93
Authority: AS 47.30.660

7 AAC 72.230. Emergency examinations
An evaluation facility shall comply with 7 AAC 72.240 - 7 AAC 72.260 when conducting an emergency examination under AS 47.30.710.
History: Eff. 3/30/85, Register 93
Authority: AS 47.30.660

7 AAC 72.240. Physician and mental health professional
An emergency examination under AS 47.30.710 must consist of a physical examination conducted by a physician and a mental health evaluation conducted by a mental health professional.
History: Eff. 3/30/85, Register 93
Authority: AS 47.30.660
AS 47.30.710
7 AAC 72.250. Physical examination
(a) In conducting the physical examination required by 7 AAC 72.240, the physician shall determine whether the patient has any reasonably apparent physical problems that require specialized medical care and treatment, and that may either more urgently require care than the patient's present psychiatric problems, or cause or aggravate the patient's psychiatric problems.
(b) The physical examination required by 7 AAC 72.240 must include
(1) an examination of the patient's chief complaint;
(2) a review of the patient's history;
(3) a review of systems;
(4) a routine physical examination;
(5) a diagnosis; and
(6) the physician's recommendations.

History: Eff. 3/30/85, Register 93
Authority: AS 47.30.660
AS 47.30.710

7 AAC 72.260. Mental health evaluation
(a) A mental health professional shall conduct the mental health evaluation required by 7 AAC 72.240 for the purposes of determining the specific mental health problems and needs of the patient and determining whether the patient meets the involuntary commitment criteria established in AS 47.30.730.
(b) A mental health evaluation required by 7 AAC 72.240 must, when reasonably possible, include
(1) an interview with the peace officers who brought the patient to the facility for the examination;
(2) a brief history of the patient, including observations or information obtained by other persons relating to the background, development, and circumstances of the patient's current problems;
(3) a brief evaluation of the patient's mental status;
(4) a history of the patient's previous treatment and medication;
(5) a diagnosis; and
(6) a determination of whether the patient meets the involuntary commitment criteria established in AS 47.30.730.
(c) If a mental health professional conducting a mental health evaluation under 7 AAC 72.240 determines that the patient meets the involuntary commitment criteria established in AS 47.30.730 and will not accept treatment on a voluntary basis, the mental health professional shall develop a treatment plan for the patient's care in the least restrictive setting.
(d) If the mental health professional conducting the mental health evaluation under 7 AAC 72.240 determines that the patient does not meet the involuntary commitment criteria established in AS 47.30.730, the facility shall develop an appropriate outpatient referral plan for the purpose of follow-up and continuing care if the patient is in need of these services.

History: Eff. 3/30/85, Register 93
Authority: AS 47.30.660
AS 47.30.710
AS 47.30.730

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Article 5
Procedures for Evaluations
Section
270. Evaluations.
280. Procedures.
290. Referral plan.

7 AAC 72.270. Evaluations
An evaluation facility, whether licensed under 7 AAC 12.100 or otherwise designated under this chapter, shall comply with 7 AAC 72.280 - 7 AAC 72.290 when evaluating a patient after an emergency examination under 7 AAC 72.220 - 7 AAC 72.260 or after admitting a patient for a 72-hour evaluation period under AS 47.30.715.
History: Eff. 3/30/85, Register 93
Authority: AS 47.30.660
AS 47.30.715

7 AAC 72.280. Procedures
An evaluation facility shall
(1) perform routine laboratory studies ordered by the attending physician;
(2) follow-up and further evaluate physical problems noted at the time of the patient's emergency examination, if any;
(3) obtain available background information relating to the patient's present condition, including relevant developmental, family, social, and occupational history;
(4) develop an initial treatment plan appropriate to the patient's target symptoms and behavior;
(5) note and record pertinent behavioral manifestations that indicate whether the patient continues to meet the involuntary commitment criteria established in AS 47.30.730; and
(6) record progress notes that document the effectiveness of treatment interventions, untoward incidents, complications, and adverse effects.
History: Eff. 3/30/85, Register 93
Authority: AS 47.30.660
AS 47.30.730

7 AAC 72.290. Referral plan
If the mental health professional of an evaluation facility who is evaluating or treating a patient determines that the patient does not meet the involuntary commitment criteria established in AS 47.30.730, the mental health professional shall ensure that the patient, upon the patient's release, is provided an appropriate outpatient referral plan for the purpose of follow-up and continuing care, if the care is needed.
History: Eff. 3/30/85, Register 93; am 3/16/2001, Register 157
Authority: AS 47.30.660
AS 47.30.720

Article 6
Procedures for Designation of Evaluation Personnel

Section
300. Scope of 7 AAC 72.310 - 7 AAC 72.350.
310. Application for evaluation personnel designation.
320. Approval.
330. Reconsideration.
350. Revocation.

7 AAC 72.300. Scope of 7 AAC 72.310 - 7 AAC 72.350
The provisions of 7 AAC 72.310 - 7 AAC 72.350 apply to a mental health professional who requests designation by the department to conduct evaluations when no staffed evaluation facility exists.
History: Eff. 3/30/85, Register 93
Authority: AS 47.30.660
AS 47.30.915

7 AAC 72.310. Application for evaluation personnel designation
A mental health professional who requests designation as evaluation personnel shall apply for the designation on a form provided by the department. The mental health professional shall certify that he or she qualifies as a mental health professional under AS 47.30.915 (11).
History: Eff. 3/30/85, Register 93
Authority: AS 47.30.660
AS 47.30.915

7 AAC 72.320. Approval
Within 60 days after receiving a written application for designation, the department will either approve or deny the application. If the department approves the application, it will authorize the individual, in writing, to perform evaluations when no staffed evaluation facility exists.
History: Eff. 3/30/85, Register 93
Authority: AS 47.30.660
AS 47.30.915

7 AAC 72.330. Reconsideration
A mental health professional whose application is denied under 7 AAC 72.320 may, within 30 days after the denial, request reconsideration of the application by the department. The request for reconsideration may contain additional materials that support the application and are relevant to the denial. The department will rule on the request for reconsideration within 30 days after receiving a request.
History: Eff. 3/30/85, Register 93
Authority: AS 47.30.660
AS 47.30.915

7 AAC 72.340. Annual renewal
A mental health professional designated by the department to conduct evaluations shall, on an annual basis, submit a statement to the department certifying that he or she continues to qualify as a mental health professional under AS 47.30.915 (11). Upon receipt of the statement, the department will renew the designation for the next year unless it finds that the mental health professional no longer meets the standards for designation.
History: Eff. 3/30/85, Register 93
Authority: AS 47.30.660
AS 47.30.915

7 AAC 72.350. Revocation
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The department will, in its discretion and upon 30 days" written notice, revoke a mental health professional’s designation as evaluation personnel if the department finds that the individual no longer meets the criteria to qualify as a mental health professional under AS 47.30.915 (11).

History: Eff. 3/30/85, Register 93
Authority: AS 47.30.660
AS 47.30.915

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Article 7
Procedures for Evaluations Conducted by Evaluation Personnel

Section
360. Evaluation where no evaluation facility exists.
370. Request for evaluation.
380. Emergency examination procedures.
390. Hospitalization.

7 AAC 72.360. Evaluation where no evaluation facility exists
In an area in which no designated evaluation facility exists, a mental health professional designated as evaluation personnel under 7 AAC 72.300 - 7 AAC 72.350 may conduct a mental health evaluation of a person suspected of being mentally ill and in need of involuntary commitment, using the procedure established under 7 AAC 72.360 - 7 AAC 72.390.

History: Eff. 3/30/85, Register 93
Authority: AS 47.30.660

7 AAC 72.370. Request for evaluation
Upon application by a peace officer under AS 47.30.705, a mental health professional designated as evaluation personnel under 7 AAC 72.300 - 7 AAC 72.350 may conduct an evaluation of a person for the purpose of determining whether the person being evaluated requires hospitalization on an emergency basis under AS 47.30.710 (b).

History: Eff. 3/30/85, Register 93
Authority: AS 47.30.660
AS 47.30.705
AS 47.30.710 (b)

7 AAC 72.380. Emergency examination procedures
In conducting an evaluation under 7 AAC 72.370, the mental health professional shall follow the procedures for emergency mental health examinations set out in 7 AAC 72.220 - 7 AAC 72.260.

History: Eff. 3/30/85, Register 93
Authority: AS 47.30.660

7 AAC 72.390. Hospitalization
If the mental health professional determines that the person being evaluated under 7 AAC 72.260 is mentally ill, that the mental illness causes the person to be gravely disabled or to present a likelihood of serious harm to that person or others, and that the person is in need of hospital care or treatment, the mental health professional may initiate involuntary
commitment by arranging for the hospitalization of that person in an appropriate local facility for a period not to exceed 72 hours for evaluation, in accordance with AS 47.30.715.

History: Eff. 3/30/85, Register 93
Authority: AS 47.30.660
AS 47.30.710
AS 47.30.715

Article 8
Requirements for Transfer of Patients Between Designated Treatment Facilities

Section
400. (Repealed).

7 AAC 72.400. Transfer requirements
Repealed.
History: Eff. 3/30/85, Register 93; repealed 3/16/2001, Register 157
Editor's note: The subject matter of 7 AAC 72.400 was relocated to 7 AAC 72.165.

Article 9
Appeals

Section
410. Scope of 7 AAC 72.420 - 7 AAC 72.440.
420. Notice of appeal.
430. Procedure for appeal.
440. Hearing on shortened time.

7 AAC 72.410. Scope of 7 AAC 72.420 - 7 AAC 72.440
The provisions of 7 AAC 72.420 - 7 AAC 72.440 apply to appeals from (1) the revocation of a facility's designation under 7 AAC 72.070; (2) the revocation of a mental health professional's designation under 7 AAC 72.350 as evaluation personnel; and (3) the denial of a mental health professional's application under 7 AAC 72.320.
History: Eff. 3/30/85, Register 93; am 3/16/2001, Register 157
Authority: AS 47.30.660

7 AAC 72.420. Notice of appeal
(a) A facility administrator or a mental health professional wishing to appeal a department action described in 7 AAC 72.410 shall submit a notice of appeal to the commissioner.
(b) The notice of appeal must be written, and may be hand-delivered, mailed, or sent by facsimile, courier-type delivery service, or telegram. The notice must be delivered or postmarked within 10 days after receipt of the notice of revocation. The notice of appeal must contain (1) a clear statement of the action appealed; (2) a concise statement of facts showing the reason for the appeal; and (3) any argument on an issue or law relevant to the appeal.
History: Eff. 3/30/85, Register 93; am 3/16/2001, Register 157
Authority: AS 47.30.660
7 AAC 72.430. Procedure for appeal
(a) The commissioner will notify an appellant of a decision to accept or reject the appeal within seven days after the department receives a notice of appeal. The commissioner will reject an appeal if the notice of appeal is untimely or if it does not allege any facts which, if true, would permit reversal of the decision appealed.
(b) The commissioner will, in a notice of a decision to accept an appeal, set a time and place for a hearing and name an impartial hearing officer.
(c) The department will record all hearings conducted under this section. The appellant may appear, be represented by legal counsel, present exhibits and witnesses on the appellant's own behalf, and examine all evidence and witnesses presented by the department. The hearing officer shall establish all other procedures for the hearing. After the hearing, the hearing officer shall prepare written findings and recommendations to the commissioner, and the commissioner will make a final decision based on the evidence presented at the hearing.

History: Eff. 3/30/85, Register 93
Authority: AS 47.30.660

7 AAC 72.440. Hearing on shortened time
(a) If the department revokes a designation under this chapter and does not notify the person or facility at least 30 days before the effective date of the revocation, then the person or facility may request a hearing on shortened time.
(b) A request for a hearing on shortened time must be designated as such, and must otherwise meet the standards of 7 AAC 72.420(b).
(c) The commissioner will appoint a hearing officer and will schedule a hearing for a time within five days, excluding weekends and state holiday, after the department receives the request.
(d) The hearing officer shall, at the close of the hearing, announce a decision to uphold or reverse the department's decision. The hearing officer's decision is effective immediately and will be the final decision in the matter except as provided in (e) of this section. Within two days after the hearing on shortened time, the hearing officer shall transmit a written notice of the decision and a transcript or electronic recording of the hearing to the commissioner.
(e) Within seven days after the close of the hearing on shortened time, the appellant or the department staff may request that the commissioner grant a rehearing in the matter. The request for a rehearing must be designated as such, and must include a concise statement of facts showing the reason for disagreement with the hearing officer's decision and any views or arguments on any issue of fact or law presented. The commissioner will reject a request for rehearing if it is untimely or if the request fails to state any facts, which, if true would permit reversal of the hearing officer's decision. The commissioner will, in a notice that a request for a rehearing has been accepted, set a time and place for rehearing. The hearing officer shall follow the procedure set out at 7 AAC 72.430(c) in conducting the rehearing. The commissioner will issue a final decision within 60 days after the request for a rehearing.

History: Eff. 3/30/85, Register 93
Authority: AS 47.30.660

Article 10
Mental Health Treatment Assistance Program
Section
500. Purpose of 7 AAC 72.500 - 7 AAC 72.540.
510. Rate of reimbursement for mental health services.
520. Mental health services eligible for financial assistance.
530. Application for financial assistance.
540. Decision regarding eligibility for financial assistance.

7 AAC 72.500. Purpose of 7 AAC 72.500 - 7 AAC 72.540
The purpose of 7 AAC 72.500 - 7 AAC 72.540 is to
(1) establish the rates to be paid for certain mental health services that are provided to persons eligible for financial assistance under AS 47.31.010;
(2) identify the types and level of mental health services for which financial assistance is available to eligible persons;
(3) set standards for verifying eligibility under AS 47.31.020; and
(4) set additional standards to interpret or implement AS 47.31.
History: Eff. 3/16/2001, Register 157
Authority: AS 47.30.660
AS 47.31.025
AS 47.31.090

7 AAC 72.510. Rate of reimbursement for mental health services
As the payor of last resort, subject to department approval and the availability of appropriations from the legislature, the department will reimburse a designated facility for a service provided under 7 AAC 72.520(a) or (b) to a person who is eligible for financial assistance under AS 47.31.010. Reimbursement will be at the Medicaid rate that is
(1) set under 7 AAC 43.670 - 7 AAC 43.709 in accordance with AS 47.07.070; and
(2) in effect for the facility at the time the service was rendered, before any year-end review under 7 AAC 43.670 - 7 AAC 43.709.
History: Eff. 3/16/2001, Register 157; am 6/24/2004, Register 170
Authority: AS 47.30.660
AS 47.31.025
AS 47.31.090

7 AAC 72.520. Mental health services eligible for financial assistance
(a) Subject to (d) of this section, if the department determines under 7 AAC 72.540 that a person who received evaluation or treatment at a designated facility is eligible for financial assistance, the department will provide reimbursement under 7 AAC 72.510 for the following mental health services that are provided by a designated facility and that are directly related to a patient's mental health condition that resulted in eligibility for financial assistance under AS 47.31.010:
(1) emergency room costs;
(2) staff physician services, if those services are not already included in the facility's daily rate;
(3) physician services, if those services require the action of a physician who is not a member of the designated facility's staff;
(4) physician court time costs for participation in a commitment hearing;
(5) medical costs, if related to the evaluation, diagnosis, and treatment of a patient's mental illness;
(6) room and board costs related to the evaluation, diagnosis, and treatment of a patient's mental illness;
(7) laboratory costs that are required for all patients entering a facility and laboratory costs related to mental health evaluation, diagnosis, and treatment;
(8) medication costs related to mental health diagnosis and treatment;
(9) transportation costs that are not covered by AS 47.30.870 or 47.30.905;
(10) other services directly related to the admission being billed, as determined by the department on a case-by-case basis.

(b) The department will reimburse a designated evaluation facility for no more than seven days for evaluation and crisis stabilization or for transition to community-based services if the department determines the amount of time is clinically appropriate and
(1) the patient continues under, or has transferred to, voluntary commitment and the treating physician has certified, on a form supplied by the department, that the patient meets the involuntary commitment criteria in AS 47.30.700 - 47.30.815; or
(2) the court extends the time for evaluation and treatment for a patient who continues to meet the involuntary commitment criteria in AS 47.30.700 - 47.30.815.

(c) The department will reimburse a designated treatment facility for no more than 40 days for evaluation, treatment, and crisis stabilization or for transition to community-based services if the department determines the amount of time is clinically appropriate and
(1) the patient continues under, or has transferred to, voluntary commitment and the treating physician has certified, on a form supplied by the department, that the patient meets the involuntary commitment criteria in AS 47.30.700 - 47.30.815; or
(2) the court extends the time for evaluation and treatment for a patient who continues to meet the involuntary commitment criteria in AS 47.30.700 - 47.30.815, or the patient is authorized to remain at the facility under AS 47.30.745 (g).
(d) The department will not reimburse a designated facility under 7 AAC 72.510 for
(1) physician time spent performing administrative or supervisory duties; this exclusion does not include time spent participating in a commitment hearing;
(2) facility costs for space, overhead, supplies, or equipment;
(3) local ambulance service, unless
(A) a medical emergency directly related to the patient's mental condition results in eligibility for financial assistance under AS 47.31.010;
(B) the patient requires restraint; or
(C) ambulance service is necessary to meet the requirements of 42 U.S.C. 1395dd (Emergency Medical Treatment and Active Labor Act (EMTALA)) and 42 C.F.R. 489.24;
(4) the co-pay portion of a third-party reimbursement;
(5) any transportation or other expense to be paid by the court system for proceedings under AS 47.30; or
(6) any service that is not directly related to the patient's mental condition that resulted in eligibility for financial assistance under AS 47.31.010.
(e) For a patient admitted after an involuntary commitment under AS 47.30.700 - 47.30.815 or a voluntary commitment chosen after the patient's physician determines that the patient meets the involuntary commitment criteria in AS 47.30.700 - 47.30.815, the treating physician shall
(1) using a form supplied by the department, certify upon admission that the patient meets the involuntary commitment criteria in AS 47.30.700 - 47.30.815; if the patient subsequently transfers to voluntary commitment, the treating physician shall certify daily, on the patient's chart, whether the patient continues to meet the involuntary commitment criteria; and
(2) recertify every seven days, on the form supplied by the department, whether the patient continues to meet the involuntary commitment criteria.
(f) The department may, on a case-by-case basis, deny reimbursement under 7 AAC 72.540 if the department determines that a service provided is not directly related to the patient's mental health condition.

History: Eff. 3/16/2001, Register 157; am 6/24/2004, Register 170
Authority: AS 47.30.660
AS 47.31.025
AS 47.31.090

7 AAC 72.530. Application for financial assistance
(a) An application for assistance that is submitted under AS 47.31.015 (a) must include
(1) a copy of the invoice for the services for which financial assistance is sought;
(2) proof of gross monthly household income; this proof includes paycheck stubs, tax records, unemployment check stubs, a signed statement from an employer, or any other document that shows evidence of income for the month during which a patient received care provided by a designated facility; and
(3) identification of and information about any third-party payor that provides insurance coverage to the patient; for purposes of this paragraph, the following persons are not third-party payors under AS 47.31.010:
   (A) the United States Department of Interior, Bureau of Indian Affairs;
   (B) the United States Department of Health and Human Services, Indian Health Service;
   (C) the patient's private insurance company, if the company does not cover mental health inpatient treatment or the maximum benefit level for that treatment has been reached.
(b) If a designated facility makes a notification under AS 47.31.015 (b), the notification must
   (1) be signed and submitted by the administrator; and
   (2) include
      (A) any information as to whether a third-party payor is responsible for payment; and
      (B) subject to the disclosure restrictions of 42 C.F.R. Part 2 for a patient who is also being treated for alcohol or drug abuse in a facility that receives federal assistance as described in 42 C.F.R. Part 2, a copy of the invoice for the services for which financial assistance is sought.
(c) If the facility receives payment from a patient or a third-party payor after being reimbursed by the department under this chapter, the administrator shall return the money to the department.

History: Eff. 3/16/2001, Register 157; am 6/24/2004, Register 170
Authority: AS 47.30.660
AS 47.31.015
AS 47.31.090

7 AAC 72.540. Decision regarding eligibility for financial assistance
(a) The department will review information submitted under 7 AAC 72.530 to verify that the patient meets the eligibility requirements of AS 47.31.010 and that each service for which financial assistance is sought is an eligible service under 7 AAC 72.520(a) or (b). Subject to the disclosure restrictions of 42 C.F.R. Part 2 for a patient who has also received treatment for alcohol or drug abuse in a facility that receives federal financial assistance as described in 42 C.F.R. Part 2, the department may, after 10 days notice to the facility, review all financial and medical records related to a patient for whom application for financial assistance has been made.
(b) If the department determines that the patient is eligible for financial assistance, payment will be made directly to the designated facility that provided any service listed in 7 AAC 72.520(a) or (b), as required by AS 47.31.030.
(c) If the department determines that the patient is ineligible for financial assistance, or that a service provided is not eligible under 7 AAC 72.520, the department will, as required by AS 47.31.020, notify the patient and the designated facility that the application for financial assistance has been denied, and will advise the patient, the patient's legal representative, if any, and the designated facility of the right to appeal the denial of assistance under AS 47.31.035.

History: Eff. 3/16/2001, Register 157; am 6/24/2004, Register 170
Authority: AS 47.30.660
AS 47.31.025
AS 47.31.090

Article 11
General Provisions

Section
900. Definitions.

7 AAC 72.900. Definitions
In this chapter
(1) "administrator" means the person with primary responsibility for the administration and operation of a facility subject to this chapter; "administrator" includes that person's designee;
(2) "commissioner" means the commissioner of health and social services;
(3) "crisis stabilization" means the administration of medication and provision of structure, observation, support, case management, or discharge planning for a person subject to voluntary or involuntary admission for treatment under AS 47.30.660 - 47.30.815;
(4) "department" means the Department of Health and Social Services;
(5) "designated" means designated by the department as an evaluation or treatment facility under this chapter;
(6) "designated evaluation facility" has the meaning given the term "evaluation facility" in AS 47.31.100;
(7) "designated treatment facility" has the meaning given in AS 47.30, 915;
(8) "evaluation" means an examination and assessment of a person's
(A) mental health, conducted by a mental health professional; and
(B) physical condition, conducted by a physician;
(9) "gravely disabled" has the meaning given in AS 47.30.915;
(10) "gross monthly household income" has the meaning given in AS 47.31.100;
(11) "household" has the meaning given in AS 47.31.100;
(12) "lacks the mental capacity to apply for assistance" means that a patient cannot or refuses to complete the financial assistance application form supplied by the department because the patient is experiencing a severe symptom of mental illness, as certified by a treating physician;
(13) "medication management" means a review by a physician, a physician’s assistant, an advanced nurse practitioner with prescriptive authority, or other appropriately licensed medical professional to assess a person's need for medication, to prescribe appropriate medication to meet the person's needs, and to monitor the person's response to medication, including documentation of medication compliance, assessment and documentation of side effects, and evaluation and documentation regarding effectiveness of the medication;
(14) "mental health professional" has the meaning given in AS 47.30.915;
(15) "mental illness" has the meaning given in AS 47.30.915;
(16) "person who has a duty of support" means a patient's spouse or, if the patient is under 18 years of age, the patient's parent, as prescribed in AS 47.30.910 and AS 47.31.015;
(17) "single-point-of-entry psychiatric facility" means a facility licensed by the state to perform initial assessments of persons suffering from mental illness and to make initial determinations regarding placement of those persons for voluntary or involuntary commitment or respite care;
(18) "treatment" means mental health or psychiatric treatment under As 47.30.660 - 47.30.915;
(19) "working day" means a day other than Saturday, Sunday, or a state holiday.

History: Eff. 3/30/85, Register 93; am 3/16/2001, Register 157; am 6/24/2004, Register 170

Authority: AS 47.30.530
AS 47.30.540
AS 47.30.660
AS 47.31.025
AS 47.31.090
Draft Inpatient Psychiatric Standards of Care

Applicability: These standards are intended to apply to Alaska Psychiatric Institute as well as other hospitals that provide designated evaluation and treatment, designated evaluation and crisis stabilization. For each standard, there are a series of icons shown that identify the applicability for that particular standard the icons are:

- **API**: Alaska Psychiatric Institute
- **DET**: Hospitals that are approved Designated Evaluation and Treatment facilities.
- **DES**: Hospitals that are approved Designated Evaluation and Crisis Stabilization facilities.

- **Adult**: Applicable to Adult Services.
- **Child**: Applicable to Children Services

Implementation: It is envisioned that these standards will be used as a tool for site reviews although this process has not been developed.

Format: The format for these standards was modeled after the format used by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The content and wording were, where possible, drawn from JCAHO.

Content: The standards apply in the following areas of concern:

- Use of Restraints and Seclusion
- Patient and Family Member Involvement in Treatment/Discharge Planning
- Clinical Appropriateness of Treatment
- Use of Behavior Management Plans
- Admission/Discharge Interaction between Inpatient and Outpatient Providers
- Grievances
GLOSSARY

Advance Directive. A document or documentation allowing a person to give directions about future medical care or to designate another person(s) to make medical decisions in the individual loses decision-making capacity. Advance directives may include living wills, durable powers of attorney, do-not-resuscitate (DNRs) orders, right to die, or similar documents expressing the individual’s preferences as specified in the Patient Self-Determination Act. (See also Mental Health Advance Directive)

Appropriateness. The degree to which the care provided is relevant to the patient’s clinical needs, given the current state of knowledge.

Assessment. (1) For purposes of patient assessment, the process established by an organization for obtaining appropriate and necessary information about each individual seeking entry into a health care setting or service. The information is used to match an individual’s need with the appropriate setting, care level, and intervention.

Behavior Management. The use of basic learning techniques, such as biofeedback, reinforcement, or aversion therapy, to manage and improve an individual’s behavior.

Behavioral Health. A broad array of mental health, chemical dependency, forensic, mental retardation, developmental disabilities, and cognitive rehabilitation services provided in settings such as acute, long term, and ambulatory.

Community. The individuals, families, groups, agencies, facilities, or institutions within the geographic area served by a health care organization.

Competence or Competency. A determination of an individual’s capability to perform up to defined expectations.

Compliance. To act in accordance with stated requirements, such as standards. Levels of compliance include non-compliance, minimal compliance, partial compliance, significant compliance, and substantial compliance.

Confidentiality. An individual’s right, within the law, to personal and informational privacy, including his or her health care records.

Continuing Care. Care provided over an extended period of time, in various settings, spanning the illness-to-wellness continuum.

Continuity. The degree to which the care of individuals is coordinated among practitioners, organizations, and over a set time frame.

Continuum of Care. Matching an individual’s ongoing needs with the appropriate level and type of medical, psychological, health, or social care or service within an organization or across multiple organizations.
**Diagnosis.** A scientifically or medically acceptable term given to a complex of symptoms (disturbances of function or sensation of which the individual is aware), signs (disturbances the physician or another individual can detect), and findings (detected by laboratory, x-ray, or other diagnostic procedures, or responses to therapy.

**Discharge.** The point at which an individual’s active involvement with an organization or program is terminated and the organization or program no longer maintains active responsibility for the care of the individual.

**Drug.** Any substance, other than food or devices, that may be used on or administered to persons as an aid in the diagnosis, treatment, or prevention of disease or other abnormal condition.

**Governing Body.** The individuals, group, or agency that has ultimate authority and responsibility for establishing policy, maintaining care quality, and providing for organization management and planning; other names for this group include board, board of trustees, board of governors, board of directors, board of commissioners, and partners (network).

**Guardian.** A parent, trustee, conservator, committee, or other individual or agency empowered by law to act on behalf of or be responsible for an individual. See also *surrogate decision maker*.

**Individual.** A person who receives treatment services. The term is synonymous with patient, client, resident, consumer, individual served, and recipient of treatment services.

**Intent of Standard.** A brief explanation of the standard’s rationale, meaning, and significance.

**Leaders.** The leaders described in the leadership function include at least the leaders of the governing body; the chief executive officer and other senior management; department leaders, the elected and appointed leaders of the medical staff and the clinical departments and other medical staff members in organizational administrative positions; and the nurse executive and other senior nursing leaders.

**Licensed Independent Practitioner.** Any individual permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the individual’s license and consistent with individually granted clinical privileges.

**Medical Record.** The account compiled by physicians and other health care professionals of a variety of patient health information, such as assessment findings, treatment details, and progress notes.

**Medical Staff.** A person that has the overall responsibility for the quality of the professional services provided by individuals with clinical privileges and also the responsibility of
accounting, therefore, to the governing body. The medical staff includes fully licensed physicians and may include other licensed individuals permitted by law and by the organization to provide patient care services independently (that is, without clinical direction or supervision) within the organization. Members have delineated clinical privileges that allow them to provide patient care services independently within the scope of their clinical privileges.

**Medication.** Any substance, other than food or devices, that may be used on or administered to persons as an aid in the diagnosis, treatment, or prevention of disease or other abnormal condition.

**Mental Health Advance Directive.** A document or documentation allowing a person to give directions about future mental health care or to designate another person(s) to make treatment decisions in event that the individual loses decision-making capacity.

**Neglect.** An impaired quality of life for an individual resulting from the absence of minimal services or resources to meet basic needs. Neglect includes withholding or inadequately providing food and hydration (without physician, patient, or surrogate approval), clothing medical care, and good hygiene. It may also include placing the individual in unsafe or unsupervised conditions.

**Patient.** An individual who receives care or services, or one who may be represented by an appropriately authorized person. The term is synonymous with patient, client, resident, consumer, individual served, and recipient of treatment services.

**Policies and Procedures.** The formal, approved description of how a governance, management, or clinical care process is defined, organized, and carried out.

**Practice Guidelines.** Descriptive tools or standardized specification for care of the typical individual in the typical situation, developed through a formal process that incorporates the best scientific evidence of effectiveness with expert opinion. Synonyms include clinical criteria, parameter (or practice parameter), protocol, algorithm, review criteria, preferred practice pattern, and guideline.

**Practitioner.** Any individual who is qualified to practice in a health care profession (for example, a physician, or nurse). Practitioners are often required to be licensed as defined by law.

**Prescribing or Ordering.** Directing the selection, preparation, or administration of medications.

**Restraint.** Any method (chemical or physical) of restricting an individual’s freedom of movement, physical activity, or normal access to the body.

**Chemical Restraint.** The inappropriate use of a sedating psychotropic drugs to manage or control behavior.
**Physical Restraint.** Any method of physically restricting a person’s freedom of movement, physical activity, or normal access to his or her body.

**Seclusion.** Involuntary confinement of a person in a room (alone) or an area where a person is physically prevented from leaving.

**Surrogate Decision-Maker.** Someone appointed to act on behalf of another, including court-appointed guardians or attorneys in fact. Surrogates make decisions only when an individual is without capacity or has given permission to involve others.
Use of Restraint and Seclusion
RS 1.0  **Restraint or seclusion use will be limited to emergencies in which there is an imminent risk of an individual physically harming himself, staff, or others, and non-physical interventions would not be effective. Non-physical techniques are the preferred intervention in the management of behavior.**

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**Intent.** Non-physical techniques are always considered as the preferred intervention. Such interventions may include redirecting the individual’s focus or employing verbal de-escalation. Restraint or seclusion will only be employed when non-physical interventions are ineffective or not viable, and when there is an imminent risk of an individual physically harming him or herself, staff, or others. The type of physical intervention selected takes into consideration information learned from the individual’s initial assessment. The organization will not permit use of restraint or seclusion for any other purpose, such as coercion, discipline, convenience, or retaliation by staff. The use of restraint or seclusion will not be based on an individual’s restraint or seclusion history or solely on a history of dangerous behavior.
**RS 2.0**

*The initial assessment of each individual at the time of admission or intake assists in obtaining information about the individual that could help minimize the use of restraint or seclusion.*

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**Population**

*Intent.* The initial assessment of an individual who is at risk of harming him or herself, staff, or others, will, in consultation with the individual and through review of his or her Mental Health Advance Directives, identify:

- Techniques, methods, or tools that would help the individual control his or her behavior. When appropriate, the individual and/or family assist in the identification of such techniques;
- Pre-existing medical conditions or any physical disabilities and limitations that would place the individual at greater risk during restraint or seclusion; and
- Any history of sexual or physical abuse that would place the individual at greater psychological risk during restraint or seclusion.

Also at the time of assessment:

- The individual and/or family will be informed of the organization’s philosophy on the use of restraint and seclusion to the extent that such information is not contraindicated.
- The role of the family, including their notification of a restraint or seclusion episode, is discussed with the individual and, as appropriate, the individual’s family. This is done in conjunction with the individual’s right to confidentiality.
- The organization will determine whether the individual has a mental health advance directive with respect to behavioral health care and will ensure that direct care staff are made aware of the mental health advance directive.
RS 3.0  A licensed independent practitioner will order the use of restraint or seclusion.

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**Population**  

**Intent.** Because restraint and seclusion use is limited to emergencies (in which a licensed independent practitioner may not be immediately available), the organization may authorize qualified registered nurses or other qualified, trained staff members who are not licensed independent practitioners to initiate the use of restraint or seclusion before an order is obtained from the licensed independent practitioner. All restraint and seclusion will be used and continued pursuant to an order by the licensed independent practitioner who is primarily responsible for the individual’s ongoing care, or his or her licensed independent practitioner designee, or other licensed independent practitioner. Immediately after the initiation of restraint or seclusion, a qualified registered nurse or other qualified staff:

- Will notify and obtain an order (verbal or written) from a licensed independent practitioner; and
- Will consult with the licensed independent practitioner about the individual’s physical and psychological condition.

The licensed independent practitioner will:

- Review with staff the physical and psychological status of the individual;
- Determine whether restraint or seclusion should be continued;
- Supply staff with guidance in identifying ways to help the individual regain control in order for restraint or seclusion to be discontinued; and
- If appropriate, issue an order.
RS 4.0  A licensed independent practitioner will see and evaluate the individual in person.

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Intent. The licensed independent practitioner who is primarily responsible for the individual’s ongoing care, or his or her licensed independent practitioner designee, or other licensed independent practitioner will conduct an in-person evaluation of the individual within one hour of the initiation of restraint or seclusion.

At the time of the in-person evaluation, the licensed independent practitioner:
- Will work with the individual and staff to identify ways to help the individual regain control;
- Will make any necessary revisions to the individual’s treatment plan; and
- If necessary, provide a new written order. This order and any subsequent orders follow the time limits cited in Standard RS 5.0.

If the individual is no longer in restraint or seclusion when an original verbal order expires, the licensed independent practitioner will conduct an in-person evaluation of the individual within 24 hours of the initiation of restraint or seclusion.
RS 5.0  
*Written or verbal orders for initiating and continuing use of restraint and seclusion will be time-limited.*

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**Intent.** Written and verbal orders for restraint and seclusion will be limited to:

- Four hours for individuals 18 years of age and older;
- Two hours for children and adolescents ages 9 to 17; and
- One hour for children under age 9.

Orders for the use of restraint or seclusion will not be written as standing orders or on an as needed basis (PRN).

If restraint or seclusion needs to continue beyond the expiration of the time-limited order, a new order continuing the restraint or seclusion will be obtained from the licensed independent practitioner who is primarily responsible for the individual’s ongoing care, or his or her licensed independent practitioner designee, or other licensed independent practitioner.

Time-limited orders do not mean that restraint or seclusion must be applied for the entire length of time for which the order is written. The standards for periodic assessment, monitoring and assisting, and reevaluation are intended to encourage the discontinuation of restraint or seclusion as soon as the individual meets the behavior criteria for its discontinuation.

When restraint or seclusion is terminated before the time-limited order expires, the original order can be used to reapply the restraint or seclusion if the individual is at imminent risk of physically harming him or herself or others, and non-physical interventions are not effective. However, when the original order expires, a new order for restraint or seclusion will be obtained from the licensed independent practitioner who is primarily responsible for the individual’s ongoing care, or his or her licensed independent practitioner designee, or other licensed independent practitioner.
RS 6.0  *Individuals who are in restraint or seclusion are regularly reevaluated.*

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**Population**

**Intent.** By the time that an order for restraint or seclusion expires, the individual will receive an in-person reevaluation. This in-person reevaluation will be conducted by:

- The licensed independent practitioner who is primarily responsible for the individual’s ongoing care; or
- His or her licensed independent practitioner designee; or
- Other licensed independent practitioner; or
- A qualified registered nurse or other qualified, trained individual who has been authorized by the organization to perform this function (see Standard RS 3.0 for conditions).

If, after reevaluation the restraint or seclusion is to be continued, the licensed independent practitioner, in conjunction with the reevaluation will:

- Give a written or verbal order for continuation that is subject to the time frames defined in Standard RS 5.0; and
- Reevaluate the efficacy of the individual’s treatment plan and work with the individual to identify ways to help him or her regain control.

If the licensed independent practitioner, or his or her licensed independent practitioner designee, is not the licensed independent practitioner who gives the order, the individual’s licensed independent practitioner will be notified of the individual’s status if the restraint or seclusion is continued.

Reevaluation of the individual in restraint or seclusion will take place every:

- Four hours for adults ages 18 and older;
- Two hours for children and adolescents ages 9 to 17; and
- One hour for children under age 9.

The licensed independent practitioner must, in any event, conduct an in-person reevaluation at least every:

- Eight hours for individuals ages 18 and older; and
- Four hours for individuals ages 17 and younger.
**RS 7.0**  
*Individuals in restraint or seclusion are assessed and assisted.*

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**Population**

**Intent.** A trained and competent staff member will assess the individual at the initiation of restraint or seclusion and every 15 minutes thereafter. This assessment will include, as appropriate to the type of restraint or seclusion employed:

- Signs of any injury associated with the application of restraint or seclusion;
- Nutrition and hydration;
- Circulation and range of motion in the extremities;
- Hygiene and elimination;
- Physical and psychological status and comfort; and
- Readiness for discontinuation of restraint or seclusion.

Staff will provide assistance to individuals in meeting behavior criteria for the discontinuation of restraint or seclusion.
RS 8.0  Individuals in restraint or seclusion will be monitored.

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**Intent.** The purpose of monitoring an individual in restraint or seclusion is to ensure the individual’s physical safety. Monitoring is accomplished through continuous in-person observation by an assigned staff member who is competent and trained in accordance with the provisions of Standard RS 12.0. After the first hour, an individual in seclusion only may be continuously monitored using simultaneous video and audio equipment, if this is consistent with the individual’s condition or wishes. For example, it may be more helpful and less disruptive to the individual if staff does not monitor him or her by physically sitting in the seclusion room or watching through the window into the seclusion room. If the individual is in a physical hold by a staff member, a second staff person is assigned to observe the individual.
RS 9.0  *Restraint and seclusion use will be discontinued when the individual meets the behavior criteria for their discontinuation.*

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**Population**

*Intent.* As early as feasible in the restraint or seclusion process, the individual will be made aware of the rationale for restraint or seclusion and the behavioral criteria for its discontinuation. Restraint or seclusion is discontinued as soon as the individual meets his or her behavior criteria. Examples of behavior criteria include:

- An individual’s ability to contract for safety;
- Whether an individual is oriented to the environment; and/or
- Cessation of verbal threats.
RS 10.0  The individual and staff will participate in a debriefing about the restraint episode.

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Intent. Debriefing is important in reducing the use of restraint and seclusion. The individual and, if appropriate, the individual’s family, will participate with the treatment team and staff who were involved in the episode and who are available, in a debriefing about each episode of restraint or seclusion. The debriefing will occur as soon as possible and appropriate, but no longer than 72 hours after the episode. The debriefing will:

- Identify what led to the incident and what could have been handled differently;
- Ascertain that the individual’s physical well-being, psychological comfort, and right to privacy were addressed;
- Counsel the individual involved for any trauma that may have resulted from the incident; and
- When indicated, modify the individual’s treatment plan.

Information obtained from debriefings will be used in performance improvement activities.
RS 11.0  *Staffing levels and assignments will be set up to minimize circumstances that give rise to restraint or seclusion use and to maximize safety when restraint and seclusion are used.*

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**Population**

**Intent.** The organization will base its staffing levels and assignments on a variety of factors, including:

- Staff qualifications;
- The physical design of the environment; and
- Diagnoses, co-occurring conditions, acuity levels, and age and developmental functioning of individuals served.
RS 12.0  **Staff will be trained and competent to minimize the use of restraints and seclusion, and in their safe use.**

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**Intent.** The organization will educate and assess the competence of staff in minimizing the use of restraint and seclusion and, before they participate in any use of restraint or seclusion, in their safe use.

**Training Requirements for all Direct Care Staff.** In order to minimize the use of restraint and seclusion, all direct care staff as well as any other staff involved in the use of restraint and seclusion will receive ongoing training in and demonstrate an understanding:

- Of the underlying causes of threatening behaviors exhibited by individuals they serve;
- That sometimes an individual may exhibit an aggressive behavior that is related to a medical condition and not related to his or her emotional condition, for example, threatening behavior may result from delirium in fevers, hypoglycemia;
- Of how their own behaviors can affect the behaviors of individuals they serve;
- Of the use of de-escalation, mediation, self-protection, and other techniques, such as time-out; and
- Recognizing signs of physical distress in individuals being held, restrained, or secluded.

**Training Requirements for Staff Authorized to Physically Apply Restraint or Seclusion.** Staff who are authorized to physically apply restraint or seclusion receive the training and demonstrate the competence required for all direct care staff defined above, and also receive ongoing training in and demonstrated competence in the safe use of restraint, including:

- Physical holding techniques;
- Take-down procedures; and
- The application and removal of mechanical restraints.

**Training Requirements for Staff Authorized to Perform 15 Minute Assessments.** Staff who are authorized to perform 15 minute assessments of individuals who are in restraint or seclusion receive the training and
demonstrate competence required for all direct care staff and those staff authorized to physically apply restraint or seclusion, as defined above, and also receive ongoing training and demonstrate competence in:

- Taking vital signs and interpreting their relevance to the physical safety of the individual in restraint or seclusion;
- Recognizing nutritional and hydration needs;
- Checking circulation and range of motion in the extremities;
- Addressing hygiene and elimination;
- Addressing physical and psychological status and comfort;
- Assisting individuals in meeting behavior criteria for the discontinuation of restraint or seclusion;
- Recognizing readiness for the discontinuation of restraint or seclusion; and
- Recognizing when to contact a medically trained licensed independent practitioner or emergency medical services in order to evaluate and/or treat the individual’s physical status.

**Training Requirements for Staff Authorized to initiate Restraint or Seclusion and/or Perform Evaluations/Reevaluations.** Staff who, in the absence of a licensed independent practitioner, are authorized to initiate restraint or seclusion, and/or perform evaluations/reevaluations of individuals who are in restraint or seclusion in order to assess their readiness for discontinuation or establish the need to secure a new order, receive training and demonstrate competence required for all direct care staff, staff authorized to physically apply restraint or seclusion, and staff authorized to perform 15 minute assessments as defined above, and are also educated and demonstrate competence in:

- Recognizing how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which an individual reacts to physical contact; and
- The use of behavior criteria for the discontinuation of restraint or seclusion and how to assist individuals in meeting these criteria.

**First Aid, Cardiopulmonary Resuscitation, and Emergency Medical Services Availability.** An appropriate number of staff who are competent to initiate first aid, cardiopulmonary resuscitation, and the use of a deliberator machine will be available at all times. The organization will have a plan for the provision of emergency medical services.

**Involvement of Individuals who have Experienced Restraint or Seclusion.** The viewpoints of individuals who have experienced restraint or seclusion will be incorporated into staff training and education in order to help staff better understand all aspects of restraint and seclusion use. Whenever possible, such individuals who have experienced restraint or seclusion will contribute to the training and education curricula and/or participate in staff training and education.
RS 13.0 \textit{The individual’s family will be promptly notified of the initiation of restraint or seclusion.}

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\textit{Intent.} In cases in which the individual has consented to have another person or persons kept informed regarding his or her care and the person has agreed to be notified, staff will promptly attempt to contact them to inform them of the restraint or seclusion episode. The timing of the notification with regard to the hour of the day or night will be included in the agreement.
RS 14.0  A Patient’s medical record will document that the use of restraint or seclusion is consistent with organization policy.

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**Intent.** The use of restraint or seclusion will be recorded in the individual’s medical record. The focus of the entries will be on the individual. The clinical record will document:

- That the individual and/or family was informed of the organization’s policy on the use of restraint;
- Any pre-existing medical conditions or any physical disabilities that would place the individual at greater risk during restraint and seclusion; and
- Any history of sexual or physical abuse that would place the individual at greater psychological risk during restraint or seclusion.

Each episode of use will be recorded. The documentation will include information about:

- The circumstances that led to their use;
- Consideration or failure of non-physical interventions;
- The rationale for the type of physical intervention selected;
- Notification of the individual’s family, when appropriate;
- Written orders for use;
- Behavior criteria for discontinuation of restraint or seclusion;
- Informing the individual of behavior criteria for discontinuation of restraint or seclusion;
- Each verbal order received from a licensed independent practitioner;
- Each in-person evaluation and reevaluation of the individual;
- 15 minute assessments of the individual’s status;
- Assistance provided to the individual to help him or her meet the behavior criteria for discontinuation of restraint or seclusion;
- Continuous monitoring;
- Debriefing of the individual with staff; and
- Any injuries that are sustained and treatment received for these injuries or death.

Documentation will be accomplished in a manner (such as restraint and seclusion log) that allows for the collection and analysis of data for performance improvement activities.
RS 15.0  The organization will collect data on the use of restraint and seclusion in order to monitor and improve its performance of processes that involve risks or may result in sentinel events.

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**Intent.** The organization will collect restraint and seclusion data:
- In order to ascertain that restraint and seclusion are used only as emergency interventions;
- To identify opportunities for incrementally improving the rate and safety of restraint and seclusion use; and
- To identify any need to redesign care processes.

The hospital leadership will determine the frequency with which data are aggregated. Using a patient identifier, data on all restraint and seclusion episodes will be collected from and classified for all settings/units/locations by:
- Shift;
- Staff who initiated the process;
- The length of each episode;
- Date and time each episode was initiated;
- Day of the week each episode was initiated;
- The type of restraint used;
- Whether injuries were sustained by the individual or staff;
- Age of the individual; and
- Gender of the individual.

Particular attention will be extended to:
- Multiple instances of restraint or seclusion experienced by an individual within a 12-hour time frame.
- The number of episodes per individual;
- Instances of restraint or seclusion that extend beyond 12 consecutive hours; and
- The use of psychoactive medications as an alternative for, or to enable discontinuation of, restraint or seclusion.

Licensed independent practitioners will participate in measuring and assessing the use of restraint and seclusion for all individuals within the organization.
RS 16.0  Hospital leadership will establish and communicate the organization’s philosophy on the use of restraint and seclusion to all staff who have direct care responsibility.

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**Intent.** At a minimum, the organization’s philosophy will address:

- Its commitment to prevent, reduce, and strive to eliminate the use of restraint and seclusion;
- Preventing emergencies that have the potential to lead to the use of restraint or seclusion;
- The role of non-physical interventions as preferred interventions;
- Limiting the use of restraint and seclusion to emergencies in which there is an imminent risk of an individual physically harming him or herself or others, including staff;
- Its responsibility to facilitate the discontinuation of restraint or seclusion as soon as possible;
- Raising awareness among staff about how the use of restraint or seclusion may be experienced by the individual; and
- Preserving the individual’s safety and dignity when restraint or seclusion is used.

This philosophy will be communicated to all members of the organization who have direct care responsibility.
RS 17.0  Clinical leadership will be informed of instances in which individuals experience extended or multiple episodes of restraint or seclusion.

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Intent. The clinical leadership is immediately notified of any instance in which an individual:

- Remains in restraint or seclusion for more than 12 hours; or
- Experiences two or more separate episodes of restraint and/or seclusion of any duration within 12 hours.

Thereafter, the clinical leadership will be notified every 24 hours if either of the above conditions continues. This information will be communicated to the clinical leadership in order for it to:

- Discharge its clinical accountability; and
- Assess whether additional resources are required to facilitate discontinuation of restraint or seclusion; or
- Minimize recurrent instances of restraint and seclusion
RS 18.0  Organization policies and procedures will address the prevention of the use of restraint and seclusion and, when employed, guides their use.

Type of Facility

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**Intent.** Organization policies and procedures will include appropriate detail that addresses:

- Staffing levels;
- Competence and training of staff;
- The initial assessment of the individual;
- The role of non-physical techniques in the management of behavior;
- Time-out;
- Limiting the use of restraint or seclusion to emergencies;
- Notification of the individual’s family when restraint or seclusion is initiated;
- Ordering of restraint and seclusion by a licensed independent practitioner;
- In-person evaluations of the individual in restraint or seclusion;
- Initiation of restraint and seclusion by an individual other than a licensed independent practitioner;
- Time-limited orders;
- Reassessment of an individual in restraint or seclusion;
- Monitoring the individual in restraint or seclusion;
- Post-restraint and seclusion practices;
- Reporting injuries and deaths to the organization’s leadership and to the appropriate external agencies consistent with applicable law and regulation;
- Documentation; and
- Data collection and the integration of restraint and seclusion into performance improvement activities.
RS 19.0  The standard for restraint and seclusion *does not apply*:

- to the use of restraint with individuals who receive treatment through formal behavior management programs; such individuals a) exhibit intractable behavior which is severely self-injurious or injurious to others, b) have not responded to traditional interventions, and c) are unable to contract with staff for safety;
- to forensic restrictions and restrictions imposed by correction authorities for security purposes; and
- to protective equipment such as helmets, gloves, etc...

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*Intent.* Non-physical techniques are always considered as the preferred intervention. The organization will not permit the use of restraint or seclusion for such purposes as coercion, discipline, convenience, or retaliation by staff, nor will the use of restraint or seclusion be based on an individual’s restraint or seclusion history or solely on a history of dangerous behavior. A facility may, for example, use ambulatory restraints for wrists or ankles, helmets, gloves, and other measures if the patient’s intractable behaviors are not manageable within the hospital’s usual treatment structures and a special behavior management plan has been developed and ordered by a physician for the safety of the patient or others.
Patient and Family Participation in Treatment Planning
PP 1.0  Patients are involved in all aspects of their care.

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Intent. Hospitals shall promote patient and family involvement in all aspects of their care through the implementation of policies and procedures that are compatible with the hospital’s mission and resources, have diverse inputs, and guarantee communication across the organization. Patients should be involved in at least the following aspects of their care:

- Giving informed consent;
- Making care decisions;
- Resolving dilemmas about care decisions; and
- Formulating advance directives.

Patients’ psychosocial, spiritual, and cultural values affect how they respond to their care. The hospital should allow patients and their families to express spiritual beliefs and cultural practices, as long as these do not harm others or interfere with treatment.
**PP 2.0 Informed consent is obtained.**

**Type of Facility**

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**Population**

**Intent.** Staff members will clearly explain any proposed treatments or procedures to the patient and, when appropriate, the family. The explanation will include:

- Potential benefits and drawbacks;
- The likelihood of success;
- Possible results of non-treatment;
- Any significant alternatives;
- The name of the physician or other practitioner who has primary responsibility for the patient’s care; and
- The identity and professional status of individuals responsible for authorizing and performing procedures or treatments.
The family participates in care decisions on the patient’s request.

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**Intent.** Care sometimes requires that people other than (or in addition to) the patient be involved in decisions about the patient’s care. This is especially true when the patient does not have mental or physical capacity to make care decisions or when the patient is a child. When the patient is not competent to make decisions regarding his or her care, a surrogate decision maker will be identified as appropriate/necessary. In the case of an unemancipated minor, the family or guardian is legally responsible for approving the care prescribed. The patient has the right to exclude any or all family members from participating in his or her care decisions, except when another individual has responsibility for care.
Patients are involved in resolving dilemmas about care decisions.

Intent. Making decisions about care sometimes presents questions, conflicts, or other dilemmas for the hospital and the patient, family, or other decision makers. These dilemmas may arise around issues of admission, treatment, or discharge. These issues can be especially difficult to resolve when the issues involve, for example, involuntary inpatient psychiatric care. The hospital will have a way of resolving such dilemmas and identities of those who need to be involved in the resolution. Patients and, when appropriate, their surrogate decision makers, will be afforded the opportunity to substantially participate in the resolution of these issues.
PP 5.0  *The hospital addresses mental health advance directives.*

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**Intent.** The hospital will determine whether a patient has or wishes to make mental health advance directives. The hospital will also ensure that health care professionals and designated representatives honor the directives within the limits of the law and consistent with reasonable medical practice and availability of the treatment requested. In the absence of the actual directive, the substance of the directive will be documented in the patient’s medical record. The lack of advance directives will not hamper access to care. The hospital, however, will provide assistance to patients who do not have an advance directive but who wish to formulate one.
The patient’s medical record will document the teamwork involved, including the participants and the process employed in the development of the treatment and discharge plan for the individual patient.

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Population

**Intent.** The intent of this standard is that the level of involvement of the patient, staff, and other participants in the treatment and discharge planning process will be reflected in the patient’s medical record. The record will document the participants and as well as a description of the process used.
PP 7.0  *The patient will be allowed, when appropriate, to make choices free from undue external influence or interference.*

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<td>Intent. When appropriate, and within the mission, philosophy, and capabilities of the hospital, the patient and, when appropriate, their family, will be allowed to make choices regarding the services and care they receive. The patient and, when appropriate, their family, will be allowed to make these choices free from undue external pressure or interference.</td>
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Appropriateness of Treatment
TX 1.0 Each patient’s physical, psychological, and social needs will be assessed within a time frame specified by organization policy.

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Intent. Upon admission for inpatient psychiatric care, each patient will be assessed in terms of his or her physical, psychological, and social needs. The primary purpose of this assessment is to assist in the treatment planning process. The time period after admission in which this assessment must occur will be specified in organizational policy.
TX 2.0 Care, treatment, and rehabilitation will be planned and delivered so to ensure appropriateness to the patient’s needs, severity of the disease, impairment, or disability.

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Population

Intent. Care will be planned to respond to each patient’s unique needs (including age-specific needs), expectations, and characteristics with effective, efficient, and individualized care. An essential element in the planning process is assessment of the patient’s condition. Patients’ care, treatment, and rehabilitation goals will be identified and documented in the individualized treatment plan. Acting on care goals requires deliberate planning. For most patients, meeting the goals requires a variety of services that often can be delivered in multiple settings. For each patient, the most appropriate settings are selected and provided. Care begins when settings and services are identified and planned.
 Patients’ progress will be periodically evaluated against care goals and the plan of care. When indicated, the plan or goal will be revised.

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Intent. Progress will be measured against the plan of care and treatment goals. The frequency of evaluation or reevaluation will be appropriate to the plan of care, services provided, and patient needs.
TX 4.0  Within the capabilities and mission of the hospital, the patient will have access to the appropriate type of care.

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Intent. None.
TX 5.0  The hospital will ensure continuity over time among the phases of services to a patient.

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**Intent.** When delivery of care spans a period of time longer than two or three days, the hospital will ensure that there is continuity among the various phases of the patient’s care and coordination among the professionals delivering the care. This continuity of care will be documented in the patient’s medical record.
TX 6.0  **Hospitals providing inpatient psychiatric treatment will ensure that direct service and managerial staff are trained in the latest tested and accepted mental health treatment paradigms contained in clinical practice guidelines.**

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**Population**

Intent. Providers of inpatient psychiatric care should offer care consistent with the latest tested and accepted treatment paradigms contained in the clinical practice guidelines. Direct service staff and managers should receive relevant treatment that will allow them to effectively and appropriately deliver these treatments consistent with reasonable medical practice and the availability of the treatments.
TX 7.0  The hospital will ensure that treatment planning and delivery of care are sensitive to cultural/religious beliefs and traditions.

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Population

**Intent.** As hospitals engage patients and, where appropriate, their families, in the treatment planning process and in the delivery of care, they will ensure that the patients’ and their families’ cultural traditions and religious beliefs are given consideration.
TX 8.0  

One of the goals of inpatient mental health treatment will be to provide the patient and, where appropriate, his or her family with information about the disease, treatment options, and medications.

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Intent. Hospitals that provide inpatient psychiatric treatment will ensure that, as a part of the treatment planning process, the goal of patient and family education regarding the disease, treatment options, and medications is included in the care plan.
Discharge and Admission Interaction Between Inpatient and Outpatient Providers
CC 1.0  The discharge process will be based upon the patient’s assessed needs at the time of discharge.

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- **Intent.** Patient needs are assessed at the time of admission and consistently reassessed during their stay. As the goals of the treatment plan are achieved and the patient prepares for discharge, a further assessment of continuing care needs will be conducted. Discharge planning will focus on meeting patients’ needs after discharge. Discharge planning will identify patients’ continuing physical, mental, emotional, social, and other needs and arranges for services to meet them.
Hospitals will enter into a written agreement with community mental health centers regarding appointment scheduling and ongoing psychiatric care.

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Intent. The facility director shall enter into a written agreement with a community mental health center in the area served by the facility to provide coordination and continuity of services related to the admission and discharge of patients receiving inpatient psychiatric care. The agreement must state that the center will schedule an appointment at the center for:

- Clinical services within one week after a patient’s discharge from the facility; and;
- The agreement will describe the arrangements in place to ensure that the medication prescribed at the facility can continue uninterrupted after the patient’s release.
CC 3.0  *The hospital will facilitate and coordinate the transition of patients to continuing care through contact with the appropriate community mental health center and other providers as appropriate.*

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**Intent.** As a part of discharge planning, the hospital staff will facilitate the contact with continuing care providers, particularly the appropriate community mental health center. Discharge planning for inpatient psychiatric care will include:

- Coordination of post-discharge continuing care with the community mental health center in the patient’s home community (or community of choice);
- Facilitating scheduling of first post-discharge outpatient appointment;
- Obtaining, where possible, appropriate patient release of information forms;
- Providing appropriate medical records to the community mental health center or other provider that will be providing continuing care; and
- Provision of back-up support, information, and expertise to the organization or individual that will deliver continuing care.
**CC 4.0**  *Hospitals will work with appropriate community mental health centers to ensure smooth transition into the hospital from the community when necessary.*

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**Population**

**Intent.** The intent of this standard is that inpatient mental health providers will maintain cooperative working relations and good lines of communication with community mental health centers in order to provide an effective continuum of care for the community.
CC 5.0  Hospitals will involve the patient and his or her family in the discharge planning process.

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Intent. The intent of this standard is that the patient and his or her family will play a substantial role in the discharge planning process. This involvement will include the following elements:

- Selection of outpatient mental health service providers if appropriate;
- Scheduling of appointments; and
- Selection of treatment approaches and methods.
CC 6.0  *Hospitals will maintain communication and provide information to appropriate outpatient providers during the course of inpatient treatment.*

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**Population**

- **Intent.** The intent of this standard is that, where inpatient mental health treatment is being provided, the appropriate outpatient mental health provider or community mental health center will be kept advised of the patient’s progress as appropriate. In some cases, where outpatient providers have hospital consulting privileges, this may take the form of case consultation. In other cases, it may take the form of written or oral reports to the outpatient provider. Any communication with outpatient providers will be subject to the approval and release of information by the patient and/or his or her family.
Use of Behavior Management Plans
BM 1.0  *If behavior management procedures are used, they will be used as a part of the patient’s treatment plan.*

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**Intent.** The intent of this standard is that behavior management procedures will not be used with punitive or retaliatory intent or for the convenience of the staff. If they are used, they will be used when clinically indicated and to prevent harm to the patient, other patients, or staff. When used, they will be documented in the patient’s plan of care. The hospital should also use educational and positive reinforcement techniques.
BM 2.0  *The use of behavior management procedures will conform to hospital policy. All behavior management procedures will be reviewed, evaluated, and approved by the Medical Director.*

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**Intent.** The hospital will define staff roles and responsibilities for all appropriate disciplines involved in using special procedures. When behavior management plans are used, they will be included in the patient’s plan of treatment. Hospital policies will describe:

- Under what conditions specific behavior management procedures can be used and when they should not be used; and
- Requirements of approval of behavior management procedures in a patient’s plan of treatment.

The hospital will use educational and positive reinforcement techniques (for example, alternate adaptive behaviors) wherever possible. When more restrictive techniques are clinically necessary, the least restrictive alternative will be used to avoid harm to the patient. Time-out and procedures using restraining devices or aversive techniques are used only consistent with the patient’s plan of treatment, policies, and procedures, and state and federal laws. The hospital will protect the patient’s nutritional status and physical safety (for example, from corporal punishment). Other patient’s may assist in implementing a patient’s behavior management program only if:

- It is conducted as a part of a structured treatment plan;
- It is conducted under the supervision of qualified staff;
- It is limited to empowering patients to provide positive reinforcement; and
- It does not become abusive.
BM 3.0  The hospital will ensure that all staff receives training appropriate to their roles and responsibilities with regard to patients.

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Intent. Hospital staff members will receive training that is appropriate for their roles and responsibilities as applied to patient contact. This training will include:

- Training to develop appropriate interactions with patients; and
- Protection, security, and observation of patients.
BM 4.0  *Patients and their families will be involved in the development of behavior management plans as a part of their involvement in the treatment planning process.*

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**Population**

Intent. To the extent possible and practicable, patients and their families will be allowed to participate in the development of behavior management procedures as applied to their specific plan of care. This involvement may include:

- Identification and, to the extent possible, compliance with patient and/or family desires regarding the methods of behavior management; and
- Setting of treatment goals regarding behavior and behavior management.
Grievances
FR 1.0 A designated evaluation and designated evaluation and treatment site, as well as API, will quarterly report on the number of times during that quarter a staff person within the facility filed charges against a patient for assault or other alleged acts.

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**Intent.** The State believes that the collection of information related to the frequency of staff reports to law enforcement is a legitimate quality improvement goal. Therefore, this standard requires DES and DET sites, as well as API, to maintain data, to the extent possible; on the number of times in a calendar quarter a hospital staff person files charges against a patient of that facility. In addition, data is requested that would describe the nature of the incident that led to the filing of the charges, as well as describe any injuries that occurred to staff, other patients, or visitors during the incident that generated the filing of the police report. Because the request for more detailed information may run afoul of a hospital’s risk management activities, which are confidential under State law, the extent to which a hospital will make this more descriptive event information available is facility dependent. At the very least, the State maintains that hospitals can make a good faith effort to keep track of the number of times a staff member files charges against a patient, since this fact is a matter of public record and should generally be known to facility supervisors/managers.
GR 1.0 The hospital has a grievance process that patients and their families are aware of and know how to access (adopted by reference from the HCFA Conditions of Participation for Hospitals).

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**Intent.** The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates to responsibility in writing to a grievance committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Peer Review Organization. At a minimum:

(i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital.

(ii) The grievance process must specify time frames for review of the grievance and the provision of the response.

(iii) In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.