

EMERGENCY AND BILLING INFORMATION

HAVE YOU CALLED YOUR INSURANCE COMPANY TO PRE-AUTHORIZE THE ASSESSMENT? Y___ N___

DATE_____ REFERRED BY_____ CLIENT #_____

CLIENT INFORMATION:

NAME_____ GENDER: M_____ F_____
ADDRESS_____ CITY_____
STATE_____ ZIP CODE_____ HOME PHONE_____
BIRTH DATE___/___/___ SS#___-___-___ CELL PHONE_____
GUARDIAN AT TIME OF ASSESSMENT_____
** List any of the above phone numbers where you do not want messages left _____

PARENT INFORMATION:

NAME_____ HOME PHONE_____
ADDRESS (if different from client)_____ CELL PHONE_____
BIRTH DATE___/___/___ SS#___-___-___ WORK PHONE_____
EMAIL (optional)_____
RELATIONSHIP TO CLIENT: Mother___ Father___ Step___ Other (explain)_____
FAMILY INCOME:_____ # IN HOUSEHOLD:_____
** List any of the above phone numbers where you do not want messages left _____

OTHER PARENT INFORMATION:

NAME_____ HOME PHONE_____
ADDRESS (if different from client)_____ CELL PHONE_____
BIRTH DATE___/___/___ SS#___-___-___ WORK PHONE_____
EMAIL (optional)_____
RELATIONSHIP TO CLIENT: Mother___ Father___ Step___ Other (explain)_____
** List any of the above phone numbers where you do not want messages left _____

INSURANCE INFORMATION:

PRIMARY INSURANCE_____ ID#_____
NAME OF POLICYHOLDER_____ GROUP#_____
RELATIONSHIP TO CLIENT: Mother___ Father___ Step___ Other (explain)_____
CHECK HERE IF INSURANCE CARD GIVEN TO VOA TO COPY FRONT AND BACK
OR PROVIDE: INSURANCE PHONE_____
CLAIM ADDRESS_____
SECONDARY INSURANCE_____ ID#_____
NAME OF POLICYHOLDER_____ GROUP#_____
RELATIONSHIP TO CLIENT: Mother___ Father___ Step___ Other (explain)_____
CHECK HERE IF INSURANCE CARD GIVEN TO VOA TO COPY FRONT AND BACK
OR PROVIDE: INSURANCE PHONE_____

EMERGENCY HEALTH INFORMATION:

PREFERRED HOSPITAL_____ ALLERGIES_____ HEIGHT_____ WEIGHT_____
PRIMARY CARE PHYSICIAN: YES/NO IF YES, NAME_____
ADDRESS_____ PHONE_____



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

ASSESSMENT
AUTHORIZATION OF MEDICAL BENEFITS AND FINANCIAL RESPONSIBILITY

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

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

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

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

Patient name – PRINTED

Parent/guardian name – PRINTED

Patient signature

Parent/guardian signature

Date

Date

Documents acceptable for sliding fee evaluation are:

- | |
|---|
| <ol style="list-style-type: none">1. Tax return AND number living in household <u>OR</u>2. Pay stubs for most recent 2 consecutive months AND number living in household |
|---|

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

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

Date of Authorization: _____

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

(Client MUST initial all categories that apply)

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

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

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

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

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

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

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

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

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45C.F.R., Parts 160 and 164, cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(MUST have specification of the date, event, or condition upon which this consent expires)

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

Signature of Client:		Date:	
Witness:		Signature of Parent/ Legal Guardian:	

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

Date of Authorization: _____

I, _____ / _____
Client Name Date of Birth

authorize:

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

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

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

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

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

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

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

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

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

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

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45C.F.R., Parts 160 and 164, cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(**MUST have** specification of the date, event, or condition upon which this consent expires)

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

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

Signature of Client:		Date:	
Witness:		Signature of Parent/Legal Guardian:	

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

Date of Authorization: _____

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

Name of Agency and/or Person:	Millennium Health, LLC	Home/Business Phone:	877-451-3534
Address:	16981 Via Tazon	Cell Phone:	
	San Diego, CA 92127	Fax:	858-451-3636

To communicate with and disclose to one another the following information verbally, written, electronic health record portal, and/or facsimile:

- My name and other personal identifying information
- Toxicology results

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

- Participation in treatment services

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

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45C.F.R., Parts 160 and 164, cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

 (**MUST have** specification of the date, event, or condition upon which this consent expires)

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

Signature of Client:		Date:	
Witness:		Signature of Parent/Legal Guardian:	

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

Date of Authorization: _____

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

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

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

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

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

	Continued treatment		Personal use
	Legal	X	Parental participation in treatment
	Other (Must indicate):		

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

X

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45C.F.R., Parts 160 and 164, cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(MUST have specification of the date, event, or condition upon which this consent expires)

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

Signature of Client:		Date:	
Witness:		Signature of Parent/Legal Guardian:	



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

PLEASE REVIEW CAREFULLY.

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

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

ACKNOWLEDGEMENT OF CONFIDENTIALITY REGULATIONS

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

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

The undersigned specifically acknowledges and agrees to the following prohibition.

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

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

Printed Name of Person Receiving Services

Signature of Person Receiving Services

Date

Signature of Legal Guardian

Date

Signature of Witness (staff)

Date

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

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

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

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

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

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

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

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

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

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

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

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE

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

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following are examples for which the federal law permits Volunteers of America Alaska, Inc. to use and disclose your protected health information without your written permission:

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

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

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

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

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

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

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

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

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

YOUR PRIVACY RIGHTS

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

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

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

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

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

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

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

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

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

OUR DUTIES TO YOU REGARDING YOUR PROTECTED HEALTH INFORMATION

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

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

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

COMPLAINTS AND REPORTING VIOLATIONS

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

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

CONTACT

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

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

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

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