ALCOHOL, DRUG & MENTAL HEALTH SERVICES
Carol Burton, NTERIM DIRECTOR

Quality Assurance Office
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Memorandum

To: All SUD Providers Participating in the ODS Implementation

From: Quality Assurance Office

Date: June 22, 2018

RE: SUD ODS Trainings- June 27 and July 19, 2018

Subject: **CQRT, Forms, and Services/Procedure Code Trainings**

Wednesday, June 27, 2018: CQRT Training, Part I – Click for Training Announcement

REQUIRED for ALL SUD ODS: OS, IOS and Residential Providers.

LOCATION CHANGE: 1900 Embarcadero, Brooklyn Basin Room, Ste.101

Limited space still available. Register at: http://alameda.netkeepers.com

Light lunch time snacks provided at 11:30.

Clinical Form Templates will be distributed and reviewed at this training (attached forms are only preliminary drafts not for use).

NTP Services and Procedure Codes: noon – 2pm

Included in Training above from noon – 2pm.

Limited space still available. Register (for the whole training, but only attend noon – 2pm at: http://alameda.netkeepers.com

Light lunch time snacks provided at 11:30.

Thursday, July 19, 2018: CQRT Training, Part II- Click for Training Announcement

REQUIRED for ALL SUD ODS: OS, IOS and Residential Providers.

Registration is open: http://alameda.netkeepers.com

AUTHORIZATION OF SUD SERVICES AND CLINICAL QUALITY REVIEW TEAM (CQRT) TRAINING

Hosted by: ACBHCS Quality Assurance Office

Date: JUNE 27, 2018

Time: 9 AM TO 2 PM

Location: 2000 EMBARCADERO COVE OAKLAND
JOAQUIN MILLER ROOM, STE 305

Training Objectives:

1. Understand the purpose of the CQRT and its function in improving compliance with documentation standards.
2. Understand the distinction between clinical and quality reviews.
3. Understand the expectations of how to participate in Alameda County BHCS CQRT meetings.
4. Understand the paperwork necessary to participate in Alameda County BHCS CQRT meetings.
5. Understand the clinical review cycles of charts and how they guide clinical practices.
6. Ability to set up and/or improve internal Clinical Quality Review Teams in their agencies.

Target Audience:

SUD counselors (Certified and Registered) and therapists (Licensed Physician, Psychologist, Social Worker or Marriage Family Therapist, Interns Registered with California Board of Psychology or the California Board of Behavioral Sciences) working within the Alameda County Behavioral Health Services system

Continuing Education:

This course does not meet the qualifications for Continuing Education Credit for the California Board of Registered Nurses, Psychologists, LMFTs, LCSWs, LPCCs, and/or LEPs as required by the California Board of Behavioral Sciences.

Free Registration

http://alameda.netkeepers.com

For more information email:

QAOffice@acgov.org

Do you have a reasonable accommodation request or grievance regarding a BHCS training?

Go to: http://www.acbhcs.org/training

A Department of Alameda County Health Care Service Agency

AUTHORIZATION OF SUD SERVICES AND CLINICAL QUALITY REVIEW TEAM (CQRT) TRAINING—PART TWO

Required for all SUD ODS: OS, IOS and Residential Providers

Hosted by: ACBHCS Quality Assurance Office

Date: JULY 19, 2018

Time: 9 AM TO 4 PM

Location: 2000 EMBARCADERO COVE OAKLAND
JOAQUIN MILLER ROOM, STE 305

Training Objectives:

1. Understand the purpose of the CQRT and its function in improving compliance with documentation standards.
2. Understand the distinction between clinical and quality reviews.
3. Understand the expectations of how to participate in Alameda County BHCS CQRT meetings.
4. Understand the paperwork necessary to participate in Alameda County BHCS CQRT meetings.
5. Understand the clinical review cycles of charts and how they guide clinical practices.
6. Ability to set up and/or improve internal Clinical Quality Review Teams in their agencies.

Target Audience:

SUD counselors (Certified and Registered) and therapists (Licensed Physician, Psychologist, Social Worker or Marriage Family Therapist, Interns Registered with California Board of Psychology or the California Board of Behavioral Sciences) working within the Alameda County Behavioral Health Services system

Continuing Education:

This course does not meet the qualifications for Continuing Education Credit for the California Board of Registered Nurses, Psychologists, LMFTs, LCSWs, LPCCs, and/or LEPs as required by the California Board of Behavioral Sciences.

Free Registration
http://alameda.netkeepers.com

For more information email:
QAOffice@acgov.org

Do you have a reasonable accommodation request or grievance regarding a BHCS training?
Go to: http://www.acbhcs.org/training

A Department of Alameda County Health Care Service Agency

The following pages are DRAFT forms and are for review ONLY.

These forms are also attached in MSword. Please also review the Word version for use.

To view attachments, please open up this document in Adobe Acrobat Reader. It is free and can be downloaded Here:

BHCS SUD Treatment Plan Form – ODS Waiver

This form is not for claiming, service must be documented in a progress note in order to be claimed

Service #: SUD Treatment Plan

Client: ______________________________

InSyst # Last Name First Name

Services were provided in: ____________________ by ☐ interpreter or ☐ clinician

STAFF INFORMATION

Provider: ______________________________ RU: __________

Primary Counselor/LPHA: ______________________________

SUD PLAN INFORMATION	
Episode Opening Date: Plan Dates: to	
Plan Type:	☐ Initial (new to this RU or client). For RES initial plan is due 10 days from EOD. NTP 28 days from EOD. All other SUD programs, 30 days from EOD. ☐ Update (90 day or change to current plan) Date of previous plan: __________ Next scheduled plan update due date: __________
Primary Included SUD ICD-10 Code:	
Primary Included SUD DSM-5/ICD-10 Name:	
Secondary Included SUD ICD-10 Code:	
Secondary Included SUD DSM-5/ICD-10 Name:	

MY OVERALL STRENGTHS
INDIVIDUAL/FAMILY STRENGTHS TOWARD OVERCOMING BARRIERS AND ACHIEVING DESIRED RESULTS:

Treatment Plan Challenges/Problems, Goals, and Actions Steps on next page. Copy additional pages as needed.

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BHCS SUD Treatment Plan Form – ODS Waiver

GOAL #:	
TYPE OF CHALENGE	**STAGE OF CHANGE**
INDIVIDUAL/FAMILY DESIRED RESULTS FROM INTERVENTIONS (Client quote if possible):	
CHALLENGES	
Specific challenges or functional impairments related to diagnose' signs & symptoms(Include date identified by provider):	
☐ Deferred (must write clinical reason why deferred below. Do not complete Action Steps Section):	

CLIENT OBJECTIVES/ACTION STEPS:		
Short-Term Achievable Objectives/Actions: Obj #:	Target Date (3 months unless specified):	At Reassessment (Optional). When appropriate indicate level of improvement, date and initial. ☐ Not Improved ☐ Somewhat Improved ☐ Very Much Improved Date Initials ☐ Met:

GOAL #:	
TYPE OF CHALENGE	**STAGE OF CHANGE**
INDIVIDUAL/FAMILY DESIRED RESULTS FROM INTERVENTIONS (Client quote if possible):	
CHALLENGES	
Specific challenges or functional impairments related to diagnose' signs & symptoms(Include date identified by provider):	
☐ Deferred (must write clinical reason why deferred below. Do not complete Action Steps Section):	

CLIENT OBJECTIVES/ACTION STEPS:		
Short-Term Achievable Objectives/Actions: Obj #:	Target Date (3 months unless specified):	At Reassessment (Optional) When appropriate indicate level of improvement, date and initial. ☐ Not Improved ☐ Somewhat Improved ☐ Very Much Improved Date Initials ☐ Met:

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BHCS SUD Treatment Plan Form – ODS Waiver

PROVIDER SERVICES:		
MODALITY	**FREQUENCY**	**DURATION**
☐ Case Management Description of services to be provided:		
☐ Collateral Description of services to be provided:		
☐ Individual Description of services to be provided:		
☐ Group Description of services to be provided:		
☐ Family Therapy Description of services to be provided:		
☐ Medication Services Description of services to be provided:		
☐ Withdrawal Management Description of services to be provided:		
☐ Patient Education Description of services to be provided:		
☐ Other: Description of services to be provided:		
☐ Other: Description of services to be provided:		

DISCHARGE PLAN
DISCHARGE PLAN (Readiness/Time Frame/Expected Referrals, etc.):

ADDITIONAL COMMENTS
(Client, Provider, Family, etc. and provide name and title of other Treatment Team members):

AUTHORIZATION/REJECT NOTES
☐ Plan was discussed in primary language

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☐	Individual/Family was offered a copy of this plan
☐	Individual/Family participated in the development of, and agreed to, this plan.
☐	Provider attests that individual signed the plan on this date:
☐	Provider attests that legal representative (Parent, Legal Guardian, Conservator, etc.) signed or verbally accepted this Plan on this date due to Individual inability to sign.
☐	Individual/Family verbally accepts this plan but not able to sign on this date (explain below).
☐	Individual/Family was offered a copy of this plan
☐	Individual/Family declines to sign (explain below).
☐	See progress note describing development of the plan with Individual/Family, dated:
TREATMENT TEAM	
☐	LPHA
☐	Physician
☐	Psychiatrist ☐ Client is being treated by a non-BHCS psychiatrist
☐	Program Supervisor
☐	Medical Director
☐	Other
This plan also sent to:	
AUTHORIZATION/REJECT NOTES	

Client Signature	Printed Name	Date
Counselor Signature	Printed Name	Date (plan date)
MD/LPHA Signature*	Printed Name	Date

*MD/LPHA co-signature required when signed by SUD counselor. Co-signature is required within 15 days of counselor signing the plan and within plan due date requirements.

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BHCS SUD Individual Service Note OS RS

Service #: New Title: Progress Note – Individual Service Note OS RS

Client: ____
InSyst # Last Name First Name

Procedure Code and Name: ______________________ Service Date: ____________

Group Count: ____________ # of group facilitators: ____________ Location: ____________

Services were provided in: ____________________ by ☐ interpreter or ☐ clinician

Staff Information & Time – ENTER ALL TIME IN MINUTES

Provider: ____________________ RU: ____________ Total Time (below):

Primary Staff: ____________________ InSyst ID: ____________

2nd Staff (Group Only): ____________________ InSyst ID: ____________

Doc. Date: ____________

Primary Start: ________ Doc. Start: ________ Travel 1 Start: ________ Travel 2 Start: ________

Primary End: ________ Doc. End: ________ Travel 1 End: ________ Travel 2 End: ________

Total Primary: ________ Total Doc. Time: ________ Total Travel Time: ________

Instructions and Pre-Existing Diagnoses

When writing progress notes, respond to problems/goals/objectives of treatment plan and signs and symptoms related to diagnosis. Include treatment interventions and address changes in the client's functioning. If there is little progress, include an explanation of the limited progress.

Topic of the Session

Provider Support & Interventions

Progress (Client's specific progress on treatment plan problems, goals, action steps, objectives, and/or referrals)

Client's Plan (including new issues or problems that affect treatment plan)

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LPHA/SUD Counselor Signature Printed Name Date

BHCS SUD Single Service Note – RES

Service #: New Title: Progress Note – Case Management/Physician Consultation

Client: ____
InSyst # Last Name First Name

Procedure Code / Name: ____________________ Date: __________ Location: ______________

Services were provided in: ____________________ by ☐ interpreter or ☐ clinician

Staff Information & Time – ENTER ALL TIME IN MINUTES

Provider: ____________________ RU: ____________________ Total Time (below):

Primary Staff: ____________________ InSyst ID: ______________

Doc. Date: __________

FF Start: __________ Doc. Start: __________ Travel 1 Start: ______ Travel 2 Start: __________

FF End: __________ Doc. End: __________ Travel 1 End: ______ Travel 2 End: __________

Total FF Time: __________ Total Doc. Time: __________ Total Travel Time: __________

Instructions and Pre-Existing Diagnoses

When writing progress notes, respond to problems/goals/objectives of treatment plan and signs and symptoms related to diagnosis. Include treatment interventions and address changes in the client's functioning. If there is little progress, include an explanation of the limited progress.

Services were provided in: by ☐ interpreter or ☐clinician

Topic of the Session

Provider Support & Interventions

Progress (Client's specific progress on treatment plan problems, goals, action steps, objectives, and/or referrals)

Client's Plan (including new issues or problems that affect diagnosis/treatment plan. Diagnosis/Plan must be updated.)

____

LPHA/SUD Counselor Signature Printed Name Date

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BHCS SUD RES Daily Note

Service #: New Title: Progress Note – RES Daily Note

Client: ______________________________
InSyst # Last Name First Name

Service Date: __________ Procedure Code: __________ EOD: __________

Services were provided in: __________ by ☐ interpreter or ☐ clinician

Staff Information & Time **(ENTER ALL TIME IN MINUTES)**

Provider: __________ RU: __________

Note Author: __________

Total Time (below):

Instructions and Pre-Existing Diagnoses

When writing progress notes, respond to problems/goals/objectives of treatment plan and signs and symptoms related to diagnosis. Include treatment interventions and address changes in the client's functioning. If there is little progress, include an explanation of the limited progress. Reminder: Providers are required to establish and maintain a sign-in sheet for every group counseling session, independent from CG. Sign-in sheet shall contain: 1) legibly printed counselor/therapist name & signature who conducts the session; 2) start & end time of group session; 3) date of group session 4) topic of session; and, 5) client legibly printed name and signature.

Daily Service 1 – Reimbursable Services ONLY

Topic/Purpose: __________ Location: __________

Start Time: __________ End Time: __________ Duration: __________

Doc. Date: __________ Doc. Start: __________ Doc. End: __________ Total Doc. Time: __________

Travel 1 Start: __________ Travel 1 End: __________

Travel 2 Start: __________ Travel 2 End: __________ Total Travel Time: __________

Daily Service 2 – Reimbursable Services ONLY

Topic/Purpose: __________ Location: __________

Start Time: __________ End Time: __________ Duration: __________

Doc. Date: __________ Doc. Start: __________ Doc. End: __________ Total Doc. Time: __________

Travel 1 Start: __________ Travel 1 End: __________

Travel 2 Start: __________ Travel 2 End: __________ Total Travel Time: __________

Daily Service 3 – Reimbursable Services ONLY

Topic/Purpose: __________ Location: __________

Start Time: __________ End Time: __________ Duration: __________

Doc. Date: __________ Doc. Start: __________ Doc. End: __________ Total Doc. Time: __________

Travel 1 Start: __________ Travel 1 End: __________

Travel 2 Start: __________ Travel 2 End: __________ Total Travel Time: __________

Daily Service 4 – Reimbursable Services ONLY

Topic/Purpose: __________ Location: __________

Start Time: __________ End Time: __________ Duration: __________

Doc. Date: __________ Doc. Start: __________ Doc. End: __________ Total Doc. Time: __________

Travel 1 Start: __________ Travel 1 End: __________

Travel 2 Start: __________ Travel 2 End: __________ Total Travel Time: __________

Daily Service 5 – Reimbursable Services ONLY

Topic/Purpose: __________ Location: __________

Start Time: __________ End Time: __________ Duration: __________

Doc. Date: __________ Doc. Start: __________ Doc. End: __________ Total Doc. Time: __________

Travel 1 Start: __________ Travel 1 End: __________ Total Travel Time: __________

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Travel 2 Start: ______ Travel 2 End: ______

Daily Service 6 – Reimbursable Services ONLY							
Topic/Purpose:				Location:			
Start Time:		End Time:		Duration:			
Doc. Date:		Doc. Start:		Doc. End:		Total Doc. Time:	
Travel 1 Start:		Travel 1 End:		Total Travel Time:			
Travel 2 Start:		Travel 2 End:					

Daily Service 7 – Reimbursable Services ONLY							
Topic/Purpose:				Location:			
Start Time:		End Time:		Duration:			
Doc. Date:		Doc. Start:		Doc. End:		Total Doc. Time:	
Travel 1 Start:		Travel 1 End:		Total Travel Time:			
Travel 2 Start:		Travel 2 End:					

Daily Summary
Note includes 1) Progress (Client's specific progress on treatment plan problems, goal, action steps, objectives, and/or referrals. 2) Provider Support and Interventions, 3) Client's Plan (including new issues or problems that affect treatment plan).

Additional Service Information (add information or description of activities if needed)

Signature of SUD Counselor/LPHA | Printed Name/Credential | Date

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SUD Initial Medical Necessity Form - Waiver

This form is not for claiming, service must be documented in a progress note in order to be claimed.

Client Information

Client: ______________________________
InSyst # Last Name First Name

Location: ______________________ Episode Opening Date: __________

Services were provided in: ______________ by ☐ interpreter or ☐ clinician

Initial Medical Necessity
A Licensed Professional of the Healing Arts (LPHA) (Physician; Nurse Practitioner (NPs); Physician Assistants (PAs); Registered Nurses (RNs); Registered Pharmacists (RPs); Licensed Clinical Psychologists (LCPs); Licensed Clinical Social Workers (LCSWs); Licensed Professional Clinical Counselors (LPCCs); Licensed Marriage and Family Therapists (LMFTs); and License-Eligible Practitioners working under the supervision of licensed clinicians) is REQUIRED to review each beneficiary's personal, medical and substance use history within thirty (30) calendar days of the beneficiary's admission to treatment date. When an unlicensed LPHA establishes medical necessity, a licensed LPHA must review and co-sign this document (within 15 days or when medical necessity is due, whichever is sooner).
The Initial Medical Necessity determination: For an individual to receive a DMC-ODS benefit, the initial medical necessity determination shall be performed through a face-to-face review or telehealth by a Medical Director, licensed physician or an LPHA. This "face-to-face" interaction must take place, at minimum, between the certified counselor who has completed the assessment for the beneficiary and the Medical Director, licensed physician, or LPHA. It would be allowable to include the beneficiary in this "face-to-face" interaction. This interaction also must be documented appropriately in the medical record to establish the determination of medical necessity for the beneficiary. After establishing a diagnosis and documenting the basis for diagnosis, the American Society of Addiction Medicine (ASAM) Criteria shall be applied by the diagnosing individual to determine placement into the level of assessed services. The service provider shall Authorize DMC-ODS services in accordance with the medical necessity criteria specified in Title 22, Section 51303 and the coverage provisions of the approved state Medi-Cal Plan.
LPHA completing IMN Form, must check the appropriate box below: ☐ LPHA met face-to-face with the beneficiary ☐ LPHA met face-to-face with the SUD counselor that conducted the intake
Primary Included SUD ICD-10 Code:
Primary Included SUD DSM-5/ICD-10 Name:
Secondary Included SUD ICD-10 Code:
Secondary Included SUD DSM-5/ICD-10 Name:
General Medical Codes:
Written Basis for Diagnosis (Must be completed by LPHA & include specific criteria of Medi-Cal included primary SUD diagnosis):
LPHA determined ASAM Level of Care: LPHA determined ASAM Level of Care: Is this level of care recommendation different than the previously assessed ALOC? ☐ Yes ☐ No Explain if yes:
Client Information that has been considered includes the following: • The beneficiary's personal, medical and substance use history; review of information with the client and/or LPHA

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SUD Initial Medical Necessity Form - Waiver

- *Physical Exam (when available)

Medical Necessity is determined by the following factors:

a) The client has a primary Medi-Cal Included SUD diagnosis from the Diagnostic and Statistical Manual (DSM-5) that is substantiated by chart documentation: ☐ Yes ☐ No

b) SUD Health Care Services are medically necessary and consistent with 22 CCR Section 51303: "…which are reasonable and necessary…"

i) To protect life ☐ Yes ☐ No

ii) To prevent significant illness or significant disability ☐ Yes ☐ No

iii) Or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury. ☐ Yes ☐ No

c) The basis for the diagnosis is documented in the client's individual client record. ☐ Yes ☐ No

d) DSM diagnostic criteria for each diagnosis that is a focus of treatment is identified above ☐ Yes ☐ No

e) Evidence based treatment is known to improve health outcomes and will be provided in accordance with generally accepted practices. ☐ Yes ☐ No

Physical Exam Requirement:

1) M.D. conducts physical exam or client provides copy
2) Client will provide copy of recent physical exam (within 12 months) or
3) The client must schedule an exam. Options 2 & 3 must be added to client tx plan.

Physical Examination generally includes vital signs; head, face, ear, throat, & nose; evaluation of organs for infectious disease; and neurological assessment conducted by a qualified physician.

Medical Director, licensed physician or LPHA **Must Initial** one of the Following:

1. ______ After in-person review of the above information with the SUD counselor, I have determined there are not physical or mental disorders or conditions that would place the beneficiary at excess risk in the treatment program planned, and that the beneficiary is receiving appropriate and beneficial treatment that can reasonably be expected to improve the diagnosed condition.

2. ______ After review of the above named information, I have determined that continued treatment is not medically necessary and the beneficiary should be discharged from treatment.

Unlicensed LPHA Signature (if completing form)	Printed Name	Date

Licensed LPHA Signature (required)	Printed Name	Date

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SUD DISCHARGE PLAN FORM - WAIVER

This form is not for claiming, service must be documented in a progress note in order to be claimed

Service #: New Title: Discharge Plan

Client: ____________________
InSyst # Last Name First Name

Location: ____________________ Episode Opening Date: __________

Services were provided in: ____________________ by ☐ interpreter or ☐ clinician

Plan

DISCHARGE/SUPPORT PLAN

The discharge plan must be completed with the client and the counselor or therapist within 30 days prior to completion of treatment services.

The following is my personalized Continuing Care Plan for my on-going recovery and support. Before completing treatment for my addiction I will present this Continuing Care Plan to someone within my support network such as my sponsor, other peers, mentor or spiritual advisor and receive thoughtful feedback, suggestions and comments about My Plan.

Episode Opening Date:	Episode Closing Date:	Date of Last Face-To-Face:

This treatment program has my permission to contact me during the next 12 months as a follow-up to my treatment and recovery: ☐ Yes ☐ No

Client Initial: Best Contact/Email: Phone:

I will attend Recovery Support Services: Day: Time: Counselor:

12 STEP AND/OR OTHER SUPPORT NETWORK: I plan to attend the following weekly meetings:

Day(s)	Location	Time	Description or Program Name

SPONSOR, MENTOR, SPIRITUAL ADVISOR OR OTHER SUPPORT PERSON:

Name of Support Person:

I WILL MEET WITH THEM: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:

Description of this commitment:

SUPPORT GROUP COMMITMENTS (e.g. Community or Other Volunteer Services-Hospitals & Institutions, Coffee Maker, Religious/Spiritual). Describe:

ADDITIONAL SUPPORT (individual therapy, medical/physical health needs, outside groups, social activities):
I have identified the following activities as an important part of my recovery. Describe:

RELAPSE PREVENTION AND WARNING SIGNS (e.g. isolation, missed meetings, missed medications, failure, success, anxiety, anger, depression,-people, places or things that jeopardize my recovery):

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Relapse Triggers/Warning Signs Are:	My Action Plan Is:

ADDITIONAL NEEDS FOR MY RELAPSE PREVENTION PLAN: (I have identified the following goals or issues as I continue to participate in my recovery (housing, employment, sponsorship, child care, transportation):

Name of Person	Telephone #

MY VISION FOR RECOVERY:

As a person in recovery I understand that neglecting my recovery plan will jeopardize my ability to maintain my recovery. I know that addiction is a chronic condition. I know how important it is that I maintain a recovery plan that includes a strong support system with people who care for me.

Time in Recovery as of this date:	Recovery Date:

My comments regarding treatment, such as: emotional highpoints; low points; & pivotal insights as a result of treatment:

Instructions: Based on the my most recent treatment plan Goals & Objectives, I will continue to work on the following:

Index #	Stage	My Continuing Goals

Was I advised of CCR 22 Sec 51341.1 Fair Hearing Rights if the discharge was due to loss of Medi-Cal benefits? ☐ Yes ☐ No

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SUD DISCHARGE PLAN FORM - WAIVER

Providers must inform each beneficiary in writing, at least ten (10) calendar days prior to the effective date of the intended action to terminate or reduce services, of the right to a fair hearing related to denial, involuntary discharge, or reduction in DMC substance use disorder services as it relates to their loss of eligibility or reduction of benefits, pursuant to Section 50951.

To request a hearing contact:

Department of Social Services: State Hearing Division P.O. Box 944243,M.S. 9-17-37 Sacramento, CA 94244-2430

Oral Requests by Telephone: 1-800-952-5253 TDD – 1-800-952-8349

Counselor/Therapist Summary of the Treatment Episode:

Prognosis (select one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Guarded ☐ Unstable

Describe prognosis and further treatment recommendations):

Discharge Summary Codes - Administrative - Table A	
Percent (%) of Tx Plan Goals Achieved	**Discharge Status Code and Description**
☐ 100 - 75%	1. Completed Tx/Recovery Plan Goals - Referred
☐ 100 – 75%	2. Completed Treatment/Recovery Plan Goals - Not Referred
☐ 75 – 50%	3. Left Before Completion with Satisfactory Progress - Referred
☐ < 50%	5. Left Before Completion with Unsatisfactory Progress - Referred

Client Received a Copy: ☐ Yes ☐ No If no, must explain why:

Provider attests that the individual signed on this date:

Client Signature (required) Printed Name Date

SUD Counselor/LPHA (required) Printed Name Date

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BHCS SUD Discharge Summary

Service #: New Title: Discharge Summary

Client: ____________________
InSyst # Last Name First Name

Location: ____________________ Episode Opening Date: __________

Services were provided in: ____________________ by ☐ interpreter or ☐ clinician

Discharge Summary – Administrative (non-billable)

The provider shall complete a Discharge Summary within 30 calendar days of the last face to face treatment contact for any beneficiary with whom the provider lost contact.

Episode Opening Date:	Episode Closing Date:	Date of Last Face-To-Face:

Discharge Summary Codes - Administrative - Table B

Percent (%) of Tx Plan Goals Achieved	**Discharge Status Code**
☐ 75 - 50%	4. Left Before Completion with Satisfactory Progress - Not Referred
☐ < 50%	6. Left Before Completion with Unsatisfactory Progress - Not Referred
☐ Death	7. Death
☐ Incarceration	8. Incarceration

Was the client pregnant during treatment? ☐ Yes ☐ No ☐ Unknown

Primary Problem:

Instructions: The counselor/therapist Narrative Summary of the Treatment Episode includes presenting problem, treatment provided and final outcome. The narrative summary must include a reference to the following applicable areas: Current Drug Usage; Legal Issues and/or Criminal Activity; Vocational/Educational Achievements; Living Situation and Referrals.

Counselor/LPHA Narrative Summary of Progress, Treatment, and Reason for Discharge:

Prognosis (select one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Guarded ☐ Unstable

Prognosis (Describe rationale for prognosis and further treatment recommendations):

The therapist/counselor must document efforts made to contact the person.

SUD Counselor/LPHA Signature Printed Name Date

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SUD CONTINUING SERVICES JUSTIFICATION FORM – WAIVER

This form is not for claiming, service must be documented in a progress note in order to be claimed

Client Information

Client: ______________________________
InSyst # Last Name First Name

Location: ______________________________ Episode Opening Date: __________

Services were provided in: __________________ by ☐ interpreter or ☐ clinician

Instructions

For each beneficiary, Continuing Services Justification (CSJ) must be completed no sooner than 5 months and no later than 6 months after date of admission or date of last CSJ. If Medical Director or LPHA met face-to-face with the beneficiary, bill time as individual service. If Medical Director or LPHA met face-to-face with SUD Counselor that conducted the Intake, claim as Case Management. This form is not for claiming, service must be documented in a progress note to claim. When an unlicensed LPHA establishes medical necessity, a licensed LPHA must review and co-sign this document (within 15 days or when medical necessity is due, whichever is sooner).

SUD Counselor / LPHA Section

Date of Most Recent IMN or CSJ:

Required Counselor/Medical Director/Licensed Physician/Licensed Professional in the Healing Arts (LPHA) Recommendation (choose one):

- ☐ I have reviewed this beneficiary's progress and eligibility to continue to receive treatment services and **RECOMMEND** client continue to receive treatment services.
- ☐ I have reviewed this beneficiary's progress and eligibility to continue to receive treatment services and **DO NOT RECOMMEND** client continue to receive treatment services.

Counselor/LPHA Comment (optional):

Counselor/LPHA Signature, Credentials (REQUIRED)

Printed Name: ______________________________ Title: ______________________

Signature/Cred: ______________________________ Date: ______________

Medical Director / LPHA Section

To ensure fulfillment of their role for establishing medical necessity, the physician shall determine whether continued services are medically necessary using DSM-5 criteria to document the basis for the diagnosis

Primary Included SUD ICD-10 Code:

Primary Included SUD DSM-5/ICD-10 Name:

Secondary Included SUD ICD-10 Code:

Secondary Included SUD DSM-5/ICD-10 Name:

Written Basis for Diagnosis Must be completed by LPHA & include specific criteria of Medi-Cal included primary SUD diagnosis):

LPHA determined ASAM Level of Care:

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SUD CONTINUING SERVICES JUSTIFICATION FORM – WAIVER

LPHA determined ASAM Level of Care:

Is this level of care recommendation different than the previously assessed ALOC? ☐ Yes ☐ No

Explain if yes:

Patient Information that has been considered includes the following:

- The beneficiary's personal, medical and substance use history
- The beneficiary's progress notes and treatment plan goals
- The beneficiary's prognosis
- The therapist or counselor's recommendation (initial or justification)
- *Physical Exam (if not available, a treatment goal to obtain within 6 months)

Medical Necessity is determined by the following factors:

a) The client has a primary Medi-Cal Included SUD diagnosis from the Diagnostic and Statistical Manual (DSM-5) that is substantiated by chart documentation: ☐ Yes ☐ No

b) SUD Health Care Services are medically necessary and consistent with 22 CCR Section 51303: "…which are reasonable and necessary…"

i) To protect life ☐ Yes ☐ No

ii) To prevent significant illness or significant disability ☐ Yes ☐ No

iii) Or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury. ☐ Yes ☐ No

c) The basis for the diagnosis is documented in the client's individual client record. ☐ Yes ☐ No

d) DSM diagnostic criteria for each diagnosis that is a focus of treatment is identified above ☐ Yes ☐ No

e) Evidence based treatment is known to improve health outcomes and will be provided in accordance with generally accepted practices. ☐ Yes ☐ No

Physical Exam Requirement:

1) M.D. conducts physical exam or client provides copy
2) Client will provide copy of recent physical exam (within 12 months) or
3) The client must schedule an exam. Options 2 & 3 must be added to client tx plan.

Physical Examination generally includes vital signs; head, face, ear, throat, & nose; evaluation of organs for infectious disease; and neurological assessment conducted by a qualified physician.

Medical Director or LPHA Must Initial one of the Following:

1. ______ After in-person review of the above information with the SUD counselor, I have determined there are not physical or mental disorders or conditions that would place the beneficiary at excess risk in the treatment program planned, and that the beneficiary is receiving appropriate and beneficial treatment that can reasonably be expected to improve the diagnosed condition.

2. ______ After review of the above named information, I have determined that continued treatment is not medically necessary and the beneficiary should be discharged from treatment.

Unlicensed LPHA Signature (if completing form)	Printed Name	Date

Licensed LPHA Signature (required)	Printed Name	Date

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SUD CONTINUING SERVICES JUSTIFICATION – COUNSELOR RECOMMENDATION FORM

Note that this form is not for claiming, a service note must be completed to claim.

Client Information

Client: ____
InSyst # | Last Name | First Name

Location: ______________________________ Episode Opening Date: __________

Services were provided in: ____________________ by ☐ interpreter or ☐ clinician

Instructions

For each beneficiary, Continuing Services Justification (CSJ) recommendation must be completed no sooner than 5 months and no later than 6 months after date of admission or date of last CSJ.

SUD Counselor

Date of Most Recent IMN or CSJ:

Required Recommendation (choose one):

☐ I have reviewed this beneficiary's progress and eligibility to continue to receive treatment services and **RECOMMEND** client continue to receive treatment services.

☐ I have reviewed this beneficiary's progress and eligibility to continue to receive treatment services and **DO NOT RECOMMEND** client continue to receive treatment services.

Counselor Comment (optional):

Counselor Signature, Credentials (REQUIRED)

Printed Name: ______________________ Title: ______________________

Signature/Cred: ______________________________ Date: ______________

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BHCS SUD Assessment Form – Waiver Version

This form is not for claiming, service must be documented in a progress note in order to be claimed

Service #: New Title: Intake and Assessment

Client: ______________________________
InSyst # Last Name First Name

Location: ______________________________ Episode Opening Date: __________

Services were provided in: ____________________ by ☐ interpreter or ☐ clinician

Staff Information

Provider: ______________________________ RU: __________

Primary Clinician: ______________________________

ASSESSMENT – SUD INTAKE & ASSESSMENT

☐ **Health Screening Questionnaire Reviewed with Client (check if reviewed)**

INTAKE INSTRUCTIONS: Per Alcohol and/or other Drug Program Certification Standards (12020) Program staff shall review each completed health questionnaire that was completed by a participant. The health questionnaire can help identify a participant's treatment needs but it is the responsibility of staff to gather additional information on the following items: Social, economic and family history, education, employment history, criminal history, legal status, medical history, alcohol and/or other drug history, and previous treatment.

Per Title 22 CCR 51341.1 (b)(13): Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders; the diagnosis of substance use disorders, and the assessment of treatment needs.

Gather the following information from Client:

Episode Opening Birthdate: Preferred Language:	
Preferred Last Name: Preferred First Name:	
What is your pronoun?	☐ She/Her ☐ He/Him ☐ They/Them ☐ Unknown/Not Reported ☐ Other:
Sex Assigned At Birth:	☐ Decline to State ☐ Male ☐ Female ☐ Intersex ☐ Other/Non-Binary:
Gender Identity:	☐ Unknown ☐ Male ☐ Female ☐ Intersex ☐ Gender Queer ☐ Decline to state ☐ Other: Transgender: ☐ Male to Female ☐ Female to Male
Sexual Orientation:	☐ Unknown ☐ Bisexual ☐ Declined to State ☐ Gay ☐ Gender Queer ☐ Lesbian ☐ Heterosexual/Straight ☐ Questioning ☐ Queer ☐ Other:
Emergency Contact: Relationship: Contact Address *(Street, City, State, Zip)* Contact Phone: ☐ Release for Emergency Contact: Clinician attests that client signed release for duration of treatment.	
Assessment Sources of Information (Check all that apply): ☐ Client ☐ Family/Guardian ☐ Hospital ☐ Other:	

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Reason For Referral (Please indicate referral source, precipitating circumstances and client's chief complaint):

ALCOHOL AND DRUG HISTORY – Per Client Report

Check if ever used	Age at first use	Current Substance Use						
		None/ Denies	Current Use	Current Intox.	Current Withdrawal	In Remission	Client-Perceived Problem	
							Yes	No
Alcohol		☐	☐	☐	☐	☐	☐	☐
Amphetamines (Speed/Uppers, Crank, etc)		☐	☐	☐	☐	☐	☐	☐
Cocaine/Crank		☐	☐	☐	☐	☐	☐	☐
Opiates (Heroin, Opium, Methadone, OxyContin		☐	☐	☐	☐	☐	☐	☐
Hallucinogens (LSD, Mushrooms, Peyote,		☐	☐	☐	☐	☐	☐	☐
Sleeping Pills, Pain Killers, Valium, OR Similar		☐	☐	☐	☐	☐	☐	☐
PSP (Phencyclidine) OR Designer Drugs (GHB)		☐	☐	☐	☐	☐	☐	☐
Inhalants (Paint, Gas, Glue, Aerosols)		☐	☐	☐	☐	☐	☐	☐
Cannabis/Marijuana/Hashish		☐	☐	☐	☐	☐	☐	☐
Tobacco/Nicotine		☐	☐	☐	☐	☐	☐	☐
Caffeine (Energy Drinks, Sodas, Coffee, etc.)		☐	☐	☐	☐	☐	☐	☐
Over the counter		☐	☐	☐	☐	☐	☐	☐
Other substance		☐	☐	☐	☐	☐	☐	☐
Complimentary Alternative Medications		☐	☐	☐	☐	☐	☐	☐

Prior Treatment

Number of prior treatment admissions in life (not including detoxification):

Name of last program: Where:

Exit date: Exit Status: ☐ Complete ☐ Incomplete Number of days there:

Number of detox admissions in Date of last detox episode:

Prior Periods of Abstinence:

Have you ever had a period of abstinence from drugs and alcohol? ☐ Yes ☐ No If yes, please answer the following:

When? (give dates): From: to :

How long did you remain abstinent most recently? – Please select one from below:

☐ Under 1 week ☐ Under 1 month ☐ From 1-3 months ☐ From 3-6 months ☐ From 6-12 months ☐ Over 1 year

After the period of abstinence, when did you return to your normal level of use? – Please select one from below:

☐ Under 1 week ☐ Under 1 month ☐ From 1-3 months ☐ From 3-6 months ☐ From 6-12 months ☐ Over 1 year

Medical History – Per Client Report

	Name	Phone (if known)	Last Date of Service (if known)
a. Primary Care Physician			
b. Other medical			

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c. Physical Exam in last 12 months? ☐ Yes ☐ No ☐ If no, a physical exam goal will be added to the treatment plan.
Date if available: ☐ A copy was provided or is in the chart.
Who do we contact for a copy?

Provider Name

Provider Address

City State Phone

d. Last Dental Appointment Approximate date:
Do you need to see a dentist? ☐ Yes ☐ No

MEDICAL HISTORY

Relevant Medical History: Indicate or check only those that are relevant

General Information:	Weight (lbs): Height (in): Sitting BP: Supine BP: Weight changes in last 6 months: ☐ Increased ☐ Decreased ☐ N/A Temp: Respiration: General Appearance:

Cardiovascular/Respiratory:	☐ Chest Pain	☐ Hypertension	☐ Hypotension	☐ Palpitation	☐ Smoking
Genital/Urinary/Bladder:	☐ Incontinence	☐ Nocturia	☐ Urinary Tract Infection	☐ Retention	☐ Urgency
Gastrointestinal/Bowel:	☐ Heartburn	☐ Diarrhea	☐ Constipation	☐ Nausea	☐ Vomiting
	☐ Ulcers	☐ Laxative Use	☐ Incontinence		
Nervous System:	☐ Headaches	☐Dizziness	☐ Seizures	☐ Memory	☐ Concentration
Musculoskeletal:	☐ Back Pain	☐ Stiffness	☐ Arthritis	☐ Mobility/Ambulatory	
Gynecology:	☐ Pregnant Last LMP:	☐ Pelvic Inflammatory Disease		☐ Menopause	☐ Breast Feeding
Skin:	☐ Scar	☐ Lesion	☐ Lice	☐ Dermatitis	☐ Cancer
Endocrine:	☐ Diabetes	☐ Thyroid	☐ Other:		
Respiratory:	☐ Bronchitis ☐ Other:	☐ Asthma	☐ COPD	☐ Live with a smoker	

☐ Others (Check if relevant and describe):

Other: ☐ Significant Accident/Injuries/Surgeries:

☐ Hospitalizations:

☐ Physical Disabilities:

☐ Chronic Illness:

☐ HIV Disease:

☐ Age of Menarche and Birth Control Method:

☐ History of Head Injury:

☐ Cardiac screening questions (required to be documented prior to starting stimulants):

☐ Yes ☐ No History of cardiac diagnosis (including heart

☐ Yes ☐ No History of palpitations, chest pain, syncope:

☐ Yes ☐ No Family history of sudden death less than age 30:

☐ If any of these three answered yes, EKG ordered?:

☐ None of the above:

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Relevant Medical/Dental Considerations for Treatment:	

Current Disability Status
☐ Developmental/Learning Disorder:
☐ Hearing/Speech:
☐ Independent Living Difficulty:
☐ Mental/Emotional/Cognitive:
☐ Mobility:
☐ No Disability:
☐ Self-Care Difficulty:
☐ Service Animal:
☐ Speech:
☐ Visual:
☐ Relevant Disability Consideration for Treatment

Alternative Healing Practice
(if known) (e.g. acupuncture, hypnosis herbs, supplements, etc.)

Current?	Year Began	Duration	Type	Reason for Treatment	Outcome Was it helpful and why?)

Current Medications
Include all prescribed, over the counter, and holistic/complimentary/alternative remedies.

	Medication Name	Effectiveness/Side Effects if known	Dosage if known	Date Started if known	Prescriber if known
Psychotropic					
Non-Psychotropic					

Previous Medications
Include all prescribed, over the counter, and holistic/complimentary/alternative remedies.

	Medication Name	Effectiveness/Side Effects if known	Dosage if known	Date Started if known	Prescriber if known
Psychotropic					

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Non-Psychotropic					

Allergies, Adverse Reactions, and Sensitivities

☐ Yes: ☐ No ☐ Unknown

☐ No new allergies reported.

Referral made to primary care or dental care or specialty: ☐ No ☐ Yes If yes, list:

Additional Medical Information, if any:

Mental Health History – Per Client Report

Psychiatric Hospitalizations: ☐ Yes ☐ No ☐ Unable to Assess

Outpatient Treatment: ☐ Yes ☐ No ☐ Unable to Assess

Risk Factors: Do you have a history of ☐ Aggressive/Violent Behaviors or ☐ Self-Harm?

In the past week how many times have you:

Been irritable?

Had an outburst of anger?

Felt like hurting another person?

Felt like hurting yourself?

☐ Client was referred to the County ACCESS line (800) 491-9099

☐ Tarasoff Warning Required

Mental Health disorders that are pre-existing, contribute to substance use/abuse, or have been exacerbated by substance use (if known):

Psychosocial History – Per Client Report

Family problems that are contributing to, or are exacerbated by substance use:

☐ Quarrels ☐ Domestic Violence ☐ Family ☐ Family worried about client's use

☐ Separated/Divorced

Family History, if known:

Social problems that are contributing to, or are exacerbated by substance use:

☐ Mild ☐ Moderate ☐ Severe ☐ None

Describe, if known:

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Economic problems that are contributing to, or are exacerbated by substance use:			
☐ Mild	☐ Moderate	☐ Severe	☐ None
Describe, if known:			
Cultural factors which may influence presenting problems: (may include ethnicity, race religion, spiritual practice, sexual orientation, gender identity, socioeconomic status, living environment, homeless or other housing needs etc.:			
Describe, if known:			
Housing/Living Arrangements:	Current (how long?):	Stable?:	
Housing/Living Arrangements:	Current:	Stable?:	

Education – Per Client Report

Education problems that are exacerbated by substance use:			
☐ Mild	☐ Moderate	☐ Severe	☐ None
Comments:			

Highest Education Completed:		
☐ Less than High School	☐ GED	☐ Completed High School
☐ Some College	☐ Completed College	☐ Greater than College

Employment History

Client currently employed:	☐ Yes ☐ No			
Profession:				
Substance use/abuse has caused problems or contributed to:				
☐ Absenteeism	☐ Tardiness	☐ Accidents	☐ Working while hung over	☐ Trouble concentrating
☐ Decreased job performance	☐ Consumed substance while at work	☐ No work problems		
☐ Lost job in past due to substance abuse				
Comments, if known:				

Criminal History / Legal Status – Per Client Report

Criminal Justice History/Violent Incidents of Individual and/or Family	Within last 90 days			Past		
	Y	N	U	Y	N	U
Assault on persons	☐	☐	☐	☐	☐	☐
Threat to persons	☐	☐	☐	☐	☐	☐
Property damage	☐	☐	☐	☐	☐	☐
Weapons involved	☐	☐	☐	☐	☐	☐
Legal History	☐	☐	☐	☐	☐	☐
Probation	☐	☐	☐	☐	☐	☐
Parole	☐	☐	☐	☐	☐	☐
Adjudicated	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐

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For funding purposes only, have you ever been arrested? ☐ Yes ☐ No

Describe criminal justice involvement/incidents (include level of community threat/safety, dates, types of crimes, outcomes, etc.), if known:

☐ Drug Court ☐ DUI ☐ PC-1000 ☐ Child Custody ☐ Other:

Describe any relevant family involvement with criminal justice (include level of community threat/safety, dates, types of crimes, outcomes, etc.) if known:

☐ Restraining order Who issued: For Whom:

ADDITIONAL ASSESSMENT (Meets Perinatal Program Requirements) (DMC & Non-DMC)

Client currently in a relationship? ☐ Yes ☐ No	Length of relationship:
History of sexual abuse? ☐ Yes ☐ No	History of physical abuse? ☐ Yes ☐ No

Comments:

How many children does the client have?

Ages of children: #1: #2: #3: #4 or more:

Assessed knowledge of parenting skills:

Skills most needed:

Assessed Education/Knowledge of harmful effects that alcohol and drugs have on the caregiver and fetus, or the caregiver and infant:

Required for Perinatal Programs

Client needs or will receive cooperative child care? ☐ Yes (and will be provided) ☐ No

Client needs to access the following ancillary services which are medically necessary to prevent risk to fetus or infant (If checked, describe in comments):

☐ Dental Services ☐ Social Services ☐ Community Services ☐ Educational/Vocational Training

☐ Other:

SUD Formulation

Instructions: Consider all information gathered in the intake for the SUD Formulation. The formulation should identify each problem that is contributing to client's substance use disorder. All issues identified during the intake and assessment process must be listed as a problem statement on the treatment plan. However some problem statements can de deferred as determined appropriate by the treatment staff. Do not include specific diagnosis unless completed by a Therapist or MD and within their scope of practice. 22 CCR § 51341.1 (b) (20) Definition of Therapist; CA Department Health Care Services & 22 CCR § 51341.1(h)(2)(A)(i)(a)

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Information for LPHA to make SUD Diagnosis

DSM-5 Diagnosis may only be made by a LPHA or MD, SUD Counselors may only gather the information below regarding signs and symptoms and may only list a DSM-5 SUD Diagnosis if reported by client.

SUD Diagnosis **as reported by client (leave blank if no diagnosis reported) :**

BASIS FOR DIAGNOSIS

A pattern of substance use leading to clinically significant impairment or distress as manifested by at least 2 of the following, occurring within a 12-month period. A diagnosis may be supported with a specifier if the beneficiary is on agonist therapy (maintenance) or was/is in a controlled environment.

Met	Symptom	Substance(s)	When symptom was experienced
☐	1) The substance is often taken in larger amounts or over a longer period than was intended.		
☐	2) There is a persistent desire or unsuccessful efforts to cut down or control the use of the substance.		
☐	3) A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recovered from its effects.		
☐	4) Craving, or a strong desire or urge to use the substance.		
☐	5) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.		
☐	6) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.		
☐	7) Important social, occupational, or recreational activities are given up or reduced because of the use of the substance.		
☐	8) Recurrent substance use in situations in which it is physically hazardous.		
☐	9) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the use of the substance.		

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☐	10) Tolerance, as defined by either of the following: a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect; and/or b) A markedly diminished effect with continued use of the same amount of the substance.		
☐	11) Withdrawal, as manifested by either of the following: a) The characteristic withdrawal syndrome for the substance; and/or b) The substance is taken to relieve or avoid withdrawal symptoms.		
☐	In Early Remission (no symptoms, except for craving, for 3 to under 12 months)		
☐	In Sustained Remission (no symptoms, except for craving, for more than 12 months)		
☐	On Maintenance Therapy (if taking a prescribed agonist medication and none of the criteria have been met for the agonist medication except symptoms 10 and 11)		
*Symptoms 10 and 11 are not applicable if the client is using sedative/hypnotic/anxiolytic, opioid, or stimulant medication as prescribed consistent with physician's orders (e.g. not combining with synergistic substances, not taking more frequently or in greater quantity than prescribed, not operating machinery, etc.) Additional Comments (if any):			

LPHA/SUD Counselor Signature Printed Name Date

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BHCS SUD ALOC Re-Assessment – Waiver

This form is not for claiming, service must be documented in a progress note in order to be claimed

Service #: ALOC Assessment

Client: ______________________________
InSyst # Last Name First Name

Location: ______________________________ Episode Opening Date: ____________

Services were provided in: ________________ by ☐ interpreter or ☐ clinician

STAFF INFORMATION

Provider: ______________________________ RU: ____________

Primary Counselor/LPHA: ______________________________

ALOC ASSESSMENT

ALOC 30 Day Assessment Continuum of Care Form

Directions: The Brief ASAM-Level of Care (A-LOC) engagement questions are designed to ensure placement into the appropriate A-LOC. If or when it is determined a different level of care may be needed the client should receive a more through A-LOC Re-Assessment. At a minimum, the ALOC should be administered every 30 days and/or if there is concern regarding the placement.

Current Relevant Information

Re-engaged with Family?	Yes ☐	No ☐	Plans to Enroll in School?	Yes ☐	No ☐
Somewhere safe to reside?	Yes ☐	No ☐	Did you put work on hold to enroll in SUD TX?	Yes ☐	No ☐
Plans to return to work?	Yes ☐	No ☐	Identified relapse triggers	Yes ☐	No ☐
Receiving services for mental illness?	Yes ☐	No ☐	Medical insurance?	Yes ☐	No ☐
Outside support system in place?	Yes ☐	No ☐		Yes ☐	No ☐

Stage of Change

☐ Pre- contemplation ☐ Contemplation ☐ Preparation ☐ Action Maintenance ☐ Relapse

Comment:

Desire to Change

☐ No desire (4) ☐ Little desire (3) ☐ Ambivalent desire (2) ☐ Desires to change, with some reservations (1)

☐ Active desire to change (0)

Comment:

Relapse Prevention

☐ Actively objects to a relapse prevention plan (4) ☐ Unwilling to develop a relapse or continued use prevention plan (3)

☐ Ambivalent about a relapse or cont. use prevention plan (2) ☐ Willing to do a relapse or cont. use prevention plan (1)

☐ Working actively on a prevention or continued use prevention plan (0)

Comment:

Interpersonal/ Social Functioning

☐ Actively toxic relationships (4) ☐ Not supportive relationships (3) ☐ Marginally supportive (2)

☐ Moderately supportive (1) ☐ Very supportive (0)

Comment:

Self-Care

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☐ No self-care deficits noted (0)
☐ Does not seek appropriate treatment/supportive services without assistance or requires significant assistance to do so; needs services to prevent relapse (1)
☐ Requires assistance in basic life and survival skills (i.e. locating food, finding shelter) (2)
☐ Requires assistance in basic hygiene, grooming and care of personal environment (3)
☐ Engages in impulsive, illegal or reckless behavior (4)
Comment:

Additional Information:

ASAM DIMENSIONS

DIMENSION 1: Acute Intoxication and/or Withdrawal Potential
(a) Past hx of serious withdrawal, life-threatening symptoms or seizures during withdrawal? e.g., need for IV therapy; hospital for seizure control; psychosis with DT's; medication management with close nurse monitoring & medical management? ☐ Yes ☐ No

(b) Currently is having severe, life-threatening and/or similar withdrawal symptoms? ☐ Yes ☐ No

DIMENSION 2: Biomedical Conditions/Complications
(a) Does the client have any current severe physical health problems? e.g., bleeding from mouth/rectum in past 24 hours; recent, unstable hypertension; severe pain in chest, abdomen, head; significant problems in balance, gait, sensory/motor abilities not related to intoxication. ☐ Yes ☐ No

(b) Does or has the client had a history or recent episode of seizures/convulsions; diagnosed with TB, emphysema, hepatitis C, heart condition? ☐ Yes ☐ No

DIMENSION 3: Emotional/Behavioral/Cognitive Conditions/Complications
(a) Imminent danger of harming self or someone else? e.g., SI+ with intent, plan, means to succeed; HI+ or violent ideation, impulses, uncertainty about ability to control impulses, with means to act. ☐ Yes ☐ No

(b) Unable to function in ADL's, care for self with imminent, dangerous consequences? e.g., unable to bathe, feed, care for self-due to psychosis, organicity or uncontrolled intoxication with threat of imminent DTS/O as regards death or severe injury. ☐ Yes ☐ No

(c) Client will benefit from a co-occurring capable program as opposed to a co-occurring enhanced program? ☐ Yes ☐ No

DIMENSION 4: Readiness to Change
(a) Does the client appear to need SUD treatment/recovery and/or mental health treatment, but is ambivalent or feels it's unnecessary? e.g., severe addiction, but client feels controlled use is still OK; psychotic, but blames a conspiracy. ☐ Yes ☐ No

(b) Client has been coerced or mandated to have assessment and/or treatment by Mental Health Court or CJ system, health or social services, work/school, or family/significant other? ☐ Yes ☐ No

(c) Client desires and is ready to change their current SUD behavior? ☐ Yes ☐ No

DIMENSION 5: Relapse/Continued Use/Continued Problem Potential
(a) Does the client understand relapse but needs structure to maintain therapeutic gains? ☐ Yes ☐ No

(b) Client is unwilling and/or ambivalent to create a continued use prevention plan? ☐ Yes ☐ No

(c) Is the client likely to continue to use or have active, acute symptoms in an imminently dangerous manner, without immediate containment? ☐ Yes ☐ No

DIMENSION 6: Recovery Environment

(a) Are there any dangerous family, significant others, living/work/school situations threatening the client's safety, immediate well-being, and/or sobriety? e.g., living with a drug dealer; someone with a Substance Use Disorder or using drugs or alcohol; client is experiencing abuse by a partner or significant other; homeless in freezing temperatures? ☐ Yes ☐ No

(b) Does the client have the life skills and/or support necessary to participate in day to day functions? ☐ Yes ☐ No

Select one: ☐ No Risk/Stable (0) Mild (1) ☐Moderate (2) ☐Significant (3) ☐Severe (4)

ASAM Clinical Placement Scoring Summary

ASAM Dimensions

1 - Acute Intoxication and/or Withdrawal Potential
2 – Biomedical Conditions and Complications
3 –Emotional/Behavioral/Cognitive Conditions and Complications
4 – Readiness to Change (including Desire to Change)
5 – Relapse/Continued Use/Continued Problem Potential
6 – Recovery Environment

Risk Ratings	Intensity of Service Need	Dimensions					
		1	2	3	4	5	6
(0) No Risk or Stable – Current risk absent. Any acute or chronic problem mostly stabilized.	No immediate services needed	☐	☐	☐	☐	☐	☐
(1) Mild – Minimal, current difficulty or impairment. Minimal or mild signs and symptoms. Any acute or chronic problems soon able to be stabilized and functioning restored with minimal difficulty.	Low intensity of services needed for this dimension. Treatment strategies usually able to be delivered tin outpatient settings.	☐	☐	☐	☐	☐	☐
(2) Moderate Moderate difficulty or impairment. Moderate signs and symptoms. Some difficulty coping or understanding, but able to function with clinical and other support services and assistance.	Moderate intensity of services, skills training or supports needed for this level of risk. Treatment strategies may require intensive levels of outpatient care.	☐	☐	☐	☐	☐	☐
(3) Significant – Serious difficulties or impairment. Substantial difficulty coping or understanding and being able to function even with clinical support.	Moderately high intensity of services, skills training, or supports needed. May be in danger or near imminent danger.	☐	☐	☐	☐	☐	☐
(4) Severe – Severe difficulty or impairment. Serious, gross or persistent signs and symptoms. Very poor ability to tolerate and cope with problems. Is in imminent danger.	High intensity of services, skills training, or supports needed. More immediate, urgent services may require inpatient or residential settings; or closely monitored case management services and a frequency greater than daily.	☐	☐	☐	☐	☐	☐

Key Findings Supporting Placement Decision:

☐ Remain in the same Level of Care and Program ☐ Transfer level of care within program

Indicated ASAM LOC/WM:	
Additional Indicated ASAM LOC/WM:	
Additional Indicated ASAM LOC/WM	

Actual ASAM Level of Care to which referred	Program to which referred

For Portals: Select the program by Level of Care and Program Name
For Residential Programs: Refer client to your own program or to the SUD Helpline Call Center for ALOC reassessment and referral 1-844-682-7215
For All Other Programs: Refer to SUD Helpline Call Center for ALOC assessment and referral 1-844-682-7215

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ASAM Level Referred:	
Choose Program:	
Intake Appointment Date:	Contact Person:
First Offered Appointment:	Time:
ASAM Level Referred:	
Choose Program:	
Intake Appointment Date:	Contact Person:
First Offered Appointment:	Time:
Non-ASAM Level of Care to which referred	**Program to which referred**
ASAM Level Referred:	
Choose Program:	
Intake Appointment Date:	Contact Person:
First Offered Appointment:	Time:
ASAM Level Referred:	
Choose Program:	
Intake Appointment Date:	Contact Person:
First Offered Appointment:	Time:

Reason for ASAM LOC Difference

If Actual LOC/WM to which referred differed from the indicated ASAM LOC, indicated the reason for the difference:
Reason:

Reason for ASAM LOC Difference

If referral is being made but admission is expected to be DELAYED, indicated the reason:
Reason:

Notes (optional):

LPHA/SUD Counselor Signature (Credentials) Printed Name Date

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BHCS SUD ALOC Initial Assessment – Waiver

This form is not for claiming, service must be documented in a progress note in order to be claimed

Service #: ALOC Assessment

Client: ____________________
InSyst # Last Name First Name

Location: ____________________ Episode Opening Date: __________

Services were provided in: __________ by ☐ interpreter or ☐ clinician

STAFF INFORMATION

Provider: ____________________ RU: __________

Primary Counselor/LPHA: ____________________

ALOC ASSESSMENT

ALOC 30 Day Assessment Continuum of Care Form

Directions: The Brief ASAM-Level of Care (A-LOC) engagement questions are designed to ensure placement into the appropriate A-LOC. If or when it is determined a different level of care may be needed the client should receive a more through A-LOC Re-Assessment. At a minimum, the ALOC should be administered every 30 days and/or if there is concern regarding the placement.

Current Relevant Information

Re-engaged with Family?	Yes ☐	No ☐	Plans to Enroll in School?	Yes ☐	No ☐
Somewhere safe to reside?	Yes ☐	No ☐	Did you put work on hold to enroll in SUD TX?	Yes ☐	No ☐
Plans to return to work?	Yes ☐	No ☐	Identified relapse triggers	Yes ☐	No ☐
Receiving services for mental illness?	Yes ☐	No ☐	Medical insurance?	Yes ☐	No ☐
Outside support system in place?	Yes ☐	No ☐		Yes ☐	No ☐

Stage of Change

☐ Pre- contemplation ☐ Contemplation ☐ Preparation ☐ Action Maintenance ☐ Relapse

Comment:

Desire to Change

☐ No desire (4) ☐ Little desire (3) ☐ Ambivalent desire (2) ☐ Desires to change, with some reservations (1)

☐ Active desire to change (0)

Comment:

Relapse Prevention

☐ Actively objects to a relapse prevention plan (4) ☐ Unwilling to develop a relapse or continued use prevention plan (3)

☐ Ambivalent about a relapse or cont. use prevention plan (2) ☐ Willing to do a relapse or cont. use prevention plan (1)

☐ Working actively on a prevention or continued use prevention plan (0)

Comment:

Interpersonal/ Social Functioning

☐ Actively toxic relationships (4) ☐ Not supportive relationships (3) ☐ Marginally supportive (2)

☐ Moderately supportive (1) ☐ Very supportive (0)

Comment:

Self-Care

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☐ No self-care deficits noted (0)
☐ Does not seek appropriate treatment/supportive services without assistance or requires significant assistance to do so; needs services to prevent relapse (1)
☐ Requires assistance in basic life and survival skills (i.e. locating food, finding shelter) (2)
☐ Requires assistance in basic hygiene, grooming and care of personal environment (3)
☐ Engages in impulsive, illegal or reckless behavior (4)
Comment:

Additional Information:

ASAM DIMENSIONS

DIMENSION 1: Acute Intoxication and/or Withdrawal Potential
(a) Past hx of serious withdrawal, life-threatening symptoms or seizures during withdrawal? e.g., need for IV therapy; hospital for seizure control; psychosis with DT's; medication management with close nurse monitoring & medical management? ☐ Yes ☐ No

(b) Currently is having severe, life-threatening and/or similar withdrawal symptoms? ☐ Yes ☐ No

DIMENSION 2: Biomedical Conditions/Complications
(a) Does the client have any current severe physical health problems? e.g., bleeding from mouth/rectum in past 24 hours; recent, unstable hypertension; severe pain in chest, abdomen, head; significant problems in balance, gait, sensory/motor abilities not related to intoxication. ☐ Yes ☐ No

(b) Does or has the client had a history or recent episode of seizures/convulsions; diagnosed with TB, emphysema, hepatitis C, heart condition? ☐ Yes ☐ No

DIMENSION 3: Emotional/Behavioral/Cognitive Conditions/Complications
(a) Imminent danger of harming self or someone else? e.g., SI+ with intent, plan, means to succeed; HI+ or violent ideation, impulses, uncertainty about ability to control impulses, with means to act. ☐ Yes ☐ No

(b) Unable to function in ADL's, care for self with imminent, dangerous consequences? e.g., unable to bathe, feed, care for self-due to psychosis, organicity or uncontrolled intoxication with threat of imminent DTS/O as regards death or severe injury. ☐ Yes ☐ No

(c) Client will benefit from a co-occurring capable program as opposed to a co-occurring enhanced program? ☐ Yes ☐ No

DIMENSION 4: Readiness to Change
(a) Does the client appear to need SUD treatment/recovery and/or mental health treatment, but is ambivalent or feels it's unnecessary? e.g., severe addiction, but client feels controlled use is still OK; psychotic, but blames a conspiracy. ☐ Yes ☐ No

(b) Client has been coerced or mandated to have assessment and/or treatment by Mental Health Court or CJ system, health or social services, work/school, or family/significant other? ☐ Yes ☐ No

(c) Client desires and is ready to change their current SUD behavior? ☐ Yes ☐ No

DIMENSION 5: Relapse/Continued Use/Continued Problem Potential
(a) Does the client understand relapse but needs structure to maintain therapeutic gains? ☐ Yes ☐ No

(b) Client is unwilling and/or ambivalent to create a continued use prevention plan? ☐ Yes ☐ No

(c) Is the client likely to continue to use or have active, acute symptoms in an imminently dangerous manner, without immediate containment? ☐ Yes ☐ No

DIMENSION 6: Recovery Environment

(a) Are there any dangerous family, significant others, living/work/school situations threatening the client's safety, immediate well-being, and/or sobriety? e.g., living with a drug dealer; someone with a Substance Use Disorder or using drugs or alcohol; client is experiencing abuse by a partner or significant other; homeless in freezing temperatures? ☐ Yes ☐ No

(b) Does the client have the life skills and/or support necessary to participate in day to day functions? ☐ Yes ☐ No

Select one: ☐ No Risk/Stable (0) Mild (1) ☐Moderate (2) ☐Significant (3) ☐Severe (4)

ASAM Clinical Placement Scoring Summary

ASAM Dimensions

1 - Acute Intoxication and/or Withdrawal Potential
2 – Biomedical Conditions and Complications
3 –Emotional/Behavioral/Cognitive Conditions and Complications
4 – Readiness to Change (including Desire to Change)
5 – Relapse/Continued Use/Continued Problem Potential
6 – Recovery Environment

Risk Ratings	Intensity of Service Need	Dimensions					
		1	2	3	4	5	6
(0) No Risk or Stable – Current risk absent. Any acute or chronic problem mostly stabilized.	No immediate services needed	☐	☐	☐	☐	☐	☐
(1) Mild – Minimal, current difficulty or impairment. Minimal or mild signs and symptoms. Any acute or chronic problems soon able to be stabilized and functioning restored with minimal difficulty.	Low intensity of services needed for this dimension. Treatment strategies usually able to be delivered tin outpatient settings.	☐	☐	☐	☐	☐	☐
(2) Moderate Moderate difficulty or impairment. Moderate signs and symptoms. Some difficulty coping or understanding, but able to function with clinical and other support services and assistance.	Moderate intensity of services, skills training or supports needed for this level of risk. Treatment strategies may require intensive levels of outpatient care.	☐	☐	☐	☐	☐	☐
(3) Significant – Serious difficulties or impairment. Substantial difficulty coping or understanding and being able to function even with clinical support.	Moderately high intensity of services, skills training, or supports needed. May be in danger or near imminent danger.	☐	☐	☐	☐	☐	☐
(4) Severe – Severe difficulty or impairment. Serious, gross or persistent signs and symptoms. Very poor ability to tolerate and cope with problems. Is in imminent danger.	High intensity of services, skills training, or supports needed. More immediate, urgent services may require inpatient or residential settings; or closely monitored case management services and a frequency greater than daily.	☐	☐	☐	☐	☐	☐

Key Findings Supporting Placement Decision:

☐ Remain in the same Level of Care and Program ☐ Transfer level of care within program

Indicated ASAM LOC/WM:	
Additional Indicated ASAM LOC/WM:	
Additional Indicated ASAM LOC/WM	

Actual ASAM Level of Care to which referred	Program to which referred

For Portals: Select the program by Level of Care and Program Name
For Residential Programs: Refer client to your own program or to the SUD Helpline Call Center for ALOC reassessment and referral 1-844-682-7215
For All Other Programs: Refer to SUD Helpline Call Center for ALOC assessment and referral 1-844-682-7215

ASAM Level Referred:	
Choose Program:	
Intake Appointment Date:	Contact Person:
First Offered Appointment:	Time:
ASAM Level Referred:	
Choose Program:	
Intake Appointment Date:	Contact Person:
First Offered Appointment:	Time:
Non-ASAM Level of Care to which referred	**Program to which referred**
ASAM Level Referred:	
Choose Program:	
Intake Appointment Date:	Contact Person:
First Offered Appointment:	Time:
ASAM Level Referred:	
Choose Program:	
Intake Appointment Date:	Contact Person:
First Offered Appointment:	Time:

Reason for ASAM LOC Difference

If Actual LOC/WM to which referred differed from the indicated ASAM LOC, indicated the reason for the difference:

Reason:

Reason for ASAM LOC Difference

If referral is being made but admission is expected to be DELAYED, indicated the reason:

Reason:

Notes (optional):

LPHA/SUD Counselor Signature (Credentials) Printed Name Date

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BHCS SUD Brief Engagement Form

Service must be documented in a note to claim, this form is not for claiming

Service #: SUD Brief Engagement Form

Client: ______________________________

InSyst # Last Name First Name

Location: ______________________________ Episode Opening Date: __________

Services were provided in: ______________________ by ☐ interpreter or ☐ clinician

STAFF INFORMATION

Provider: ______________________________ RU: __________

Primary Counselor/LPHA: ______________________________

ASSESSMENT

Brief Engagement & Assessment Review

Directions: The Brief ASAM-Level of Care (A-LOC) engagement questions are designed to ensure placement into the appropriate A-LOC. If or when it is determined a different level of care may be needed the client should receive a more through A-LOC Re-Assessment. At a minimum, the Brief A-LOC should be administered every 45-50 days and/or if there is concern regarding the placement.

Date of Birth: ______________________ Client's Phone Number: ______________________

Program: ______________________ Modality: ______________________

For the next month, would you find it most helpful to (choose one):

(1) ☐ Stay in the same level of treatment intensity
(2) ☐ Move to a more intensive level of treatment
(3) ☐ Move to a less intense level of treatment

Do you believe you need more time in this treatment program? ☐ Yes ☐ No

If yes, how long? Why?

Do you have an outside support system in place? ☐ Yes ☐ No

If yes, what? Where?

Have you identified your relapse triggers? ☐ Yes ☐ No

If yes, what are they?

Do you have an employment opportunity? ☐ Yes ☐ No

If yes, when? Where?

Do you have a safe place to live? ☐ Yes ☐ No

If yes, where? With who?

Do you have transportation? ☐ Yes ☐ No

If yes, how?

Does the counselor need to schedule an individual counseling session with the client? ☐ Yes ☐ No

____

LPHA/Counselor Signature (Credentials) Printed Name Date

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