The Michigan Department of Health and Human Services (MDHHS) is required to designate the ASAM level of care for all licensed outpatient treatment programs. In order to make this determination, the following questionnaire is required to be filled out for each licensed program seeking to provide publicly funded services. The information provided and submitted with this questionnaire will allow MDHHS to assign an ASAM level for the program.

Program/Facility Name:      

Facility Address:      

City/State/Zip:      

License Number:      

Treatment Capacity:

(If Applicable)

Please indicate the ASAM Level being applied for (select only one):

0.5 Early Intervention

1.0 Outpatient Services

2.1 Intensive Outpatient Services

2.5 Partial Hospitalization Services

Please indicate the population served by the program:

Adolescent  Adult

Please indicate which Pre-paid Inpatient Health Plan(s) the program is currently contracted with (or planning to contract with for new programs)to provide services: (check all that apply)

Community Mental Health Partnership of Southeast Michigan

Detroit Wayne Mental Health Authority

Lakeshore Regional Entity

Macomb County Community Mental Health Services

Mid-State Health Network

Northcare Network

Northern Michigan Regional Entity

Oakland County Community Mental Health Authority

Region 10 Pre-paid Inpatient Health Plan

Southwest Michigan Behavioral Health

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| **SERVICE DELIVERY and SETTING** |

Please indicate the type of setting where services are provided.

Behavioral health clinic/office-based program

Primary care office/clinic

Integrated care clinic (combined physical and behavioral health)

Work sites

School

Community based

Individuals home

On average, over the past 90 days, what percentage of clients with a substance use disorder were served **(Level 0.5 programs can skip this)**: (Total must equal 100%)

1. Without a co-occurring mental health disorder –     %
2. Combined with a co-occurring mental health disorder –    %

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| **SUPPORT SYSTEMS** |

Please select “yes” or “no” for each of the following questions designated for your level:

Level 0.5

1. Does your program provide referral and linking to ongoing treatment?
   1. Y/N
2. Does your program provide referral for medical, psychological, and/or psychiatric services (including assessment)?
   1. Y/N
3. Does your program provide referral for community social services?
   1. Y/N

Level 1

1. Are emergency services available 24/7 outside normal program hours?
   1. Y/N
2. Does your program have direct affiliations with other levels of care and/or close coordination for referrals to other services?
   1. Y/N

Level 2.1

1. Does your program have the ability to conduct and/or arrange for laboratory/toxicology tests or other needed procedures?
   1. Y/N
2. Does your program offer psychiatric and other medical consultation within 24 hours over telephone and within 72 hours in person?
   1. Y/N
3. Are emergency services available 24/7 through telephone outside normal program hours?
   1. Y/N
4. Does your program have direct affiliation with more and less intensive levels of care?
   1. Y/N

Level 2.5

1. Does your program have the ability to conduct and/or arrange for laboratory/toxicology tests or other needed procedures?
   1. Y/N
2. Does your program offer psychiatric and other medical consultation within 8 hours over telephone and within 48 hours in person?
   1. Y/N
3. Are emergency services available 24/7 through telephone outside normal program hours?
   1. Y/N
4. Does your program have direct affiliation with more and less intensive levels of care?
   1. Y/N

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| **STAFF** |

Please select “yes” or “no” for each of the following questions designated for your level:

Level 0.5

1. Do you employ trained personnel who are knowledgeable about substance use and addiction?
   1. Y/N
2. Is counseling/therapy provided by appropriately licensed and credentialed professionals (not required yet possible)?
   1. Y/N

Level 1

1. Do you employ credentialed/licensed treatment professionals to assess and treat substance-related, mental, and addictive disorders?
   1. Y/N
2. Is there a generalist physician(s) and/or physician assistant(s) available?
   1. Y/N

Level 2.1/2.5

1. Is your program staffed by an interdisciplinary team of appropriately credentialed addiction treatment professionals?
   1. Y/N
2. Is there a generalist physician(s) and/or physician assistant(s) available?
   1. Y/N
3. Does most—if not, all—staff have sufficient cross-training to understand signs and symptoms of mental disorders, also being able to explain the uses of psychotropic medications and their interactions with substance use and other addictive disorders?
   1. Y/N

4) Please indicate program staff conducting each service.

Check all that apply on the following table:

| License or Certification/ Registration | Screening and/or  Assessments | Individual Counseling Sessions | Group Counseling Sessions | Didactic/  Educational Sessions | COD  Treatment Services | Medical  RX  Services |
| --- | --- | --- | --- | --- | --- | --- |
| MD/DO |  |  |  |  |  |  |
| LP/LLP/TLLP |  |  |  |  |  |  |
| LMFT/LLMFT |  |  |  |  |  |  |
| LPC/LLPC |  |  |  |  |  |  |
| RN,NP,LPN |  |  |  |  |  |  |
| PA |  |  |  |  |  |  |
| LMSW/LLMSW |  |  |  |  |  |  |
| LBSW/LLBSW |  |  |  |  |  |  |
| Occupational Therapist |  |  |  |  |  |  |
| Recreational Therapist |  |  |  |  |  |  |
| CADC-M/CADC |  |  |  |  |  |  |
| CAADC |  |  |  |  |  |  |
| CCJP-R |  |  |  |  |  |  |
| CCDP |  |  |  |  |  |  |
| CCDP-D |  |  |  |  |  |  |
| CCS-M |  |  |  |  |  |  |
| CCS-R |  |  |  |  |  |  |
| DP-S |  |  |  |  |  |  |
| DP-C |  |  |  |  |  |  |
| Recovery Coach |  |  |  |  |  |  |
| Specifically trained staff |  |  |  |  |  |  |

Specifically trained staff explanation:

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| **THERAPIES** |

Please describe the following in reference to the program:

1. Focus of program activities for the level of care requested in this application:
2. Recovery support services:

Please select “yes” or “no” for each of the following questions:

1. Individual therapy/counseling/psychotherapy provided?

Yes No

1. Group therapy provided?

Yes No

1. Family therapy provided?

Yes No

* 1. If provided is there involvement of family members, guardians and significant others in the assessment, treatment and continuing care of the client?

Yes No

1. Educational/didactic services provided?

Yes No

1. Occupational therapy?

Yes No

1. Recreational therapy available?

Yes No

1. Medication management (SUD) available?

Yes No

1. Medication management (mental health) available?

Yes No

1. Monitoring of medication adherence (for behavioral health and physical health)?

Yes No

1. Use of laboratory and toxicology services (on-site/consultation/referral)?

Yes No

1. For **Levels 2.1 and 2.5** please submit a weekly schedule of services with the individual, group, educational and/or other treatment services labeled to verify the minimum amount of hours of skilled treatment services for the level are available.

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| **ASSESSMENT/ TREATMENT PLAN REVIEW** |

Indicate if the program’s assessment & treatment plan review processes include the following?

Level 0.5

1. Screening to rule in or out substance related addictive disorders?

Yes No

Levels 1, 2.1, 2.5

1. Assessment of ASAM dimensional risk and severity of need performed prior to and throughout the process of delivering services?

Yes No

1. Physical examination by (MD/DO, PA, NP) available for conditions as warranted based on physician approved protocols?

Yes No

1. Individualized treatment plan, developed in collaboration with client and reflects client’s personal goals?

Yes No

1. Treatment plan reviews are conducted at specified times, as noted in the plan or with a frequency as determined by appropriately credentialed staff?

Yes No

1. Documentation of mental health problems and relationship to substance use disorder?

Yes No

1. Documentation of progress and treatment changes?

Yes No

1. Ongoing recovery/continuing care planning?

Yes No

# I CERTIFY THAT THE INFORMATION PROVIDED REGARDING THE OPERATION OF THIS PROGRAM IS ACCURATE, TRUE, AND COMPLETE IN ALL MATERIAL ASPECTS. (Electronic signatures are acceptable)

|  |  |  |  |
| --- | --- | --- | --- |
| **AUTHORIZED INDIVIDUAL** | **TITLE** | **SIGNATURE** | **DATE** |
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**ENTER THE CONTACT INFORMATION OF THE PERSON THAT CAN BE REACHED FOR FOLLOW-UP IF NEEDED.**

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| --- | --- | --- | --- |
| **NAME** | **TITLE** | **EMAIL** | **TELEPHONE** |
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Please submit the completed, signed form and any attachments to [TXreports@midstatehealthnetwork.org](mailto:TXreports@midstatehealthnetwork.org)