Michigan Department of Health and Human Services
American Society of Addiction Medicine (ASAM) Outpatient Level of Care Designation
Application Completion Instructions

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.

This form must be completed electronically, saved and then sent to the email address at the end of the document

Program/Facility Name: **As it appears on the state license**

Facility Address: **As it appears on the state license**

City/State/Zip: **As it appears on the state license**

License Number: **As it appears on the state license–include letters and numbers**

Treatment Capacity: **If there is a capacity limit, please provide the maximum number of clients that can be served in the program.** (If Applicable)

Please indicate the ASAM Level being applied for (select only one): **Only one level of care can be selected on each application. If a program has more than one level of care, an application needs to be completed for each 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: **Indicate what population you serve in the program – if you can serve both, please mark both.**

☐ 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) **Please indicate which PIHPs you currently hold a contract with for providing the services in the level of care you are requesting. Proposed new contractors should indicate the PIHPS they are negotiating with to provide services.**

☐ 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

SERVICE DELIVERY and SETTING

Please indicate the type of setting where services are provided. **Please choose the best answer or answers that describe where services are provided as part of the program.**

☐ 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%)

Please provide the requested information as a percentage, not a number served

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

SUPPORT SYSTEMS

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Please select "yes" or "no" for each of the following questions designated for your level: **This information relates to the ASAM criteria for the various outpatient levels of care. Please answer only the questions designated for the level you are requesting.**

Level 0.5

1) Does your program provide referral and linking to ongoing treatment?
   Yes ☐ No ☐
2) Does your program provide referral for medical, psychological, and/or psychiatric services (including assessment)?
   Yes ☐ No ☐
3) Does your program provide referral for community social services?
   Yes ☐ No ☐

Level 1

1) Are emergency services available 24/7 outside normal program hours?
   Yes ☐ No ☐
2) Does your program have direct affiliations with other levels of care and/or close coordination for referrals to other services?
   Yes ☐ No ☐

Level 2.1

1) Does your program have the ability to conduct and/or arrange for laboratory/toxicology tests or other needed procedures?
   Yes ☐ No ☐
2) Does your program offer psychiatric and other medical consultation within 24 hours over telephone and within 72 hours in person?
   Yes ☐ No ☐
3) Are emergency services available 24/7 through telephone outside normal program hours?
   Yes ☐ No ☐
4) Does your program have direct affiliation with more and less intensive levels of care?
   Yes ☐ No ☐

Level 2.5

1) Does your program have the ability to conduct and/or arrange for laboratory/toxicology tests or other needed procedures?
   Yes ☐ No ☐
2) Does your program offer psychiatric and other medical consultation within 8 hours over telephone and within 48 hours in person?
   Yes ☐ No ☐
3) Are emergency services available 24/7 through telephone outside normal program hours ?
   Yes ☐ No ☐
4) Does your program have direct affiliation with more and less intensive levels of

care?

Yes ☐ No ☐

STAFF

Please select "yes" or "no" for each of the following questions designated for your level: **This information relates to the ASAM criteria for the various outpatient levels of care. Please answer only the questions designated for the level you are requesting.**

Level 0.5

1) Do you employ trained personnel who are knowledgeable about substance use and addiction?
   Yes ☐ No ☐
2) Is counseling/therapy provided by appropriately licensed and credentialed professionals (not required yet possible)?
   Yes ☐ No ☐

Level 1

1) Do you employ credentialed/licensed treatment professionals to assess and treat substance-related, mental, and addictive disorders?
   Yes ☐ No ☐
2) Is there a generalist physician(s) and/or physician assistant(s) available?
   Yes ☐ No ☐

Level 2.1/2.5

1) Is your program staffed by an interdisciplinary team of appropriately credentialed addiction treatment professionals?
   Yes ☐ No ☐
2) Is there a generalist physician(s) and/or physician assistant(s) available?
   Yes ☐ No ☐
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?
   Yes ☐ No ☐
4) Please indicate program staff conducting each service.

Check all that apply on the following table: **Indicate in the table what staff are providing the various services within the program. As it is possible that some staff may have combined licensure and certification in this list (i.e. LMSW with a CADC) please only count these individuals once and provide answers based on the licensure held (i.e. LMSW). The columns for the credentials (those through MCBAP) should be used for those with only that credential. If your**

program uses staff that are not on this list, please list them in the "specifically trained staff" row and provide a brief explanation of the individual(s) in the space after the table.

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

Specifically trained staff explanation:

THERAPIES

Please describe the following in reference to the program: **This information relates to the ASAM criteria for the various outpatient levels of care. Please answer based on the level you are requesting. An answer of "no" is not a negative as the question may not relate to your level.**

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1) Focus of program activities for the level of care requested in this application: **A description of the overall therapeutic approach of the program and the aspects of programming that make it unique to the level of care being requested.**
2) Recovery support services: **Describe any recovery support services that are offered through the program.**

Please select "yes" or "no" for each of the following questions: **Answer as directed.**

3) Individual therapy/counseling/psychotherapy provided?
☐Yes ☐No
4) Group therapy provided?
☐Yes ☐No
5) Family therapy provided?
☐Yes ☐No
   a. If provided is there involvement of family members, guardians and significant others in the assessment, treatment and continuing care of the client?
   ☐Yes ☐No
6) Educational/didactic services provided?
☐Yes ☐No
7) Occupational therapy?
☐Yes ☐No
8) Recreational therapy available?
☐Yes ☐No
9) Medication management (SUD) available?
☐Yes ☐No
10) Medication management (mental health) available?
☐Yes ☐No
11) Monitoring of medication adherence (for behavioral health and physical health)?
☐Yes ☐No
12) Use of laboratory and toxicology services (on-site/consultation/referral)?
☐Yes ☐No

13) 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 number of hours of skilled treatment services for the level are available. **Please submit information that will demonstrate that your program meets the minimum ASAM required hours of weekly service for the level of care requested.**

ASSESSMENT/ TREATMENT PLAN REVIEW

Indicate if the program's assessment & treatment plan review processes include the following? **This information relates to the ASAM criteria for the various outpatient levels of care. Please answer only the questions designated for the level you are requesting.**

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
2) Physical examination by (MD/DO, PA, NP) available for conditions as warranted based on physician approved protocols?
   ☐Yes ☐No
3) Individualized treatment plan, developed in collaboration with client and reflects client's personal goals?
   ☐Yes ☐No
4) 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
5) Documentation of mental health problems and relationship to substance use disorder?
   ☐Yes ☐No
6) Documentation of progress and treatment changes?
   ☐Yes ☐No
7) Ongoing recovery/continuing care planning?
   ☐Yes ☐No

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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

ENTER THE CONTACT INFORMATION OF THE PERSON THAT CAN BE REACHED FOR FOLLOW-UP IF NEEDED.

NAME	TITLE	EMAIL	TELEPHONE

Please submit the completed, signed form and any attachments to QMPMeasures@michigan.gov

All applications must be submitted to the QMPMeasures mailbox in order for them to be processed.