Michigan Department of Health and Human Services
American Society of Addiction Medicine (ASAM) Residential Level of Care Designation
Directions for Completion

The Michigan Department of Health and Human Services (MDHHS) is required to designate the ASAM level of care for all licensed residential treatment facilities. In order to make this determination, the following questionnaire is required to be filled out for each licensed facility 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 completely electronically, saved and then sent to the email address at the end of the document

Program/Facility Name: **As appears on current state issued license**

Facility Address: **As appears on current state issued license**

City/State/Zip: **As appears on current state issued license**

License Number: **As appears on current state issued license**

Treatment Capacity: **Maximum number of individuals that can be treated in the facility**

Please indicate the ASAM Level being applied for: **Indicate which ASAM level is being applied for (can only check one)**

- ☐ 3.1 Clinically Managed Low Intensity
- ☐ 3.3 Clinically Managed Population Specific High Intensity
- ☐ 3.5 Clinically Managed High Intensity
- ☐ 3.7 Medically Monitored Intensive Inpatient Services

Please indicate the population served by the program: **Indicate if the program is for adolescents or adults (only one can be checked)**

☐ Adolescent ☐ Adult

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

Indicate the appropriate plan(s) as directed

- ☐ 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 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. **Identify the best description of the program setting for 1-3 (only one can be checked)**

1) ☐ Freestanding community setting.

2) ☐ Unit within a licensed health care facility.

3) ☐ Secure community setting in the criminal justice system.

4) On average, over the past 90 days, what percentage of residents were treated for moderate or severe substance use disorders: (Total must equal 100%) **In looking at the admissions to the program over the last 90 days – describe those admissions based on whether or not there were other issues being addressed with the substance use disorder**

   a. Without a co-occurring mental health disorder – %
   b. Combined with a co-occurring mental health disorder – %
   c. Combined with functional limitations that were primarily cognitive in nature? (For example: Traumatic Brain Injury, Dementia, Memory Problems) – %

SUPPORT SYSTEMS

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

1) Telephone or in-person consultation with physician and emergency services available 24/7? ☐Yes ☐No

2) Direct affiliations with other levels of care and/or close coordination for referrals to other services? ☐Yes ☐No

3) Ability to conduct and/or arrange for laboratory/toxicology tests or other needed procedures. ☐Yes ☐No

4) Ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications. ☐Yes ☐No

5) Psychiatric/psychological consultation available as needed. ☐Yes ☐No

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STAFF

Please select "yes" or "no" for each of the following questions: **Answer 1-3 as directed**

1) Professional staff available on-site 24 hours a day.
☐Yes ☐No

2) Treatment team consists of medical, addiction and mental health professionals.
☐Yes ☐No

3) One or more clinicians available on site or by telephone 24 hours a day.
☐Yes ☐No

4) Please indicate program staff conducting each service. **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 just that credential**

Check all that apply on the following table:

License or Certification/ Registration	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	☐	☐	☐	☐	☐
CADC-M/CADC	☐	☐	☐	☐	☐
CAADC	☐	☐	☐	☐	☐
CCJP-R	☐	☐	☐	☐	☐
CCDP	☐	☐	☐	☐	☐
CCDP-D	☐	☐	☐	☐	☐
CCS-M	☐	☐	☐	☐	☐
CCS-R	☐	☐	☐	☐	☐
DP-S	☐	☐	☐	☐	☐
DP-C	☐	☐	☐	☐	☐
Recovery Coach	☐	☐	☐	☐	☐

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THERAPIES

Please describe the therapy services that are available:

1) Planned clinical program activities (professionally directed) hours per week: **Indicate how many hours of clinical programming, provided by the clinical staff in the program, is available during a 7 day period**

2) Focus of counseling and clinical program activities: **Describe the focus of each counseling and clinical program activity**

3) Recovery support services available: **Describe the recovery support services that are being provided in the program**

4) Involvement of family members and significant others? **Answer as directed**
☐Yes ☐No

5) Medication assisted treatment available? **Indicate if the program allows for the use of medications to assist in the treatment of a substance use disorder. The program does not have to prescribe the medication (i.e Methadone, Suboxone) but it can have arrangements with another provider (i.e. opioid treatment program or physician) to provide the medication for individual.**
☐Yes ☐No

6) Monitoring of medication adherence (for behavioral health and physical health)? **Indicate if program staff track or log when individuals take prescribed medications to ensure compliance. This can be for medication prescribed as a result of services received in the program or medications brought to the program that are self-administered.**
☐Yes ☐No

7) Use of random drug screens to monitor compliance? **Answer as directed.**
☐Yes ☐No

8) Please submit a weekly schedule of services with the individual, group, educational and/or other treatment services labeled to verify hours reported above. Attach other programmatic documentation that will support the ASAM Level being sought. **The information that is submitted must validate the information being reported in this application. Do not submit entire policy manuals. Documents should reflect the schedule of services being offered in the program and a description of the overall program and its focus.**

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ASSESSMENT/ TREATMENT PLAN REVIEW

Does the program's assessment & treatment plan review include: **Answer each as directed**

1) Individualized, comprehensive bio-psychosocial assessment utilized?
☐Yes ☐No

2) Individualized treatment plan, developed in collaboration with client and reflects client's personal goals?
☐Yes ☐No

3) Daily assessment of progress and treatment changes?
☐Yes ☐No

4) Physical examination by (MD/DO, PA, NP) performed as part of initial assessment/admission process?
☐Yes ☐No

5) Ongoing transition/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

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