The Michigan Department of Health and Human Services (MDHHS) is required to designate the ASAM level of care for all licensed withdrawal management 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.

Program/Facility Name:

Facility Address:      

City/State/Zip:      

License Number:      

Treatment Capacity:

Please indicate the ASAM Level being applied for: (Select Only One)

Level 1-WM – Ambulatory Withdrawal Management without Extended On-site Monitoring (Outpatient Withdrawal Management)

Level 2-WM – Ambulatory Withdrawal Management with Extended On-site Monitoring (Outpatient Withdrawal Management)

Level 3.2-WM – Clinically Managed Residential Withdrawal Management (Residential Withdrawal Management)

Level 3.7-WM – Medically Monitored Inpatient Withdrawal Management (Residential Withdrawal Management)

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 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

|  |
| --- |
| **SERVICE DELIVERY and SETTING** |

Please indicate the type of setting where services are provided:

1. Client Home
2. Office or agency setting
3. Healthcare facility
4. Day hospital or residential type setting
5. Freestanding withdrawal management facility

Please indicate how services are provided in the program:

Regularly scheduled services  
 Services delivered under physician approved policies and procedures or clinical  
 protocols.

|  |
| --- |
| **SUPPORT SYSTEMS** |

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

1. Available specialized psychological and psychiatric/clinical consultation and supervision. Yes No
2. Comprehensive medical history and physical examination completed as part of admission. Yes No
3. Affiliation with other levels of care, including other specialty substance use disorder treatment. Yes No
4. Ability to conduct and or arrange for laboratory/toxicology tests.

Yes No

1. 24 hour access to emergency medical consultation services.

Yes No

1. Ability to provide/assist with access to safe transportation services.

Yes No

|  |
| --- |
| **STAFF** |

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

1. Physicians and/or nurses present as needed. Yes No
2. Physicians and/or nurses readily available. Yes No
3. Physicians and/or nurses present at all times. Yes No
4. Counseling staff available or accessed through affiliation relationships.

Yes No

1. Recovery coach/peer support staff available or accessed through affiliation relationships. Yes No
2. Please indicate program staff conducting each service. Check all that apply:

| 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 |  |  |  |  |  |

|  |
| --- |
| **THERAPIES** |

Please describe the therapy services that are available:

1. Medication supported withdrawal management.

Yes No

1. Self-administered withdrawal management medications.

Yes No

1. Supervised self-administered withdrawal management medications.

Yes No

1. Non-medication supported withdrawal management.

Yes No

1. Education/didactics.

Yes No

1. Involvement of family members and significant others.

Yes No

1. Discharge/transfer planning.

Yes No

1. Physician/nurse monitoring/management of intoxication and/or withdrawal.

Yes No

1. Range of therapies available in group and/or individual format (cognitive, behavioral, medical).

Yes No

1. Please submit a weekly schedule of services with the individual, group, educational and/or other treatment services labeled to verify what is reported above and attach other programmatic documentation that will support the ASAM Level being sought.

|  |
| --- |
| **ASSESSMENT/TREATMENT PLAN REVIEW** |

Does the program’s assessment and treatment plan review include:

1. Addiction focused history part of initial assessment and conducted or reviewed by physician. Yes No
2. Physical examination (by MD/DO, PA, NP) performed as part of initial assessment.

Yes No

1. Biopsychosocial screening assessments used to determine level of care and to address treatment priorities in ASAM dimensions 2-6.

Yes No

1. Interdisciplinary team available to participate in treatment and to obtain and interpret information regarding client needs.

Yes No

1. Individual treatment plan, with problem identification for ASAM dimensions 2-6, with treatment goals and measureable objectives.

Yes No

1. Daily assessment of progress and treatment changes.

Yes No

1. Transfer/discharge planning beginning at point of admission.

Yes No

1. Referral and linking arrangements for continuing care.

Yes No

1. Medical assessments, using appropriate measures of withdrawal.

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** |
|  |  |  |  |