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

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| **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.

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| **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

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| **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 | CODTreatment 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. 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.

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| **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** |
|       |       |       |       |