**Michigan Department of Health and Human Services**
**American Society of Addiction Medicine (ASAM) Withdrawal Management 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 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: **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: (Select Only One) **Indicate which ASAM level is being applied for (Multiple levels at one location require separate applications for each level)**

- ☐ 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: **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 10 Pre-paid Inpatient Health Plan
- ☐ Southwest Michigan Behavioral Health

## SERVICE DELIVERY and SETTING

Please indicate the type of setting where services are provided: **Identify the best description of the program setting**

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: **Identify the best description of how the services for individuals are provided**

- ☐ 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: **Answer each as directed**

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

5) 24 hour access to emergency medical consultation services.
☐Yes ☐No

6) Ability to provide/assist with access to safe transportation services.
☐Yes ☐No

## STAFF

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

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
5) Recovery coach/peer support staff available or accessed through affiliation relationships. ☐Yes ☐No

6) Please indicate program staff conducting each service. Check all that apply: **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**

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| 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 indicate if the following therapy services are available: **Answer as directed**

1) Medication supported withdrawal management. **Does the program allow the use medication to support withdrawal management**
   ☐Yes ☐No
2) Self-administered withdrawal management medications. **Are clients allowed to self-administer their own medication without supervision/monitoring**
   ☐Yes ☐No
3) Supervised self-administered withdrawal management medications. **Are clients allowed to self-administer their own medication with supervision/monitoring**
   ☐Yes ☐No
4) Non-medication supported withdrawal management. **Does the program support withdrawal management through non-medication interventions**
   ☐Yes ☐No

5) Education/didactics. **Answer as directed**
   ☐Yes ☐No
6) Involvement of family members and significant others. **Answer as directed**
   ☐Yes ☐No
7) Discharge/transfer planning. **Answer as directed**
   ☐Yes ☐No
8) Physician/nurse monitoring/management of intoxication and/or withdrawal. **Answer as directed**
   ☐Yes ☐No
9) Range of therapies available in group and/or individual format (cognitive, behavioral, medical). **Answer as directed**
   ☐Yes ☐No
10) 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. **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.**

## ASSESSMENT/TREATMENT PLAN REVIEW

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

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

3) Biopsychosocial screening assessments used to determine level of care and to address treatment priorities in ASAM dimensions 2-6.
   ☐Yes ☐No

4) Interdisciplinary team available to participate in treatment and to obtain and interpret information regarding client needs.
   ☐Yes ☐No

5) Individual treatment plan, with problem identification for ASAM dimensions 2-6, with treatment goals and measureable objectives.
☐Yes ☐No

6) Daily assessment of progress and treatment changes.
☐Yes ☐No

7) Transfer/discharge planning beginning at point of admission.
☐Yes ☐No

8) Referral and linking arrangements for continuing care.
☐Yes ☐No

9) 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 |
|---|---|---|---|
| | | | |