Uniform Record Manual

For Substance Use Disorder

Treatment Providers

(July 2019)

CLIENT FILE ORDER

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	DMC Eligibility Printout
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104b	Brief ASAM Screening Tool
104c	Adult Initial Level of Care Assessment
104d	Adolescent Initial Level of Care Assessment
104e	Parent Guardian Initial Level of Care Assessment
	Client Fee Collection Form
	Copy of ID/Social Security Card/Medi-Cal Card
S107	Financial Responsibility & Info
	SanWITS Admission Profile Printout
	Additional Intake/Financial

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	Indicates there is no standardized form. If the information is collected by your program, it would be placed in this position in the client file.

Section 1
Intake/Financial

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	Indicates there is no standardized form. If information is collected by your program, it would be placed in this position in the client file.

Client Tracking Form Instructions

REQUIRED FORM:

This form is a required document in the client file for Drug Medi-Cal Organized Delivery System (DMC-ODS) providers in Outpatient Services and Intensive Outpatient Services programs.

WHEN:

At client's first billable service and every potentially billable visit thereafter

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

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- **IOS/OS/Recovery Services:** Check appropriate box: Intensive Outpatient Services (IOS), Outpatient Services (OS), or Recovery Services.
- **Client Name:** Complete with client's full name.
- **Client ID:** Complete the client ID number by entering the client's SanWITS' Unique Client Number (UCN).
- **Admit Date:** Complete the date of admission.
- **Date DMC Eligibility Began:** Complete the date of client's first month of DMC eligibility.
- **Tracking Chart:**
    (1) **Service Date:** Complete each date of client's services.
    (2) **Service Type & Counselor (CO):**
        - Complete the type of service client received from County billing activity codes: Type (AS = Assessment, GR = Group, CM = Case Management, TP = Treatment Planning, DC = Discharge, CR = Crisis, MAT = Medication Assisted Treatment, MED = Medication, IND = Ind. Counseling, FT = Family Therapy, PE = Patient Education, PC = Physician Consultation, O = Other).
        - Document the initials of the counselor (CO) that provided the service.
    (3) **Date Entered:** Complete the date service was entered into SanWITS
    (4) **Total Minutes:** Complete the total amount of minutes including total service time, total documentation time (if applicable), and total travel time (if applicable).
    (5) **Funding Source*:** Check funding source corresponding to service (see Funding Source Key at bottom right corner). NOTE: For any services marked County or Non-Billable, explain on page 2.
        - **DMC = Drug Medi-Cal -** An individual client service that has been delivered and documented as being medically necessary within a treatment episode billable to DMC-ODS, such as OS, IOS, OTP, Residential Services, WM, CM, Recovery Services, etc.
        - **CB = County-Billable -** An individual client service that has been delivered and documented within a treatment episode that is not billable to DMC; examples include:
            - Clients not eligible for Medi-Cal
            - Justice over-ride clients
            - Medically necessary and authorized residential treatment days that exceed DMC-ODS benefits

        - Physician consultation
        - Assessed No Admit & Assessed Delayed Admit (see Memo – Assessed No Admit and Assess Delayed Admit 10-18 for more details)
        - DMC clients with OHC (other healthcare)
        - <u>**Please note:**</u> Services that do not meet DMC standards, such as progress notes not completed within timelines, services provided without an active Treatment Plan in place, group services where the group sign-in sheet does not have all required elements, etc. are ***never*** County billable (see Non-Billable section below)
    - **NB = Non-Billable -** An individual client service that has been delivered and documented within a treatment episode that is not DMC or County billable, such as, clinical group with more than 12 clients, progress note completed & signed late, etc.
- **Review Date:** The date tracking form is reviewed at Quality Assurance Review (QAR).
- **QA Reviewer Printed Name:** QAR representative must print name after reviewing tracking form.
- **QA Reviewer Signature:** QAR representative must sign after reviewing tracking form.
- **QAR Determination:** QAR representative must select and check the appropriate box according to the review determination.
- **Comments:** Enter any applicable comments here (e.g. "Client lost MC eligibility for month of March 2019")

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- **Please explain reason why service is County-Billable or Non-Billable in corresponding number below:** If service is designated as County or Non-Billable on page 1, explain reason(s) here. Please note: if any reason is same for certain consecutive days, you may write the reason once and draw a line through all consecutive days.

NOTE: Will be reviewed at QAR.

CLIENT TRACKING FORM

☐ **OS** ☐ **IOS** ☐ **Recovery Services**

Client Name: ____________________________ Client ID: ______________________ Admit Date: ________________ Date DMC Eligibility Began: ______________

Service Date	Service Type & CO	Date Entered	Total Mins	Funding Source* (see key)	Service Date	Service Type & CO	Date Entered	Total Mins	Funding Source* (see key)	Service Date	Service Type & CO	Date Entered	Total Mins	Funding Source* (see key)
1.				DMC☐ CB☐ NB☐	16.				DMC☐ CB☐ NB☐	31.				DMC☐ CB☐ NB☐
2.				DMC☐ CB☐ NB☐	17.				DMC☐ CB☐ NB☐	32.				DMC☐ CB☐ NB☐
3.				DMC☐ CB☐ NB☐	18.				DMC☐ CB☐ NB☐	33.				DMC☐ CB☐ NB☐
4.				DMC☐ CB☐ NB☐	19.				DMC☐ CB☐ NB☐	34.				DMC☐ CB☐ NB☐
5.				DMC☐ CB☐ NB☐	20.				DMC☐ CB☐ NB☐	35.				DMC☐ CB☐ NB☐
6.				DMC☐ CB☐ NB☐	21.				DMC☐ CB☐ NB☐	36.				DMC☐ CB☐ NB☐
7.				DMC☐ CB☐ NB☐	22.				DMC☐ CB☐ NB☐	37.				DMC☐ CB☐ NB☐
8.				DMC☐ CB☐ NB☐	23.				DMC☐ CB☐ NB☐	38.				DMC☐ CB☐ NB☐
9.				DMC☐ CB☐ NB☐	24.				DMC☐ CB☐ NB☐	39.				DMC☐ CB☐ NB☐
10.				DMC☐ CB☐ NB☐	25.				DMC☐ CB☐ NB☐	40.				DMC☐ CB☐ NB☐
11.				DMC☐ CB☐ NB☐	26.				DMC☐ CB☐ NB☐	41.				DMC☐ CB☐ NB☐
12.				DMC☐ CB☐ NB☐	27.				DMC☐ CB☐ NB☐	42.				DMC☐ CB☐ NB☐
13.				DMC☐ CB☐ NB☐	28.				DMC☐ CB☐ NB☐	43.				DMC☐ CB☐ NB☐
14.				DMC☐ CB☐ NB☐	29.				DMC☐ CB☐ NB☐	44.				DMC☐ CB☐ NB☐
15.				DMC☐ CB☐ NB☐	30.				DMC☐ CB☐ NB☐	45.				DMC☐ CB☐ NB☐

Review Date:______________________

______________________________ ______________________________

QA Reviewer Printed Name **QA Reviewer Signature**

QAR Determination

☐ Client file in full compliance

☐ Corrective Action Required

☐ Please note denials were noted on QAR Tool Billing Summary

Funding Source* Key:

DMC = Drug Medi-Cal

CB = County-Billable

NB = Non-Billable

For any services marked County or Non-Billable, explain on page 2.

Comments:

CLIENT TRACKING FORM

Please explain reason why service is County-Billable or Non-Billable in corresponding number below.

1.	16.	31.
2.	17.	32.
3.	18.	33.
4.	19.	34.
5.	20.	35.
6.	21.	36.
7.	22.	37.
8.	23.	38.
9.	24.	39.
10.	25.	40.
11.	26.	41.
12.	27.	42.
13.	28.	43.
14.	29.	44.
15.	30.	45.

DMC Eligibility Printout

REQUIRED FORM:

This printout is required in the client file for Medi-Cal providers only

WHEN:

Completed at Intake/Admission, when client becomes Medi-Cal eligible, and monthly for the duration of DMC services

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

- **Subscriber ID:** This is the client's Medi-Cal subscriber number. You may also use the client's social security number.
- **Client's Birth Date**: This is the client's date of birth. The format is as follows: 00/00/0000
- **Service Date**: This is the date of service you will be billing to Medi-Cal
- **Issue Date**: This is the date that Medi-Cal was issued to the client. If you do not have the issue date, you may use today's date in the following format: 00/00/0000

NOTES:

Providers may verify Medi-Cal eligibility in one of three ways:

1. Point of Service (POS) Device – See the DHCS POS Device User Guides for instructions
2. Transaction Services on the DHCS Medi-Cal Website – See DHCS Medi-Cal Website Quick Start Guide for instructions
3. Automated Eligibility Verification System (AEVS) – See Medi-Cal Program and Eligibility Manual for instructions
4. For **Residential programs**, Optum will check eligibility as part of authorization. Please follow the process for documentation submission per the authorization process.

All clients who are eligible for Medi-Cal must have a verification of eligibility in their file. Programs that provide DMC services shall be responsible for verifying the Medi-Cal eligibility of each client for each month of services prior to billing for DMC services to that client for that month. Medi-Cal eligibility verification should be performed prior to rendering service, in accordance with and as described in the Department of Health Care Services DMC Provider Billing Manual. Options for verifying the eligibility of Medi-Cal beneficiary are described in the DHCS DMC Provider Billing Manual. The DMC Provider Billing Manual can be found at:

http://www.dhcs.ca.gov/formsandpubs/Documents/DMC_Billing_Manual_2017.pdf

Programs must provide documentation of Medi-Cal eligibility in the client file for the duration of the clients' treatment episode or until the client becomes ineligible for Medi-Cal.

Minor Children Information Form

REQUIRED FORM:

This is not a required form. This form will be used as a supplement in programs collecting additional information regarding minor children

WHEN:

Completed at Screening/Intake Admission

COMPLETED BY:

Authorized agency representative and client

REQUIRED ELEMENTS:

- **Client's Name:** Complete client's full name.
- **Date of Admission:** Complete the admission date.
- **Child's Name:** Complete child's full name.
- **Gender:** Complete child's gender (e.g., Male, Female).
- **Age:** Complete the age of the child.
- **Who Do They Live With:** Complete the child's current living situation (e.g., with the client, grandparents, foster care, other parent, etc.).
- **Will They Be Entering the Program:** Complete appropriate yes or no.

Minor Children Information Form

Client's Name: ___________________________ Date of Admission: _____________________

Child's Name	Gender	Age	With whom do they live?	Will they be entering the program? Y/N

Brief ASAM Screening Instructions
(For use by ACL/Program)

REQUIRED FORM: For the ACL (Access and Crisis Line)

OPTIONAL FORM: For any other SUD Treatment program

WHEN: To be completed by a designated screen personnel/staff as each client call is received.

PURPOSE: The Brief ASAM Screening Tool provides identification of immediate needs and a provisional level of care determination based on ASAM criteria.

REQUIRED ELEMENTS:

- **Client Name:** Client's full name.
- **Date:** Enter date of phone call.
- **City/geographic region:** Enter information**.**
- **Phone:** Enter the client's contact number.
- **Okay to leave a V/M:** Check Yes or No. This is important for privacy reasons.
- **Referral source:** Check the appropriate box. If "Other", enter details.
- **Gender:** Check the appropriate box. If "Other", enter information as provided by client. "Unknown" may be selected when someone other than the client is calling on the client's behalf and does not have the information.
- **If Female, are you currently pregnant?** Check the appropriate box.
- **Sexual Orientation:** Check the appropriate box. If "Other" enter information as provided by client. "Unknown" may be selected when someone other than the client is calling on the client's behalf and does not have the information.

ASAM DIMENSION 1: WITHDRAWAL/DETOX POTENTIAL

1. **Are you experiencing any current severe withdrawal symptoms?**
   Check Yes, No, Unknown, or N/A. (cite examples if asked; nausea, vomiting, excessive sweating, fever, tremors, seizures, rapid heart rate, blackouts, hallucinations, "DTs")
   - If YES**,** *make immediate referral for medical evaluation of need for acute, inpatient care. Follow agency policy and procedure; respond as directed by agency policy and procedure.*
   - "Unknown" may be selected if the caller is not the client, but someone calling on the client's behalf (and they do not know the answer). "N/A" may be selected if the client responded and the item did not apply to the client.

2. **Are you under the influence of any substances right now?**
   Check Yes, No, Unknown or N/A
   - "Unknown" may be selected if the caller is not the client, but someone calling on the client's behalf (and they do not know the answer). "N/A" may be selected if the client responded and the item did not apply to the client.

3. **If no to above question, have you used any substances in the last 1 – 3 days?**
   Check Yes, No, Unknown or N/A
   If yes to the above question, consider Withdrawal Management. Continue screening.
   - "Unknown" may be selected if the caller is not the client, but someone calling on the client's behalf (and they do not know the answer). "N/A" may be selected if the client responded and

the item did not apply to the client.

4. **How does drinking alcohol/using drugs impact your daily life or functioning? Please describe:**

Severity Rating – Dimension 1 (Substance Use, Acute Intoxication, and Withdrawal Potential): Follow the prompts and check the current, assessed level of risk.

ASAM DIMENSION 2: BIOMEDICAL CONDITIONS/COMPLICATIONS (not related to Withdrawal)

1. **Are you having a medical emergency:**
   Check Yes, No, Unknown or N/A
   a. If yes to 1, *make an immediate referral for further medical evaluation of need for acute, impatient care.* **STOP SCREEN**
   b. If no**,** continue the screening.
   - "Unknown" may be selected if the caller is not the client, but someone calling on the client's behalf (and they do not know the answer). "N/A" may be selected if the client responded and the item did not apply to the client.

2. **Do you have any physical health conditions or disabilities?**
   Check Yes, No, Unknown or N/A
   a. If yes, obtain additional information: type, how severe, under current treatment, is it a barrier for access to treatment services?
   b. If yes to #2, do any of these health conditions have an impact on your daily life or functioning?
   Check Yes, No, Unknown or N/A
   c. If yes, obtain additional information.
   - "Unknown" may be selected if the caller is not the client, but someone calling on the client's behalf (and they do not know the answer). "N/A" may be selected if the client responded and the item did not apply to the client.

3. **Do you require any special accommodations? (e.g., wheelchair, other?)** Check Yes, No, Unknown or N/A
   a. If yes, obtain additional information (i.e. need for wheelchair, walker, therapy animal, hearing impaired, deaf, etc.)
   - "Unknown" may be selected if the caller is not the client, but someone calling on the client's behalf (and they do not know the answer). "N/A" may be selected if the client responded and the item did not apply to the client.

Severity Rating – Dimension 2 (Biomedical Conditions and Complications): Follow prompts and check the current, assessed level of risk.

ASAM DIMENSION 3: EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS/COMPLICATIONS

1. **Are you currently having thoughts suicide or hurting yourself?**
   Check Yes, No, Unknown or N/A
   a. If YES**,** *ask additional questions to client to further assess if client has a plan and the means to harm themselves or others. If clinically indicated due to client's answers, refer to the nearest psychiatric emergency facility, follow and respond as directed agency policy and procedure.*
   - "Unknown" may be selected if the caller is not the client, but someone calling on the client's behalf (and they do not know the answer). "N/A" may be selected if the client responded and

the item did not apply to the client.

2. **Are you currently having thoughts or causing physical harm to others?**
   Check Yes, No, Unknown or N/A
   a. If yes, do you have a plan and the means to harm others?
   b. If YES, ask additional questions to further assess for Tarasoff. **If found to be a Tarasoff incident, follow current Tarasoff process.**
- “Unknown” may be selected if the caller is not the client, but someone calling on the client’s behalf (and they do not know the answer). “N/A” may be selected if the client responded and the item did not apply to the client.

3. **Are you currently experiencing a behavioral health crisis, such as severe mental or emotional issues?**
   Check Yes, No, Unknown or N/A
   a. If yes, document in detail additional information. *If clinically indicated due to client’s answer “yes” and details, refer to the nearest psychiatric emergency facility, follow and respond as directed by agency policy and procedure.* **STOP SCREEN**
4. **Do you have a mental health diagnosis?**
   Check Yes, No, Unknown or N/A
   a. If yes, enter details.
- “Unknown” may be selected if the caller is not the client, but someone calling on the client’s behalf (and they do not know the answer). “N/A” may be selected if the client responded and the item did not apply to the client.

5. **If yes to #4, does your mental health have an impact on your daily life or functioning?** Check Yes, No, Unknown or N/A If yes, describe in detail
- “Unknown” may be selected if the caller is not the client, but someone calling on the client’s behalf (and they do not know the answer). “N/A” may be selected if the client responded and the item did not apply to the client.

Severity Rating – Dimension 3 (Emotional, Behavioral or Cognitive (EBC) Conditions or Complications): Follow prompts and check the current, assessed level of risk.

ASAM DIMENSION 4: READINESS TO CHANGE

1. **Have you been mandated or directed to receive SUD (substance use disorder) treatment?**
   Check Yes, No, Unknown or N/A
   a. If yes, describe in detail.
- “Unknown” may be selected if the caller is not the client, but someone calling on the client’s behalf (and they do not know the answer). “N/A” may be selected if the client responded and the item did not apply to the client.

2. **How ready are you to change your alcohol or other drug use now?** Check the appropriate box: Not Ready, Getting Ready, Ready, In process of making changes, Sustained Change made. *DO NOT LEAVE BLANK.*
- “Unknown” may be selected if the caller is not the client, but someone calling on the client’s behalf (and they do not know the answer). “N/A” may be selected if the client responded and the item did not apply to the client.

Severity Rating – Dimension 4 (Readiness to Change): Follow prompts and check the current, assessed level of risk.

ASAM DIMENSION 5: RELAPSE, CONTINUED USE POTENTIAL

1. **Have you drank or used on most days (15 or more) in the last 30 days?**
   Check Yes, No, Unknown or N/A
   - "Unknown" may be selected if the caller is not the client, but someone calling on the client's behalf (and they do not know the answer). "N/A" may be selected if the client responded and the item did not apply to the client.

2. **Are you likely to continue to drink/use without treatment?**
   Check Yes, No, Unknown or N/A
   - "Unknown" may be selected if the caller is not the client, but someone calling on the client's behalf (and they do not know the answer). "N/A" may be selected if the client responded and the item did not apply to the client.

3. **On a scale from 0 to 10, with 0 being "none" and 10 being "very likely", how would you describe your desire/urge to use substances?** Fill in client self-report in the appropriate numbered box. *DO NOT LEAVE BLANK.*
   - "Unknown" may be selected if the caller is not the client, but someone calling on the client's behalf (and they do not know the answer). "N/A" may be selected if the client responded and the item did not apply to the client.

Severity Rating – Dimension 5 (Relapse, continued Use, or Continued Problem Potential): Follow the prompts and check the current, assessed level of risk.

ASAM DIMENSION 6: RECOVERY ENVIRONMENT

1. **Is your current living situation unsafe or harmful to your recovery?**
   Check Yes, No, Unknown or N/A
   - "Unknown" may be selected if the caller is not the client, but someone calling on the client's behalf (and they do not know the answer). "N/A" may be selected if the client responded and the item did not apply to the client.

2. **Do you have relationships that are supportive of you and your recovery?**
   Check Yes, No, Unknown or N/A
   - "Unknown" may be selected if the caller is not the client, but someone calling on the client's behalf (and they do not know the answer). "N/A" may be selected if the client responded and the item did not apply to the client.

3. **Do you struggle to care for yourself?**
   Check Yes, No, Unknown or N/A
   - "Unknown" may be selected if the caller is not the client, but someone calling on the client's behalf (and they do not know the answer). "N/A" may be selected if the client responded and the item did not apply to the client.

4. **Have your ever been arrested/charged/convicted/registered for arson?**
   Check Yes, No, Unknown or N/A
   - "Unknown" may be selected if the caller is not the client, but someone calling on the client's behalf (and they do not know the answer). "N/A" may be selected if the client responded and the item did not apply to the client.

5. **Have you ever been arrested/charged/convicted/registered for a sex crime(s)?**
   Check Yes, No, Unknown, or N/A
   - "Unknown" may be selected if the caller is not the client, but someone calling on the client's behalf (and they do not know the answer). "N/A" may be selected if the client responded and the item did not apply to the client.

Severity Rating – Dimension 6 (Recovery Environment): Follow the prompts and check the current, assessed level of risk.

<u>LEVEL OF CARE INQUIRY</u>

- **Do you have an idea about the type of treatment you're interested in?**
  Check Yes, No, Unknown or N/A
  a. If yes, check the appropriate box: Outpatient, Intensive Outpatient, Residential, MAT, or Other. If "Other", enter client self-report on the line provided.
  - "Unknown" may be selected if the caller is not the client, but someone calling on the client's behalf (and they do not know the answer). "N/A" may be selected if the client responded and the item did not apply to the client.

<u>LEVEL OF CARE DISPOSITION</u>

- **<u>Recommended Level of Care</u>:** Check appropriate box based on ASAM risk ratings.
- **<u>Actual Level of Care Offered</u>:** Check the appropriate box based on client referral.
- **Reason for Discrepancy (if any):** Check reasons for difference between levels of care recommendation vs level of care offered within the box selections. If "Other" is selected, enter more details.
- **Program Referral:** Enter information regarding the program(s) client was referred to.
- **Printed Name:** Print name of person completing screen.
- **Signature:** Signature of person completing the screen.
- **Date:** Enter date screening was completed and signed.

Brief ASAM Screening Tool

Client Name: ______________________________ Date: ________________________

City/geographic region: ______________________ Phone: _________________________

Okay to leave V/M ☐ Yes ☐ No

Were responses provided by a third party? ☐ Yes ☐ No

Referral source:

☐ Self ☐ Access/Crisis Line (ACL) ☐ Drug Dependency Court

☐ CalWorks Case Management ☐ Other: ______________ ☐ Decline to state

Gender Identity:

☐ Male ☐ Female ☐ Transgender (M to F) ☐ Transgender (F to M)

☐ Questioning/Unsure ☐ Other ____________ ☐ Decline to state ☐ Unknown

If female, are you currently pregnant? ☐ Yes ☐ No

Sexual Orientation:

☐ Heterosexual/Straight ☐ Lesbian ☐ Gay ☐ Bisexual

☐ Questioning/Unsure ☐ Other: _____________ ☐ Decline to state ☐ Unknown

Dimension 1: Withdrawal/Detox Potential

1. Are you experiencing any current severe withdrawal symptoms? ☐ Yes ☐ No ☐ Unknown ☐ N/A
   (Ex.: Nausea & vomiting, excessive sweating, fever, tremors, seizures, rapid heart rate, blackouts, hallucinations, "DTs")

   If YES to 1, make immediate referral for medical evaluation of need for acute, inpatient care. **Stop Screen.**

2. Are you under the influence of any substances right now? ☐ Yes ☐ No ☐ Unknown ☐ N/A
3. If NO, have you used any substances in the last 1-3 days? ☐ Yes ☐ No ☐ Unknown ☐ N/A

   If YES to 2, consider Withdrawal Management. Continue screening.

4. How does drinking alcohol/using drugs impact your daily life or functioning? Please describe:

   ____

   ____

   ____

   ____

Comments: ____

____

____

____

____

____

Severity Rating – Dimension 1 (Substance Use, Acute Intoxication, Withdrawal Potential) *Please Check one of the following levels of severity*				
☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Fully functioning, no signs of intoxication or W/D present.	Mild to moderate intoxication interferes with daily functioning, but does not pose a danger to self/others. Minimal risk of severe W/D.	Intoxication may be severe, but responds to support; not posing a danger to self or others. Moderate risk of severe W/D.	Severe signs/symptoms of intoxication indicate an imminent danger to self/others. Risk of severe but manageable W/D; or W/D is worsening.	Incapacitated, with severe signs/symptoms. Severe W/D presents danger, such as seizures. Continued use poses an imminent threat to life (e.g., liver failure, GI bleeding, or fetal death).

Dimension 2: Biomedical Conditions and Complications (not related to withdrawal)

1. Are you having a medical emergency? ☐ Yes ☐ No ☐ Unknown ☐ N/A

   If YES to 1, make immediate referral for medical evaluation of need for acute, inpatient care. **Stop Screen.**

2. Do you have any physical health conditions or disabilities? If yes, describe below.
   ☐ Yes ☐ No ☐ Unknown ☐ N/A

   ____

   ____

   ____

   ____

   ____

   If yes to #2, do any of these health conditions have an impact on your daily life or functioning?
   ☐ Yes ☐ No ☐ Unknown ☐ N/A

   If yes, describe: ____

   ____

   ____

   ____

3. Do you require any special accommodations? (e.g., wheelchair, other?) ☐ Yes ☐ No ☐ Unknown ☐ N/A
   If yes, specify: ____

   ____

Comments: ____

____

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Severity Rating – Dimension 2 (Biomedical Conditions and Complications) ***Please Check one of the following levels of severity***				
☐ 0: None	**☐ 1: Mild**	**☐ 2: Moderate**	**☐ 3: Significant**	**☐ 4: Severe**
Fully functioning and able to cope with any physical discomfort or pain.	Adequate ability to cope with physical discomfort. Mild to moderate symptoms (such as mild to moderate pain) interfere with daily functioning.	Some difficulty tolerating physical problems. Acute, non-life threatening medical symptoms (such as acute episodes of chronic, distracting pain, or signs of malnutrition or electrolyte imbalance) are present. Serious biomedical problems are neglected.	Poor ability to tolerate and cope with physical problems, and/or general health condition is poor. Serious medical problems neglected during outpatient or IOT services. Severe medical problems (such as severe pain requiring medication, or hard to control Type 1 Diabetes) are present but stable.	The person is incapacitated, with severe medical problems (such as extreme pain, uncontrolled diabetes, GI bleeding, or infection requiring IV antibiotics).

Dimension 3: Emotional/Behavioral/Cognitive Conditions and Complications

1. Are you currently having thoughts of suicide or hurting yourself? ☐ Yes ☐ No ☐ Unknown ☐ N/A

   If yes, please explain below and explain if you have a plan and the means to attempt suicide or hurt yourself:

   ____

   ____

2. Are you currently having thoughts of causing physical harm to others? ☐ Yes ☐ No ☐ Unknown ☐ N/A
   If yes, do you have a plan and the means to harm others? Please explain:______________________

   ____

   If YES to 2, ask additional questions to further assess for Tarasoff. **If found to be a Tarasoff incident, follow current Tarasoff process.**

3. Are you currently experiencing a behavioral health crisis, such as severe mental or emotional issues?
   ☐ Yes ☐ No ☐ Unknown ☐ N/A

If yes, document additional information in detail: ____

____

____

If clinically indicated due to client's answer "yes" and details, refer to nearest psychiatric emergency facility, follow and respond as directed by agency policy and procedure. **Stop Screen.**

4. Do you have a mental health diagnosis? ☐ Yes ☐ No ☐ Unknown ☐ N/A
   If yes, specify: ____

   ____

   ____

5. If yes to #4, does your mental health have an impact on your daily life or functioning?
   ☐ Yes ☐ No ☐ Unknown ☐ N/A
   If yes, describe: ____

   ____

   ____

Comments: ____

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Severity Rating – Dimension 3 (Emotional, Behavioral or Cognitive (EBC) Conditions or Complications) ***Please Check one of the following levels of severity***				
☐ 0: None	**☐ 1: Mild**	**☐ 2: Moderate**	**☐ 3: Significant**	**☐ 4: Severe**
Good impulse control, coping skills and sub-domains (dangerousness/lethality, interference with recovery efforts, social functioning, self-care ability, course of illness).	There is a suspected or diagnosed EBC condition that requires intervention, but does not significantly interfere with treatment. Relationships are being impaired but not endangered by substance use.	Persistent EBC condition, with symptoms that distract from recovery efforts, but are not an immediate threat to safety and do not prevent independent functioning.	Severe EBC symptomatology, but sufficient control that does not require involuntary confinement. Impulses to harm self/others, but not dangerous in a 24-hr. setting	Severe EBC symptomatology; requires involuntary confinement. Exhibits severe and acute life-threatening symptoms (e.g., dangerous or impulsive behavior or cognitive functioning) posing imminent danger to self/others.

Dimension 4: Readiness to Change

1. Have you been mandated or directed to receive SUD (substance use disorder) treatment?
   ☐ Yes ☐ No ☐ Unknown ☐ N/A
   If yes, describe mandate/direction: ____
   ____
   ____

2. How ready are you to change your alcohol or drug use now? ☐ Unknown ☐ N/A

☐ Not ready ☐ Getting Ready ☐ Ready ☐ In process of making changes ☐ Sustained change made (Maintenance)

Comments: ____
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Severity Rating – Dimension 4 (Readiness to Change) ***Please check one of the following levels of severity***				
☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Engaged in treatment as a proactive, responsible participant. Committed to change.	Ambivalent of the need to change. Willing to explore need for treatment and strategies to reduce or stop substance use. May believe it will not be difficult to change, or does not accept a full recovery treatment plan.	Reluctant to agree to treatment. Able to articulate negative consequences (of substance use and/or mental health problems) but has low commitment to change. Passively involved in treatment (variable follow through, variable attendance)	Minimal awareness of need to change. Only partially able to follow through with treatment recommendations.	Unable to follow through, little or no awareness of problems, knows very little about addiction, sees no connection between substance use/consequences. Not willing to explore change. Unwilling/unable to follow through with treatment recommendations.

Dimension 5: Relapse/Continued Use Potential

1. Have you drank or used on most days (15 or more) in the last 30 days? ☐ Yes ☐ No ☐ Unknown ☐ N/A

2. Are you likely to continue to drink or use without treatment? ☐ Yes ☐ No ☐ Unknown ☐ N/A

3. On a scale from 0 to 10, with 0 being "none" and 10 being "very likely", how would you describe your desire/urge to use substances? ☐ Unknown ☐ N/A

None	☐ **0**	☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**	☐ **6**	☐ **7**	☐ **8**	☐ **9**	☐ **10**	**Very likely**

Comments: ____

____

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____

Severity Rating – Dimension 5 (Relapse, Continued Use, or Continued Problem Potential) ***Please check one of the following levels of severity***				
☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Low or no potential for further substance use problems or has low relapse potential. Good coping skills in place.	Minimal relapse potential. Some risk, but fair coping and relapse prevention skills.	Impaired recognition and understanding of substance use relapse issues. Able to self-manage with prompting.	Little recognition and understanding of relapse issues, poor skills to cope with relapse.	Repeated treatment episodes have had little positive effect on functioning. No coping skills for relapse/addiction problems. Substance use/behavior places self/others in imminent danger.

<u>Dimension 6: Recovery Environment</u>

1. Is your current living situation unsafe or harmful to your recovery? ☐ Yes ☐ No ☐ Unknown ☐ N/A
2. Do you have relationships that are supportive of you and your recovery? ☐ Yes ☐ No ☐ Unknown ☐ N/A
3. Do you struggle to care for yourself? ☐ Yes ☐ No ☐ Unknown ☐ N/A
4. Have your ever been arrested/charged/convicted/registered for arson? ☐ Yes ☐ No ☐ Unknown ☐ N/A
5. Have you even been arrested/charged/convicted/registered for a sex crimes(s)? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Comments: ____

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Severity Rating – Dimension 6 (Recovery/Living Environment) ***Please check one of the following levels of severity***				
☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Supportive environment and/or able to cope in environment.	Passive/disinterested social support, but not too distracted by this situation and still able to cope.	Unsupportive environment, but able to cope with clinical structure most of the time.	Unsupportive environment and the client has difficulty coping, even with clinical structure.	Environment toxic/hostile to recovery (i.e. many drug-using friends, or drugs are readily available in the home environment, or there are chronic lifestyle problems). Unable to cope with the negative effects of this environment on recovery (i.e. environment may pose a threat to recovery).

Level of Care Inquiry:

Do you have an idea about the type of treatment you are interested in? ☐ Yes ☐ No ☐ Unknown ☐ N/A

☐ Outpatient ☐ Intensive Outpatient ☐ Residential ☐ OTP/MAT

☐ Withdrawal Management ☐ Other: ____

Level of Care Disposition:

Recommended Level of Care:

☐ Outpatient ☐ Intensive Outpatient ☐ Residential

☐ OTP/MAT ☐ Withdrawal Management ☐ Urgent/Crisis

Actual Level of Care Offered:

☐ Outpatient ☐ Intensive Outpatient ☐ Residential

☐ OTP/MAT ☐ Withdrawal Management ☐ Urgent/Crisis

Reason for Discrepancy (if any): ____

☐ Not Applicable ☐ Service not available ☐ Provider judgment ☐ Client preference

☐ Transportation ☐ Accessibility ☐ Financial ☐ Preferred to wait

☐ Language/Cultural Factors ☐ Environment ☐ Mental Health ☐ Physical Health

☐ Court/Probation ordered ☐ Other ____

☐ Client on waiting list for indicated level

Program referral(s): ____

Printed Name: ____

Signature: ____ **Date:** ________________________________

ADULT INITIAL LEVEL OF CARE ASSESSMENT INSTRUCTIONS

REQUIRED FORM: This form is required within the client file.

WHEN: Form to be completed by LPHA/SUD counselor with the client during the assessment/admission process for adult clients in a SUD program.

Timelines:

- **Outpatient programs** – To be completed within **7 calendar days** from day of admit
- **Residential programs** – To be completed with **24 hours** from day of admit

PURPOSE: To determine possible admission of a client into a SUD treatment program and appropriate level of care. Increased collaboration between LPHA/SUD counselor and client by use of Motivational Interviewing techniques will result in a more comprehensive and useful assessment.

REQUIRED ELEMENTS:

- **Client Name:** Enter "Client Name." On the form-fill, hit tab to get to "Client ID #", *once you hit tab again to get to the next field, the client name and ID will populate on the rest of the pages.*
- **Client ID#:** Complete the client ID number by entering the client's SanWITS' Unique Client Number (UCN).
- **Staff Completing the Form:** Name of staff completing the assessment
- **Place of Interview:** Location of assessment (jail, program, etc.)
- **Date of Assessment:** Date of assessment
- **Referral source:** Referral source name (e.g., Probation, CWS, Parole, etc.) and contact information (e.g., contact person, phone number, etc.).

PERSONAL INFORMATION

- **Name:** Client's first name, middle initial and last name. (Obtain copy of legal ID, if available)
- **Age:** Client's age.
- **Social Security Number:** Client's social security number (obtain a copy of card, if available). If client does not have a social security number, follow your agency guidelines.
- **Birth Date:** Client's month/day/year of birth.
- **Phone Number:** Client's phone number.
- **Ok to leave a message:** Check the appropriate box.
- **Preferred language:** Client's preferred language.
- **Address:** Client's current, physical address. If client is homeless, document "homeless" and address issue on ASAM Dimension 6: Recovery Environment.
- **What are the main reasons you are seeking help here today?** Write in client's own words, ask client to prioritize based upon importance/risk.
- **Gender Identity:** Check the appropriate box. If "OTHER", write in client's own words specifics.
- **Sexual Orientation:** Check the appropriate box. If "OTHER", write in client's own words specifics.
- **Veteran Status:** Check Yes or No.
- **Pregnant /Due date:** Client's pregnancy status.
    - If pregnant, complete due date. Inform client they may be asked to provide

documentation such as proof of pregnancy.

- **Number of Children Under 18:** Complete client's number of children under the age of 18. Programs requiring additional information may refer to "Supplemental A: Minor Children Information Form."
- **Medi-Cal:** Check Yes or No.
  - o If yes, complete Medi-Cal card number. Inform client they may be required to provide proof of Medi-Cal eligibility. Follow agency guidelines for Medi-Cal eligibility.
- **Health Insurance:** Check Yes or No.
  - o If yes, complete Insurance Company's name. Inform client they may be required to provide proof of insurance. Follow agency guidelines for health insurance eligibility.
- **Medically Assisted Treatment:** Check Yes or No.
  - o If yes, list medication(s) and name of program client receives the medication. (Note: Post COSD-ODS, services may become billable).
- **Have you ever been arrested/charged/convicted/registered for arson?** Check Yes or No.
- **Have you ever been arrested/charged/convicted/registered for a sex crime(s)?** Check Yes or No.
- **<u>Emergency Contact Information</u>:** Name, relationship, and contact number of designated emergency contact.

<u>ALCOHOL AND/OR OTHER DRUG USE</u>

- **Alcohol and/or other drug use:** Fill in *ALL* prompts within the boxes, document with N/A or "client denies" within boxes as appropriate. *<u>DO NOT LEAVE ANY BOXES BLANK.</u>*
- **Have you used needles in the Past 12 Months:** Check Yes, No, or decline to state.
  - o If yes, specify date.
- **Date last used any drugs including alcohol:** Enter date.
- **Number of days in a Row using:** Complete the number of consecutive days the client has been using alcohol and/or other drugs, up to the last date used.
- **How long do you think you have had a problem with alcohol and/or other drugs?** Enter in clients own words.

<u>ALCOHOL AND/OR OTHER DRUG TREATMENT HISTORY</u>

- **Have you received treatment for alcohol and/or other drugs in the past?** Check Yes or No.
  - o If yes, specify in the boxes below; Type of Treatment, Name of Treatment Facility, Dates of Treatment, and if treatment was completed. *<u>DO NOT LEAVE ANY FIELDS BLANK.</u>*

<u>ASAM DIMENSION 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL</u>

- **History of serious withdrawal, seizures, or life-threatening symptoms during last withdrawal:** Check Yes or No.
  - o If yes, describe in detail using client's own words.
- **Are you currently experiencing withdrawal symptoms, tremors, excessive sweating, rapid heart rate, blackouts, anxiety, vomiting:** Check Yes or No.
  - o *<u>If yes, immediately follow agency policy and procedure for further medical evaluation of client.</u>*

- **Severity Rating – Dimension 1 (Substance Use, Acute Intoxication, and Withdrawal Potential):** Follow the prompts and check the current, assessed level of risk.

ASAM DIMENSION 2: BIOMEDICAL CONDITIONS/COMPLICATIONS
(LPHA/Counselor to review the Health Questionnaire and TB Questionnaire in your determination below)

- **Are you currently taking prescription medications for any medical conditions:** Check Yes or No.
  - If yes, describe in detail.
- **If recently enrolled in Medi-Cal, have you received a health screening to identify health needs within 90 days of enrollment into Medi-Cal?:** Check Yes, No, or N/A

- **Severity Rating – Dimension 2 (Biomedical Conditions and Complications):** Follow the prompts and check the current, assessed level of risk. (Include review of Health Questionnaire and TB Questionnaire in your determination).
- **For residential programs**: if risk rating in this dimension is greater than "zero" (0), submit completed Health Screening Questionnaire along with Initial Assessment/Intake Form to assist with obtaining initial authorization.

ASAM DIMENSION 3: EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS/COMPLICATIONS
(Review Risk Assessment and Co-Occurring Screening from for historical information relevant to this dimension include as a part of your assessment of severity below)

- **Do you have current thoughts of hurting yourself or others?** Check Yes or No.
  - *If yes continue questions per your agency policy and procedures to include additional screens, and assessment if client has a plan or means to harm self or others. Document client responses and respond according to your agency policy and procedure.*
- **Are you currently being treated or sought help in the past for a mental health condition (Depression, Anxiety, PTSD, Bipolar, other mental health condition):** Check Yes or No.
  - If yes, describe in detail. (Include as much information as possible; who, what for, where, when, was treatment helpful or not, was treatment completed or not.
  - If yes to above, are you currently prescribed medications**:** Check Yes or No.
  - If yes, describe in detail.
- **Do you feel like you are unable to care for yourself (hygiene, food, clothing, shelter, etc.)?** Check Yes or No.
  - If yes, describe in detail.
- **Do you currently have a LPHA and/or Psychiatrist?** Check Yes or No.
  - If yes, provide contact information to include; name, agency, address, and contact number/email.
- **Over the past 2 weeks, how often have you been bothered by any of the following problems:** Check *ALL* the following six questions with either: Not at all, Several Days, More Than Half the Days, Nearly Every Day. *DO NOT LEAVE ANY QUESTIONS BLANK.*

- **Severity Rating – Dimension 3 (Emotional, Behavioral or Cognitive (EBC) Conditions or Complications):** Follow the prompts and check the current, assessed level of risk. (Review Co-Occurring Conditions Screening Form for historical information relevant to this dimension)

ASAM DIMENSION 4: READINESS TO CHANGE

- **How long do you think you have had a problem with alcohol and/or other drugs?** Document client self-report in as much detail as possible, in client's own words.
- **Have you tried to stop drinking/using before? If so, what interfered with your success with**

that goal? Document client self-report in as much detail as possible in client's own words.

- **Do you intend to reduce or quit drinking/using in the next 2 weeks?** Check appropriate box.
- **What substance(s) are you willing to stop using?** Document client self-report in as much detail as possible.
- **What would be helpful for you now in order to change your drinking/using?** Document client self-report in as much detail as possible using client's own words.
- **What is the possibility that 12 months from now, you will not have a problem with alcohol and/or other drugs?** Check the appropriate box.
- **How important is it for you to receive treatment for Alcohol Problems:** Check the appropriate box.
- **How important is it for you to receive treatment for Drug Problems:** Check the appropriate box.

- **Severity Rating – Dimension 4 (Readiness to Change):** Follow the prompts and check the current, assessed level of risk.

<u>**ASAM DIMENSION 5: RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL**</u>

- **What's the longest period of time that you have gone without using alcohol and/or other drugs?** Document client self-report.
- **If you previously stopped using alcohol and/or other drugs, what are the reasons you started using again?** Document client self-report in as much detail as possible using client's own words.
- **Are you aware of your triggers to use alcohol and/or other drugs?** Check Yes or No.
    - o If yes, list triggers.
- **What are some coping tools you have used in the past to avoid using?** Document client self-report in as much detail as possible.

- **Severity Rating – Dimension 5 (Relapse, Continued Use, or Continued Problem Potential):** Follow the prompts and check the current, assessed level of risk.

<u>**ASAM DIMENSION 6: RECOVERY ENVIRONMENT**</u>

- **Are you homeless or at risk?** Check Yes or No.
    - o If yes, obtain additional information; how long, do you have a caseworker, would you be interested in a referral and linkage with housing services, has this/will this be a barrier to your receiving/continuing with services? Enter living situation.
- **Are you currently employed?** Check Yes or No.
- **Vocational/Educational Achievements (Highest grade level completed, training or technical education, etc.):** List and attempt to make the list all inclusive.
- **Do you have friends and/or family that are supportive of your seeking treatment for problems related to substance use?** Check Yes or No.
    - o If yes, describe: what do the friends/family of the client do that he/she feels is supportive? Are they currently involved in the client's life?
- **Do you have friends and/or family that might interfere with your treatment for problems related to substance use?** Check Yes or No.
    - o If yes, describe how might they interfere in your treatment; has this happened in the past?
- **PO Contact Name and Phone Number:** Enter information or N/A
- **Pending Court Date(s):** Check Yes or No.

- If yes, enter reason and date(s).

- **Are there any transportation, childcare, housing or employment issues that could interfere with your treatment for problems related to substance use?** Check Yes or No.
  - If yes, describe: is the client able to problem solve these issues so they are not a barrier to treatment.

- **Severity Rating – Dimension 6 (Recovery Environment):** Follow the prompts and check the current, assessed level of risk.

- **READ LEVEL OF CARE DEETERMINATION INSTRUCTIONS ON THE FORM.**
- ***Optional Risk Rating Summary**: (provided to the left of the Level of Care Determination Instructions) Optional to enter risk ratings for each of the 6 dimensions here.*
- **Recommended Level of Care: Enter ASAM LOC that offers the most appropriate treatment setting given the client's current severity and functioning:** Read "Level of Care Determination Instructions" above. Based on the ASAM risk ratings, enter client's recommended level of care.
- **Actual Level of Care:** Enter next appropriate level of care if a level of care other than the recommended level of care above is provided.
- **Reason for Discrepancy (Clinical Override):** Check reasons for discrepancy between level of care recommendation and level of care provided. Document an explanation of the reason(s) on the line provided. Put N/A if not applicable.
- **Designated Treatment Provider Name/Location:** Complete this if services are NOT going to be provided by the program completing this assessment and they are referring the client to another program.
- **Counselor/LPHA Name:** Print name, signature, credentials, and date, if applicable.

THE FOLLOWING SECTIONS MUST BE COMPLETED BY AN LPHA

PROVISIONAL DIAGNOSIS

All programs must provide a provisional diagnosis.

- **Enter Provisional DSM-5 Diagnostic Label(s) & ICD-10 Code(s):** Ensure to utilize correct DSM-5 diagnostic label and ICD-10 code; a diagnosis of Substance Use will be the primary and listed first. There can be additional DSM-5 Diagnostic Labels and ICD-10 codes listed as well, but will need to follow the SUD label if appropriate.
- **A Face to Face interaction occurred between both SUD Counselor and LPHA to validate medical necessity:** Enter the date of the face to face interaction, if applicable.
  Note: If an LPHA does not conduct the assessment, a face-to-face interaction must take place, at a minimum, between the SUD counselor who has completed the assessment for the client and the medical director, licensed physician, or LPHA. The medical director, licensed physician, or LPHA must document the date when the face-to-face interaction took place and then sign and date the Assessment form.
- **LPHA* Name:** Print name, signature, credentials, and date.

**Licensed Practitioner of the Healing Arts (LPHA) includes: MD, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LPC), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family LPHA (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.*

Client Name: ______________________________ Client ID #:________________________

ADULT
Initial Level of Care Assessment

Staff completing the form: ____________________________________ Place of interview: _________________________

Date of screening: _____________ Referral source (Name & Phone #) ____

PERSONAL INFORMATION

First Name: ______________________________ M.I. ___ Last Name: ______________________________ Age: ______

Social Security Number: ________________________ Birth Date: ____/____/____

Phone Number: (____) ______________ OK to leave message? ☐ YES ☐ NO Preferred Language: ___________________

Address: ____
Street City State Zip Code

What are the main reasons you are seeking help here today? ____

____

____

Gender Identity: ☐ Male ☐ Female ☐ Transgender (M to F) ☐ Transgender (F to M)
☐ Questioning/Unsure ☐ Other _____________________ ☐ Decline to state

Sexual Orientation: ☐ Heterosexual/Straight ☐ Lesbian ☐ Gay ☐ Bisexual
☐ Questioning/Unsure ☐ Other _____________________ ☐ Decline to state

Are you a veteran? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO Due Date: ________________ # of Children under 18: _________

Do you have Medi-Cal? ☐ YES ☐ NO Medi-Cal Card #: ____

Do you have Health insurance? ☐ YES ☐ NO Insurance Company: ____

Are you on Medically Assisted Treatment (MAT) (i.e., Methadone, Vivitrol, Suboxone)? ☐ YES ☐ NO

If YES, list the medication: ____________________________ Where do you obtain this? __________________________

Have you ever been arrested/charged/convicted/registered for arson? ☐ YES ☐ NO

Have you ever been arrested/charged/convicted/registered for a sex crime(s)? ☐ YES ☐ NO

EMERGENCY CONTACT

Name: ____________________________________ Relationship: ______________________ Phone # (_____)_____________

Name: ____________________________________ Relationship: ______________________ Phone # (_____)_____________

Client Name: ______________________________ Client ID #:________________________

ALCOHOL AND/OR OTHER DRUG USE

Primary Drug	# of Days used in past 30 days	Route of Admission	Age at first use	Date Last Used
Secondary Drug	**# of Days used in past 30 days**	**Route of Admission**	**Age at first use**	**Date Last Used**
Tertiary Drug	**# of Days used in past 30 days**	**Route of Admission**	**Age at first use**	**Date Last Used**

Have you used needles in the past 12 months? ☐ YES ☐ NO ☐ Decline to state/NA If yes, last used: ___/____/____

Date you last used any drugs including alcohol: _____/_____/_____ Number of days in a row you have been using: _____

How long do you think you have had a problem with alcohol and/or other drugs? ________________________________

ALCOHOL AND/OR OTHER DRUG TREATMENT HISTORY

Have you received treatment for alcohol and/or other drugs in the past? ☐ YES ☐ NO

If yes, please give details:

Type of Recovery Treatment (Outpatient, Residential, Detoxification)	Name of Treatment Facility	Dates of Treatment	Treatment Completed (yes or no)

ASAM Dimension 1: Acute Intoxication and/or Withdrawal Potential

Do you have a history of serious withdrawal, seizures, or life-threatening symptoms during withdrawal? ☐ YES ☐ NO

If yes, please describe:

____

____

Are you currently experiencing withdrawal symptoms, such as tremors, excessive sweating, rapid heart rate, blackouts, anxiety, vomiting, etc.? ☐ YES ☐ NO

If yes, please describe:

____

____

Client Name: ______________________________ Client ID #:________________________

Severity Rating – Dimension 1 (Substance Use, Acute Intoxication, Withdrawal Potential) *COUNSELOR: Please Check one of the following levels of severity*				
☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Fully functioning, no signs of intoxication or W/D present.	Mild to moderate intoxication interferes with daily functioning, but does not pose a danger to self/others. Minimal risk of severe W/D.	Intoxication may be severe, but responds to support; not posing a danger to self or others. Moderate risk of severe W/D.	Severe signs/symptoms of intoxication indicate an imminent danger to self/others. Risk of severe but manageable W/D; or W/D is worsening.	Incapacitated, with severe signs/symptoms. Severe W/D presents danger, such as seizures. Continued use poses an imminent threat to life (e.g., liver failure, GI bleeding, or fetal death).

ASAM Dimension 2: Biomedical Conditions/Complications

(Include review of Health Questionnaire and TB Questionnaire in your determination below)

Are you currently taking prescription medications for any medical conditions? ☐ YES ☐ NO If yes, please describe:

____

____

If recently enrolled in Medi-Cal, have you received a health screening to identify health needs within 90 days of Medi-Cal enrollment? ☐ YES ☐ No ☐ N/A

Severity Rating – Dimension 2 (Biomedical Conditions and Complications) *COUNSELOR: Please Check one of the following levels of severity*				
☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Fully functioning and able to cope with any physical discomfort or pain.	Adequate ability to cope with physical discomfort. Mild to moderate symptoms (such as mild to moderate pain) interfere with daily functioning.	Some difficulty tolerating physical problems. Acute, non-life threatening medical symptoms (such as acute episodes of chronic, distracting pain, or signs of malnutrition or electrolyte imbalance) are present. Serious biomedical problems are neglected.	Poor ability to tolerate and cope with physical problems, and/or general health condition is poor. Serious medical problems neglected during outpatient or IOT services. Severe medical problems (such as severe pain requiring medication, or hard to control Type 1 Diabetes) are present but stable.	The person is incapacitated, with severe medical problems (such as extreme pain, uncontrolled diabetes, GI bleeding, or infection requiring IV antibiotics).

***Note: For residential programs, if the risk rating on ASAM Dimension 2 is greater than "zero" (0), please submit the completed Health Screening Questionnaire along with this form to assist with obtaining initial authorization.**

Client Name: ______________________________ Client ID #:________________________

ASAM Dimension 3: Emotional/Behavioral/Cognitive Conditions/Complications

Review Risk Assessment and Co-Occurring Conditions Screening form for historical information relevant to this dimension. Include as part of your assessment of severity, below.

Do you have any current thoughts of hurting yourself or others? ☐ YES ☐ NO If yes, please describe:

____

____

Are you currently being treated or sought help in the past for a mental health condition? (For example, depression, bipolar disorder, anxiety, PTSD, psychosis, or other mental health condition). ☐ YES ☐ NO
If yes, please describe:

____

____

If yes to the question above, are you currently prescribed medications for the mental health condition(s) you described?
☐ YES ☐ NO
If yes, please describe: ____

Do you feel like you are unable to care for yourself (hygiene, food, clothing, shelter, etc.)? ☐ YES ☐ NO
If yes, please describe: ____

Do you currently have a therapist and/or psychiatrist? ☐ YES ☐ NO
If yes, provide name/contact information: ____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

- Feeling down, depressed or hopeless
  ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every Day
- Needed much less sleep than usual and found you didn't really miss it
  ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every Day
- Feeling nervous, anxious, or on edge
  ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every Day
- Had nightmares about a frightening, horrible or upsetting event you've experienced
  ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every Day
- Seen things that other people can't see or don't seem to see
  ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every Day
- Heard things that other people can't hear or don't seem to hear
  ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every Day

Severity Rating – Dimension 3 (Emotional, Behavioral or Cognitive (EBC) Conditions or Complications) ***COUNSELOR: Please Check one of the following levels of severity***				
☐ 0: None	**☐ 1: Mild**	**☐ 2: Moderate**	**☐ 3: Significant**	**☐ 4: Severe**
Good impulse control, coping skills and sub-domains (dangerousness/lethality, interference with recovery efforts, social functioning, self-care ability, course of illness).	There is a suspected or diagnosed EBC condition that requires intervention, but does not significantly interfere with treatment. Relationships are being impaired but not endangered by substance use.	Persistent EBC condition, with symptoms that distract from recovery efforts, but are not an immediate threat to safety and do not prevent independent functioning.	Severe EBC symptomatology, but sufficient control that does not require involuntary confinement. Impulses to harm self/others, but not dangerous in a 24-hr. setting.	Severe EBC symptomatology; requires involuntary confinement. Exhibits severe and acute life-threatening symptoms (e.g., dangerous or impulsive behavior or cognitive functioning) posing imminent danger to self/others.

Client Name: ______________________________ Client ID #:________________________

ASAM Dimension 4: Readiness to Change

How long do you think you have had a problem with alcohol and/or other drugs?

____

Have you tried to stop drinking/using before? If so, what interfered with your success with that goal?

____

____

Do you intend to reduce or quit drinking/using in the next 2 weeks?

☐ Definitely no ☐ Probably no ☐ Probably yes ☐ Definitely yes

What substance(s) are you willing to stop using?

____

What would be helpful for you now in order to change your drinking/using?

____

____

____

What is the possibility 12 months from now you will not have a problem with alcohol and/or other drugs?

☐ Definitely not ☐ Probably not ☐ Probably will ☐ Definitely will

How important is it for you to receive treatment for:

Alcohol problems: ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

Drug problems: ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

Severity Rating – Dimension 4 (Readiness to Change)

COUNSELOR: Please Check one of the following levels of severity

☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Engaged in treatment as a proactive, responsible participant. Committed to change.	Ambivalent of the need to change. Willing to explore need for treatment and strategies to reduce or stop substance use. May believe it will not be difficult to change, or does not accept a full recovery treatment plan.	Reluctant to agree to treatment. Able to articulate negative consequences (of substance use and/or mental health problems) but has low commitment to change. Passively involved in treatment (variable follow through, variable attendance)	Minimal awareness of need to change. Only partially able to follow through with treatment recommendations.	Unable to follow through, little or no awareness of problems, knows very little about addiction, sees no connection between substance use/consequences. Not willing to explore change. Unwilling/unable to follow through with treatment recommendations.

ASAM Dimension 5: Relapse, Continued Use, or Continued Problem Potential

What's the longest period of time that you have gone without using alcohol and/or other drugs? ___________________

If you previously stopped using alcohol and/or other drugs, what are the reasons you started using again?

____

____

"Triggers" are events, feelings, people, places or things that cause someone to justify using again. Are you aware of your triggers to use alcohol and/or other drugs? ☐ YES ☐ NO

If yes, please list: ____

____

What are some coping tools you have used in the past to avoid using?

____

____

Severity Rating – Dimension 5 (Relapse, Continued Use, or Continued Problem Potential) ***Please Check one of the following levels of severity***				
☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Low or no potential for further substance use problems or has low relapse potential. Good coping skills in place.	Minimal relapse potential. Some risk, but fair coping and relapse prevention skills.	Impaired recognition and understanding of substance use relapse issues. Able to self-manage with prompting.	Little recognition and understanding of relapse issues, poor skills to cope with relapse.	Repeated treatment episodes have had little positive effect on functioning. No coping skills for relapse/addiction problems. Substance use/behavior places self/others in imminent danger.

Client Name: ______________________________ Client ID #:________________________

ASAM Dimension 6: Recovery Environment

Are you homeless or at risk? ☐ YES ☐ NO Living Situation: ___________________________

Are you currently employed? ☐ YES ☐ NO

Vocational/Educational Achievements (Highest grade level completed, any training or technical education, etc.):
____

Do you have friends and/or family that are supportive of you seeking treatment for problems related to substance use?
☐ YES ☐ NO If yes, describe:
____

Do you have friends and/or family that might interfere with your treatment for problems related to substance use?
☐ YES ☐ NO If yes, describe:
____

PO Contact Name & Phone Number: ____

Pending court date(s)? ☐ YES ☐ NO If yes, reason(s) and date(s):
____

Are there any transportation, childcare, housing or employment issues that could interfere with your treatment for problems related to substance use? ☐ YES ☐ NO

Severity Rating – Dimension 6 (Recovery Environment) *COUNSELOR: Please Check one of the following levels of severity*				
☐ 0: None	**☐ 1: Mild**	**☐ 2: Moderate**	**☐ 3: Significant**	**☐ 4: Severe**
Supportive environment and/or able to cope in environment.	Passive/disinterested social support, but not too distracted by this situation and still able to cope.	Unsupportive environment, but able to cope with clinical structure most of the time.	Unsupportive environment and the client has difficulty coping, even with clinical structure.	Environment toxic/hostile to recovery (i.e. many drug-using friends, or drugs are readily available in the home environment, or there are chronic lifestyle problems). Unable to cope with the negative effects of this environment on recovery (i.e. environment may pose a threat to recovery).

Client Name: ______________________________ Client ID #:________________________

Optional Risk Rating Summary	
Dimension	Risk Rating
1 (page 3)	
2 (page 3)	
3 (page 4)	
4 (page 5)	
5 (page 6)	
6 (page 7)	

Level of Care Determination Instructions

After completing the screening (and determining the risk ratings) in each of the six dimensions, review the "Levels of Care" document which describes the typical risk ratings associated with each level of care and can help guide your level of care recommendation.

Once the recommended level of care is determined, document it in the space below. Also document the level of care to be provided. If there is a discrepancy between the two, document the reason(s) for the discrepancy in the spaces provided.

If the screening results indicate a level of care different than the one your program provides, complete the "Designated Treatment Provider Name/Location" field with the information from the program you will be linking the client to.

DMC-ODS regulations require that a "Licensed Practitioner of the Healing Arts" (LPHA) make level of care determinations. In the event an LPHA does not conduct the screening (and an AOD/SUD Counselor does), the Counselor and LPHA must have a face-to-face review of the information, and the LPHA must co-sign the form, indicating their agreement with the level of care determination.*

Recommended Level of Care: Enter the ASAM Level of Care that offers the most appropriate treatment setting given client's current severity and functioning: ____

Actual Level of Care: If a level of care other than the recommended is provided, enter the next appropriate level of care: ____

Reason for Discrepancy (Clinical Override): Check off the reason for discrepancy between level of care determination and level of care provided, and document the reason(s) why:

☐ Not applicable	☐ Service not available	☐ Provider judgment	☐ Client preference
☐ Transportation	☐ Accessibility	☐ Financial	☐ Preferred to wait
☐ Language/Cultural Factors	☐ Environment	☐ Mental Health	☐ Physical Health
☐ Court/Probation Ordered	☐ Other: ____		

Explanation of Discrepancy:

____

____

Designated Treatment Provider Name/Location: ____

_____________________________ _________________________________ ____________

Counselor Name (if applicable) **Signature** (if applicable) **Date**

Provisional Diagnosis

All programs must provide a provisional diagnosis

Provisional Diagnosis DSM-5 Diagnostic Label(s) & ICD-10 Code(s): ____

____

***A face-to face interaction between the AOD counselor and the LPHA to verify the determination of medical necessity for the client regarding this intake screening and related forms occurred on:** ___/____/____ (if applicable)*

_____________________________ _________________________________ ____________

LPHA* Name **Signature** **Date**

*Licensed Practitioner of the Healing Arts (LPHA) includes: MD, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

Adolescent Initial Level of Care Assessment Instructions

REQUIRED FORM: This form is required within the client file

WHEN: Form to be completed by LPHA/SUD counselor with the client during the assessment/admission process for adolescent clients in a SUD program.

Timelines:

- Outpatient programs – To be completed within **7 calendar days** from day of admit
- Residential programs – To be completed with **24 hours** from day of admit

PURPOSE: To determine possible admission of a client into a SUD treatment program and appropriate level of care. Increased collaboration between LPHA/Counselor and client by use of Motivational Interviewing techniques will result in a more comprehensive and useful assessment/intake.

REQUIRED ELEMENTS:

- **Client Name:** Enter “Client Name”. If using the form-fill, hit tab to get to “Client ID #”, *once you hit tab again to go to the next field, the client name and ID will populate on the rest of the pages*
- **Client ID#:** Client ID number by entering the client’s SanWITS’ Unique Client Number (UCN).
- **Staff Completing the Form:** Name of staff completing the assessment/intake.
- **Place of Interview/assessment:** Location of assessment (jail, program, etc.)
- **Date of assessment/interview:** Date of assessment/interview.
- **Referral source:** Referral source name (Probation, CWS, Parole, etc.) and contact information (contact person, phone number, address, etc.).

<u>PERSONAL INFORMATION</u>

- **Name:** Client’s first name, middle initial and last name (obtain copy of legal ID, if available).
- **Age:** Client’s age.
- **Social Security Number:** Client’s social security number (obtain a copy of card, if available). If client does not have a social security number, follow your agency guidelines.
- **Birth Date:** Client’s month/day/year of birth.
- **Phone Number:** Client’s phone number/email address. Check if permitted to leave a message.
- **Preferred language**: Client’s preferred language.
- **Address:** Client’s current, physical address. If client is homeless, document “homeless” and address issue on ASAM Dimension 6: Recovery Environment.
- **What are the main reasons you are seeking help here today?** Write in client’s own words, ask the client to prioritize in importance to him/her.
- **Gender Identity:** Check appropriate box. If “Other”, write in client’s own words specifics.
- **Sexual Orientation:** Check appropriate box. If “Other”, write in client’s own words specifics.
- **Pregnant /Due date:** Client’s pregnancy status, check Yes or No.
    - If yes, complete due date. (Inform client they may be asked to provide documentation such as proof of pregnancy).
- **Number of Children:** Complete client’s number of children.
- **Medi-Cal:** Check Yes or No.
    - If yes, complete Medi-Cal card number. (Inform client they may be required to provide proof of Medi-Cal eligibility. Follow agency guidelines for Medi-Cal eligibility).

- **Health Insurance:** Check Yes or No.
  - If yes, complete Insurance Company's name. (Inform client they may be required to provide proof of insurance. Follow agency guidelines for health insurance eligibility).
- **Have you ever been arrested/charged/convicted/registered for arson?** Check Yes or No.
- **Have you ever been arrested/charged/convicted/registered for a sex crime(s)?** Check Yes or No.
- **Emergency Contact:** Name, relationship, and contact number of designated emergency contact.
- **Parent/Guardian Information:** Name, relationship, and contact number of person designated parent/guardian.

THE FOLLOWING SECTIONS ARE TO BE COMPLETED BY THE ADOLESCENT AND THERPIST/COUNSELOR TOGETHER

ASAM DIMENSION 1: SUBSTANCE USE, ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL

- **In the past year how many times have you used?:** Mark an (X) as Never, Once or Twice, Monthly, Weekly, for all the following: Alcohol, Marijuana, Illegal Drugs, Prescription drugs not prescribed to client, Overuse of your prescription drugs, Inhalants, Herbs or synthetic drugs, Other. *If "Other" is checked, enter details on the line provided.*
- **Complete ALL boxes as appropriate for:** Primary Drug, Secondary Drug, and Tertiary Drug. If any of the boxes do not apply, enter N/A. This is based upon the client's *current* self-report of use.
- **Have you used needles in the past 12 months?** Check Yes, No, or Declined to State.
  - If yes, enter date last used.
- **Date you last used any drugs including alcohol:** Enter date.
- **Number of days in a row you have been using:** Enter number.

Alcohol and/or other drug treatment history

- **Have you received treatment for alcohol and/or other drugs in the past?** Check Yes or No.
  - If yes, provide details, and follow prompts in the boxes: Type of Recovery Treatment, Name of Treatment Facility, Dates of Treatment, Treatment Completed or Not.

- **Severity Rating – Dimension 1 (Substance Use, Acute Intoxication, Withdrawal Potential):** Follow the prompts and check the current, assessed level of risk. Include information from Parent/Guardian Form when determining risk rating.

ASAM DIMENSION 2: BIOMEDICAL CONDITIONS/COMPLICATIONS

(*LPHA/Counselor will review the Client Health Questionnaire and TB Screening as part of this Dimension).*

- **Are you currently taking prescription medication for any medical conditions?** Check Yes or No.
  - If yes, describe in detail.

- **Severity Rating – Dimension 2 (Biomedical Conditions and Complications):** Follow the prompts; check the current, assessed level of risk. Include information from the Parent/Guardian Form as well as the client health questionnaire and TB screening when determining risk rating.

- F**or residential programs:** if risk rating in this dimension is greater than "zero" (0), submit completed Health Screening Questionnaire along with Initial Assessment/Intake Form to

assist with obtaining initial authorization.

ASAM DIMENSION 3: EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS/COMPLICATIONS
(*LPHA/Counselor to review the Risk Assessment and Co-Occurring Conditions Screening Forms for historical information relevant to this dimension. Include as part of your assessment of severity below*).

- **Do you have any current thoughts of hurting yourself or others?** Check Yes or No.
  - *If yes, continue questions per your agency policy and procedure to include additional screens, and assessment if client has a plan or means to harm self or others. Document client responses and respond accordingly per your agency policy and procedure.*
- **Are you currently seeing a therapist/Counselor, (or sought help in the past), for a mental health or behavioral need?** Check Yes or No.
  - If yes, describe in detail to include therapist name, address, how long, successful discharge, what was client being seen for, did the client feel treatment helped or not.
  - If yes to above, are you currently prescribed medications for mental health/behavioral health conditions described above? Check Yes or No.
  - If yes, describe; name, dosage, frequency, prescribed by whom. Did client take as directed?
- **Have you ever had trouble controlling your anger?** Check Yes or No.
  - If yes, describe with additional detail; how often, when was the last time, what does it look like, what helps to calm you, what's the worst that happened when you had trouble controlling your anger?
- **Over the past (2) weeks, how often have you been bothered by any of the following problems?** Ask *all* six prompts, check the appropriate box: Not at all, Several Days, More Than Half the Days, Nearly Every Day. *DO NOT LEAVE BLANK.*

- **Severity Rating – Dimension 3 (Emotional, Behavioral or Cognitive (EBC) Conditions or Complications):** Follow the prompts and check the current, assessed level of risk. Include information from Parent/Guardian Form as well as the risk assessment and co-occurring screening forms when determining the risk rating.

ASAM DIMENSION 4: READINESS TO CHANGE

- **On a scale of 0 (not ready) to 4 (very ready) how important is it you to stop drinking or using other drugs:** Check the appropriate box. Add additional comments as appropriate. Use the client's own words as much as possible.
- **Do you intend to reduce or quit drinking alcohol or using other drugs in the next 2 weeks:** Check the appropriate box.
- **Does your family or friends ever tell you that you should cut down on your drinking or drug user:** Check the appropriate box.
  - If yes, provide additional information.

- **Severity Rating – Dimension 4 (Readiness to Change):** Follow the prompts and check the current, assessed level of risk. Include information from Parent/Guardian Form when determining risk rating.

ASAM DIMENSION 5: RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL

- **Do you ever use alcohol or other drugs while you are by yourself or alone?** Check Yes or No.
- **Do you ever use alcohol or other drugs to relax feel better about yourself, or fit in?** Check Yes or No.
- **How often do you want to or feel like using or drinking?** Document in client's own words.
- **What's the longest time you have gone without using alcohol and/or other drugs?** Document in client's own words; try to obtain specific timeframes, what helped him/her to achieve this.

- **Severity Rating – Dimension 5 (Relapse, Continued Use, or Continued Problem Potential):** Follow the prompts and check the current, assessed level of risk. Include information from Parent/Guardian Form when determining risk rating.

ASAM DIMENSION 6: RECOVERY ENVIRONMENT

- **Have you ever gotten into trouble while you were using alcohol or other drugs?** Check Yes or No.
  - If yes, describe in detail; timeframes, whom involved, consequences, how many times, times when client avoided getting into trouble and how did he/she achieve that?
- **Vocational/Educational Achievements (Highest grade level completed, any training or technical education, etc.:** Enter vocational/educational school or training.
- **Do you feel supported in your current living environment?** Check Yes or No.
- **Are you homeless or at risk?** Check Yes or No.
  - If yes, obtain additional information: how long, do you have a caseworker? Is the client interested in a housing referral and/or linkage? Could this be a barrier to service?
- **Where do you live/who do you live with?** Enter client self-report. How many times has the client moved within the last 18 months and why? How often do the people whom the client lives with change?
- **Does anyone else at home drink alcohol or use other drugs?** Check Yes or No.
  - If yes describe with as much detail as possible. Has Child Welfare ever come to your home or school?
- **Do your close friends drink alcohol or use other drugs?** Check Yes or No.
  - If yes, describe to include if any are currently in treatment.

- **Severity Rating – Dimension 6 (Recovery/Living Environment):** Follow the prompts and check the current, assessed level of risk. Include information from Parent/Guardian Form when determining risk rating.

YOUTH "AT" RISK :

- **Youth is at-risk for SUD and does not have a SUD diagnosis**: Check Yes or No.
  - If yes, refer to appropriate community resource.

LEVEL OF CARE DETERMINATION

(Read Level of Care Determination Instructions provided on the Screen/Intake Form carefully).

- **Recommended Level of Care**: Enter the ASAM Level of Care that offers the most appropriate treatment setting given client's current severity and functioning.
- **Acute Level of Care**: If a level of care other than the determination is provided, enter the next appropriate level of care.
- **Reason for Discrepancy**: Check the reason(s) for a discrepancy in the recommended level of

care vs. acute level of care if appropriate. Provide a written explanation of the discrepancy on the line provided.

- **Designated Treatment Provider Name/Location**: Complete this information if services are NOT going to be provided by program completing this assessment and they are referring the client to another program.
- **Counselor Name**: If applicable, print name, signature, credentials, and date.

THE FOLLOWING SECTIONS MUST BE COMPLETED BY A LPHA

PROVISIONAL DIAGNOSIS

NOTE: All programs must provide a provisional diagnosis

- **Enter Provisional DSM-5 Diagnosis & ICD-10 Code(s):** Ensure to utilize correct DSM-5 diagnostic label and ICD-10 code; a diagnosis of Substance Use will be the primary and listed first. There can be additional DSM-5 Diagnostic Labels and ICD-10 codes listed as well, but will need to follow the SUD label if appropriate.
- **A Face to Face interaction occurred between both counselor and LPHA to validate medical necessity:** Enter the date of the face to face interaction, if applicable.
Note: If a LPHA does not conduct the assessment, a face-to-face interaction must take place, at a minimum, between the counselor who has completed the assessment for the client and the medical director, licensed physician, or LPHA. The medical director, licensed physician, or LPHA must document the date when the face-to-face interaction took place and then sign and date the assessment form.
- **LPHA* Name**: Print name, signature, credentials, and date.

**Licensed Practitioner of the Healing Arts (LPHA) includes: MD, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LPC), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.*

Client Name:_______________________ Client ID#:_______________________

ADOLESCENT

Initial Level of Care Assessment

Staff completing the form: ____________________ Place of interview: ____________________

Date of screening: ____________ Referral source (Name & Phone #): ____________________

(if Referral is from an agency, document agency name): ____________________

PERSONAL INFORMATION

First Name: ____________ M.I. ____ Last Name: ____________ Age: ____

Social Security Number: ____________ Birth Date: ___/___/___

Phone Number: (____) ________ OK to leave message? ☐ YES ☐ NO Preferred Language: ________

Address: ____

Street City State Zip Code

What are the main reasons you are seeking help here today? ______________________________

____

Gender Identity: ☐ Male ☐ Female ☐ Transgender (M to F) ☐ Transgender (F to M)
☐ Questioning/Unsure ☐ Other: ____________ ☐ Decline to state

Sexual Orientation: ☐ Heterosexual/Straight ☐ Lesbian ☐ Gay ☐ Bisexual
☐ Questioning/Unsure ☐ Other: ____________ ☐ Decline to state

Are you pregnant? ☐ YES ☐ NO Due Date: ________ # of Children : ______

Do you have Medi-Cal? ☐ YES ☐ NO Medi-Cal Card #: ____________________

Do you have Health insurance? ☐ YES ☐ NO Insurance Company: ____________________

Have you ever been arrested/charged/convicted/registered for arson? ☐ YES ☐ NO
Have you ever been arrested/charged/convicted/registered for a sex crime(s)? ☐ YES ☐ NO

EMERGENCY CONTACT

Name: ____________ Relationship: ____________ Phone #: (____) ________

PARENT/GUARDIAN INFORMATION

Name: ____________ Relationship: ____________ Phone #: (____) ________

Name: ____________ Relationship: ____________ Phone #: (____) ________

Client Name:____ Client ID#:____

The following sections are completed by the adolescent and counselor together

ASAM Dimension 1: Substance Use, Acute Intoxication and/or Withdrawal Potential

In the past year, how many times have you used [X]?	Never	Once or Twice	Monthly	Weekly	Daily
Alcohol	☐	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐	☐
Illegal Drugs (i.e. cocaine or Ecstasy)	☐	☐	☐	☐	☐
Prescription drugs that were not prescribed for you (i.e. Pain Medication or Adderall)	☐	☐	☐	☐	☐
Overuse of your prescription drugs (i.e. Pain Medication or Adderall)	☐	☐	☐	☐	☐
Inhalants (i.e. nitrous oxide)	☐	☐	☐	☐	☐
Herbs or synthetic drugs (i.e. salvia, K2, or bath salts)	☐	☐	☐	☐	☐
Other:____________________________	☐	☐	☐	☐	☐

Primary Drug	**# of Days Used in past 30 days**	**Route of Admission**	**Age at first use**	**Date Last Used**
Secondary Drug	**# of Days Used in past 30 days**	**Route of Admission**	**Age at first use**	**Date Last Used**
Tertiary Drug	**# of Days Used in past 30 days**	**Route of Admission**	**Age at first use**	**Date Last Used**

Have you used needles in the past 12 months? ☐ YES ☐ NO ☐ Decline to state/NA If yes, last used: ____/____/____

Date you last used any drugs including alcohol: ____/____/____ Number of days in a row you have been using: ______

ALCOHOL AND/OR OTHER DRUG TREATMENT HISTORY

Have you received treatment for alcohol and/or other drugs in the past? ☐ YES ☐ NO

If yes, please give details:

Type of Recovery Treatment (Outpatient, Residential, Detoxification)	**Name of Treatment Facility**	**Dates of Treatment**	**Treatment Completed (yes or no)**

Client Name:______________________________________ Client ID#:____

Severity Rating – Dimension 1 (Substance Use, Acute Intoxication, Withdrawal Potential) *COUNSELOR: Please Check one of the following levels of severity*				
☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Fully functioning, no signs of intoxication or W/D present.	Mild to moderate intoxication interferes with daily functioning, but does not pose a danger to self/others. Minimal risk of severe W/D.	Intoxication may be severe, but responds to support; not posing a danger to self or others. Moderate risk of severe W/D.	Severe signs/symptoms of intoxication indicate an imminent danger to self/others. Risk of severe but manageable W/D; or W/D is worsening.	Incapacitated, with severe signs/symptoms. Severe W/D presents danger, such as seizures. Continued use poses an imminent threat to life (e.g., liver failure, GI bleeding, or fetal death).

<u>ASAM Dimension 2: Biomedical Conditions/Complications</u>

Note: Counselor, please review Client Health Questionnaire and TB Screening as part of this Dimension

Are you currently taking prescription medications for any medical conditions? ☐ YES ☐ NO

If yes, please describe:____

____

Severity Rating – Dimension 2 (Biomedical Conditions and Complications) *COUNSELOR: Please Check one of the following levels of severity. Include information from Parent/Guardian Form when determining risk rating*				
☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Fully functioning and able to cope with any physical discomfort or pain.	Adequate ability to cope with physical discomfort. Mild to moderate symptoms (such as mild to moderate pain) interfere with daily functioning.	Some difficulty tolerating physical problems. Acute, non-life threatening medical symptoms (such as acute episodes of chronic, distracting pain, or signs of malnutrition or electrolyte imbalance) are present. Serious biomedical problems are neglected.	Poor ability to tolerate and cope with physical problems, and/or general health condition is poor. Serious medical problems neglected during outpatient or IOT services. Severe medical problems (such as severe pain requiring medication, or hard to control Type 1 Diabetes) are present but stable.	The person is incapacitated, with severe medical problems (such as extreme pain, uncontrolled diabetes, GI bleeding, or infection requiring IV antibiotics).

<u>ASAM Dimension 3: Emotional/Behavioral/Cognitive Conditions/Complications</u>

Review Risk Assessment and Co-Occurring Conditions Screening form for historical information relevant to this dimension. Include as part of your assessment of severity, below.

Do you have any current thoughts of hurting yourself or others? ☐ YES ☐ NO If yes, please describe:

____

____

Are you currently seeing a therapist/counselor (or sought help in the past) for a mental health or behavioral need? (For example, depression, anxiety, ADHD, or other mental health condition) ☐ YES ☐ NO
If yes, please describe:

____

Client Name:____ Client ID#:____

If yes to the previous question, are you currently prescribed medications for the mental health condition(s) you described?

☐ YES ☐ NO If yes, please describe: ____

Have you ever had trouble controlling your anger? ☐ YES ☐ NO

If yes, please describe:

____

____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

- Feeling down, depressed or hopeless
  ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every Day
- Needed much less sleep than usual and found you didn't really miss it
  ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every Day
- Feeling nervous, anxious, or on edge
  ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every Day
- Had nightmares about a frightening, horrible or upsetting event you've experienced
  ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every Day
- Seen things that other people can't see or don't seem to see
  ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every Day
- Heard things that other people can't hear or don't seem to hear
  ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every Day

Severity Rating – Dimension 3 (Emotional, Behavioral or Cognitive (EBC) Conditions or Complications)

COUNSELOR: Please Check one of the following levels of severity. Include information from Parent/Guardian Form when determining risk rating

☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Good impulse control, coping skills and sub-domains (dangerousness/lethality, interference with recovery efforts, social functioning, self-care ability, course of illness).	There is a suspected or diagnosed EBC condition that requires intervention, but does not significantly interfere with treatment. Relationships are being impaired but not endangered by substance use.	Persistent EBC condition, with symptoms that distract from recovery efforts, but are not an immediate threat to safety and do not prevent independent functioning.	Severe EBC symptomatology, but sufficient control that does not require involuntary confinement. Impulses to harm self/others, but not dangerous in a 24-hr. setting	Severe EBC symptomatology; requires involuntary confinement. Exhibits severe and acute life-threatening symptoms (e.g., dangerous or impulsive behavior or cognitive functioning) posing imminent danger to self/others.

ASAM Dimension 4: Readiness to Change

On a scale of 0 (not ready) to 4 (very ready) how important is it to you to stop drinking alcohol or using other drugs?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Comments:____

Do you intend to reduce or quit drinking alcohol or using other drugs in the next 2 weeks?

☐ Definitely no ☐ Probably no ☐ Probably yes ☐ Definitely yes

Does your family or friends ever tell you that you should cut down on your drinking or drug use? ☐ Yes ☐ No

If yes, please explain: ____

Client Name:____ Client ID#:_____________________________________

Severity Rating – Dimension 4 (Readiness to Change) *COUNSELOR: Please Check one of the following levels of severity. Include information from Parent/Guardian Form when determining risk rating*				
☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Engaged in treatment as a proactive, responsible participant. Committed to change.	Ambivalent of the need to change. Willing to explore need for treatment and strategies to reduce or stop substance use. May believe it will not be difficult to change, or does not accept a full recovery treatment plan.	Reluctant to agree to treatment. Able to articulate negative consequences (of substance use and/or mental health problems) but has low commitment to change. Passively involved in treatment (variable follow through, variable attendance)	Minimal awareness of need to change. Only partially able to follow through with treatment recommendations.	Unable to follow through, little or no awareness of problems, knows very little about addiction, sees no connection between substance use/consequences. Not willing to explore change. Unwilling/unable to follow through with treatment recommendations.

ASAM Dimension 5: Relapse, Continued Use, or Continued Problem Potential

Do you ever use alcohol or drugs while you are by yourself or alone? ☐ YES ☐ NO

Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in? ☐ YES ☐ NO

How often do you want to or feel like using or drinking? ____

What's the longest time you have gone without using alcohol and/or other drugs? ______________________________

Severity Rating – Dimension 5 (Relapse, Continued Use, or Continued Problem Potential) *COUNSELOR: Please Check one of the following levels of severity. Include information from Parent/Guardian Form when determining risk rating*				
☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Low or no potential for further substance use problems or has low relapse potential. Good coping skills in place.	Minimal relapse potential. Some risk, but fair coping and relapse prevention skills.	Impaired recognition and understanding of substance use relapse issues. Able to self-manage with prompting.	Little recognition and understanding of relapse issues, poor skills to cope with relapse.	Repeated treatment episodes have had little positive effect on functioning. No coping skills for relapse/addiction problems. Substance use/behavior places self/others in imminent danger.

ASAM Dimension 6: Recovery Environment

Have you ever gotten into trouble while you were using alcohol or other drugs? ☐ YES ☐ NO

If yes, explain: ____

Vocational/Educational Achievements (Highest grade level completed, any training or technical education, etc.):

____

Do you feel supported in your current living environment? ☐ YES ☐ NO

Client Name:____ Client ID#:____

Are you homeless or at risk? ☐ YES ☐ NO

Where do you live/who do you live with? ____

Does anyone else at home drink alcohol or use other drugs? ☐ YES ☐ NO
If yes, explain:

____

Do your close friends drink alcohol or use other drugs? ☐ YES ☐ NO
If yes, explain:

____

Severity Rating – Dimension 6 (Recovery/Living Environment)

COUNSELOR: Please Check one of the following levels of severity. Include information from Parent/Guardian Form when determining risk rating

☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Supportive environment and/or able to cope in environment.	Passive/disinterested social support, but not too distracted by this situation and still able to cope.	Unsupportive environment, but able to cope with clinical structure most of the time.	Unsupportive environment and the client has difficulty coping, even with clinical structure.	Environment toxic/hostile to recovery (i.e. many drug-using friends, or drugs are readily available in the home environment, or there are chronic lifestyle problems). Unable to cope with the negative effects of this environment on recovery (i.e. environment may pose a threat to recovery).

Youth "At Risk"

*Per DHCS, the intergovernmental agreement between the County of San Diego and the State allows at-risk youth to be served at the **ASAM Level 0.5 (Early Intervention) level of care**. At-risk youth (those without a DSM-5 SUD Diagnosis) would not meet medical necessity criteria for outpatient or residential services.*

Youth is at-risk for SUD and does not have a SUD Diagnosis: ☐ Yes ☐ No
(If yes, refer to appropriate community resource)

Client Name:_______________________________________ Client ID#:_______________________________________

Optional Risk Rating Summary	
Dimension	**Risk Rating**
1 (page 3)	
2 (page 3)	
3 (page 4)	
4 (page 5)	
5 (page 5)	
6 (page 6)	

Level of Care Determination Instructions

After completing the screening (and determining the risk ratings) in each of the six dimensions, review the "Levels of Care" document which describes the typical risk ratings associated with each level of care and can help guide your level of care recommendation.

Once the recommended level of care is determined, document it in the space below. Also document the level of care to be provided. If there is a discrepancy between the two, document the reason(s) for the discrepancy in the spaces provided.

If the screening results indicate a level of care different than the one your program provides, complete the "Designated Treatment Provider Name/Location" field with the information from the program you will be linking the client to.

DMC-ODS regulations require that a "Licensed Practitioner of the Healing Arts" (LPHA) make level of care determinations. In the event an LPHA does not conduct the screening (and an AOD/SUD Counselor does), the Counselor and LPHA must have a face-to-face review of the information, and the LPHA must co-sign the form, indicating their agreement with the level of care determination.*

Recommended Level of Care: Enter the ASAM Level of Care that offers the most appropriate treatment setting given client's current severity and functioning: ____

Actual Level of Care: If a level of care other than the determination is provided, enter the next appropriate level of care:

____

Reason for Discrepancy (Clinical Override): Check off the reason for Discrepancy between level of care determination and level of care provided, and document the reason(s) why:

☐ Not Applicable ☐ Service not available ☐ Provider judgment ☐ Client preference
☐ Transportation ☐ Accessibility ☐ Financial ☐ Preferred to wait
☐ Language/Cultural Factors ☐ Environment ☐ Mental Health ☐ Physical Health
☐ Court/Probation Ordered ☐ Other: ____

Explanation of Discrepancy: ____

____

Designated Treatment Provider Name/Location: _______________________________________

_______________________ _______________________ _______________
Counselor Name (if applicable) **Signature** (if applicable) **Date**

Provisional Diagnosis

All programs must provide a provisional diagnosis

Provisional Diagnosis DSM-5 Diagnostic Label(s) & ICD-10 Code(s): ___________________________

____

A face-to face interaction between the AOD counselor and the LPHA to verify the determination of medical necessity for the client regarding this intake screening and related forms occurred on: ___/____/____ *(if applicable)*

_______________________ _______________________ _______________
LPHA* Name **Signature** **Date**

*Licensed Practitioner of the Healing Arts (LPHA) includes: MD, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

ADOLESCENT (Parent/Guardian Version)
Initial Level of Care Assessment Instructions

REQUIRED FORM:

This form is required within the client file, if client has an available parent or guardian to complete the form.

WHEN: This form is to be completed by a Parent/Guardian of the adolescent in collaboration with the LPHA/Counselor during the completion of the Initial Assessment/Intake. The LPHA/Counselor will also complete the Adolescent Initial Level of Care Assessment.

Timelines:

- Outpatient programs – To be completed within 7 calendar days from day of admit
- Residential programs – To be completed with 24 hours from day of admit

PURPOSE: Completion of the form will assist the program in determining possible client admission and level of care determination within a SUD treatment program. Increased collaboration between LPHA/Counselor and Parent/Guardian by use of Motivational Interviewing techniques will result in a more comprehensive and useful screen/intake.

REQUIRED ELEMENTS

The following sections are completed by the parent/guardian and counselor

- **Client Name:** Enter "Client Name". Hit tab to get to "Client ID #", *once you hit tab again to get to the next field, the client name and ID will populate on the rest of the pages.*
- **Client ID#:** Client ID number as determined by agency guidelines.

ASAM DIMENSION 1: SUBSTANCE USE, ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL

- **Do you know if your child is drinking alcohol or using other drugs?** Check Yes or No.
  - If yes, describe in detail.
- **Do you know if your child is using anything else to get high?** Check Yes or No.
  - If yes, explain in detail.
- **Has your child ever been hospitalized or experienced blackouts due to alcohol or other drug use?** Check Yes or No.
  - If yes, provide additional details such as dates, name of ER or Hospital, and discharge recommendations, if any.
- **Has your child received treatment for alcohol and/or other drugs in the past?** Check Yes or No.
  - If yes, provide details as prompted in the box; Type of Recovery Treatment, Name of Treatment Facility, Dates of Treatment, Treatment Completed or not (yes or no).

ASAM DIMENSION 2: BIOMEDICAL CONDITIONS/COMPLICATIONS

- **Does your child have any current physical health problems (seizures)?** Check Yes or No.
  - If yes provide additional details; treating physician, include prescribed medications, surgeries, and hospitalizations due to medical conditions.
- **If recently enrolled in Medi-Cal, has your child received a health screening to identify health needs within 90 days of enrollment into Medi-Cal?** Check Yes, No, or N/A.
- **If female, is your child pregnant?** Check Yes or No.
  - If yes, how many weeks/months, under whose care?

ASAM DIMENSION 3: EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS/COMPLICATIONS

- **Have you ever taken your child to a Therapist or Counselor?** Check Yes or No.
  - If yes, explain; provide details such as name, dates, how treatment ended or if continued, reason for seeking treatment, opinion as to effectiveness of treatment.
- **Has your child ever harmed themselves or others (cutting, acted violent toward others):** Check Yes or No.
  - If yes, describe in detail to include; how recent, what happened before and what happened after self-harm or harm towards others, frequency, in what way/method.
- **Has your child ever received services in an inpatient setting (hospital), or outpatient setting for mental or behavioral health needs?** Check Yes or No.
  - If yes, describe in detail, follow the prompts within the box: Name of provider, Dates of Treatment, Comments.
- **Is he/she currently taking medications for mental or behavioral health needs?** Check Yes or No.
  - If yes, please describe: name, dosage, frequency, prescriber, did he/she take medications as prescribed, were the medications effective?

ASAM DIMENSION 4: READINESS TO CHANGE

- **On a scale of 0 (not ready) to 4 (very ready) what is your child's readiness to stop using alcohol or other drugs**? Check the appropriate box. Add additional comments and give as much detail as possible.

ASAM DIMENSION 5: RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL

- **As far as you know, has your child ever used alcohol or other drugs while by themselves or alone?** Check the appropriate box.
- **Do you feel your child could stop using or drinking without help?** Check the appropriate box. Add additional comments.

ASAM DIMENSION 6: RECOVERY ENVIRONMENT

- **Has your child ever got into trouble while using alcohol or other drugs?** Check Yes or No.
  - If yes, provide additional details: what type of trouble, how often, age first began, consequences of trouble.
- **Does your child have problems with transportation?** Check Yes or No.
- **Does your child have a stable living environment?** Check Yes or No.
- **Do your child's friends use alcohol or other drugs?** Check Yes or No.
- Add additional comments.

STAFF SIGNATURES

- **Counselor Name/Signature/Date:** Counselor to print name, signature, credentials, and date (if applicable)
- **LPHA Name/Signature/Date:** LPHA to print name, signature, credentials, and date.

**Licensed Practitioner of the Healing Arts (LPHA) includes: MD, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LPC), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.*

Client Name: ______________________________ Client ID #:________________________

ADOLESCENT (Parent/Guardian Version)
Initial Level of Care Assessment

The following sections are completed by the parent/guardian and counselor

ASAM Dimension 1: Substance Use, Acute Intoxication and/or Withdrawal Potential

Do you know if your child is drinking alcohol or using other drugs? ☐ YES ☐ NO
If yes, describe: ____

____

Do you know if your child is using anything else to get high? ☐ YES ☐ NO (“anything else” includes illegal drugs, over the counter and prescription drugs, and things that you sniff or “huff”)
If yes, please explain: ____

____

Has your child ever been hospitalized or experienced blackouts due to alcohol or other drug use? ☐ YES ☐ NO
If yes, when? ____

____

Has your child received treatment for alcohol and/or other drugs in the past? ☐ YES ☐ NO If yes, detail:

Type of Recovery Treatment (Outpatient, Residential, Detoxification)	Name of Treatment Facility	Dates of Treatment	Treatment Completed (yes or no)

ASAM Dimension 2: Biomedical Conditions/Complications

Does your child have any current physical health problems (i.e. seizures, other conditions)? ☐ YES ☐ NO
If yes, please describe (include any medications that are currently prescribed by a physician):

____

____

If recently enrolled in Medi-Cal, has your child received a health screening to identify health needs within 90 days of enrollment into Medi-Cal? ☐ YES ☐ NO ☐ N/A
If female, is your child pregnant? ☐ YES ☐ NO ☐ N/A If yes, how many weeks/months? _______________

ASAM Dimension 3: Emotional/Behavioral/Cognitive Conditions/Complications

Have you ever taken your child to an outpatient therapist or counselor? ☐ YES ☐ NO
If yes, explain why: ____

____

Has your child ever harmed themselves or someone else (cutting, acted violent toward others)? ☐ YES ☐ NO
If yes, please describe: ____

Client Name: ______________________________ Client ID #:________________________

Has your child ever received services in an inpatient setting (hospital) or outpatient for mental or behavioral health needs?
☐ YES ☐ NO If yes, please detail:

Name of Provider	Dates of Treatment	Comments

Is he or she currently taking medications for mental or behavioral health needs? ☐ YES ☐ NO
If yes, please describe: ____

____

ASAM Dimension 4: Readiness to Change

On a scale of 0 (not ready) to 4 (very ready), what is your child's readiness to stop using alcohol or other drugs?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Comments: ____

____

____

ASAM Dimension 5: Relapse, Continued Use, or Continued Problem Potential

As far as you know, has your child ever used alcohol or drugs while by themselves or alone? ☐ YES ☐ NO

Do you feel your child could stop using or drinking without help? ☐ YES ☐ NO
Comments: ____

ASAM Dimension 6: Recovery Environment

Has your child ever got into trouble while using alcohol or drugs? ☐ YES ☐ NO
If yes, explain: ____

Does your child have problems with transportation? ☐ YES ☐ NO

Does your child have a stable living environment? ☐ YES ☐ NO

Do your child's friends use alcohol or other drugs? ☐ YES ☐ NO

Comments: ____

______________________________ ___________________________________ ___________
Counselor Name (if applicable) **Signature (if applicable)** **Date**

______________________________ ___________________________________ ___________
LPHA* Name **Signature** **Date**

*Licensed Practitioner of the Healing Arts (LPHA) includes: MD, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

Client Fee Collection Form

This is not a standardized form. If your agency is currently using this form, place it in this section.

Copy of Identification, Social Security Card, and/or Medi-Cal Card*

This section is optional.

If your agency is requiring a copy of the client's ID, SS card, and/or Medi-Cal card, it is generally made at Screening/Intake Admission (*or when client becomes eligible to Medi-Cal for Medi-Cal card). Place the copies in this section.

FINANCIAL RESPONSIBILITY INFORMATION AND MEDI-CAL SHARE OF COST INSTRUCTIONS

REQUIRED FORM:

This form is a required document in the client file for all San Diego County funded Substance Use Disorder programs.

WHEN:

Completed upon admission for all clients and monthly for clients with a Medi-Cal Share of Cost (SOC). **Reminder:** Programs must verify all clients' Medi-Cal eligibility along with any applicable SOC on a monthly basis. For additional information, refer to the **DMC Eligibility Printout** instructions in Section 1 of the Substance Use Disorder Utilization Review Management (SUDURM).

> ***Note:*** *If a client received DMC services* ***prior to*** *becoming Medi-Cal eligible, staff must inform the client to request an evaluation for retroactive Medi-Cal and assist client with applying for retroactive Medi-Cal benefits as needed. Staff should also check Medi-Cal eligibility for the prior month(s) when Drug Medi-Cal service(s) were received to verify if those services may be billed to DMC, now. (For example: Client was admitted into program 10/25/2018 with no health coverage and began receiving services during this time. On 11/15/2018, client receives a letter of approval for Medi-Cal with an effective date of 11/01/2018. Since the client received services prior to 11/01/2018, the counselor and client contact a Medi-Cal Eligibility Worker to request an evaluation for retroactive Medi-Cal for the month of October. The client is later approved for retroactive Medi-Cal for month of October and DMC services received from 10/25/2018 – 10/31/2018 can now be billed to DMC.)*

COMPLETED BY:

Authorized agency representative or client

REQUIRED ELEMENTS:

- **Client's name:** Complete client's first and last name.
- **Parent or authorized representative's name**: If minor, complete name of parent or authorized representative.
- **Do you and/or your family have health coverage:** Circle appropriate yes, no, or N/A answer. If client does not have health coverage, client must be provided a referral to 2-1-1 and Covered California website.
- **If answer is NO, were you provided a referral to 2-1-1 and Medi-Cal or Covered California:** Circle appropriate yes, no, or N/A answer.
- **CalWORKS recipient:** Circle appropriate yes or no answer.
- **Medi-Cal Eligible**: Circle appropriate yes or no answer.
- **Do you currently have Medi-Cal**: Circle appropriate yes or no answer.
    - If answer is YES, complete "For Medi-Cal Recipients" section below
    - If answer is NO, complete "For Non-Medi-Cal Clients" section on page 2

For Medi-Cal Recipients: Complete this section if client answered yes to having Medi-Cal

- **Do you have a Medi-Cal Monthly Share of Cost:** Circle appropriate yes or no answer. If YES, complete the following sections:
    - **Spend Down Amount:** Monthly amount required to meet the Share of Cost
    - **Agreed amount to pay:** Amount client agreed to pay towards the monthly Share of Cost

  - **One-time payment due on:** Indicate the amount the client will pay one-time
  - **Installment payment plan:** Indicate the amount client will pay and check how often
    - **Daily:** Complete with daily payment amount (if applicable)
    - **Monthly:** Complete with monthly payment amount (if applicable)
    - **Weekly:** Complete with weekly payment amount (if applicable)
    - **Others (please specify):** Complete with other payment amount and specify payment plan (if applicable)
    - **The first payment is due on and the final payment is due on:** Complete with when first and last payments are due

Note: For more information regarding how to handle Share of Cost, please refer to the **BHS Drug Medi-Cal Organizational Providers Billing Manual**.

For Non-Medi-Cal Clients: Complete this section if client answered no to having Medi-Cal

- **Number of dependent(s) on income (including self):** Complete the number of people dependent on the income of the client including self.
- **Gross Family Income (before taxes**): Complete the client's gross family income earned before taxes.
- **Court-ordered revenue and recovery expenses:** Complete total deductions taken for court ordered revenue and recovery expenses. Client may be asked to provide proof of payments.
- **Adjusted Income:** This is gross family income minus court-ordered revenue and recovery expenses.
- **Fee based on sliding scale:** Use the County Sliding Fee Scale to determine the fee. (Located in Appendix E.1 of the Substance Use Disorder Provider Operations Handbook - SUDPOH)
- **Adjusted Fee**: This is the final fee based on client's ability to pay or funding source (e.g., indigent, Medi-Cal eligible, CalWorks, third party pay).
- **Reason for fee adjustment:** This is an explanation of why client's fee was adjusted.
- **Client signature:** Client must sign and date affirming all statements are true and correct.
- **Parent or authorized Representative Signature:** If minor, parent or authorized representative must sign and date.
- **Completed by:** The staff completing or reviewing this form must sign and date.

FINANCIAL RESPONSIBILITY INFORMATION AND MEDI-CAL SHARE OF COST

This form shall be completed upon admission for every client and shall be completed ***monthly*** for clients with a Medi-Cal Share of Cost (SOC).

If the client is seeking treatment without the knowledge or consent of a parent or authorized representative, the information given below should be based only on the client's financial information. If the client is seeking treatment with the knowledge and/or consent of a parent or authorized representative, the information given below should be based on the parent or authorized representative's financial information.

Client's Name: ____

Parent or authorized representative's name: ____

Do you and/or your family have health coverage? ☐YES ☐NO ☐N/A

Were you provided a referral to 2-1-1 and Medi-Cal or Covered California? ☐YES ☐NO

CalWORKS Recipient: ☐YES ☐NO

Medi-Cal Eligible: ☐YES ☐NO

Do you currently have Medi-Cal? ☐YES ☐NO

(If YES, complete "**For Medi-Cal Recipients**" section below. If NO, complete "**For Non-Medi-Cal Clients**" section on page 2.)

For Medi-Cal Recipients

Do you have a Medi-Cal Monthly Share of Cost? ☐YES ☐NO

If YES, complete the following:

Spend Down Amount $_________________________

Agreed amount to pay $________________________

☐ One-time payment due on ___________________

☐ Installment payment plan

☐ Daily $____________ ☐ Weekly $ ______________

☐ Monthly $____________ ☐ Others (please specify) _______________ $_____________

The first payment is due on _____________ and the final payment is due on _______________.

NOTE: If it has been determined to require the client to pay a minimum Share of Cost fee, the fee is owed to the program, but no service will be refused due to a client's inability to pay.

For Non-Medi-Cal Clients

Number of dependents on income (*including self*):

____

Gross Family Income (*before taxes*) $ ________________________

Court-ordered revenue and recovery expenses $ _________________________

(Client may be asked to provide proof of payments)

Adjusted income (*gross minus court expenses*) $ _________________________

Fee based on sliding scale $ _________________________

Adjusted fee $ _________________________

Reason for fee adjustment: ____

Indigent Clients

It has been determined to require clients to pay a minimum fee even when indigent, although no service will be refused due to client's inability to pay, the fee is owed to the program.

I affirm that the statements made herein are true and correct to the best of my knowledge:

Client Signature: ____ Date: ____________________________

Authorized Representative Name: _______________________________________ Relationship: ______________________

Signature: ____ Date: ____________________________

Completed by:

Program Staff Name: ____

Signature: ____ Date: ____________________________

SanWITS Admission Printout

Place printout of client's SanWITS

admission profile here.

Please refer to SanWITS User's Guide and CalOMS Admission form and instructions for additional information.

Section 2
Consents

	Consent to Release Information
	Admission Agreement / Consent for Treatment
F203	Client Personal Rights
	42 CFR Written Summary Requirements
	Notice of Privacy Practice/HIPAA
	Consent to Follow Up
	Consent for Photo, TV, Video
F209	Acknowledgement of DMC-ODS Beneficiary Handbook and Provider Directory
F210	SUD Program Admission Checklist
	Additional Policies and Consents

	Indicates there is no standardized form. If information is collected by your program, it would be placed in this position in the client file.

Consent to Release Information

This is not a standardized form. Place current consent to release information used by your agency in this section.

Please note: In order to document coordination of care, programs shall obtain a signed authorization to release information for the client's primary care physician, mental health provider and/or other health providers ***and*** document all care coordination efforts in the progress notes.

Admissions Agreement Consent for Treatment

This is not a standardized form. Place current Admission Agreement/Consent for Treatment used by your agency in this section.

YOUR PERSONAL RIGHTS AT AN AOD CERTIFIED PROGRAM FORM INSTRUCTIONS

REQUIRED FORM:

This form is a required document in the client file

WHEN:

Completed at Intake/Admission

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

- **Review the form with the client**
- **Program Name:** Document the name of the program providing the service.
- **Client's Printed Name/Client's Signature/Date:** Client must print name, sign name, and date the form.

ACKNOWLEDGEMENT:
Indicate name of Program/Provider

CLIENT PRINTED NAME, SIGNATURE, AND COPY:
The client must review, print and sign name, and date the form. The client is to be provided a copy of this form at admission. The program shall place the original signed document in the client's file.

YOUR PERSONAL RIGHTS AT AN AOD CERTIFIED PROGRAM

In accordance with Alcohol and/or Other Drug (AOD) Program Certification Standards, the Client Personal Rights include, but are not limited to, the following:

- The right to confidentiality as provided for in HIPAA and Title 42, Code of Federal Regulations, part 2.
- The right to be accorded dignity in contact with staff, volunteers, board members, and other individuals.
- The right to be accorded safe, healthful and comfortable accommodations to meet his or her needs.
- The right to be free from verbal, emotional, physical abuse and/or inappropriate sexual behavior.
- The right to be informed by the program of the procedures to file a grievance or appeal discharge.
- The right to be free from discrimination based on ethnic group identification, religion, age, gender, race, sexual orientation, or disability.
- The right to be accorded access to his or her file.

Please note: If you are a **Medi-Cal beneficiary**, you are entitled to additional rights. To review these rights, please refer to the **Drug Medi-Cal Organized Delivery System Beneficiary Handbook** offered to you at the time of admission to the program.

Acknowledgement

I have been personally advised and have received a copy of my personal rights at the time of my admission to:

____

(Program Name)

____

(Client's Printed Name) **(Client's Signature)** **(Date)**

42 CFR Written Summary Requirements

This is not a standardized form. Place current 42 CFR Written Summary Requirements used by your agency in this section.

Notice of Privacy Practices/HIPAA

This is not a standardized form. Place current Notice of Privacy Practices/HIPAA used by your agency in this section.

Consent to Follow Up

This is not a standardized form. Place current Consent to Follow Up form used by your agency in this section.

Consent for

Photo, TV, Video

This is not a standardized form. Place current Consent for Photo, TV and Video used by your agency in this section.

Acknowledgement and Provision of the Drug Medi-Cal Organized Delivery System (DMC-ODS) Beneficiary Handbook and BHS Provider Directory Instructions

REQUIRED FORM: This form is required within the client file for all Medi-Cal and Medi-Cal eligible clients.

WHEN: To be completed when the Beneficiary Handbook and BHS Provider Directory is offered to a client either during the screening and/or upon admission to program.

PURPOSE: All programs are required to offer the Drug Medi-Cal Organized Delivery System (DMC-ODS) Beneficiary Handbook and BHS Provider Directory link to all Medi-Cal and Medi-Cal eligible clients. This form establishes both Beneficiary Handbook and BHS Provider Directory link was provided/offered to the client.

Programs shall serve as community referral resources, directing individuals in need of other services beyond the scope of the program. Per 42 CFR 438, Medi-Cal beneficiaries are to be offered a copy of the Beneficiary Handbook describing their rights, including grievance and appeal rights related to their SUD services as well as making a provider directory available should they require services beyond the scope of the program. This form documents compliance with these requirements.

REQUIRED ELEMENTS:

- **Please identity which printed version of the handbook you would prefer:** Ensure client checks the appropriate box (e.g., English, Farsi, etc.)

Acknowledgement

- **Client Name:** Enter client's full name
- **Client Signature/Date:** Client enters signature with date
- **Counselor Printed Name/Signature/Date:** Enter Counselor's printed name with signature and date
- Offer client a copy of this form and keep original form in client chart

*If the client is offered and refuses to accept, either the Beneficiary Handbook and/or BHS Provider Directory link, or refuses to sign the form, document the refusal on the form and file within the client chart.

County of San Diego Behavioral Health Services

Acknowledgement of DMC-ODS Beneficiary Handbook, Practice Guidelines, and Provider Directory

As a beneficiary, you have certain rights and responsibilities, which are described in the **Drug Medi-Cal Organized Delivery System (DMC-ODS) Beneficiary Handbook**. It is important that you understand how the Drug Medi-Cal Organized Delivery System (DMC-ODS) works so you can get the care you need. This handbook explains your benefits and how to get care. It will also answer many of your questions.

Please identify which printed version of the Handbook you would prefer:

☐ English	☐ Spanish	☐ Tagalog
☐ Arabic	☐ Farsi	☐ Vietnamese

☐ I request a large print format of the Handbook

☐ I decline a printed copy of the Handbook

The **General Practice Guidelines** provide a general overview of clinically appropriate substance use care for clients in the County of San Diego DMC-ODS services and are available for you to review. Although each person seeking services is unique and there are many things that impact care, these guidelines are a helpful way to outline generally accepted clinical standards.

The **BHS Provider Directory** provides information on all County operated and contracted programs that provide Mental Health Services and Substance Use Disorder Services. The listing includes type of service, program names, administrative phone numbers, hours of operation, and populations served.

Acknowledgement and Electronic Access

To access an electronic copy of the **DMC-ODS Beneficiary Handbook**, **General Practice Guidelines in DMC-ODS**, and **BHS Provider Directory**, please visit the link below and click their corresponding links under the "Popular Services" menu on the right-hand side:

https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/alcohol_drug_services/dmc_ods_consumer.html

I, ____, have been personally advised about and have been offered

(Client's Full Name)

*a copy of the **Drug Medi-Cal Organized Delivery System (DMC-ODS) Beneficiary Handbook** in my preferred format and have been personally advised about and provided with access to the **General Practice Guidelines** and the **BHS Provider Directory.***

____

(Client's Signature) **(Date)**

____

(Counselor's Printed Name) **(Counselor's Signature)** **(Date)**

***Note: Client is to be provided a copy of this document and original document is to be kept in client's chart.**

SUD Program Admission Checklist Instructions

REQUIRED FORM: This form is required within the client file.

WHEN: To be completed by the SUD Counselor during the client admission process.

PURPOSE: To ensure all items on the admission checklist are offered to the client and completed as instructed upon client admission to program.

REQUIRED ELEMENTS:

- **Date:** Provide the date each item on the admission checklist was reviewed/explained and offered/provided to the client or write "N/A" if not applicable
- **Counselor's Printed Name/Signature/Date:** Enter Counselors printed name, signature, and date the checklist was completed

**Should the client refuse to accept and/or sign any form listed on the admission checklist, document client refusal.

SUD Program Admission Checklist

Admission Item	Date
Admission Agreement/Consent For Treatment reviewed and signed on	
Notice of Privacy Practices/HIPAA reviewed and provided on	
42 CFR Written Summary Requirements reviewed and signed on	
Grievance and Appeal Process explained and brochure with form and envelope offered on	
Client Rights explained on	
Drug Medi-Cal Organized Delivery System (DMC-ODS) Beneficiary Handbook explained and offered on	
Provider Directory explained and provided on	
Community Resource List explained and provided on (e.g. different levels of care, medical, dental, mental health, social services and where to apply for State, Federal, or county entitlement programs)	
Language/Interpretation Service availability reviewed and offered on (if applicable)	
Voter Registration material offered to client at intake or change of address on	
Primary Counselor name and contact information provided to the client on	
Case Manager name and contact information provided to the client on	

(Counselor's Printed Name) **(Counselor's Signature)** **(Date)**

Section 3
Assessments

F301	Stay Review Justification
F302	Alcohol/Drug History
F303	ASI/YAI
F304	Co-Occurring Conditions Screening
F305a,b	High Risk Assessment (HRA) and High Risk Index (HRI)
F306	ASAM LOC Recommendation
F307	Assessment Summary
F308	Diagnosis Determination Note
	Additional Assessments

	Indicates there is no standardized form. If information is collected by your program, it would be placed in this position in the client file.

Justification for Continuing Services Instructions

REQUIRED FORM:

This form is a required document in client file for outpatient and residential treatment services.

WHEN:

This form must be completed no sooner than five (5) months and no later than six (6) months from client's admission to the program, or after the completion date of the most recent justification for continuing services. The SUD counselor or LPHA shall review the client's progress and eligibility to continue to receive treatment services, and recommend whether the client should or should not continue to receive treatment services at the same level of care. The Medical Director or LPHA shall determine and document the medical necessity for continued services.

COMPLETED BY:

Authorized agency representative and LPHA or Medical Director.

REQUIRED ELEMENTS:

- **Client Name:** Complete client's full name.
- **Admission Date:** Complete the date of admission.
- **Client ID Number:** Complete with the client's SanWITS Unique Client Number (UCN).
- **List and explain medical/psychological reasons to continue client's treatment. Include client's substance use history and personal history:** Document medical/psychological reasons that client should continue treatment including criteria for specific substance use disorder(s). Explain client's personal history and substance use history.
    - **Did client provide documentation of a physical examination completed within the past 12 months?** Check yes or no.
    - **If yes, provide date of physical (must be completed within last 12 months):** Complete with date of physical exam that client provided documentation for, if applicable.
    - **Describe findings from review of client's most recent physical examination (if applicable):** Document medical information reviewed on client's physical examination
- **Describe client's progress in treatment during the past six months including review of client's progress notes and treatment plan goals (please be detailed and descriptive):** Complete a detailed and descriptive summary of client's progress in treatment during the past six months and explain information reviewed from client's progress notes and treatment plan goals.
- **Client Name:** Re-enter client's full name.
- **Admission Date:** Re-enter the date of admission.
- **Client ID Number:** Re-enter the client's SanWITS Unique Client Number (UCN).
- **Explain the consequences of discontinuing client's treatment and describe LPHA or Counselor's recommendations:** Complete consequences that may occur if client discontinues treatment. (e.g., recidivism, relapse) and LPHA/Counselor's recommendations on whether or

not the client should or should not continue to receive treatment services at the same level of care.

- **What is expected to be achieved during continued treatment (MUST include client's prognosis):** Mark the appropriate box for client's prognosis (good, fair, poor) and explain below. Complete a summary of what client is expected to achieve during continued treatment.
- **Target date for client to complete treatment:** Complete the expected target date for client to complete treatment.
- **Counselor or LPHA Name (printed):** Legibly print the counselor or LPHA's name.
- **Counselor or LPHA Signature and Date:** Counselor or LPHA completing the above-mentioned sections of the form must hand-sign and date.
- **Continued services are medically necessary and <u>all of the following</u> have been considered:** LPHA or Medical Director completes this section by marking **all** boxes have been considered when determining if client continues to meet medical necessity.
- **Continuing services for the client is not medically necessary, the client must be discharged from treatment:** LPHA or Medical Director marks this box if client does not meet medical necessity for continued services. The client must be discharged from treatment and referral to appropriate level of treatment services shall be made. ***<u>Please note:</u>** Justice override clients may **<u>not</u>** be discharged from treatment for not meeting medical necessity; however, these services may not be billed to DMC.
- **LPHA or MD Name (printed):** Legibly print the LPHA or Medical Director's name.
- **LPHA or MD Signature and Date:** LPHA or Medical Director reviewing this form to determine the need for continuing services must hand-sign and date.

NOTES:

- If <u>Justification for Continuing Services</u> is missing from client's file, all Medi-Cal billings submitted after the date the justification was due (within six months from admission date) will be disallowed.

Justification for Continuing Services

Client Name		Admission Date	
Client ID Number			

List and explain medical/psychological reasons to continue client's treatment. Include client's substance use history and personal history:
____
____
____
____
____
____
____
____
Did client provide documentation of a physical exam completed within the past 12 months? ☐ YES ☐ NO
If yes, provide date of physical (must be completed within last 12 months): ______________________
Describe findings from review of client's most recent physical exam (if applicable): ______________________
____
____
____
____

Describe client's progress in treatment during the past six months including review of client's progress notes and treatment plan goals (please be detailed and descriptive):
____
____
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____

Justification for Continuing Services

Client Name		Admission Date	
Client ID Number			

Explain the consequences of discontinuing client's treatment and describe LPHA or Counselor's recommendations:
____
____
____
____
____

What is expected to be achieved during continued treatment (MUST include client's prognosis):
Client's Prognosis: ☐ **Good** ☐ **Fair** ☐ **Poor (please also elaborate below)**
____
____
____
____
____

Target date for client to complete treatment:	

Counselor or LPHA Printed Name	Counselor or LPHA Signature	Date

Below to be completed by an LPHA or Medical Director:

☐ **CONTINUED SERVICES ARE MEDICALLY NECESSARY AND ALL OF THE FOLLOWING HAVE BEEN CONSIDERED**:

- ☐ The client's personal, medical, and substance use history
- ☐ Documentation of the client's most recent physical examination
- ☐ The client's progress notes and treatment plan goals
- ☐ The LPHA or counselor's recommendation
- ☐ The client's prognosis

☐ **CONTINUING SERVICES FOR THE CLIENT IS NOT MEDICALLY NECESSARY, THE CLIENT MUST BE DISCHARGED FROM TREATMENT* AND ARRANGEMENTS SHALL BE MADE TO APPROPRIATE LEVEL OF TREATMENT SERVICES (IF APPLICABLE).**

*For clients where a justice override applies, please refer to instructions.

LPHA or MD Printed Name	LPHA or MD Signature	Date

Alcohol and Drug History

REQUIRED FORM:

This form is an optional document in client file

WHEN:

Completed at Screening/Intake Admission or at the time of Assessment

COMPLETED BY:

Authorized agency representative with client

REQUIRED ELEMENTS:

- **Client Name:** Complete the client's full name.
- **Date:** Complete the date the form is completed.
- **Drug Name:** Complete the name of specific drug or type of alcohol.
- **Age First Used:** Complete the age client first used specific alcohol or drug.
- **Age Regular use began:** Complete the age client used specific alcohol or drug regularly. Regular use refers to the pattern of use becoming more frequent.
- **Frequency 30 Days Prior to Treatment:** Complete the frequency of use. Frequency refers to the number of days the specific alcohol or drug used (i.e., daily, every other day, once a week, etc.).
- **Usual Route:** Complete the usual route of administration. Usual route refers to the preferred method(s) the client uses specific alcohol or drugs (e.g., oral, smoking, inhalation, injection, other).
- **Date last Used:** Complete the last date client used specific alcohol or drugs.
- **Average Amount Used at One Time:** This section refers to amount of alcohol or drug client used at one setting (e.g., four 24 oz of light beer, one gram of heroin, etc.).
- **Problem Rank:** This section reflects the client's self-reported level of concern or problem with specific alcohol or drugs. The ranking is numerical, with number one being the most troubling substance.

Alcohol & Drug History

Client Name: ____ Date: ____________________

Drug (Circle if Ever Used)	Drug Name	Age First Used	Age Regular Use Began	Frequency 30 Days Prior to Treatment	Usual Route (Oral, Smoke, Inhalation, I.V.)	Date Last Used	Average Amount Used at One Setting	Problem Rank*
Alcohol								
Amphetamine								
Cocaine								
Heroin								
Marijuana/Hash								
Other Opiates								
Sedatives								
Hallucinogens								
Inhalants								
Club Drugs								
PCP/Angel Dust								
Non-Prescribed Methadone								
Over The Counter								
Other								

*Rank is numerical with 1 being most troubling substance.

Staff Signature:____ **Date:**____________________

ASI (Addiction Severity Index Lite) and YAI (Youth Assessment Index)

REQUIRED FORM:

This form is a required document in client's file

- Adult programs must utilize the ASI (Addiction Severity Index Lite)
- Adolescent programs must utilize the YAI (Youth Assessment Index)

NOTE: This form is **not** required for Withdrawal Management (WM) or Opioid Treatment Programs (OTP).

WHEN:

This form must be completed within the following timelines:

- Outpatient – within 30 days of admission
- Residential – within 10 days of admission

COMPLETED BY:

An SUD Counselor or LPHA at the program

REQUIRED ELEMENTS:

- All sections of the ASI/YAI must be completed.
- Follow all guidelines on the ASI and YAI instrument.
- Refer to the ASI and YAI manual for any further instructions.

NOTES:

It is a good practice to conduct the ASI/YAI as soon as possible to develop a treatment plan in a timely manner.

Addiction Severity Index *Lite* - CF

Clinical/Training Version

Thomas McLellan, Ph.D.
John Cacciola, Ph.D.
Deni Carise, Ph.D.
Thomas H. Coyne, MSW

Remember: This is an interview, not a test

≈Item numbers circled are to be asked at follow-up.≈
≈Items with an asterisk* are cumulative and should be rephrased at follow-up.≈
≈Items in a double border gray box are questions for the interviewer. Do not ask these questions of the client.≈

INTRODUCING THE ASI: Seven potential problem areas: Medical, Employment/Support Status, Alcohol, Drug, Legal, Family/Social, and Psychological. All clients receive this same standard interview. All information gathered is confidential.
There are two time periods we will discuss:

1. The past 30 days
2. Lifetime Data

Patient Rating Scale: Patient input is important. For each area, I will ask you to use this scale to let me know how bothered you have been by any problems in each section. I will also ask you how important treatment is for you for the area being discussed.

The scale is:
- 0 - Not at all
- 1 - Slightly
- 2 - Moderately
- 3 - Considerably
- 4 - Extremely

If you are uncomfortable giving an answer, then don't answer.

Please do not give inaccurate information!

INTERVIEWER INSTRUCTIONS:

1. Leave no blanks.
2. Make plenty of Comments (if another person reads this ASI, they should have a relatively complete picture of the client's perceptions ofhis/her problems).
3. X = Question not answered.
   N = Question not applicable.
4. Terminate interview if client misrepresents two or more sections.
5. When noting comments, please write the question number.
6. Tutorial/clarification notes are preceded with "•".

HALF TIME RULE: If a question asks the number of months, round up periods of 14 days or more to 1 month. Round up 6 months or more to 1 year.

CONFIDENCE RATINGS:
⇒ Last two items in each section.
⇒ Do not over interpret.
⇒ Denial does not warrant misrepresentation.
⇒ Misrepresentation = overt contradiction in information.

Probe and make plenty of comments!

HOLLINGSHEAD CATEGORIES:

1. Higher execs, major professionals, owners of large businesses.
2. Business managers if medium sized businesses, lesser professions, i.e., nurses, opticians, pharmacists, social workers, teachers.
3. Administrative personnel, managers, minor professionals, owners/proprietors of small businesses, i.e., bakery, car dealership, engraving business, plumbing business, florist, decorator, actor, reporter, travel agent.
4. Clerical and sales, technicians, small businesses (bank teller, bookkeeper, clerk, draftsman, timekeeper, secretary).
5. Skilled manual - usually having had training (baker, barber, brakeman, chef, electrician, fireman, lineman, machinist, mechanic, paperhanger, painter, repairman, tailor, welder, policeman, plumber).
6. Semi-skilled (hospital aide, painter, bartender, bus driver, cutter, cook, drill press, garage guard, checker, waiter, spot welder, machine operator).
7. Unskilled (attendant, janitor, construction helper, unspecified labor, porter, including unemployed).
8. Homemaker.
9. Student, disabled, no occupation.

LIST OF COMMONLY USED DRUGS:

Alcohol:	Beer, wine, liquor
Methadone:	Dolophine, LAAM
Opiates:	Pain killers = Morphine, Dilaudid, Demerol, Percocet, Darvon, Talwin, Codeine, Tylenol 2,3,4, Syrups = Robitussin, Fentanyl
Barbiturates:	Nembutal, Seconal, Tuinal, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinal
Sed/Hyp/Tranq:	Benzodiazepines = Valium, Librium, Ativan, Serax Tranxene, Dalmane, Halcion, Xanax, Miltown, Other = Chloral Hydrate, Quaaludes
Cocaine:	Cocaine Crystal, Free-Base Cocaine or Crack, and "Rock Cocaine"
Amphetamines:	Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal
Cannabis:	Marijuana, Hashish
Hallucinogens:	LSD (Acid), Mescaline, Psilocybin (Mushrooms), Peyote, Green, PCP (Phencyclidine), Angel Dust, Ecstacy
Inhalants:	Nitrous Oxide (Whippits), Amyl Nitrite (Poppers), Glue, Solvents, Gasoline, Toluene, Etc.

Just note if these are used:
- Antidepressants,
- Ulcer Meds = Zantac, Tagamet
- Asthma Meds = Ventolin Inhaler, Theodur
- Other Meds = Antipsychotics, Lithium

ALCOHOL/DRUG USE INSTRUCTIONS:
The following questions look at two time periods: the past 30 days and lifetime. Lifetime refers to the time prior to the last 30 days. However if the client has been incarcerated for more than 1 year, you would only gather lifetime information, unless the client admits to significant alcohol /drug use during incarceration. This guideline only applies to the Alcohol/Drug Section.

⇒30 day questions only require the number of days used.
⇒Lifetime use is asked to determine extended periods of use.
⇒Regular use = 3+ times per week, binges, or problematic irregular use in which normal activities are compromised.
⇒Alcohol to intoxication does not necessarily mean "drunk", use the words felt the effects", "got a buzz", "high", etc. instead of intoxication. As a rule of thumb, 5+ drinks in one setting, or within a brief period of time defines "intoxication".
⇒ "How to ask these questions:
→ "How many days in the past 30 have you used....?
→ "How many years in your life have you regularly used....?"

Revised- 06/02/99 DC/TRJ

Addiction Severity Index *Lite* - Training Version

GENERAL INFORMATION

G1.ID No.: ☐☐☐☐☐☐☐☐☐☐☐

G2. SS No. : ☐☐☐ - ☐☐ - ☐☐☐☐

G3. Program No: ___ ___ ___

G4. Date of Admission: ☐☐ / ☐☐ / ☐☐☐☐

G5. Date of Interview: ☐☐ / ☐☐ / ☐☐☐☐

G8. Class: 1. Intake 2. Follow-up ☐

G9. Contact Code: ☐
1. In person
2. Telephone (Intake ASI must be in person)
3. Mail

G10. Gender: 1. Male 2. Female ☐

G11. Interviewer Code No.: ☐☐

G12. Special: ☐
1. Patient terminated
2. Patient refused
3. Patient unable to respond

____
Name

____
Address 1

____
Address 2

_______________________(____)______
City State Zip Code Tel. No.

G14. How long have you lived at this address? ☐☐ Years ☐☐ Months

G16. Date of birth: ☐☐ / ☐☐ / ☐☐☐☐
(Month/Day/Year)

G17. Of what race do you consider yourself? ☐

1. White (not Hisp) 5. Asian/Pacific 9. Other Hispanic
2. Black (not Hisp) 6. Hispanic-Mexican
3. American Indian 7. Hispanic-Puerto Rican
4. Alaskan Native 8. Hispanic-Cuban

G18. Do you have a religious preference? ☐

1. Protestant 3. Jewish 5. Other
2. Catholic 4. Islamic 6. None

G19. Have you been in a controlled environment in the past 30 days? ☐

1. No 4. Medical Treatment
2. Jail 5. Psychiatric Treatment
3. Alcohol/Drug Treat. 6. Other: ______________

•A place, theoretically, without access to drugs/alcohol.

G20. How many days? ☐☐

•"NN" if Question G19 is No. Refers to <u>total</u> number of days detained in the past 30 days.

(Clinical/Training Version)

MEDICAL STATUS

M1.* How many times in your life have you been hospitalized for medical problems? [ ][ ]

- Include O.D.'s and D.T.'s. Exclude detox, alcohol/drug, psychiatric treatment and childbirth (if no complications). Enter the number of ***overnight*** hospitalizations for medical problems.

M3. Do you have any chronic medical problems which continue to interfere with your life? 0 -No 1 - Yes [ ]

- ***If "Yes", specify in comments.***
- A chronic medical condition is a serious physical condition that requires regular care, (i.e., medication, dietary restriction) preventing full advantage of their abilities.

M4. Are you taking any prescribed medication on a regular basis for a physical problem? 0 - No 1 - Yes [ ]

- ***If Yes, specify in comments.***
- Medication prescribed by a MD for medical conditions; ***not psychiatric medicines***. Include medicines prescribed whether or not the patient is currently taking them. The intent is to verify chronic medical problems.

M5. Do you receive a pension for a physical disability? 0 - No 1 - Yes [ ]

- ***If Yes, specify in comments.***
- Include Workers' compensation, exclude psychiatric disability.

M6. How many days have you experienced medical problems in the past 30 days? [ ][ ]

- Do not include ailments directly caused by drugs/alcohol.
- Include flu, colds, etc. Include serious ailments related to drugs/alcohol, which would continue even if the patient were abstinent (e.g., cirrhosis of liver, abscesses from needles, etc.).

For Questions M7 & M8, ask the patient to use the Patient Rating scale.

M7. How troubled or bothered have you been by these medical problems in the past 30 days? [ ]

- Restrict response to problem days of Question M6.

M8. How important to you *now* is treatment for these medical problems? [ ]

- Refers to the need for ***new*** or ***additional*** medical treatment by the patient.

CONFIDENCE RATINGS

Is the above information significantly distorted by:

M10. Patient's misrepresentation? 0 - No 1 - Yes [ ]

M11. Patient's inability to understand? 0 - No 1 - Yes [ ]

MEDICAL COMMENTS

(Include question number with your notes)

EMPLOYMENT/SUPPORT STATUS

E1.* Education completed:
- GED = 12 years, note in comments.
- Include formal education only.

Years | Months

E2.* Training or Technical education completed:
- Formal/organized training only. For military training, only include training that can be used in civilian life, i.e., electronics or computers.

Months

E4. Do you have a valid driver's license?
- Valid license; not suspended/revoked. 0 - No 1 - Yes

E5. Do you have an automobile available?
- If answer to **E4** is "**No**", then **E5** must be "**No**". 0 - No 1 - Yes
Does not require ownership, only requires availability on a regular basis.

E6. How long was your longest full time job?
- Full time = 35+ hours weekly; does not necessarily mean most recent job.

Yrs / Mos

E7.* Usual (or last) occupation?
(specify) ________________________________
(use Hollingshead Categories Reference Sheet)

E9 Does someone contribute the majority of your support? 0 - No 1 - Yes

E10. Usual employment pattern, past three years?
1. Full time (35+ hours)
2. Part time (regular hours)
3. Part time (irregular hours)
4. Student
5. Service
6. Retired/Disability
7. Unemployed
8. In controlled environment

- Answer should represent the *majority* of the last 3 years, not just the most recent selection. If there are equal times for more than one category, select that which best represents more current situation.

E11. How many days were you paid for working in the past 30 days?
- Include "under the table" work, paid sick days and vacation.

EMPLOYMENT/SUPPORT COMMENTS
(Include question number with your notes)

EMPLOYMENT/SUPPORT (cont.)

For questions E12-17: How much money did you receive from the following sources in the past 30 days?

E12. Employment? ☐☐☐☐☐
- Net or "take home" pay, include any "under the table" money.

E13. Unemployment Compensation? ☐☐☐☐☐

E14. Welfare? ☐☐☐☐☐
- Include food stamps, transportation money provided by an agency to go to and from treatment.

E15. Pensions, benefits or Social Security? ☐☐☐☐☐
- Include disability, pensions, retirement, veteran's benefits, SSI & workers' compensation.

E16. Mate, family, or friends? ☐☐☐☐☐
- Money for personal expenses, (i.e. clothing), include unreliable sources of income (e.g. gambling). Record ***cash*** payments only, include windfalls (unexpected), money from loans, gambling, inheritance, tax returns, etc.).

E17. Illegal? ☐☐☐☐☐
- ***Cash*** obtained from drug dealing, stealing, fencing stolen goods, gambling, prostitution, etc. ***Do not*** attempt to convert drugs exchanged to a dollar value.

E18. How many people depend on you for the majority of their food, shelter, etc.? ☐☐
- Must be regularly depending on patient, do include alimony/child support, do not include the patient or self-supporting spouse, etc.

E19. How many days have you experienced employment problems in the past 30 ? ☐☐
- Include inability to find work, if they are actively looking for work, or problems with present job in which that job is jeopardized.

For Question E20, ask the patient to use the Patient Rating scale.

E20. How troubled or bothered have you been by these employment problems in the past 30 days? ☐
- If the patient has been incarcerated or detained during the past 30 days, they cannot have employment problems.

E21. How important to you *now* is counseling for these employment problems? ☐
- The patient's ratings in Questions E20-21 refer to Question E19.
- Stress help in finding or preparing for a job, not giving them a job.

CONFIDENCE RATINGS

Is the above information significantly distorted by:

E23. Patient's misrepresentation 0-No 1-Yes ☐

E24. Patient's inability to understand? 0-No 1-Yes ☐

EMPLOYMENT/SUPPORT COMMENTS

(Include question number with your notes)

ALCOHOL/DRUGS

Route of Administration Types:

1. Oral 2. Nasal 3. Smoking 4. Non-IV injection 5. IV

• *Note the usual or most recent route. For more than one route, choose the most severe. The routes are listed from least severe to most severe.*

		Past 30 Days	Lifetime (years)	Route of Admin
D1	Alcohol (any use at all)			
D2	Alcohol (to intoxication)			
D3	Heroin			
D4	Methadone			
D5	Other Opiates/Analgesics			
D6	Barbiturates			
D7	Sedatives/Hypnotics/ Tranquilizers			
D8	Cocaine			
D9	Amphetamines			
D10	Cannabis			
D11	Hallucinogens			
D12	Inhalants			
D13	More than 1 substance per day (including alcohol)			

D17. How many times have you had Alcohol DT's?

• ***Delirium Tremens*** (DT's): Occur 24-48 hours after last drink, or significant decrease in alcohol intake, shaking, severe disorientation, fever, , hallucinations, they usually require medical attention.

ALCOHOL/DRUGS COMMENTS

(Include question number with your notes)

ALCOHOL/DRUGS (cont.)

How many times in your life have you been treated for :

D19*. Alcohol abuse? ☐☐

D20*. Drug abuse? ☐☐

- Include detoxification, halfway houses, in/outpatient counseling, and AA or NA (if 3+ meetings within one month period).

How many of these were detox only:

D21. Alcohol? ☐☐

D22. Drugs? ☐☐

- If D19 = "00", then question D21 is "NN"
  If D20 = '00', then question D22 is "NN"

How much money would you say you spent during the past 30 days on:

D23. Alcohol? ☐☐☐☐☐

D24. Drugs? ☐☐☐☐☐

- Only count actual ***money*** spent. What is the financial burden caused by drugs/alcohol?

D25. How many days have you been treated as an outpatient for alcohol or drugs in the past 30 days? • Include AA/NA ☐☐

For Questions D28-D31, ask the patient to use the Patient Rating scale. The patient is rating the need for additional substance abuse treatment.

How many days in the past 30 have you experienced:

D26. Alcohol problems? ☐☐

How troubled or bothered have you been in the past 30 days by these

D28. Alcohol problems? ☐

How important to you *now* is treatment for these:

D30. Alcohol problems? ☐

How many days in the past 30 have you experienced:

D27. Drug problems? ☐☐

- Include only: Craving, withdrawal symptoms, disturbing effects of use, or wanting to stop and being unable to.

How troubled or bothered have you been in the past 30 days by these

D29. Drug problems? ☐

How important to you *now* is treatment for these:

D31. Drug problems? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

D34. Patient's misrepresentation? 0-No 1-Yes ☐

D35. Patient's inability to understand? 0-No 1-Yes ☐

ALCOHOL/DRUGS COMMENTS

(Include question number with your notes)

LEGAL STATUS

L1. Was this admission prompted or suggested by the criminal justice system? 0 - No 1 -Yes [ ]
- Judge, probation/parole officer, etc.

L2. Are you on parole or probation? 0 - No 1 -Yes [ ]
- Note duration and level in comments.

How many times in your life have you been arrested and charged with the following:

L3 * Shoplift/Vandal	[ ][ ]	L10* Assault	[ ][ ]
L4 * Parole/Probation	[ ][ ]	L11* Arson	[ ][ ]
L5 * Drug Charges	[ ][ ]	L12* Rape	[ ][ ]
L6 * Forgery	[ ][ ]	L13* Homicide/Mansl.	[ ][ ]
L7* Weapons Offense	[ ][ ]	L14* Prostitution	[ ][ ]
L8* Burglary/Larceny/B&E	[ ][ ]	L15* Contempt of Court	[ ][ ]
L9 * Robbery	[ ][ ]	L16* Other: _________	[ ][ ]

- Include total number of counts, not just convictions. Do not include juvenile (pre-age 18) crimes, unless they were charged as an adult.
- Include formal charges only.

L17* How many of these charges resulted in convictions? [ ][ ]
- If L03-16 = 00, then question L17 = "NN".
- Do not include misdemeanor offenses from questions L18-20 below.
- Convictions include fines, probation, incarcerations, suspended sentences, and guilty pleas.

How many times in your life have you been charged with the following:

L18.* Disorderly conduct, vagrancy, public intoxication? [ ][ ]

L19.* Driving while intoxicated? [ ][ ]

L20.* Major driving violations? [ ][ ]
- Moving violations: speeding, reckless driving, no license, etc.

L21* How many months were you incarcerated in your life? [ ][ ]
- If incarcerated *2 weeks or more*, round this up to 1 month. List total number of months incarcerated.

L24. Are you presently awaiting charges, trial, or sentence? 0 - No 1 - Yes [ ]

L25. What for? [ ][ ]
- Use the number of the type of crime committed: 03-16 and 18-20
- Refers to Q. L24. If more than one, choose most severe.
- Don't include civil cases, unless a criminal offense is involved.

L26. How many days in the past 30, were you detained or incarcerated? [ ][ ]
- Include being arrested and released on the same day.

LEGAL COMMENTS

(Include question number with your notes)

LEGAL STATUS (cont.)

L27. How many days in the past 30 have you engaged in illegal activities for profit? ☐☐

- Exclude simple drug possession. Include drug dealing, prostitution, selling stolen goods, etc. May be cross checked with Question E17 under Employment/Family Support Section.

For Questions L28-29, ask the patient to use the Patient Rating scale.

L28. How serious do you feel your present legal problems are? ☐

- Exclude civil problems

L29. How important to you *now* is counseling or referral for these legal problems? ☐

- Patient is rating a need for ***additional*** referral to legal counsel for defense against criminal charges.

CONFIDENCE RATINGS

Is the above information significantly distorted by:

L31. Patient's misrepresentation? 0 - No 1- Yes ☐

L32. Patient's inability to understand? 0 - No 1 - Yes ☐

LEGAL COMMENTS

(Include question number with your notes)

FAMILY/SOCIAL RELATIONSHIPS

F1. Marital Status: ☐
1-Married 3-Widowed 5-Divorced
2-Remarried 4-Separated 6-Never Married
- Common-law marriage = 1. Specify in comments.

F3. Are you satisfied with this situation? ☐
0-No 1-Indifferent 2-Yes
- Satisfied = generally liking the situation. - Refers to Questions F1 & F2.

F4.* Usual living arrangements (past 3 years): ☐
1-With sexual partner & children
2-With sexual partner alone
3-With children alone
4-With parents
5-With family
6-With friends
7-Alone
8-Controlled Environment
9-No stable arrangement
- Choose arrangements most representative of the past 3 years. If there is an even split in time between these arrangements, choose the most recent arrangement.

F6. Are you satisfied with these arrangements? ☐
0-No 1-Indifferent 2-Yes

Do you live with anyone who:

F7. Has a current alcohol problem? 0-No 1-Yes ☐

F8 Uses non-prescribed drugs? 0-No 1-Yes ☐

F9. With whom do you spend most of your free time? 1-Family 2-Friends ☐
Alone
- If a girlfriend/boyfriend is considered as family by patient, then they must refer to them as family throughout this section, not a friend.

F10. Are you satisfied with spending your free time this way? 0-No 1-Indifferent 2-Yes ☐
- A satisfied response must indicate that the person generally likes the situation. Referring to Question F9.

Have you had significant periods in which you have experienced serious problems getting along with:

0 - No 1 - Yes

	Past 30 days	In Your Life
F18. Mother	☐	☐
F19. Father	☐	☐
F20. Brother/Sister	☐	☐
F21. Sexual Partner/Spouse	☐	☐
F22. Children	☐	☐
F23. Other Significant Family (specify)____________	☐	☐
F24. Close Friends	☐	☐
F25. Neighbors	☐	☐
F26. Co-workers	☐	☐

- "Serious problems" mean those that endangered the relationship.
- A "problem" requires contact of some sort, either by telephone or in person.

Did anyone abuse you? 0- No 1-Yes

	Past 30 days	In Your Life
F28. Physically? • Caused you physical harm.	☐	☐
F29. Sexually? • Forced sexual advances/acts.	☐	☐

FAMILY/SOCIAL COMMENTS

(Include question number with your notes)

FAMILY/SOCIAL (cont.)

How many days in the past 30 have you had serious conflicts:

F30. With your family? ☐☐

For Questions F32-34, ask the patient to use the Patient Rating scale.

How troubled or bothered have you been in the past 30 days by:

F32. Family problems ? ☐

F**How important to you now is treatment or counseling for these:**

F34. Family problems ☐

- Patient is rating *his/her* need for counseling for family problems, not whether the family would be willing to attend.

How many days in the past 30 have you had serious conflicts:

F31. With other people (excluding family)? ☐☐

For Questions F33-35, ask the patient to use the Patient Rating scale.

How troubled or bothered have you been in the past 30 days by:

F33. Social problems? ☐

How important to you now is treatment or counseling for these:

F35. Social problems ☐

- Include patient's need to seek treatment for such social problems as loneliness, inability to socialize, and dissatisfaction with friends. Patient rating should refer to dissatisfaction, conflicts, or other serious problems.

CONFIDENCE RATING

Is the above information significantly distorted by:

F37. Patient's misrepresentation? 0-No 1-Yes ☐

F38. Patient's inability to understand? 0-No 1-Yes ☐

FAMILY/SOCIAL COMMENTS

(Include question number with your notes)

PSYCHIATRIC STATUS

How many times have you been treated for any psychological or emotional problems:

P1.* In a hospital or inpatient setting? ☐☐

P2.* Outpatient/private patient? ☐☐

- Do not include substance abuse, employment, or family counseling.

Treatment episode = a series of more or less continuous visits or treatment days, not the number of visits or treatment days.

- Enter diagnosis in comments if known.

P3. Do you receive a pension for a psychiatric disability? ☐

0-No 1-Yes

Have you had a significant period of time (that was not a direct result of alcohol/drug use) in which you have:

0-No 1-Yes

	Past 30 Days	Lifetime
P4. Experienced serious depression-sadness, hopelessness, loss of interest, difficulty with daily function?	☐	☐
P5. Experienced serious anxiety/ tension, uptight, unreasonably worried, inability to feel relaxed?	☐	☐
P6. Experienced hallucinations-saw things or heard voices that were not there?	☐	☐
P7. Experienced trouble understanding, concentrating, or remembering?	☐	☐
For Items P8-10, Patient can have been under the influence of alcohol/drugs.		
P8. Experienced trouble controlling violent behavior including episodes of rage, or violence?	☐	☐
P9. Experienced serious thoughts of suicide? • Patient seriously considered a plan for taking his/her life.	☐	☐
P10. Attempted suicide? • Include actual suicidal gestures or attempts.	☐	☐
P11. Been prescribed medication for any psychological or emotional problems? • Prescribed for the patient by MD. Record "Yes" if a medication was prescribed *even if* the patient is not taking it.	☐	☐

P12. How many days in the past 30 have you experienced these psychological or emotional problems? ☐☐

- This refers to problems noted in Questions P4-P10.

For Questions P13-P14, ask the patient to use the Patient Rating scale

P13. How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days? ☐

- Patient should be rating the problem days from Question P12.

P14. How important to you *now* is treatment for these psychological or emotional problems? ☐

CONFIDENCE RATING

Is the above information significantly distorted by:

P22. Patient's misrepresentation? 0-No 1-Yes ☐

P23. Patient's inability to understand? 0-No 1-Yes ☐

PSYCHIATRIC STATUS COMMENTS

(Include question number with your comments)

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(Sponsored by: QuickStart Systems, Inc.)

Dr. David Metzger
A. Thomas McLellan, Ph.D.

Remember: This is an interview, not a test.

Call QuickStart Systems at (214)342-9020 for:
- Free copies of the Youth Assessment Index
- Free copies of the Clinical/Training ASI
- The Easy-YAI software, and
- Other Treatment Tracking Software.

INTRODUCING THE YAI:
Eight potential problem areas:
Current living situation, Legal, Medical, Family Relationships, Education/Work, Drug/Alcohol, Psycho/Social Adjustment, and Personal Relationships. All clients receive this same standard interview. All information gathered is confidential.
There are two time periods we will discuss:
0 - Has never occurred
1 - Occurred more than 30 days ago
2 - Occurred the last 30 days
3 - Occurred during and before the last 30 days
Client Input:
Client input is important. For each area, I will ask you to let me know how bothered you have been by any problems in each section. I will also ask you how important counseling is to you for the area being discussed. The response to these questions will be a yes or no.

If you are uncomfortable giving an answer, then don't answer. *Please do not give inaccurate information! Remember: This is an interview, not a test.*

INTERVIEWER INSTRUCTIONS:
1. Leave no blanks.
2. Make plenty of Comments (if another person reads this YAI, they should have a relatively complete picture of the client's perceptions of his/her problems).
3. X = Question not answered.
4. N = Question not applicable.
5. Privately interview the youth about drug and alcohol use and personal relationships unless parents are reluctant or unwilling to leave.

HALF TIME RULE: If a question is interested in the number of months, round up periods of 14 days or more to 1 month. If the question is only interested in the number of years, round up 6 months or more to 1 year.

ALCOHOL/DRUG USE INSTRUCTIONS:
The following questions look at two time periods: the past 30 days and lifetime. Lifetime refers to the time prior to the last 30 days.

> 30 day questions only require the number of days used.
> Lifetime use is asked to determine extended periods of use.
> How to ask these questions:
> How many days in the past 30 have you used....?
> How many years in your life have you regularly used....?
> Use 99 percent to represent number of times used is one hundred or more

01 = Family /Friend
05 = Self Referral
06 = Employer
07 = School
09 = Technician Alternatives to Street Crime (TASC)
32 = Physician
33 = Council on alcohol and Drug Abuse
34 = Employee Assistance Program (EAP)
37 = Clergy
38 = Texas Rehabilitation Commission (TRC)
39 = Court Commitment
40 = Texas Dept. of Human Services (DPW, DHR)
41 = Substitute for Foster Care
50 = State Hospital Outreach Program
51 = AA, NA, Alanon, Alateen, Other Peer Support
52 = Community MHMR Center
53 = Other Non-Residential Program
60 = State Hospital
61 = Other Hospital
62 = Halfway House - Intermediate Care
63 = Long Term Care
64 = Non-Hospital Detox Facility
65 = Other Residential Program
70 = Police
71 = Probation (non-DWI)
72 = Probation (DWI)
73 = Parole
74 = Other Law Enforcement
75 = Texas Youth Commission
76 = TDJC/ID
77 = TAIP
78 = City/County Jail
80 = Other Individual
81 = Other Community Agency(not treatment, not law enforcement)

LIST OF COMMONLY USED DRUGS:

Alcohol:	Beer, wine, liquor
Methadone:	Dolophine, LAAM
Opiates:	Pain killers = Morphine, Diluaudid, Demerol, Percocet, Darvon, Talwin, Codeine, Tylenol 2,3,4, Syrups = Robitussin, Fentanyl
Barbiturates:	Nembutal, Seconal, Tuinol, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinol
Sed/Hyp/Tranq:	Benzodiazepines = Valium, Librium, Ativan, Serax Tranxene, Dalmane, Halcion, Xanax, Miltown, Other = ChloralHydrate (Noctex), Quaaludes
Cocaine	Cocaine Crystal, Free-Base Cocaine or "Crack", and "Rock Cocaine"
Amphetamines:	Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetimine, Speed, Ice, Crystal,
Cannabis:	Marijuana, Hashish
Hallucinogens:	LSD(Acid), Mescaline, Mushrooms(Psilocybin), Peyote, Green, PCP (Phencyclidine), Angel Dust, Ecstasy
Inhalants:	Nitrous Oxide, Amyl Nitrate (Whippets, Poppers), Glue, Solvents, Gasoline, Toluene, Etc.
Just note if these are used:	Antidepressants, Ulcer Meds = Zantac, Tagamet Asthma Meds = Ventoline Inhaler, Theodur Other meds = Antipsychotics, Lithium

Source or referral:

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Section I: General Information

Interview site____________________________________

Date: _____/_____/_____

Case #: [| | | | | | | | |]

Interviewer: [| | |]

Initial/Follow-up: I=Initial F=Follow-up [ ]

1.____
First Name Middle Last Name

2.____
Address Line 1

____
Address Line 2

____
City State Zip Code County

(_____) ________-___________
Home Phone Number

(_____) ________- ___________ Ext.________
Work Phone number

3. Sex : 1=Male 2=Female [ ]

4. Race: [ ]

1. White(not Hisp.)
2. African American (not Hisp.)
3. Hispanic-Mexican American
4. Hispanic-Mexican National
5. Hispanic-Puerto Rican
6. Hispanic-Cuban
7. Hispanic-Other
8. Alaskan Native
9. Asian/Pacific
0. Other
x. Unknown

5. Date of Birth: _____/_____/_____ Age: YEARS [|]

6.a. Your (youth's) Marital Status: [ ]
0=Never Married 1=Married 2=Divorced 3=Separated

b. Have you had any children (yes/no)? 0=No 1=Yes [ ]

c. Are you currently responsible for the care of any children(yes/no)? 0=No 1=Yes [ ]

7. SSN: [| |] - [|] - [| | |]

8. Health Insurance type: [ ]

0=No health insurance
1=Blue Cross/Blue Shield WITHOUT Substance Abuse Coverage
2=Other private insurance WITHOUT Substance Abuse Coverage
3=Blue Cross/Blue shield WITH Substance Abuse Coverage
4=Other private insurance WITH Substance Abuse Coverage
5=Medicaid
6=Medicare
7=CHAMPUS
8=Other Public Funds For Health Care
X=Unknown

9. ____
Insurance Provider Name

10. Ins. Policy #: [| | | | | | | | |]

11. ____
Insurance Provider Address Line 1

____
Insurance Provider Address Line 2

____
Insurance Provider's City State Zip

12. Source of referral: (see cover page) [|]

If referred by probation/parole (or if currently on probation /parole) :

13. ____
Probation/Parole Officer Name:

14. (______)_______-__________Ext:__________
Probation /Parole Officer Phone Number

15. ____
Judge Name

16. Case Number [| | | | | | | | |]

17. Charge Code [| | | | |]

18. ____
Charge Description

19. Other available documents on file (check all that apply):

a.) _____ Drug and Alcohol Assessment
b.) _____ School/Employment
c.) _____ Police
d.) _____ Psychological
e.) _____ Other ________________________

20. Does adolescent: [ ]

1=Understand and agree with the reason for the interview?
2=Agree?
3=understand?
4=Niether understand nor agree.

General Information Comments:
(Include the question number with your notes)

____

____

____

____

____

____

____

Section II: Current Living Situation

1. Have you been in a controlled environment in the past 30 days? [ ] #DAYS [|]

1. No
4. Residential Treatment

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2. Group Home
3. Prison
5. Hospital-Based Program

2. With whom do you live (current caretakers)? ☐

1=Both Parents
2=Mother Only
3=Father Only
4=Mother & Stepfather
5=Father & Stepmother
6=Substitute or Foster Care
7=Institution
8=Alone
9=other
0=Other Relatives
A=Friends

3a. Current marital status of natural parents: ☐

0=Never Married
1=Married and living together
2=Divorced
3=Separated (married, not living together nor incarcerated)
4=Both Deceased
5=Father Deceased
6=Mother Deceased

3b. If either parent(s) is (are) deceased, how old were you at the time of their death: Mother ☐☐ Father ☐☐

3c. Who has custody if parents are divorced/separated? ☐

N=N/A, Not divorced/separated
1=N/A, Youth is over 18
2=Father
3=Mother
4=Other Individual
5=Institution
6=Other

4. HEAD OF HOUSEHOLD:

a. Name: ______________________
b. Relationship: ______________________
c. Address: ______________________

City State Zip County

d. Phone: (________)________-__________
e. Date of Birth: ______/______/______ ☐☐
f. Social Security #: ☐☐☐ ☐☐ ☐☐☐☐
g. Current employment Status: ☐

1=Unemployed, has not sought employment in the last 30 days
2=Unemployed, has sought employment in last 30 days
3=Part-Time (less than 35 hours/week)
4=Full- Time (35 or more hours/week)

<<if working>>

h. Occupation:______________________
i. Employer: ______________________
j. Address: ______________________

(city) (state) (zip) (county)

k. (______)_____-_________ Hours:___:___-___:___
Work Phone From To

<<If not working>>

l. Primary reason for no paid employment ☐

0=Cannot find a job
1=Unable to work for health reasons
2=unable to keep job due to substance abuse problems
3=Needed at home to work or take care of other family members
4=Attending School
5=Not interested in working
6=Lack of transportation
7=Lack of job skills
8=Retired
9=Other
N=Not applicable (employed)

m. Income:

Employment:	$______	Pension:	$______
Public Assistance:	$______	Family:	$______
Disability:	$______	Illegal:	$______

n. Marital status of Head of Household:

0=Never Married
1=Married and living together
2=Divorced
3=Separated(married, not living together nor incarcerated)
4=Deceased

o. Highest Grade Completed: ☐☐

5. OTHER PRIMARY CARETAKER:

a. Name: ______________________
b. Relationship: ______________________
c. Address: ______________________

City State Zip County

d. Phone: (________)________-__________
e. Date of Birth: ______/______/______ ☐☐
f. Social Security #: ☐☐☐ ☐☐ ☐☐☐☐
g. Current employment Status: ☐

1=Unemployed, has not sought employment in the last 30 days
2=Unemployed, has sought employment in last 30 days
3=Part-Time (less than 35 hours/week)
4=Full- Time (35 or more hours/week)

<<if working>>

h. Occupation:______________________
i. Employer: ______________________
j. Address: ______________________

(city) (state) (zip) (county)

k. (______)_____-_________ Hours:___:___-___:___
Work Phone From To

<<If not working>>

l. Primary reason for no paid employment ☐

0=Cannot find a job
1=Unable to work for health reasons
2=unable to keep job due to substance abuse problems
3=Needed at home to work or take care of other family members
4=Attending School
5=Not interested in working
6=Lack of transportation
7=Lack of job skills
8=Retired
9=Other
N=Not applicable (employed)

m. Income:

Employment:	$______	Pension:	$______
Public Assistance:	$______	Family:	$______
Disability:	$______	Illegal:	$______

n. Marital status of Head of Household:

0=Never Married
1=Married and living together
2=Divorced
3=Separated(married, not living together nor incarcerated)
4=Deceased

o. Highest Grade Completed: ☐☐

6. OTHER INVOLVED ADULTS:

a. ______________________
Name

b. ______________________
Relationship

c. ______________________

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Address

City State Zip County

d. (__________)_________-________________
Phone

e. Date of Birth: ________/________/_______ Age [ ][ ]

f. Social Security #: [ ][ ][ ] [ ][ ] [ ][ ][ ][ ]

g. Current employment Status: [ ]
1=Unemployed, has not sought employment in the last 30 days
2=Unemployed, has sought employment in last 30 days
3=Part-Time (less than 35 hours/week)
4=Full- Time (35 or more hours/week)

<<if working>>

h. Occupation:_______________________________

i. _______________________________
Employer

j. _______________________________
Address

(city) (state) (zip) (county)

k. (_____)_____-________ Hours:___:___-___:___
Work Phone From To

7. OTHER INVOLVED ADULTS:

a. _______________________________
Name

b. _______________________________
Relationship

c. _______________________________
Address

City State Zip County

d. (__________)_________-________________
Phone

e. Date of Birth: ________/________/_______ Age [ ][ ]

f. Social Security #: [ ][ ][ ] [ ][ ] [ ][ ][ ][ ]

g. Current employment Status: [ ]
1=Unemployed, has not sought employment in the last 30 days
2=Unemployed, has sought employment in last 30 days
3=Part-Time (less than 35 hours/week)
4=Full- Time (35 or more hours/week)

<<if working>>

h. Occupation:_______________________________

i. _______________________________
Employer

j. _______________________________
Address

(city) (state) (zip) (county)

k. (_____)_____-________ Hours:___:___-___:___
Work Phone From To

Comments on Current Living Situation:
(Include the question number with your notes)

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SECTION III: LEGAL

(Include the question number with your notes)

1. Do you have a drivers license? 0=No 1=Yes ☐
   a.) Have your driving privileges ever been postposed, suspended or revoked? 0=No 1=Yes ☐

2. Have you ever been picked up by the police? 0=No 1=Yes ☐

   a.) How many times and at what age(first time)? Times ☐☐ Years ☐☐

3. Have you ever been taken to a police station? 0=No 1=Yes ☐

4. Have you ever been locked up? 0=No 1=Yes ☐

5. Have you ever been in front of a judge? 0=No 1=Yes ☐

6. Do you have a probation officer now? 0=No 1=Yes ☐

   a.)____
   (Probation Officer name)

   b.) (_______)_________-_____________ Ext:__________
   Probation officer's phone number

7. Are you currently facing charges or waiting to see a judge? 0=No 1=Yes ☐

8. Have you ever spent time in jail or in a detention center? 0=No 1=Yes ☐ DAYS ☐☐

9. When do you feel a need to defend yourself, what do you use (carry)? ☐
   0=Nothing 2=Guns
   1=Knives 3=Other (specify in comments)

10. Have you ever had a weapon taken away from you? 0=No 1=Yes ☐

11. When involved with the legal system, was:
    a.) someone hurt? 0=No 1=Yes ☐
    b.) property damaged? 0=No 1=Yes ☐

12. Do you think that you have legal problems? 0=No 1=Yes ☐

13. Would you like counseling for these problems? 0=No 1=Yes ☐

14. Interviewer Severity Rating: 0=No Need 1=Minor 2=Moderate 3=Urgent ☐

15. Confidence Rating: 0=No 1=Yes ☐

Comments on Legal Section:

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SECTION IV: MEDICAL

1. How long ago was your last physical examination? MONTHS [ ][ ]
2. Do you have any chronic medical problems (e.g. diabetes, asthma, allergies, etc)? 0=No 1=Yes [ ]
3. Are you taking any prescribed medication at this time? 0=No 1=Yes [ ]
4. Have you had to visit an emergency room in the past year? 0=No 1=Yes [ ] TIMES [ ][ ]
5. Do you feel that you have a medical problem? 0=No 1=Yes [ ]
6. Would you like treatment for these medical problems? 0=No 1=Yes [ ]
7. Interviewer Severity Rating: 0=No need 1=Minor 2=Moderate 3=Urgent [ ]
8. Confidence Rating 0=No 1=Yes [ ]

SECTION V: FAMILY RELATIONSHIPS

1. Has your living arrangement changed in the past year? 0=No 1=Yes [ ]
2. Are you unhappy or dissatisfied with the current situation at home? 0=No 1=Yes [ ]
3. Have you ever lived away from home or parents (or current guardians)? 0=No 1=Yes [ ]
4. Have any of your brothers or sisters ever had to live away from home before they were eighteen years old? 0=No 1=Yes [ ]
5. Have you ever run away from home? 0=No 1=Month + 2=Past Mo. 3=Past&Bfr [ ] TIMES [ ][ ]
6. Is there a lot of arguing or fighting in your house? <OPT> If yes, how many times? 0=No 1=Yes [ ] TIMES [ ][ ]
7. Have you ever been a member of a gang? 0=No 1=Yes [ ]

   a) _______________________________ b) Age at Start: YEARS [ ][ ]

   <OPT> Gang Name
8. Has any member of your immediate family or household?
   a) been arrested? 0=No 1=Month + 2=Past Mo. 3=Past&Bfr [ ]
   b) been hospitalized overnight or longer? 0=No 1=Month + 2=Past Mo. 3=Past&Bfr [ ]
   c) died? 0=No 1=Month + 2=Past Mo. 3=Past&Bfr [ ]
9. Have you ever:
   a) had serious problems in getting along with anyone in your household? 0=No 1=Month + 2=Past Mo. 3=Past&Bfr [ ]
   b) had a physical fight with either of your parents /guardians? 0=No 1=Month + 2=Past Mo. 3=Past&Bfr [ ]
   c) been involved in family counseling, or had a caseworker assigned to visit your family? 0=No 1=Month + 2=Past Mo. 3=Past&Bfr [ ]
10. Do you feel that you have a family problem? 0=No 1=Yes [ ]
11. Would you like counseling for these problems? 0=No 1=Yes [ ]
12. Interviewer Severity Rating: 0=No Need 1=Minor 2=Moderate 3=Urgent [ ]
13. Confidence Rating 0=No 1=Yes [ ]

Comments on Medical Section:
(Include the question number with your notes)

Comments on Family Relationships:
(Include the question number with your notes)

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SECTION VI: EDUCATION/WORK

1. ____________________
Name of current or last school attended

2. ____________________
School Address Line 1

____
School Address Line 2

3. Current School Status: [ ]
1 = Graduated (or GED)
2 = Quit or dropped out
3 = Suspended
4 = Still in School(incl. Summer vacn).
5 = Enrolled in other educational skill development program
6 = Enrolled in or transferred from an institutional educational program

4. Current or highest grade completed: [ ][ ]

5. Days absent from school during last 6 week period: Days [ ][ ]

6. Have you ever received any special programming? 0=No 1=Yes [ ]

7. Number of D's or F's on last report card: [ ][ ]

a.) <OPT> Are you currently failing any classes? 0=No 1=Yes [ ]

8. Have you ever failed or repeated a grade: 0=No 1=Yes [ ] Times [ ][ ]

9. How many times have you been suspended or expelled (include in-school suspensions): Times [ ][ ]

a. Suspended? Times [ ][ ] b. Expelled? Times [ ][ ]

c. Are you currently suspended or expelled 0=No 1=Yes [ ]

d. # of days suspended in the last 6 weeks? Days [ ][ ]

10. Do you plan on graduating (or getting a GED)? 0=No 1=Yes [ ]

11. Have you ever:

a. skipped school or cut classes more than one time a week? 0=No 1=Month+ 2=Past Mo. 3=Past&Bfr [ ]

b. <OPT> If yes, have you gotten high when you skip? 0=No 1=Yes [ ]

c. had your parents been called by the school because of your behavior? 0=No 1=Month+ 2=Past Mo. 3=Past&Bfr [ ]

d. Had a serious argument or fight with a teacher? 0=No 1=Month+ 2=Past Mo. 3=Past&Bfr [ ]

12. What are your current source(s) of income(check all that apply):

__ Employment __ Public Assistance __ Other
__ Parents __ Social Security

<<If working>> a. Number of hours: Hours [ ][ ]

b. Net Income/week: $ [ ][ ][ ][ ]

13. Have you ever been fired from a job? 0=No 1=Yes [ ]

14. On average, how many weeks do you stay on a job? Weeks [ ][ ]

15. Do you have any skills or training that could help you get a job? (If yes, specify in comments). 0=No 1=Yes [ ]

16. Do you feel that you have a school or work problem? 0=No 1=Yes [ ]

17. Would you like counseling for these problems? 0=No 1=Yes [ ]

18. Interviewer Severity Rating: 0=No Need 1=Minor 2=Moderate 3=Urgent [ ]

19. Confidence Rating: 0=No 1=Yes [ ]

SECTION VII: DRUG / ALCOHOL

Comments on Education/Work:
(Include the question number with your notes)

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1. How many of your five closest friends:
a. Smoke [ ][ ] b. Drink [ ][ ] c. Do Drugs [ ][ ]

2. Do you smoke cigarettes? 0=NO 1=YES [ ]
a. <OPT> If yes, how old were you when you started smoking regularly (3 or more times/week)? YEARS [ ][ ]

3. Substance Abuse Patterns:
a. Have you ever used drugs & alcohol? 0=NO 1=YES [ ]
<<IF NO ALCOHOL OR DRUG USE IS REPORTED IN #3a, SKIP TO QUESTION #5>>

b.

SUBSTANCE:	CODAP Code	1ST AGE	#TIMES LAST YR	#TIMES LAST MO.	CODAP FREQ <OPT>	CODAP ROUTE <OPT>
ALCOHOL	04					
MARIJUANA	09					
COCAINE	08					
CRACK	08					
INHALANTS	11					
SPEED	07					
TOTAL DEPRESSANTS	05					
HALLUCINOGENS	10					
HERION	01					
NON-RX METHADONE	02					
OTHER OPIATES	03					
OVER-THE-COUNTER	12					
TRANQUILIZERS	13					
ECSTACY	15					
PCP	21					
OTHER	14					
TOTAL OTHER						

The frequency and Route columns in the substance table are not required or entered into the computer system. They are used to gather data for the CODAP summary below.

c. <OPT> CODAP Summary:
(To be filled out by interviewer after interview)

PROBLEMS	Primary	Secondary	Tertiary
Substances:			
Severity:			
Frequency:			
Route:			
Year of 1st use:			

SEVERITY
0=Use (not a problem)
1=Primary
2=Secondary
3=Tertiary

FREQUENCY
0=None, did not happen
1=Less than once/week
2=Once per week
3=Several times/week
4=Once daily
5=2 to 3 times daily
6=More than 3 times daily

ROUTE OF ADMIN
1=Oral
2=Smoking
3=Inhalation
4=Intramuscular
5=Intravenous

Comments on Alcohol/Drug use:
(Include the question number with your notes)

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4. Have you ever:
   a. used drugs or alcohol before or during school? (0=No 1=Month+ 2=Past Mo. 3=Past&Bfr) ☐
   b. missed school because you were hung over? (0=No 1=Month+ 2=Past Mo. 3=Past&Bfr) ☐
   c. missed work because you were high or hung over? (0=No 1=Month+ 2=Past Mo. 3=Past&Bfr) ☐
   d. been told you should cut down or stop using drugs or alcohol? (0=No 1=Month+ 2=Past Mo. 3=Past&Bfr) ☐
   e. been in a program to get help for a drug problem? (0=No 1=Month+ 2=Past Mo. 3=Past&Bfr) ☐
   f. been in a program to get help for an alcohol problem? (0=No 1=Month+ 2=Past Mo. 3=Past&Bfr) ☐
   g. gotten into trouble (including this incident) for things you've done while you were using drugs or alcohol? (0=No 1=Month+ 2=Past Mo. 3=Past&Bfr) ☐

5. Have you ever been:
   a. at a party where alcohol was served? (0=No 1=Month+ 2=Past Mo. 3=Past&Bfr) ☐
   b. at a party where drugs were available? (0=No 1=Month+ 2=Past Mo. 3=Past&Bfr) ☐
   c. accused by your parents, teachers, or employer of being drunk or high? (0=No 1=Month+ 2=Past Mo. 3=Past&Bfr) ☐
   d. in a car where the driver or others were using drugs or alcohol? (0=No 1=Month+ 2=Past Mo. 3=Past&Bfr) ☐

6. Have any of you FRIENDS ever:
   a. asked you to get drugs or alcohol for them? (0=No 1=Month+ 2=Past Mo. 3=Past&Bfr) ☐
   b. tried to get you to drink or use drugs? (0=No 1=Month+ 2=Past Mo. 3=Past&Bfr) ☐
   c. been treated for drug or alcohol problems? (0=No 1=Month+ 2=Past Mo. 3=Past&Bfr) ☐

7. How much money have you spent during the last month on:
   a. Alcohol $ ☐☐☐☐
   b. Drugs $ ☐☐☐☐

8. Do either of your parents or other members of your household have (or have had) a drug or alcohol problem?

Mother: (0=NO 1=YES) ☐ Father: (0=NO 1=YES) ☐
Brothers/Sisters (0=NO 1=YES) ☐ Other Relatives: (0=NO 1=YES) ☐
Other Non-Related (0=NO 1=YES) ☐

9. Are you permitted to drink at home (excluding small amounts on special occasions)? (0=NO 1=YES) ☐

10. Do you feel that you have drug/alcohol problems? (0=NO 1=YES) ☐

11. Would you like treatment or counseling for these problems? (0=NO 1=YES) ☐

12. Interveiwer Severity Rating: (0=No Need 1=Minor 2=Moderate 3=Urgent) ☐

13. Confidence Rating: (0=NO 1=YES) ☐

Comments:
(Include the question number with your notes)

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SECTION VIII: PSYCHO/SOCIAL ADJUSTMENT

1. Have you ever been treated for an emotional problem by a psychiatrist, psychologist or other counselor? (0=NO 1=YES) ☐
   (If yes, specify name, company name and address in comments).

2. Has there been a time (a few days or more) when you have:

a. felt very unhappy, sad, depressed?	☐	f. had trouble falling or staying asleep?	☐
b. felt worried, afraid, scared?	☐	g. lost your appetite or worried about your weight?	☐
c. felt very lonley, all alone, isolated?	☐	h. heard voices?	☐
d. felt like a failure or worthless?	☐	i. seen things?	☐
e. had trouble controlling your anger?	☐		

SCALE

0=No	2=Past Mo.
1=Month+	3=Past& Bfr.

3. Have you ever had serious thoughts of hurting yourself? (0=No Need 1=Minor 2=Moderate 3=Urgent) ☐

4. Have you ever attempted suicide? (0=No Need 1=Minor 2=Moderate 3=Urgent) ☐

5. Have you ever:

   a. had trouble making or keeping friends? (0=NO 1=YES) ☐

   b. had serious problems with your girlfriend/boyfriend? (0=NO 1=YES) ☐

   c. felt like no one really cared about you? (0=NO 1=YES) ☐

   d. gotten into trouble because of your friends? (0=NO 1=YES) ☐

   e. gambled? (0=NO 1=YES) ☐

6. Do you think that you have emotional problems? (0=NO 1=YES) ☐

7. Would you like counseling for these problems? (0=NO 1=YES) ☐

8. Interviewer Severity Rating: (0=No Need 1=Minor 2=Moderate 3=Urgent) ☐

9. Confidence Rating: (0=NO 1=YES) ☐

Comments on Psycho/Social Adjustment:
(Include the question number with your notes)

SECTION IX: PERSONAL RELATIONSHIPS

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1. Have you ever had a serious relationship (boyfriend or girlfriend)? 0=NO 1=YES [ ]
2. Are you currently involved in a serious relationship? 0=NO 1=YES [ ]
   a. If yes, are you unhappy or dissatisfied with this relationship? 0=NO 1=YES [ ]
3. Have you ever had sex? <<If no, skip to question#11>> 0=NO 1=YES [ ]
4. How old were you when you first had sex? YEARS [ ][ ]
5. How many sexual partners have you had in the last six months? [ ][ ]
6. Have you ever had sex without using precautions? 0=NO 1=YES [ ]
7. How about in the last six months? 0=NO 1=YES [ ]
8. What methods of protection do you currently use:

a. Nothing	0=SOME 1=EVERY [ ]	e. Condom	0=SOME 1=EVERY [ ]
b. Withdrawal	0=SOME 1=EVERY [ ]	f. Implant	0=SOME 1=EVERY [ ]
c. Diaphram	0=SOME 1=EVERY [ ]	g. Other	0=SOME 1=EVERY [ ]
d. B. C. Pill	0=SOME 1=EVERY [ ]	(Specify in comments)	

9. Have you ever had a sexually transmitted disease (like gonorrhea, clap, VD, etc.) 0=NO 1=YES [ ]
10. a. <FEMALE>Have you ever been pregnant? 0=NO 1=YES [ ]
    b. <MALE>Have you ever gotten somebody pregnant? 0=NO 1=YES [ ]
11. Have you been taught about avoiding HIV/AIDS? Can you tell me how someone can avoid getting AIDS? (Specify in comments) 0=NO 1=YES [ ]
12. Have you ever been abused:
    a. Physically? 0=NO 1=YES [ ]
    b. Sexually? 0=NO 1=YES [ ]
    c. If yes, was the incident investigated? 0=NO 1=YES [ ]
    d. Have you ever physically or sexually abused someone else? 0=NO 1=YES [ ]
13. Have you ever seriously considered calling the police because of the way members of your household were acting? (If yes, specify in comments). 0=NO 1=YES [ ]
14. Have you ever been forced/pressured into having sex? 0=NO 1=YES [ ]
    a. If no, have you ever been touched in a way that you did not like? 0=NO 1=YES [ ]
    b. Have you ever forced/pressured someone into having sex? 0=NO 1=YES [ ]
15. If 12, 13, 14 or 14a is YES, are you currently in a relationship where this is happening? 0=NO 1=YES [ ]
16. Do you need help/counseling on the above subjects? 0=NO 1=YES [ ]
17. Interviewer Severity Rating: 0=No Need 1=Minor 2=Moderate 3=Urgent [ ]
18. Confidence Rating 0=NO 1=YES [ ]

Comments on Personal Relationships:
(Include the question number with your notes)

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SECTION X: PROFILE

(Include the question number with your notes)

1. Severity Profile:

	0	1	2	3
Legal				
Family				
Education				
Medical				
Psy. /Soc. Adj.				
Substance use				
Personal				

2. Guardian Assessment:

	Agree	Disagree
Legal		
Family		
Education		
Medical		
Psy./Soc. Adj.		
Substance use		
Personal		

Relationship of Rater: ______________________________

3. Overall Confidence Rating:

Do you feel the information is significantly distorted by:

a. Client's misrepresentation? 0=NO 1=YES [ ]

b. Client's inability to understand? 0=NO 1=YES [ ]

4. How long did this interview last? MINUTES [| |]

Comments on Profile:

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Co-Occurring Conditions Screening Form

REQUIRED FORM:

This form is an optional document in client file

WHEN:

Completed at Screening/Intake Admission

COMPLETED BY:

Client will complete the questionnaire and authorized agency representative will review and score

REQUIRED ELEMENTS:

(Co-occurring conditions screening form, page 1)

- **Client Name:** Complete the client's full name.
- **Program Name:** Complete the program's name.
- **Sections one, two, and three:** Client responds yes or no by checking each question
- **Client Signature:** Complete with client signature.
- **Date:** Complete the date the form is completed.

(Co-occurring conditions scoring form, page 2)

- **Staff scoring page one must follow directions outlined on page two.**
- **Observations/Comments:** Staff documents any observations or makes additional comments.
- **Referral(s) Made:** Document any referral given to client based on this screening.
- **Staff Signature:** Staff scoring the form must sign.
- **Date:** Complete the date the screening was completed.

NOTES:

This form is used as a screening tool for determining appropriateness of client for a program and/or referral for further mental health assessment. This form is not intended to be used as a diagnostic tool.

CO-OCCURRING CONDITIONS SCREENING FORM

Client Name: _______________________________ Program: _________________________________

SECTION I	YES √	NO √
1. In the past year, have you been diagnosed by a doctor with a mental health condition such as anxiety, depression, bipolar, psychosis, or any other emotional conditions? If yes, specify:		
2. Are you currently taking any medication(s) for mental health or emotional issues? (i.e., Prozac, Paxil, Zoloft, Wellbutrin, Serzone, Lithium, Klonopin, Trazadone, Xanax, Valium, Risperdal, Zyprexa, Clozapine, Depakote, Neurontin, Mellaril, etc.). List medications you take:		
SECTION II		
3. In the past year, have you had any serious thoughts, plans, or attempts of suicide, or serious plans to harm others? If yes, explain:		
4. Have you ever been treated for serious mental health problems? If yes, where (i.e., crisis house, hospital, clinic, etc.)?		
5. Do you receive SSI or SSDI for mental health or emotional problems?		
6. Do you have a history of chronic relapses or failed attempts at sobriety?		
SECTION III		
7. Before you were using any alcohol or drugs, or after you were clean from alcohol and other drugs for 60 days, have you ever:		
A. Felt so depressed that you had difficulty taking care of yourself, going to work or school, or keeping up with family responsibilities?		
B. Felt extreme panic around other people or in public places, or been completely unable to leave the house for a noticeable length of time?		
C. Seen or heard things that other people didn't see or hear, such as seeing shadows or hearing voices telling you what to do?		
D. Felt suspicious of other people, believing that they were following you or spying on you, or talking about you, or were going to harm you?		
E. Believed that someone could control your mind by putting thoughts into or taking thoughts out of your head?		
F. Do things repeatedly in order to keep something bad from happening (i.e., counting, re-checking the door locks, frequent hand-washing, or other rituals)?		
G. Had a period of a week or more when you didn't need to sleep, had constant racing thoughts, or go on spending or sexual binges?		
H. Had unwanted, repeated thoughts or nightmares of a traumatic event that made you feel just as anxious, scared, or numb as when the event happened?		

Client Signature: ____ Date: _____________________

--- *For staff use only*--

CO-OCCURRING CONDITIONS SCORING FORM

DIRECTIONS: For each section, count the number of "yes" answers and put that number by the corresponding score.	
SECTION I: GENERAL SIGNS ***<u>1</u>*** *"yes" to any question in this section* ***<u>plus 1</u>*** *from another section* ***may*** *indicate a need for referral.* *A "yes" in this section is not necessarily an automatic referral point, but should be considered in the referral decision process (use your clinical judgment).*	**SCORE: ______**
<u>SECTION II: Serious Indicators Of The Need For Further Assessment</u> *If* ***<u>1</u>*** *from this section is present, it* ***may*** *mean that referral is important to determine the client's stability level.* *If* ***<u>1</u>*** *from this section is combined with any* ***<u>1</u>*** *of Section III, referral is* ***strongly recommended****.*	**SCORE: ______**
<u>SECTION III: Specific Disorder Indicators</u> *If* ***<u>1</u>*** *from this section with no score in any other section, a referral for assessment* ***may*** *be made during the course of treatment for consultation and/or assessment.* *If* ***<u>2 or more</u>*** *from this section are marked, referral to a dual diagnosis program is* ***recommended****, and* ***strongly recommended*** *when combined with a score in Section II.*	**SCORE: ______**

<u>NOTES</u>:

<u>Section 1, Question #1</u>: If clients states "no" to this question, then ask: Have you ever been diagnosed by a doctor with anxiety, depression, bi-polar, psychosis, or other emotional issues?

<u>Section I, Question #2</u>: If client states they are currently taking no medications for mental health or emotional issues, then ask: Have you ever in your lifetime taken medications for mental health or emotional issues? If yes, what are they and how long did you take each?

<u>Section II, Question #3</u>: If client states that in the past year they have had serious thoughts, plans, or attempts of suicide or serious plans to harm others, then ask how recently and get detailed information.

<u>Section III, Question #7</u>: If client says they have never had a sustained period of sobriety, ask client if they have ever experienced the symptoms listed in A-H.

Observations / Comments: ____

____

____

____

Referral(s) made: ____

Staff Signature: ____ Date: _________________________

Risk Assessment and Safety Management Plan Instructions

REQUIRED FORM:

This form is a required document in the client file.

WHEN:

This form must be completed upon admission and updated as clinically necessary, but at least annually.

COMPLETED BY:

Counselor or LPHA with the client upon admit; if completed by Counselor, then must be reviewed and signed by LPHA.

- **Outpatient programs** – To be reviewed and signed by LPHA within **7 calendar days** from day of admit.
- **Residential programs** – To be reviewed and signed by LPHA within **24 hours** from day of admit.

REQUIRED ELEMENTS:

- **Client Name:** Complete the client's full name.
- **Client ID#:** Complete the client's SanWITS Unique Client Number (UCN).
- **Date:** Complete with date assessment was completed.
- **Assessment of Risk Factors:** Ask the client the questions in **bold** and **underlined**. Document client's responses by checking the boxes marked yes or no. If the client responds "yes" to the 2nd question, then ask questions 3, 4, 5, and 6. If the client responds "no" to the 2nd question, then go directly to question 6.
  - **Note:** Questions 1-5 are regarding the past month and question 6 is about the client's lifetime and the past 3 months.
- **Check the Appropriate Level of Risk:** Select the appropriate level of risk (e.g. no identified risk, low, moderate, or high) at the bottom based on the highest risk level color code of the client's responses.
  - **Note:** Each program is required to develop and implement their own practice guidelines for each level of risk (e.g. Low Risk = a behavioral health referral, Moderate Risk = same day behavioral health evaluation and consider suicide precautions, High Risk = immediate suicide risk precautions). See Safety Management Plan Guidelines for further details.
- **Current Violence/Homicidal Ideation:** Select the appropriate boxes for no, yes, or refuse/cannot assess, following the prompts indicated on the form.
  - **Tarasoff Warning indicated?** Select appropriate answer: No, Yes.
  - **If yes, include potential victim(s) name and contact information (Tarasoff Warning Details):** If yes to Tarasoff Warning indicted, complete victim(s) information.
  - **Tarasoff Reported To:** If the Tarasoff Warning indicated is marked yes, complete this field with the law enforcement agency representative to whom the Tarasoff report was given.
  - **Date:** Complete the date Tarasoff Warning was reported.
- **Current Domestic Violence:** Select the appropriate boxes for no, yes, or refuse/cannot assess, following the prompts indicated on the form.
  - **If yes, detailed documentation and child/adult protective services question mandatory. Describe situation:** Explain the domestic violence situation.
  - **If yes, is a Child Welfare/Adult Protective Services Notification Indicated?** Select appropriate box for No or Yes.

  - **Reported To:** If there is current domestic violence, complete this field with the CWS/APS representative to whom the report was given.
  - **Date:** Complete the date the domestic violence incident was reported.
- **Protective Factors:** Discuss protective factors with client (examples are listed on the form) and ask the client to identify their own protective factors. Document responses in the space provided.
- **Safety Management Plan:** If client is identified at any level of risk, then a Safety Management Plan is required. Staff must document the plan and **ACTIONS** to be taken.
  - **Note:** If found that there is an Immediate Risk and staff is not licensed/licensed eligible, then a consultation with a supervisor must be completed before the client leaves your program.
  - **Safety Management Plan Guidelines**
    Each program must develop internal guidelines for the risk assessment with regards to the Safety Management Plan as what will be the plan of action when someone is identified at the various levels of risk (e.g. low, moderate, high). If the risk assessment is completed by staff that is not licensed/licensed eligible and risk is identified, then a consultation with the supervisor must be included as part of the internal guidelines. The Safety Management Plan may include the following information:
    - Documentation about consultation
    - Considerations of higher level of services or additional services such as case management, more frequent sessions, and/or coordination for care with current mental health treatment providers
    - Coordination with emergency contacts (e.g. client's spouse or parents)
    - Linkage to additional resources such as providing client with referrals to 211 or Access & Crisis Line (1-888-724-7240; TDD/TTY Dial 711)
    - Referrals made to higher level of care such as a crisis house or psychiatric hospital
    - Contacting Psychiatric Emergency Response Team (PERT) or the police
    - If applicable, changes made to the client's treatment plan
    - Frequency of re-assessment for risk
    - The documentation should also include how the use of Protective Factors and coping skills will be employed by the client

Please note: If more room is needed to document Safety Management Plan, please document on a Progress Note and reference the Progress Note in this section

- **Name and Signature of Counselor and Date:** If applicable, Counselor to print or type name, sign and date by hand
- **Name and Signature of *LPHA and Date:** LPHA that completed or reviewed the form to print or type name, sign and date by hand

*Licensed Practitioner of the Healing Arts (LPHA) includes: MD, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

Client Name: _______________________________ Client ID#: _________________________ Date: __________________

Risk Assessment and Safety Management Plan

***COLUMBIA-SUICIDE SEVERITY RATING SCALE** (*Screen Version – Recent*)

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method: Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*" ***Have you been thinking about how you might do this?***		
4) Suicidal Intent: Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question: ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***Were any of these in the past 3 months?***	**Lifetime**	
	Past 3 Months	

Check the Appropriate Level of Risk: ☐ No Identified Risk ☐ Low Risk ☐ Moderate Risk ☐ High Risk

**For inquiries and training information contact: Kelly Posner, Ph.D.*
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Client Name: ____________________ Client ID#: ______________ Date: __________

Risk Assessment and Safety Management Plan

CURRENT VIOLENCE/HOMICIDAL IDEATION:

1) Current violent impulses and/or homicidal ideation? ☐No ☐Yes ☐Refuse/Cannot Assess

2) If yes, are these thoughts towards a reasonably identified victim? ☐No ☐Yes ☐Refuse/Cannot Assess

3) If yes, is a Tarasoff Warning indicated? ☐No ☐Yes

4) If yes, include potential victim(s) name and contact information (Tarasoff Warning Details):

5) Tarasoff Reported To: Date:

CURRENT DOMESTIC VIOLENCE:

6) Have you ever been emotionally or physically abused by your partner or someone important to you?
☐No ☐Yes ☐Refuse/Cannot Assess

7) Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?
☐No ☐Yes ☐Refuse/Cannot Assess

8) If yes, detailed documentation and child/adult protective services questions are mandatory. Describe situation:

9) If yes, is a Child Welfare/Adult Protective Services Notification Indicated? ☐ No ☐Yes

10) Reported To: Date:

PROTECTIVE FACTORS: (strong religious, cultural, or inherent values against harming self/others, strong social support system, positive planning for future, engagement in treatment, valued care giving role (people or pets) and strong attachment/responsibility to others.)

SAFETY MANAGEMENT PLAN: (Document enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care.)

______________________	______________________	______________
Counselor Name (if applicable)	**Counselor Signature** (if applicable)	**Date**
______________________	______________________	______________
***LPHA Name**	***LPHA Signature**	**Date**

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High Risk Assessment (HRA) Instructions

OPTIONAL FORM:

This form is an **OPTIONAL** document in client file

WHEN:

Completed at admission or when clinically indicated

COMPLETED BY:

*LPHA with client

REQUIRED ELEMENTS:

- **Client Name:** Complete the client's full name.
- **Client ID#:** Complete the client's SanWITS Unique Client Number (UCN).
- **Date:** Complete the date assessment was completed.
- **Assessment of Immediate Risk Factors:** Document client's responses by checking the boxes marked yes, no, or refuse/cannot assess.
- **Additional Youth Risk Factors:** For adolescent clients, document response by checking the box marked yes, no, or refuses/cannot assess.
- **Protective Factors:** Discuss protective factors with client (examples are listed on the form) and ask the client to identify their own protective factors. Document responses in the space provided.
- **Self-Injury/Suicide/Violence Management Plan:** If client responds yes to any of the Immediate Risk Factors, completion of a Self-Injury/Suicide/Violence Management Plan is required. Staff should document the developed plan in the space provided.
  <u>Please note:</u> If more room is needed to document Safety Management Plan, please document on a Progress Note and reference the Progress Note in this section
- **Tarasoff Assessment:** Staff checks the corresponding boxes, for yes, no, or refuse/cannot assess, following the prompts indicated on the form.
- **Reported To:** If the Tarasoff assessment is marked yes, complete this field with the law enforcement agency representative to whom the Tarasoff report was given.
- **Current Domestic Violence:** Staff checks the corresponding boxes for yes, no, or refuse/cannot assess, following the prompts indicated on the form.
- **Reported To:** If there is current domestic violence, complete this field with the CPS/APS representative to whom the report was given.
- **Printed Name of *LPHA:** Print or type name of LPHA completing assessment
- **Signature of *LPHA:** LPHA completing assessment hand-signs here
- **Signature Date:** LPHA completing assessment hand-dates here

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NOTES:

Self-Injury/Suicide/Violence Management Plan

This is the safety management plan located in the middle of the first page of the HRA. A safety management plan must be completed documenting the **ACTIONS** to be taken.

What to include in the Self-Injury/Suicide/Violence Management Plan:

- Documentation about any consultation
- Referrals made to higher level of care such as a crisis house or psychiatric hospital
- Referrals to Psychiatric Emergency Response Team (PERT), CPS and/or APS
- Considerations of higher level of services or additional services such as case management, more frequent sessions, and/or coordination for care with current MH treatment providers
- Documentation about any emergency contacts made such as calling the client's spouse or parents
- Linkage to additional resources such as providing client with referrals to 211 or Access & Crisis Line (1-888-724-7240. TDD/TTY Dial 711.)
- If applicable, documentation about changes made to the client's treatment plan
- The documentation should also include how the use of Protective Factors will be employed by the client

HIGH RISK ASSESSMENT (HRA)

CLIENT NAME: ________________________________ CLIENT ID#: _______________________ DATE: ________________

ASSESSMENT OF IMMEDIATE RISK FACTORS: Any "yes" response triggers enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.

Direct (past 2 weeks) discharge from 24 hour program ***due to suicidal or homicidal crisis*** (hospital, IMD, START, residential treatment, etc.)	☐No	☐Yes	☐Refuse/Cannot Assess
Current serious thoughts/impulses of hurting/killing self or others: *Note if access to fire arms (guns) or other lethal means:*	☐No	☐Yes	☐Refuse/Cannot Assess
Pre-death behavior/committed to dying (e.g. giving away possessions) and/or current hopelessness/sees no options	☐No	☐Yes	☐Refuse/Cannot Assess
Preoccupied with incapacitating or life threatening illness and/or chronic intractable pain and/or catastrophic social loss	☐No	☐Yes	☐Refuse/Cannot Assess
Current command hallucinations, intense paranoid delusions and/or command override symptoms (belief that others control thoughts/actions)	☐No	☐Yes	☐Refuse/Cannot Assess
Current behavioral dyscontrol with intense anger/humiliation, recklessness, risk taking, self-injury and/or physical aggression and violence	☐No	☐Yes	☐Refuse/Cannot Assess
Additional Youth Risk Factors: Current extreme social alienation, isolation and/or victim of bullying	☐No	☐Yes	☐Refuse/Cannot Assess

PROTECTIVE FACTORS: (strong religious, cultural, or inherent values against harming self/others, strong social support system, positive planning for future, engagement in treatment, valued care giving role (people or pets) and strong attachment/responsibility to others.)

SELF-INJURY/SUICIDE/VIOLENCE MANAGEMENT PLAN: (Document enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.)

HIGH RISK ASSESSMENT (HRA)

TARASOFF ASSESSMENT:

Current Violent Impulses and/or Homicidal ideation toward a reasonably identified victim? ☐No ☐Yes ☐Refuse/Cannot Assess

Tarasoff Warning Indicated? ☐No ☐Yes

If yes, include victim(s) name and contact information (Tarasoff Warning Details):

Reported To: Date:

CURRENT DOMESTIC VIOLENCE? ☐No ☐Yes ☐Refuse/Cannot Assess

If yes, detailed documentation and child/adult protective services question mandatory. Describe situation:

Child/Adult Protective Services Notification Indicated? ☐ No ☐Yes

Reported To: Date:

Printed Name of *LPHA	Signature of *LPHA	Signature Date

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ASAM LOC Recommendation Instructions

REQUIRED FORM: This form is required within the client file.

WHEN: This form is to be completed after completion of the ASI or YAI and **in conjunction with (and not after) the Initial Treatment Plan**, in accordance with timeframes specified below:

- Outpatient Programs - within 30 calendar days from date of admission.
- Residential Programs - within 10 days from date of admission.

This form is to also be completed **in conjunction with (and not after) all Updated Treatment Plans** in accordance with timeframes specified below:

- Outpatient Programs - when a change in problem identification or focus of recovery or treatment occurs, or no later than 90 calendar days after signing the initial treatment plan or the previous treatment plan.
- For Residential Programs - when a change in problem identification or focus of recovery or treatment occurs, or no later than 30 calendar days after signing the initial treatment plan or previous treatment plan.

COMPLETED BY: To be completed by SUD Counselor and/or LPHA* (if completed by SUD counselor, not qualifying as a LPHA*, then include date of face to face discussion between counselor and LPHA).

REQUIRED ELEMENTS (do not leave any blanks):

- **Client Name:** Client's full name. (**NOTE:** entered on each page)
- **Client ID#:** Complete the client ID number by entering the client's SanWITS' Unique Client Number (UCN).
- **Date:** Date completed
- **Dimensions 1 thru 6:** Considering client's current needs, choose the appropriate current risk level 0-4. Document any clarifying comments/Level of Care indications using information obtained from all intake screening forms, assessments, treatment plans (if there are previous treatment plans) and the client and significant other's current input.
  1. Acute Intoxication and/or Withdrawal Potential
  2. Biomedical Conditions and Complications
  3. Emotional, Behavioral or Cognitive Conditions and Complications
  4. Readiness to Change
  5. Relapse, Continued Use, or Continued Problem Potential
  6. Recovery Environment
- **Recommended Level of Care**: Indicate specific level of care (include specific level of care number) indicated by ASAM Criteria and the identified risk level for each of the 6 dimensions (Note: Utilization of ASAM LOC Guidelines is recommended).
- **Actual Level of Care**: If a different level of care is to be provided, enter that level of care (include specific level of care number).

- **Reason for Discrepancy (Clinical Override)**: If applicable, indicate the reason for any discrepancy between the recommended level of care and the actual level of care provided and document the reason(s) why.
- **Designated Treatment Provider Name/Location**: If referring to another provider, enter the name of the program and the location of the program where the client will be receiving services.
- **Date:** Document the date a face to face interaction between the SUD counselor and LPHA* occurred (if applicable) to discuss the determination of medical necessity in regards to the ASAM Criteria and risk ratings for each of the 6 dimensions and Level of Care recommendations and placement for the client.

SIGNATURES

- **SUD Counselor/LPHA Name, Signature, and Date:** SUD Counselor/LPHA legibly printed or typed name, signature with credentials, and date
- **LPHA Name, Signature, and Date:** LPHA legibly printed or typed name, signature with credentials, and date

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ASAM LOC Recommendation

Client Name ____________________________ Client ID # ______________________________ Date _________________

1.	ACUTE INTOXICATION AND/OR WITHDRAWAL (W/D) POTENTIAL	
☐	0	Fully functioning, no signs of intoxication or W/D present.
☐	1	Mild to moderate intoxication interferes with daily functioning, but does not pose a danger to self/others. Minimal risk of severe W/D.
☐	2	Intoxication may be severe, but responds to support; not posing a danger to self or others. Moderate risk of severe W/D.
☐	3	Severe signs/symptoms of intoxication indicate an imminent danger to self/others. Risk of severe but manageable W/D; or W/D is worsening.
☐	4	Incapacitated, with severe signs/symptoms. Severe W/D presents danger, such as seizures. Continued use poses an imminent threat to life (e.g., liver failure, GI bleeding, or fetal death).
Comments/Level of Care Indications:		

2.	BIOMEDICAL CONDITIONS AND COMPLICATIONS	
☐	0	Fully functioning and able to cope with any physical discomfort. No biomedical signs/symptoms present, or biomedical problems are stable (ex. Adolescents: stable asthma or stable juvenile arthritis. Adults: stable hypertension or chronic pain).
☐	1	Adequate ability to cope with physical discomfort. Mild to moderate symptoms (such as mild to moderate pain) interfere with daily functioning.
☐	2	Some difficulty tolerating physical problems. Acute, non-life threatening medical symptoms (such as acute episodes of chronic, distracting pain, or signs of malnutrition or electrolyte imbalance) are present. Serious biomedical problems are neglected.
☐	3	Poor ability to tolerate and cope with physical problems, and/or general health condition is poor. Serious medical problems neglected during outpatient or IOT services. Severe medical problems (ex. Adolescents: asthma or diabetes is complicated, or client is on a new treatment regimen; Adults: severe pain requiring medication, or hard to control Type 1 Diabetes) are present but stable.
☐	4	The person is incapacitated, with severe medical problems (such as extreme pain, uncontrolled diabetes, GI bleeding, or infection requiring IV antibiotics).
Comments/Level of Care Indications:		

ASAM LOC Recommendation

Client Name ______________________________ Client ID # ______________________________ Date ________________

3.	EMOTIONAL, BEHAVIORAL OR COGNITIVE (EBC) CONDITIONS AND COMPLICATIONS	
☐	0	Good impulse control, coping skills and sub-domains (dangerousness/lethality, interference with recovery efforts, social functioning, self-care ability, course of illness).
☐	1	There is a suspected or diagnosed EBC condition that requires intervention, but does not significantly interfere with treatment. Relationships are being impaired but not endangered by substance use.
☐	2	Persistent EBC condition, with symptoms that distract from recovery efforts, but are not an immediate threat to safety and do not prevent independent functioning.
☐	3	Severe EBC symptomatology, but sufficient control that does not require involuntary confinement. Impulses to harm self/others, but not dangerous in a 24-hr. setting
☐	4	Severe EBC symptomatology; requires involuntary confinement. Exhibits severe and acute life-threatening symptoms (e.g., dangerous or impulsive behavior or cognitive functioning) posing imminent danger to self/others.
Comments/Level of Care Indications:		

4.	READINESS TO CHANGE (Consider both Substance Use and Mental Health Disorders)	
☐	0	Engaged in treatment as a proactive, responsible participant. Committed to change.
☐	1	Ambivalent of the need to change. Willing to explore need for treatment and strategies to reduce or stop substance use. May believe it will not be difficult to change, or does not accept a full recovery treatment plan.
☐	2	Reluctant to agree to treatment. Able to articulate negative consequences (of substance use and/or mental health problems) but has low commitment to change. Passively involved in treatment (variable follow through, variable attendance)
☐	3	Minimal awareness of need to change. Only partially able to follow through with treatment recommendations.
☐	4	Unable to follow through, little or no awareness of problems, knows very little about addiction, sees no connection between substance use/consequences. Not willing to explore change. Unwilling/unable to follow through with treatment recommendations.
Comments/Level of Care Indications:		

ASAM LOC Recommendation

Client Name ______________________________ Client ID #_______________________________ Date __________________

5.	RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL (Consider both Substance Use and Mental Health Disorders)	
☐	0	Low or no potential for further substance use problems or has low relapse potential. Good coping skills in place.
☐	1	Minimal relapse potential. Some risk, but fair coping and relapse prevention skills.
☐	2	Impaired recognition and understanding of substance use relapse issues. Able to self-manage with prompting.
☐	3	Little recognition and understanding of relapse issues, poor skills to cope with relapse.
☐	4	Repeated treatment episodes have had little positive effect on functioning. No coping skills for relapse/addiction problems. Substance use/behavior places self/others in imminent danger.
Comments/Level of Care Indications:		

6.	RECOVERY ENVIRONMENT (Consider both Substance Use and Mental Health Disorders)	
☐	0	Supportive environment and/or able to cope in environment.
☐	1	Passive/disinterested social support, but not too distracted by this situation and still able to cope.
☐	2	Unsupportive environment, but able to cope with clinical structure most of the time.
☐	3	Unsupportive environment and the client has difficulty coping, even with clinical structure.
☐	4	Environment toxic/hostile to recovery (i.e. many drug-using friends, or drugs are readily available in the home environment, or there are chronic lifestyle problems). Unable to cope with the negative effects of this environment on recovery (i.e. environment may pose a threat to recovery).
Comments/Level of Care Indications:		

ASAM LOC Recommendation

Client Name ____________________________ Client ID #______________________________ Date _________________

Recommended Level of Care: Enter the ASAM Level of Care that offers the most appropriate treatment setting given client's current severity and functioning. Please include specific level of care number (e.g. Level 3.5 Residential):

____

Actual Level of Care: If a level of care other than the determination is provided, enter the next appropriate level of care Please include specific level of care number (e.g. Level 2.1 Outpatient):

____

Reason for Discrepancy (Clinical Override): Check off the reason for discrepancy between level of care recommended and actual level of care provided, and document the reason(s) why:

☐ Not Applicable	☐ Service not available	☐ Provider judgment	☐ Client preference
☐ Transportation	☐ Accessibility	☐ Financial	☐ Preferred to wait
☐ Language/Cultural Consideration	☐ Environment	☐ Mental Health	☐ Physical Health
☐ Court/Probation Ordered	☐ Other: ___________________________		

Explanation of Discrepancy/Comments:

Designated Treatment Provider Name/Location: ____

A face-to face interaction between the AOD counselor and the LPHA to verify the determination of medical necessity for the client regarding this ASAM LOC Recommendation form occurred on the following date: __________________

(if applicable)

______________________________ ______________________________ ________________________

Counselor Name (if applicable) **Signature** (if applicable) **Date**

______________________________ ______________________________ ________________________

LPHA* Name **Signature** **Date**

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Assessment Summary Form Instructions

OPTIONAL FORM:

This form is an optional document in the client file

WHEN:

Completed at Intake/Admission

COMPLETED BY:

An LPHA or Counselor as needed to summarize assessments completed

ELEMENTS:

- **Client Name:** Enter the client's full name
- **Client ID:** Enter the client's SanWITS' Unique Client Number (UCN).
- **Date ASI/YAI Completed:** If this form is being utilized as a progress note for the ASI/YAI completion, date ASI/YAI completed is ***required*** here
- **Summary:** Enter summary of information gathered from client's completed assessments here (e.g. ASI/YAI, Alcohol and Drug History Form, ASAM Level of Care Recommendation Form, etc…)
- **SUD Counselor or LPHA Printed Name and Credentials:** Type or legibly print name and credentials of counselor or LPHA completing summary
- **SUD Counselor or LPHA Signature:** Complete signature and credentials by hand
- **Date:** Enter date summary form is completed by hand

ASSESSMENT SUMMARY FORM

Client Name:	**Client ID:**	**Date ASI/YAI Completed:**
Summary Please summarize information from client's completed ASI/YAI and other completed assessments below:		
SUD Counselor or LPHA Printed Name and Credentials:		
SUD Counselor or LPHA Signature:		**Date:**

Diagnosis Determination Note Instructions

REQUIRED FORM: This form is required in client file.

WHEN:

- **For Outpatient:** Completed within thirty (30) days from date of admission.
- **For Residential:** Completed within ten (10) days from date of admission.

COMPLETED BY: This form is to be completed by the Medical Director (MD) or a LPHA.

REQUIRED ELEMENTS:

- **Client Name:** Document client's full name.
- **Client ID:** Complete the client ID number by entering the client's SanWITS' Unique Client Number (UCN).
- **Substance Use Disorder Criteria:** Identify the name of each substance and check off the DSM – 5 criteria that have occurred in the **past 12 months** related to each substance.
- **Total number of Criteria:** add checks from each column.
- **Basis for Diagnosis Narrative:** Document the basis or justification for diagnosis using applicable DSM – 5 criteria. The narrative should be individualized to capture the client's substance use history and medical necessity to justify treatment services. It should include all applicable DSM – 5 specifiers, including if a client has only maintained sobriety in a Controlled Environment. Document all relevant symptoms, impairments, and timeframes, etc.
    - **Sobriety for More than 365 Days:** Documentation must clearly state the medical necessity as outlined in Title 22 CCR 51303:
        - "health care services… which are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through diagnosis of treatment of disease, illness or injury are covered by the Medi-Cal program, subject to utilization controls… Such utilization controls shall **take into account these diseases, illnesses or injuries which require preventative health services or treatment to prevent serious deterioration of health.**"
        - Document client specific potential risk factors for relapse (e.g., unstable living environment, physical and mental health issues, past behaviors, etc.)

- **DSM – 5 Diagnosis(es)/ICD -10 codes:** Based on criteria documented in the narrative the MD or LPHA must document the diagnosis and matching ICD – 10 code(s).
- **Printed Name and Credentials:** MD or LPHA who completed the form print their name and credentials
- **Signature and date:** MD of LPHA who completed the form signs and dates it

NOTE: Must be reviewed by QAR for an initial, stay, extension, and discharge.

DIAGNOSIS DETERMINATION NOTE

Client Name:	Client ID:

Substance Use Disorder Criteria

Below: Identify the name of each substance and check off the DSM-5 criteria that have occurred in the **past 12 months** related to each substance.

Substance #1:	**Substance #2:**	**Substance #3:**	**#1**	**#2**	**#3**
1. Substance often taken in larger amounts or over a longer period than was intended			☐	☐	☐
2. There is a persistent desire or unsuccessful efforts to cut down or control substance use			☐	☐	☐
3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects			☐	☐	☐
4. Craving, or a strong desire or urge to use the substance			☐	☐	☐
5. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home			☐	☐	☐
6. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance			☐	☐	☐
7. Important social, occupational, or recreational activities are given up or reduced because of substance use			☐	☐	☐
8. Recurrent substance use in situations in which it is physically hazardous			☐	☐	☐
9. Continued substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance			☐	☐	☐
10. Tolerance, as defined by either of the following: a need for markedly increased amounts of the substance to achieve intoxication or desired effect or a markedly diminished effect with continued use of the same amount of the substance			☐	☐	☐
11. Withdrawal, as manifested by either of the following: the characterizing withdrawal syndrome for the substance or substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms			☐	☐	☐
		Total Number of Criteria			

Basis for Diagnosis Narrative (Document the basis or justification for the diagnosis using applicable DSM-5 criteria. Narrative should be individualized to capture client specifics for each criteria checked. Include all applicable DSM-5 specifiers, including if a client has only maintained sobriety in a Controlled Environment.)

DSM-5 Diagnosis(es)/ICD-10 Code(s): ____________________

LPHA or MD Printed Name and Credentials	LPHA or MD Signature	Date

Section 4
Health/Medical

F401	Withdrawal Management Observation Log
F402	Centrally Stored Medication List (Residential and Detox)
F403	Health Questionnaire
F404	TB Screening Questionnaire and Results
F406	Physician Direction Form
	MD Recommendations/Orders to Client
	Proof of Pregnancy (Perinatal)
	Additional Medical Documents

	Indicates there is no standardized form. If information is collected by your program, it would be placed in this position in the client file.

Withdrawal Management Observation Log

REQUIRED FORM:

This form is a required document in the client file for withdrawal management programs. The observation record must document close observation and face-to-face physical checks every 30 minutes for a minimum of the first 24 hours following admission. After 24 hours, trained staff will assess client symptoms to determine whether the frequency of the observations and checks be continued, reduced or discontinued in accordance with the provider's policies and procedures.

WHEN: Completed upon Admission and as needed

COMPLETED BY: Authorized agency representative

REQUIRED ELEMENTS:

- **Client Name:** Complete client's full name.
- **Client ID#:** Enter the SanWITS Unique Client Number
- **Admission Date:** Complete the date client was admitted to program.
- **Admission Time:** Complete the time client was admitted to program.
- **Observation Date:** Complete the date of observation.
- **Substance(s) of Withdrawal/Date of Last Use:** List all known substance(s) of withdrawal and date of last use.
- **Time:** Start time according to the client's time of admission to program. Every 30 minutes after admission the staff must complete the activity field. The record must be completed for the first 24 hours of client's admission but may be continued, decreased or discontinued after 24 hours, if symptomology meets policies and protocols approved by the Medical Director.
- **Client Activity:** Client's activity must be checked every 30 minutes and documented (e.g., resting, asleep, any withdrawal signs or lack of, etc.)
- **Initial:** Staff completing the record must initial each entry.
- **Observation Continues, Decreased or Discontinued:** 24 hours from admission and periodically throughout the client stay, staff will select a status of observations.
- **Rational:** Staff will record the reason for the selected Observation Status based on symptomology and protocols approved by the Medical Director.
- **Initials/Time:** Staff selecting an Observation Status and Rationale will complete the entry with Initials and time
- **Observer Printed Name/Signature/Credential/Initials:** Staff conducting observations will be identified by printed name, signature and credential, and first and last initials. The form allows for up to four observers.

Withdrawal Management Observation Log

Client Name: ______________________ Client ID #:______________________
Admission Date: __________ Admission Time: ________ Observation Date: ________________
Substance(s)/Date(s) of Last Use: ____

Time	Client Activity	Initials	Time	Client Activity	Initials
12:00 a.m.			12 noon		
12:30 a.m.			12:30 p.m.		
1:00 a.m.			1:00 p.m.		
1:30 a.m.			1:30 p.m.		
2:00 a.m.			2:00 p.m.		
2:30 a.m.			2:30 p.m.		
3:00 a.m.			3:00 p.m.		
3:30 a.m.			3:30 p.m.		
4:00 a.m.			4:00 p.m.		
4:30 a.m.			4:30 p.m.		
5:00 a.m.			5:00 p.m.		
5:30 a.m.			5:30 p.m.		
6:00 a.m.			6:00 p.m.		
6:30 a.m.			6:30 p.m.		
7:00 a.m.			7:00 p.m.		
7:30 a.m.			7:30 p.m.		
8:00 a.m.			8:00 p.m.		
8:30 a.m.			8:30 p.m.		
9:00 a.m.			9:00 p.m.		
9:30 a.m.			9:30 p.m.		
10:00 a.m.			10:00 p.m.		
10:30 a.m.			10:30 p.m.		
11:00 a.m.			11:00 p.m.		
11:30 a.m.			11:30 p.m.		

Observation Status: Continued ☐ Decreased ☐ Discontinued ☐

Rational: **Initials/Time:**

Observer Printed Name/Signature/Credential	Initials	Observer Printed Name/Signature/Credential	Initials
1)		3)	
2)		4)	

Centrally Stored Medication and Destruction Record

REQUIRED FORM:

This form is a required document in client file for detox and residential programs

WHEN:

Completed at Screening/Intake Admission

COMPLETED BY:

Completed by authorized agency representative

REQUIRED ELEMENTS:

Centrally Stored Medication Instruction:

- **Resident's Name:** Complete client's full name.
- **Admission Date:** Complete the client's date of admission.
- **Attending Physician:** Complete the name of the client's primary physician.
- **Facility Name:** Complete the name of the program.
- **Facility ID Number:** This number will be provided by your agency.
- **Program Director:** Complete the full name of the program director.
- **Medication Name:** Complete the name of the medication as stated on the medication label.
- **Strength/Quantity:** List the strength and the amount of the medication brought in at the time of admission (e.g., 20mg/30 pills).
- **Instructions/ Control/Custody:** List directions for the administration of the medication as prescribed by the physician.
- **Expiration Date:** Document the medication's expiration date as stated on the medication label.
- **Date Filled:** Document the date prescription was filled as stated on the medication label.
- **Prescribing Physician:** Document the name of the physician prescribing the medication as stated on the medication label.
- **Prescription Number:** Document the prescription number as stated on the medication label.
- **Number of Refills:** Document the number of refills as stated on the medication label.
- **Name of Pharmacy:** Document the name of pharmacy which filled the prescription.

Medication Destruction Record Instruction:

- **Medication Name:** Complete the name of the medication as stated on the medication label.
- **Strength/Quantity:** List the strength and the amount of the medication to be destroyed (e.g., 20mg/30 pills).
- **Date Filled:** Document the date prescription was filled as stated on the medication label.

- **Prescription Number:** Document the prescription number as stated on the medication label.
- **Disposal Date:** Document the actual disposal date of the medication as outlined by the agency's policies and procedures.
- **Name of Pharmacy:** Document the name of pharmacy which filled the prescription.
- **Administrator's Signature:** The administrator of the agency responsible for the disposal of the medications must sign.
- **Witness' Signature:** Staff member other than the administrator witnessing the disposal of the medications must sign.

NOTE:

For additional space, you may duplicate this form.

Department of Health Care Services
Licensing and Certification Branch, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

C-6A – CENTRALLY STORED MEDICATION AND DESTRUCTION RECORD

Resident's Name:	Admission Date:	Attending Physician:
Facility Name:	Facility ID No.:	Program Director:

CENTRALLY STORED MEDICATION INSTRUCTIONS: Licit medications which are permitted by the licensee shall be controlled as specified by the licensee's written goals, objectives and procedures.

Medication Name	Strength/ Quantity	Instructions Control/Custody	Expiration Date	Date Filled	Prescribing Physician	Prescription Number	No. Refills	Name of Pharmacy

MEDICATION DESTRUCTION RECORD INSTRUCTIONS: Prescription drugs not taken with the resident upon termination of services or otherwise disposed of shall be destroyed in the facility by the Program Director or designated representative and witnessed by one other authorized individual (NON-RESIDENT).

Medication Name	Strength/ Quantity	Date Filled	Prescription Number	Disposal Date	Name of Pharmacy	Administrator's Signature	Witness' Signature

Health Questionnaire Form

REQUIRED FORM:

This form is a required document in the client's file

WHEN:

Completed upon Admission

COMPLETED BY:

Completed by the client and reviewed by authorized agency representative

REQUIRED ELEMENTS:

- **Name:** Complete client's full name.
- **Client ID#:** Enter client's SanWITS Unique Client Number
- All items of the Health Questionnaire must be completed by marking the appropriate yes or no answer or documenting as indicated. If the answer to a question is "yes", the client must provide further details.
- **Client Signature & Date:** Client must sign and date the form when completed.
- **Reviewing Facility/Program Staff Name, Signature, & Date:** Staff must review the form and then print their name and sign and date the form when completed.

NOTES:

This form was developed to replace the required DHCS 5103 (06/16) Health Questionnaire and Initial Screening Form. It is to be completed in conjunction with the Initial Level of Care Assessment, TB Screening Form, and the ASI or YAI Forms to ensure all the required Health Questionnaire items are addressed. However, programs may use the DHCS 5103 (06/16) form in place of this form, if they prefer.

If current physical health issues are identified, then these items should be reviewed with the program's MD and documented on the client treatment plan as needed for follow up. Coordination of care with the client's physical health care provider may be required to ensure the client's needs are met. If a program determines that the client needs services beyond what they can provide, the client should be referred to another appropriate agency and/or facility.

Client Name: ______________________________ Client ID #:________________________

CLIENT HEALTH QUESTIONNAIRE

1. Have you ever had a heart attack or any problem associated with the heart? ☐ Yes ☐ No
   If ***yes***, please list when, what was the diagnosis and if you are currently taking medication:

   ____

   ____

2. Are you currently experiencing chest pain(s)? ☐ Yes ☐ No
   If ***yes***, please give details:

   ____

   ____

3. Do you have any serious health problems or illnesses (such as tuberculosis or active pneumonia) that may be contagious to others around you? ☐ Yes ☐ No
   If ***yes***, please give details:

   ____

   ____

4. Have you ever been treated for HIV or AIDS? ☐ Yes ☐ No If ***yes,*** when? Please give details:

   ____

   ____

5. Have you ever been tested for sexually transmitted diseases? ☐ Yes ☐ No If ***yes***, please give details and list any medications you are taking:

   ____

   ____

6. Have you had a head injury in the last 6 months? Have you ever had a head injury that resulted in a period of loss of consciousness? ☐ Yes ☐ No
   If ***yes***, please give details:

   ____

   ____

7. Have you ever been diagnosed with diabetes? ☐ Yes ☐ No
   If ***yes***, please give details, including insulin, oral medications, or special diet:

   ____

   ____

8. Do you have any open lesions/wounds? ☐ Yes ☐ No
   If ***yes***, please explain and list any medications you are taking:

   ____

   ____

Client Name: ______________________________ Client ID #:_________________________

9. Have you ever had any form of seizures, delirium tremens or convulsions? ☐ Yes ☐ No
If ***yes***, date of last seizure episode(s) and list any medications you are taking:

____

____

10. Do you use a C-PAP machine or dependent upon oxygen? ☐ Yes ☐ No
If ***yes***, please explain:

____

____

11. Have you ever had a stroke? ☐ Yes ☐ No
If ***yes***, please give details:

____

____

12. Are you pregnant? ☐ Yes ☐ No
a. If yes, which trimester: ☐ 1st ☐ 2nd ☐ 3rd
Are you receiving pre-natal care? ☐ Yes ☐ No
Any complications? ☐ Yes ☐ No If yes, please explain:

____

____

13. Do you have a history of any other illness that may require frequent medical attention? ☐ Yes ☐ No
If ***yes***, please give details and list any medications you are taking:

____

____

14. Have you ever had blood clots in the legs or elsewhere that required medical attention? ☐ Yes ☐ No
If ***yes***, please give details:

____

____

15. Have you ever had high-blood pressure or hypertension? ☐ Yes ☐ No
If ***yes***, please give details:

____

____

16. Do you have a history of cancer? ☐ Yes ☐ No
If ***yes***, please give details and list any medications you are taking:

____

____

17. Do you have any allergies to medication, foods, animals, chemicals, or any other substance? ☐ Yes ☐ No
If ***yes***, please give details and list any medications you are taking:

____

____

18. Have you had an ulcer, gallstones, internal bleeding, or any type of bowel or colon inflammation? ☐ Yes ☐ No
If ***yes***, please give details:

____

____

19. Have you ever been diagnosed with any type of hepatitis or other liver illness? ☐ Yes ☐ No
If ***yes***, please give details and list any medications you are taking:

____

____

20. Have you ever been told you have problems with your thyroid gland, been treated for, or told you need to be treated for, any other type of glandular disease? ☐ Yes ☐ No
If ***yes***, please give details:

____

____

21. Do you currently have any lung diseases such as asthma, emphysema, or chronic bronchitis? ☐ Yes ☐ No
If ***yes***, please give details:

____

____

22. Have you ever had kidney stones or kidney infections, or had problems, or been told you have problems with your kidney or bladder? ☐ Yes ☐ No
If ***yes***, please give details:

____

____

23. Do you have any of the following: arthritis, back problems, bone injuries, muscle injuries, or joint injuries?
☐ Yes ☐ No If ***yes***, please give details, including any ongoing pain or disabilities:

____

____

24. Do you take over the counter pain medications such as aspirin, Tylenol, or Ibuprofen? ☐ Yes ☐ No
If ***yes***, list the medication(s) and how often you take it:

____

____

25. Do you take over the counter digestive medications such as Tums or Maalox? ☐ Yes ☐ No
If ***yes***, list the medication(s) and how often you take it:

____

____

26. Do you wear glasses, contact lenses, or hearing aids? ☐ Yes ☐ No
Or do you ***need*** glasses, contact lenses, or hearing aids? ☐ Yes ☐ No
If ***yes*** to either, please give details:

____

____

27. When was your last dental exam? Date: ______________________

28. Are you in need of dental care? ☐ Yes ☐ No
If ***yes***, please give details:

____

____

29. Do you wear or need to wear dentures or other dental appliances that may require dental care? ☐ Yes ☐ No
If ***yes***, please give details:

____

____

30. Please describe any surgeries or hospitalizations due to illness or injury that you have had in the past:

____

____

31. When was the last time you saw a physician and/or psychiatrist? What was the purpose of the visit?

____

____

32. Over the last 2 weeks, have you had thoughts of suicide or thought you would be better off dead? ☐ Yes ☐ No
If ***yes***, describe:

____

____

33. Have you attempted suicide in the past two (2) years? ☐ Yes ☐ No If ***yes***, give dates:

____

____

34. Have you ever harmed yourself/others or thought about harming yourself/others? ☐ Yes ☐ No If ***yes,*** describe:

____

____

35. Have you ever been in a relationship where your partner has pushed or slapped you? ☐ Yes ☐ No
If ***yes***, describe:

____

____

36. Additional Comments:

____

____

____

____

____

____

I declare that the above information is true and correct to the best of my knowledge:			
Client Signature		**Date**	
Reviewing Facility/Program Staff Name			
Reviewing Facility/Program Staff Signature		**Date**	

TB Screening Questionnaire

REQUIRED FORM:

This is a required form for all San Diego County funded Substance Use Disorder programs and is a required document in the client file

WHEN:

Completed at Screening/Intake Admission

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

- **Client Name:** Complete client's full name
- **Date of Birth:** Complete client's month/day/year of birth
- **ID #:** Complete the client ID number by entering the client's SanWITS' Unique Client Number (UCN).

The next five questions are to determine possible signs of tuberculosis. The responses to the questions may exclude signs and symptoms related to alcohol or drug use, withdrawal signs, voluntary weight loss, or current diagnosed medical conditions.

1. **Have you recently coughed up blood?** Complete yes or no answer.
2. **Have you been coughing for more than 2 - 3 weeks?** Complete yes or no answer.
3. **Have you lost more than 5 lbs in the last 2 months?** Complete yes or no answer.
4. **Have you had frequent fevers in the last month?** Complete yes or no answer.
5. **Have you had unusual sweating, especially at night?** Complete yes or no answer.

If there is a **"Yes"** answer to question 1, or **"Yes"** answer to two-or-more of the other symptoms; go to the **Evaluate for Active** TB section at the bottom of the form.

For other findings ("**Yes**" to one symptom): Refer to medical provider as needed, depending on the severity of the symptom

The following three questions are to determine client's previous history of TB skin test.

- **Have you ever had a TB skin test?** Complete yes or no answer.
- **What type?** Complete the yes or no answer for each of the questions regarding type: TB Skin Test and TB Blood Test
- **What was the result?** When a "yes" answer is given to the above question, the screener should ask for the client's last results for either of the types of TB tests. Circle the appropriate answer.

- **Do you have proof of your test?** Complete yes or no answer. If yes, the client must provide copy of result.
- **Previous test documentation:** If the client is able to provide proof of either negative or positive TB test results, complete the test date. Also record date in the appropriate fields (mm, IU and/or Spots). Retain the copy of the result for program and client records.

Summary: This section applies to action taken by the agency for compliance with TB Control of County of San Diego. Check all applicable action **and** follow directions per client's specific situation and obtain a TB test within timelines specified.

- **Not known/No previous TB test done:** Place a checkmark if TB test is not known or no previous test was performed. **Refer clients for TB testing ASAP (7 days max).**
- **Negative (no documentation available):** Place a checkmark if previous test was negative but no documentation is provided. **Refer clients for TB testing ASAP (7 days max).**
- **Negative (documented as done within last 3 months):** Place a checkmark if the test was negative and the client provided copy of the test result. The test result must be within the last 3 months. **No TB test needed now.**
- **Positive history (No documentation):** Place a checkmark if client reported positive test result and no documentation was provided. **Refer for an evaluation of TB testing ASAP (7 days max).**
- **Positive history (documented; date and size recorded above):** Place a checkmark if client reported positive test result and provided with documentation. **Refer clients for chest x-ray within 7 days of admission. If client presents documented proof of a "normal" X-ray done within the last 3 months, record date.**
- **Evaluate for Active TB (coughing up blood or two-or-more other symptoms):** Place a checkmark if client answered 'yes' to coughing up blood or 'yes' to two or more other symptoms. **Contact TB control at 619-692-5565 to discuss the situation.**
- **Staff completing this form:** The staff completing this form is required to sign and date this form.

TB SCREENING QUESTIONNAIRE

CLIENT_____________________________________ DOB:__________________ ID #:______________________
Last First

	Question	Yes	No
1.	Have you recently coughed up blood?	Yes	No
2.	Have you been coughing for more than 2 – 3 weeks?	Yes	No
3.	Have you lost more than 5 lbs in the last 2 months?	Yes	No
4.	Have you had frequent fevers in the last month?	Yes	No
5.	Have you had unusual sweating, especially at night?	Yes	No

- If **"Yes"** to question 1 or **"Yes"** to two-or-more of the other symptoms; go to **Evaluate for Active TB** below
- Other findings ("**Yes**" to one symptom): Refer to medical provider as needed, depending on the severity of the symptom

Have you ever had a TB Test?	Yes	No		
What type?			**What was the result?**	
TB Skin Test	Yes	No	Positive	Negative
TB Blood Test	Yes	No	Positive	Negative

Do you have proof of your TB test*? Yes No

- Previous TB test documentation: Record date and result:
- Copy TB test document for program and client's records

TB test Date

_____________ mm

______________IU

_____________Spots

*Current, acceptable TB tests are Mantoux TB skin test, QuantiFERON blood test, TSpot blood test

SUMMARY (Check all applicable)

If TB Test is:

____ **Not known/No Previous TB test Done**: Refer clients for TB testing ASAP (7 days max)

____ **Negative (no documentation available)**: Refer client for TB testing ASAP (7 days max)

____ **Negative (documented as done within the last 3 months)**: No TB test needed now

____ **Positive History (no documentation)**: Refer for an evaluation of TB testing ASAP (7 days max)

____ **Positive History (documented, date and size recorded above)**:

Chest x-ray needed within 7 days of admission UNLESS client presents documented proof of a normal x-ray done within the last 3 months. Copy x-ray report for clinic record and record date here: **X-ray Date**_____________________

____ **Evaluate for Active TB** (coughing up blood or two-or-more other symptoms): Contact TB Control to discuss situation – (619) 692-5565

Staff completing this form:____ **Date:**___________________________

PHYSICIAN DIRECTION FORM

Based on my review of the client's Health Questionnaire, medical, and drug history the following client:

Client Name__________________________________ Client ID#_______________________________

1. ☐ **Must** have the following tests and/or examinations to screen for infectious or communicable disease:____
After my orders are completed, the results **must** be returned to me for review. The client **may not** participate in the program while the tests are being completed.

2. ☐ **Should** have the following tests and/or examinations to rule out infectious or communicable disease and provide further information for treatment planning purposes:___________________
____
The results may be returned to me for review and further input into treatment planning.

3. ☐ **May** be referred for the following tests and/or examinations for his/her own information and health promotion:____

____ ________________________________
Medical Director's Signature Date

****

MEDICAL DIRECTOR FOLLOW-UP

Based on my follow-up review of the results of the above tests and/or examinations, the client:

1. ☐ **May** participate in the program.

____ ________________________________
Medical Director's Signature Date

HIV testing, other than court ordered testing, cannot be mandated.

Physician Direction Form Instructions

_Note_*: The Medical Director must review a client's Health Questionnaire along with their medical and drug history. This review, along with any medical orders and/or recommendations, must be documented by the Medical Director either through the use of this form or a progress note.*

OPTIONAL FORM:

This form is an optional document in the client file as the information may otherwise be captured by the Medical Director in the form of a progress note.

WHEN:

This form must be completed or the information must be captured in a progress note by the Medical Director within thirty days of client's admission.

COMPLETED BY:

Medical Director

REQUIRED ELEMENTS:

- **Client's Name:** Complete client's full name.
- **Client ID#:** Complete the client ID number by entering the client's SanWITS' Unique Client Number (UCN).

The selection of next three directives is determined by Medical Director based on review of client's Health Questionnaire, medical, and drug history.

- **#1:** Medical Director will check this box when client is ordered further tests and/or examinations **_to screen for infectious or communicable disease_**. Space is provided for Medical Director to list types of tests and/or examinations. Client may not participate in program while the tests are being completed. Results must be returned to Medical Director.
- **#2:** Medical Director will check this box when client should have the listed tests and/or examinations in the space available **_to rule out infectious or communicable disease_**. Results may be returned to Medical Director for further review and input into treatment plan.
- **#3:** Medical Director will check this box when client is referred for listed tests and/or examinations for client's own information and health promotion.
- **Medical Director's Signature and Date:** Medical Director reviewing client's file must sign and date.

Medical Director Follow-Up

This section does not need to be completed by Medical Doctor unless box #1 is checked and file has been returned to Medical Director for review of results. If the results are acceptable by Medical Director, the client may be cleared to participate in program.

- **#1:** Medical Director will check this box if client is permitted to participate in program.
- **Medical Director's Signature and Date:** Medical Director reviewing client's file must sign and date.

MD Recommendations-Orders to Client*

This is not a standardized form. If your agency is currently using this form, place it in this section.

***Medi-Cal Providers Only**

Proof of Pregnancy

Place current proof of pregnancy documentation provided by client in this section.

This is not a standardized form. For perinatal services, medical documentation that substantiates the client's pregnancy and the last day of pregnancy shall be maintained in the client's file. It is generally obtained at admission or during treatment, as needed. It must have verification by client's medical provider.

Section 5
Planning

F501	Initial Treatment Plan
F502	Updated Treatment Plan
F503	Addendum Treatment Plan
F504	Recovery Services Individualized Recovery Plan
F505	Treatment Effectiveness Assessment
	Additional Planning Documents

Initial Treatment Plan Instructions

REQUIRED FORM:

An Individual Treatment Plan is a required document within the client file.
(Residential Programs: Submit to Optum as part of ongoing authorization process.)

WHEN:

This form is to be completed in accordance with timeframes specified below:

- Outpatient Programs - within 30 calendar days from date of admission.
- Residential Programs - within 10 days from date of admission.

COMPLETED BY:

To be completed jointly by LPHA/Counselor and client based upon the information obtained during the initial intake, assessment and treatment planning sessions with the client.

REQUIRED ELEMENTS (do not leave any blanks):

CLIENT INFORMATION

- **Client Name:** Client's full name. (**NOTE:** to be entered on each page of the Treatment Plan)
- **Primary Counselor Name:** Primary LPHA/Counselor's name.
- **Case Manager Name:** Case manager's name.
- **Client ID#:** Complete the client ID number by entering the client's SanWITS' Unique Client Number (UCN). (**NOTE:** to be entered on each page of the Treatment Plan)
- **Admission Date:** Date client was admitted to program.
- **DSM-5 Diagnosis(es):** Enter the DSM-5 diagnosis. More than one diagnosis can be entered, but the *Primary diagnosis must be a Substance Use Disorder.*
- **Date of the Initial Treatment Plan:** Enter date the Treatment Plan was completed.
- **Was a physical exam completed?** Check the appropriate box**.** If Yes is checked, provide the date of the physical. (Inform client that further proof of physical exam may be required).
- **Assessments/Forms Reviewed:** Check the appropriate boxes; if other, provide details.
- **If client's preferred language is not English, were linguistically appropriate services provided?** Check the appropriate box; if No, explain in detail.
- **What does the client want to obtain from treatment:** Document the client's expectations regarding treatment services and what the client hopes to gain from receiving services at the program. You may use client's own words.
- **Client Strengths/Resources/Abilities/Interests (to be used to reach treatment plan goals):** Use Motivational Interviewing techniques to obtain strengths-based client information to use when creating treatment plan goals.

PROBLEM'S #1, #2, #3

- **Select related ASAM Dimension:** Check appropriate box(s). Review all 6 ASAM dimension criteria to assess which box(s) to check.
- **Problem Statement:**
    - Personalize problem(s) unique to the client.
    - Write problems in client language and *prioritize* (emergent, realistic for completion, what is needed to prevent relapse?)
    - If a physical health concern is identified (e.g., pregnancy or lack of a physical in the last 12 months), this needs to be addressed in one of the problem areas on the plan.
    - Multiple related issues may be combined into one problem statement that fall under the same ASAM dimension(s). For example, a client may have multiple Bio-medical issues, such as needing a physical exam, follow up care on diabetes, and dental work which could all be incorporated into one problem as they are all related to ASAM dimension 2.
    - If the client cannot demonstrate having had a physical exam within 12 months prior to admission to treatment, then a problem must identify lack/need for a physical exam.
    - If the client has demonstrated completion of a physical exam within 12 months prior to admission to treatment, and a significant medical illness has been identified; then a problem may be that the client needs to address appropriate treatment for the illness.

- **Goal(s):** What does the client and program want to accomplish? Use "SMART" acronym (Specific, Measurable, Attainable, Realistic, Time-Related):
    1. Goals must be measurable and achievable.
    2. If multiple problems are grouped together, then include a specific goal to resolve each of the specific problems.
    3. If the client has not received a physical exam within 12 months prior to admission to treatment, a goal that the client completes a physical examination must be included.
    4. Should a client demonstrate completion of a physical exam within 12 months prior to admission to treatment, and a significant medical illness has been identified; a client goal to obtain appropriate treatment for the illness must be included.

- **Action Steps:** Action steps to be taken by the LPHA/Counselor and/or client to accomplish identified goals:
    1. Include specific actions the LPHA/counselor will do while providing treatment services to the client (e.g., individual counseling, group, etc.) to help the client reach their goals. Include the use of evidence-based treatment interventions (e.g., Motivational Interviewing, Relapse Prevention) to be utilized, if applicable.
    2. Include specific actions the client will do to reach their goals (e.g., Client will identify a list of potential doctors and contact at least 1 to schedule an appointment to complete a physical).
    3. If multiple problems are grouped together, then include a specific action step to accomplish each of the specific problem goals.

- **Target Date(s):** Estimated date of completion per action step. Dates to reflect each of the specific goals and action steps (i.e., if there are 3 goals, there will be 3 target dates).

- **Resolution Date(s):** Actual task completion date to be documented on the treatment plan after the treatment plan has been developed. Remember to document if the client did not complete a goal or action step when carrying over the same goal/action to the next plan. Dates to reflect each of the specific goals and action steps (i.e., if there are 3 goals, there will be 3 resolution dates).

PROPOSED TYPE OF INTERVENTION/MODALITY FOR SUCCESSFUL GOAL COMPLETION (INCLUDE FREQUENCY AND DURATION)

- **Check the appropriate Modality box and enter frequency and duration for each box checked:** List includes the following modalities: Outpatient Services (OS), Intensive Outpatient Services (IOS), Residential Treatment, Recovery Services

- **Indicate type of services below:** check appropriate type(s) of service(s) and indicate frequency and duration of each service (except for Withdrawal Management Services; indicate duration)

Does this treatment plan include the Treatment Plan Addendum form for additional problems: Mark Yes or No to indicate if a Treatment Plan Addendum form was utilized to complete this treatment plan.

If yes, how many total problems are documented in this entire treatment plan? If a Treatment Plan Addendum form was utilized, document the total number of problems documented on the entire treatment plan as there will be more than 3 problems.

Client was offered a copy of the plan: Check Yes or No; if No, document why.

TREATMENT PLAN SIGNATURES

- **Client Signature:** Client to sign and date.
  1. The client must be present and participate in the treatment plan to bill for treatment plan services.
  2. Client signature provides evidence of client participation and agreement with the Individual Recovery/Treatment Planning process.
     - **For Outpatient:** Client must sign within 30 days from the date of admission.
     - **For Residential:** All signatures must be in place within 10 days from the date of admission.
     - If client **refuses to sign** the treatment plan, please document reason for refusal and the strategy that will be used to engage client for participation in treatment plan. Future attempts to obtain the client's signature on the treatment plan should be documented in progress notes.
- **Counselor/LPHA Name, Signature, and Date:** LPHA/Counselor's legibly printed or typed name, signature with degree and/or credentials, and date of completed Individual Treatment Plan.
  - **For Outpatient:** Counselors must sign the treatment plan within 30 days from the date of admission.
  - **For Residential:** All signatures must be in place within 10 days from the date of admission.
  - The date of LPHA/Counselor signature is considered the treatment plan completion date.
- ***MD or LPHA Name, Signature, and Date:** MD/LPHA legibly printed or typed name, signature with credentials and date of signature.
  - **For Outpatient:** The MD or LPHA has up to 15 days after the counselor's signature date to sign the treatment plan.
  - **For Residential:** All signatures must be in place within 10 days from the date of admission.

Client Name: ______________________ Client ID: ______________________

Initial Treatment Plan

CLIENT INFORMATION		
Name:	**Client Id#:**	**Admission Date:**
Primary Counselor Name:	**Case Manager Name:**	
DSM-5 Diagnosis(es):		
Date of Initial Treatment Plan:		

Was a physical exam completed?

☐ If yes, provide the date of physical (must be completed within last 12 months): ______________________

☐ If no, include the goal of obtaining a physical exam under the appropriate problem area below (must remain a goal until completed)

Assessments Reviewed:

☐ ASI or YAI ☐ ASAM LOC Recommendation

☐ Risk Assessment ☐ Health Questionnaire

☐ Other:

If client's preferred language is not English, were linguistically appropriate services provided?

☐ Yes ☐ No (**If no, please explain below**)

What does the client want to obtain from treatment (use client's own words):

Client Strengths/Resources/Abilities/Interests (to be used to reach treatment plan goals):

PROBLEM #1

Select related ASAM Dimension: ☐ 1. Acute Intoxication and/or Withdrawal Potential; ☐ 2. Biomedical Conditions and Complications; ☐ 3. Emotional, Behavioral or Cognitive Conditions/Complications; ☐ 4. Readiness to Change; ☐ 5. Relapse, Continued Use, or Continued Problem Potential; ☐ 6. Recovery Environment

Problem Statement(s):

Goals (Specific & Quantifiable):	**Target Date(s):**	**Resolution Date(s):**

Action Steps (Identify if steps will be taken by the provider and/or client to accomplish identified goals):	**Target Date(s):**	**Resolution Date(s):**

Client Name: ______________________________ Client ID: ______________________________

PROBLEM #2		
Select related ASAM Dimension: ☐ 1. Acute Intoxication and/or Withdrawal Potential; ☐ 2. Biomedical Conditions and Complications; ☐ 3. Emotional, Behavioral or Cognitive Conditions/Complications; ☐ 4. Readiness to Change; ☐ 5. Relapse, Continued Use, or Continued Problem Potential; ☐ 6. Recovery Environment		
Problem Statement(s):		
Goals (Specific & Quantifiable):	**Target Date(s):**	**Resolution Date(s):**
Action Steps (Identify if steps will be taken by the provider and/or client to accomplish identified goals):	**Target Date(s):**	**Resolution Date(s):**

PROBLEM #3		
Select related ASAM Dimension: ☐ 1. Acute Intoxication and/or Withdrawal Potential; ☐ 2. Biomedical Conditions and Complications; ☐ 3. Emotional, Behavioral or Cognitive Conditions/Complications; ☐ 4. Readiness to Change; ☐ 5. Relapse, Continued Use, or Continued Problem Potential; ☐ 6. Recovery Environment		
Problem Statement(s):		
Goals (Specific & Quantifiable):	**Target Date(s):**	**Resolution Date(s):**
Action Steps (Identify if steps will be taken by the provider and/or client to accomplish identified goals):	**Target Date(s):**	**Resolution Date(s):**

Client Name: ______________________________ Client ID: ______________________________

PROPOSED TYPE OF INTERVENTION/MODALITY FOR SUCCESSFUL GOAL COMPLETION (Include proposed frequency and duration)
☐ Outpatient Services (OS):_____ x weekly for ______________________________
☐ Intensive Outpatient Services (IOS):______x weekly for ______________________________
☐ Residential Treatment (indicate ASAM level and duration established via ongoing Re-Assessment/Authorization process): ______________________________
☐ Recovery Services:_____x weekly☐ or monthly☐ for ______________________________
***** Indicate type of services below *****
☐ Individual Counseling:______x weekly☐ or monthly☐ for ______________________________
☐ Group Counseling:________x weekly☐ or monthly☐ for ______________________________
☐ Case Management:_______x weekly☐ or monthly☐ for ______________________________
☐ Collateral Services:_______x weekly☐ or monthly☐ for ______________________________
☐ Patient Education:_______x weekly☐ or monthly☐ for ______________________________
☐ OTP/NTP______x weekly for______________________ ☐ Withdrawal Management Services: ______________________

Does this treatment plan include the Treatment Plan Addendum form for additional problems? ☐ Yes ☐ No
If yes, how many total problems are documented in this entire treatment plan? ______________________________

TREATMENT PLAN SIGNATURES

Client was offered a copy of the plan: ☐ YES
☐ NO (if no, document why): ______________________________

Client Signature		**Date**
If client refuses or is unavailable to sign the treatment plan, please explain:		
Counselor Name	**Counselor Signature**	**Date**
LPHA or MD Name	**LPHA or MD Signature**	**Date**

Updated Treatment Plan Instructions

REQUIRED FORM:

An Individual Treatment Plan is a required document within the client file.
(Residential Programs: Submit to Optum as part of ongoing authorization process, as needed.)

WHEN:

This form is to be completed in accordance with timeframes specified below:

- Outpatient Programs - when a change in problem identification or focus of recovery or treatment occurs, or no later than 90 calendar days after signing the initial treatment plan, and not later than every 90 calendar days thereafter. (Note: Remember to complete the ASAM Level of Care form whenever completing an Updated Treatment Plan)

- For Residential Programs - when a change in problem identification or focus of recovery or treatment occurs, or no later than 30 calendar days after signing the initial treatment plan, and not later than every 30 calendar days thereafter. (Note: Remember to complete the ASAM Level of Care form whenever completing an Updated Treatment Plan)

COMPLETED BY:

To be completed jointly by LPHA/Counselor and client based upon the information obtained during the initial Intake, assessment and previous Treatment Plans along with information provided by the client and collateral sources over the course of treatment.

REQUIRED ELEMENTS (do not leave any blanks):

- **Client Name:** Client's full name. (**NOTE:** to be entered on each page of the Treatment Plan)
- **Primary Counselor Name:** Primary LPHA/Counselor's name.
- **Case Manager Name:** Case manager's name.
- **Client ID#:** Client ID number by entering the client's SanWITS' Unique Client Number (UCN). (**NOTE:** to be entered on each page of the Treatment Plan)
- **Admission Date:** Date client was admitted to program.
- **DSM-5 Diagnosis(es):** Enter the DSM-5 diagnosis. More than one diagnosis can be entered, but the *Primary diagnosis must be a Substance Use Disorder.*
- **Date of the Last Treatment Plan:** Enter date of initial or previous Treatment Plan.
- **Date of Treatment Plan Update:** Enter date this treatment plan was completed.
- **Was a physical exam completed?** Check the appropriate box**.** If Yes is checked, provide the date of the physical. (Inform client that further proof of physical exam may be required).
- **Assessments/Forms Reviewed:** Check the appropriate boxes; if other, provide details.
- **If client's preferred language is not English, were linguistically appropriate services provided?** Check the appropriate box; if No, explain in detail.
- **What does the client want to change on their current treatment plan from the previous treatment plan?** Document the client's expectations regarding continuing treatment services

and what the client hopes to gain from continuing to receive services at the program. You may use client's own words.

- **What does the client want to change on their current treatment plan from the previous treatment plan?** Attempt to obtain client's expectations regarding continuing treatment services and document using the client's own words.
- **Client Strengths/Resources/Abilities/Interests (to be used to reach treatment plan goals):** Use Motivational Interviewing techniques to obtain strengths-based client information to use when creating treatment plan goals.
- **Current Needs at Time of Treatment Plan Update:** Check the appropriate box after assessing the client's progress on their treatment plan goals and appropriate level of care. Then, enter client's Recommended Level of Care and Actual Level of Care based on the information from the ASAM Level of Care form that was completed with this treatment plan update.

PROBLEM'S #1, #2, #3

- **Select related ASAM Dimension:** Check appropriate box(s). Review all 6 ASAM Dimension criteria to assess which box(s) to check.

- **Problem Statement:**
  1. Personalize problem(s) unique to the client.
  2. Write problems in client language and *prioritize* (emergent, realistic for completion, what is needed to prevent relapse?)
  3. If a physical health concern is identified (e.g., pregnancy or lack of a physical in the last 12 months), this needs to be addressed in one of the problem areas on the plan.
  4. Multiple related issues may be combined into one problem statement that fall under the same ASAM dimension(s). For example, a client may have multiple Bio-medical issues, such as needing a physical exam, follow up care on diabetes, and dental work which could all be incorporated into one problem as they are all related to ASAM dimension 2.
  5. If the client cannot demonstrate having had a physical exam within 12 months prior to admission to treatment, problem must identify lack/need for a physical exam.
  6. Should a client demonstrate completion of a physical exam within 12 months prior to admission to treatment, and a significant medical illness has been identified; client problem to address appropriate treatment for the illness.

- **Goal(s):** What do the client and program want to accomplish? Use "SMART" acronym (Specific, Measurable, Attainable, Realistic, Time-Related):
  1. Goals must be measurable and achievable.
  2. If multiple problems are grouped together, then include a specific goal to resolve each of the specific problems.
  3. If the client has not received a physical exam within 12 months prior to admission to treatment, a goal that the client completes a physical examination must be included.

4. Should a client demonstrate completion of a physical exam within 12 months prior to admission to treatment, and a significant medical illness has been identified; a client goal to obtain appropriate treatment for the illness must be included.

- **Action Steps:** Action steps to be taken by the LPHA/Counselor and/or client to accomplish identified goals:
    1. Include specific actions the LPHA/counselor will do while providing treatment services to the client (e.g., individual counseling, group, etc.) to help the client reach their goals. Include the use of evidence-based treatment interventions (e.g., Motivational Interviewing, Relapse Prevention) to be utilized, if applicable.
    1. Include specific actions the client will do to reach their goals (e.g., Client will identify a list of potential doctors and contact at least 1 to schedule an appointment to complete a physical).
    2. If multiple problems are grouped together, then include a specific action step to accomplish each of the specific problem goals.

- **Target Date(s):** Estimated date of completion per action step. Dates to reflect each of the specific goals and action steps (i.e., if there are 3 goals, there will be 3 target dates).

- **Resolution Date(s):** Actual task completion date to be documented on the treatment plan after the treatment plan has been developed. Remember to document if the client did not complete a goal or action step when carrying over the same goal/action to the next plan. Dates to reflect each of the specific goals and action steps (i.e., if there are 3 goals, there will be 3 resolution dates).

PROPOSED TYPE OF INTERVENTION/MODALITY FOR SUCCESSFUL GOAL COMPLETION (INCLUDE FREQUENCY AND DURATION)

- **Check the appropriate Modality box and enter frequency and duration for each box checked:** List includes the following modalities: Outpatient Services (OS), Intensive Outpatient Services (IOS), Residential Treatment, Recovery Services

- **Indicate type of services below:** check appropriate type(s) of service(s) and indicate frequency and duration of each service (except for Withdrawal Management Services; indicate duration)

Does this treatment plan include the Treatment Plan Addendum form for additional problems: Mark Yes or No to indicate if a Treatment Plan Addendum form was utilized to complete this treatment plan.

If yes, how many total problems are documented in this entire treatment plan? If a Treatment Plan Addendum form was utilized, document the total number of problems documented on the entire treatment plan as there will be more than 3 problems.

TREATMENT PLAN SIGNATURES

- **Client was offered a copy of the plan:** Check Yes or No; if No, document why.

- **Client Signature:** Client to sign and date.
  1. The client must be present and participate in the treatment plan to bill for treatment plan services.
  2. Client signature provides evidence of client participation and agreement with the Individual Recovery/Treatment Planning process.
     - **For Outpatient:** Client must sign within 90 days from the previous treatment plan's completion date.
     - **For Residential:** All signatures must be in place within 30 days from the previous treatment plan.
     - If client **refuses to sign** the treatment plan, please document reason for refusal and the strategy that will be used to engage client for participation in treatment plan. Future attempts to obtain the client's signature on the treatment plan should be documented in progress notes.
- **Counselor/LPHA Name, Signature, and Date:** LPHA/Counselor's legibly printed or typed name, signature with degree and/or credentials, and date of completed Individual Treatment Plan.
  - o **For Outpatient:** Counselors must sign the treatment plan within 90 days from the previous treatment plan's completion date.
  - o **For Residential:** All signatures must be in place within 30 days from the previous treatment plan.
  - o The date of LPHA/Counselor signature is considered the treatment plan completion date.
- ***MD/LPHA Name, Signature, and Date:** MD/LPHA legibly printed or typed name, signature with credentials and date of completed Individual Treatment Plan.
  - o **For Outpatient:** The MD or LPHA has up to 15 days after the counselor's signature date to sign the treatment plan.
  - o **For Residential:** All signatures must be in place within 30 days from the previous treatment plan.

Client Name: ______________________ Client ID: ______________________

Updated Treatment Plan

CLIENT INFORMATION		
Name:	**Client Id#:**	**Admission Date:**

Primary Counselor Name:	**Case Manager Name:**

DSM-5 Diagnosis(es):

Date of Initial Treatment Plan:

Was a physical exam completed?

☐ If yes, provide the date of physical (must be completed within last 12 months): ______________________

☐ If no, include the goal of obtaining a physical exam under the appropriate problem area below (must remain a goal until completed)

Assessments Reviewed:	**If client's preferred language is not English, were linguistically appropriate services provided?**
☐ ASI or YAI ☐ ASAM LOC Recommendation ☐ Risk Assessment ☐ Health Questionnaire ☐ Other:	☐ Yes ☐ No (**If no, please explain below)**

What does the client want to obtain from treatment (use client's own words):

Client Strengths/Resources/Abilities/Interests (to be used to reach treatment plan goals):

PROBLEM #1

Select related ASAM Dimension: ☐ 1. Acute Intoxication and/or Withdrawal Potential; ☐ 2. Biomedical Conditions and Complications; ☐ 3. Emotional, Behavioral or Cognitive Conditions/Complications; ☐ 4. Readiness to Change; ☐ 5. Relapse, Continued Use, or Continued Problem Potential; ☐ 6. Recovery Environment

Problem Statement(s):

Goals (Specific & Quantifiable):	**Target Date(s):**	**Resolution Date(s):**

Action Steps (Identify if steps will be taken by the provider and/or client to accomplish identified goals):	**Target Date(s):**	**Resolution Date(s):**

Client Name: ________________________________ Client ID: ________________________________

PROBLEM #2		
Select related ASAM Dimension: ☐ 1. Acute Intoxication and/or Withdrawal Potential; ☐ 2. Biomedical Conditions and Complications; ☐ 3. Emotional, Behavioral or Cognitive Conditions/Complications; ☐ 4. Readiness to Change; ☐ 5. Relapse, Continued Use, or Continued Problem Potential; ☐ 6. Recovery Environment		
Problem Statement(s):		
Goals (Specific & Quantifiable):	**Target Date(s):**	**Resolution Date(s):**
Action Steps (Identify if steps will be taken by the provider and/or client to accomplish identified goals):	**Target Date(s):**	**Resolution Date(s):**

PROBLEM #3		
Select related ASAM Dimension: ☐ 1. Acute Intoxication and/or Withdrawal Potential; ☐ 2. Biomedical Conditions and Complications; ☐ 3. Emotional, Behavioral or Cognitive Conditions/Complications; ☐ 4. Readiness to Change; ☐ 5. Relapse, Continued Use, or Continued Problem Potential; ☐ 6. Recovery Environment		
Problem Statement(s):		
Goals (Specific & Quantifiable):	**Target Date(s):**	**Resolution Date(s):**
Action Steps (Identify if steps will be taken by the provider and/or client to accomplish identified goals):	**Target Date(s):**	**Resolution Date(s):**

Client Name: ______________________________ Client ID: ______________________________

PROPOSED TYPE OF INTERVENTION/MODALITY FOR SUCCESSFUL GOAL COMPLETION (Include proposed frequency and duration)
☐ Outpatient Services (OS):______ x weekly for ______________________
☐ Intensive Outpatient Services (IOS):______x weekly for ______________________
☐ Residential Treatment (indicate ASAM level and duration established via ongoing Re-Assessment/Authorization process): ______________________
☐ Recovery Services:_____x weekly☐ or monthly☐ for ______________________
***** Indicate type of services below *****
☐ Individual Counseling:_______x weekly☐ or monthly☐ for ______________________
☐ Group Counseling:________x weekly☐ or monthly☐ for ______________________
☐ Case Management:_______x weekly☐ or monthly☐ for ______________________
☐ Collateral Services:_______x weekly☐ or monthly☐ for ______________________
☐ Patient Education:_______x weekly☐ or monthly☐ for ______________________
☐ OTP/NTP______x weekly for______________________ ☐ Withdrawal Management Services: ______________________

Does this treatment plan include the Treatment Plan Addendum form for additional problems? ☐ Yes ☐ No
If yes, how many total problems are documented in this entire treatment plan? ______________________

TREATMENT PLAN SIGNATURES

Client was offered a copy of the plan: ☐ YES

☐ NO (if no, document why): ______________________

Client Signature		Date
If client refuses or is unavailable to sign the treatment plan, please explain:		
Counselor Name	**Counselor Signature**	**Date**
LPHA or MD Name	**LPHA or MD Signature**	**Date**

Treatment Plan Addendum Instructions

WHEN:

This form is to be utilized, as needed, if additional problems are identified beyond the 3 problems allocated on the initial or updated Treatment Plan Form. It is to be attached to the Initial or Updated Treatment Plan form.

NOTE: The ASAM Level of Care Recommendation form (F306) shall be completed in conjunction with (and not after) the Initial/Updated Treatment Plan.

COMPLETED BY:

To be completed jointly by LPHA/Counselor and client as needed to complete the Treatment Plan.

REQUIRED ELEMENTS:

- **Client Name:** Complete with client's full name.
- **Client ID:** Complete by entering the client's SanWITS' Unique Client Number (UCN).
- **What type of Treatment Plan is this Addendum attached to:** Mark Initial Treatment Plan or Updated Treatment Plan to indicate what type of treatment plan this addendum is attached to.
- **Date of this Treatment Plan:** Document the date of the treatment plan this Addendum Treatment Plan form is attached to.

PROBLEM

- **Problem #:** Indicate the appropriate problem number (i.e. 4, if this is the first additional problem)
- **Select related ASAM Dimension(s):** Check appropriate box(s). Review all 6 ASAM dimension criteria to assess which box(s) to check.
- **Problem Statement(s):**
  1. Personalize problem(s) unique to the client.
  2. Write problems in client language and *prioritize* (emergent, realistic for completion, what is needed to prevent relapse?)
  3. If a physical health concern is identified (e.g., pregnancy or lack of a physical in the last 12 months), this needs to be addressed in one of the problem areas on the plan.
  4. Multiple related issues may be combined into one problem statement that fall under the same ASAM dimension(s). For example, a client may have multiple bio-medical issues, such as needing a physical exam, follow up care on diabetes, and dental work which could all be incorporated into one problem as they are all related to ASAM dimension 2.
  5. If the client cannot demonstrate having had a physical exam within 12 months prior to admission to treatment, then a problem must identify lack/need for a physical exam.
  6. If the client has demonstrated completion of a physical exam within 12 months prior to admission to treatment, and a significant medical illness has been identified; then a problem may be that the client needs to address appropriate treatment for the illness.
- **Goal(s):** What does the client and program want to accomplish? Use "SMART" acronym (Specific, Measurable, Attainable, Realistic, Time-Related):

1. Goals must be measurable and achievable. If multiple problems are grouped together, then include a specific goal to resolve each of the specific problems.
2. If the client has not received a physical exam within 12 months prior to admission to treatment, a goal that the client completes a physical examination must be included.
3. Should a client demonstrate completion of a physical exam within 12 months prior to admission to treatment, and a significant medical illness has been identified; a client goal to obtain appropriate treatment for the illness must be included.

- **Action Steps:** Action steps to be taken by the LPHA/Counselor and/or client to accomplish identified goals:
    1. Include specific actions the LPHA/counselor will do while providing treatment services to the client (e.g., individual counseling, group, etc.) to help the client reach their goals. Include the use of evidence-based treatment interventions (e.g., Motivational Interviewing, Relapse Prevention) to be utilized, if applicable.
    1. Include specific actions the client will do to reach their goals (e.g., Client will identify a list of potential doctors and contact at least 1 to schedule an appointment to complete a physical).
    2. If multiple problems are grouped together, then include a specific action step to accomplish each of the specific problem goals.
- **Target Date(s):** Estimated date of completion per action step. Dates to reflect each of the specific goals and action steps (i.e., if there are 3 goals, there will be 3 target dates).
- **Resolution Date(s):** Actual task completion date to be documented on the treatment plan after the treatment plan has been developed. Remember to document if the client did not complete a goal or action step when carrying over the same goal/action to the next plan. Dates to reflect each of the specific goals and action steps (i.e., if there are 3 goals, there will be 3 resolution dates).

Client Name: Client ID:

Treatment Plan Addendum

(Note: Form to be attached to Initial or Update Treatment Plan)

What type of Treatment Plan is this Addendum attached to? ☐ **Initial Treatment Plan** ☐ **Updated Treatment Plan**

Date of this Current Treatment Plan: ________________________

PROBLEM #____		
Select related ASAM Dimension(s): ☐ 1. Acute Intoxication and/or Withdrawal Potential; ☐ 2. Biomedical Conditions and Complications; ☐ 3. Emotional, Behavioral or Cognitive Conditions/Complications; ☐ 4. Readiness to Change; ☐ 5. Relapse, Continued Use, or Continued Problem Potential; ☐ 6. Recovery Environment		
Problem Statement(s):		
Goals (Specific & Quantifiable):	**Target Date(s):**	**Resolution Date(s):**
Action Steps (Identify if steps will be taken by the provider and/or client to accomplish identified goals):	**Target Date(s):**	**Resolution Date(s):**

PROBLEM #____		
Select related ASAM Dimension(s): ☐ 1. Acute Intoxication and/or Withdrawal Potential; ☐ 2. Biomedical Conditions and Complications; ☐ 3. Emotional, Behavioral or Cognitive Conditions/Complications; ☐ 4. Readiness to Change; ☐ 5. Relapse, Continued Use, or Continued Problem Potential; ☐ 6. Recovery Environment		
Problem Statements:		
Goals (Specific & Quantifiable):	**Target Date(s):**	**Resolution Date(s):**
Action Steps (Identify if steps will be taken by the provider and/or client to accomplish identified goals):	**Target Date(s):**	**Resolution Date(s):**

Recovery Services Individualized Recovery Plan Instructions

REQUIRED FORM:

A Recovery Plan is required for clients receiving Recovery Services.

WHEN:

This form is to be completed within the following timelines:

- **Initial Recovery Plan** – Within 30 days of admission into Recovery Services
- **Updated Recovery Plan** – Within 90 days of date the last Recovery Plan was completed **OR** as needed when a significant change occurs

COMPLETED BY:

To be completed jointly by LPHA/Counselor and client based upon the information obtained during client's transition/admission into Recovery Services.

REQUIRED ELEMENTS (do not leave any blanks):

- **Client Name:** Client's full name. (**NOTE:** to be entered on each page of the Recovery Plan)
- **Client ID#:** Client ID number as determined by SanWITS' Unique Client Number (UCN). (**NOTE:** to be entered on each page of the Recovery Plan)
- **Date of Recovery Plan:** Indicate date of completion of recovery plan
- **Proposed Intervention:** Case Management
  - **Frequency:** Indicate how many times CM Services will be provided per month
  - **Duration:** Indicate how long CM Services will be provided
  - **Identity the services and/or skills that will be accomplished**: Check any/all that apply and describe in box provided below
  - **Identify which supports will be required to achieve the plan:** Check any/all that apply and describe in box provided below
  - **Identify any other needs and/or assistance necessary to support the recovery plan:** Check any/all that apply and describe in box provided below
- **Proposed Intervention:** Individual Counseling Services
  - **Frequency:** Indicate how many times Individual Counseling Services will be provided per month
  - **Duration:** Indicate how long Individual Counseling Services will be provided
  - Describe individual counseling services in box provided
- **Proposed Intervention:** Group Counseling Services
  - **Frequency:** Indicate how many times Group Counseling Services will be provided per month
  - **Duration:** Indicate how long Group Counseling Services will be provided
  - Describe group counseling services in box provided

- **Client was offered a copy of the plan:** Check Yes or No (if no, document why)
- **Client Signature:** Client to sign and date.
    1. The client must be present and participate in the recovery plan to bill for recovery planning services.
    2. Client signature provides evidence of client participation and agreement with the Recovery Planning process.
        - If client **refuses to sign** the Recovery plan, please document reason for refusal and the strategy that will be used to engage client for participation in Recovery plan. Future attempts to obtain the client's signature on the Recovery plan should be documented in progress notes.
- **Counselor/LPHA Name, Signature, and Date:** LPHA/Counselor's legibly printed or typed name, signature with degree and/or credentials, and date of completed Individual Recovery Plan.
- ***MD or LPHA Name, Signature, and Date:** MD/LPHA legibly printed or typed name, signature with credentials and date of signature.

RECOVERY SERVICES INDIVIDUALIZED RECOVERY PLAN

A recovery plan is to assist you, the client, in continuing your recovery and to help you understand that recovery is a long-term, lifestyle change. This recovery plan is to be reviewed and updated on an as needed basis.

Client Name: ___________________________ **Client ID**: ___________________________

Date of Recovery Plan: ___________________________

PROPOSED INTERVENTION	FREQUENCY	DURATION
☐ Case Management (see options below)	______x/month	For: ___________

Identity the services and/or skills that will be accomplished:

☐ Education ☐ Job Skills ☐ Life Skills ☐ Employment ☐ N/A

Identify which supports will be required to achieve the plan:

☐ Childcare ☐ Parent Education ☐ Child Development Support Services ☐ Family/Marriage Education ☐ N/A

Identify any other needs and/or assistance necessary to support the recovery plan:

☐ Housing ☐ Transportation ☐ Primary Care Physician ☐ Dental ☐ Other ☐ N/A

RECOVERY SERVICES INDIVIDUALIZED RECOVERY PLAN

Client Name: ______________________________ **Client ID:** ______________________________

PROPOSED INTERVENTION	FREQUENCY	DURATION
☐ Individual Counseling Services	______x/month	For: _________
☐ Group Counseling Services	______x/month	For: _________

RECOVERY PLAN SIGNATURES

Client was offered a copy of the plan: ☐ YES

☐ NO (if no, document why): ______________________________

CLIENT SIGNATURE		DATE
If a client refuses or is unavailable to sign the recovery plan, please explain:		
COUNSELOR NAME	**COUNSELOR SIGNATURE**	**DATE**
LPHA/MD NAME	**LPHA/MD SIGNATURE**	**DATE**

Treatment Effectiveness Assessment (TEA) Instructions

REQUIRED FORM:

This form is required in the client file for clients in Recovery Services.

WHEN:

This form is to be completed within 30 days of admission to Recovery Services and in conjunction with Recovery Plan updates (at least every 90 days).

COMPLETED BY:

This form is to be completed by the client and reviewed by the counselor and/or LPHA.

REQUIRED ELEMENTS:

- **Client Name**: Document client's full name.
- **Client ID#:** Document the client's Unique Client Number (UCN) as determined by SanWITS.
- **First TEA?:** Check the box that applies (Yes/No). If this is the First TEA for this recovery services episode, then mark "yes". Otherwise mark "no".
- **1. Substance Use:** How much better are you with drug and alcohol use? Consider the frequency and amount of use, money spent on drugs, amount of drug craving, time spent being loaded, being sick, in trouble and in other drug-using activities, etc.
    - Think about how things have become better and circle the results on the scale from 1 (not better at all) to 10 (very much better) with the more improvement reflecting the higher the number.
    - **Remarks:** Write down the one or two changes most important to you with regards to Substance use.
- **2. Health:** Has your health improved? In what way and how much? Think about your physical and mental health: Are you eating and sleeping properly, exercising, taking care of health problems or dental problems, feeling better about yourself, etc?
    - Think about how things have become better and circle the results on the scale from 1 (not better at all) to 10 (very much better) with the more improvement reflecting the higher the number.
    - **Remarks:** Write down the one or two changes most important to you with regards to Health.
- **3. Lifestyle:** How much better are you in taking care of personal responsibilities? Think about your living conditions, family situation, employment, relationships: Are you paying your bills? Following through with your personal or professional commitments?

- Think about how things have become better and circle the results on the scale from 1 (not better at all) to 10 (very much better) with the more improvement reflecting the higher the number.
  - **Remarks:** Write down the one or two changes most important to you with regards to Lifestyle.
- **4. Community:** Are you a better member of the community? Think about things like obeying laws and meeting your responsibilities to society: Do your actions have positive or negative impacts on other people?
  - Think about how things have become better and circle the results on the scale from 1 (not better at all) to 10 (very much better) with the more improvement reflecting the higher the number.
  - **Remarks:** Write down the one or two changes most important to you with regards to Community.
- **TEA Completed By**
  - **Client Signature:** Client to sign name here
  - **Date:** Client to document date TEA completed
- **TEA Reviewed By**
  - **Counselor or LPHA Name:** SUD Counselor or LPHA reviewing completed TEA to print name here
  - **Counselor or LPHA Signature:** SUD Counselor or LPHA reviewing completed TEA to sign name here
  - **Date:** SUD Counselor or LPHA to document date completed TEA was reviewed

Treatment Effectiveness Assessment (TEA)

The TEA asks you, the client, to express the extent of changes for the better from your involvement in the program to this point (or how things are if it's your first TEA or baseline) in four areas: substance use, health, lifestyle, and community. For each area, think about how things have become better and circle the results on the scale below: the more you have improved, the higher the number – from 1 (not better at all) to 10 (very much better). In each area write down the one or two changes most important to you in the Remarks section.

Client Name:	**Client ID#:**	**First TEA?** ☐ Yes ☐ No

1. Substance use: How much better are you with drug and alcohol use? Consider the frequency and amount of use, money spent on drugs, amount of drug craving, time spent being loaded, being sick, in trouble and in other drug-using activities, etc.

None or not much — Better — Much better

1 2 3 4 5 6 7 8 9 10

Remarks:

2. Health: Has your health improved? In what way and how much? Think about your physical and mental health: Are you eating and sleeping properly, exercising, taking care of health problems or dental problems, feeling better about yourself, etc?

None or not much — Better — Much better

1 2 3 4 5 6 7 8 9 10

Remarks:

3. Lifestyle: How much better are you in taking care of personal responsibilities? Think about your living conditions, family situation, employment, relationships: Are you paying your bills? Following through with your personal or professional commitments?

None or not much — Better — Much better

1 2 3 4 5 6 7 8 9 10

Remarks:

4. Community: Are you a better member of the community? Think about things like obeying laws and meeting your responsibilities to society: Do your actions have positive or negative impacts on other people?

No or not much — Better — Much better

1 2 3 4 5 6 7 8 9 10

Remarks:

TEA Completed By	**Client Signature**		**Date**
TEA Reviewed By	**Counselor or LPHA Name**	**Counselor or LPHA Signature**	**Date**

The County of San Diego Behavioral Health Services has permission to utilize the TEA through Dr. Walter Ling of UCLA's David Geffen School of Medicine.

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Withdrawal Management Treatment Plan Instructions

REQUIRED FORM:

Based on Intergovernmental Agreement guidelines, an Individual Recovery/Treatment Plan is a required document within the client file.

WHEN:

This form is to be completed in accordance with timeframes specified below:

- Withdrawal Management – within 72 hours of admission to program.

COMPLETED BY:

To be completed jointly by LPHA/Counselor and client based upon the information obtained during the initial intake, assessment and treatment planning sessions with the client.

REQUIRED ELEMENTS (do not leave any blanks):

CLIENT INFORMATION

- **Client Name:** Client's full name. (**NOTE:** to be entered on each page of the Treatment Plan)
- **Primary Counselor:** Primary LPHA/SUD Counselor name.
- **Client ID#:** Client ID is SanWITS number (**NOTE:** to be entered on each page of the Treatment Plan)
- **Admission Date:** Date client was admitted to program.
- **DSM-5 Diagnosis(es):** Enter the DSM-5 diagnosis. More than one diagnosis can be entered, but the *Primary diagnosis must be a Substance Use Disorder.*
- **Date of the Initial Treatment Plan:** Enter date the Treatment Plan was completed.
- **Was a physical exam completed?** Check the appropriate box**.** If Yes is checked, provide the date of the physical. (Inform client that further proof of physical exam may be required).
- **Assessments/Forms Reviewed:** Check the appropriate boxes; if other, provide details.
- **If client's preferred language is not English, were linguistically appropriate services provided?** Check the appropriate box; if No, explain in detail.
- **What does the client want to obtain during and after withdrawal management (use client's own words):** Document the client's expectations regarding treatment services and what the client hopes to gain from receiving services at the program. You may use client's own words.
- **Client Strengths/Resources/Abilities/Interests (to be used to reach treatment plan goals):** Use Motivational Interviewing techniques to obtain strengths-based client information to use when creating treatment plan goals.

Goals Short Term and Long Term:

- **Select related ASAM Dimension:** Check appropriate box(es). Review all 6 ASAM dimension criteria to assess which box(s) to check.
- **Problem Statement:**
  - Personalize problem(s) unique to the client.
  - Write problems in client language and *prioritize* (withdrawal concerns, medical condition, emergent, realistic for completion, what is needed for safety of client)

- If a physical health concern is identified (e.g., pregnancy or medical condition such as diabetes), this needs to be addressed in one of the problem areas on the plan.
- Multiple related issues may be combined into one problem statement that fall under the same ASAM dimension(s). For example, a client may have multiple Bio-medical issues, such as needing a physical exam, follow up care on diabetes, medical condition that may be of a concern while detoxing and dental work which could all be incorporated into one problem as they are all related to ASAM dimension 2.
- If the client cannot demonstrate having had a physical exam within 12 months prior to admission to treatment, then a problem must identify lack/need for a physical exam.
- If the client has demonstrated completion of a physical exam within 12 months prior to admission to treatment, and a significant medical illness has been identified; then a problem may be that the client needs to address appropriate treatment for the illness.

- **Goal(s):** What does the client and program want to accomplish? Use "SMART" acronym (Specific, Measurable, Attainable, Realistic, Time-Related):
  1. Goals must be measurable and achievable.
  2. If multiple problems are grouped together, then include a specific goal to resolve each of the specific problems.
  3. If client has been identified as having a medical conditions or having withdrawal symptoms, a goal that the clients completes is withdrawal management services.
  4. If the client has not received a physical exam within 12 months prior to admission to treatment, a goal that the client completes a physical examination must be included.
  5. Should a client demonstrate completion of a physical exam within 12 months prior to admission to treatment, and a significant medical illness has been identified; a client goal to obtain appropriate treatment for the illness must be included.

- **Action Steps:** Action steps to be taken by the LPHA/Counselor and/or client to accomplish identified goals:
  1. Include specific actions the LPHA/counselor will do while providing treatment services to the client (e.g., individual counseling, group, etc.) to help the client reach their goals. Include the use of evidence-based treatment interventions (e.g., Motivational Interviewing, Relapse Prevention) to be utilized, if applicable.
  2. Include specific actions the client will do to reach their goals (e.g., Client will follow medical advice during withdrawal and take medication as prescribed).
  3. If multiple problems are grouped together, then include a specific action step to accomplish each of the specific problem goals.

- **Target Date(s):** Estimated date of completion per action step. Dates to reflect each of the specific goals and action steps (i.e., if there are 3 goals, there will be 3 target dates).

  - **Resolution Date(s):** Actual task completion date to be documented on the treatment plan after the treatment plan has been developed. Remember to document if the client did not complete a goal or action step when carrying over the same goal/action to the next plan. Dates to reflect each of the specific goals and action steps (i.e., if there are 3

goals, there will be 3 resolution dates).

WITHDRAWAL MANAGEMENT PROPOSED SERVICES (INCLUDE FREQUENCY AND DURATION) (Ex: Observation: every 30 minutes for a duration of 24 hours)

- **Check the appropriate Modality box and enter frequency and duration for each box checked:** List includes observation and medication services, individual services, case management, collateral services, patient education, and group services.

Client was offered a copy of the plan: Check Yes or No; if No, document why.

<u>TREATMENT PLAN SIGNATURES</u>

- **Client Signature:** Client to sign and date.
    1. The client must be present and participate in the treatment plan to bill for treatment plan services.
    2. Client signature provides evidence of client participation and agreement with the Individual Recovery/Treatment Planning process.
        - **For Withdrawal Management**: Client must sign within 72 hours of admission to program. If client **refuses to sign** the treatment plan, please document reason for refusal and the strategy that will be used to engage client for participation in treatment plan. Future attempts to obtain the client's signature on the treatment plan should be documented in progress notes.
- **Counselor/LPHA/MD Name, Signature, and Date:** LPHA/Counselor/MD's legibly printed or typed name, signature with degree and/or credentials, and date of completed Individual Treatment Plan.
    - **For Withdrawal Management**: All signatures must be in place within 72 hours from time of admission.
    - The date of LPHA/Counselor/MD signature is considered the treatment plan completion date.

Client Name: ________________________ Client ID: ________________________

Withdrawal Management Treatment Plan

CLIENT INFORMATION	
Name:	**Primary Counselor:**
Client Id #:	**Admission Date:**
DSM-5 Diagnosis(es):	
Date of Initial Withdrawal Management (WM) Treatment Plan ***(within 72 hours of Admission):***	
Was a physical exam completed? ☐If yes, provide the date of physical (must be completed within last 12 months): ____________ ☐If no, include the goal of obtaining a physical exam under the appropriate goal area below (must remain a goal until completed)	
Assessments Reviewed: ☐ Initial LOC Assessment ☐ Health Questionnaire ☐ Risk Assessment ☐ Observation Log ☐ Other:	**If client's preferred language is not English, were linguistically appropriate services provided?** ☐ Yes ☐ No (**If no, please explain below)**
What does the client want to obtain during and after withdrawal management (use client's own words):	
Client Strengths/Resources/Abilities/Interests (to be used to reach treatment plan goals):	

SHORT TERM GOALS		
Select related ASAM Dimension: ☐ 1. Acute Intoxication and/or Withdrawal Potential; ☐ 2. Biomedical Conditions and Complications; ☐ 3. Emotional, Behavioral or Cognitive Conditions/Complications; ☐ 4. Readiness to Change; ☐ 5. Relapse, Continued Use, or Continued Problem Potential; ☐ 6. Recovery Environment		
Problem Statement(s):		
Goals (Specific & Quantifiable):	**Target Date(s):**	**Resolution Date(s):**
Action Steps (Identify if steps will be taken by the provider and/or client to accomplish identified goals): ☐**Client's responsibility:** ☐**Counselor/LPHA responsibility:**	**Target Date(s):**	**Resolution Date(s):**

Client Name: ________________________ Client ID: ________________________

LONG TERM GOALS		
Select related ASAM Dimension: ☐ 1. Acute Intoxication and/or Withdrawal Potential; ☐ 2. Biomedical Conditions and Complications; ☐ 3. Emotional, Behavioral or Cognitive Conditions/Complications; ☐ 4. Readiness to Change; ☐ 5. Relapse, Continued Use, or Continued Problem Potential; ☐ 6. Recovery Environment		
Problem Statement(s):		
Goals (Specific & Quantifiable):	**Target Date(s):**	**Resolution Date(s):**
Action Steps (Identify if steps will be taken by the provider and/or client to accomplish identified goals): ☐**Client's responsibility:** ☐**Counselor/LPHA responsibility:**	**Target Date(s):**	**Resolution Date(s):**

Client Name: ______________________________ Client ID: ______________________________

Withdrawal Management Proposed Services
***** Indicate type of services below *****
Provide the proposed frequency and duration of treatment: Ex: Observation: every 30 minutes for a duration of 24 hours, ex. proposed length of length of stay (3 to 7 days).

☐ Observation :________________________ for a duration of ______________________________

☐ Medication Services: ________ x daily for ______________________________

☐ Individual Counseling:______x daily ☐ weekly ☐ for ______________________________

☐ Case Management:_______x daily ☐ weekly ☐ for ______________________________

☐ Collateral Services:_______x daily ☐ weekly ☐ for ______________________________

☐ Patient Education:_______x daily ☐ weekly ☐ for ______________________________

☐ Group Counseling:_______x daily ☐ weekly ☐ for ______________________________

TREATMENT PLAN SIGNATURES

Client was offered a copy of the plan: ☐ YES

☐ NO (if no, document why): ______________________________

Client Signature		**Date**
If client refuses or is unavailable to sign the treatment plan, please explain:		
Counselor Name	**Counselor Signature**	**Date**
LPHA/MD Name	**LPHA/MD Signature**	**Date**

Section 6
Progress Notes

F601	SUD Treatment Progress Note
F602a	Weekly Progress Note Residential - Narrative
F602b	Weekly Progress Note Residential - Services
F603	Residential or Withdrawal Management – Daily Progress Note
F604	Outpatient Group Progress Note

SUD Treatment Progress Note Instructions

REQUIRED FORM:

This form is a required document in the client file to document SUD services provided and includes progress toward achieving the client's recovery or treatment plan goals.

WHEN:

This form is to be completed to document individual services provided to a client.

This form must be completed within the following guidelines:

- Outpatient programs must document a progress note for each client service attended (except for group services; see dot point below) within 7 calendar days from the date of service.
  - Group services must be documented on the **Outpatient Group Progress Note (Form F604)**; all other services may be documented on this form (F601).
  - Services with progress notes documented after 7 calendar days will not be billable.
- A Residential program may use this form if the program does not use the Weekly **SUD Treatment Progress Note – Narrative/Services record (Forms F602a and F602b)** or the **Residential or Withdrawal Management Daily Progress Note (Form F603)**.
  - Residential programs **must** use this form to document **Case Management**, **Physician Consultations**, and **MAT** (these services cannot be documented on the ResidentialWeekly Progress Note – Narrative/Service Record (Forms F602a and F602b) or on the Residential or Withdrawal Management Daily Progress Note (Form F603)).
  - If a residential program is using this form (F601) to document client services, group services must be documented on the **Outpatient Group Progress Note (Form F604)**.
  - Services with progress notes documented after 7 calendar days will not be billable.

COMPLETED BY:

Each progress note is written by the SUD counselor or LPHA who provided the service.

REQUIRED ELEMENTS:

Progress notes shall be legible

- **Client Name:** Complete client's full name
- **Client ID:** Complete the client ID number by entering the client's SanWITS' Unique Client Number (UCN)
- **Service Date:** Complete date of the service
- Is service billable? (to the County or DMC)
- If yes, is service DMC billable?
- Start Time of Service
- End Time of Service
- Total Service Time in minutes

- Travel to Location Start Time/End Time *
- Travel from location Start Time/End Time *
- Total Travel Time in minutes*
- Date Documentation Completed – enter the date that documentation of the progress note, treatment plan, continuing services justification, or discharge paperwork was completed
- Documentation Start Time/End Time *
- Total Documentation Time in Minutes *
- Total time (including: service, documentation, travel) in minutes *
- Language of Service (if other than English)
- Translator Utilized (if applicable)
- Contact Type (F-F = Face to Face, TEL = Telephone, TH = Telehealth, COM = In Community)
- Service Type (AS = Assessment, GR = Group, CM = Case Management, TP = Treatment Planning, DC = Discharge, CR = Crisis, MAT = Medication Assisted Treatment, IND = Ind. Counseling, FT = Family Therapy, PC = Physician Consultation, O = Other)
- Topic of Session or Purpose of Service – describe the purpose of the service or specific group topic
- EBP Utilized (progress note must document specifics of how EBP was utilized the narrative)

Progress Note Narrative Section

A complete progress note addresses:

1. Provider support intervention including specific EBP technique utilized.
2. Client's progress towards one or more goals in the client's recovery or treatment or plan, action steps, and/or referrals.
3. New issues or problems that affect the client's recovery or treatment plan.
4. Other appropriate health care providers support.
5. Next steps in plan of care and referrals, if applicable.

Provider Signature: All entries must include the printed name with title/credentials, signature with title/credentials and date of the staff completing the progress note.

Date of completion: must be completed within 7 days of service to be billable.

*For residential programs – documentation time and travel time are not required elements, except when the service is for Case Management, Physician Consultation or MAT.

SUD TREATMENT PROGRESS NOTE

Client Name:____ **Client ID:**______________________________

Service Date*:	**Is service billable?** ☐Yes ☐No	**If yes, is service DMC-billable?** ☐Yes ☐No	**Start Time of Service:** ☐am ☐pm	**End Time of Service:** ☐am ☐pm	**Total Service Time:**

Travel To Location Start Time: ☐am ☐pm	**Travel To Location End Time:** ☐am ☐pm	**Travel From Location Start Time:** ☐am ☐pm	**Travel From Location End Time:** ☐am ☐pm	**Total Travel Time:**

Date Documentation Completed:	**Documentation Start Time:** ☐am ☐pm	**Documentation End Time:** ☐am ☐pm	**Total Documentation Time:**

Language of Service (if other than English): ☐N/A	**Translator Utilized?** ☐Yes ☐No ☐N/A	**Contact Type:**		**Service Type:**		**Total Time** (including service, doc, travel):

Topic of Session or Purpose of Service:	**EBP Utilized:** ☐Motivational Interviewing ☐Relapse Prevention ☐Other ☐N/A

Contact Type: **F-F** = Face-to-Face **TEL** = Telephone **TH** = Telehealth **COM** = In Community

Service Type: **AS** = Assessment **GR** = Group **CO** = Collateral **CM** = Case Mngt **TP** = Tx Planning **DC** = Discharge **CR** = Crisis **MAT** = Medication Assisted Tx **IND** = Ind. Counseling **FT** = Family Therapy **PC =** Physician Consultation **O** = Other

Narrative Must Include: 1) provider support and interventions 2) description of client's progress on treatment plan problems, goals, action steps, objectives, and/or referrals 3) client's ongoing plan including any new issues 4) if service was provided in the community, identify location and how confidentiality was maintained.

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Counselor/LPHA Printed Name, Title	**Signature, Credentials**	**Date of Completion***

*The date of service may be different than the date note is signed. Notes must be legibly printed, signed and dated by the counselor/LPHA within 7 days of the services provided.

Residential Weekly Progress Note – Narrative Instructions

REQUIRED FORM:

If the residential program has opted to use weekly progress notes, this form is a required document and must be used in conjunction with the “Residential Weekly Progress Note – Services” form.

WHEN:

The LPHA or counselor shall type or legibly print their name and sign and date the weekly progress note within the following calendar week. Weekly progress notes shall be completed from Sunday – Saturday.

This form is used to summarize the client’s participation and progress in weekly activities/services.

If you do not use this form (along with the “Residential Weekly Progress Note – Services” form), you may use the following forms:

- **SUD Treatment Progress Note (Form F601)**
  - In conjunction with the **Outpatient Group Progress Note (Form F604)** to document group services

OR you may use the:

- **Residential or Withdrawal Management Daily Progress Note (Form F603)**.

NOTE: Case management and/or physician consultation services are never captured on weekly or daily notes. An individual progress note (Form 601) must be completed for every case management and/or physician consultation service that is provided/claimed.

COMPLETED BY:

BHS SUDQM recommends that the primary counselor writes the narrative summary of the weekly services.

REQUIRED ELEMENTS:

Progress notes shall be legible.

1. **Client Name:** Enter the client’s full name.
2. **Client ID:** Enter the the client’s SanWITS’ Unique Client Number (UCN).
3. **Week of:** Enter the beginning date through the ending date of the service week.
4. Total service hours
5. Total clinical hours

Narrative must include a summary of the clinical services provided to the client during the week:

1) **Provider support & interventions:** Enter support and/or treatment intervention services delivered to the client.
   - Support/treatment intervention services to compliment the client’s treatment goals/objectives as listed on his/her Treatment Plan.
   - Specify which of the two recommended Evidence Based Treatment Interventions were used; Motivational Interviewing (MI), or Relapse Prevention (RP), and how the EBT interventions were utilized.
   - Interventions to address client level of participation/stage of change.

- Specify attempts to refer or link the client to additional resources, unless this was provided in a case management service (Reminder: case management services are documented on an individual progress note)

2) **Description of client's specific progress on treatment plan problems, goals, action steps, objectives, and/or referrals:** Enter information regarding client's progress.
   - Client's progress on treatment plan problems, goals and action steps
   - client's ongoing plan including any new issues

3) **If service (s) are provided in the community, identify location(s) and how confidentiality was maintained:** Enter where services were provided if in the community and explain how counselor/LPHA ensured confidentiality during provision of service.

Client's plan: Enter information regarding client's indicated goals.

- May use client's own words
- Client issues/goals may reflect existing goals on the Treatment Plan or may be a "new" treatment issue. If it appears that the "new" treatment issue will be of an ongoing nature, it is recommended to update the client's treatment plan.
- Offer the client to rate the priority of his/her stated "issue" or "goal" in his/her current life circumstance.
- Next steps in plan of care.

Signature:

- **Counselor/LPHA Printed Name, Title:** Type or legibly print primary counselor (**who documented the service/note**) name and title.
- **Signature, Credentials:** Complete signature and credentials by hand.
- **Date of Completion:** Complete date of progress note is signed here by hand. This must be completed within the following calendar week from when the service(s) were provided.

RESIDENTIAL WEEKLY PROGRESS NOTE – NARRATIVE

Client Name	**Client ID**

Narrative for week of:_______________to _______________

Total Service Hours:	**Total Clinical Hours:**
NOTE: This Narrative Form must be accompanied with a **"RESIDENTIAL WEEKLY PROGRESS NOTE – SERVICES"** to be considered valid. In addition, total number of service and clinical hours **must** match the hours documented on accompanying Services Progress Note.	

Narrative Must Include: 1) provider support and interventions, 2) client's progress on treatment plan problems, goals, & action steps, and 3) client's ongoing plan including any new issues 4) if service(s) provided in the community, identify location(s) and how confidentiality was maintained.

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Counselor/LPHA Printed Name, Title	**Signature, Credentials**	**Date of Completion***

*Notes must be legibly printed, signed and dated by the counselor/LPHA within the following calendar week of the services provided.

Residential Weekly Progress Note – Services Instructions

REQUIRED FORM:

If the residential program has opted to use weekly progress notes, this form is a required document and must be used in conjunction with the "Residential Weekly Progress Note – Narrative" form.

WHEN:

The LPHA or counselor shall type or legibly print their name and sign and date the weekly progress note within the following calendar week. Weekly progress notes shall be completed from Sunday – Saturday.

This form must be completed within the following guidelines: Residential Weekly Progress Note – Narrative/Service Record

- Any/each service provided to a client shall be reflected separately on the form

If you do not use this form (along with the "Residential Weekly Progress Note – Narrative" form), you may use the following forms:

- **SUD Treatment Progress Note (Form F601)**
  - In conjunction with the **Outpatient Group Progress Note (Form F604)** to document group services

OR you may use the:

- **Residential or Withdrawal Management Daily Progress Note (Form F603)**.

NOTE: Case management and/or physician consultation services are never captured on the weekly or daily notes. An individual progress note (Form 601) must be completed for every case management and/or physician consultation service that is provided/claimed.

COMPLETED BY:

Each service provided to the client can be documented by the LPHA or the SUD counselor who provided the service.

BHS SUDQM recommends the primary counselor who is responsible for writing the weekly narrative also be responsible for completing the Residential Weekly Progress Note – Services record.

REQUIRED ELEMENTS:

All documentation in the Service record shall be legible.

- Client Name: Enter the client's full name.
- Client ID: Enter the client's SanWITS' Unique Client Number (UCN).
- Week of: Enter the beginning date through the ending date of the service week.
- For each service provided, enter:

1. Service Date
2. Service start and end time
3. Indicate if service is clinical (Intake/Assessment, Individual Counseling, Group Counseling, Family Therapy, Collateral Services, Crisis Intervention Services, Treatment Planning, Discharge Services). **Note**: Patient Education and Transportation Services are NOT clinical services.
4. Service topic or purpose of service
5. Total service duration

6. Service contact type using the table (contact type) at the top of the form.
7. Service type using the selections indicated in the table (Service Type) at the top of the form
8. EBP Utilized
9. Is service billable? - A service is billable when it meets all documentation standards, has a valid authorization from Optum, and other requirements (such as group size limitations, etc.) are met. When all standards/requirements are met, a service will be billable to either the County or to Drug Medi-Cal (DMC).
10. Is service DMC billable? – A service is DMC billable when a client has Medi-Cal, is within the time limited DMC treatment episode requirements, has a valid authorization from Optum, and all DMC standards are met.

    Note: It is possible for a service to be marked differently for #9 and #10. Some examples:

    - Client does not meet medical necessity for residential level of care but they are court ordered to residential treatment – mark "yes" for is service billable (since the County will pay) and mark "no" for is service DMC billable (since DMC will only pay for residential services when medical necessity criteria are met).
    - Client continues to meet medical necessity for residential care, has received authorization from Optum, but has no residential treatment episodes left for the year per DMC standards – mark "yes" for is service billable (since the County will pay) and mark "no" for is service DMC billable (since DMC will only pay for residential services within specific time-limited treatment episodes)

    It is also possible for a service to be marked the same in #9 and #10. For example:

    - Group counseling session is more than 12 participants – mark "no" for is service billable (because it doesn't meet group size requirements, the County will not count this towards the minimum clinical hour requirements for residential treatment) and "no" for is service DMC billable (because it exceeds group requirements for DMC).
11. Language of Service (if other than English)
12. Translator Utilized (if applicable)

This process can be repeated up to seven (7) times on each form. Use as many forms as needed to document all the services provided to the client for the week.

Signature:

1. **Counselor/LPHA Printed Name, Title**: Type or legibly print primary counselor (who documented the service/note) name and title.
2. **Signature, Credentials**: Complete signature and credentials by hand.
3. **Date of Completion:** Complete date of progress note is signed here by hand. This must be completed within the following calendar week from when the service(s) were provided.

RESIDENTIAL WEEKLY PROGRESS NOTE – SERVICES

Client Name: ____________________________ **Client ID:**____________________ **Week of:** _____________ to ____________

Contact Type:		Service Type:			EBP Utilized:
F-F = Face-to-Face **TH** = Telehealth	**TEL** = Telephone **COM** = In Community	**AS** = Assessment **GR** = Group **CR** = Crisis **CO** = Collateral	**DC**=Discharge **IND** = Ind. Counseling **TP** = Tx Planning **PE** = Patient Education	**FT** = Family Therapy **TR** = Transportation to & from medically necessary treatment **O** = Other	**MI** = Motivational Interviewing **RP** = Relapse Prevention **O** = Other **N/A** = Not Applicable

Service Date	**Is this service clinical?** ☐ Yes ☐ No	**Topic:**					
Start Time ☐am ☐pm	**End Time** ☐am ☐pm	**Total Duration:**		**Contact Type:**		**Service Type:**	**EBP Utilized:**
Is service billable? ☐Yes ☐No	**Is service DMC-billable?** ☐Yes ☐No	**Language of Service (if other than English):**	☐N/A			**Translator Utilized?** ☐Yes ☐No ☐N/A	

Service Date	**Is this service clinical?** ☐ Yes ☐ No	**Topic:**					
Start Time ☐am ☐pm	**End Time** ☐am ☐pm	**Total Duration:**		**Contact Type:**		**Service Type:**	**EBP Utilized:**
Is service billable? ☐Yes ☐No	**Is service DMC-billable?** ☐Yes ☐No	**Language of Service (if other than English):**	☐N/A			**Translator Utilized?** ☐Yes ☐No ☐N/A	

Service Date	**Is this service clinical?** ☐ Yes ☐ No	**Topic:**					
Start Time ☐am ☐pm	**End Time** ☐am ☐pm	**Total Duration:**		**Contact Type:**		**Service Type:**	**EBP Utilized:**
Is service billable? ☐Yes ☐No	**Is service DMC-billable?** ☐Yes ☐No	**Language of Service (if other than English):**	☐N/A			**Translator Utilized?** ☐Yes ☐No ☐N/A	

Service Date	**Is this service clinical?** ☐ Yes ☐ No	**Topic:**					
Start Time ☐am ☐pm	**End Time** ☐am ☐pm	**Total Duration:**		**Contact Type:**		**Service Type:**	**EBP Utilized:**
Is service billable? ☐Yes ☐No	**Is service DMC-billable?** ☐Yes ☐No	**Language of Service (if other than English):**	☐N/A			**Translator Utilized?** ☐Yes ☐No ☐N/A	

Service Date	**Is this service clinical?** ☐ Yes ☐ No	**Topic:**					
Start Time ☐am ☐pm	**End Time** ☐am ☐pm	**Total Duration:**		**Contact Type:**		**Service Type:**	**EBP Utilized:**
Is service billable? ☐Yes ☐No	**Is service DMC-billable?** ☐Yes ☐No	**Language of Service (if other than English):**	☐N/A			**Translator Utilized?** ☐Yes ☐No ☐N/A	

Service Date	**Is this service clinical?** ☐ Yes ☐ No	**Topic:**					
Start Time ☐am ☐pm	**End Time** ☐am ☐pm	**Total Duration:**		**Contact Type:**		**Service Type:**	**EBP Utilized:**
Is service billable? ☐Yes ☐No	**Is service DMC-billable?** ☐Yes ☐No	**Language of Service (if other than English):**	☐N/A			**Translator Utilized?** ☐Yes ☐No ☐N/A	

Service Date	**Is this service clinical?** ☐ Yes ☐ No	**Topic:**					
Start Time ☐am ☐pm	**End Time** ☐am ☐pm	**Total Duration:**		**Contact Type:**		**Service Type:**	**EBP Utilized:**
Is service billable? ☐Yes ☐No	**Is service DMC-billable?** ☐Yes ☐No	**Language of Service (if other than English):**	☐N/A			**Translator Utilized?** ☐Yes ☐No ☐N/A	

Counselor/LPHA Printed Name, Title	**Signature, Credentials**	**Date of Completion**

Residential or Withdrawal Management – Daily Progress Note

REQUIRED FORM:

If the Residential or Withdrawal Management program has opted to use a daily progress note, this form is a required document.

WHEN:

The daily progress note shall be completed every day a service is provided. Multiple daily notes may be written each day.

The LPHA or counselor shall type or legibly print their name and sign and date the Daily Progress Note within 7 days of the date of service.

This form is to summarize the client's participation in services in the program on a daily basis.

This form must be completed within the following guidelines:

- Residential and Withdrawal Management programs shall document each client's progress on a daily basis and complete the form within the following seven (7) days.

NOTE: Case Management and/or physician consultation services are never captured on the Daily Progress Note. An individual progress note (Form 601) must be completed for every case management and/or physician consultation service that is provided/claimed.

COMPLETED BY:

The LPHA or the SUD counselor who provided the majority of services for that day, or the primary counselor if they provided any services to the client that day, should complete the note.

REQUIRED ELEMENTS:

Progress Notes shall be legible.

1. **Client Name**: Enter the client's full name
2. **Client ID**: Enter the SanWITS Unique Client Number
3. **Date**: Enter the date the service(s) were provided
4. **Shift time**: If the daily note covers the entire day, write "All day" or "12am-12am" or write the timeframe of when all services were provided for that day "8am-10pm". If there will be multiple daily notes documented that day, write the time of each shift (e.g., 8am-4pm; 4pm-12am).
5. Service topic or purpose of service
6. Language of Service (if other than English)
7. Translator Utilized (if applicable)
8. Start time of service
9. End time of service
10. Total service duration
11. Service contact type using the table (contact type) at the top of the form
12. Service type using the selections indicated in the table (Service Type) at the top of the form

13. EBP utilized using the selections indicated in the table (EBP Utilized) at the top of the form. Note: If EBPs were utilized, they must be detailed in the narrative of the note.

Narrative must include a summary of the clinical services provided to the client during the day:

1) **Provider support & interventions:** Enter support and/or treatment intervention services delivered to the client.
   - Support/treatment intervention services to compliment the client's treatment goals/objectives as listed on his/her Treatment Plan.
   - If applicable, specify which of the two recommended Evidenced Based Practices were used: Motivational Interviewing (MI), or Relapse Prevention (RP) and specific details how the EBP interventions were utilized. If other, identify the type of EBP and describe how it was utilized.
   - Interventions to address client level of participation/stage of change.
   - If applicable, describe attempts to refer or link the client to additional resources, unless this was provided in a case management service (Reminder: case management services are documented on an individual progress note).

2) **Description of client's specific progress on treatment plan: problems, goals, action steps, objectives, and/or referrals:** Enter information regarding client's progress.
   - Client's progress on treatment plan problems, goals and action steps.

3) **Client's ongoing plan, including any new issues:** Enter client's plan in treatment and any new issues that arise in treatment.

4) **If any service(s) are provided in the community, identify the location(s) and how confidentiality was maintained:** Enter where the service(s) were provided and explain how confidentiality was maintained during provision of service(s).

Signature:

- **Counselor/LPHA Printed Name, Title:** Type or legibly print the counselor or LPHA name and title.
- **Signature, Credentials:** Complete signature and credentials by hand.
- **Date of Completion:** Complete date the progress note is signed by hand. The note must be documented and signed within seven (7) days from date of service(s).

RESIDENTIAL OR WITHDRAWAL MANAGEMENT - DAILY PROGRESS NOTE

Client Name:_________________________**Client ID:** _______________________ **Date:** _____________**Shift Time:** __________

Contact Type		Service Type			EBP Utilized
F-F = Face-to-Face **TH** = Telehealth	**TEL** = Telephone **COM** = In Community	**AS** = Assessment **GR** = Group **CR** = Crisis **CO** = Collateral	**DC**=Discharge **IND** = Ind. Counseling **TP** = Tx Planning **PE** = Patient Education	**FT** = Family Therapy **TR** = Transportation to & from medically necessary treatment **O** = Other	**MI** = Motivational Interviewing **RP** = Relapse Prevention **O** = Other **N/A** = Not Applicable

Topic						**Language of Service (if other than English):** ☐N/A				**Translator Utilized?** ☐Yes ☐No ☐N/A	
Start Time	☐am ☐pm	**End Time**	☐am ☐pm	**Total Duration**		**Contact Type**		**Service Type**		**EBP Utilized**	

Topic						**Language of Service (if other than English):** ☐N/A				**Translator Utilized?** ☐Yes ☐No ☐N/A	
Start Time	☐am ☐pm	**End Time**	☐am ☐pm	**Total Duration**		**Contact Type**		**Service Type**		**EBP Utilized**	

Topic						**Language of Service (if other than English):** ☐N/A				**Translator Utilized?** ☐Yes ☐No ☐N/A	
Start Time	☐am ☐pm	**End Time**	☐am ☐pm	**Total Duration**		**Contact Type**		**Service Type**		**EBP Utilized**	

Topic						**Language of Service (if other than English):** ☐N/A				**Translator Utilized?** ☐Yes ☐No ☐N/A	
Start Time	☐am ☐pm	**End Time**	☐am ☐pm	**Total Duration**		**Contact Type**		**Service Type**		**EBP Utilized**	

Narrative must include: 1) Provider support and interventions, 2) Client's progress on treatment plan: problems, goals, & action steps, 3) Client's ongoing plan including any new issues, and 4) If service(s) provided in the community, identify location(s) and how confidentiality was maintained.

Counselor/LPHA Printed Name, Title	**Signature, Credentials**	**Date of Completion**

Outpatient Group Progress Note Instructions

REQUIRED FORM:

This form is a required document in the client file to document Outpatient group counseling or group patient education services provided and includes progress toward achieving the client's recovery or treatment plan goals. Any Residential programs documenting services individually using the **SUD Treatment Progress Note (Form F601)** as their progress note is also required to utilize this form for group services.

WHEN: blatant

This form is to be completed to document group services provided to a client.

This form must be completed within the following guidelines:

- Outpatient programs must document a progress note for group sessions attended (complete with staff signature) within 7 calendar days from the date of service.
    - Services with progress notes documented after 7 calendar days will not be billable.
- A Residential program must use this form if the program documents services individually using the **SUD Treatment Progress Note (Form F601)** instead of the **Residential or Withdrawal Management Daily Progress Note (Form F603)** or the **Weekly SUD Treatment Progress Note – Narrative/Services record (Forms F602a and F602b)**.
    - Timelines remain the same as above: must be done within 7 calendar days from date of service and any services documented after 7 calendar days will not be billable.

COMPLETED BY:

Each progress note is written by the SUD counselor or LPHA who provided the service.

REQUIRED ELEMENTS:

Progress notes shall be legible.

- **Client Name:** Complete client's full name
- **Client ID:** Complete the client ID number by entering the client's SanWITS' Unique Client Number (UCN)
- **Service Date:** Complete date of the service
- Is service billable? (to the County or DMC)
- If yes, is service DMC billable?
- Start time of Service
- End time of Service
- Group Service time in minutes
- Travel to Location Start time/End time*
- Travel from location Start time/End time*
- Group travel time in minutes*

- Date of Progress Note (PN) Documentation – enter the date that the documentation for the progress note was completed
- PN Doc Start time/End time*
- PN Doc Time in minutes*
- Language of Service (if other than English)
- Translator Utilized (if applicable)
- Service Type (Group Counseling or Patient Education)
- EBP Utilized (progress note must document specifics of how EBP was utilized the narrative)
- # of Group Participants
- Total Time (including: service, travel, doc time) in minutes*
- Topic of Session or Purpose of Service (describe specific group topic or the purpose of the service)

Description of group to include: A complete progress note addresses:

1. Provider support intervention including specific EBP technique utilized.
2. If service was provided in the community, identify location and how confidentiality was maintained
3. Other appropriate health care providers support
4. Description of group may be the same for all clients who participated in this specific group session.

Description of client's response to include: This section must be individualized to the specific client. A complete progress note addresses:

1. Client's participation in the group
2. Client's progress towards one or more goals in the client's recovery or treatment or plan, action steps, and/or referrals
3. New issues or problems that affect the client's recovery or treatment plan
4. Next steps in plan of care and referrals, if applicable

Counselor/LPHA Printed Name and Signature: All entries must include the printed name, signature with credentials, and date staff completed the progress note.

Date of completion: Must be completed within 7 days of service to be billable.

*For residential programs documenting each service individually using the **SUD Treatment Progress Note (Form F601)**, rather than the **Residential or Withdrawal Management Daily Progress Note (Form F603)** or the **Weekly SUD Treatment Progress Note – Narrative/Services record (Forms F602a and F602b)**, documentation time and travel time are <u>not</u> required fields as group services are included in the treatment bed day rate.

OUTPATIENT GROUP PROGRESS NOTE

Client Name:____ **Client ID:**____________________________________

Service Date*:	**Is service billable?** ☐Yes ☐No	**If yes, is service DMC-billable?** ☐Yes ☐No	**Start Time of Service:** ☐am ☐pm	**End Time of Service:** ☐am ☐pm	**Group Service Time:**

Travel to Location Start Time: ☐am ☐pm	**Travel to Location End Time:** ☐am ☐pm	**Travel from Location Start Time:** ☐am ☐pm	**Travel from Location End Time:** ☐am ☐pm	**Group Travel Time:**

Date of Progress Note (PN) Documentation Completed:	**PN Doc Start Time:** ☐am ☐pm	**PN Doc End Time:** ☐am ☐pm	**PN Doc Time:**

Language of Service (if other than English): ☐N/A	**Translator Utilized?** ☐Yes ☐No ☐N/A	**Service Type:** ☐Group Counseling ☐Patient Education	**EBP Utilized:** ☐Motivational Interviewing ☐Relapse Prevention ☐Other ☐N/A	**# of Group Participants:**	**Total Time:**

Topic of Session or Purpose of Service:

Description of group to include: 1) provider support and interventions 2) if service was provided in the community, identify location and how confidentiality was maintained.

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Description of client's response to include: 1) client's participation in the group 2) client's progress on treatment plan goals and 3) client's ongoing plan including any new issues.

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Counselor/LPHA Printed Name	**Signature, Credentials**	**Date of Completion***

*The date of service may be different than the date note is signed. Notes must be legibly printed, signed and dated by the counselor/LPHA within 7 days of the services provided.

Section 7
Discharge

F701	Discharge Summary
	SanWITS Discharge Profile Printout
F704	Client Discharge Plan
	Additional Discharge Documents

	Indicates there is no standardized form. If information is collected by your program, it would be placed in this position in the client file.

Discharge Summary Instructions

REQUIRED FORM:
This form is a required document in client file

WHEN:
Completed within 30 days of the date of the provider's last face-to-face or telephone treatment contact with the client

COMPLETED BY:
An SUD Counselor or LPHA from the program

REQUIRED ELEMENTS:

- **Client Name:** Complete client's full name.
- **ID #:** Complete the client's unique client number (UCN) as designated for the client in SanWITS.
- **Admission Date:** Complete client's date of admission to program.
- **Discharge Date: (Date of Last Contact):** This is the date of the client's last treatment contact (face-to-face or telephone) and his/her SanWITS discharge date.
- **Treatment Summary:** Summarize client's presenting problems, treatment provided, and outcome. Must include current alcohol/drug use, legal status/criminal activity, vocational/educational achievements, living situation, and referrals. If a component is not applicable, list and state "not applicable".

- **Health & Medical**
  Medications at Discharge: If YES, list name(s) and dosage(s)
  Did client provide documentation of a physical exam completed within the past 12 months?
  Notified client's primary care physician of discharge?

- **Employment & Income**
  Read prompt, If YES, provide explanation

- **Care Coordination**
  List other service providers working with the client at discharge, if applicable.
  Did the client meet medical necessity for another level of care at the end of treatment phase?
  If YES, was client provided a warm hand-off to another level of care?
  If YES, please explain in Discharge Recommendations/Referrals section below
  Discharge Recommendations/Referrals (include ASAM Level of Care if referred to another SUD provider)

- **Discharge**
  Prognosis: Mark the appropriate box for client's prognosis (good, fair, poor) and explain.
  Reasons for Discharge: Mark the appropriate box for client's reason for discharge. This must match the client's SanWITS reason for discharge.
  If discharge was involuntary: Mark the appropriate yes/no, or not applicable box if client was advised of the Grievance and Appeal Process and applicable Notice of Adverse Benefit Determination given.
- **Client Comments:** Use this space to document any client comments at discharge. If completing for a client with whom the program lost contact, note that here.
- **Counselor or LPHA Printed Name:** Counselor/LPHA completing the discharge summary to print name here.
- **Counselor or LPHA Signature & Date:** Counselor completing the discharge summary must sign and date.

DISCHARGE SUMMARY

Client Name		Client ID Number	
Admission Date		Discharge Date	

Treatment Summary

Write in narrative form; include current alcohol and other drug use, living situation, legal status/criminal activity, vocational/educational achievements:

____

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Health & Medical

Medications at Discharge: ☐ YES (if yes, list name(s) and dosage(s) below) ☐ NO ☐ Unknown

____

____

Did client provide documentation of a physical exam completed within the past 12 months? ☐ YES ☐ NO

Notified client's primary care physician of discharge? ☐ YES ☐ NO

Employment & Income

Is client employed, in a structured employment preparation program, enrolled in a formal education setting, or enrolled in an eligibility program (another source of income such as Supplemental Security Income (SSI)) at the end of the treatment phase? ☐ YES ☐ NO ☐ Unknown

If yes, please explain:

____

____

Care Coordination

List other service providers working with the client at discharge: ☐ N/A

____

____

Did client meet medical necessity for another level of care at the end of treatment phase? ☐ YES ☐ NO ☐ N/A

If yes, was client provided a warm hand-off to another level of care? ☐ YES ☐ NO

(If yes, please explain in Discharge Recommendations/Referrals section below)

Was client referred and provided Recovery Services at the end of the treatment phase? ☐ YES ☐ NO

Discharge Recommendations/Referrals (include ASAM Level of Care if referred to another SUD Provider): ☐ N/A

____

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Discharge

Prognosis: ☐ Good ☐ Fair ☐ Poor

Explain: ____

____

Reason for Discharge (check appropriate box):

☐ Completed Treatment/Recovery Plan Goals/Referred/Standard
☐ Completed Treatment/Recovery Plan Goals/Not Referred/Standard
☐ Left Before Completion w/ Satisfactory Progress/Standard
☐ Left Before Completion w/ Satisfactory Progress/Administrative
☐ Left Before Completion w/Unsatisfactory Progress/Standard
☐ Left Before Completion w/Unsatisfactory Progress/Administrative
☐ Death
☐ Incarceration

If discharge was involuntary, was client advised of the Grievance and Appeal Process and applicable Notice of Adverse Benefit Determination given? ☐ YES ☐ NO

Client comments if applicable:

____

____

____

Counselor or LPHA Printed Name	Counselor or LPHA Signature	Date

SanWITS Discharge Printout

Place printout of client's SanWITS discharge profile here.

Please refer to SanWITS User's Guide and CalOMS Discharge form and instructions for additional information.

Client Discharge Plan Instructions

REQUIRED FORM:

Program shall develop a discharge plan with client within thirty (30) days prior to the anticipated discharge date, *except when program loses contact with client* (Note: If program loses contact with client, then complete a Discharge Summary). Plan shall detail client's triggers and how to avoid a relapse along with what support will be provided to the client after completing the program. (Reference 22 CCR 51341.1)

WHEN:

This form must be completed within 30 calendar days prior to the date of the last face-to-face treatment with the client.

COMPLETED BY:

Developed with client and reviewed by counselor or agency representative

REQUIRED ELEMENTS:

- **Client Name:** Complete client's full name.
- **Planned Discharge Date:** Client completes the anticipated discharge date.
- **Recovery and Support Plan:** Client completes questions in all sections including relapse triggers, how to avoid the identified relapse triggers, physical and mental health, housing, financial/employment/education, and legal.
- **Client given a copy of this Client Discharge Plan:** Indicate that client was given a copy of discharge plan by selecting the check-box.
- **Client's Signature and Date:** Client must print name, sign and date after completion of the form.
- **Counselor's Signature and Date:** The counselor must print name, sign and date after reviewing the completed form.

REFERENCE: Title 22 CCR 51341.1

Client Name: ____ Client ID#:______________________________________

CLIENT DISCHARGE PLAN

Please answer the following questions regarding your ongoing recovery plans after you are discharged. Describe your plan including who, what, where, and when. Be as precise as you can in the spaces provided.

Planned Discharge Date: ___________________________

Recovery and Support Plan

Describe your discharge plan:____

____

____

____

____

Describe your support system (People I can call who I trust and speak with honestly):____________________________

____

____

Do you have a sponsor? Yes No If yes, please explain how you work together and what step you are working. If no, what are your plans about obtaining a sponsor? ____

____

What support meetings will you attend? Include specific meetings (i.e. 12-step, home group, faith based etc.). How often will you attend, and how will you get there?

____

____

Relapse Triggers

a. ____ d. ____

b. ____ e. ____

c. ____ f. ____

How to Avoid a Relapse with these Identified Triggers?

a. ____ d. ____

b. ____ e. ____

c. ____ f. ____

Client Name: ____ Client ID#:______________________________________

Physical and Mental Health

How will you support your physical health (Specify arrangements made with your doctors and include how you will stay healthy with exercise, diet, etc.)

____

____

Where will you continue aftercare, counseling, mental health services (Include name of program, type of counseling or therapy, counselor or therapist name, days and times you will attend)?

____

____

Housing

Where will you be living and who will you live with? Is this a safe, comfortable, clean and sober environment?

____

____

Financial/Employment/Education

What will you do for financial support (Employment, job searching, or other methods of supporting yourself)?

____

____

What will you do to continue your education or improve your job skills (vocational training, school, etc.)?

____

____

Legal

How will you address any legal issues or concerns (probation, parole, CWS, etc.)?

____

____

☐ **Client was given a copy of the discharge plan**

Client's Printed Name	Client's Signature	Date
Counselor's Printed Name	**Counselor's Signature**	**Date**

Section 8
Drug Test Results/Reports

F801	Drug Test & Results Log
	Drug Test Results From Lab
	Progress Reports
	Referral Source Documents
F806	FAX COVER SHEET - RSUD AUTH REQUEST
	SanWITS Residential Authorization Printout (For Residential programs only)
	Additional Correspondence
	Additional Forms

	Indicates there is no standardized form. If information is collected by your program, it would be placed in this position in the client file.

Drug Test and Results Log

REQUIRED FORM:

This form is an optional document in client file

WHEN:

This log will be completed each time alcohol or drug testing is initiated and will be used throughout the client's treatment period

COMPLETED BY:

Authorized agency representative

REQUIRED ELEMENTS:

- **Client Name:** Complete the client's full name.
- **Client ID #:** Complete the client ID number by entering the client's SanWITS' Unique Client Number (UCN).
- **Date Tested:** Complete the date the specimen was collected.
- **Chain of Custody #:** Complete chain of custody number from the laboratory paperwork. If no paperwork from the laboratory is used, complete by stating N/A, not applicable.
- **Reason for Test:** Complete the reason for testing (e.g., baseline, random, suspicious behavior, etc.).
- **Type of Test:** Complete the type of test used (e.g., urine analysis, breathalyzer, alcohol testing swab).
- **Date Test Results Received:** Complete the date the test results were received.
- **Test Results:** Complete the result of testing (e.g., positive, negative, diluted, etc.).

NOTES:

Authorized agency staff must complete the log as soon as the client is informed of testing by filling in the date, chain of custody number (if applicable), reason for testing, and type of test. If the client failed to provide a sample or refused to test it needs to be reflected in the result column. If the test was successfully conducted, the result must be logged in when received.

Drug Test and Results Log

Client Name: ____________________________________ **Client ID #:**___________________________

Date Tested	Chain of Custody #	Reason for Test (Baseline, Random, etc.)	Type of Test	Date Test Results Received	Test Results

Drug Test Results From Lab

This section is optional. If your agency is currently receiving lab results for drug testing, place that information in this section.

Progress Reports

This is not a standardized form. Letters reporting client's progress to outside sources will be placed in this section.

Referral Source Documents

This is not a standardized form. All documents to and from the referral source will be placed in this section.

RSUD AUTH REQUEST FAX COVER SHEET

(To be faxed to 855-244-9359)

Date:__________________ Program Name:________________ Point of Contact:__________________

Phone#:________________ Fax #:________________________ # Pages Included:__________________

For All Requests:

Requested Level of Care: 3.1 ☐ 3.5 ☐ Requested Start Date: ___________

PO Referral for Assessment/Treatment? Yes ☐ No ☐

Court Order for Residential? Yes ☐ No ☐

Date of Birth Included? Yes ☐ No ☐

Medi-Cal Number or Social Security Number Included? Yes ☐ No ☐

☐ **Initial Authorization:**

- ✓ Date and Time When Request Was Called In: ______________________________
- ✓ Initial Level of Care Assessment
- ✓ Health Questionnaire (if rating higher than a 0 in Dimension 2)

☐ **Continuing Authorization:**

- ✓ Initial Treatment Plan
- ✓ ASAM Level of Care Recommendation Form
- ✓ ASI/YAI (Addiction Severity Index/Youth Assessment Index)
- ✓ Health Questionnaire (if rating higher than a 0 in Dimension 2)
- ✓ Diagnosis Determination Note

☐ **Extension:**

- ✓ Updated Treatment Plan
- ✓ ASAM Level of Care Recommendation Form
- ✓ Diagnosis Determination Note, if diagnosis changed

☐ **Request to Change Level of Care:**

- ✓ Updated Treatment Plan
- ✓ ASAM Level of Care Recommendation Form
- ✓ Diagnosis Determination Note, if diagnosis changed

☐ **Discharge:**

- ✓ Discharge Plan/Summary

Notice of Disclosure and Confidentiality

This information has been disclosed to you from records whose confidentiality is protected by Federal and State laws and regulations. You may be prohibited from further disclosing this information without the specific written authorization from the person to whom such information pertains, or as otherwise permitted by State/Federal law.
THE INFORMATION CONTAINED IN THIS FACSIMILE IS CONFIDENTIAL AND/OR PRIVILEGED AND IS INTENDED ONLY FOR THE USE OF THE DESIGNATED RECIPIENT NAMED ABOVE. If the reader of this message is not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error, and that any review, disclosure, dissemination, distribution or copying of this message, or the taking of any action in reliance on its contents, is strictly prohibited. If you have received this communication in error, you must notify us immediately and inform us of the return or destruction of the documents.

SanWITS Residential Authorization Printout

(For Residential programs only)

Place printout of client's SanWITS

Residential Authorization(s) here.

Please refer to SanWITS User's Guide for additional information.