Instructions ASAM LOC Recommendation Form

REQUIRED FORM

WHEN: This form is to be completed after completion of the ASI or YAI as in accordance with timeframes specified below:

- Outpatient Programs - within 30 calendar days from date of admission.
- For Residential Programs - within 10 days from date of admission.

This form is to also be completed with 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 AOD Counselor and/or LPHA* (if completed by AOD 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:** to be entered on each page)
- **Client ID#:** Client ID number as determined by agency guidelines. (**NOTE:** to be entered on each page)
- **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 AOD 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

- **AOD Counselor/Therapist Name, Signature, and Date:** AOD Counselor's 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

*****Licensed Practitioner of the Healing Arts (LPHA) includes: MD, Nurse Practitioner, Physician Assistant, Registered Nurse, Registered Pharmacist, Licensed Clinical Psychologist, Licensed Clinical Social Worker, Licensed Professional Clinical counselor, Licensed Marriage and Family Therapist and licensed-eligible practitioners working under the supervision of licensed clinicians.