Assessment and Level of Care Authorization

Client ID: | | | | | | | Client First Name: | Client Last Name: | DOB:

A. Client Information

Assess Date: | Assessment Type: | Client Phone #:

Admit Date: | Current/Referring Provider: | Other Provider:

Counselor Name: | Counselor Phone: | Counselor Fax

Counselor E-mail: | Referral Source: | Other Referral Source:

SUD DX: F Code: (Not for Billing Purposes) | DSM SUD DX Impression: | Severity:

Valid Payor/Insurance: | * Other Payor:

Authorization for Use or Disclosure of Protected Health Information: ◯ Yes ◯ No Expires On:

B. Authorizations (complete ONLY one section B1 or B2 or B3)

1. Initial authorization for residential LOC:

Refer for placement. In the specific dimensions, list the medically necessary reasons.

2. Reauthorization for Residential LOC.

Number of days in Current Episode as of today: 1 If prior, date of last Auth:

Current Tx Plan: # of Action Steps assigned: # of Action Steps completed: Current RES LOC:

Additional Discharge Plan Details:

In the specific dimensions, write a brief summary of medically necessary issues on TX Plan that require continued stabilization. List progress made and remaining problem areas. Specify actions to be taken for each dimension.

3. Progress Report, Transfer or Other Re-Assessment Documentation:

If above Other, explain: | OP Prov. Referred to:

OP Appoint. Date: | Current Tx Plan: # of Action Steps Assigned: | # of Action Steps Completed:

Current LOC:

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C. ASAM Dimensions

Risk Rating Scale

4	Critical impairments in coping and functioning, with signs and SX indicating an imminent danger concern.	LOW - MODERATE - HIGH
3	A serious issue or difficulty. May be considered in or near imminent danger.	
2	Moderate difficulty in functioning, however relevant skills or support systems may be present.	
1	Mildly difficult issue or minor signs and SX. Any chronic issues or problems should be resolved in a short period of time.	
0	Non-issue or very low risk.	

1. Acute Intoxication and/or Withdrawal Potential Risk Rating: Date of Last Use:

Days Used in Past 30 Days: Days Injected in Past 30 Days: Current Severe, life-threatening WX SX: ◯ Yes ◯ No

Night Sweats: ◯ Yes ◯ No Hand Tremors: ◯ Yes ◯ No HX of SZ: ◯ Yes ◯ No

Comments:

2. Biomedical Conditions and Complications Risk Rating:

a. Current severe physical health problems (bleeding mouth or rectum last 24 hours; recent: unstable hypertension, recent abdomen, head; severe pain in chest, significant problems in balance, gait sensory or motor abilities, not related to intoxication? ◯ Yes ◯ No

b. Do you have any chronic health conditions: ◯ Yes ◯ No

c. List Medications currently (or should be) taking:

d. Do you have a Primary Care Doctor: ◯ Yes ◯ No If Yes, Name:

Comments:

3. Emotional, Behavioral, or Cognitive Conditions and Complications: Risk Rating:

a. Imminent danger of harming self or another in past 30 days (e.g. Suicidal ideation w/ intent, plan & means to succeed; homicidal or violent ideation; impulses & uncertainty to control impulses, w/ means to act on) ◯ Yes ◯ No

b. Unable to function in activities of daily living or care for self w/ imminent, dangerous consequences, past 30 days (e.g. unable to bathe, feed, groom & care for self, due to psychosis, organicity or uncontrolled intoxication w/ threat to imminent safety of self or others as regards death or severe injury)? ◯ Yes ◯ No

Are you currently receiving mental health services? ◯ Yes ◯ No If yes, doctor or clinic name:

List medication currently (or should be) taking:

Comments:

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4. Readiness to Change: SOC: Risk Rating:

a. Does person appear to need SUD TX/recovery and/or MH TX, but ambivalent or feels it is unnecessary (e.g. Severe addiction, but feels controlled use still ok; psychotic but blames a conspiracy)? ◯ Yes ◯ No

b. Has been coerced, mandated or required to have assessment/TX by MH court or criminal justice system, health or social services, work or school, or family/significant other? ◯ Yes ◯ No

Comments:

5. Relapse, Continued Use, or Continued Problem Potential: Risk Rating:

a. Currently under the influence and/or acutely psychotic, manic, suicidal? ◯ Yes ◯ No

b. Likely to continue to use and have active, acute Sx in an imminently dangerous manner, without immediate secure placement? ◯ Yes ◯ No

c. Are the most troubling presenting problem(s) that brings the person for assessment dangerous to self or others? (See examples in Dim. 1, 2, 3) ◯ Yes ◯ No

Comments:

6. Recovery Environment: Risk Rating:

Any dangerous family; significant others; living, work, or school situations threatening the person's safety, immediate wellbeing and/or sobriety (e.g. living w/ a drug dealer; physically abused by partner or significant other; homeless in freezing temperatures)? ◯ Yes ◯ No

Comments:

D. Indicated and Actual LOC

1a. Indicated LOC:

1b. Additional Indicated LOC:

2a. Actual LOC Decision:

2b. Additional Actual LOC Decision:

3. Perinatal: ◯ Yes ◯ No

4. If actual LOC was not indicated, reason for difference:

5. Explain reason why Actual LOC provided was not among those indicated, if reason for difference between Indicated LOC and Actual LOC was "Other"

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6. If referral is being made but admission is expected to be DELAYED, reason.

7. Explain reason why admission is expected to be delayed if reason for delay is "Other"

E. Client Short-Term Strength-Based Target Objectives:

1.

2.

3.

Counselor Name (print): | Counselor Signature: | Certificate/ License #: | Date:

Co-signed by LPHA (print): (Optional) | LPHA Signature: (Optional) | LPHA Certificate /License #: | Date:

For QI Admin Staff Only:

QI Authorization #: | Date Request Received:

Type of Authorization:

Number of Residential Treatment Episode(s) in current plan year: MC: | Non - MC: | |

Determination: | Approved LOC: | Perinatal: ◯ Yes ◯ No

Reason for Determination:

Authorization Effective Date: | Authorization Expiration Date: | Allowable # of Bed Day:

Comments:

Authorizing Staff: | Signature: | Date:

Save As | Print Form | Send E-mail | Exit Form

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