The Michigan Department of Health and Human Services (MDHHS) is required to designate the ASAM level of care for all licensed residential treatment facilities. In order to make this determination, the following questionnaire is required to be filled out for each licensed facility seeking to provide publicly funded services. The information provided and submitted with this questionnaire will allow MDHHS to assign an ASAM level for the program.

Program/Facility Name:      

Facility Address:      

City/State/Zip:      

License Number:      

Treatment Capacity:

Please indicate the ASAM Level being applied for:

3.1 Clinically Managed Low Intensity

3.3 Clinically Managed Population Specific High Intensity

3.5 Clinically Managed High Intensity

3.7 Medically Monitored Intensive Inpatient Services

Please indicate the population served by the program:

Adolescent  Adult

Please indicate which Pre-paid Inpatient Health Plan(s) the program is currently contracted with or planning to contract with to provide services: (check all that apply)

Community Mental Health Partnership of Southeast Michigan

Detroit Wayne Mental Health Authority

Lakeshore Regional Entity

Macomb County Community Mental Health Services

Mid-State Health Network

Northcare Network

Northern Michigan Regional Entity

Oakland County Community Mental Health Authority

Region 10 Pre-paid Inpatient Health Plan

Southwest Michigan Behavioral Health

|  |
| --- |
| **SERVICE DELIVERY and SETTING** |

Please indicate the type of setting where services are provided.

1. Freestanding community setting.
2. Unit within a licensed health care facility.
3. Secure community setting in the criminal justice system.
4. On average, over the past 90 days, what percentage of residents were treated for moderate or severe substance use disorders: (Total must equal 100%)
5. Without a co-occurring mental health disorder –     %
6. Combined with a co-occurring mental health disorder –    %
7. Combined with functional limitations that were primarily cognitive in nature? (For example: Traumatic Brain Injury, Dementia, Memory Problems) –     %

|  |
| --- |
| **SUPPORT SYSTEMS** |

Please select “yes” or “no” for each of the following questions:

1. Telephone or in-person consultation with physician and emergency services available 24/7? Yes No
2. Direct affiliations with other levels of care and/or close coordination for referrals to other services? Yes No
3. Ability to conduct and/or arrange for laboratory/toxicology tests or other needed procedures. Yes No
4. Ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications. Yes No
5. Psychiatric/psychological consultation available as needed.

Yes No

|  |
| --- |
| **STAFF** |

Please select “yes” or “no” for each of the following questions:

1. Professional staff available on-site 24 hours a day.   
   Yes No
2. Treatment team consists of medical, addiction and mental health professionals. Yes No
3. One or more clinicians available on site or by telephone 24 hours a day.

Yes No

4) Please indicate program staff conducting each service.

Check all that apply on the following table:

| License or Certification/ Registration | Individual Counseling Sessions | Group Counseling Sessions | Didactic/  Educational Sessions | COD  Treatment Services | Medical  RX  Services |
| --- | --- | --- | --- | --- | --- |
| MD/DO |  |  |  |  |  |
| LP/LLP/TLLP |  |  |  |  |  |
| LMFT/LLMFT |  |  |  |  |  |
| LPC/LLPC |  |  |  |  |  |
| RN,NP,LPN |  |  |  |  |  |
| PA |  |  |  |  |  |
| LMSW/LLMSW |  |  |  |  |  |
| LBSW/LLBSW |  |  |  |  |  |
| CADC-M/CADC |  |  |  |  |  |
| CAADC |  |  |  |  |  |
| CCJP-R |  |  |  |  |  |
| CCDP |  |  |  |  |  |
| CCDP-D |  |  |  |  |  |
| CCS-M |  |  |  |  |  |
| CCS-R |  |  |  |  |  |
| DP-S |  |  |  |  |  |
| DP-C |  |  |  |  |  |
| Recovery Coach |  |  |  |  |  |

|  |
| --- |
| **THERAPIES** |

Please describe the therapy services that are available:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 3.1 | 3.3 | 3.5 | 3.7 |
| Planned clinical activities | At least 5 hours of professionally directed treatment a week  Y/N | Designed to stabilize and maintain stability of SUD symptoms  Y/N | Designed to stabilize and maintain stability of SUD symptoms  Y/N | Designed to stabilize acute addiction and psychiatric symptoms  Y/N |
| Clinical services | Designed to improve daily living and recovery  Y/N | On a daily basis to improve daily living and recovery  Y/N | On a daily basis to improve daily living and recovery  Y/N | On a daily basis, provided by an interdisciplinary team, to improve daily living and recovery  Y/N |
| Random Drug Testing | Y/N | Y/N | Y/N | Y/N |
| Counseling and clinical monitoring | Y/N | Y/N | Y/N | Y/N |
| A range of therapies administered on an individual and group basis | Y/N | Y/N | Y/N | Y/N |
| Regular monitoring of the patient’s family, as appropriate | Y/N | Y/N | Y/N | Y/N |
| Motivational enhancement and engagement strategies | Used in preference to confrontational approaches  Y/N | Evidence-based and used in preference to confrontational approaches  Y/N | Evidence-based and used in preference to confrontational approaches  Y/N | Evidence-based and used in preference to confrontational approaches  Y/N |
| Services for patient’s family and significant other | Y/N | Y/N | Y/N | Y/N |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Pharmacotherapy | Y/N |  |  |  |
| Daily scheduled professional addiction and mental health services |  | Y/N | Y/N | Y/N |
| Health education services |  |  |  | Y/N |
| Planned community reinforcement |  | Y/N | Y/N | Y/N |
| Monitoring of patients’ adherence to prescribed medication |  |  | Y/N | Y/N |

1. Please submit a weekly schedule of services with the individual, group, educational and/or other treatment services labeled to verify hours reported above. Attach other programmatic documentation that will support the ASAM Level being sought.

|  |
| --- |
| **ASSESSMENT/ TREATMENT PLAN REVIEW** |

Does the program’s assessment & treatment plan review include:

1. Individualized, comprehensive bio-psychosocial assessment utilized?  
   Yes No
2. Individualized treatment plan, developed in collaboration with client and reflects client’s personal goals?  
   Yes No
3. Daily assessment of progress and treatment changes?   
   Yes No
4. Physical examination by (MD/DO, PA, NP) performed as part of initial assessment/admission process?  
   Yes No
5. Ongoing transition/continuing care planning?   
   Yes No

# I CERTIFY THAT THE INFORMATION PROVIDED REGARDING THE OPERATION OF THIS PROGRAM IS ACCURATE, TRUE, AND COMPLETE IN ALL MATERIAL ASPECTS. (Electronic signatures are acceptable)

|  |  |  |  |
| --- | --- | --- | --- |
| **AUTHORIZED INDIVIDUAL** | **TITLE** | **SIGNATURE** | **DATE** |
|  |  |  |  |

**ENTER THE CONTACT INFORMATION OF THE PERSON THAT CAN BE REACHED FOR FOLLOW-UP IF NEEDED.**

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME** | **TITLE** | **EMAIL** | **TELEPHONE** |
|  |  |  |  |

Please submit the completed, signed form and any attachments to [TXreports@midstatehealthnetwork.org](mailto:TXreports@midstatehealthnetwork.org)