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 Pre-paid Inpatient Health Plan

[ ]  Southwest Michigan Behavioral Health

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| **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) –     %

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| **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

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| **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 | CODTreatment 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 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

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| **THERAPIES** |

Please describe the therapy services that are available:

1. Planned clinical program activities (professionally directed) hours per week:
2. Focus of counseling and clinical program activities:
3. Recovery support services available:
4. Involvement of family members and significant others?
[ ] Yes [ ] No
5. Medication assisted treatment available?
[ ] Yes [ ] No
6. Monitoring of medication adherence (for behavioral health and physical health)?
[ ] Yes [ ] No
7. Use of random drug screens to monitor compliance?
[ ] Yes [ ] No
8. 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.

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| **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 QMPMeasures@michigan.gov