The Michigan Department of Health and Human Services (MDHHS) is required to designate the ASAM level of care for all licensed outpatient treatment programs. In order to make this determination, the following questionnaire is required to be filled out for each licensed program 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:

(If Applicable)

Please indicate the ASAM Level being applied for (select only one):

[ ]  0.5 Early Intervention

[ ]  1.0 Outpatient Services

[ ]  2.1 Intensive Outpatient Services

[ ]  2.5 Partial Hospitalization 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 for new programs)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

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| **SERVICE DELIVERY and SETTING** |

Please indicate the type of setting where services are provided.

[ ]  Behavioral health clinic/office based program

[ ]  Primary care office/clinic

[ ]  Integrated care clinic (combined physical and behavioral health)

[ ]  Work sites

[ ]  School

[ ]  Community based

[ ]  Individuals home

On average, over the past 90 days, what percentage of clients with a substance use disorder were served **(Level 0.5 programs can skip this)**: (Total must equal 100%)

1. Without a co-occurring mental health disorder –     %
2. Combined with a co-occurring mental health disorder –    %

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| **SUPPORT SYSTEMS** |

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

1. Does your program provide referral and linking to ongoing treatment?

[ ] Yes [ ] No

1. Does your program provide referral for community social services?

[ ] Yes [ ] No

1. Are emergency services available 24/7 outside normal program hours?

 [ ] Yes [ ] No

1. Does your program have direct affiliations with other levels of care and/or close coordination for referrals to other services? [ ] Yes [ ] No
2. Does your program have the ability to conduct and/or arrange for laboratory/toxicology tests or other needed procedures? [ ] Yes [ ] No
3. Does your program have the ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications? [ ] Yes [ ] No
4. Are psychiatric and medical consultation available within 24 hours by phone and in person based on severity of condition (Level 1)?

 [ ] Yes [ ] No

1. Are psychiatric and medical consultation available within 24 hours by phone and 72 hours in person (Level 2.1)? [ ] Yes [ ] No
2. Are psychiatric and medical consultation available within 8 hours by phone and 48 hours in person (Level 2.5)? [ ] Yes [ ] No

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| **STAFF** |

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

1. Do you employ trained personnel who are knowledgeable about substance use and addiction?

[ ] Yes [ ] No

1. Is counseling/therapy provided by appropriately licensed and credentialed professionals?

 [ ] Yes [ ] No

1. Is there a generalist physician(s) and/or physician assistant(s) available?

[ ] Yes [ ] No

1. Are nursing staff available?

[ ] Yes [ ] No

1. Is the physician(s) or physician assistant specially trained in addiction medicine?

[ ] Yes [ ] No

1. Are staff cross-trained in mental health, psychotropic medications and interactions with addictive substances?

[ ] Yes [ ] No

7) Please indicate program staff conducting each service.

Check all that apply on the following table:

| License or Certification/ Registration | Screening and/orAssessments | 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 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Occupational Therapist | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Recreational Therapist | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| CADC-M/CADC | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| CAADC | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| CCJP-R | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| CCDP | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| CCDP-D | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| CCS-M | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| CCS-R | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| DP-S | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| DP-C | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Recovery Coach | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Specifically trained staff | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

Specifically trained staff explanation:

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| **THERAPIES** |

Please describe the following in reference to the program:

1. Focus of program activities for the level of care requested in this application:
2. Recovery support services:

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

1. Individual therapy/counseling/psychotherapy provided?

[ ] Yes [ ] No

1. Group therapy provided?

[ ] Yes [ ] No

1. Family therapy provided?

[ ] Yes [ ] No

* 1. If provided is there involvement of family members, guardians and significant others in the assessment, treatment and continuing care of the client?

[ ] Yes [ ] No

1. Educational/didactic services provided?

[ ] Yes [ ] No

1. Occupational therapy?

[ ] Yes [ ] No

1. Recreational therapy available?

[ ] Yes [ ] No

1. Medication management (SUD) available?

[ ] Yes [ ] No

1. Medication management (mental health) available?

[ ] Yes [ ] No

1. Monitoring of medication adherence (for behavioral health and physical health)?

[ ] Yes [ ] No

1. Use of laboratory and toxicology services (on-site/consultation/referral)?

[ ] Yes [ ] No

1. For **Levels 2.1 and 2.5** please submit a weekly schedule of services with the individual, group, educational and/or other treatment services labeled to verify the minimum amount of hours of skilled treatment services for the level are available.

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| **ASSESSMENT/ TREATMENT PLAN REVIEW** |

Indicate if the program’s assessment & treatment plan review processes include the following?

1. Screening to rule in or out substance related addictive disorders?

[ ] Yes [ ] No

1. Assessment of ASAM dimensional risk and severity of need performed prior to and throughout the process of delivering services?

[ ] Yes [ ] No

1. Individualized, comprehensive bio-psychosocial assessment utilized?

[ ] Yes [ ] No

1. Physical examination by (MD/DO, PA, NP) available for conditions as warranted based on physician approved protocols?

[ ] Yes [ ] No

1. Individualized treatment plan, developed in collaboration with client and reflects client’s personal goals?

[ ] Yes [ ] No

1. Treatment plan reviews are conducted at specified times, as noted in the plan or with a frequency as determined by appropriately credentialed staff?

[ ] Yes [ ] No

1. Documentation of mental health problems and relationship to substance use disorder?

[ ] Yes [ ] No

1. Documentation of progress and treatment changes?

[ ] Yes [ ] No

1. Ongoing recovery/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