**Fax: 206.205.1634  Backup Fax: 206.205.8262**

 **SUD Residential Treatment**

 **Authorization Request Cover Sheet vF5**

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **REFERRING PROVIDER INFORMATION** |
| **AGENCY NAME** | **AGENCY SITE/PROGRAM NAME** |
|  |  |
| **CONTACT PERSON** | **PHONE NUMBER** |
|  |  |
| **EMAIL ADDRESS** | **FAX NUMBER** |
|  |  |
| **Client Identification** |
| **Last NamE** | **First Name** | **Middle Name** | **Other Last Name** | **SuffiX**  |
|  |  |  |  |  |
| **Home street Address (enter “homeless” if clt is homeless)** | **City** | **County** | **Zip Code:** |
|  |  |  |  |
| **mailing Street Address (county notifications will be sent to this address. enter “same” if home street address)** | **City** | **County** | **Zip Code:** |
|  |  |  |  |
| **phone number (including area code)** | **Provider One ID (if known)** | **DATE OF BIRTH** | **SOCIAL SECURITY NUMBER** |
|  |  |  |  |
| **FUNDING SOURCE**[ ]  Medicaid  | [ ] Non-Medicaid (see below) | [ ] CJTA  | [ ] Medicare | [ ] Other (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  |
| **IF REQUESTING USE OF NON-MEDICAID FUNDS, PLEASE PROVIDE CLIENT’S MONTHLY HOUSEHOLD INCOME:** $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **PRIORITY POPULATION?**  | [ ] Yes [ ]  No | **If Yes, check the appropriate box** |
| [ ]  Woman pregnant injecting drugs | [ ]  Parenting Woman | [ ] Offender |
| [ ]  Woman pregnant w/STD’s | [ ]  Postpartum Woman | [ ]  Referred by SBIRT |
| [ ]  Individual injecting drugs | [ ]  Parenting Individual w/CPS involvement |  |
|  **INVOLVED IN CRIMINAL JUSTICE OR CHILD WELFARE SYSTEM?**  |  [ ] Yes [ ] No |
| [ ]  Adult Drug Diversion Ct | [ ]  Regional Mental Health Ct | [ ]  Family Treatment Ct | [ ]  Probation | [ ]  CPS | [ ]  Other ( )  |
| **GENDER (AS REPORTED BY CLIENT)**[ ]  Male [ ]  Female [ ]  Transgender [ ]  Intersex (born with characteristics of both male and female)  |
| **Marital Status** | **SEXUAL ORIENTATION** |
| [ ]  Single or Never Married  | [ ]  Divorced | [ ]  Heterosexual | [ ]  Questioning |
| [ ]  Married or Committed Relationship | [ ]  Widowed | [ ]  Gay/Lesbian/Queer/ Homosexual | [ ]  Not Asked |
| [ ]  Separated | [ ]  Unknown | [ ]  Bisexual | [ ]  Unknown |
|  |  | [ ]  Choose Not to Disclose |  |
| **Has client served in the military?** | **IS CLIENT DEPENDENT CHILD/SPOUSE/PARTNER OF PERSON IN MILITARY?** |
| [ ]  Yes [ ]  No [ ]  Not asked/refused to answer [ ]  Unknown | [ ]  Yes [ ]  No [ ]  Not asked/refused to answer [ ]  Unknown |
| **Ethnicity (Select as many as the client reports from the following list)** |
| [ ]  White/Caucasian  | [ ]  Other Pacific Islander | [ ]  Chinese | [ ]  Laotian | [ ]  Samoan |
| [ ]  American Indian/Alaskan Nat | [ ]  Other Asian | [ ]  Filipino | [ ]  Thai | [ ]  Middle Eastern |
| [ ]  Asian Indian | [ ]  Black/African Am | [ ]  Japanese | [ ]  Vietnamese | [ ]  African – Ethnic |
| [ ]  Native Hawaiian | [ ]  Cambodian | [ ]  Korean | [ ]  Guamanian/Chamorro | [ ]  Some Other Race |
|  |  |  |  | [ ]  Not Reported/Unknown |
| **Hispanic Origin (Select One)** |
| [ ]  Cuban  | [ ]  Other Spanish/Hispanic | [ ]  Puerto Rican  | [ ]  Not Spanish/Hispanic | [ ]  Unknown |
| **PRIMARY/PREFERRED LANGUAGE** | **INTERPRETER REQUIRED:** [ ]  **YES** [ ]  **NO** |
|  | **LANGUAGE REQUESTED:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **SUBSTANCE USE HISTORY** |
| **CURRENTLY PRESCRIBED MEDICATIONS FOR Opioid Use Disorder (MOUD)?** [ ]  YES [ ]  NO |  **IF YES, IDENTIFY MEDICATIONS PRESCRIBED:** [ ]  Buprenorphine (Suboxone) [ ]  Methadone [ ]  Naltrexone (Vivitrol) |
| **USED NEEDLE WITHIN LAST 30 DAYS** | **NEEDLE USE EVER** |  |
| [ ]  Yes [ ]  No | [ ]  Continuously  | [ ] Intermittently | [ ]  Rarely | [ ]  Never |
| SUBSTANCES |
| SUBSTANCE | PST (CHECK ONE BOX PER SUBSTANCE) | SUBSTANCE | PST (CHECK ONE BOX PER SUBSTANCE) |
| 1. None |  1 [ ]  2 [ ]  3 [ ]  | 12. Benzodiazepine |  1 [ ]  2 [ ]  3 [ ]  |
| 2. Alcohol |  1 [ ]  2 [ ]  3 [ ]  | 13. Other Non-Benzodiazepine Tranquilizers |  1 [ ]  2 [ ]  3 [ ]  |
| 3. Cocaine/Crack |  1 [ ]  2 [ ]  3 [ ]  | 14. Barbiturates |  1 [ ]  2 [ ]  3 [ ]  |
| 4. Marijuana/Hashish |  1 [ ]  2 [ ]  3 [ ]  | 15. Other Non-Barbiturate Sedatives or Hypnotics |  1 [ ]  2 [ ]  3 [ ]  |
| 5. Heroin |  1 [ ]  2 [ ]  3 [ ]  | 16. Inhalants |  1 [ ]  2 [ ]  3 [ ]  |
| 6. Other Opiates & Synthetics |  1 [ ]  2 [ ]  3 [ ]  | 17. Over the Counter |  1 [ ]  2 [ ]  3 [ ]  |
| 7. PCP – phencyclidine |  1 [ ]  2 [ ]  3 [ ]  | 18. Oxycodone |  1 [ ]  2 [ ]  3 [ ]  |
| 8. Other Hallucinogens |  1 [ ]  2 [ ]  3 [ ]  | 19. Hydromorphone |  1 [ ]  2 [ ]  3 [ ]  |
| 9. Methamphetamine |  1 [ ]  2 [ ]  3 [ ]  | 20. MDMA (ecstasy, Molly, etc.) |  1 [ ]  2 [ ]  3 [ ]  |
| 10. Other Amphetamines |  1 [ ]  2 [ ]  3 [ ]  | 21. Other |  1 [ ]  2 [ ]  3 [ ]  |
| 11. Other Stimulants |  1 [ ]  2 [ ]  3 [ ]  | 22. Fentanyl |  1 [ ]  2 [ ]  3 [ ]  |
| KEY CODES |
| PST CODESPrimary (1) Tertiary (3)Secondary (2) | ADMINISTRATION CODESInhalation (I) Smoking (S) Other (X)Injection (J) Oral (O)  | FREQUENCY OF USE/PEAK USE PER MONTH1 – No use 3 – 4 to 12 times 5 - Daily2 – 1 to 3 times 4 – 13 or more times |
| IN THE FOLLOWING TABLE DESCRIBE SUBSTANCE USE WITH THE ABOVE KEY CODES |
| PST | SUBSTANCE(CODE) | ADMIN(CODE) | AGE OFFIRST USE | FREQUENCY OF USE -LAST 30 DAYS(CODE) | FREQUENCY OF USE –UNCONTROLLED ENVIRONMENT(CODE) | PEAK USE PER MONTH - LAST YEAR(CODE) | DATE LAST USEDMM/DD/YYYY |
| 1 |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **CURRENT HOUSING** |
| **RESIDENTIAL ARRANGEMENT (see attached)** |  |
| [ ]  Permanent housing – unassisted | [ ]  Skilled Nursing/Nursing/Intermediate Care Facility |
| [ ]  Permanent housing – assisted | [ ]  Other institutional setting |
| [ ]  Temporary housing – unassisted | [ ]  Residential SUD treatment (more than 90 days) |
| [ ]  Temporary housing – assisted | [ ]  Jail/Juvenile Correctional Facility (more than 60 days) |
| [ ]  Temporary housing – dependent | [ ]  Psychiatric Inpatient Facility (more than 90 days) |
| [ ]  Transitional housing | [ ]  Foster Care |
| [ ]  Residential Care | [ ]  Homeless |
| [ ]  Adult Family Home |  |
| **RESIDENTIAL treatment INFORMATION** |
| **REQUESTED ADMIT DATE:** | **REQUESTED SUD Residential FACILITY OR GENERAL LOCATION (If any):** |
|  |  |
| **OTHER CONSIDERATIONS OR REQUESTS REGARDING BED PLACEMENT? # OF CHILDREN THAT WILL**  |
| [ ]  Yes [ ]  No If yes, please describe below: **RESIDE W/CLIENT IN FACILITY?** |
| **REQUESTED Service LEvel:** |
| [ ]  Adult Intensive Inpatient | [ ]  Pregnant & Parenting Women (PPW) | [ ]  Youth – Intensive Inpatient (Level I) |
| [ ]  Adult Long-Term Care | [ ]  Adult Co-Occurring | [ ]  Youth – Recovery House |
| [ ]  Adult Recovery House | [ ]  Youth Intensive Inpatient (Level II) |  |
| **date of asam assessment:**  |  |
| **recommended asam assessment level** |  |
| [ ]  3.1 Clinically Managed Low Intensity Residential Services | [ ]  3.5 Clinically Managed High Intensity Residential Services |
| [ ]  3.3 Clinically Managed Population Specific High Intensity Res Services | [ ]  3.7 Medically Monitored Intensive Inpatient Services |
| **EDUCATION/EMPLOYMENT/MISCELLANEOUS INFORMATION** |
| **EMPLOYMENT STATUS** |
| [ ] Employed Competitively Full Time | [ ]  Not Employed – Actively Looking | [ ] NLF: Disabled |
| [ ] Employed Competitively Part-Time > 20 hrs. | [ ]  Not in Labor Force (NLF): Homemaker | [ ] NLF: Other |
| [ ] Employed Competitively Part-Time <20 hrs. | [ ] NLF: Student | [ ] Unknown |
| [ ] Employed Non-Competitive Job | [ ] NLF: Retired |  |
| **CURRENT EDUCATIONAL STATUS** |
| [ ]  Full-time education: (1-12 grade: 20+ hours per week; kindergarten and >12 grade: 12+ hours per week). A person is considered enrolled in school during scheduled vacations or term breaks that follow a period of enrollment as defined above. |
| [ ]  Part-time education: (1-12 grade: less than 20 hours per week; kindergarten and >12 grade: less than 12 hours per week). A person is considered enrolled in school during scheduled vacations or term breaks that follow a period of enrollment as defined above. |
| [ ]  Not in educational activities |
| **HIGHEST GRADE LEVEL ACHIEVED** |
| [ ]  Grade 1 | ☐ Grade 9 | ☐ 3 years of college |
| [ ]  Grade 2 | ☐ Grade 10 | [ ]  4 years of college |
| [ ]  Grade 3 | [ ]  Grade 11 | [ ]  Vocational |
| [ ]  Grade 4 | [ ]  High School Diploma or GED | [ ]  Nursery school, pre-school, head start |
| [ ]  Grade 5 | [ ]  2 years of college or Associate Degree | [ ]  Kindergarten |
| [ ]  Grade 6 | [ ]  Bachelor’s Degree | [ ]  Grade 12 (no diploma or GED) |
| [ ]  Grade 7 | [ ]  1 year of college | [ ]  Never attended or below preschool |
| [ ]  Grade 8 | [ ]  Post-graduate education | [ ]  Unknown |
| **BIRTHDATE OF YOUNGEST CHILD:** | **PREGNANT?**[ ] Yes [ ]  No |
| **SMOKING STATUS** | **Look Up ROI Signed?** |
| [ ]  Current Smoker | [ ]  Former Smoker | [ ]  Never Smoker | [ ]  Yes [ ]  No |
| **SELF HELP COUNT** |
| [ ]  No attendance | [ ]  About once a week | [ ]  At least 4 times a week |
| [ ]  Less than once a week | [ ]  2 to 3 times per week | [ ]  Unknown |
| **DIAGNOSIS(ES) – all that apply** |
| ICD-10 Code: |  |
| ICD-10 Code:  |  |
| ICD-10 Code: |  |
| ICD-10 Code: |  |
| **PSYCHOTROPIC MEDICATIONS** |
| NAME | DOSE | FREQUENCY |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **BIOMEDICAL MEDICATIONS** |
| NAME | DOSE | FREQUENCY | MEDICAL CONDITION TREATED |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **ADDITIONAL INFORMATION****Questions 1 – 5 are intended to guide placement decisions and not grounds for immediate exclusion. History of arson and/or sex offense may exclude applicants from facilities.** |
| 1. **BEHAVIORAL HEALTH SYMPTOMS**
 |
| Does the individual exhibit behavioral health symptoms that may impact treatment? [ ]  Yes [ ]  No |
| If so, are they described in biopsychosocial assessment? [ ]  Yes [ ]  No  |
| If no, please describe in “Notes” section. |
| 1. **BEHAVIORS**
 |
| Does the individual exhibit behaviors that may impact treatment? [ ]  Yes [ ]  No |
| If so, are they described in biopsychosocial assessment? [ ]  Yes [ ]  No  |
| If no, please describe in “Notes” section. |
| 1. **MEDICAL CONDITIONS**
 |
| Does the individual have medical conditions that may impact treatment? [ ]  Yes [ ]  No |
| If so, are they described in biopsychosocial assessment? [ ]  Yes [ ]  No  |
| If no, please describe in “Notes” section. |
| 1. **HISTORY OF VIOLENCE**
 |
| Does the individual have a history of violence? [ ]  Yes [ ]  No |
| If so, is it described in biopsychosocial assessment? [ ]  Yes [ ]  No  |
| If no, please describe in “Notes” section. |
| 1. **HISTORY OF ARSON**
 |
| Does the individual have a history of arson? [ ]  Yes [ ]  No |
| If so, is it described in biopsychosocial assessment? [ ]  Yes [ ]  No  |
| If no, please describe in “Notes” section. |
| 1. **SEX OFFENSE**
 |
| Is the individual a registered sex offender? [ ]  Yes [ ]  No  |
| If so, what level? [ ]  Level 1 [ ]  Level 2 [ ]  Level 3 |
|  |
| **CARE COORDINATION** |
| The following unmet needs have been identified for this client and will be coordinated, as needed, as part of their treatment and discharge planning process:

|  |  |
| --- | --- |
| **Community-Based Services** | **Medical and Behavioral Health Services** |
| [ ]  Housing | [ ]  Substance Use Disorder Outpatient Services |
| [ ]  Peer Support Services | [ ]  Mental Health Outpatient Services |
| [ ]  Other:  | [ ]  Medication Management |
|  | [ ]  Other: |

 |
| **NOTES** |
|  |