Please initial next to the applicable boxes below and include this form with the application to ensure that the necessary items are included for proper processing.

If the necessary information is not included, EEU staff will return this form indicating what is missing and a timeframe to return the missing item(s). If the information is not received within that time, the application will be rejected and a new application will need to be submitted for processing.

|  |  |  |
| --- | --- | --- |
| **Done** | **Necessary Documents for Completion** | **EEU Comments** |
|  | Page 1 of the application with the demographic information completed, including release date, if client is not in the community. |  |
|  | Proof of Delaware residency (see DSAMH043 EEU PROMISE Application Policy). |  |
|  | All sections of the ASAM are completed, including all applicable boxes being checked and supporting comments documented. |  |
|  | A release of information signed by the client (even if the client is < 18 years old). |  |
|  | If the client has a legal guardian, a copy of the guardianship paperwork is included. The legal guardian can sign the release in lieu of the client if the guardianship paperwork is included for processing. |  |
|  | If the client is court ordered to treatment, a copy of the court order is necessary for completion. A release of information is not necessary if the court order is included. |  |
|  | A recent psychiatric evaluation within the past 12 months and signed by a psychiatrist or psychiatric nurse practitioner. Three psychiatric notes with a diagnosis provided are acceptable that meet the criteria above on the documentation. |  |

**Upon completion of the application, submit the application to one of the following:**

1. DTRN
2. [DSAMH\_EEU@delaware.gov](mailto:DSAMH_EEU@delaware.gov)
3. EEU Fax Number: 302-622-4168

In compliance with Federal Regulations (42 U.S.C. 4582 and 21 U.S.C. 1175) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (45 C.F.R. Pts. 160 and 164), I, the undersigned,

|  |  |  |  |
| --- | --- | --- | --- |
| Client Name: |  | | |
| Date of Birth: | Click or tap to enter a date. | SSN: |  |

do hereby consent to services provided by PROMISE including care management services, level of care assessment, and referral to external providers.

**This consent extends from this date until 60 days post discharge from PROMISE services.**

|  |  |  |  |
| --- | --- | --- | --- |
| Signed: |  | Date: | Click or tap to enter a date. |

By  Client OR (Specify relationship if not client) Click or tap here to enter text.

**EEU APPLICATION FOR SERVICES**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Demographics and Status Request** | | | | | | | | Today’s Date: | | | Click or tap to enter a date. | | | | | |
| Consumer Last Name: | |  | | | | | | First: |  | | | | | | MI: |  |
| SSN: |  | | | | | | | DOB: | Click or tap to enter a date. | | | | | | Age: |  |
| Assigned Gender: M  F | | | | | Gender Identity: | | |  | | | | Ethnicity: | |  | | |
| Amount of Income: | | | | | |  | | | | | | | | | | |
| Source of Income: | | | | | |  | | | | | | | | | | |
| Medicaid #: | | |  | | | | | | | | | | | | | |
| Medicare #: | | |  | | | | | | | | | | | | | |
| Other Insurance (specify): | | | | | | |  | | | | | | | | | |
| TASC Client: Yes  No  Unknown | | | | | | | | | | On Probation:  Yes  No | | | | | | |
| Probation Officer Name: | | | |  | | | | | | Probation Officer Phone Number: | | |  | | | |

|  |
| --- |
| Current Residence (type): |
| Private Supervised  Private Unsupervised  Adult Foster Care  Boarding House |
| Group Setting Supervised  Group Setting Unsupervised  Psychiatric Inpatient Facility  Nursing Home  DOC Level 5  DOC Level 4  Other Institutional Setting  Homeless  Or  Other |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Other Than Private Residence Please Specify Facility Name: | | |  | | | | |
| Current Street Address: | |  | | | | | |
| City: |  | | | State: |  | Zip Code: |  |
| Home Phone: |  | | | Work Phone: |  | Cell Phone: |  |

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| --- | --- | --- | --- |
| Emergency Contact: |  | Relationship: |  |
| Phone Number: |  | | |
| Address: |  | | |

|  |  |  |
| --- | --- | --- |
| Primary Language:  English  Spanish  American Sign Language  Other: | | |
| Does the enrollee have a guardian?  No Yes/specify | |  |
| Does the enrollee have a representative payee?  No Yes/specify | |  |
| Current Provider: |  | |

Application completed by:

|  |  |
| --- | --- |
| (print) |  |
| (signature) |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Referring Agency: |  | | |
| Phone/ext.: |  | FAX #: |  |

***FOR MH SERVICES ATTACH A RECENT (within last year) PSYCHIATRIC EVALUATION WHICH INCLUDES THE INDIVIDUALS DIAGNOSTIC PROFILE***

**Psychiatric evaluation must be signed by the individual completing the evaluation**

**Qualified Psychiatric Practitioner (Psychiatrist or PMHNP) who performed the evaluation and formulated the diagnosis:**

|  |
| --- |
| Click or tap here to enter text. |

(Print Name of QPP)

|  |  |  |  |
| --- | --- | --- | --- |
| Phone #: |  | Date of Diagnosis: | Click or tap to enter a date. |

A. “What is the most important concern that you have at the moment?” Please answer in the client’s own words not what the clinician believes the need is.

|  |
| --- |
| Click or tap here to enter text. |

B. **ASAM Dimensions:** Provide a brief narrative for each dimension that explains your Rating of Severity/Function. Focus on brief relevant **history** information and relevant **here and now** information. CHECK ALL ITEMS THAT APPLY

**Dimension 1: Acute Intoxication and/or Withdrawal Potential - Substance Use: Include Amount, Duration and Last Use for each substance** (except “no known risk,” explain any item checked)

No known risk

Adequate ability to tolerate/cope with intoxication or withdrawal symptoms

Some difficulty tolerating/coping with intoxication or withdrawal discomfort

Past history of complicated withdrawal needing medical intervention

Current potential for complicated withdrawal needing medical intervention

Use is current and complicated withdrawal needing medical intervention is imminent

|  |
| --- |
| Click or tap here to enter text. |

**Dimension 2: Biomedical conditions/complications** (except “no known,” explain any item checked)

No known biomedical conditions/complications

Current physical illnesses exist, and are: stable unstable acute

There is a history of chronic conditions

|  |
| --- |
| Click or tap here to enter text. |

**Dimension 3:** **Emotional/Behavioral/Cognitive Conditions or Complications:**

SUICIDALITY (except “no history,” explain any item checked)

No history or current suicidal ideation

Has frequent passive thoughts of being better off dead

Exhibits suicidal ideation without a plan

Exhibits suicidal ideation with a plan

Has recently attempted suicide or made credible threats with a plan and means

Has a history of suicidal gestures or threats

|  |
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| Click or tap here to enter text. |

SELF-CONTROL/IMPULSIVITY (except “no history,” explain any item checked)

Has no history of self-control/impulsivity issues

Is involved with the judicial or legal system

Has been arrested for alcohol- or drug-related crimes, or for use/possession/distribution of drugs, for minor theft, destruction of property, vagrancy/loitering, disturbing the peace, or public intoxication within the past 6 months

Currently experiencing problems related to gambling

Has a history of arrests for illegal or unsafe activities

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| --- |
| Click or tap here to enter text. |

DANGEROUSNESS (except “no known history,” explain any item checked)

Has no known history of dangerousness

Lacks impulse control/control of violent behavior

Has a history of violent or dangerous social behavior

Exhibits inappropriate or dangerous social behavior dangerous to others, e.g. physical or sexual assault, fire setting

Engages in behavior dangerous to himself/herself

Engages in behavior dangerous to property

Engages in behavior that leads to victimization

|  |
| --- |
| Click or tap here to enter text. |

SELF-CARE (except “no self-care deficits,” explain any item checked)

No self-care deficits noted

Does not seek appropriate treatment/supportive services without assistance or requires significant oversight to do so; needs services to prevent relapse

Requires assistance in basic life and survival skills (i.e. locating food, finding shelter)

Requires assistance in basic hygiene, grooming and care of personal environment

Engages in impulsive, illegal or reckless behavior

Experiences frequent crisis contacts ( contacts within months)

Experiences frequent detoxification admissions ( admissions within months)

|  |
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| Click or tap here to enter text. |

PSYCHIATRIC/EMOTIONAL HEALTH (except “does not exhibit signs/symptoms,” explain any item checked)

Does not exhibit signs/symptoms of psychiatric or emotional illness

Psychiatric symptoms are well managed with medication/treatment

Symptoms persist in spite of medication adherence

Psychiatric symptoms and signs are present and debilitating

Experiences delusions and/or hallucinations which interfere with client’s ability to function

Acute or severe psychiatric symptoms are present which seriously impair client’s ability to function

Currently taking medications for these symptoms (list below)

Medication adherence is inconsistent

Experiences mood abnormality (depression, mania)

Is frequently very anxious or tense

Is unable to appropriately express emotions

Experiences hopelessness, apathy, lack of interest in life

Experiences physical symptoms related to their psychiatric illness or addiction (e.g. sleeplessness, stomach aches)

Lacks any sense of emotional well-being

PSYCHIATRIC/EMOTIONAL HEALTH/continued

|  |
| --- |
| Click or tap here to enter text. |

**Current medications and dosages. You may attach a copy of your Medication Administration Record (MAR) or order sheet if it is legible.**

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dosage** | **Effectiveness** |
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Allergies:

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| --- |
| Click or tap here to enter text. |

**Dimension 4:** **Readiness to Change:**

UNDERSTANDING OF ILLNESS AND RECOVERY (explain any item checked)

Exhibits understanding of the nature of his/her mental health and/or substance use illness and/or physical health and its effects

Exhibits some understanding of the nature of his/her mental health and/or substance use illness and/or physical health and its effects

Little or no understanding of the nature of his/her mental health and/or substance use illness and/or physical health and its effects

Limited understanding of the nature of his/her mental health and/or substance use illness and/or physical health and its effects

Does not have an understanding of his/her illness(es) and recovery

|  |
| --- |
| Click or tap here to enter text. |

DESIRE TO CHANGE (explain any item checked)

States desire to change

Indicates some desire to change

Limited desire or commitment to change

Doesn’t understand the need to change

Relates to treatment with some difficulty and establishes few, if any trusting relationships

Does not use available resources independently or only in cases of extreme need

Does not have a commitment to recovery

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| Click or tap here to enter text. |

**Dimension 5:** **Relapse, Continued Use, Continued Problem Potential:**

CURRENT AND PREVIOUS TREATMENT HISTORY AND RESPONSE (explain any item checked)

Takes medication with good response/complete remission of symptoms

Takes medications (with or without assistance) as prescribed with continued symptoms/partial remission of symptoms

Not using but no behavioral changes to support recovery

Not taking prescribed medications with a history of violence

Previous or current treatment has not achieved remission of symptoms

Previous treatment exposures have been marked by minimal effort or motivation and no significant success or recovery period was achieved

Attempts to maintain treatment gains have had limited success

Has had extensive and intensive treatment

Has had some treatment

This is the first treatment

Court ordered to treatment:  civil  criminal

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| Click or tap here to enter text. |

**Treatment Service history. Include all inpatient and outpatient treatment. We are particularly interested in the past 24 months or since last placement summary. If more space is needed, attach additional page(s).**

|  |  |  |  |
| --- | --- | --- | --- |
| DATES | | PROVIDER | Effectiveness (treatment goals met, premature discharge before goals met; problems encountered) |
| FROM | TO |
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RELAPSE PREVENTION, ILLNESS MANAGEMENT AND COPING (explain any item checked)

Has awareness of relapse triggers and ways to cope with MH breakthrough symptoms and/or substance use cravings

Has some awareness of relapse triggers and ways to cope with MH breakthrough symptoms and/or substance use cravings

Is unaware of relapse triggers and ways to cope with mental health breakthrough symptoms and/or substance use cravings

Lacks skills to control impulses to use or harm self or others

Doesn’t follow medication regimen

Requires assistance and/or support to actively manage relapse prevention

Tolerates organized daily activities or environmental changes

Exhibits some tolerance for organized daily activities or environmental changes

Has little tolerance for organized daily activities or environmental changes

Is unable to tolerate organized daily activities or environmental changes (e.g. activities or changes cause agitation, exacerbation of symptoms or withdrawal

Is unable to cope with stressful circumstances associated with work, school, family or social interaction

Lack of resilience in response to stress

|  |
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| Click or tap here to enter text. |

**Dimension 6:** **Recovery Environment:**

RECOVERY ENVIRONMENT: (except “safe affordable housing of own choosing,” explain any item checked)

Resides in safe affordable housing of own choosing

Resides in safe affordable housing but is not of own choosing

Resides in licensed Adult Foster Care

Resides in unlicensed Adult Foster Care

Resides in a Group Home

Resides in Supervised Housing/Apartment

Living arrangement puts client at risk of harm

Living environment increases client’s stress

Unable to or only marginally able to support themselves in independent housing

At risk of eviction due to behavioral health problems

At risk of homelessness for other reasons (e.g. family refuses to allow a return to the home, community complaints…)

Homeless

There is serious disruption of family or social milieu due to illness, death, severe conflict, etc.

Estranged from their family

Significant difficulties in interacting with family members

Lacks ability to provide food for self or dependent children

No transportation

No childcare presenting a barrier to participate in treatment

Language barriers interfere with full participation in treatment

Resides in environment where easily victimized

Other

|  |
| --- |
| Click or tap here to enter text. |

INTERPERSONAL/SOCIAL FUNCTIONING (explain any item checked)

Has several close relationships or group affiliations

Has one or two close relationships or group affiliations

Lacks connections to supportive social systems in the community

Unable to form close friendships or group affiliations

Unable to interact appropriately with family and/or the community

Unable to engage in meaningful activities

Is socially isolated

Is in abusive relationship(s)

|  |
| --- |
| Click or tap here to enter text. |

**Client strengths that will help him/her be successful at this level of care:**

|  |
| --- |
| Click or tap here to enter text. |

**Possible barriers to treatment:**

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| Click or tap here to enter text. |

D. **Rating of Severity/Function**: Using assessment protocols that address all six dimensions, assign a severity rating of **0 to 4** for each dimension that best reflects the client’s functioning and severity. Place a check mark or rating in the appropriate box for each dimension. **If applicable, for dimensions 4 and 5, rate mental health, substance use and physical health separately.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Risk Ratings** | **Intensity of Service Need** | **Dimensions** | | | | | |
| **1** | **2** | **3** | **4** | **5** | **6** |
| **(0) No Risk or Stable –** Current risk absent. Any acute or chronic problem mostly stabilized. | No immediate services needed. |  |  |  |  |  |  |
| **(1) Mild -** Minimal, current difficulty or impairment. Minimal or mild signs and symptoms. Any acute or chronic problems soon able to be stabilized and functioning restored with minimal difficulty. | Low intensity of services needed for this Dimension. Treatment strategies usually able to be delivered in outpatient settings |  |  |  |  |  |  |
| **(2) Moderate -** Moderate difficulty or impairment. Moderate signs and symptoms. Some difficulty coping or understanding, but able to function with clinical and other support services and assistance. | Moderate intensity of services, skills training, or supports needed for this level of risk. Treatment strategies may require intensive levels of outpatient care. |  |  |  |  |  |  |
| **(3) Significant** – Serious difficulties or impairment. Substantial difficulty coping or understanding and being able to function even with clinical support. | Moderately high intensity of services, skills training, or supports needed. May be in, or near imminent danger. |  |  |  |  |  |  |
| **(4) Severe -** Severe difficulty or impairment. Serious, gross or persistent signs and symptoms. Very poor ability to tolerate and cope with problems. Is in imminent danger. | High intensity of services, skills training, or supports needed. More immediate, urgent services may require inpatient or residential settings; or closely monitored case management services at a frequency greater than daily. |  |  |  |  |  |  |