



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Substance Abuse and Mental Health

1901 North DuPont Highway, New Castle, Delaware 19720

ELIGIBILITY AND ENROLLMENT UNIT

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Clinical Redetermination of Placement

ANNUAL REDETERMINATION

Eligibility Determination Review

Section I

Demographics and Status Request

Today's Date: _____

Consumer Last name (print): _____ First: _____ MI.: _____

SS#: _____ - _____ - _____ DOB: (mm/dd/yyyy) ____ / ____ / ____ Age: _____

Gender Expression: ____ (M) ____ (F) Marital Status: _____ Ethnicity: _____

TASC Client: Yes ____ No ____ Unknown ____ Probation Officer: _____

MCI # (if known) 000 _____ Source and Amount of Income: _____

Medicaid #: _____ Medicare # _____ Other Insurance (specify): _____

Current Residence (type): _____

Indicate whether the applicant lives in a private residence (supervised or unsupervised), Adult Foster Care, Boarding House, Group Setting (supervised or supervised), psychiatric inpatient facility (provide name), Nursing Home (specify), other Institutional Setting (specify), homeless or other (explain)

Current Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Person to Contact in Case of an Emergency: _____

Address: _____

Telephone Number: _____ Relationship: _____

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)

Date of **most recent** Assessment or Assessment Update completion (if applicable): _____ Appeal: Yes ____ No ____**Status Request:** LOC Requested: _____

Reason for Re-determination: Annual Re-determination: ____ Change in Level of Care: ____

Current Provider/LOC: _____

Date of enrollee's admission to current provider: _____

DISCHARGE (No more treatment needed.) _____

REFERRAL (Treatment to be provided by a different program) _____

TRANSFER (Treatment to be provided at the same program at a different intensity) _____

Assessor/Therapist (print): _____ Phone/ext.: _____ FAX # _____

Signature of Assessor/Therapist: _____

Referring Agency: _____

(Section 2)

Current Diagnoses and Symptoms**RECENT (within last 6 months) PSYCHIATRIC EVALUATION MUST ACCOMPANY APPLICATION****Axis I: Clinical Disorder**

Code: _____ Diagnosis: _____

Code: _____ Diagnosis: _____

Code: _____ Diagnosis: _____

Describe the clinical symptoms and conditions that justify the diagnosis indicated.

Axis II: Personality Disorders/Mental Retardation

Code: _____ Diagnosis: _____

Code: _____ Diagnosis: _____

Code: _____ Diagnosis: _____

Please describe the clinical symptoms and conditions that justify the diagnosis indicated.

Axis III: General Medical Conditions (ICD-9-CM name) Use additional space if needed.

Code: _____ Diagnosis: _____

Code: _____ Diagnosis: _____

Code: _____ Diagnosis: _____

Code: _____ Diagnosis: _____

Code: _____ Diagnosis: _____

Please describe the clinical symptoms and conditions that justify the diagnosis indicated.

Axis IV: Psychosocial and Environmental Problems (Check and Describe):

() Problems with primary support group (specify) _____

() Problems related to the social environment (specify) _____

() Educational problems (specify and indicate the highest grade completed) _____

() Occupational problems (specify) _____

() Housing problems (specify) _____

() Economic problems (specify) _____

() Problems with access to health care (specify) _____

() Problems related to interaction with the legal system/crime (specify) _____

() History of trauma (specify) _____

() Other psychosocial and environmental problems (specify) _____

Axis V: Global Assessment of Functioning Scale:

Current: _____ Highest level in the past year: _____

Diagnostician: Psychiatrist or other authorized person who performed the evaluation and formulated the diagnosis:_____
Print Name_____
Signature

Phone #: _____ Date of Diagnosis: _____

Section 3

A. What is the *most important thing* the client wants or made the client decide to call or come in for help right now? What is most important to you that the client would like help with right now?

B. Immediate Need Profile

Consider each dimension and with just sufficient data to assess immediate needs, checks “yes” or “no” for the following questions:

1. Acute Intoxication and/or Withdrawal Potential

(a) Past history of serious withdrawal, life-threatening symptoms or seizures during withdrawal? e.g., need for IV therapy; hospitalization for seizure control; psychosis with DT's; medication management with close nurse monitoring and medical management? ___No___Yes; (b) Currently having severe, life-threatening and/or similar withdrawal symptoms? ___No___Yes

2. Biomedical Conditions/Complications

Any current severe physical health problems? e.g., bleeding from mouth or rectum in past 24 hours; recent, unstable hypertension; recent, severe pain in chest, abdomen, head; significant problems in balance, gait, sensory or motor abilities not related to intoxication? ___No___Yes

3. Emotional/Behavioral/Cognitive Conditions/Complications

(a) Imminent danger of harming self or someone else? e.g., suicidal ideation with intent, plan and means to succeed; homicidal or violent ideation, impulses and uncertainty about ability to control impulses, with means to act on? ___No___Yes; (b) Unable to function in activities of daily living, care for self with imminent, dangerous consequences? e.g., unable to bath, feed, groom and care for self, due to psychosis, organicity or uncontrolled intoxication with threat of imminent safety to self, others as regards death or severe injury? ___No___Yes

4. Readiness to Change

(a) Does client appear to need alcohol or other drug treatment/recovery and/or mental health treatment, but ambivalent or feels it unnecessary? e.g., severe addiction, but client feels controlled use still OK; psychotic, but blames a conspiracy ___No___Yes; (b) Client has been coerced, mandated or required to have assessment and/or treatment by mental health court or criminal justice system, health or social services, work/school, or family/significant other? ___No___Yes

5. Relapse/Continued Use/Continued Problem Potential

(a) Is client currently under the influence and/or acutely psychotic, manic, suicidal? ___No___Yes; (b) Is client likely to continue to use or have active, acute symptoms in an imminently dangerous manner, without immediate containment? ___No___Yes; (c) Is client's most troubling, presenting problem(s) that brings the client for assessment, dangerous to self or others? (See examples above in dimensions 1, 2 and 3) ___No___Yes

6. Recovery Environment

Are there any dangerous family, sig. others, living/work/school situations threatening client's safety, immediate well-being, and/or sobriety? e.g., living with a drug dealer; physically abused by partner or significant other; homeless in freezing temperatures? ___No___Yes

IMPORTANT

- **Yes to questions 1a and 1b; or 1b alone; 2 and/or 3 requires** that the caller/client immediately receive medical or psychiatric care for evaluation of need for acute, inpatient care. **TAKE IMMEDIATE ACTION. STOP THE ASSESSMENT HERE.**
- **Yes to questions 4a and/or 4b alone,** requires caller/client to be seen for assessment within 48 hours, and preferably earlier, for motivational strategies, unless patient imminently likely to walk out and needs a more structured intervention.
- **Yes to question 5a alone,** assess further for need for immediate intervention e.g., taking keys of car away; having a relative/friend pick client up if severely intoxicated and unsafe; evaluate need for immediate psychiatric intervention.
- **Yes to questions 5b, 5c and/or 6,** without any Yes in questions 1, 2 and/or 3, requires that the caller/client be referred to a safe or supervised environment e.g., shelter, alternative safe living environment, or residential or sub-acute care setting depending on level of severity and impulsivity.

C. 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 all items 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
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-
-

Dimension 2: Biomedical conditions/complications (Except “no known,” explain all items checked)

- ☐ No known biomedical conditions/complications
 - ☐ Current physical illnesses exist, and are: stable unstable acute (circle as appropriate)
 - ☐ There a history of chronic conditions
-
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-

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

SUICIDALITY (Except “no history,” explain all items 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
-
-
-

SELF-CONTROL/IMPULSIVITY (Except “no history,” explain all items 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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-

DANGEROUSNESS (except “no known history,” explain all items 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
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-

SELF-CARE (except “no self-care deficits,” explain all items 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 (____ (number) within ____ (number) months)
 - ☐ Experiences frequent detoxification admissions (____ (number) within ____ (number) months)
-
-
-

PSYCHIATRIC/EMOTIONAL HEALTH (except “does not exhibit signs/symptoms,” explain all items 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
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-
-
-
-
-

ASAM CLINICAL PLACEMENT SUMMARY (Re-determination)

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
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

When available attach the most recent laboratory tests results, including tests for therapeutic drug levels, alcohol/drug screens, Complete Blood Count (CBC), Complete Metabolic Profile (CMP), Thyroid Stimulating Hormone (TSH) and any other diagnostic studies or indicate tests completed and results (e.g., Li Level WNL).

Other Comments about medications and dosage: _____

Dimension 4: Readiness to Change**UNDERSTANDING OF ILLNESS AND RECOVERY** (explain all items 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

DESIRE TO CHANGE (explain all items 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

Dimension 5: Relapse, Continued Use, Continued Problem Potential**CURRENT AND PREVIOUS TREATMENT HISTORY AND RESPONSE** (explain all items checked)

- ☐ Takes medication with good response/complete remission of symptoms
- ☐ Takes medications as prescribed (with or without assistance) 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)

Treatment Service history. Include all inpatient and outpatient treatment. We are particularly interested in period 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		

RELAPSE PREVENTION, ILLNESS MANAGEMENT AND COPING (explain all items 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

Dimension 6: Recovery Environment**RECOVERY ENVIRONMENT:** (except “safe affordable housing of own choosing,” explain all items 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 child care presenting a barrier to participate in treatment
- ☐ Language barriers interfere with full participation in treatment
- ☐ Resides in environment where easily victimized
- ☐ Other

INTERPERSONAL/SOCIAL FUNCTIONING (explain all items 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)

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.						

(Section 4)

E. Placement Decisions: Indicate for each dimension, the least intensive level consistent with sound clinical judgment, based on the client's functioning/severity and service needs

ASAM PPC-2R Level of Detoxification Service	Level	Dimen. 1 Intoxic/ Withdr.					
Ambul. Detox without Extended On-Site Monitor.	I-D						
Ambul. Detox with Extended On-Site Monitoring	II-D						
Clinically-Managed Residential Detoxification	III.2-D						
Medically-Monitored CD Inpatient Detoxification	III.7-D						
Medically-Managed Intensive Inpatient Detox.	IV-D						
ASAM PPC-2R Level of Care for Other Treatment and Recovery Services *	Level *		Dimen. 2 Biomed.	Dimen. 3 Emot./ Behav/ Cognitive	Dimen. 4 Readiness to Change	Dimen. 5 Relapse, Continued Use/Problem	Dimen. 6 Recovery Environ.
Early Intervention / Prevention	0.5						
Outpatient Services / Individual	I						
Outpatient with Care Manager	I.2						
Intensive Outpatient Treatment (IOP)	II.1						
ICM	II.2						
ACT	II.3						
CRISP	II.4						
Partial Hospitalization (Partial)	II.5						
Clinically-Managed Low-Int. Res. Svcs.	III.1						
Clinically-Managed Med-Intens. Residential Svcs.	III.3						
Clinically-Managed High-Intens. Residential Svcs	III.5						
Medically-Monitored Intens. Inpatient Treatment	III.7						
Medically-Managed Intensive Inpatient Services	IV						
Opioid Maintenance Therapy	OMT						

PLACEMENT SUMMARY

Level of Care/Service Indicated - Insert the ASAM Level number that offers the most appropriate level of care/service that can provide the service intensity needed to address the client's current functioning/severity ; and/or the service needed e.g., shelter, housing, vocational training, transportation, language interpreter	
Level of Care/Service Received - ASAM Level number -- If the most appropriate level or service is not utilized, insert the most appropriate placement or service available and circle the Reason for Difference between Indicated and Received Level of Service	
Reason for Difference - Circle only one number – 1. No difference; 2. Service not available; 3. Provider judgment; 4. Client preference; 5. Client is on waiting list for appropriate level; 6. Service available, but no payment source; 7. Geographic accessibility; 8. Family responsibility; 9. Language; 10. Court ordered; 11. Not listed (Specify):	
Anticipated Outcome If Service Cannot Be Provided – Circle only one number - 1. Admitted to acute care setting; 2. Discharged to street; 3. Continued stay in higher level of care; 4. Incarcerated; 5. Client will dropout until next crisis; 6. Probation Violation; 7. Not listed (Specify):	

Indicate types/frequency of services offered during last/current treatment period:

- | | |
|--|------------------|
| <input type="checkbox"/> Family Psycho-Education | Frequency: _____ |
| <input type="checkbox"/> Psychiatric Services/Appointments | Frequency: _____ |
| <input type="checkbox"/> Assistance with Medication (AWSAM) | Frequency: _____ |
| <input type="checkbox"/> Psychiatric Rehabilitative: assistance with self-care | Frequency: _____ |
| <input type="checkbox"/> Psychiatric Rehabilitative: assistance with social/interpersonal skills | Frequency: _____ |
| <input type="checkbox"/> Psychiatric Rehabilitative: assistance with community living | Frequency: _____ |
| <input type="checkbox"/> Treatment: therapy | Frequency: _____ |
| <input type="checkbox"/> Treatment: group counseling | Frequency: _____ |
| <input type="checkbox"/> Treatment: supportive counseling | Frequency: _____ |
| <input type="checkbox"/> Treatment : emergency services | Frequency: _____ |
| <input type="checkbox"/> Case Management: service linkage | Frequency: _____ |
| <input type="checkbox"/> Case Management: resource management | Frequency: _____ |
| <input type="checkbox"/> Other (explain) _____ | Frequency: _____ |

Indicate types/frequency of services anticipated current/next last treatment period:

- | | |
|--|------------------|
| <input type="checkbox"/> Family Psycho-Education | Frequency: _____ |
| <input type="checkbox"/> Psychiatric Services/Appointments | Frequency: _____ |
| <input type="checkbox"/> Assistance with Medication (AWSAM) | Frequency: _____ |
| <input type="checkbox"/> Psychiatric Rehabilitative: assistance with self-care | Frequency: _____ |
| <input type="checkbox"/> Psychiatric Rehabilitative: assistance with social/interpersonal skills | Frequency: _____ |
| <input type="checkbox"/> Psychiatric Rehabilitative: assistance with community living | Frequency: _____ |
| <input type="checkbox"/> Treatment: therapy | Frequency: _____ |
| <input type="checkbox"/> Treatment: group counseling | Frequency: _____ |
| <input type="checkbox"/> Treatment: supportive counseling | Frequency: _____ |
| <input type="checkbox"/> Treatment : emergency services | Frequency: _____ |
| <input type="checkbox"/> Case Management: service linkage | Frequency: _____ |
| <input type="checkbox"/> Case Management: resource management | Frequency: _____ |
| <input type="checkbox"/> Other (explain) _____ | Frequency: _____ |

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

Possible Barriers to treatment:

ADDITIONAL COMMENTS: (Please use the space below for additional comments about placement for this client.)
