SUD Level of Care Change Request

DIRECTIONS: Please complete this form when requesting an increase in level of care to recovery housing, partial hospital (day treatment), and sub-acute detox/residential. Please fax this form and any relevant clinical documentation to Region 10 PIHP Access/UM – Genesee Site (810) 257-1347. You will receive a response no later than 14 days from receipt of this request.

Consumer Name: _____

Case Number: _____

Medicaid ID#: _____

Provider Name: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

Clinician: _____

Service Requested:

☐ Subacute Detox ☐ Residential ☐ Partial Hospital (Day Treatment**)** ☐ Recovery Housing

What does the consumer want? _____

Substance:	**Method of Use:**	**Prescription (yes/no):**	**Amount:**	**Frequency:**	**Length of Current Use:**

Population Type (check all that apply):

☐ Pregnant Injecting drug user
☐ Pregnant non-injecting drug user
☐ Injecting drug user
☐ Parent at risk of losing children
☐ HIV Infected
☐ Psychiatric Discharge from the hospital
☐ Drug Court Consumer
☐ ACT/IDDT Consumer
☐ Mental Court
☐ All Others

Based on the multidimensional assessment, what are the risk ratings of each of the dimensions:

- Dimension 1: Alcohol Intoxication and/or Withdrawal Potential (please explain):

  Rating: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

  Problems: _____

  Services and intensity of services needed to address this dimension: _____

- Dimension 2: Biomedical Conditions and Complications (please explain):

  Rating: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

  Problems:

  Services and intensity of services needed to address this dimension:

- Dimension 3: Emotions, Behavioral or Cognitive Conditions and Complications (please explain):

  Rating: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

  Problems:

  Services and intensity of services needed to address this dimension:

- Dimension 4: Readiness to Change (please explain):

  Rating: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

  Problems:

  Services and intensity of services needed to address this dimension:

- Dimension 5: Relapse/Continued Use or Continued Problem Potential (please explain):

  Rating: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

  Problems:

  Services and intensity of services needed to address this dimension:

- Dimension 6: Recovery Environment (please explain):

  Rating: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

  Problems:

  Services and intensity of services needed to address this dimension:

Signature: _____ Date: _____

Name (print): _____

GHS UM Use Only:

REGION 10 RESPONSE:

TYPE/SOURCE OF REVIEW OF INFORMATION:

☐ Approved ☐ Denied

Disposition: _____

If wait-listed Type of Interim Services offered:

☐ Counseling and education on HIV/AIDS, TB, and Hepatitis C
☐ Counseling and education about the risk of needle sharing
☐ Counseling and education about the risks of HIV/AIDS transmission to sexual partners and children, and steps that can be taken to ensure that HIV/AIDS transmission does not occur
☐ Counseling on the effects of alcohol, tobacco and other drugs (ATOD) use on the fetus
☐ Referral for prenatal care
☐ No Interim Services referral

Signature: _____ Date: _____