Sample Initial Authorization Request – Training Tool June 2009
Not Reviewed

Client Information			
CLIENT NAME XXXXXXXXX	CLIENT ID XXXXXXXXX	DATE OF BIRTH XX/XX/XX	COUNTY OF RESIDENCE XXXXXXXXX

BILLING TYPE Block Grant (requested as Block Grant)	PROVIDER NAME Treatment Center	PROVIDER LICENSE # XXXXXX	PROVIDER CONFIDENTIAL Fax #
REQUEST DATE XX/XX/XXXX	CONTACT PERSON therapist name *required	HOURS AVAILABLE hours therapist is available *required	

Military Service:	( ) Yes (X) No *required
Injecting Drug Use:	( ) Yes (X) No *required
Pregnant:	( ) Yes (X) No *required
Corrections Related Status:	XXXXXXX *required

Diagnosis			
AXIS I		Primary: XXX.XX Secondary: XXX.XX	
Comments:		**(Identify frequency, amount and date of last use (DOLU) for each drug.)**	
As Evidenced By	Dependence	[ ] TOLERANCE - increased amount to achieve desired effect with same amount used [ ] WITHDRAWAL - characteristic w/drawal syndrome for the substance and/or use of similar substance to avoid w/drawal [ ] USE IN LARGER AMOUNTS OR FOR A LONGER TIME PERIOD THAN INTENDED [ ] PERSISTENT DESIRE AND/OR FAILED ATTEMPTS TO CUT DOWN OR CONTROL [ ] INCREASED TIME SPENT IN SUBSTANCE RELATED ACTIVITIES [ ] ACTIVITIES (SOCIAL, OCCUPATIONAL, RECREATIONAL) REDUCED OR GIVEN UP [ ] CONTINUED USE DESPITE MEDICAL OR PSYCHOLOGICAL PROBLEMS	[ ] TOLERANCE - increased amount to achieve desired effect with same amount used [ ] WITHDRAWAL - characteristic w/drawal syndrome for the substance and/or use of similar substance to avoid w/drawal [ ] USE IN LARGER AMOUNTS OR FOR A LONGER TIME PERIOD THAN INTENDED [ ] PERSISTENT DESIRE AND/OR FAILED ATTEMPTS TO CUT DOWN OR CONTROL [ ] INCREASED TIME SPENT IN SUBSTANCE RELATED ACTIVITIES [ ] ACTIVITIES (SOCIAL, OCCUPATIONAL, RECREATIONAL) REDUCED OR GIVEN UP [ ] CONTINUED USE DESPITE MEDICAL OR PSYCHOLOGICAL PROBLEMS

	Abuse	[ ] FAILURE TO FULFILL MAJOR ROLE OBLIGATIONS (HOME, SCHOOL, WORK) [ ] RECURRENT USE IN HAZARDOUS SITUATIONS [ ] RECURRENT SUBSTANCE RELATED LEGAL PROBLEMS [ ] CONTINUED USE DESPITE PERSISTENT SOCIAL OR INTERPERSONAL PROBLEMS	[ ] FAILURE TO FULFILL MAJOR ROLE OBLIGATIONS (HOME, SCHOOL, WORK) [ ] RECURRENT USE IN HAZARDOUS SITUATIONS [ ] RECURRENT SUBSTANCE RELATED LEGAL PROBLEMS [ ] CONTINUED USE DESPITE PERSISTENT SOCIAL OR INTERPERSONAL PROBLEMS

AXIS I MH	Primary: XXX.XX Secondary: XXX.XX		
Comments:	**(Comment on Axis I MH symptoms)**		
AXIS II	XXX.XX **(Comment on Axis II symptoms)**		
AXIS III	**(Comment on Medical diagnosis or symptoms)**		
Axis IV	[ ] PROBLEMS WITH PRIMARY SUPPORT GROUP	[ ] PROBLEMS RELATED TO SOCIAL ENVIRONMENT	[ ] EDUCATIONAL PROBLEMS
	[ ]OCCUPATIONAL PROBLEMS	[ ] HOUSING PROBLEMS	[X] ECONOMIC PROBLEMS
	[ ] PROBLEMS WITH ACCESS TO HEALTH CARE	[ ] PROBLEMS RELATED TO THE LEGAL SYSTEM	[ ]OTHER
AXIS V	GAF Score: XX *required		

ASAM Patient Placement Criteria

Dimension	.05	OMT	I	II.1	II.5	III.1	III.3	III.5	III.7	IV	I-D	II-D	III.2-D	III.7-D	IV-D
1. Acute Intoxication and/or Withdrawal Potential	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Evidenced by: **(Identify withdrawal symptoms.)**															
2. Biomedical Conditions and Complications (unrelated to withdrawal)	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Evidenced by: **(Identify all medical issues & impact on treatment.)**															
3. Emotional/Behavioral Conditions and Complications	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Evidenced by: **(Identify emotional/behavioral issues & impact on treatment.)**															
4. Treatment Acceptance/Resistance	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Evidenced by: **(Identify stage of change, internal vs. external motivation.)**															

5. Relapse/Continued Use Potential	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Evidenced by: **(Identify level of risk, knowledge of recovery, coping skills.)**															
6. Recovery Environment	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Evidenced by: **(Identify peer group, home environment, housing, employment...)**															

ASAM PPC Level of Care Indicated: **(by ASAM)**	ASAM PPC Level of Care Requested: **(Identify ASAM LOC that you are asking for, especially if it does not match the indicated LOC.)**

For Methadone Clients **(methadone clinic clients only)**	
Current Dosage: Number of Days Take Home:	
Indicate the current status and provide evidence for each of the following ASAM Patient Placement Criteria for Continuing Care dimensions.	
DIMENSION 1: Acute Intoxication and/or Withdrawal Potential	
[ ]	Client requires continued opioid maintenance therapy to prevent his or her return to illicit opiate use
[ ]	Client evidences current use (or increased risk of use) of drugs other than opiates
[ ]	Client has a history of inability to abstain from opiate use, despite multiple attempts at detoxification.
As evidenced by:	
DIMENSION 2: Biomedical Conditions and Complications (unrelated to withdrawal)	
[ ]	Client's status is characterized by biomedical conditions, if any, continue to be sufficiently stable to permit the client's continued participation in outpatient treatment
[ ]	Client evidences, or is at risk of, a serious or chronic biomedical condition that may be exacerbated by a return to illicit opiate use.
As evidenced by:	
DIMENSION 3: Emotional/Behavioral Conditions and Complications	
[ ]	Client has achieved stable emotional/behavioral functioning, which may be jeopardized by discontinuation of opioid maintenance treatment
[ ]	Client demonstrates the potential for making use of OMT, but has not yet made necessary life changes
[ ]	An emotional/behavioral disorder, which is being concurrently managed, continues to distract the client from focusing on treatment goals/ however, the client is responding to treatment and, with further interventions, is expected to achieve treatment objectives
[ ]	Client continues to manifest behaviors that pose a risk to self or others, but the condition is improving.
[ ]	Emotional/behavioral complications of addiction are still present and are manageable in a structured outpatient environment but requires continued therapeutic interventions
As evidenced by:	
DIMENSION 4: Readiness to Change	
[ ]	Client recognizes the severity of his or her drug problem but demonstrates minimal understanding of the self-defeating nature of his or her drug or alcohol use; however, the client is progressing in treatment
[ ]	Client recognizes the severity of his or her drug problem and demonstrates an understanding of the self-defeating nature of such alcohol or drug involvement; however, the client does not demonstrate behaviors that indicate

	the level of responsibility necessary to cope with the problem
[ ]	Client is beginning to accept responsibility for addressing his or her drug problem but still requires this level of intensity of motivational strategies to sustain progress in treatment
[ ]	Client has accepted responsibility for his or her drug problem and has determined that ongoing treatment with OMT is the most effective means of preventing relapse to drug addiction
As evidenced by:	
DIMENSION 5: Relapse/Continued Use Potential	
[ ]	Client continues to require structured therapy, pharmacotherapy and programmatic milieu to promote treatment progress because the client attributes continued relapse to physiological craving/need for opiates.
[ ]	Client recognizes relapse triggers but has not developed sufficient coping skills to interrupt or postpone gratification or to change inadequate impulse control behaviors
[ ]	Client's addiction symptoms, while stabilized, have not been reduced sufficiently to support functioning outside a structured milieu
[ ]	Pharmacotherapy has been part of an effective treatment process that has alleviated addiction symptoms and prevented relapse, and the withdrawal of methadone or LAAM is likely to lead to a recurrence of addiction symptoms.
As evidenced by:	
DIMENSION 6: Recovery Environment	
[ ]	Client has not yet developed sufficient coping skills to withstand stressors in the work environment so as to prevent return to illicit opiate use and has not developed vocational alternatives
[ ]	Client has not yet developed sufficient coping skills to deal with a non-supportive family/social environment to prevent return to illicit opiate use and has not developed alternative support systems
[ ]	Client has not yet integrated the socialization skills necessary to establish a supportive social network
[ ]	Problem aspects of the client's social and interpersonal life are responding to treatment, but not sufficiently supportive of recovery to allow transfer to a less intensive level of care
[ ]	Client's social and interpersonal life has established while he or she has been in treatment and indicates the need for continued OMT.
As evidenced by:	

Presenting Problem: (Age, sex, priority status, precipitating event that motivated the client to seek treatment.)
(Identify why the client is seeking treatment at this time. Identify what it is that the client is looking for. Identify if no use in over 30 days, further explain the medical necessity for treatment at this time.)
PRESENTING PROBLEM

Date Last Seen:	XX/XX/XXXX *required **(If new client, it is the date you saw the client. If the client is transferring from another program, identify the date client was last in treatment.)**
Date Last Used:	XX/XX/XXXX *required **(Identify date of most recent drug use)**
Motivation:	**(Identify stage of change; internal vs. external. If external, identify the source - family, PO, Dr...)**
Frequency of Sessions:	**(Identify how often you intend to see the client based on what it will take to interrupt use.)**
Estimated Discharge Date:	XX/XX/XXXX *required **(Identify an estimate of how long the client may require treatment.)**
Identify objective measure(s) of abstinence:	**(Identify Portable Breath Test (PBT), urine screens - if used-how often.)**
Type of 12-Step meeting attendance and frequency:	**(Identify AA, NA, rational recovery, smart recovery, church, frequency of contact with a sponsor or sober support.)**
Type of ancillary services provided or referred: (include referrals to QHP, CMH, Health Dept.)	**(Identify services that you provided or others in the recovery community provide such as mental health case management/ACT, MI Works or MRS...)**

Current Medications:	[ ] None	Risk Assessment:	[X] None
List Psychotropic Medications:	**(Identify medications prescribed for mental health issues listed on Axis I or III if used for pain...)**	Suicidality:	**(Identify ideation, plan, intent, method, means, opportunity) ****Emergent mental health services may be necessary.**
		Homicidality:	**(Identify ideation, plan, intent, method, means, opportunity) ****Emergent mental health services may be necessary.**
List Medical:	**(Identify medications prescribed for medical purposes or over the counter medication for Axis III.)**	Other Risk Behaviors:	**(Identify self injurious behavior if present.)**

Previous Treatments: **(Identify number of times treated by a professional.)**	Current Leisure/Stress Management Activities:

Substance Abuse Treatments:	#*required	**(Identify current positive coping techniques.)**
Mental Health Treatments:	#*required	

Referrals and Follow-up to Community Resources:
(Identify services that you do not provide that others in the community provide, mental health case management/ACT, MI Works, MRS...)

Symptoms: **(Identify symptoms that are impacting functioning which should be taken into consideration when providing treatment.)**		
[ ] Depressed	[ ] Decreased Energy	[ ] Grief
[ ] Hopelessness	[ ] Worthlessness	[ ] Guilt
[ ] Anxiousness	[ ] Obs./Compulsion	[ ] Medical
[ ] Impulsiveness	[ ] Irritability	[ ] Paranoia
[ ] Elevated Mood	[ ] Delusions	[ ] Hyperactivity
[ ] Hallucinations	[ ] Impulsiveness	[ ] Dissociative
[ ] Oppositionalism	[ ] Trauma Victim	[ ] Perpetrator
[ ] Serious/Chronic Infection		
[ ] Other (specify 'other' in comments box)		
[ ] Wt. Loss Or Gain		
[ ] Current Legal Problems:	**(Specify)**	

Functioning: **(Identify on scale of 0-3 how client's use is the impacting the following:)**				
	No impairment **0**	Mild **1**	Moderate**2**	Severe**3**
Marriage/Family	( )	( )	( )	( )
Job/School/Work	( )	( )	( )	( )
Friendship/Peers	( )	( )	( )	( )
Financial	( )	( )	( )	( )
Hobbies/Leisure	( )	( )	( )	( )
Daily Living/Hygiene	( )	( )	( )	( )
Ability to concentrate	( )	( )	( )	( )
Ability to control temper	( )	( )	( )	( )
Sexual Functioning	( )	( )	( )	( )
Sleeping Habits	( )	( )	( )	( )
Comments:	**(Identify possible diagnosis on Axis I-V which accounts for some of the symptoms above may comment on this.)**			

Generally, condition has been present: **(Identify the duration of the presence of the symptoms or functioning scaled above.)**			
( ) 3 months	( ) 6 months	( ) 12 months	( ) several yrs.

All Women **(IF CLIENT IS A MALE PLEASE SELECT NO IN ALL REQUIRED FIELDS.)**			
Pregnant? ( ) Yes ( ) No *required			
CPS Involvement? ( ) Yes ( ) No *required [ ] Abuse / Neglect [ ] Abandonment / Endangerment [ ] Incarceration [ ] Drug Use [ ] Other			
Client Referrals? ( ) Yes ( ) No*required **(If your program is a women's designated program and you are asking for ancillary services, this section should not be empty nor identified as none nor inapplicable. This is where you are placing the needed service justification.)**			
		Date Referral Made	Comments
Medical	( ) Yes ( ) No		
Mental Health	( ) Yes ( ) No		
Immunizations	( ) Yes ( ) No		
Transportation	( ) Yes ( ) No		
Child Care	( ) Yes ( ) No		
Dept. of Human Services	( ) Yes ( ) No		
MI Rehab Services	( ) Yes ( ) No		
Client's Children Referrals? ( ) Yes ( ) No *required			
		Date Referral Made	Comments
Medical	( ) Yes ( ) No		
Mental Health	( ) Yes ( ) No		
Immunizations	( ) Yes ( ) No		
Transportation	( ) Yes ( ) No		
Child Care	( ) Yes ( ) No		
Dept. of Human Services	( ) Yes ( ) No		
MI Rehab Services	( ) Yes ( ) No		
Therapeutic Intervention	( ) Yes ( ) No		
Date of Last Substance Use:			

SUBSTANCE ABUSE HISTORY					
	Drug	Route of	Age at First	Days Used in Last	Initially a Prescript. ?

	Code	Admin.	Use	30	
Primary Drug	*required	*required	*required	*required	( ) N/A ( ) Yes ( ) No *required
Secondary Drug	*required	*required	*required	*required	( ) N/A ( ) Yes ( ) No *required
Tertiary Drug	*required	*required	*required	*required	( ) N/A ( ) Yes ( ) No *required
				Injecting Drug Use in the Last 10 Years:	( ) N/A ( ) Yes (X) No *required

(Current)	Drug **(List Drug)**	Time and Amount of Last Use **(Identify frequency, amount, date of last use.)**	BAL or PBT Reading as applicable
Primary			
Secondary			
Tertiary			

Current use during the past 48-72 hours?	( ) Yes ( ) No
History of serious withdrawal symptoms?	( ) Yes ( ) No
History of life threatening symptoms?	( ) Yes ( ) No
History of seizures during withdrawal?	( ) Yes ( ) No
Currently experiencing withdrawal symptoms?	( ) Yes ( ) No
Comments	

History of Withdrawal

Admission Information	
Click Here for Admission/SARF Dates.	
Admission Date	Service Category

CLIENT ID				
XXXXXXXXX				
PROCEDURE CODE	DESCRIPTION	UNITS REQUESTED	UNITS AUTHORIZED	FREQUENCY OF CONTACT PER MONTH
(Code #)	**(Select description)**	X	0	X
(Code #)	**(Select description)**	X	0	X
(Code #)	**(Select description)**	X	0	X

Authorization Dates
Requested: XX/XX/XXXX- XX/XX/XXXX Authorized: -
Comments / Clinical Pathway / Interviewers Impressions
Authorization Comments: No Authorization Information
Request Comments: Comment Added by xxxxxxxx on XX/XX/XXXX XX:XX:XX PM
(Continuum of Care Comments)
Lapse Comments: No Lapse Information

This clinical authorization does not guarantee payment.
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