Adolescent Initial Level of Care Assessment Instructions

REQUIRED FORM: This form is required within the client file

WHEN: Form to be completed by LPHA/SUD counselor with the client during the assessment/admission process for adolescent clients in a SUD program.

All providers - Providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice.

Residential Providers – For the purposes of the "Multidimensional Assessment" required within 72 hours, residential providers will use the Optum SUD Residential Authorization Request and submit to Optum within 72 hours of admission.

PURPOSE: To determine possible admission of a client into a SUD treatment program and appropriate level of care. Increased collaboration between LPHA/Counselor and client by use of Motivational Interviewing techniques will result in a more comprehensive and useful assessment/intake.

NOTE: A separate care plan is no longer required (i.e. Peer Support Specialist Service, Perinatal Plan of Care, documentation of a client's need for a physical exam, etc.) Required care plan elements can be notated within the assessment record, problem list, progress notes, or by using a dedicated care plan template.

REQUIRED ELEMENTS:

- **Client Name:** Enter "Client Name". If using the form-fill, hit tab to get to "Client ID #", *once you hit tab again to go to the next field, the client name and ID will populate on the rest of the pages*
- **Client ID#:** Client ID number by entering the client's SanWITS' Unique Client Number (UCN).
- **Staff Completing the Form:** Name of staff completing the assessment/intake.
- **Place of Interview/assessment:** Location of assessment (jail, program, etc.)
- **Date of assessment/interview:** Date of assessment/interview.
- **Referral source:** Referral source name (Probation, CWS, Parole, etc.) and contact information (contact person, phone number, address, etc.).
- **If referral is being made but admission is expected to be DELAYED, reason:** (Must select one of the reasons below, if applicable)
    - Waiting for level of care availability
    - Hospitalized
    - Waiting for ADA accommodation
    - Waiting for language-specific services
    - Incarcerated
    - Other: (if selected, must explain): _____
    - Waiting for other special population-specific svcs
    - Patient preference

PERSONAL INFORMATION

- **Name:** Client's first name, middle initial and last name (obtain copy of legal ID, if available).
- **Age:** Client's age.
- **Social Security Number:** Client's social security number (obtain a copy of card, if available). If client does not have a social security number, follow your agency guidelines.
- **Birth Date:** Client's month/day/year of birth.
- **Phone Number:** Client's phone number/email address. Check if permitted to leave a message.
- **Preferred language**: Client's preferred language.
- **Address:** Client's current, physical address. If client is homeless, document "homeless" and address issue on ASAM Dimension 6: Recovery Environment.
- **What are the main reasons you are seeking help here today?** Write in client's own words, ask the client to prioritize in importance to him/her.
- **Gender Identity:** Check appropriate box. If "Other", write in client's own words specifics.
- **Sexual Orientation:** Check appropriate box. If "Other", write in client's own words specifics.
- **Pregnant /Due date:** Client's pregnancy status, check Yes or No.
    - If yes, complete due date. (Inform client they may be asked to provide documentation such as proof of pregnancy).
- **Number of Children:** Complete client's number of children.
- **Medi-Cal:** Check Yes or No.
    - If yes, complete Medi-Cal card number. (Inform client they may be required to provide proof of Medi-Cal eligibility. Follow agency guidelines for Medi-Cal eligibility).

- **Health Insurance:** Check Yes or No.
    - If yes, complete Insurance Company's name. (Inform client they may be required to provide proof of insurance. Follow agency guidelines for health insurance eligibility).
- **Have you ever been arrested/charged/convicted/registered for arson?** Check Yes or No.
- **Have you ever been arrested/charged/convicted/registered for a sex crime(s)?** Check Yes or No.
- **Emergency Contact:** Name, relationship, and contact number of designated emergency contact.
- **Parent/Guardian Information:** Name, relationship, and contact number of person designated parent/guardian.

THE FOLLOWING SECTIONS ARE TO BE COMPLETED BY THE ADOLESCENT AND THERPIST/COUNSELOR TOGETHER

ASAM DIMENSION 1: SUBSTANCE USE, ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL

- **In the past year how many times have you used?:** Mark an (X) as Never, Once or Twice, Monthly, Weekly, for all the following: Alcohol, Marijuana, Illegal Drugs, Prescription drugs not prescribed to client, Overuse of your prescription drugs, Inhalants, Herbs or synthetic drugs, Other. *If "Other" is checked, enter details on the line provided.*
- **Complete ALL boxes as appropriate for:** Primary Drug, Secondary Drug, and Tertiary Drug. If any of the boxes do not apply, enter N/A. This is based upon the client's *current* self-report of use.
- **Have you used needles in the past 12 months?** Check Yes, No, or Declined to State.
    - If yes, enter date last used.
- **Date you last used any drugs including alcohol:** Enter date.
- **Number of days in a row you have been using:** Enter number.

Alcohol and/or other drug treatment history

- **Have you received treatment for alcohol and/or other drugs in the past?** Check Yes or No.
    - If yes, provide details, and follow prompts in the boxes: Type of Recovery Treatment, Name of Treatment Facility, Dates of Treatment, Treatment Completed or Not.
- **Severity Rating – Dimension 1 (Substance Use, Acute Intoxication, Withdrawal Potential):** Follow the prompts and check the current, assessed level of risk. Include information from Parent/Guardian Form when determining risk rating.
- **Nicotine or Tobacco:** # of days used in the past 30 days, Route of Admission, Age at first use and Date Last Used.
    - If Nicotine or Tobacco Use is identified indicate if it is cigarette or vaping.
- Alcohol and Other Drug Treatment, if yes, document details for type of treatment, treatment facility and dates of treatment and treatment completed.

ASAM DIMENSION 2: BIOMEDICAL CONDITIONS/COMPLICATIONS

(*LPHA/Counselor will review the Client Health Questionnaire and TB Screening as part of this Dimension).*

- **Are you currently taking prescription medication for any medical conditions?** Check Yes or No.
    - If yes, describe in detail.
- **Severity Rating – Dimension 2 (Biomedical Conditions and Complications):** Follow the prompts; check the current, assessed level of risk. Include information from the Parent/Guardian Form aswell as the client health questionnaire and TB screening when determining risk rating.
- F**or residential programs:** if risk rating in this dimension is greater than "zero" (0), submit completed Health Screening Questionnaire along with Initial Assessment/Intake Form to assist with obtaining initial authorization.

ASAM DIMENSION 3: EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS/COMPLICATIONS

(*LPHA/Counselor to review the Risk Assessment and Co-Occurring Conditions Screening Forms for historical information relevant to this dimension. Include as part of your assessment of severity below*).

- **Do you have any current thoughts of hurting yourself or others?** Check Yes or No.
    - *If yes, continue questions per your agency policy and procedure to include additional screens, and assessment if client has a plan or means to harm self or others. Document client responses and respond accordingly per your agency policy and procedure.*
- **Are you currently seeing a therapist/Counselor, (or sought help in the past), for a mental health or behavioral need?** Check Yes or No.
    - If yes, describe in detail to include therapist name, address, how long, successful discharge, what was client being seen for, did the client feel treatment helped or not.
    - If yes to above, are you currently prescribed medications for mental health/behavioral health conditions described above? Check Yes or No.
    - If yes, describe; name, dosage, frequency, prescribed by whom. Did client take as directed?
- **Have you ever had trouble controlling your anger?** Check Yes or No.
    - If yes, describe with additional detail; how often, when was the last time, what does it look like, what helps to calm you, what's the worst that happened when you had trouble controlling your anger?
- **Over the past (2) weeks, how often have you been bothered by any of the following problems?** Ask *all* six prompts, check the appropriate box: Not at all, Several Days, More Than Half the Days,

Nearly Every Day. *DO NOT LEAVE BLANK.*

- **Severity Rating – Dimension 3 (Emotional, Behavioral or Cognitive (EBC) Conditions or Complications):** Follow the prompts and check the current, assessed level of risk. Include information from Parent/Guardian Form as well as the risk assessment and co-occurring screening forms when determining the risk rating.

ASAM DIMENSION 4: READINESS TO CHANGE

- **On a scale of 0 (not ready) to 4 (very ready) how important is it you to stop drinking or using other drugs:** Check the appropriate box. Add additional comments as appropriate. Use the client's own words as much as possible.
- **Do you intend to reduce or quit drinking alcohol or using other drugs in the next 2 weeks:** Check the appropriate box.
- **Does your family or friends ever tell you that you should cut down on your drinking or drug user:** Check the appropriate box.
    - If yes, provide additional information.
- **Severity Rating – Dimension 4 (Readiness to Change):** Follow the prompts and check the current, assessed level of risk. Include information from Parent/Guardian Form when determining risk rating.

ASAM DIMENSION 5: RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL

- **Do you ever use alcohol or other drugs while you are by yourself or alone?** Check Yes or No.
- **Do you ever use alcohol or other drugs to relax feel better about yourself, or fit in?** Check Yes or No.
- **How often do you want to or feel like using or drinking?** Document in client's own words.
- **What's the longest time you have gone without using alcohol and/or other drugs?** Document in client's own words; try to obtain specific timeframes, what helped him/her to achieve this.
- **Severity Rating – Dimension 5 (Relapse, Continued Use, or Continued Problem Potential):** Follow the prompts and check the current, assessed level of risk. Include information from Parent/Guardian Form when determining risk rating.

ASAM DIMENSION 6: RECOVERY ENVIRONMENT

- **Have you ever gotten into trouble while you were using alcohol or other drugs?** Check Yes or No.
    - If yes, describe in detail; timeframes, whom involved, consequences, how many times, times when client avoided getting into trouble and how did he/she achieve that?
- **Vocational/Educational Achievements (Highest grade level completed, any training or technical education, etc.:** Enter vocational/educational school or training.
- **Do you feel supported in your current living environment?** Check Yes or No.
- **Are you homeless or at risk?** Check Yes or No.
    - If yes, obtain additional information: how long, do you have a caseworker? Is the client interested in a housing referral and/or linkage? Could this be a barrier to service?

- **Where do you live/who do you live with?** Enter client self-report. How many times has the client moved within the last 18 months and why? How often do the people whom the client lives with change?

- **Does anyone else at home drink alcohol or use other drugs?** Check Yes or No.
    - If yes describe with as much detail as possible. Has Child Welfare ever come to your home or school?
- **Do your close friends drink alcohol or use other drugs?** Check Yes or No.
    - If yes, describe to include if any are currently in treatment.
- **Severity Rating – Dimension 6 (Recovery/Living Environment):** Follow the prompts and check the current, assessed level of risk. Include information from Parent/Guardian Form when determining risk rating.

YOUTH "AT" RISK :

- **Youth is at-risk for SUD and does not have a SUD diagnosis**: Check Yes or No.
    - If yes, refer to appropriate community resource.

LEVEL OF CARE DETERMINATION

(Read Level of Care Determination Instructions provided on the Screen/Intake Form carefully).

- **Recommended Level of Care**: Enter the ASAM Level of Care that offers the most appropriate treatment setting given client's current severity and functioning.
- **Acute Level of Care**: If a level of care other than the determination is provided, enter the next appropriate level of care.
- **Reason for Discrepancy**: Check the reason(s) for a discrepancy in the recommended level of care vs. acute level of care if appropriate. Provide a written explanation of the discrepancy on the line provided.
- **Designated Treatment Provider Name/Location**: Complete this information if services are NOT going to be provided by program completing this assessment and they are referring the client to another program.
- **Counselor Name**: If applicable, print name, signature, credentials, and date.

THE FOLLOWING SECTIONS MUST BE COMPLETED BY AN LPHA

PROVISIONAL DIAGNOSIS

NOTE: All programs must provide a provisional diagnosis

PLEASE NOTE THAT REGISTERED NURSES (RNs) MAY NOT DIAGNOSE

- **Enter Provisional DSM-5 Diagnosis & ICD-10 Code(s):** Ensure to utilize correct DSM-5 diagnostic label and ICD-10 code; a diagnosis of Substance Use will be the primary and listed first. There can be additional DSM-5 Diagnostic Labels and ICD-10 codes listed as well, but will need to follow the SUD label if appropriate.
- **A Face to Face interaction occurred between both counselor and LPHA to validate medical necessity:** Enter the date of the face to face interaction, if applicable.
  Note: If a LPHA does not conduct the assessment, a face-to-face interaction must take place, at a minimum, between the counselor who has completed the assessment for the client and the medical director, licensed physician, or LPHA. The medical director, licensed physician, or LPHA must document the date when the face-to-face interaction took place and then sign and date the assessment form.
- **Provisional Diagnosis Narrative:** Explain basis for provisional diagnosis here
- **LPHA* Name**: Print name, signature, credentials, and date.

**Licensed Practitioner of the Healing Arts (LPHA) includes: MD, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LPC), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.*