

Check box for:

☐ Initial client placement notification or

☐ Extension request

☐ Funding change

## Client Placement Notification\_Extension Request

Placement Notification - fill out this form in full and attach SUD Comprehensive Assessment  
Extension Request - complete extension request sections and attach the most recent treatment plan

Request date \_\_\_\_\_ Name of person completing \_\_\_\_\_

Email/direct dial \_\_\_\_\_

|                                                                                                                                                                                                                                 |                                                                                                                                                         |                                                                             |                                                                          |                                                   |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------------------------|---------------------------------------------------|--|
| Initial placement date                                                                                                                                                                                                          | Extension start date                                                                                                                                    | PMI# (Recip ID)                                                             | Client's legal name (Last name, first, middle)                           |                                                   |  |
| Client alias (if any)                                                                                                                                                                                                           | DOB (MM/DD/YYYY)<br><br>/ /                                                                                                                             | For extension requests, total units used (days)                             | For extension requests, total units used<br>15 min. inc.:                | Last county of residence before any excluded time |  |
| Date processed by county                                                                                                                                                                                                        | County reviewer signature                                                                                                                               | SSIS WG#                                                                    | Social Security number<br><br>- -                                        |                                                   |  |
| Marital status:<br><input type="checkbox"/> Divorced<br><input type="checkbox"/> Married<br><input type="checkbox"/> Legally separated                                                                                          | <input type="checkbox"/> Never married<br><input type="checkbox"/> Living apart<br><input type="checkbox"/> Widowed<br><input type="checkbox"/> Unknown | Gender:<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female | Hispanic?<br><input type="checkbox"/> Yes<br><input type="checkbox"/> No | Language                                          |  |
| Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian<br><input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown |                                                                                                                                                         |                                                                             |                                                                          |                                                   |  |

## Placement & Financial

|                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                         |                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
| Comprehensive assessment date or date of update<br><br>/ /                                                                                                                                                                                                                                                                                                                     | Risk assessment ratings (0-4):<br>Dim 1: _____ Dim 4: _____<br>Dim 2: _____ Dim 5: _____<br>Dim 3: _____ Dim 6: _____                                                                                                                                                                                                                                                                             | Indicate if client is:<br><input type="checkbox"/> Minor <input type="checkbox"/> Pregnant<br><input type="checkbox"/> Adult with minor | Diagnosis Code<br><br>_____ |
| Procedure code (if applicable)<br><input type="checkbox"/> H2036<br><input type="checkbox"/> H0004 U8<br><input type="checkbox"/> H2017 U8<br><input type="checkbox"/> H2027 U8<br><input type="checkbox"/> H0005-U8<br><input type="checkbox"/> H2017 U8-HQ<br><input type="checkbox"/> H2027 U8-HQ                                                                           | Program specifics/modifiers (must check all that apply)<br><input type="checkbox"/> Co-occurring services<br><input type="checkbox"/> Recipients with children<br><input type="checkbox"/> Special populations<br><input type="checkbox"/> Committed client<br><input type="checkbox"/> Medical services<br><input type="checkbox"/> Disability responsive<br><input type="checkbox"/> Adolescent | Service start date<br><br>/ /                                                                                                           | Service end date<br><br>/ / |
| Revenue code: <input type="checkbox"/> 944 Drugs <input type="checkbox"/> 945 Alcohol <input type="checkbox"/> 953 Drugs and Alcohol<br><input type="checkbox"/> 0101 Hospital Daily <input type="checkbox"/> 1002 Room and Board same location <input type="checkbox"/> 1003 Room and Board different location<br><input type="checkbox"/> (Sober housing-recovery residence) |                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                         |                             |
| Total # units<br><br>___ Days<br><br>___ 15 min. inc.                                                                                                                                                                                                                                                                                                                          | NPI #<br><br>___ ASAM Level of Care<br><br>11 Location of service (office)                                                                                                                                                                                                                                                                                                                        | Provider name and location or address where services will be delivered                                                                  |                             |
|                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                   | Provider FAX number                                                                                                                     |                             |

Glossary on page 5.

Client initials \_\_\_\_\_

Date of birth \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------|
| Procedure code (if applicable)<br><input type="checkbox"/> H2036<br><input type="checkbox"/> H0004 U8<br><input type="checkbox"/> H2017 U8<br><input type="checkbox"/> H2027 U8<br><input type="checkbox"/> H0005-U8<br><input type="checkbox"/> H2017 U8-HQ<br><input type="checkbox"/> H2027 U8-HQ                                                                           | Program specifics/modifiers (must check all that apply)<br><input type="checkbox"/> Co-occurring services<br><input type="checkbox"/> Recipients with children<br><input type="checkbox"/> Special populations<br><input type="checkbox"/> Committed client<br><input type="checkbox"/> Medical services<br><input type="checkbox"/> Disability responsive<br><input type="checkbox"/> Adolescent | Service start date<br><br>/   /                                        | Service end date<br><br>/   / |
| Revenue code: <input type="checkbox"/> 944 Drugs <input type="checkbox"/> 945 Alcohol <input type="checkbox"/> 953 Drugs and Alcohol<br><input type="checkbox"/> 0101 Hospital Daily <input type="checkbox"/> 1002 Room and Board same location <input type="checkbox"/> 1003 Room and Board different location<br><input type="checkbox"/> (Sober housing-recovery residence) |                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                               |
| Total # units<br><br>___ Days<br><br>___ 15 min. inc.                                                                                                                                                                                                                                                                                                                          | NPI #<br><br>___ ASAM Level of Care<br><br>11_ Location of service (office)                                                                                                                                                                                                                                                                                                                       | Provider name and location or address where services will be delivered |                               |
|                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                   | Provider FAX number                                                    |                               |

|                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------|
| Procedure code (if applicable)<br><input type="checkbox"/> H2036<br><input type="checkbox"/> H0004 U8<br><input type="checkbox"/> H2017 U8<br><input type="checkbox"/> H2027 U8<br><input type="checkbox"/> H0005-U8<br><input type="checkbox"/> H2017 U8-HQ<br><input type="checkbox"/> H2027 U8-HQ                                                                           | Program specifics/modifiers (must check all that apply)<br><input type="checkbox"/> Co-occurring services<br><input type="checkbox"/> Recipients with children<br><input type="checkbox"/> Special populations<br><input type="checkbox"/> Committed client<br><input type="checkbox"/> Medical services<br><input type="checkbox"/> Disability responsive<br><input type="checkbox"/> Adolescent | Service start date<br><br>/   /                                        | Service end date<br><br>/   / |
| Revenue code: <input type="checkbox"/> 944 Drugs <input type="checkbox"/> 945 Alcohol <input type="checkbox"/> 953 Drugs and Alcohol<br><input type="checkbox"/> 0101 Hospital Daily <input type="checkbox"/> 1002 Room and Board same location <input type="checkbox"/> 1003 Room and Board different location<br><input type="checkbox"/> (Sober housing-recovery residence) |                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                               |
| Total # units<br><br>___ Days<br><br>___ 15 min. inc.                                                                                                                                                                                                                                                                                                                          | NPI #<br><br>___ ASAM Level of Care<br><br>11_ Location of service (office)                                                                                                                                                                                                                                                                                                                       | Provider name and location or address where services will be delivered |                               |
|                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                   | Provider FAX number                                                    |                               |

For extension requests see instructions on page 3, you do not need to complete an assessment update.

Please submit within 10 days of admission or 10 days before initial units will be exhausted  
Submit to: **Hennepin County Addiction and Recovery Services**   [hc.reviewteam@hennepin.us](mailto:hc.reviewteam@hennepin.us)  
Fax: **612-466-9546** (alternative analog fax 612-330-2318) Phone: 612-879-3671

Client initials \_\_\_\_\_

Date of birth \_\_\_\_\_

Initial placements will be limited to the following intervals before an extension request is required:

- 18 days for inpatient hospital-based stays
- 60 days for residential placements
- 1200 units group services combined (120 units individual services combined) for outpatient treatment services

Extension Request

Contact information for primary counselor:

Name

Phone

Email

Please attach client’s treatment plan with risk ratings at admission and current risk ratings with supporting rationale. Indicate any changes from previous reviews. Give client specific examples of progress toward goals, discharge plans, community referrals, client acceptance of referrals, and barriers to program completion or step down to a lower level of care.

Clinical Information Requested

1. What is this patient’s treatment plan? Please also include progress made.

2. What are the patient’s discharge plan? Please include if member is accepting of aftercare recommendations, status of referrals made, barriers preventing a step down.

Summary of Progress Toward Treatment Goals

Please indicate any changes from previous reviews. Provide Intake Dimension Ratings and a brief summary to support each rating. Please be specific in how ratings are determined for this patient, where patient continues to struggle, and what goals or recommendations are being made to aid this patient in these areas. Please provide specific examples, not generalized statements.

Dimension 1 – Acute Intoxication and/or Withdrawl Potential

Please include any PAWS, cravings with ratings or severity, is member utilizing MAT

Risk rating at admission \_\_\_\_\_

Current risk rating \_\_\_\_\_

Client initials \_\_\_\_\_

Date of birth \_\_\_\_\_

Risk rating at admission \_\_\_\_\_

Current risk rating \_\_\_\_\_

**Dimension 2 – Biomedical Conditions and Complications**

Please include labs if abnormal and preventing medication initiation, vitals if abnormal.

**Dimension 3 – Emotional, Behavioral, or Cognitive Conditions and Complications**

Please include any impulsive behaviors, mood changes, unstable mood, etc.

Risk rating at admission \_\_\_\_\_

Current risk rating \_\_\_\_\_

**Dimension 4 – Readiness to Change**

Please include progress being made, motivation, identified coping skills, relapse triggers, is member completing treatment plan assignments, attendance, interaction with peers/staff, minimizing or glorifying use, etc.

Risk rating at admission \_\_\_\_\_

Current risk rating \_\_\_\_\_

**Dimension 5 – Relapse, Continued Use, or Continued Problem Potential**

Please identify coping skills and implementation, relapse triggers, commitment to abstaining, relapse prevention plan status, barriers preventing a step down to a lower level of care.

Risk rating at admission \_\_\_\_\_

Current risk rating \_\_\_\_\_

Client initials \_\_\_\_\_

Date of birth \_\_\_\_\_

Risk rating at admission \_\_\_\_\_

Current risk rating \_\_\_\_\_

**Dimension 6 – Recovery/Living Environment**

Please include any family/support involvement while in treatment, any identified sober hobbies/activities/structure outside of programing, living environment after treatment, employment, etc.

**Glossary**

**Modifiers**

- ☐ Co-occurring (HH)
- ☐ Medical (U5)
- ☐ Co-occurring and Medical combined (UC)
- ☐ Disability Responsive (U3)
- ☐ Special Populations/Culturally Specific (U4)
- ☐ Client with Child (U6)
- ☐ Committed Complex (HK)
- ☐ Adolescent (HA)

**Additional Billable Services**

- ☐ Comprehensive Assessments (H001)
- ☐ Care Coordination (T1016 HN,U8)  
(15-minute increments-up to 2 hours per day per client)
- ☐ Peer Support (H0038 U8)  
(15-minute increments-up to 4 hours per day per client, maximum of 56 units month/14 hours per week)
- ☐ Room and Board (1002)
- ☐ Room and Board/different location (1003)

**Level of care**

- ☐ 1.0 outpatient up to 8 hrs. per week
- ☐ 2.1 outpatient 9-19 hrs. per week
- ☐ 2.5 Partial Hospital 20 hours or more per week

**H0004-U8 (Individual Counseling)**

**H2017-U8 (Individual Recovery Support)**

**H2027-U8 (Individual Education)**

**H0005-U8 (Group Counseling)**

**H2017-U8-HQ (Group Recovery Support)**

**H2027-U8-HQ (Group Education)**

**Adult Residential (H2036)**

- ☐ 3.1 Low Intensity 5 hrs. per week
- ☐ 3.1 Low Intensity 15 hrs. per week
- ☐ 3.3 Disability responsive/daily skilled services 7 days per week
- ☐ 3.5 High Intensity daily skilled services 7 days per week

**Hospital Inpt. (0101)**

- ☐ 3.7 Hospital Inpt. SUD

**Opiate Treatment Program (180 Days)**

- ☐ MOUD Methadone \_\_ see 20 possible CMS combinations DHS-8849-ENG
- ☐ MOUD Other \_\_ see 20 possible CMS combinations DHS-8849-ENG

**Adolescent level of care**

- ☐ 1.0 outpatient up to 5 hours per week
- ☐ 2.1 outpatient 6 or more hrs. per week
- ☐ 3.5 Residential daily skilled services 7 days per week (H2036)