Hennepin Health
your community health plan

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) / /	For extension requests,total units used (days)	For extension requests, total units used Hours: 15 min. inc.:	Last county of residence before any excluded time

Date processed by county	County reviewer signature	SSIS WG#	Social Security number _ _

Marital status:		Gender:	Hispanic?	Language
❑ Divorced	❑ Never married	❑ Male	❑ Yes	
❑ Married	❑ Living apart	❑ Female	❑ No	
❑ Legally separated	❑ Widowed			
	❑ Unknown			

Race: ❑ White ❑ Black ❑ American Indian
❑ Asian/Pacific Islander ❑ Other ❑ Unknown

Placement & Financial

Comprehensive assessment date or date of update / /	Risk assessment ratings (0-4): Dim 1: _____ Dim 4: _____ Dim 2: _____ Dim 5: _____ Dim 3: _____ Dim 6: _____	Indicate if client is: ❑ Minor ❑ Pregnant ❑ Adult with minor	Diagnosis Code _____

Procedure code (if applicable)	Program specifics/modifiers (must check all that apply)	Service start date	Service end date
❑ H2036 ❑ H2035 ❑ H2035-HQ	❑ Co-occurring services ❑ Recipients with children ❑ Special populations ❑ Committed client ❑ Medical services ❑ Disability responsive ❑ Adolescent	/ /	/ /

Revenue code: ❑ 944 Drugs ❑ 945 Alcohol ❑ 953 Drugs and Alcohol
❑ 0101 Hospital Daily ❑ 1002 Room and Board same location ❑ 1003 Room and Board different location
❑ (Sober housing-recovery residence)

Total # units	NPI #	Provider name and location or address where services will be delievered
___ Days ___ Hours ___ 15 min. inc.	___ ASAM Level of Care 11_ Location of service (office)	
		Provider FAX number

Glossary on page 5.

Client initials _____

Date of birth _____

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___ Days ___ Hours ___ 15 min. inc.	___ ASAM Level of Care 11_ Location of service (office)	
		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**
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
- 300 group hours (30 one to one hours) 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 _____

Dimension 2 – Biomedical Conditions and Complications

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

Risk rating at admission _____

Current risk rating _____

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

Additional Billable Services

___ Comprehensive Assessments (H001)
___ Room and Board (1002)
___ Care Coordination (T1016 HN,U8)
___ Room and Board/different location (1003)
(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)

Level of care

Adult outpatient (H2035 HQ Group) (H2035 one to one)

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

Adult Residential (H2036)

___ 3.1 Low Intensity 5 hrs. per week
___ 3.3 Disability responsive/daily skilled services 7 days per week
___ 3.1 Low Intensity 15 hrs. 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 (H0020) __ Plus 9 additional hrs. per week (UA)
___ MOUD Other (H0047) __ Plus 9 additional hrs. per week (UB)

Adolescent level of care

___ 1.0 outpatient up to 5 hours per week (H2035 HQ Group) (H2035 one to one)
___ 2.1 outpatient 6 or more hrs. per week (H2035 HQ Group) (H2035 one to one)
___ 3.5 Residential daily skilled services 7 days per week (H2036)