

Blair County Drug and Alcohol Client Admission/Re-Authorization Form

Client Name: _____ **SS#** _____

Provider Name: _____

Admission Request

Date of Admission: _____ **Date individual showed up for the first day of treatment**

If this is an adolescent treatment service, is the individual involved with the school SAP _____ YES _____ NO

Level of Care: (Please circle one level of care)

OP OP – Methadone IOP PHP Halfway House Non-Hospital Detox
 Non Hospital Rehab ST Non Hospital LT Hospital based Detox Hospital based Rehab

Units for All levels of care listed above **except Outpatient** will be in accordance with Authorization Guidelines (Attachment 19)

Outpatient Services –Please indicate the number of units being requested (This does not include IOP)

Outpatient/IOP
 Individuals: # of Units _____ (Based on Authorization guidelines)
 Groups: # of Units _____ (Based on Authorization guidelines)
 Family # of Units _____ (Based on Authorization guidelines)
 Methadone Dosing # of Units _____ (initial-no more than units)

MA Eligibility Status: In order for an authorization to be generated the provider is required to assist the person with completing the medical assistance application and to fax to the Blair County Assistance office. Please complete the appropriate box:
 _____ Provider has Fax application to Blair County CAO office on _____ but has not received notification of their status. EVS slip is in client’s chart.
 _____ Client has been denied MA. (Copy of denial letter placed in client file)

Re-Authorizations Request

Requesting Additional Units Only – Time frame of current authorization will cover the additional unit request:

Outpatient – Individual: # Units _____ **Group #Units** _____ **Family # Units** _____
Intensive Outpatient: # Group Units _____ **#Indiv Units** _____
Partial Hospital: # Units _____

No Continued stay review ASAM is required with this type of request.

Requesting additional time and units: The individual meets clinical criteria for continued stay at the current level of care and additional time and units are being requested OR the individual has enough units but needs additional time to complete the service.

Authorization Time Frame request: Start date _____ End Date _____

Units being Requested: _____ None being requested (please check if no additional units are needed)

OP – **IOP-** **Methadone OP:**
Individual: # Units _____ **IOP: #Group Units** _____ **Dosing Units:** _____
Group #Units _____ **IOP: #Individual Units** _____
Family # Units _____
PHP:# Units _____ **Halfway House: #Units** _____ **Residential: #Units** _____

Continued Stay Review ASAM is required to extend the time frame, please submit with this request.

Name and Phone Number of Person completing the form. (Please Print) Fax to Blair County Drug and Alcohol: 814-381-0922. Any questions please contact Donna Carter at 814-381-0921 ext 305 or Judy Rosser at 814-381-0921 extension 301