Clear Form

Client Name: _____ Client ID #:_____

ADULT
Initial Level of Care Assessment

Staff completing the form: _____ Place of interview: _____

Date of screening: _____ Referral source (Name & Phone #) _____

PERSONAL INFORMATION

First Name: _____ M.I. ___ Last Name: _____ Age: _____

Social Security Number: _____ Birth Date: ____/____/____

Phone Number: (____) _____ OK to leave message? ☐ YES ☐ NO Preferred Language: _____

Address: _____
Street City State Zip Code

What are the main reasons you are seeking help here today? _____

_____

_____

Gender Identity: ☐ Male ☐ Female ☐ Transgender (M to F) ☐ Transgender (F to M)
☐ Questioning/Unsure ☐ Other _____ ☐ Decline to state

Sexual Orientation: ☐ Heterosexual/Straight ☐ Lesbian ☐ Gay ☐ Bisexual
☐ Questioning/Unsure ☐ Other _____ ☐ Decline to state

Are you a veteran? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO Due Date: _____ # of Children under 18: _____

Do you have Medi-Cal? ☐ YES ☐ NO Medi-Cal Card #: _____

Do you have Health insurance? ☐ YES ☐ NO Insurance Company: _____

Are you on Medically Assisted Treatment (MAT) (i.e., Methadone, Vivitrol, Suboxone)? ☐ YES ☐ NO

If YES, list the medication: _____ Where do you obtain this? _____

Have you ever been arrested/charged/convicted/registered for arson? ☐ YES ☐ NO

Have you ever been arrested/charged/convicted/registered for a sex crime(s)? ☐ YES ☐ NO

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone # (_____)_____

Name: _____ Relationship: _____ Phone # (_____)_____

Client Name: _____ Client ID #:_____

ALCOHOL AND/OR OTHER DRUG USE

Primary Drug	# of Days used in past 30 days	Route of Admission	Age at first use	Date Last Used
Secondary Drug	**# of Days used in past 30 days**	**Route of Admission**	**Age at first use**	**Date Last Used**
Tertiary Drug	**# of Days used in past 30 days**	**Route of Admission**	**Age at first use**	**Date Last Used**

Have you used needles in the past 12 months? ☐ YES ☐ NO ☐ Decline to state/NA If yes, last used: ___/____/____

Date you last used any drugs including alcohol: _____/_____/_____ Number of days in a row you have been using: _____

How long do you think you have had a problem with alcohol and/or other drugs? _____

ALCOHOL AND/OR OTHER DRUG TREATMENT HISTORY

Have you received treatment for alcohol and/or other drugs in the past? ☐ YES ☐ NO

If yes, please give details:

Type of Recovery Treatment (Outpatient, Residential, Detoxification)	Name of Treatment Facility	Dates of Treatment	Treatment Completed (yes or no)

ASAM Dimension 1: Acute Intoxication and/or Withdrawal Potential

Do you have a history of serious withdrawal, seizures, or life-threatening symptoms during withdrawal? ☐ YES ☐ NO

If yes, please describe:

_____

_____

Are you currently experiencing withdrawal symptoms, such as tremors, excessive sweating, rapid heart rate, blackouts, anxiety, vomiting, etc.? ☐ YES ☐ NO

If yes, please describe:

_____

_____

Client Name: _____ Client ID #:_____

Severity Rating – Dimension 1 (Substance Use, Acute Intoxication, Withdrawal Potential) *COUNSELOR: Please Check one of the following levels of severity*				
☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Fully functioning, no signs of intoxication or W/D present.	Mild to moderate intoxication interferes with daily functioning, but does not pose a danger to self/others. Minimal risk of severe W/D.	Intoxication may be severe, but responds to support; not posing a danger to self or others. Moderate risk of severe W/D.	Severe signs/symptoms of intoxication indicate an imminent danger to self/others. Risk of severe but manageable W/D; or W/D is worsening.	Incapacitated, with severe signs/symptoms. Severe W/D presents danger, such as seizures. Continued use poses an imminent threat to life (e.g., liver failure, GI bleeding, or fetal death).

ASAM Dimension 2: Biomedical Conditions/Complications

(Include review of Health Questionnaire and TB Questionnaire in your determination below)

Are you currently taking prescription medications for any medical conditions? ☐ YES ☐ NO If yes, please describe:

_____

_____

If recently enrolled in Medi-Cal, have you received a health screening to identify health needs within 90 days of Medi-Cal enrollment? ☐ YES ☐ No ☐ N/A

Severity Rating – Dimension 2 (Biomedical Conditions and Complications) *COUNSELOR: Please Check one of the following levels of severity*				
☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Fully functioning and able to cope with any physical discomfort or pain.	Adequate ability to cope with physical discomfort. Mild to moderate symptoms (such as mild to moderate pain) interfere with daily functioning.	Some difficulty tolerating physical problems. Acute, non-life threatening medical symptoms (such as acute episodes of chronic, distracting pain, or signs of malnutrition or electrolyte imbalance) are present. Serious biomedical problems are neglected.	Poor ability to tolerate and cope with physical problems, and/or general health condition is poor. Serious medical problems neglected during outpatient or IOT services. Severe medical problems (such as severe pain requiring medication, or hard to control Type 1 Diabetes) are present but stable.	The person is incapacitated, with severe medical problems (such as extreme pain, uncontrolled diabetes, GI bleeding, or infection requiring IV antibiotics).

***Note: For residential programs, if the risk rating on ASAM Dimension 2 is greater than "zero" (0), please submit the completed Health Screening Questionnaire along with this form to assist with obtaining initial authorization.**

Client Name: _____ Client ID #:_____

ASAM Dimension 3: Emotional/Behavioral/Cognitive Conditions/Complications

Review Risk Assessment and Co-Occurring Conditions Screening form 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? ☐ YES ☐ NO If yes, please describe:

_____

_____

Are you currently being treated or sought help in the past for a mental health condition? (For example, depression, bipolar disorder, anxiety, PTSD, psychosis, or other mental health condition). ☐ YES ☐ NO
If yes, please describe:

_____

_____

If yes to the question above, are you currently prescribed medications for the mental health condition(s) you described?
☐ YES ☐ NO
If yes, please describe: _____

Do you feel like you are unable to care for yourself (hygiene, food, clothing, shelter, etc.)? ☐ YES ☐ NO
If yes, please describe: _____

Do you currently have a therapist and/or psychiatrist? ☐ YES ☐ NO
If yes, provide name/contact information: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

- Feeling down, depressed or hopeless
  ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every Day
- Needed much less sleep than usual and found you didn't really miss it
  ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every Day
- Feeling nervous, anxious, or on edge
  ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every Day
- Had nightmares about a frightening, horrible or upsetting event you've experienced
  ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every Day
- Seen things that other people can't see or don't seem to see
  ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every Day
- Heard things that other people can't hear or don't seem to hear
  ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every Day

Severity Rating – Dimension 3 (Emotional, Behavioral or Cognitive (EBC) Conditions or Complications) *COUNSELOR: Please Check one of the following levels of severity*				
☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Good impulse control, coping skills and sub-domains (dangerousness/lethality, interference with recovery efforts, social functioning, self-care ability, course of illness).	There is a suspected or diagnosed EBC condition that requires intervention, but does not significantly interfere with treatment. Relationships are being impaired but not endangered by substance use.	Persistent EBC condition, with symptoms that distract from recovery efforts, but are not an immediate threat to safety and do not prevent independent functioning.	Severe EBC symptomatology, but sufficient control that does not require involuntary confinement. Impulses to harm self/others, but not dangerous in a 24-hr. setting.	Severe EBC symptomatology; requires involuntary confinement. Exhibits severe and acute life-threatening symptoms (e.g., dangerous or impulsive behavior or cognitive functioning) posing imminent danger to self/others.

Client Name: _____ Client ID #:_____

ASAM Dimension 4: Readiness to Change

How long do you think you have had a problem with alcohol and/or other drugs?

_____

Have you tried to stop drinking/using before? If so, what interfered with your success with that goal?

_____

_____

Do you intend to reduce or quit drinking/using in the next 2 weeks?

☐ Definitely no ☐ Probably no ☐ Probably yes ☐ Definitely yes

What substance(s) are you willing to stop using?

_____

What would be helpful for you now in order to change your drinking/using?

_____

_____

_____

What is the possibility 12 months from now you will not have a problem with alcohol and/or other drugs?

☐ Definitely not ☐ Probably not ☐ Probably will ☐ Definitely will

How important is it for you to receive treatment for:

Alcohol problems: ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

Drug problems: ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

Severity Rating – Dimension 4 (Readiness to Change) ***COUNSELOR: Please Check one of the following levels of severity***				
☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Engaged in treatment as a proactive, responsible participant. Committed to change.	Ambivalent of the need to change. Willing to explore need for treatment and strategies to reduce or stop substance use. May believe it will not be difficult to change, or does not accept a full recovery treatment plan.	Reluctant to agree to treatment. Able to articulate negative consequences (of substance use and/or mental health problems) but has low commitment to change. Passively involved in treatment (variable follow through, variable attendance)	Minimal awareness of need to change. Only partially able to follow through with treatment recommendations.	Unable to follow through, little or no awareness of problems, knows very little about addiction, sees no connection between substance use/consequences. Not willing to explore change. Unwilling/unable to follow through with treatment recommendations.

ASAM Dimension 5: Relapse, Continued Use, or Continued Problem Potential

What's the longest period of time that you have gone without using alcohol and/or other drugs? _____

If you previously stopped using alcohol and/or other drugs, what are the reasons you started using again?

_____

_____

"Triggers" are events, feelings, people, places or things that cause someone to justify using again. Are you aware of your triggers to use alcohol and/or other drugs? ☐ YES ☐ NO

If yes, please list: _____

_____

What are some coping tools you have used in the past to avoid using?

_____

_____

Severity Rating – Dimension 5 (Relapse, Continued Use, or Continued Problem Potential) *Please Check one of the following levels of severity*				
☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Low or no potential for further substance use problems or has low relapse potential. Good coping skills in place.	Minimal relapse potential. Some risk, but fair coping and relapse prevention skills.	Impaired recognition and understanding of substance use relapse issues. Able to self-manage with prompting.	Little recognition and understanding of relapse issues, poor skills to cope with relapse.	Repeated treatment episodes have had little positive effect on functioning. No coping skills for relapse/addiction problems. Substance use/behavior places self/others in imminent danger.

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ASAM Dimension 6: Recovery Environment

Are you homeless or at risk? ☐ YES ☐ NO Living Situation: _____

Are you currently employed? ☐ YES ☐ NO

Vocational/Educational Achievements (Highest grade level completed, any training or technical education, etc.):

_____

Do you have friends and/or family that are supportive of you seeking treatment for problems related to substance use?
☐ YES ☐ NO If yes, describe:

_____

Do you have friends and/or family that might interfere with your treatment for problems related to substance use?
☐ YES ☐ NO If yes, describe:

_____

PO Contact Name & Phone Number: _____

Pending court date(s)? ☐ YES ☐ NO If yes, reason(s) and date(s):

_____

Are there any transportation, childcare, housing or employment issues that could interfere with your treatment for problems related to substance use? ☐ YES ☐ NO

Severity Rating – Dimension 6 (Recovery Environment) ***COUNSELOR: Please Check one of the following levels of severity***				
☐ **0: None**	☐ **1: Mild**	☐ **2: Moderate**	☐ **3: Significant**	☐ **4: Severe**
Supportive environment and/or able to cope in environment.	Passive/disinterested social support, but not too distracted by this situation and still able to cope.	Unsupportive environment, but able to cope with clinical structure most of the time.	Unsupportive environment and the client has difficulty coping, even with clinical structure.	Environment toxic/hostile to recovery (i.e. many drug-using friends, or drugs are readily available in the home environment, or there are chronic lifestyle problems). Unable to cope with the negative effects of this environment on recovery (i.e. environment may pose a threat to recovery).

Client Name: _____ Client ID #:_____

Optional Risk Rating Summary	
Dimension	Risk Rating
1 (page 3)	
2 (page 3)	
3 (page 4)	
4 (page 5)	
5 (page 6)	
6 (page 7)	

Level of Care Determination Instructions

After completing the screening (and determining the risk ratings) in each of the six dimensions, review the "Levels of Care" document which describes the typical risk ratings associated with each level of care and can help guide your level of care recommendation.

Once the recommended level of care is determined, document it in the space below. Also document the level of care to be provided. If there is a discrepancy between the two, document the reason(s) for the discrepancy in the spaces provided.

If the screening results indicate a level of care different than the one your program provides, complete the "Designated Treatment Provider Name/Location" field with the information from the program you will be linking the client to.

DMC-ODS regulations require that a "Licensed Practitioner of the Healing Arts" (LPHA) make level of care determinations. In the event an LPHA does not conduct the screening (and an AOD/SUD Counselor does), the Counselor and LPHA must have a face-to-face review of the information, and the LPHA must co-sign the form, indicating their agreement with the level of care determination.*

Recommended Level of Care: Enter the ASAM Level of Care that offers the most appropriate treatment setting given client's current severity and functioning: _____

Actual Level of Care: If a level of care other than the recommended is provided, enter the next appropriate level of care: _____

Reason for Discrepancy (Clinical Override): Check off the reason for discrepancy between level of care determination and level of care provided, and document the reason(s) why:

☐ Not applicable ☐ Service not available ☐ Provider judgment ☐ Client preference
☐ Transportation ☐ Accessibility ☐ Financial ☐ Preferred to wait
☐ Language/Cultural Factors ☐ Environment ☐ Mental Health ☐ Physical Health
☐ Court/Probation Ordered ☐ Other: _____

Explanation of Discrepancy:

_____

_____

Designated Treatment Provider Name/Location: _____

_____ _____ _____
Counselor Name (if applicable) **Signature** (if applicable) **Date**

Provisional Diagnosis

All programs must provide a provisional diagnosis

Provisional Diagnosis DSM-5 Diagnostic Label(s) & ICD-10 Code(s): _____

_____

A face-to face interaction between the AOD counselor and the LPHA to verify the determination of medical necessity for the client regarding this intake screening and related forms occurred on: ___/____/____ *(if applicable)*

_____ _____ _____
LPHA* Name **Signature** **Date**

*Licensed Practitioner of the Healing Arts (LPHA) includes: MD, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), 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.