SUBSTANCE ABUSE IDENTIFICATION AND TREATMENT NOTIFICATION

Enrollee Name _____ **AU No.**_____
MA No._____
Address_____**Zip**_____ **SS No.** _____
DOB _____ **Telephone No.** (_____) _____ - _____ **MCO** _____

Addiction Specialist/DSS Office _____
Address _____ **Telephone No.** (_____) _____ - _____
Treatment Provider _____
Address _____ **Telephone No.** (_____) _____ - _____
SAMIS Identification No._____ **Provider No.**_____

Part I. Comprehensive Substance Abuse Assessment o **or Drug Test** o (Check one)

1. Date provider received consent form and referral _____/_____/_____
2. Date of appointment _____/_____/_____
3. Results of drug test: Positive o Negative o
4. o Patient failed to keep appointment for comprehensive substance abuse assessment or drug test.
5. o Comprehensive assessment indicates patient not in need of substance abuse treatment.
6. o Patient referred for treatment to: _____ on _____/_____/_____.

Signature of addictions specialist _____ Telephone No. (_____) _____ - _____

Print or type name _____ Date _____

Part II. Treatment Compliance Notification

Level of Care Provided _____

1. Date provider received consent form and referral _____/_____/_____
2. o Patient failed to appear for initial appointment within 30 days of referral or if no appointment available within 30 days of referral, patient failed to schedule and appear for first available appointment.
3. o Awaiting available vacancy.
4. o Enrolled in treatment program
5. o Not maintaining active attendance/participation.
6. o Discharged for noncompliance.
7. o Successfully completed program.
8. o Referred to _____ on _____/_____/_____.
   New Program Date

Admission date: _____/_____/_____ Discharge date: _____/_____/_____

Discharged to (provider) _____ Level of Care _____

New Provider's Address _____ Zip _____ Telephone No. (_____) _____ - _____

Signature of addictions specialist _____ Date _____/_____/_____

Print or type name _____ Telephone No. (_____) _____ - _____

Part III. Work Readiness

1. o Not able to work
2. o Not ready to work but could participate in job readiness/training/education
3. o Able to work.
4. o Other_____

Signature of addictions specialist _____ Date _____/_____/_____

Part IV. Case Manager Action Taken **Case Manager Name**_____

1. o Conciliation _____/_____/_____ date began.
2. o Sanction_____/_____/_____ effective date.
3. Active Service case o YES o NO

Comments:_____