Substance Use Disorder Residential/Subacute Rehabilitation
Intensity of Service Questions
ASAM Level 3.5

Please circle YES or NO

Facility Name: _____
Name of Person Completing the Form: _____
Title: _____
Date Completed: _____
Ages treated: _____
Is your facility accredited? YES◉ NO○
If yes, by which organization: _____
Please provide copy of program description and relevant policies supporting the below requirements for this level of care.

1. Is the provider licensed by the appropriate state agency?
   YES◉ NO○
   If Yes, please provide state agency: _____
   Please provide copy of licensure.
   If no, please explain:
   sdsdfdsfds
   _____
   _____

2. Documentation that the member's history and physical examination with medical clearance is completed within 48 hours of admission, unless completed within 72 hours prior to admission or if transferred from an acute inpatient level of care.
   YES○ NO◉
   If no, please explain:
   _____
   _____

3. Drug screens and relevant lab tests are available and completed and documented, as clinically indicated.
   YES○ NO◉
   If no, please explain:
   _____
   _____

4. Appropriately credentialed medical staff are responsible for completing diagnostic evaluation within 48 hours of admission.
   YES○ NO◉
   If no, please explain:
   _____
   _____

5. The physician or physician extender provides daily medical management and evaluation services with documentation. The physician or physician extender must be available 24 hours a day, 7 days per week via telehealth or telephonic consultation.
   YES ◯ NO ◉
   If no, please explain:

_____

_____

6. After a multidisciplinary assessment, and within 72 hours of admission, an individualized treatment plan using evidence-based concepts, where applicable, is developed and amended as needed for changes in the individual's clinical condition.
   YES ◯ NO ◉

   **Please note: This plan should reference the following to develop treatment and discharge plans focused on the member:*

   a. Precipitants to admission, including social determinants of health ◉ YES ◯ NO
   b. Family/other support systems available after discharge ◉ YES ◯ NO
   c. Community resources ◉ YES ◯ NO
   d. Need for supportive living placement to continue recovery ◉ YES ◯ NO
   e. Need for services for comorbid medical or psychiatric conditions ◉ YES ◯ NO

   Please cite relative policy reference supporting the above, and if the answer is no, please explain with further detail:

_____

_____

7. Treatment programing includes and documents one individual counseling session weekly or more as clinically indicated.
   YES ◯ NO ◉
   If no, please explain:

_____

_____

8. Members and/or family members are being made aware of FDA-approved Medication Assisted Treatments (MAT). *MAT is defined as the provision of medications in any level of care and includes use of medicine in an ongoing care plan to reduce cravings and relapse.*
   YES ◯ NO ◉
   If no, please explain:

_____

_____

9. Members and/or family members are provided informed consent including the risks and benefits of MAT treatment as well as the risks of no MAT treatment.
   YES ◯ NO ◉
   If no, please explain:

_____

_____

10. Members are evaluated on each program day by a licensed behavioral health practitioner.
    YES ◯ NO ◉
    If no, please explain:

    _____

    _____

11. Mental health and medical services are available 24 hours per day, seven days per week, either onsite or offsite by referral.
    YES ◯ NO ◉
    If no, please explain:

    _____

    _____

12. On-site nursing (e.g., LPNs) is available at least eight hours a day, five days per week, and RNs are available 24 hours a day to respond, including responding to significant events within one hour.
    YES ◯ NO ◉
    If no, please explain:

    _____

    _____

13. Licensed clinical staff is available onsite or by telephone 24 hours a day, seven days a week adequate to supervise the member's medical and psychological needs.
    YES ◯ NO ◉
    If no, please explain:

    _____

    _____

14. A multidisciplinary treatment program provides daily clinical services to comprehensively address the needs identified in the member's treatment plan.
    YES ◯ NO ◉
    If no, please explain:

    _____

    _____

15. Family participation:
    a. For adults: Family treatment is provided at an appropriate frequency. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy.
    YES(•) NO( ) N/A( )
    If no, please explain:

    b. For children/adolescents: Family treatment is provided as part of the treatment plan. If Family treatment is not held, the facility/provider specifically lists the contraindications to Family Therapy.
    YES( ) NO( ) N/A(•)
    If no, please explain:

    c. For children/adolescents: The family/support system assessment is completed within 48 hours of admission with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur at least weekly or more often if clinically indicated.
    YES( ) NO( ) N/A(•)
    If no, please explain:

    d. Family participation is conducted via telephonic sessions when there is a significant geographic or other limitation.
    YES( ) NO(•)
    If no, please explain:

16. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan within 72 hours of admission.
    YES( ) NO(•)
    If no, please explain: