REGISTRATION FORM for Outpatient, Family Support Team (FST), Methadone Maintenance & Ambulatory Detox

PLEASE COMPLETE AND FAX TO: 1-(866)-434-7681

Provider EDS/CMAP ID # (Medicaid 9-digit ID) _____

Name of clinician who filled out this form _____Credentials/Title _____

Contact number _____ Ext:_____

Facility/Provider Name_____ Telephone Number_____

Facility/Provider Service Location _____

Member Name _____

Medicaid/Consumer ID# _____DOB: _____ ***AND/OR*** SSN: _____

REQUESTED LEVEL OF CARE: ☐ **Outpatient** ☐ **FST** ☐ **Methadone Maintenance** ☐ **Ambulatory Detox**

QUESTIONS:

1. RACE (optional): ☐ American Indian/Alaskan ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific ☐ White
2. ETHNICITY: Hispanic/Latino Origin (optional): ☐ YES ☐ NO
3. REFERRAL SOURCE: ☐ Self/Family Member ☐ PCP/Medical Provider ☐ Step Down Intermediate LOC ☐ Step Down Inpatient LOC ☐ Other BH Provider ☐ School ☐ Comm. Collaborative ☐ CT BHP ASO ☐ DCF ☐ DMR ☐ DMHAS ☐ Hospital Emergency Dept ☐ Managed Service System ☐ Court-ordered ☐ Other Legal ☐ Other
4. FIRST DIRECT SCREENING W/ MEMBER: Date_____
5. SCREENING TYPE: ☐ Walk-in ☐ Telephone
6. REFERRAL TYPE: ☐ Routine ☐ Urgent ☐ Emergent
   a. If Routine or Urgent: Date Appt. Offered: _____ Did Member Accept the Appointment? ☐ YES ☐ NO
      Date of first face-to-face Clinical Evaluation: _____
   b. If Emergent : Date and Time Presented at the Clinic: _____ DATE _____ AM / PM
      Date and Time of Clinical Evaluation: _____ DATE _____ AM / PM
7. AXIS I – V (AXIS IDSM IV Diagnosis Code)
   a. AXIS I & II
      AXIS I _____ (circle one: Primary, Secondary, Rule Out)
      AXIS I _____ (circle one: Primary, Secondary, Rule Out)
      AXIS II (if deferred, pls indicate)_____ (circle one: Primary, Secondary, Rule Out)
      AXIS II _____ (circle one: Primary, Secondary, Rule Out)
   b. AXIS III: ☐ None ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Cardiac Problem ☐ Chronic Pain ☐ Cystic Fibrosis ☐ Eating Disorder ☐ HIV ☐ Hearing Impairment ☐ Hepatitis ☐ Lupus ☐ Mobility impairment ☐ Neurological disorder ☐ Obesity ☐ Pregnancy ☐ Post-partum ☐ Sickle Cell ☐ Traumatic Brain Injury ☐ Type I Diabetes ☐ Type II Diabetes ☐ Visual impairment ☐ Other Axis III _____
   c. AXIS IV: _____
   d. AXIS V (GAF Score ✓ & enter appropriate #) ☐ 1-10 _____ ☐ 11-20 _____ ☐ 21-30 _____ ☐ 31-40 _____ ☐ 41-50 _____ ☐ 51-60 _____ ☐ 61-70 _____ ☐ 71-80 _____ ☐ 81-90 _____ ☐ 91-100 _____
8. If member had previous behavioral hlth treatment within the past 6 mos. Select all that apply: ☐ N/A ☐ Mntl Hlth ☐ Sub Abuse
9. Are there family members or significant others involved in the members treatment and recovery? ☐ YES ☐ NO ☐ N/A
   a. If yes, are any of the family members/significant others receiving their own MH or SA treatment? ☐ YES ☐ NO

10. Have you obtained consent to contact:
    a. School ☐ YES ☐ NO ☐ DENIED
    b. Medical Provider ☐ YES ☐ NO ☐ DENIED
    c. Previous behavioral health treatment provider ☐ YES ☐ NO ☐ DENIED ☐ N/A
    d. BH treatment provider for family member/significant other ☐ YES ☐ NO ☐ DENIED ☐ N/A

11. Who is the lead case management provider? ☐ None ☐ DCF Case Worker ☐ DCF Enhance CC
    ☐ CC (System of Care Collaborative) ☐ DMHAS Case Manager

12. Is the member currently taking psychiatric medications? ☐ YES ☐ NO

13. Is a psychiatric medication evaluation or medication management visit indicated? ☐ YES ☐ NO

14. Does member have co-occurring mental health and substance use conditions? ☐ YES ☐ NO ☐ Not Assessed

15. If the member is involved with the legal system, please select all that apply

    a. ☐ Juvenile Justice ☐ N/A ☐ Probation ☐ Parole ☐ Other Court

16. Have you provided information regarding peer support or self-help options? ☐ YES ☐ NO

17. **Effective date/Start date of authorization?** (EX: 09/01/06): _____

FEDERAL REPORTING REQUIREMENTS *ONLY* FOR MEMBERS 0-17 YEARS OF AGE

18. SED (Seriously/Severely Emotionally Disturbed): ☐ YES ☐ NO ☐ UNKNOWN

19. Co-Occuring Disorder: ☐ YES ☐ NO ☐ UNKNOWN

20. Living Situation ☐ Independent Living w/Supports ☐ Crisis Stabilization Residential
    ☐ Foster Care (Therapeutic or Professional) ☐ Foster Care (Standard) ☐ Group Home ☐ Homeless
    ☐ Jail/Correctional Facility ☐ Private Residence ☐ Psychiatric Residential Treatment Facility
    ☐ Residential Treatment Center ☐ Safe Home ☐ Shelter

21. Within the past 12 mos. has the child/youth been: Arrested? ☐ YES ☐ NO ☐ UNKNOWN
    a. Suspended/Expelled? ☐ YES ☐ NO ☐ UNKNOWN

ADDITIONAL REQUIRED QUESTIONS *ONLY* FOR METHADONE MAINTENANCE/AMBULATORY DETOX:

Methadone Maintenance

1. Is the member currently maintained on Methadone? ☐ YES ☐ NO
    a. If yes, how long has the member received Methadone services?
        ☐ 6 mos or less ☐ 7 mos – 1 yr ☐ 1-3 yrs ☐ 3-5 yrs ☐ 5 yrs >
    b. If no, what has been the duration of the member's opioid use?
        ☐ Less than 1 yr ☐ 1-3 yrs ☐ 3-5 yrs ☐ 5 yrs or >
2. What other services are included in the treatment plan?
    a. ☐ OP Therapy ☐ Comm. Supp. (NA/AA) ☐ IOP/PHP ☐ Other Behavioral Health Services ☐ PCP/MD Follow-up
3. What is the ultimate treatment goal? ☐ Methadone Maintenance ☐ Abstinence

Ambulatory Detox

6. From what substance is the member in need of detoxification? (**select all that apply**) ☐ Alcohol ☐ Opiates ☐ Benzodiazepines
7. Has the member had a previous detox in any setting in the past year? ☐ YES ☐ NO
8. If yes, number of detoxes in the past year? ☐ 1 ☐ 2 ☐ 3 ☐ 4+
9. What is the identified discharge plan? (**select all that apply**) ☐ OP Therapy ☐ Comm. Supp. (NA/AA) ☐ IOP/PHP
    ☐ Other Behavioral Health Services ☐ Methadone Services ☐ PCP/MD Follow-up

Please note: **If Axis I is Deferred (799.9 or V71.09) only one (1) unit/day will be authorized for Outpatient level of care. It will be necessary to submit a new Registration Form with the actual diagnosis to receive authorization for the additional units. Deferred Diagnosis NOT accepted for Family Support Teams (FST), Methadone Maintenance or Ambulatory Detox.**