Level of Care Placement Assessment

NAME / MRN

Program Name:		**Type of Assessment:**
Facility ID:	**Program ID:**	Initial Admission ☐ Date: ______ Continued Stay/Extension ☐ Date: ______ Transfer of Level of Care/Service ☐ Date: ______ **Service Code:** ☐ **115** Level of Care Placement Assessment

Client Information

Beneficiary Name: ______________________ Age: ________ DOB: ______________

Address: ____

Phone Number: ______________ Is it okay to leave voicemail? ☐ Yes ☐ No SSN: ______________

Gender: ☐ Male ☐ Female ☐ Transgender F-M ☐ Transgender M-F ☐ Intersex Other ______________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Widowed Other______________

Race/Ethnicity: ____

Admission Priority for Special Populations

Pregnant and IV user	Pregnant	IV user	SAMHWORKS	All Other
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Language

Primary Language: ______________________ Preferred Language: ______________________

Interpreter Needed: ☐ Yes ☐ No Name of Interpreter: ______________________

Referral Source

☐ Primary Care Physician ☐ Probation ☐ Social Services ☐ Court ☐ Self ☐ CFS ☐ AB109

☐ Other: ____

Living Arrangement Information

☐ Couch Surfing ☐ Shelter ☐ Extended Family ☐ Car ☐ Apt/House ☐ Alone

☐ Sober Living Housing ☐ Recovery Residence ☐ Shared Housing ☐ Homeless ☐ With Family ☐ With Partner and Child

CFS Involvement and Criminal Justice History

☐ Probation ☐ Parole ☐ Other If Other: ____

☐ CFS If yes, how many children involved? ☐ Family Court

Have you been incarcerated in the last 12 months? ☐ Yes ☐ No

Agency Contact (Social Worker, DPO, Public Defender, DA, etc.):____

Have you ever been arrested? Please describe: ____

NAME / MRN

IMMEDIATE NEED PROFILE: ACUTE WITHDRAWAL POTENTIAL

Client currently having **SEVERE** withdrawal symptoms such as tremors, excessive sweating, rapid heart rate, blackouts, anxiety, vomiting, etc.
☐ Yes ☐ No **If yes, make immediate referral for medical evaluation STOP ASSESSMENT; If life-threatening: Call 911**

Client currently having **SEVERE** physical health problems and/or experiencing out of the ordinary in relation to physical health (Non-imminent problems, examples may include: high blood pressure, broken limb(s) ☐ Yes ☐ No
If yes, make Immediate referral for medical evaluation; STOP ASSESSMENT

Client currently in danger of harming self or someone else ☐ Yes ☐ No
Client has the intent and a plan to do so ☐ Yes ☐ No
If Yes to either or both of the above; Call 911 and Make Immediate Referral for Psychiatric Evaluation; STOP ASSESSMENT

Client currently under the influence of alcohol and/or other drugs ☐ Yes ☐ No
If YES to the above question, REFER to Withdrawal Management, CONTINUE ASSESSMENT

Substance Use History

Brief Explanation of Treatment Needs

Can you please describe any attempts you have made to either control or cut down on your alcohol and/or drug use?

Have you ever been in Alcohol and Other Drug Treatment? ☐ Yes ☐ No If Yes, when and where?

DIMENSION 1: SUBSTANCE USE, ACUTE INTOXICATION, WITHDRAWAL
Please complete table for all substances that apply

Drug of Choice	Date of Last Use	Prior Use (Lifetime)?	Used in last 12 months?	Method of Use	Frequency of Use in Last 30 Days	Amount of Use in Last 30 days	Age at First Use
Alcohol		☐	☐				
Amphetamines (Meth, Ice, Crank)		☐	☐				
Cocaine/Crack		☐	☐				
Hallucinogens		☐	☐				
Heroin		☐	☐				
Marijuana		☐	☐				
Non-prescribed Opioids		☐	☐				
Non-prescribed Sedatives		☐	☐				
Inhalants		☐	☐				
Misuse of Over the Counter		☐	☐				
Nicotine		☐	☐				
Other: ________		☐	☐				

Client has past history of serious withdrawal, life-threatening symptoms or seizures during withdrawal? e.g. need for IV therapy; hospital for seizure control; psychosis/DT's; medication management with close nurse monitoring and medical management ☐ Yes ☐ No

What happens when you stop using alcohol and/or drugs? Please describe:

NAME / MRN

Do you find yourself using more alcohol and/or drugs that you intend to?	☐ Yes ☐ No
Do you find yourself using more alcohol and/or drugs in order to get the same high?	☐ Yes ☐ No
Has your alcohol and/or drug use changed recently (increase/decrease, changed Method of Use)	☐ Yes ☐ No

*If Client has been misusing prescription drugs, refer to Medication Assisted Treatment including Opioid Treatment Programs (Methadone)

SEVERITY RATING-DIMENSION 1 (Substance Use, Acute Intoxication, Withdrawal Potential)

☐ 0-No Risk/Stable ☐ 1-Mild ☐ 2-Moderate ☐ 3-Severe ☐ 4-Very Severe

DIMENSION 2: BIOMEDICAL CONDITIONS/COMPLICATIONS

Name of Primary Care Physician: ____

Do you have any of the following medical conditions? ☐ None, Unknown Medical Conditions

☐ Hepatitis C	☐ Seizure/Neurological	☐ Muscle/Joint Problems	☐ Diabetes
☐ Tuberculosis	☐ Thyroid	☐ Vision Problems	☐ Sleep Problems
☐ High Blood Pressure	☐ Kidney Problems	☐ Hearing Problems	☐ Chronic Pain
☐ High Cholesterol	☐ Liver Problems	☐ Dental Problems	☐ Heart Problems
☐ Blood Disorder	☐ Asthma/Lung Problems	☐ Sexually Transmitted Disease(s): ____________	
☐ Stomach/Intestinal Problems	☐ Abscesses/Open Wounds	☐ Infection(s): ____________	
☐ Cancer (specify type[s]): ____________		☐ Other (Etc., and Major Injuries): ____________	

☐ Allergies: (If allergies, please note reaction to each allergy) ☐ No Known Allergies

Do any of the conditions listed previously significantly interfere with your life? ☐ Yes ☐ No If Yes, please describe:

Have you ever been hospitalized? ☐ Yes ☐ No If Yes, please include dates and reason(s) for hospitalization:

Does the Beneficiary report any medical symptoms that would be considered life-threatening or require immediate treatment?

☐ Yes ☐ No **If Yes, consider immediate referral to Emergency Department and/or call 911; STOP ASSESSMENT**

List all medication(s) client is currently taking for biomedical conditions:

Medication	Dose/Frequency	Reason	Compliant
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N

SEVERITY RATING-DIMENSION 2 (Biomedical Conditions and Complications)

☐ 0-No Risk/Stable ☐ 1-Mild ☐ 2-Moderate ☐ 3-Severe ☐ 4-Very Severe

DIMENSION 3: EMOTIONAL, BEHAVIORAL, OR COGNITIVE CONDITIONS AND COMPLICATIONS

Previous mental health diagnosis ☐ Yes ☐ No ☐ Decline to State

If yes, diagnosis as reported by Client:

____

If so, by whom? ____________________________ when? ____________________

Are you currently receiving or have you previously received any supportive treatment (e.g. counseling/therapy) for mental health needs?

☐ Yes ☐ No If Yes, most recent Mental Health provider, when and where:

Professional's Name:____________________ Date:____________ Location:____________________

NAME / MRN

Are you currently or have you ever been prescribed any medication for psychological or emotional needs? ☐ Yes ☐ No
If yes, List all medication(s)client is currently taking for psychological or emotional needs:

Medication	Dose/Frequency	Reason	Compliant
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N

Do you consider any of the following behaviors or symptoms to be problematic in your daily life? ☐None/Decline to State

☐ Depression/Sadness ☐ Loss of Pleasure/Interest ☐ Hopelessness ☐ Irritability/Anger
☐ Impulsivity ☐ Pressured Speech ☐ Grandiosity ☐ Racing Thoughts
☐ Anxiety/Excessive Worry ☐ Obsessive Thought ☐ Compulsive Behaviors ☐ Flashbacks
☐ Paranoia ☐ Sleep Problems ☐ Memory/Concentration ☐ Gambling
☐ Risky Sexual Behavior
☐ Hallucinations (Please describe):

☐ Delusions (Please describe):

☐ Abuse (Physical, Emotional, Sexual):

☐ Traumatic Event(s) (Please describe):

☐ Prior attempts of self-harm (If Yes, please describe):

☐ Other:

☐ Suicidal Thoughts (Please describe):

☐ Thoughts of Harming Others (Please describe):

If Yes to either or both of the above; Call 911 STOP ASSESSMENT

Do you notice a relationship between any psychological or emotional needs and your alcohol and/or substance use? ☐ Yes ☐ No
If Yes, please describe: ______________________________

Do you have any history of memory loss and/or head trauma? ☐ Yes ☐ No

Based on the previous questions, is further assessment of mental health needed? ☐ Yes ☐ No
If Yes, refer client for further assessment of mental health; CONTINUE ASSESSMENT

SEVERITY RATING-DIMENSION 3 (Emotional, Behavioral, or Cognitive Conditions and Complications)

☐ 0-No Risk/Stable ☐ 1-Mild ☐ 2-Moderate ☐ 3-Severe ☐ 4-Very Severe

NAME / MRN

DIMENSION 4: READINESS TO CHANGE

Have you been mandated, directed or coerced into alcohol and other drug treatment? ☐ Yes ☐ No

Identified areas in which alcohol and/or drug use is having a negative impact on functioning

☐ Work	☐ School	☐ Physical Health	☐ Finances
☐ Relationships	☐ Legal Matters (Probation)	☐ Handling Everyday Tasks	☐ Self Esteem
☐ Hygiene	☐ Recreational Activities	☐ CFS	☐ Family Court

☐ Other: ____________________

Do you continue to use alcohol and/or drugs despite having it affect the areas listed above? ☐ Yes ☐ No

On a scale of 0 (low) to 4 (very), how important is it for you to stop using alcohol and/or any substances? 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐

On a scale of 0 (low) to 4 (very), how important is it for you to address any mental health needs? 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐

SEVERITY RATING-DIMENSION 4 (Readiness to Change)

☐ 0-No Risk/Stable ☐ 1-Mild ☐ 2-Moderate ☐ 3-Severe ☐ 4-Very Severe

DIMENSION 5: RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL

Do you feel that you will either relapse or continue to use, without treatment or additional support? ☐ Yes ☐ No

In the last 30 days, how often have you experienced cravings, withdrawal symptoms, disturbing effects of use?

Occasionally=between 1-5 times in 30 days, Frequently = 3x per week, Constantly =Daily

Alcohol:	☐ None	☐ Occasionally	☐ Frequently	☐ Constantly
Drug:	☐ None	☐ Occasionally	☐ Frequently	☐ Constantly
Opiates:	☐ None	☐ Occasionally	☐ Frequently	☐ Constantly

(such as Heroin, Vicodin, Oxycontin, Percocet, Fentanyl, etc.)

Do you find yourself spending time searching for alcohol and/or drugs, or trying to recover from its effects? ☐ Yes ☐ No

If Yes, please describe:

Are you aware of any triggers to use alcohol and/or drugs?

☐ Strong Cravings	☐ Work Pressure	☐ Mental Health	☐ Relationship Problems
☐ Difficulty Dealing with Feelings	☐ Financial Stressors	☐ Physical Health	☐ School Pressure
☐ Environment	☐ Unemployment	☐ Chronic Pain	☐ Peer Pressure
☐ None		☐ Other: ____________________	

Please describe what you do when you are triggered.

What is the longest period of time that you have gone without using alcohol and/or drugs?

____

When did this time period occur? ____________________

What helped you and what did not help you during this period?

SEVERITY RATING-DIMENSION 5 (Relapse, Continued Use, or Continued Problem Potential)

☐ 0-No Risk/Stable ☐ 1-Mild ☐ 2-Moderate ☐ 3-Severe ☐ 4-Very Severe

NAME / MRN

DIMENSION 6: RECOVERY/LIVING ENVIRONMENT
Do you have any relationships that are supportive of your recovery (e.g., family, friends)? ☐ Yes ☐ No If Yes, please describe:
Is your current living/work/school/social situation unsafe or harmful to your well-being and/or sobriety? ☐ Yes ☐ No If Yes, please describe:
Do you currently spend time with others that use alcohol and/or drugs? ☐ Yes ☐ No If Yes, please describe:
Are you employed? ☐ Yes ☐ No If Yes, please describe: ________________________________ Are you enrolled in school or training program? ☐ Yes ☐ No If Yes, please describe: ________________________________ Do you have transportation? ☐ Yes ☐ No If Yes, please describe: ________________________________
SEVERITY RATING-DIMENSION 6 (Recovery/Living Environment) ☐ 0-No Risk/Stable ☐ 1-Mild ☐ 2-Moderate ☐ 3-Severe ☐ 4-Very Severe
Are Case Management services indicated? ☐ Yes ☐ No If Case Management is not needed, provide reason: ☐ Beneficiary currently connected to other Case Management Services: ☐ Mental Health ☐ Health, Housing, Homeless ☐ CCHP ☐ Community Connect ☐ SUD Transition Team ☐ Other, please list:

Intake Counselor Name (Print)	**Intake Counselor Name (Signature)**	**Date**