

Organization Name:	Program Name:	Date:
Individual's Name (First / MI / Last):	Record #:	DOB:

Initial Determination (For Residential Only)

This individual appears to be in need of chemical dependence services: ☐ No ☐ Yes

This individual appears to be free of serious communicable disease that can be transmitted through ordinary contact. ☐ No ☐ Yes

This individual appears to not be in need of acute hospital care, acute psychiatric care or other intensive services which cannot be provided in conjunction with residential care or would prevent him/her from participating in chemical dependence service. ☐ No ☐ Yes

Non-Crisis Level of Care Determination (LOCADTR) Tool (For Outpatient and Residential)

LOCADTR Criteria	Indicated Level of Care
1. Dependence condition or abuse condition ☐ yes, continue ☐ no, go to #15	
2. Unable to participate in or comply with treatment outside 24-hour structured treatment setting ☐ yes, go to #4 ☐ no, continue	
3. Imminent health risk from continued alcohol or drug use ☐ yes, continue ☐ no, go to #6	
4. Substantial deficits in functional skills ☐ yes, continue ☐ no →	Inpatient Rehabilitation
5. Complications or comorbidities requiring medical management/monitoring daily ☐ yes → ☐ no →	Inpatient Rehabilitation Intensive Residential Rehabilitation
6. Established opiate dependence condition ☐ yes, continue ☐ no, go to #8	
7. Chooses to participate in Methadone Treatment ☐ yes → ☐ no, continue	Referral to Methadone Treatment, continue
8. Substantial deficits in functional skills ☐ yes, go to #10 ☐ no, continue	
9. Physical health care needs ☐ yes, continue ☐ no, go to #11	
10. Inadequate social support system ☐ yes → ☐ no, continue	Outpatient Rehabilitation (go to #13)
11. Substantial risk of relapse ☐ yes → ☐ no, continue	Intensive Outpatient (go to #13)
12. Moderate to severe dependence condition ☐ yes → ☐ no →	Intensive Outpatient (go to #13) Outpatient non-intensive (go to #13)
13. Inadequate Living Environment ☐ yes, continue ☐ no, end	
14. Requires 24-hour a day residential services and ongoing clinical support ☐ yes → ☐ no →	Community Residence Supportive Living
15. Significant other ☐ yes → ☐ no, end	Outpatient non-intensive

Level of Care Disposition



OASAS Initial Determination/Level of Care/Admission Decision

Revision Date: 11-1-12

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Organization Name:	Program Name:	Date:
Individual's Name (First / MI / Last):	Record #:	DOB:
Level of Care Determined By: ☐ LOCADTR ☐ ASAM OR ☐ Summary of patient functioning to support the level of care: Indicated Level of Care: Are there individual factors that argue against this level of care? ☐ No ☐ Yes – If Yes, describe: Clinically Recommended Level of Care (if different): Additional Factors Relevant to Placement:		
If the individual is not admitted, note reasons and if applicable, identify alternate referral :		
Signature of Clinical Staff who Completed LOCADTR:		Date:

Admission Decision

Having reviewed the screening information, Initial Determination and the Level of Care Determination, as noted by my signature below, I have determined this individual can be admitted to the following service (Fill out applicable section and checkboxes):

Outpatient Services

☐ The individual will be **Admitted to Outpatient Services** based on the following criteria:

- ☐ 1. The individual is determined to have a substance abuse disorder based on the criteria in the most recent version of the Diagnostic and Statistical Manual or the International Classification of Diseases.
- ☐ 2. The individual reports no known or suspected infectious disease that can be a danger to others and that is spread through casual contact.
- ☐ 3. The individual appears not to be in need of acute hospital care, acute psychiatric care, a higher level of chemical dependency treatment services or other intensive services that cannot be provided in conjunction with outpatient care or would prevent him/her from participating in a chemical dependence outpatient service: OR
- ☐ 4. The individual is a significant other who manifests psychological, behavioral and/or emotional effects arising from another individual's chemical abuse or dependence and has been determined by the provider to be able to actively participate in and benefit from the treatment process.

☐ The individual will be **Admitted to Outpatient Rehabilitation** based on the following additional criteria:

- ☐ 1. The individual has an inadequate social support system AND EITHER
- ☐ 2. The individual has substantial deficits in functioning skills OR
- ☐ 3. The individual has health care needs requiring attention or monitoring by health care staff.

Residential Services



OASAS Initial Determination/Level of Care/Admission Decision

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Organization Name:	Program Name:	Date:
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☐ The individual will be **Admitted to Residential Services** based on the understanding the person is able to achieve or maintain abstinence and recovery goals with the application of Residential Services and for:

☐ **Community Residential Services**

- ☐ 1. The individual is homeless or has a living environment not conducive to recovery, AND
- ☐ 2. The individual has been determined to need outpatient treatment and/or other support services such as vocational or educational services, in addition to the residential services provided by the community residence.

OR

☐ **Supportive Living Services**

- ☐ 1. The individual requires support of a residence that provides an alcohol and drug free environment, AND
- ☐ 2. The individual requires peer support of fellow residents to maintain abstinence, AND
- ☐ 3. The individual does not require twenty four hour a day on site supervision by clinical staff, And
- ☐ 4. The individual exhibits the skills and strengths necessary to maintain abstinence and re-adapt to independent living in the community while receiving the minimal clinical and peer support provided by this residential environment.

OR

☐ **Intensive Residential Rehab Services**

The individual has demonstrated an inability to participate in or comply with treatment outside of a twenty-four hour setting as indicated by **One or More** of the following:

- ☐ a) Recent unsuccessful attempts at abstinence; OR
- ☐ b) A history of prior treatment episodes, including a demonstrated inability to complete outpatient treatment; OR
- ☐ c) Substantial deficits in functioning skills evidencing the need for extensive habilitation or rehabilitation in order to achieve lasting recovery in an independent setting.

For residential only - Responsible Clinical Staff Member:

Initial Plan for Services

(Provider may skip this section and initiate services by completing at least one goal with one objective on the IAP, and for Outpatient base on presenting problem and any individual identified priority issues)

For Outpatient only – Goals based on presenting problem and any other individual identified priority issues:

And, For All OASAS: Initial Plan for Services to be offered prior to Initial IAP:

Service/Intervention		Preliminary Schedule/Plan		
		Number	Times Per	Day/Week/Month
☐	Individual Counseling		x	
☐	Group Counseling		x	
☐	Other:		x	
☐	Other:			
☐	Other:			

[illegible]