| **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 [ ]  YesThis 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 RehabilitationIntensive 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 ResidenceSupportive Living |
| 15. ***Significant other*** | [ ]  yes **🡺**[ ]  no, end | Outpatient non-intensive |
| **Level of Care Disposition**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 DecisionHaving 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** |
| [ ]  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. [ ]  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. [ ]  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:       |  |
| **Individual’s Signature (Required for Residential):** | **Date:** | **Number of Assessment Visits/Days:** |
| **Signature(s) verifying review of Admission Assessment criteria: Identifying Information and Chief Complaint/Presenting Problem; Psychiatric Illness; Substance Abuse Screen/Assessment; Brief Mental Health Screen; and Treatment History from Comprehensive Assessment begun:      ; Initial Plan for Services; and Admission Decision above.** |
| **QHP Signature**: | **Date:** |
| **Completed By - Print Name/Credential:** | **Staff Signature:** | **Date:** |
| **Supervisor - Print Name/Credential** (if needed): | **Supervisor Signature** (if needed): | **Date:** |
| Date of Service | Staff Identifier | Loc. Code | Service Code | Mod 1 | Mod 2 | Mod 3 | Mod 4 | Start Time | Stop Time | Duration in Minutes |
|       |       |       |       |     |     |     |     |       |       |       |