

Check box for:

☐ Initial client treatment notification

☐ Extension request

☐ MA admit now enrolled with HH

HH SUD Treatment Notification_Extension request

Placement Notification - fill out this form in full and attach SUD Comprehensive Assessment
Extension Request - complete extension request sections and attach the most recent treatment plan

Request date _____ Name of person completing _____

Email/direct dial _____

Initial placement date	Extension start date	PMI# (Recip ID)	Client's legal name (Last name, first, middle)		
Client alias (if any)	DOB (MM/DD/YYYY) / /	For extension requests,total units used (days)	For extension requests, total units used Hours: 15 min.:	Last county of residence before any excluded time	
Date processed by county / /	County reviewer signature	SSIS WG#	Social Security number - -		
Marital status: ☐ Divorced ☐ Married ☐ Legally separated	☐ Never married ☐ Living apart ☐ Widowed ☐ Unknown	Gender: ☐ Male ☐ Female	Hispanic? ☐ Yes ☐ No	Language	
Race: ☐ White ☐ Black ☐ American Indian ☐ Asian/Pacific Islander ☐ Other ☐ Unknown					

Placement & Financial

Comprehensive assessment date or date of update / /	Risk assessment ratings (0-4): Dim 1: _____ Dim 4: _____ Dim 2: _____ Dim 5: _____ Dim 3: _____ Dim 6: _____	Indicate if client is: ☐ Minor ☐ Pregnant ☐ Adult with minor	Diagnosis Code _____	
Procedure code (if applicable) ☐ H2036 ☐ H2035 ☐ H2035-HQ ☐ H0020 ☐ H0047	Program specifics/modifiers (must check all that apply) ☐ Co-occurring services ☐ Recipients with children ☐ Special populations ☐ Committed client ☐ Medical services ☐ Disability responsive ☐ Adolescent	Drug code (if applicable) ☐ Methadone (M) ☐ Naltrexone (N) ☐ Buphenorphine (B)	Service start date / /	Service end date / /
Revenue code: ☐ 944 Drugs ☐ 945 Alcohol ☐ 953 Drugs and Alcohol ☐ 0101 Hospital Daily ☐ 1002 Room and Board same location ☐ 1003 Room and Board different location ☐ (Sober housing-recovery residence)				
Total # units ____ Days ____ Hours ____ 15 min.	NPI # ____ ASAM Level of Care	Provider name and location or address where services will be delivered		
Glossary on page 3.		Provider FAX number		

Client initials _____

Date of birth _____

Procedure code (if applicable) ☐ H2036 ☐ H2035 ☐ H2035-HQ ☐ H0020 ☐ H0047	Program specifics/modifiers (must check all that apply) ☐ Co-occurring services ☐ Recipients with children ☐ Special populations ☐ Committed client ☐ Medical services ☐ Disability responsive ☐ Adolescent	Drug code (if applicable) ☐ Methadone (M) ☐ Naltrexone (N) ☐ Buphenorphine (B)	Service start date / /	Service end date / /
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For extension requests, you do not need to complete an assessment update. **On the blank sheet provided, or on a separate sheet**, please explain in 1-2 paragraphs why the client would benefit from continued services at the current level of care, and what specific issues or services need to be addressed/provided for the client to be ready to step down to the next level or to complete treatment. Show current risk ratings/rationale by attaching an updated treatment plan review.

Please submit within 10 days of admission or 10 days before initial units will be exhausted
Submit to: **Hennepin County Addiction and Recovery Services** hc.reviewteam@hennepin.us
Fax: **612-466-9546** (alternative analog fax 612-330-2318) Phone: 612-879-3671

Client initials _____

Date of birth _____

Initial placements will be limited to the following intervals before an extension request is required:

- 18 days for inpatient hospital-based stays
- 60 days for residential placements
- 300 group hours (30 one to one hours) for outpatient treatment services

Glossary

Modifiers

- ☐ Co-occurring (HH)

☐ Medical (U5)

☐ Co-occurring and Medical combined (UC)

☐ Disability Responsive (U3)
- ☐ Special Populations/Culturally Specific (U4)

☐ Client with Child (U6)

☐ Committed Complex (HK)

☐ Adolescent (HA)

Additional Billable Services

- ☐ Comprehensive Assessments (H001)

☐ Care Coordination (T1016 HN,U8)

☐ Peer Support (H0038 U8)
- ☐ Room and Board (1002)

☐ Room and Board/different location (1003)
- (15-minute increments-up to 2 hours per day per client)

(15-minute increments-up to 4 hours per day per client, maximum of 56 units month/14 hours per week)

Level of care

Adult outpatient (H2035 HQ Group) (H2035 one to one)

- ☐ 1.0 outpatient up to 8 hrs. per week

☐ 2.1 outpatient 9-19 hrs. per week
- ☐ 2.5 Partial Hospital 20 hours or more per week

Adult Residential (H2036)

- ☐ 3.1 Low Intensity 5 hrs. per week

☐ 3.1 Low Intensity 15 hrs. per week
- ☐ 3.3 Disability responsive/daily skilled services 7 days per week

☐ 3.5 High Intensity daily skilled services 7 days per week

Hospital Inpt. (0101)

- ☐ 3.7 Hospital Inpt. SUD

Opiate Treatment Program (180 Days)

- ☐ MOUD Methadone (H0020)

☐ MOUD Other (H0047)
- __ Plus 9 additional hrs. per week (UA)

__ Plus 9 additional hrs. per week (UB)

Adolescent level of care

- ☐ 1.0 outpatient up to 5 hours per week (H2035 HQ Group) (H2035 one to one)

☐ 2.1 outpatient 6 or more hrs. per week (H2035 HQ Group) (H2035 one to one)

☐ 3.5 Residential daily skilled services 7 days per week (H2036)

Extension Request Rationale

What has the client accomplished previously, what they are working on now, and what do they need to work on given additional time in treatment using ASAM criteria as a framework.

Client initials _____

Date of birth _____