Phone Screening Form

Date of request_____ Client Name _____ Case #_____

Reason for seeking treatment_____ Referred by: _____

Telephone # _____ Secondary Contact # _____

Current address: _____

Is the address provided a recovery home? ☐Yes ☐No If yes, where was your last independent address?

_____

If their last independent address is outside of Macomb County, refer client to that PIHP for services.

Did the client recently complete treatment at another agency? ☐ Yes ☐ No If yes, who funded that treatment?

_____

If another PIHP funded their last treatment, refer client to that PIHP for services.

Is the client currently receiving treatment at any other agency? ☐ Yes ☐ No

If client is open with another OP provider, refer them back to that provider for further treatment.

Payor: ☐Medicaid ☐Medicare ☐HMP ☐Block Grant ☐Self-Pay ☐Other Insurance

Third Party Insurance _____ Insurance verified? ☐Yes (documentation in chart) ☐No

If Block Grant: Gross Annual Income _____ Family Size _____

Client informed to bring: ☐ Proof of income ☐Proof of residence

Has client completed an ASAM Continuum at another agency within the last 45 days?☐ Yes ☐ No If yes, will they sign a release to obtain this assessment? ☐ Yes ☐ No

Current medications: _____ Prescribed by: _____

Priority Population Screening:

Are you pregnant? ☐Yes ☐No ☐Unsure Have you use drugs by injection in the last 30 days? ☐Yes ☐No

If yes, must be offered an appointment within 24 hours.

Are you a parent at risk of losing your children due to SUD? ☐Yes ☐No Were you referred by MDOC? ☐Yes ☐No

Must be offered an appointment within 14 days.

Appointment offered: _____ Appointment accepted: _____ Appointment rescheduled: _____

Appointment offered within required time frames: ☐Yes ☐ No If no, client was referred to PIHP for timely appointment: ☐Yes ☐ No Did client choose an appointment outside of required time frames ☐ Yes ☐No

Therapist assigned case: _____ Person completing form: _____