Clinical Documents

Clinical Assessment

- All MCCMH-SUD contracted providers must use the ASAM Continuum or GAIN assessment tools.
- New clients should receive an assessment at intake.
- If the GAIN or ASAM Continuum is started but cannot be completed at intake, it must be completed at the next appointment. The date the assessment was completed is the date the intake code (H0001) would be billed. H0004 can be billed for the date the intake was started, but not completed.
- If the client has been in treatment with another provider within the last 45 days, your agency should obtain a copy of the ASAM Continuum completed with that agency and review/record updates with the client rather than completing a new ASAM Continuum. A 90791 code can be billed for intakes where the ASAM Continuum is reviewed only.
- ASAM Continuum or GAIN Assessments must be completed annually. Once the annual assessment is completed, a BH-TEDS update should be entered into FOCUS.
- All sections of the ASAM Continuum must be completed , including any notation needed about level of care not matching the ASAM Continuum's recommendation.

Clinical Assessment Cont.

Assessments should also include an interpretive summary completed by the clinician. This summary should be clinical in nature rather than a historical re-telling of biopsychosocial history and unique to the client served.

Example: New is a 39-year-old, Caucasian, single female. She presents with a history of alcohol use. She reported periods of clean time in the past, the longest being two years after the birth of her son in 2012. Most recently, she has been drinking up to ten beers a few times per week. New recently lost her job due to absences. She has been living with her boyfriend for the last six months. New reports that he does drink on occasion but has never had any SUD treatment. New reported recent symptoms of anxiety including: excessive worry about the future, insomnia, fatigue, trouble concentrating, and trouble with decision making. New presents with diagnoses of Alcohol Use Disorder-Moderate and Generalized Anxiety Disorder. It is recommended that she attend monthly individual sessions and weekly group sessions to explore triggers for use, increase positive coping mechanisms, explore employment needs/opportunities, increase knowledge of addiction and post acute withdrawals and decrease symptoms of anxiety. New may benefit from a psychiatric evaluation to clarify a mental health diagnosis.

Adding and ASAM Continuum

Please see instruction sheet for detailed instructions on adding an ASAM Continuum.

Other Required Documents

- Communicable disease risk screens must be completed for all clients. Any client identified as “high risk” must be provided with a referral for follow-up care. (Referrals must be documented)
- All clients must have an initial fee agreement completed in full. These are then reviewed every 90 days or if there is a change in the clients' income.
- Any clients funded by Block Grant must have verification of income in the chart. This may be a bank statement, a check stub, or a letter attesting to a lack of income. Failure to document income verification may result in a take-back of claims.
- All charts must include documentation of whether or not a client has a primary care physician and, if so, coordination of care with that physician (with a release of information). Any client without a PCP should be assisted in obtaining a PCP or given a referral to an FQHC.
- The Communicable Disease Risk Screen and Fee Agreement Form can be located at our website: www.mccmh.net in the Substance Use Provider Manual

Admission Date: _____ Agency ID (optional): _____

MACOMB COUNTY COMMUNITY MENTAL HEALTH SUBSTANCE USE DISORDER (MCCMH-SUD)
VERIFICATION OF INCOME & FEE AGREEMENT FORM

Name: _____
(Last) (First) (Middle)

Social Security Number (required): _____ Date of Birth: _____

Marital Status: ☐ Single ☐ Married/living with partner ☐ Divorced ☐ Separated ☐ Widowed

Current County of Residence: ☐ Macomb ☐ Other _____

Number of Dependents (include self): _____ Ages (include self): _____

I understand that a portion of the cost of my treatment may be subsidized by public funds. As required by eligibility guidelines, I hereby certify that my *current* yearly income is as follows:

Hourly Wage: $_____ Hours worked in past two (2) weeks: _____

Annual Personal Income: $_____ Annual Household Income: $_____

Source(s) of Income:	☐ Employment	☐ Unemployment	☐ Parent (only if you are under 18)
Documentation	☐ Alimony/Child Support	☐ Disability	☐ No Income (Attestation Letter)
Required	☐ Spouse/partner	☐ Public Assistance	

I understand that public funding should be the funding of last resort, and I certify that my *current* health insurance status is as follows (check all that apply):

Private/Employer Health Insurance:	☐ Yes	☐ No	If yes, Name of Insurer: _____
Medicaid:	☐ Yes	☐ No	Plan Name: _____
Medicaid w/Deductible/Spend-Down:	☐ Yes	☐ No	Deductible Amount (if known): $_____
Healthy Michigan Plan (HMP):	☐ Yes	☐ No	Plan Name: _____
Medicare:	☐ Yes	☐ No	
VA Healthcare Benefits:	☐ Yes	☐ No	

Client to read and initial:

_____ ***I verify that the above statements are true, to the best of my knowledge. I understand that I will be required to provide verification of the above information for the purpose of substantiating eligibility for public funds and/or determining the fees to be charged for the services provided.***

_____ ***I understand that if I am otherwise eligible for third-party insurance coverage (private, employer, etc.), including Medicaid or Healthy Michigan Plan, and do not apply for, or decline to use my insurance, MCCMH-SUD is not obligated to supplement the cost of my treatment.***

_____ ***I understand that I cannot be enrolled in more than one MCCMH-SUD-funded (Medicaid, Healthy Michigan, Block Grant) treatment program at the same time, and will inform my therapist if I am enrolled in any substance use treatment elsewhere. If I choose to remain at my other substance use treatment program, MCCMH-SUD will not fund my current request for substance use treatment and I will be responsible for any costs incurred.***

COMPLETED BY PROVIDER:

Section 1 – Verification of Residency – *Maintain proof of documentation in client file*

- ○ Driver's License/State ID with Macomb County Address
- ○ Mail addressed to client with Macomb County Address
- ○ Other _____

Section 2 – Admission Category – Meets MCCMH-SUD Quality Assurance Guidelines, ASAM Criteria and Medical Necessity criteria for admission to the following category below:

- ○ Detox/Residential – no copay
- ○ Medication Assisted Treatment
- ○ IOP/Outpatient
- ○ Outpatient Significant Other Admission (*Maximum length of outpatient funding up to 12 sessions in 90 days; not eligible for reauthorization)*
- ○ Outpatient Relapse Prevention (*Admission for an individual with a diagnosis of substance use disorder in Sustained Full or Partial Remission, with the sole purpose of averting an impending relapse. Maximum length of outpatient funding up to 90 days. If diagnosis changes to active SUD during treatment, update admission category)*
- ○ Case Management – no copay
- ○ Peer Recovery Coach – no copay
- ○ Adolescent Outreach Program – no copay

Section 3 – Reimbursement Level Assignment

Type of Income Verification (**attach proof to this Fee Agreement form)*:

- ○ Medicaid/Healthy Michigan (verified in the MCCMH-SUD data system)
- ○ *Pay stub
- ○ *Income tax return
- ○ *Unemployment
- ○ *Receipt of application for Healthy Michigan Plan/Medicaid
- ○ *Lack of Income Attestation Letter from Person Served/Support Person

Check one:

- ○ Medicaid: No co-payment
- ○ Healthy Michigan Plan: No co-payment $_____ Effective Date: _____
- ○ Community Grant: Co-payment amount per service:

Explanation for exception, if applicable:

Client Acknowledgment & Acceptance of Fee	**Agency Authorization**
Signature: Date:	Signature: Date:

Client Name: ______________________________	Agency ID (optional): __________________

Fee Review

A review of assigned fees is required every 90 days, when submitting re-authorization request, or when client's financial situation changes, whichever comes first.

Fees Reviewed on (Date): ____________

Financial Situation Changed: ☐ **No (skip to signatures)** ☐ **Yes**

If yes, current household income $____________ (attach verification to fee agreement)
Revised Fees Amount: $____________________ New Amount Effective On (Date): ____________

Explanation for exception, if applicable:

Client Acknowledgment & Acceptance of Fees:	**Agency Review:**
Signature: Date:	Signature: Date:

Fees Reviewed on (Date): ____________

Financial Situation Changed: ☐ **No (skip to signatures)** ☐ **Yes**

If yes, current household income $____________ (attach verification to fee agreement)
Revised Fees Amount: $____________________ New Amount Effective On (Date): ____________

Explanation for exception, if applicable:

Client Acknowledgment & Acceptance of Fees:	**Agency Review:**
Signature: Date:	Signature: Date:

Fees Reviewed on (Date): ____________

Financial Situation Changed: ☐ **No (skip to signatures)** ☐ **Yes**

If yes, current household income $____________ (attach verification to fee agreement)
Revised Fees Amount: $____________________ New Amount Effective On (Date): ____________

Explanation for exception, if applicable:

Client Acknowledgment & Acceptance of Fees:	**Agency Review:**
Signature: Date:	Signature: Date:

(Attach additional pages of "Fee Reviews" to this fee agreement packet, if needed.)

Page 3 of the Fee Agreement is completed every 90 days or if there is a change in the clients' income. If there are changes to the clients' income, a new SUD self-pay policy should be added in FOCUS to reflect this.

Macomb County Community Mental Health
Sliding Fee Scale

Sliding Fee Scale (SFS) for qualified people who are Uninsured or Under insured, for qualified Mental Health or SUD services:

Sliding Fee Scale daily visit amounts (SFSdva) are based on your ability to pay as established by State Law and Administrative Rules.
Annual Income Limits in the chart are based on the 2024 Federal Poverty Level guidelines and are updated annually.
Your SFSdva is determined at least annually and whenever your financial situation changes.
Documentation of your Annual Income and Family Size are required before a final, discounted SFSdva is approved.
The primary source of income documentation required is your State or Federal tax return (form 1040).

Mental Health - Sliding Fee Scale daily visit amount (SFSdva) Chart:

Income Category	A	B	C	D	E	F	G	
Family Size	<=133%	<=200%	<=250%	<=300%	<=350%	<=400%	>400%	FPL
1	$20,080	$30,120	$37,650	$45,180	$52,710	$60,240	>$60,240	$15,060.00
2	$27,253	$40,880	$51,100	$61,320	$71,540	$81,760	>$81,760	$20,440.00
3	$34,427	$51,640	$64,550	$77,460	$90,370	$103,280	>$103,280	$25,820.00
4	$41,600	$62,400	$78,000	$93,600	$109,200	$124,800	>$124,800	$31,200.00
5	$48,773	$73,160	$91,450	$109,740	$128,030	$146,320	>$146,320	$36,580.00
6	$55,947	$83,920	$104,900	$125,880	$146,860	$167,840	>$167,840	$41,960.00
7	$63,120	$94,680	$118,350	$142,020	$165,690	$189,360	>$189,360	$47,340.00
8	$70,293	$105,440	$131,800	$158,160	$184,520	$210,880	>$210,880	$52,720.00
Add for each additional family member:	$7,173	$10,760	$13,450	$16,140	$18,830	$21,520.00		
	133%	200%	250%	300%	350%	400%		

Sliding Fee Scale

Based on annual income and family size provided to MCCMH and applied to the SFSdva Chart above.

Your Income Category	A	B	C	D	E	F	G		Est Monthly Visits
Ability to pay % of Income (Not to publish)		6%	8%	10%	12%	14%	N/A		
Services Excluding Residential/Inpatient Services	$0	$15	$30	$50	$75	$105	₸	8	10

₸ - Full Feescreen is charged upto the monthly maximum calculated under Michigan Compiled Law 330.1818-1820 and Administrative Rule R330.8242

SUD - Sliding Fee Scale daily visit amount (SFSdva) Chart:

Income Category	A	B	C	D	E	F	G	
Family Size	<=133%	<=200%	<=250%	<=300%	<=350%	<=400%	>400%	FPL
1	$20,080	$30,120	$37,650	$45,180	$52,710	$60,240	>$60,240	$15,060.00
2	$27,253	$40,880	$51,100	$61,320	$71,540	$81,760	>$81,760	$20,440.00
3	$34,427	$51,640	$64,550	$77,460	$90,370	$103,280	>$103,280	$25,820.00
4	$41,600	$62,400	$78,000	$93,600	$109,200	$124,800	>$124,800	$31,200.00
5	$48,773	$73,160	$91,450	$109,740	$128,030	$146,320	>$146,320	$36,580.00
6	$55,947	$83,920	$104,900	$125,880	$146,860	$167,840	>$167,840	$41,960.00
7	$63,120	$94,680	$118,350	$142,020	$165,690	$189,360	>$189,360	$47,340.00
8	$70,293	$105,440	$131,800	$158,160	$184,520	$210,880	>$210,880	$52,720.00
Add for each additional family member:	$7,173	$10,760	$13,450	$16,140	$18,830	$21,520.00		
	133%	200%	250%	300%	350%	400%		

Sliding Fee Scale

Based on annual income and family size provided to MCCMH and applied to the SFSdva Chart above.

Your Income Category	A	B	C	D	E	F	G	Est Monthly Visits
Ability to pay % of Income (Not to publish)		6%	N/A	N/A	N/A	N/A	N/A	
Services Excluding Residential/Inpatient Services	$0	$15	₸	₸	₸	₸	₸	10

₸ - Full Feescreen is charged upto the monthly maximum calculated under Michigan Compiled Law 330.1818-1820 and Administrative Rule R330.8242

MCCMH SUBSTANCE USE DISORDER SERVICES
COMMUNICATION FORM TO PRIMARY CARE PHYSICIAN

Date:_____

To: _____
Primary Care Physician

_____
Address City State
Zip

From: _____
Treatment Agency

_____
Therapist and Psychiatrist (if applicable)

_____
Address City State Zip

(___)_____ (___)_____ _____
Phone Number Fax Number Email Address

Re: _____ _____
Client Name Date of Birth

The above client was admitted to _____ on _____
Level of care Date

Treatment Plan: Type_____ Frequency_____ Est. length of Tx_____

Diagnosis:_____

Medication(s) Prescribed:_____
_____
_____

Comments:_____
_____
_____

Date of last session: _____ Treatment completed? Yes____No___

We ask that the Primary Care Physician please send information related to relevant medical history, current medications prescribed and treatment to the above psychiatrist/therapist.

Thank you for your assistance.

Date sent:_____ Initials of sender_____ Method: Fax__ Mail__Email__

cc: client chart

MACOMB COUNTY COMMUNITY MENTAL HEALTH

An example form that can be utilized for care coordination with primary care physicians.

MCCMH-SUD ASAM ASSESSMENT
ADULT SUBSTANCE ABUSE OUTPATIENT PLACEMENT
(Required for Direct Outpatient and IOP Admissions)

This ASAM-based placement tool is to be used as a guide to determine whether or not a consumer is appropriate for the ambulatory (outpatient/IOP) level of treatment. It is required to be placed in all MCCMH-SUD funded ambulatory treatment substance abuse records when an ASAM Continuum is not completed. It may also be used for substance abuse treatment funded by other sources.

Consumer Name: _____ Identification No: _____

DIMENSION 1. WITHDRAWAL/DETOXIFICATION POTENTIAL

Intoxicated/high during assessment? ☐ No ☐ Yes
Current withdrawal signs? ☐ No ☐ Yes
If yes, specify: _____
History of severe withdrawals? ☐ No ☐ Yes
If yes, specify: _____
History of medical problems, such as seizures, stroke, hypertension, etc., that would complicate outpatient detoxification? ☐ No ☐ Yes
If yes, specify: _____

Is client appropriate for ambulatory level of treatment? ☐ ***No*** ☐ ***Yes****

DIMENSION 2. BIOMEDICAL CONDITIONS AND COMPLICATIONS (not related to withdrawal):

Current and/or chronic physical/medical illnesses that may complicate Tx? ☐ No ☐ Yes
If yes, specify: _____
Current prescribed medications that may interfere with abstinence? ☐ No ☐ Yes
If yes, describe: _____

Is client appropriate for ambulatory level of treatment? ☐ ***No*** ☐ ***Yes****

DIMENSION 3. EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS AND COMPLICATIONS

Current and/or chronic co-occurring mood and/or thought disorder(s) or symptom(s) that needs to be addressed immediately or will interfere with treatment? ☐ No ☐ Yes
If yes, specify: _____

Does consumer meet criteria for Serious and/or Persistent Mental Condition with co-occurring substance use disorder? ☐ No ☐ Yes
Current psychiatric medication use? ☐ No ☐ Yes
If yes, specify type/date of last use: _____

Is client appropriate for ambulatory level of treatment? ☐ ***No*** ☐ ***Yes****

****If answering "No," not appropriate for ambulatory treatment, to any of ASAM Dimensions 1, 2 or 3, consider phone contact with the AMS to screen for an alternate level of treatment. Individuals with acute Medical and/or Psychiatric problems should be directly referred to Medical or Psychiatric emergency/urgent services for stabilization prior to referral to CARE or admission to treatment.***

DIMENSION 4. READINESS TO CHANGE

Lacks internal motivation for treatment? ☐ No ☐ Yes
Refuses to accept other's perceptions that s/he has a substance use problem? ☐ No ☐ Yes
Impulse control is poor, does not respond to negative consequences? ☐ No ☐ Yes

Is client appropriate for ambulatory level of treatment? ☐ ***No*** ☐ ***Yes*****

DIMENSION 5. RELAPSE/CONTINUED USE POTENTIAL

Potential for continued or increased use is high? ☐ No ☐ Yes
Lacks recovery skills to cope with addiction and avoid relapse? ☐ No ☐ Yes
Lacks awareness of relapse triggers, urge management techniques? ☐ No ☐ Yes
If abstinent, risk for using(including needle use) or imminent crisis is high? ☐ No ☐ Yes ☐ N/A

Is client appropriate for ambulatory level of treatment? ☐ ***No*** ☐ ***Yes*****

DIMENSION 6. RECOVERY ENVIRONMENT

Family/living circumstances pose a threat to engaging or succeeding in Tx ? ☐ No ☐ Yes
Lacks sufficient drug free social outlets or friendships to support abstinence/recovery? ☐ No ☐ Yes
Family/living environment limits access to substances and/or other using individuals? ☐ No ☐ Yes

Is client appropriate for ambulatory level of treatment? ☐ ***No*** ☐ ***Yes*****

*****If answering "No,"not appropriate for ambulatory treatment, to two or more of ASAM Dimensions 4, 5 or 6, consider phone contact with the AMS to screen for referral to an alternate level of treatment.***

Consumer is appropriate for the following level of care (check THE most acute problem area that applies):

Outpatient (Level I) _____ (Direct admission, MCO screen not required)
Intensive Outpatient (Level II) _____ (Direct admission, MCO screen not required)
Detox- Subacute (Level III.2/7 D) _____ (Requires MCO Screen)
Residential (Level III.7) _____ (Requires MCO Screen)
Detox- Acute Hospital Based _____ (Not a MCCMH-SUD-funded service, refer as needed)
Inpatient Medical/Psych (Level IV) _____ (Not a MCCMH-SUD-funded service, refer as needed)
Methadone (MOUD) _____ (Requires MCO screen)

ASSESSOR'S NAME: _____ **DATE:** _____