**For youth with ASAM level 3.5+ who require expedited access to primary SUD treatment services and supports, please fully complete and submit this form with a current (less than 30 days old) CANS and current, valid CSA consent to exchange information. This information must be received by the CSA office within 2 calendar days and reviewed by the FAPT within 14 calendar days of the start of service(s).**

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| **DEMOGRAPHICS INFORMATION** |
| **Youth Information** |
| **Name:** Click or tap here to enter text.*Preferred Name (optional)*: enter text. | DOB: enter a date. | Sex: Select*Preferred pronoun*: enter text. |
| CANVAS# *(if known)*:enter text. | Private Insurance: Select | Medicaid: Select |
| Race: Click to select item. | Hispanic Origin: Select  |
| Address: Click or tap here to enter text. | City: enter text | State: enter text. | ZIP: enter text. |
| **PARENT/GUARDIAN INFORMATION** |
| Parent Guardian 1: |
| Name: Click or tap here to enter text. |
| [ ]  *Check here if address is same as above* | Address: Click or tap here to enter text. |
| City: enter text. | State: enter text. | ZIP: enter text. |
| Phone: enter text. | Email: enter text. |
| Parent Guardian 2: |
| Name: enter text. |
| [ ]  *Check here if address is same as above*  | Address: enter text. |
| City: enter text. | State: enter text. | ZIP: enter text. |
| Phone: enter text. | Email: enter text. |
| **CASE MANAGER INFORMATION** |
| Name: enter text. | Agency: enter text. |
| Phone: enter text. | Email: enter text. |
| **PARENTAL CONTRIBUTION INFORMATION** |
| [ ]  Youth is currently open to and receiving CSA-funded services (refer to copayment assessment on file)[ ]  Youth is a new referral to CSA; copayment waiver is requested |

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| **CURRENT / IMMEDIATE NEEDS** |
| DSM Diagnosis: Click or tap here to enter text. | Medications: Click or tap here to enter text. |
| ASAM level and date of assessment: Click or tap here to enter text. | Assessor name and agency: Click or tap here to enter text. |
| Youth and Family Strengths: Click or tap here to enter text. |
| Brief description of current needs: Click or tap here to enter text. |
| **REQUESTED SERVICES (can include the following for up to 60 days) Dates: start date - end date.** |
| ☐ Inpatient Detoxification | **\***requires Parental Agreement to be completed prior to authorization |
| ☐ Residential SUD Treatment  | \*requires Parental Agreement to be completed prior to authorization |
| ☐ Partial SUD Hospitalization | \*requires DMAS Comprehensive Needs Assessment completed by provider |
| ☐ Intensive SUD Outpatient |  |
| ☐ Transportation | \*requires Transportation Estimation Calculator to be completed prior to authorization |
| ☐ Interpretation | \*please provide language requested |
| **Please explain whether Medicaid or Private insurance can be utilized for the requested services:** |
| Click or tap here to enter text. |

**Signatures**

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| Case Manager’s Name |  | Case Manager Signature |  | Date |
|  |  |  |  |  |
| Supervisor’s Name |  | Supervisor’s Signature |  | Date |