**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 |