GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Addiction Prevention and Recovery Administration

Office of Clinical Services
Assessment and Referral Center

NOTE: This form must be faxed to 202-535-2318 or hand delivered to APRA.

Adult Reauthorization, Step-up, Step-down Form

SECTION A:							
VOUCHER #				**APRA Client ID #**			
DOB		**START DATE**		**DISCHARGE DATE**		**TOTAL # OF DAYS/SESSIONS**	

SECTION B:	
PROVIDER NAME	
CONTACT PERSON	
DATE OF REQUEST	

SECTION C:			
	INITIAL DIAGNOSIS (include code #)		**CURRENT DIAGNOSIS (include code #)**
AXIS I		AXIS I	
AXIS II		AXIS II	
AXIS III		AXIS III	
AXIS IV		AXIS IV	
AXIS V	(Highest level in past year)	**AXIS V**	**(Must indicate change in GAF score)**

SECTION D:		
LEVEL OF CARE (LOC)	**LOC PROVIDED**	**LOC REQUESTED**
LEVEL IV Detoxification		
LEVEL III Sub-Acute Non-Hospital Medically Monitored Detox		
LEVEL III Non Hospital Residential Treatment Program		
LEVEL III Day Treatment/Partial Hospitalization Program		
LEVEL II Intensive Outpatient		
LEVEL I Outpatient		

Revised October 30, 2008

SECTION E:			
TOTAL # OF DRUG SCREENS		**TOTAL # OF POSITIVE DRUG SCREENS**	
OVERALL PROGRESS AT ____ DAY INTERVAL (15, 30, 45, etc.)			
☐ Marked Improvement	☐ Moderate Improvement	☐ No Change	
☐ Marked Regression	☐ Moderate Regression	☐ Unknown	

SECTION F:	
ASSESSMENT SUMMARY	☐ **Attached**
INITIAL TREATMENT PLAN	☐ **Attached**

SECTION G:
PRESENTING PROBLEM (Initial presenting problem)

SECTION H:
MEDICAL/PSYCHIATRIC HISTORY (include hospitalizations, suicidal and homicidal ideation)

SECTION I:
CLINICAL HISTORY

SECTION J:
CLINICAL JUSTIFICATION FOR CHANGE IN TREATMENT (include # of sessions/days requested)

SECTION K:
NEW TREATMENT PLAN (please attach a copy of the proposed treatment plan)

SECTION L:	
PREPARER'S NAME (PRINTED)	
PREPARER SIGNATURE	
CREDENTIALED PROFESSIONAL (PRINTED)	
CREDENTIALED PROFESSIONAL SIGNATURE	
DATE	

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Addiction Prevention and Recovery Administration

Office of Clinical Services
Assessment and Referral Center/Central Intake Division-Youth

NOTE: This form must be faxed to 202-535-2318 or hand delivered to APRA.

INSTRUCTIONS TO COMPLETE

ADULT/ YOUTH Authorization, Reauthorization, Step-up, Step-down Form

SECTION A:	
VOUCHER #	Enter current voucher number for client.
DOB	Enter date of birth for client.
APRA CLIENT ID #	Enter APRA assigned client identification number.
START DATE	Enter the date client entered the program.
DISCHARGE DATE	Enter the projected date of discharge from your program.
TOTAL # OF DAYS/SESSIONS	Enter the total number of sessions the client received authorization for Level I services or the total number of days the client received authorization for Level II or Level III services.

SECTION B:	
PROVIDER NAME	Enter the provider name.
CONTACT PERSON	Enter the name of the person APRA should contact regarding this form.
DATE OF REQUEST	Enter the date of request for services.

SECTION C:	
INITIAL DIAGNOSIS	Indicate the diagnosis the client received when he/she first entered services. Enter DSM IV-TR code number **AND** description to record diagnosis.
CURRENT DIAGNOSIS	Indicate any changes in the diagnosis if the initial diagnosis has changed. Enter "SAME" if there is no change in diagnosis.
AXIS I, II, III, IV	Use the DSM IV-TR to determine diagnosis.
AXIS V	Indicate the client's Global Assessment of Functioning (GAF) Score for their initial diagnosis **AND** current diagnosis. Use the highest recorded GAF score during the prior twelve-month period for the initial Axis V diagnosis.

Revised October 30, 2008

SECTION D:	
LOC PROVIDED	Indicate the services client received while enrolled in your program.
LOC REQUESTED	Indicate the level of care you are requesting for the client.
LEVEL IV Detoxification	
LEVEL III Sub-Acute Non Hospital Medically Monitored Detox	
LEVEL III Non Hospital Residential Treatment Program	
LEVEL III Day Treatment/Partial Hospitalization Program	
LEVEL II Intensive Outpatient	
LEVEL I Outpatient	

SECTION E:	
TOTAL # OF DRUG SCREENS	Enter total number of drug screens the client received.
TOTAL # OF POSITIVE DRUG SCREENS	Enter the total number of positive drug screens the client received.
OVERALL PROGRESS AT ___ DAY INTERVAL (15,30,45)	

SECTION F:	
ASSESSMENT SUMMARY	Attach a copy of the client's initial assessment (GAIN report or ASI).
INITIAL TREATMENT PLAN	Attach a copy of the client's initial treatment plan for the client.

SECTION G:	
PRESENTING PROBLEM	Enter the presenting problem in this section. Indicate why the client initiated services.

SECTION H:	
MEDICAL/PSYCHIATRIC HISTORY	Beginning with the most recent, enter the medical/psychiatric history of the client in this section. Indicate any hospitalizations, and/or history of suicidal/homicidal ideation/attempts.

SECTION I:	
CLINICAL HISTORY	Beginning with the most recent treatment history, enter the type(s) of treatment client received, client's response to treatment, and any significant clinical information.

SECTION K:	
CLINICAL JUSTIFICATION FOR CHANGE IN TREATMENT	Indicate why it is clinically necessary for a change in treatment.

SECTION L:	
NEW TREATMENT PLAN	Indicate suggested changes in the revised treatment plan that reflects and supports the desired course of treatment.

SECTION M:	
PREPARERS' NAME (PRINTED)	Print the name of the person who completed this form.
PREPARER SIGNATURE	Provide the signature for the person who completed this form.
CREDENTIALED PROFESSIONAL (PRINTED)	Print the name of the credentialed professional who reviewed and approved this form. Include their credentials.
CREDENTIALED PROFESSIONAL SIGNATURE	Provide the signature for the person who approved this form.
DATE	Enter submission date.