Inquiry for Adolescent Outpatient Substance Use Disorder Treatment Levels 2.5, 2.1, and 1

Filling out the Inquiry:
Please complete each section of this Inquiry. Indicate "NA" or "Unknown" throughout as applicable. Complete inquiries will be processed quicker. Incomplete inquiries will require follow up phone calls from Eckert Staff. If you have any questions or need assistance regarding completing this inquiry, please contact Eckert Staff at 701-609-5305.

Submitting the Inquiry:
If you need help filling out this inquiry, please contact Eckert Staff. This inquiry and supporting documents may be submitted by email to outpatient@eckertyouth.com

- You are encouraged to follow-up via phone or email to confirm your information has been received and verify if any additional documents will be needed.
- You will receive a response acknowledging receipt of your inquiry within 24 hours.

Additional Documentation:

Items required for Admission:

- Completed Eligibility Inquiry
- Necessary Releases of Information
- ASAM assessment reflecting need for ASAM Level 2.5, 2.1, or 1 Level of Care (Eckert can assist in completing this via face to face or via tele-med appointment)
- Previous assessments and/or collateral information may be requested

If a referring agency is submitting this inquiry, please include the necessary signed Release of Information with CFR 42 Part 2 requirements to allow for communication regarding this inquiry. If no ROI is included, you will not be contacted. If available, please attach written documentation of applicant's integrated mental health and substance abuse intake, diagnosis, and recommendations from a qualified mental health professional from within the last year.

NOTE: For youth ages 14 and above, a release of information must be signed by the youth only for release of drug and alcohol treatment records. Parents/guardians are not able to access the youth's records without signed permission by the youth. Please attach release of information if applicable.

Consent:
By completing this inquiry, I understand that its contents may be shared with Admissions Staff at Eckert Youth Homes. The information received in this inquiry will be handled in accordance with State and Federal Regulatory Confidentiality laws including HIPAA and CFR 42 Part 2.

Name of the person filling out this inquiry:		
Agency:	Contact Phone Number:	Contact Email Address:
Relationship to the Youth (or indicate if the youth is filling out for self):		
Signature:	Date:	

I hereby certify that the above statements are true and correct to the best of my knowledge.

Eligibility:

- Ages 14-17, males and females (Ages above or below this range will be looked at on a case by case basis)
- North Dakota resident
- Preference given to pregnant youth and youth with IV drug use
- Meets diagnostic criteria for a substance use disorder as described in the DSM
- Meets specifications in each of the ASAM dimensions required for the recommended level of care.

START OF THE APPLICATION

Section A: High Risk Screen

1. Pregnancy
Is the youth currently pregnant? ☐ Yes ☐ No
If yes, please explain current prenatal care and length of pregnancy:

2a. IV Drug Use
Does the youth have a history of IV drug use? ☐ Yes ☐ No ☐ Unknown
If yes, please explain the type and frequency of IV drug use, and the last known date of IV drug use:

2b. Drug Use
What drugs is the youth using?
How often does the youth use?
How much does the youth use?
Has the youth ever overdosed? If so, how many times?

Section B: Demographic and Home Information

1. Demographics

Youth name:		Gender ☐ Male ☐ Female ☐ Transgender
Date of Birth:	Age:	Social Security Number:

Mother's Name:	Mother's phone number:
Mother's Address	Mother's email:
Father's Name:	Father's phone number:
Father's Address:	Father's email:
Other Guardian/ Family Name and Relationship:	Phone Number:
Address:	Email:

2. Home Residence

Youth Home Address and Information			
Lives with:		Telephone Number:	
Address:	City:	State:	ZIP code:
Describe home environment:			

Applicant's Other Placement Address and Information (If currently in a different setting):			
Agency or foster home name:	Telephone Number:	Fax:	
Address:	City:	State:	Zip:
Agency of Foster home Contact Person and Information:			

Section C: Referral Information

3. Referral Narrative

Description of reason for referral:
What services has the youth received in the past year?:

Section D: Medical History

4. MEDICAL HISTORY

Are there any known current or past Medical Problems? ☐ Yes ☐ No ☐ Unknown If yes, please explain:
Does the youth have any disabilities? ☐ Yes ☐ No ☐ Unknown If yes, please explain:

Section D: Billing Information

5. Coverage Type

What type of health coverage does the youth have?: ☐ Medicaid ☐ BCBS ☐ Sanford ☐ Other Insurance ☐ No coverage
Other Comments:

6. Coverage Information

Primary Insurance

Third Party Insurance Company Name:	Telephone Number:		
Address:	City:	State:	ZIP Code:
Name of Policy Holder and Relationship to Youth:	Telephone Number:		
Address:	City:	State:	ZIP Code:
Policy Number			

Secondary Insurance

Third Party Insurance Company Name:	Telephone Number:		
Address:	City:	State:	ZIP Code:
Name of Policy Holder and Relationship to Youth:	Telephone Number:		
Address:	City:	State:	ZIP Code:
Policy Number:			

END OF INQUIRY