Inquiry for Adult Outpatient Substance Use Disorder Treatment Level 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 1 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.

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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 applicant (or indicate if the applicant 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 18-20, 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 adult and adult 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 INQUIRY

Section A: High Risk Screen

1. **Pregnancy**

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

2. **IV Drug Use**

Does the applicant 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:

Section B: Demographic and Home Information

3. **Demographics**

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

4. **Home Residence**

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

5. **Referral Narrative**

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

Section D: Medical History

6. **MEDICAL HISTORY**

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

Section D: Billing Information

7. **Coverage Type**

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

8. **Coverage Information**
Primary Insurance

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

END OF INQUIRY