Attachment A – Substance Use Disorder Service/Privilege Request

Refer to [MDHHS Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services](https://www.michigan.gov/documents/mdch/PIHP-MHSP_Provider_Qualifications_219874_7.pdf) for Provider/Staff Qualifications

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| **Indicate with a checkmark below the services and population(s) for which you are requesting to provide in the Mid-State Health Network. Please check all that apply.** | | | | | | | | | |
| **C/A** – Child/Adolescent (<18 years old) | | | **MO** – Men Only | | | | | | |
| **A** – Adult population (18 - 65 years old) | | | **WO** – Women Only | | | | | | |
| **OA** – Older adult population (>65 years old) | | | **WS** – Women’s Specialty Designated Services | | | | | | |
| **SP** – Special Populations (Please specify in Attachment) | | | **PR** – Prison Resident – Jail or Prison Based Services | | | | | | |
|  | **C/A** | **A** | | **OA** | **SP** | **WO** | **MO** | **WS** | **PR** |
| **Crisis Intervention** |  |  | |  |  |  |  |  |  |
| **Case Management (Refer/Link/Coordination)** |  |  | |  |  |  |  |  |  |
| **Detox/Withdrawal Monitoring** |  | | | | | | | | |
| Ambulatory Detox |  |  | |  |  |  |  |  |  |
| Clinically Managed Detoxification |  |  | |  |  |  |  |  |  |
| Medically Managed Detoxification |  |  | |  |  |  |  |  |  |
| Residential Detox |  |  | |  |  |  |  |  |  |
| **Early Intervention** |  |  | |  |  |  |  |  |  |
| **Integrated Treatment** |  |  | |  |  |  |  |  |  |
| **Medication Assisted Treatment** |  |  | |  |  |  |  |  |  |
| Methadone |  |  | |  |  |  |  |  |  |
| Vivitrol |  |  | |  |  |  |  |  |  |
| Suboxone |  |  | |  |  |  |  |  |  |
| **Medically Managed Supports** |  | | | | | | | | |
| Established Patient Medication Review |  |  | |  |  |  |  |  |  |
| Lab Tests |  |  | |  |  |  |  |  |  |
| Medication Compliance Monitoring |  |  | |  |  |  |  |  |  |
| New Patient Medication Review |  |  | |  |  |  |  |  |  |
| Nursing Services |  |  | |  |  |  |  |  |  |
| Physical Examination |  |  | |  |  |  |  |  |  |
| Physician Encounters |  |  | |  |  |  |  |  |  |
| TB Skin Test |  |  | |  |  |  |  |  |  |
| **Non-Medication Assisted Outpatient** |  |  | |  |  |  |  |  |  |
| **Outpatient/Ambulatory Care** |  | | | | | | | | |
| Family Assessment |  |  | |  |  |  |  |  |  |
| Family Therapy |  |  | |  |  |  |  |  |  |
| Group Therapy |  |  | |  |  |  |  |  |  |
| Individual Assessment |  |  | |  |  |  |  |  |  |
| Individual Therapy |  |  | |  |  |  |  |  |  |
| **Peer Recovery, Recovery Coaching and Support** |  |  | |  |  |  |  |  |  |
| **Prevention Services** |  | | | | | | | | |
| **Residential (Facility Based) Services** |  | | | | | | | | |
| Clinically Managed High Intensity (ASAM 111.5) |  |  | |  |  |  |  |  |  |
| Clinically Managed Medium (ASAM 111.3) |  |  | |  |  |  |  |  |  |
| Clinically Managed Low (ASAM 111.1) |  |  | |  |  |  |  |  |  |
| **Special Assessment Services** |  |  | |  |  |  |  |  |  |
| Health |  |  | |  |  |  |  |  |  |
| Psychiatric Evaluation |  |  | |  |  |  |  |  |  |
| Psychological Testing |  |  | |  |  |  |  |  |  |
| Other Assessments, Tests |  |  | |  |  |  |  |  |  |

**Authorized Applicant Signature: Date:**