**Steps to Follow for a WFNJ SAI/BHI Assessment**

1. Prior to beginning the assessment the CC must read all previous episodes of care to ensure an understanding of the client’s history.
2. Review all HIPAA policies and procedures with the client and have client sign the HIPAA Notice and Acknowledgement and offer HIPAA notice. If “SAI” or DCPP-referred, inform the client that a UDS will be required as part of completing the assessment. The UDS should be conducted within 48 hours of the assessment. (Please note - If a client is not eligible for Medicaid at the time of the assessment, the client should NOT be referred for treatment and or an assessment UDS until Medicaid is active.)
3. Review the client’s current address and phone number in Atlantis and obtain their preferred method of contact. Enter this information into Atlantis. If a client has provided you with a collateral contact, add that collateral contact information in Atlantis under collateral contact and obtain a signed general release for that person.
4. Just before saving the ASI and discussing the treatment recommendations, make sure there are comments on ALL positive responses. Currently, all comments to the red questions will be pulled through to the ASAM Assessment Summary.
5. Save the ASI and begin to discuss your treatment recommendation/LOC and service plan, including substance use, mental health, medical, DCP&P, dental, etc.
6. Have client sign releases (Multi-Agency, General Release, Health Release, etc.). Once the releases are signed by the client, the CC must go into the Status section in Atlantis and select “signed” for each release that was generated and signed by the client.
7. Have client initial and sign the “Treatment Agreement” and give a copy to the client. Contact the agreed upon treatment provider(s) to obtain intake date (s) for client.
8. Discuss any emerging medical needs or other services that client may need (e.g., probation, DCP&P, LSNJ referral) and assist with making connections to those services. Give the client a copy of their “Treatment Service Form” with all of their scheduled appointments.
9. If the CC has a Care Coordinator Support Specialist that may assist with client needs, please inform the client of this person and coordinate necessary services with the CCSS.
10. Staff in Newark and Camden with TANF and/or DCP&P-involved clients must complete the “Care Coordination Plan” at the time of assessment with the client. All other Care Coordination may use the Care Coordination Plan module but are not required to use it at this time. Give the client a copy of their Care Coordination Plan.
11. Review your IMMEDIATE NEEDS PROFILE again and make any changes, you can add comments if necessary based on your assessment of the client.
12. Complete the ASI page in Atlantis, select “Managing CC,” and “Diagnostic Category.” (The Diagnostic Category should be congruent with information in the ASI, ASAM Assessment Note and the DSM-5 diagnostic impression. For example, if you have chosen a diagnostic category of SA2 for a client, the client should be referred to a treatment program that offers co-occurring services for both substance use and mental health disorders.)
13. Make a referral to the appropriate treatment provider while the client is present. If in a network or non-network provider, inform the provider that the documents are available on the web portal and that the ASAM Note with preauthorization will be available within 24 hours. If the client will be referred to a MH provider, fax the required paperwork as soon as possible.
14. Complete the ASAM Assessment Summary. Dimensions 1-6 should all have clinically sound problem statements. If there are no issues within that dimension, DO NOT leave it blank. Document “Not Clinically Indicated” in that space.
15. Your DSM-5 Diagnostic Impression must be in the order of clinical severity and match the Diagnostic Category.
16. Enter the initial service log with the following information: “Client came in for his/her scheduled assessment. Assessment was completed. Client was referred for an assessment UDS at (*name of the treatment provider(s) on (date/time*). Client signed releases for (*DFD, DCP&P, mother,* etc). Client's preferred method of contact is (*cell, home phone or through mail*). Client was referred to LOC and (*state your recommended discharge plan for the client’s next LOC in their continuum of care*).”
17. If the client has current DCP&P involvement and a release was signed by the client, contact the County’s Systems Coordinator to request the NJC Spirit number other DCP&P information so that it can be entered into Atlantis, if it was not already entered. If your county does not have a System’s Coordinator, the client may know their NJ Spirit number and other information or the CC can ask the DCP&P worker for the number when they make initial contact.
18. A Referral Response Letter (RRL) must be generate and faxed to the DCP&P worker indicating the results of assessment and treatment placement recommendations. The ASAM Assessment Summary must be faxed along with the RRL.
19. Call the DCP&P hotline if a negative event was reported during the assessment and child safety is at risk.
20. Complete the initial assessment Case Worker Referral Response Form (CWRRF) and fax it to the referring working. The CWRRF must include the number of episodes of care, the name of the program and the days/hours the person is in, or scheduled for, treatment.
21. All faxes, interactions with client, follow-up calls made on the client's behalf should be documented in the service log.