STATE OF FLORIDA SUBSTANCE ABUSE & MENTAL HEALTH SUBSTANCE ABUSE ASAM FORM

(* Mandatory Fields) (Reference: Chapter 10, DCF Pam 155-2)

Client's Name:

1. *CONTRACTOR IDENTIFIER: ___ ___ - ___ ___ ___ ___ ___ ___ ___ Federal Tax Identification number	Page 10 - 4
2. *CLIENT SSN: ___ ___ - ___ ___ - ___ ___ ___ ___	Page 10 – 4
3. *EVALUATION DATE: ___ ___ ___ ___ ___ ___ ___ ___ (Format = YYYYMMDD)	Page 10 - 4
4. *PURPOSE: ___ **[1]** Admission **[2]** Continued **[3]** Discharge **[9]** No ASAM Required	Page 10 - 4
5. *PROVIDER ID: ___ ___ - ___ ___ ___ ___ ___ ___ ___	Page 10 - 4
6. *ASAM DATE: ___ ___ ___ ___ ___ ___ ___ ___ (Format = YYYYMMDD)	Page 10 - 4
7. SA PROGRAM: ___ **[2]** Adult SA **[4]** Children's SA	Page 10 - 4
8. RECOMMENDED ASAM LOC: ___ ___	Page 10 - 4
9. PLACEMENT: ___ ___	Page 10 – 5
10. BEGIN DATE: ___ ___ ___ ___ ___ ___ ___ ___ (Format = YYYYMMDD)	Page 10 – 5
11. *END DATE: ___ ___ ___ ___ ___ ___ ___ ___ (Format = YYYYMMDD)	Page 10 – 5
12. *CONTRACT NUMBER 1: ___ ___ ___ ___ ___	Page 10 - 5
13. CONTRACT NUMBER 2: ___ ___ ___ ___ ___	Page 10 - 5
14. CONTRACT NUMBER 3: ___ ___ ___ ___ ___	Page 10 - 5
15. *STAFF ID: ___ ___ - ___ ___ ___ ___ ___ ___ ___ ___ ___	Page 10 - 5
16. PROVIDER INFORMATION: __	Page 10 - 5
Signature: ____ Date: _____/______/________	

CODES FOR PLACEMENT AND RECOMMENDED LEVL OF CARE

[01] Residential Level 1
[02] Residential Level 2
[03] Residential Level 3
[04] Residential Level 4
[07] Residential Detox

[09] Outpatient Detox
[11] Outpatient
[12] Day/Night
[14] Intervention
[17] Methadone Maintenance