

## 1115 Waiver: Substance Use Disorder (SUD) Pilot Programs

### Service Request Form

**Submission Instructions:** The SUD Pilot Programs Service Request Form must be submitted, along with any required supporting documentation identified in Section 1, to HFS via fax at 217-524-1221 or via email at HFS.BHClinical@illinois.gov, using the subject line "SUD Pilot Request."

Service Requests for the Clinically Managed Residential Withdrawal Management pilot must be submitted no later than 1 business day after the service begin date. Service Requests for the SUD Case Management and Peer Recovery Support Services must be submitted at least 5 business days prior to the requested service begin date.

All service requests require approval from HFS. Referents will be notified if the SUD Service Request is determined to be incomplete. HFS will notify referents whether the Service Request is approved or denied using the fax number provided in Section 3, Provider Information.

#### 1. Service Request Information

**1115 Waiver Pilot being requested:**

- Clinically Managed Residential Withdrawal Management - Attach a copy of the participant's current assessment and treatment plan/individual plan of care
- SUD Case Management – Attach the completed SUD Case Management referral form, found on page 2 of the Service Request Form OR a referral form from the referring court. \*No "Authorizing Physician" is required for this service.\*
- Peer Recovery Support Services - Attach a copy of the participant's current assessment and treatment plan/individual plan of care

**Requested Service Begin Date:** \_\_\_\_\_

#### 2. Participant Information

<b>First Name:</b>	<b>Last Name:</b>	<b>Date of Birth:</b>	<b>RIN:</b>	<b>Gender:</b>
<b>Current Living Arrangement:</b> <input type="checkbox"/> Lives alone <input type="checkbox"/> Independent Living <input type="checkbox"/> Lives with parent(s), relative(s), or guardian(s) <input type="checkbox"/> State operated facility (mental health/dev. disability) <input type="checkbox"/> Jail or correctional facility		<input type="checkbox"/> Residential/Institutional Setting (residential, shelter) <input type="checkbox"/> Community integrated living arrangement (CILA) <input type="checkbox"/> Foster Care <input type="checkbox"/> Homeless <input type="checkbox"/> Other: _____		

**List all ICD-10 Diagnoses below:**

Diagnostic Code	ICD-10 Name	Primary Diagnosis?
		<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> Y <input type="checkbox"/> N

**List all SUD services the participant is currently receiving, from any provider, below.**

Service Name	Provider Name	Service Begin Date

#### 3. Provider Information

<b>Agency Name:</b>	<b>HFS Provider ID:</b>	<b>Email:</b>
<b>Referent Name:</b>	<b>Phone Number:</b>	<b>Fax Number:</b>

#### 4. Signatures

<b>Completing Staff:</b>	<b>Credentials:</b>	<b>Date:</b>
<b>*Authorizing Physician:</b>	<b>Credentials:</b>	<b>Date:</b>

## 1115 Waiver: SUD Case Management Pilot Court Referral Form

This form must be completed by an officer of the court system from which the participant is being referred. Completion of this form is required as part of the process for referring a Medicaid-eligible individual to the 1115 Waiver SUD Case Management pilot program. Questions regarding this form may be addressed to the Bureau of Behavioral Health at the Department of Healthcare and Family Services by calling 217-557-1000 or emailing HFS.BBH@illinois.gov.

### Referral Information

**Participant Name:**

**Court Case Number:**

**Court/Jurisdiction:**

### Attestation of Participant Eligibility:

By signing below, I confirm that the following is true to the best of my knowledge:

- I am currently an official within the court system identified above.
- The individual being referred is not currently an inmate of a public institution.
- The individual being referred qualifies for diversion from the criminal justice system into treatment for his/her substance use disorder or opioid use disorder.

### Signature

\_\_\_\_\_

Court Official (print name)

\_\_\_\_\_

Title

\_\_\_\_\_

Signature

\_\_\_\_\_

Date