**Department of**

**Health and Social Services**

Division of Behavioral Health

Central Office

P.O. Box 110620

Juneau, Alaska 99811-0620

Main: 907.465.3370

Toll free: 800.465.4828

Fax: 907.465.2668

**DIVISION OF BEHAVIORAL HEALTH (DBH)**

**REQUEST FOR SUBSTANCE USE DISORDER TREATMENT SERVICES**

 **TRAVEL ASSISTANCE**

**(Non-Medicaid eligible clients only)**

**REFERRAL AGENCY:** The agency that is assisting the client by coordinating treatment and facilitating travel to access medically necessary residential treatment, transition to continuing care, or return to the home community. This agency may or may not have performed the assessment determining the medically necessary level of care. This agency submits the completed form with the signed Medicaid Consent for Release of Information to DBH via fax. This agency becomes the Receiving Agency when coordinating return travel.

Agency:

Name/Title:

Address:

City:       State: AK Zip Code:

Telephone number:       Fax Number:

**RECEIVING AGENCY:** The agency that has agreed to admit the client to residential SUD services or aftercare. The admission date should be provided to the Referring Agency to include on the Travel Assistance Request. This agency becomes the Referring Agency when arranging return travel.

Agency:

Name/Title:

Address:

City:       State: AK Zip Code:

Telephone number:       Fax Number:

**[ ]  Release of Confidential Information and HIPAA privacy notice signed by client and on file**

1. Client Name:       DOB:

 Address:

2. Date of last assessment and **ASAM Level of Care:** Date:       Level of Care:

3. **DSM-5 or ICD 10** Diagnostic Code(s):

4. Reason for travel (check all that apply):

 [ ]  Detoxification [ ]  Culturally Relevant Treatment

 [ ]  No Capacity in Community of Residence [ ] Other:

 [ ]  Continuing Care following treatment: Arranged with

 (Indicate facility or agency)

 (Please explain treatment)

5. If this request is for discharge travel, specify the type of discharge:

[ ]  Successfully Completed Program [ ]  Left on own, Refused Treatment [ ]  Removed from Program

6. Is the client from one of the priority categories? (check all that apply)

**[ ]** Pregnant **[ ]**  IDU [ ]  Women with Children **[ ]** OCS Involved Families

7. Admission Date:       Discharge Date *(if returning home*):

8. Cost of One-Way Ticket:       Date of Travel:

9. Name/Title of Escort:       Cost of RT Ticket:

Reason for escort:       Approved: Yes [ ]  No [ ]

10. What other methods of payment have been explored?

 [ ]  Medicaid [ ]  Insurance [ ]  Native Corps. [ ]  Tribal [ ]  Other

Authorized by DBH Behavioral Health Specialist: Date: