FY22 Mandatory Treatment Questionnaire – Complete one form for in-house treatment services and one for each contracted treatment provider.

Provider Name: _____

Can this provider bill Medicaid or any other medical insurance:

☐ Yes

☐ No

If No, is there a plan in place to become a Medicaid provider:

1	Please describe what treatment service(s) the program will provide: ☐ Intensive Outpatient Services (IOP) ☐ Outpatient treatment/therapy ☐ Peer Support ☐ Comprehensive Community Support Services (CCSS) ☐ Psychoeducation ☐ AccuDetox ☐ Other treatment/therapy. Please describe:
2	Which evidence-based program(s) (EBP) or promising practice will be used in the treatment program such as Moral Reconation Therapy (MRT), Stages of Change, Community Reinforcement and Family Training (CRAFT), etc.? Please list all:

3	Briefly describe how the treatment component functions, from intake to discharge, including intensity and duration of services:
4	Will you refer to a less intensive level of care when the individual completes the treatment program provided? ☐ No ☐ Yes If Yes, list available options:
5	a. How often will you report attendance and treatment progress for clients served to the DWI Coordinator and/or Compliance staff? b. Please describe how the progress is reported

6	List cost per client per program component: Intensive Outpatient Services (IOP): _____ Outpatient treatment/therapy: _____ Peer Support: _____ CCSS: _____ Psychoeducation: _____ AccuDetox: _____ Other treatment/therapy. Please describe: