FORM ORT-1
REVISED 03/2014

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2014

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4103
www.shpda.alabama.gov

STREET ADDRESS (Commercial Carrier)
100 NORTH UNION STREET STE 870
MONTGOMERY AL 36104
FAX: (334) 242-4113
bradford.williams@shpda.alabama.gov

2013 ANNUAL REPORT FOR OPIATE REPLACEMENT TREATMENT FACILITIES

Enter Facility ID Number Here

Enter Facility Name Here

Mailing Address: _____ (STREET ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Physical Address: _____ (STREET ADDRESS) _____ (CITY) **AL** _____ (ZIP)

County of Location: _____

Facility Telephone: _____ (AREA CODE) & TELEPHONE NUMBER **Facility Fax:** _____ (AREA CODE) & TELEPHONE NUMBER

This reporting period is for January 1, 2013, through December 31, 2013*; or for **partial** year of operation beginning _____ (MONTH DAY) and ending _____ (MONTH DAY) a period of _____ days.

*Data for the agency's fiscal year, other than the time frame specified, may be provided, but no more than 12 months of consecutive data should be reported. ***If there was a change in ownership during the reporting period, data for the full year should be reported by the current owner.***

We hereby affirm and attest that the reported information has been verified, and to the best of our knowledge, the information contained in the following pages of this report is a true and accurate representation of the services, equipment, and utilization of this facility.

PRINTED NAME OF PREPARER	SIGNATURE OF PREPARER	DATE
DIRECT TELEPHONE NUMBER	TITLE OF PREPARER	E-MAIL ADDRESS

A member of administration <u>MUST</u> also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above.

PRINTED NAME OF ADMINISTRATION OFFICIAL	SIGNATURE OF ADMINISTRATION OFFICIAL	DATE
DIRECT TELEPHONE NUMBER	TITLE OF ADMINISTRATION OFFICIAL	E-MAIL ADDRESS

FOR OFFICE USE ONLY

Facility Verified:		Initial Scan:		Completed:	
Entered:		Final Scan:		Audited:	

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OWNERSHIP (check one)

◯ Corporation	◯ Non-Profit Organization	◯ Partnership
◯ Individual	◯ Healthcare Authority	◯ LLC
◯ Joint Venture	◯ Government	◯ Other

Does this facility operate under a management contract? ◯ Yes ◯ No

Management Firm: _____
NAME

_____
BASE ADDRESS CITY STATE ZIP

List the total patient census on the FIRST day of the reporting period _____

List the total number of admissions during the reporting period _____

List the total number of discharges during the reporting period _____

I. ADMISSIONS

A. Admissions by age and gender

	Male	Female	Total
0-17 Years			0
18-34 Years			0
35-54 Years			0
55-64 Years			0
65-74 Years			0
75-84 Years			0
85+ Years			0
Totals	0	0	0

B. Admissions by race

a. White/Caucasian	
b. Black/African American/Negro	
c. Hispanic/Spanish/Latino	
d. Asian	
e. American Indian/Alaskan Native	
f. Pacific Islander	
g. India	
h. Middle Eastern	
i. Other (specify) _____	
Totals	0

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C. Admissions by source of payment

a.	Self Pay	
b.	Medicaid/SCHIP	
c.	Private Insurance	
d.	No Charge (charity & other free care)	
e.	Other (specify) _____	
TOTALS		0

D. Admissions by source of referral

a.	Criminal Justice/DUI	
b.	Healthcare/Community	
c.	Self/Family	
d.	Other (specify) _____	
TOTALS		0

E. Admissions by primary source of addiction

a.	Heroin	
b.	Buprenorphine	
c.	Hydrocodone	
d.	Oxycodone	
e.	Demerol (meperidine)	
f.	Dilaudid (hydromorphone)	
g.	Fentanyl	
h.	Other	
	TOTALS	0

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F. Admissions by county of residence (If unable to determine patient county of residence, fill out section VI on page 8)

County	Methadone Treatment Admissions	Other Modality Admissions	Total Admissions
			0
			0
			0
			0
			0
			0
			0
			0
			0
			0
			0
			0
TOTALS	0	0	0

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II. Methadone Maintenance Therapy

A. Utilization

	Methadone Maintenance Therapy	Total Patients
1. Patient Census on FIRST day of reporting period	_____	_____
2. Total Admissions	_____	_____
a. Criminal Justice/DUI	_____	_____
b. Healthcare/Community	_____	_____
c. Self/Family	_____	_____
d. Other	_____	_____
3. Total Discharges	_____	_____
a. Completed Treatment	_____	_____
b. Transferred to further treatment	_____	_____
c. Dropped out of treatment (voluntary)	_____	_____
d. Treatment Terminated by facility	_____	_____
e. Other	_____	_____
1. Death	_____	_____
2. Arrest	_____	_____
3. Unknown/Other	_____	_____

B. Length of Stay (based on all active patients on the LAST day of the reporting period)

	Methadone Maintenance Therapy	Total Patients
0-30 Days	_____	_____
30-60 Days	_____	_____
60-90 Days	_____	_____
90-120 Days	_____	_____
120-180 Days	_____	_____
180-365 Days	_____	_____
366 or more Days	_____	_____

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III. DISCHARGES

A. Discharges by Category and Length of Stay

	0-180 days	181-365 days	366 or more days
a. Completed Treatment – Methadone Patients			
b. Completed Treatment – Other Patients			
c. Transferred to further treatment – Methadone Patients			
d. Transferred to further treatment – Other Patients			
e. Dropped out of treatment (voluntary) – Methadone Patients			
f. Dropped out of treatment (voluntary) – Other Patients			
g. Treatment terminated by facility – Methadone Patients			
h. Treatment terminated by facility – Other Patients			
i. Other			
1. Death – Methadone Patients			
2. Death – Other Patients			
3. Arrest – Methadone Patients			
4. Arrest – Other Patients			
5. Unknown/Other – Methadone Patients			
6. Unknown/Other – Other Patients			
TOTALS	0	0	0

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B. Discharges by Modality of Treatment

a. Methadone	
b. Buprenorphine	
c. Other medication	
d. Non-medical	
e. Other	
TOTAL	0

C. Discharges by Number of Prior Treatments

a. 0 Prior Treatments	
b. 1 or more Prior Treatments	
TOTAL	0

IV. SERVICES OFFERED

Services	Yes	No
a. Drug Testing	○	○
b. Individual Counseling	○	○
c. Occupational Training/Placement	○	○
d. Education Training/Placement	○	○
e. Group Counseling	○	○
f. Other (specify) _____	○	○

V. EXPENSES AND REVENUES

a. Total Revenues	
b. Total Expenses	
c. Total Bad Debt	
d. Total Charity Care	

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VI. Admissions by Zip Code of Residence

(Please fill out this section ONLY if your facility currently does not have the capability of filling out section I-F above (admissions by county of residence). The information provided below will NOT be a part of any published dataset, and will be used by the Agency only to assign patients to their county of residence according to their zip code. Make additional copies of this sheet as required to complete the report.)

Zip Code	Methadone Treatment Admissions	Other Modality Admissions	Total Admissions
			0
			0
			0
			0
			0
			0
			0
			0
			0
			0
			0
			0
TOTALS	0	0	0