

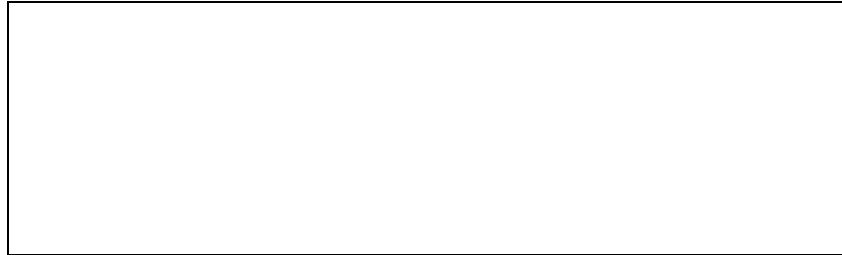
THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2014

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2013 ANNUAL REPORT FOR OPIATE REPLACEMENT TREATMENT FACILITIES



**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 \_\_\_\_\_ and ending \_\_\_\_\_ a period of \_\_\_\_\_ days.

MONTH DAY

MONTH DAY

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

<input type="checkbox"/> Corporation	<input type="checkbox"/> Non-Profit Organization	<input type="checkbox"/> Partnership
<input type="checkbox"/> Individual	<input type="checkbox"/> Healthcare Authority	<input type="checkbox"/> LLC
<input type="checkbox"/> Joint Venture	<input type="checkbox"/> Government	<input type="checkbox"/> 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	_____	_____	_____
18-34 Years	_____	_____	_____
35-54 Years	_____	_____	_____
55-64 Years	_____	_____	_____
65-74 Years	_____	_____	_____
75-84 Years	_____	_____	_____
85+ Years	_____	_____	_____
<b>Totals</b>	_____	_____	_____

**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** \_\_\_\_\_

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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** \_\_\_\_\_

**D. Admissions by source of referral**

- a. Criminal Justice/DUI \_\_\_\_\_
- b. Healthcare/Community \_\_\_\_\_
- c. Self/Family \_\_\_\_\_
- d. Other (specify) \_\_\_\_\_
- TOTALS** \_\_\_\_\_

**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** \_\_\_\_\_

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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)**

<b>County</b>	<b>Methadone Treatment Admissions</b>	<b>Other Modality Admissions</b>	<b>Total Admissions</b>
<b>TOTALS</b>			

## 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	_____	_____

### 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			
<b>TOTALS</b>			

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**B. Discharges by Modality of Treatment**

a. Methadone	_____
b. Buprenorphine	_____
c. Other medication	_____
d. Non-medical	_____
e. Other	_____
<b>TOTAL</b>	_____

**C. Discharges by Number of Prior Treatments**

a. 0 Prior Treatments	_____
b. 1 or more Prior Treatments	_____
<b>TOTAL</b>	_____

**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
<b>TOTALS</b>			