**STATE OF FLORIDA, DEPT OF CHILDREN & FAMILES**

**SUBSTANCE ABUSE & MENTAL HEALTH**

**WAITING LIST FORM**

(\* Mandatory Fields) (Reference Chapter 7, DCF Pam 155-2)

| **#** | **Waiting List Data** | **Enter Value Here** | **Chapter Reference** |
| --- | --- | --- | --- |
| 1 | **\* Provider Identifier** Federal Tax Identification Number | \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | FederalTaxIdentifierSection 3.1.3 |
| 2 | **\* Contract Number**Not required for DCF Operated State Mental Health Treatment facilities. |  | ContractNumberSection 3.1.3 |
| 3 | **Subcontract Number**Required if provider is under contract with a managing entity. |  | SubcontractNumberSection 3.1.3 |
| 4 | **\*Site ID** |  | SiteIdentifierSection 3.1.3 |
| 5 | **\* Client SSN**Or Source Record Identifier. | \_\_ \_\_ \_\_ - \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_ | ClientSourceRecordIdentifierSection 3.1.3 |
| 6 | **\*Program Area**  |

|  |  |
| --- | --- |
| 🞎 1 Adult Mental Health | 🞎 4 Child Substance |
| 🞎 2 Adult Substance |  Abuse |
|  Abuse | 🞎 5 Adult Mental Health |
| 🞎 3 Child Mental Health |  And Substance Abuse |
|  | 🞎 6 Child Mental Health |
|  |  And Substance Abuse |

 | ProgramAreaCodeSection 3.1.3 |
| 7 | **\*Treatment Setting**Must be a valid code from Appendix 5. | \_\_ \_\_ | TreatmentSettingCodeSection 3.1.3 |
| 8 | **\*Covered Service**Must be a valid code from Appendix 5. | \_\_ \_\_ | CoveredServiceCodeSection 3.1.3 |
| 9 | **\*Level of Care Evaluation Tool**Must be a valid code from Appendix 5. | \_\_ | LevelOfCareEvaluationToolCodeSection 3.1.3 |
| 10 | **\*Level of Care Evaluation Date**Must be less than or equal to the Placement Date. | \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ | LevelOfCareEvaluationDateSection 3.1.3 |
| 11 | **\*Recommended Level of Care** Must be a valid code from Appendix 5 for the given Evaluation Tool. | \_\_ \_\_ | RecommendedLevelOfCareCodeSection 3.1.3 |
| 12 | **Actual Level of Care**Must be a valid code from Appendix 5 for the given Evaluation Tool. Required if Outcome Code is 1 or 7. | \_\_ \_\_ | ActualLevelOfCareCodeSection 3.1.3 |
| 13 | **\*Placement Date** | \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ | PlacementDateSection 3.1.3 |
| 14 | **\*Pregnancy Code** |

|  |  |
| --- | --- |
| 🞎 0 No | 🞎 6 Not Applicable |
| 🞎 1 Yes |  (Male) |

 | PregnantCodeSection 3.1.3 |
| 15 | **\*IV Drug Use Code** |

|  |  |
| --- | --- |
| 🞎 0 No | 🞎 1 Yes |

 | IntravenousDrugUseCodeSection 3.1.3 |
| 16 | **\*Homeless Code** |

|  |  |
| --- | --- |
| 🞎 0 No | 🞎 1 Yes |

 | HomelessCodeSection 3.1.3 |
| 17 | **Outcome Date**Required when an individual is removed from the waiting list. Must be greater than or equal to Placement Date. | \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ | OutcomeDateSection 3.1.3 |
| 18 | **Outcome Code**Required when an individual is removed from the waiting list. |

|  |  |
| --- | --- |
| 🞎 1 Receiving Services | 🞎 7 Receiving Services |
|  at this Provider |  At another Provider |
| 🞎 2 Moved Out of State | 🞎 8 Incarcerated |
| 🞎 3 Moved out of ME | 🞎 9 Not had face to face |
|  Catchment Area |  Telephone or other |
| 🞎 4 Declined |  Contact in last 30 days |
| 🞎 5 Died |  |
| 🞎 6 Evaluation  |  |
|  Determined that |  |
|  Service is no longer |  |
|  appropriate |  |

 | OutcomeCodeSection 3.1.3 |

| **Signature** | **Date**  |
| --- | --- |
|  | \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ |