Questionnaire: Intensive Outpatient Program (IOP)

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1. Members seeking IOP services must be:
   (Please select between 1 and 5 items.)

   [ ] Transitioning from a higher level of care (e.g., residential treatment or inpatient psychiatric hospitalization) to a lower level of care when discharge is imminent within thirty (30) days or less
   [ ] At risk of Placement in a residential treatment setting
   [ ] At risk of Involvement in the criminal justice or juvenile justice system
   [ ] At risk of Inpatient psychiatric hospitalization,
   [ ] At risk of Homelessness

2. Is member transitioning from a higher level of care (e.g., residential treatment or inpatient psychiatric hospitalization) to a lower level of care when discharge is imminent within thirty (30) days or less?
   (Please select one.)

   [ ] Yes
   [ ] No

   2.1.1. Please identify which level of care.

3. Does member Present with a level of clinical acuity that cannot be safely and successfully treated in an outpatient level of care?
   (Please select one.)

   [ ] Yes
   [ ] No

4. Does member have a primary substance use disorder or a substance use disorder with a co-occurring mental health disorder and meet ASAM Level 2.1 placement criteria?
(Please select one.)

[ ] Yes
[ ] No

5. Does member have a primary mental health disorder or a mental health disorder with a co-occurring substance use disorder and exhibit moderate to severe psychiatric symptoms?
(Please select one.)

[ ] Yes
[ ] No

6. Does member have an Autism Spectrum Disorder (ASD) or an Intellectual Disability and exhibit functional limitations, verbal and/or physical aggression, self-injurious behaviors, severe emotional dysregulation, and other serious problem behaviors?
(Please select one.)

[ ] Yes
[ ] No

7. Does member have a primary mental health disorder or a co-occurring mental health and substance use disorder and exhibit moderate to severe psychiatric symptoms and has reached at least sixty-five (65) years of age?
(Please select one.)

[ ] Yes
[ ] No

8. Does member have an eating disorder, to include Otherwise Specified Feeding or eating disorder and Unspecified Feeding or eating disorder?
(Please select one.)

[ ] Yes
[ ] No

8.1.1. Please indicate the type(s) of eating disorder(s).
(Please select between 1 and 4 items.)

[ ] Avoidant/Restrictive Food Intake Disorder
[ ] Anorexia Nervosa
[ ] Binge Eating Disorder
[ ] Bulimia Nervosa

9. Does member have a primary mental health diagnosis or mental health disorder with a co-occurring substance use disorder
(Please select one.)

[ ] Yes
[ ] No

10. Does member have at least three (3) of the following criteria?
(Please select between 1 and 7 items.)

[ ] Severe emotional dysregulation
[ ] Chronic suicidality
[ ] Impulsivity
[ ] Self-harm
[ ] Strained interpersonal relationships
[ ] Inability to engage in appropriate coping skills
[ ] History of mental health crises and/or psychiatric hospitalizations.

11. Please select all applicable substances that are current:
(Please select between 1 and 15 items.)

[ ] Alcohol
[ ] Cocaine / Crack
[ ] Marijuana / Hashish / THC
[ ] Heroin / Morphine
[ ] Non Rx-Methadone
[ ] Other Opiates and Synthetics
[ ] PCP
[ ] Other Hallucinogens LSD, DMT, STP, etc.
[ ] Methamphetamines
[ ] Other Amphetamines
[ ] Other Stimulants
[ ] Benzodiazepines
[ ] Other Tranquilizers
[ ] Barbiturates
[ ] Other Sedatives and Hypnotics
[ ] N/A