**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 | \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | FederalTaxIdentifier  Section 3.1.3 |
| 2 | **\* Contract Number**  Not required for DCF Operated State Mental Health Treatment facilities. |  | ContractNumber  Section 3.1.3 |
| 3 | **Subcontract Number**  Required if provider is under contract with a managing entity. |  | SubcontractNumber  Section 3.1.3 |
| 4 | **\*Site ID** |  | SiteIdentifier  Section 3.1.3 |
| 5 | **\* Client SSN**  Or Source Record Identifier. | \_\_ \_\_ \_\_ - \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_ | ClientSourceRecordIdentifier  Section 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 | | ProgramAreaCode  Section 3.1.3 |
| 7 | **\*Treatment Setting**  Must be a valid code from Appendix 5. | \_\_ \_\_ | TreatmentSettingCode  Section 3.1.3 |
| 8 | **\*Covered Service**  Must be a valid code from Appendix 5. | \_\_ \_\_ | CoveredServiceCode  Section 3.1.3 |
| 9 | **\*Level of Care Evaluation Tool**  Must be a valid code from Appendix 5. | \_\_ | LevelOfCareEvaluationToolCode  Section 3.1.3 |
| 10 | **\*Level of Care Evaluation Date**  Must be less than or equal to the Placement Date. | \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ | LevelOfCareEvaluationDate  Section 3.1.3 |
| 11 | **\*Recommended Level of Care**  Must be a valid code from Appendix 5 for the given Evaluation Tool. | \_\_ \_\_ | RecommendedLevelOfCareCode  Section 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. | \_\_ \_\_ | ActualLevelOfCareCode  Section 3.1.3 |
| 13 | **\*Placement Date** | \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ | PlacementDate  Section 3.1.3 |
| 14 | **\*Pregnancy Code** | |  |  | | --- | --- | | 🞎 0 No | 🞎 6 Not Applicable | | 🞎 1 Yes | (Male) | | PregnantCode  Section 3.1.3 |
| 15 | **\*IV Drug Use Code** | |  |  | | --- | --- | | 🞎 0 No | 🞎 1 Yes | | IntravenousDrugUseCode  Section 3.1.3 |
| 16 | **\*Homeless Code** | |  |  | | --- | --- | | 🞎 0 No | 🞎 1 Yes | | HomelessCode  Section 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. | \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ | OutcomeDate  Section 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 |  | | OutcomeCode  Section 3.1.3 |

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