



# Accessing York/Adams SCA Funding for Outpatient Services

York/Adams Drug and Alcohol  
Commission (YADAC)

[YADAC Website](#)

(717) 771-9222

# PLEASE NOTE

- Hyperlinks within this document are included for your convenience.
- This document is *not all inclusive*.
- Policies, Memos and Procedures link: [Policies, Memos & Procedures](#)
- SCA Documents shall be made available upon request.
- Non-WITS SCA related documents must be retained in the individual's chart and are considered a permanent part of the individual's record.

# YADAC TREATMENT FUNDING FUNDAMENTALS

- Providers must ensure that YADAC funding is the payment of last resort.
- Providers must complete and submit Medical Assistance applications to the appropriate County Assistance Office (York or Adams)
- Complete all forms in their entirety
- Retain all PA WITS documents in the PA WITS system and all other documents in the individual's chart.

# EMERGENT CARE SCREENING

- First activity provided to individual seeking services.
- Screenings must be provided 24/7
- Screenings with/without identified outcome must be completed in the Intake and Screening Tool in PA WITS
- Determines need for emergent care services in Detoxification, Prenatal Care, and Psychiatric Care
- Telephone or in person but should be done by speaking with individual seeking services
- Needs identified must be addressed at the time of identification
- Priority populations must be offered admission to withdrawal management immediately.
- Others in need of withdrawal management must be admitted within 24 hours. (If timeframe cannot be met, reason must be documented in individual's file)
- May be times individuals are assessed at initial contact but not screened. (In these situations, must document the reason screening was not conducted)

## YADAC's 24/7 SCREENING

- Screenings must be provided 24 hours a day, seven days a week.
- White Deer Run Admissions Support Center (ASC) manages screenings 24/7
- White Deer Run Admissions Support Center: 1-866-769-6822.
- YADAC funded individuals who meet withdrawal management services are placed accordingly
- YADAC encourages all providers to include this number in their afterhours protocol.

## LEVEL OF CARE ASSESSMENT (LOCA)

- Must be completed within seven (7) calendar days from the date of initial contact. (If this timeframe cannot be met, the reason must be documented in the individual's file)
- Must be completed in one (1) session prior to referral to the appropriate level of care. (If this timeframe cannot be met, the reason must be documented in the individual's file)
- Individuals must be referred to and admitted to the appropriate level of care within 14 days of the LOCA. (If this timeframe cannot be met, the reason must be documented in the individual's file)
- Pregnant Women and Injection Drug Users must be referred to and admitted to the appropriate level of care immediately. (If this timeframe cannot be met, the reason must be documented in the individual's file)
- Individuals admitted directly to withdrawal management LOC without assessment, must have assessment completed before admitting into any other LOC.
- Use most recent version of the ASAM Criteria and DDAP's Guidance Document (ASAM in WITS) to determine LOC

# CASE MANAGEMENT FILE CONTENT

**Providers must utilize PA WITS system to complete requirements listed below:**

- Client Profile
- Screening Tool
- Treatment Assessment Protocol (TAP)
- Miscellaneous Note for Tuberculosis (TB) Screening and Referral
- ASAM
- Program Enrollment
- Discharge
- Case Management Notes including, but not limited to, admission and discharge info using Encounter Notes
- Intake
- Treatment Assessment Protocol (TAP)
- Miscellaneous Note for Problem Gambling Screening and Referral
- Admission
- Case Management Service Plan (AKA: Recovery Plan in WITS)
- Discharge
- Documentation of interim services using miscellaneous notes

**In addition to the WITS documentation above, the following information must be retained as part of an individual's file: Liability Forms, SCA Grievance and Appeal, Consents, and valid MA eligibility letter**

# TREATMENT FUNDING AUTHORIZATION

- There is no pre-authorization paperwork required to be sent to the SCA to secure funding for outpatient levels of care. (OP, IOP, and Partial)
- There is pre-authorization paperwork required to be sent to the SCA to secure funding for Inpatient levels of care. (Rehab and Halfway House)
- [T – 11 Policy](#) outlines procedures for referring individuals into inpatient levels of care
- There is no pre-authorization paperwork required to be sent to the SCA to secure funding for withdrawal management – this is done at the withdrawal management provider
- Utilize the office coverage on call person at YADAC M-F 8:00-4:30 for any questions or concerns with paperwork, funding, access, etc.

# CLIENT LIABILITY DETERMINATION

- All individuals receiving YADAC funding must have a liability on file, except detox individuals.
- Liabilities shall be determined prior to referral or admission into applicable treatment services.
- Monthly gross income to be based on the last 30 days.
- Please refer to section 7.01 of the current [DDAP Fiscal Manual](#) for any further clarifications.
- [Client Liability Tables for York/Adams Counties](#)

Client Liability Determination Form.pdf - Adobe Acrobat

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**CLIENT LIABILITY DETERMINATION FORM**  
(Please refer to Section 7.03 of the DDAP Fiscal Manual for completion of the form.)

Client Name: \_\_\_\_\_ County of Residence: \_\_\_\_\_ Client ID #: \_\_\_\_\_

Initial  Re-determination  
 Date: \_\_\_\_\_

**PART I: INSURANCE**

Does the client have insurance (private and/or public) coverage?  Yes  No

If insurance has been denied, indicate the reason for denial. Denied: \_\_\_\_\_

Insurance Company	Name of Insured	Group #	ID #

*If the SCA is not reimbursing for the cost of service or the service is exempt, DDAP does not require completion of the form.*

**PART II: FAMILY (As determined by Federal Law/Federal Tax Return)**

Name of Dependents	Relationship
	Self

Total # of Dependents (including Self): \_\_\_\_\_

**PART III: MONTHLY GROSS INCOME**

List all income from full- and part-time employment as well as other types of income, as applicable, including that of Self, Spouse and Parents (see Section 7.03 of the DDAP Fiscal Manual for income to be included). See description of types of income below.

Family Member	Employers
Self	
Spouse	
Parent I (if applicable)	
Parent II (if applicable)	

Types of Income	Self	Spouse	Parent I	Parent II	Totals
Earned Income (i.e., wages, salaries, tips, bonuses, etc.)					
Interest Income					
Dividends					
Benefits (i.e., unemployment, social security, public assistance, pensions, etc.)					
Alimony					
Other Taxable Income					
Totals					

Total Monthly Gross Income: \_\_\_\_\_

Note: Client liability determined on this day shall be valid for a period of no more than 12 months, with a re-determination to occur at the end of the 12-month period.

# REQUEST FOR LIABILITY REDUCTION OR ELIMINATION

- Complete this form to request liability reduction or elimination of amount individual is liable to pay.
- Section two is completed to request specifically what the individual needs.
- Email requests to the YADAC RFA mailbox @ [rfa@yorkcountypa.gov](mailto:rfa@yorkcountypa.gov) for response within two days.

RequestForLiabilityReductionForm.pdf - Adobe Acrobat

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### REQUEST FOR LIABILITY REDUCTION OR ELIMINATION

CLIENT'S NAME:	CLIENT ID #
AGENCY NAME:	

I am requesting an adjustment to my liability for the following reason(s):

\_\_\_\_\_

\_\_\_\_\_

Client / Liable Person Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby request a review by the SCA Administrator (Designee) of this client's assessed liability. I request that the liability be (check one from each column):

<input type="checkbox"/> Abated in full	<input type="checkbox"/> For the period: _____ to _____
<input type="checkbox"/> Current Liability of _____ Modified to _____	<input type="checkbox"/> Ongoing

This statement is being requested due to:

<input type="checkbox"/> Clinical Reasons	<input type="checkbox"/> Substantial Financial Hardship
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Description of reason (be specific):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify that to the best of my knowledge and belief, the imposition of the assessed liability would be likely to negate the effectiveness of treatment, or prohibit the client's access to, or continuation of, treatment and that failure to provide such treatment would result in serious harm to the client's welfare or in greater cost to the Commonwealth due to deterioration in the client's condition.

I do not support the request for reduction or elimination of liability at this time.

Date \_\_\_\_\_ Staff Signature, Title \_\_\_\_\_

\_\_\_\_\_ SCA USE \_\_\_\_\_

<input type="checkbox"/> Approved	<input type="checkbox"/> Partial Approval as Follows: _____
<input type="checkbox"/> Denied	_____

Effective Date \_\_\_\_\_ SCA or Designee Signature, Title \_\_\_\_\_

# REQUEST FOR INSURANCE EXCEPTION AUTHORIZATION

- Use this form for individuals with private insurance who cannot afford treatment due to high co-pays or deductibles.
- Verification documents from insurance company must accompany this form. Please see [Insurance Exception Memorandum 12/15/17](#).
- Email requests to the YADAC RFA mailbox @ [yadac-rfa@YorkCountyPA.gov](mailto:yadac-rfa@YorkCountyPA.gov) for response within two days.

YORK/ADAMS DRUG & ALCOHOL COMMISSION

**Request for Insurance Exception Authorization**  
E-Mail to [yadac-rfa@YorkCountyPA.gov](mailto:yadac-rfa@YorkCountyPA.gov)  
Or fax to 717-771-9709

Treatment Provider Name: \_\_\_\_\_  
Treatment Provider Representative: \_\_\_\_\_  
Name of Individual with hardship: \_\_\_\_\_  
Level of Care: \_\_\_\_\_

This individual is insured through \_\_\_\_\_ Insurance Company.  
We have determined that the individual has a deductible of \$ \_\_\_\_\_. Of this deductible, \$ \_\_\_\_\_  
has been met previous to this treatment episode. This individual has a co-pay of \$ \_\_\_\_\_. We are  
requesting that YADAC authorize a hardship due to the financial burden this deductible/co-pay places on the  
individual.

An Insurance Exception Authorization for YADAC funding is requested to begin on \_\_\_\_\_.

Included with this Request for Insurance Exception Authorization (please check to indicate completion and  
attach):

\_\_\_ Valid Liability form  
\_\_\_ Valid Release of Information giving YADAC permission to release information to the provider.  
\_\_\_ Insurance documentation listing amount of insurance benefit deductible amount

I certify that to the best of my knowledge and belief, the existence of the financial burden would likely negate  
the effectiveness of treatment, or prohibit the individual's access to or continuation of, treatment; and that  
failure to access such treatment would result in serious deterioration to the individual's current condition.

\_\_\_\_\_  
Treatment Provider Representative - Signature Date

**YADAC USE ONLY:**

Date Request Received: \_\_\_\_\_

Approved  
 Denied  
Reason/Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

YADAC Agency Representative Date

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# TREATMENT UPDATE REPORT

- Complete this form to facilitate active, ongoing communication for individuals participating in Treatment Courts and Day Reporting Center (DRC).
- Email completed forms to YADAC Treatment Updates Mailbox @ [yadac-treatmentupdates@yorkcountypa.gov](mailto:yadac-treatmentupdates@yorkcountypa.gov)
- Submit to YADAC regardless of funding.
- A [Redisclosure Consent](#) is needed (located on YADAC website).
- Is crucial to involve YADAC in aftercare planning for Treatment Court and DRC individuals.

**YORK/ADAMS DRUG AND ALCOHOL COMMISSION**

**TREATMENT UPDATE REPORT**

This report serves to inform all Treatment Court Team, DRC and Pretrial Members of the individual's progress in treatment while involved in these York County Programs.

\*\*\* Please forward completed reports to the designated email account following each week\*\*\*  
Email Account: [yadac-treatmentupdates@yorkcountypa.gov](mailto:yadac-treatmentupdates@yorkcountypa.gov)

Client is involved in (please check one):  
 Drug Court  DUI Court  Pre-Trial  DRC

Today's Date: \_\_\_\_\_  
From Individual and Agency: \_\_\_\_\_  
Client's Name: \_\_\_\_\_ Current LOC: \_\_\_\_\_ Anticipated Discharge: \_\_\_\_\_

What scheduled sessions has the client attended in the past week? Please indicate the date below.  
Monday: \_\_\_\_\_ Tuesday: \_\_\_\_\_ Wednesday: \_\_\_\_\_  
Thursday: \_\_\_\_\_ Friday: \_\_\_\_\_ Weekends: \_\_\_\_\_

Has the client missed any scheduled sessions?  YES  NO  
If YES, please indicate the date/time of the missed session(s): \_\_\_\_\_  
Did the client call to reschedule?  YES  NO

Please contact the respective Case Management Specialist IMMEDIATELY if the client No Call/No Show OR for any other situation that needs IMMEDIATE attention.

CLIENT PROGRESS: (please  one)  
Please indicate the client's treatment progress:  Good  Fair  Poor

**RECOMMENDATIONS & COMMENTS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has the client been informed that the above information is being disclosed and has signed a YADAC consent for re-disclosure?  YES  NO

Counselor Signature \_\_\_\_\_ Date \_\_\_\_\_ Client Signature \_\_\_\_\_ Date \_\_\_\_\_

If you are interested in observing a Treatment Court, please contact York County Adult Probation at (717) 771-9602.

Completed reports may alternatively be FAXED to YADAC at 717-771-9709.

YADAC 2/21/17; 9/21/17

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# FISCAL INFORMATION

# FEE FOR SERVICE INVOICE REPORT HDA310

- Invoices for services rendered are due by the 15<sup>th</sup> day of the month following the services rendered.
- As YADAC is the payer of last resort, any insurance must be billed first.
- Denials must be retained in charts and presented upon request.
- Unique client numbers are created using the last initial, the first initial and the last four digits of a individual's social security number.
- Any unusual approvals by the SCA must be sent with the billing

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HDA310 (HDA)  
FEE FOR SERVICE INVOICE REPORT  
York/Albany Drug & Alcohol Commission (DAC)

Report No. \_\_\_\_\_  
Pay Period \_\_\_\_\_

Client Number	Primary Response	Type of Service	Dates		Rate	Total Cost	Client Pmt	Client Health Insurance	Medical Assistance	Other Aid/Help	Total Fees	Client Pmt SCA
			Start/End	Start/End								
Columns Totals												



# TIPS

- Please call YADAC with any unusual circumstances.
- Please call YADAC if there is any question about whether funding is available or not.
- SCA paperwork should follow the individual to the next level of care as outlined in our [T-13 Policy](#).
- Please use our [Level of Care Assessment & Continuum of Care Process](#) flow chart as a guide to the above T-13 tip.