

DIRECTIONS/DEFINITIONS

Please note, individuals waiting for dual services should be documented on the Weekly Substance Abuse Capacity Report and not

Total Agency Capacity' Section Definitions:

1. 'Total agency capacity' is the total number of beds or slots that are available in the region, regardless of payer source.
2. 'Total agency capacity used today' is the total number of beds or slots in the region that are filled on the last day of the reporting period of payer source.
3. '% of total agency capacity' is the total number of beds or slots in the region that are filled on the last day of the reporting period divided by the total number of beds or slots available in the region (column d). Agencies are to use this column to determine if they have reached their total agency capacity.

Region Capacity' Section Definitions:

1. 'Total region capacity' is the total number of beds or units per service type under contract with the regional authority. Regional capacity for services is generally purchased in units or under non-fee for service expenses, not beds. This number should be consistent and any flex in capacity will be reflected in the 'total region capacity used today' (which may be higher than 'total region capacity' at time of reporting). This should not include Medicaid matched services.
2. 'Total region capacity used today' is the total number of beds or units per service type under contract with the regional authority of the reporting period. This should not include Medicaid matched services.
3. '% of region capacity' is the total number of beds or units per service type under contract with the region that are filled on the last day of the reporting period (column h) divided by the total number of beds or units per service type available in the region (column g). This should not include Medicaid matched services.

Waiting List' Section Definitions:

1. 'Total # on waiting list' is the number of individuals on the waiting list on the last day of the reporting period per service type, regardless of payer source.
2. '# eligible for regional reimbursement' is the number of individuals on the waiting list on the last day of the reporting period per service type and determined to be financially eligible for regional reimbursement.
3. 'Priority Levels' are the number of individuals on the waiting list on the last day of the reporting period that fall within each priority level. These numbers should be reported separately for both the total number of individuals on the waiting list on the last day of the reporting period and the number of individuals eligible for regional reimbursement. Priority populations are based on federal and state statutes and/or regulations for admission into treatment services. Contracted providers receiving Substance Abuse Block Grant Funds must offer priority population admission into the appropriate recommended treatment, or priority placement on the waiting list and the provision of interim services upon request for treatment and until they are admitted into the appropriate recommended treatment. Please note that to fall into the 'priority' population level categories, an individual must currently be 1) injecting drugs intravenously, or 2) seeking treatment for intravenous drug use right now (e.g., temporarily abstaining yet still waiting for services).

'Faith-based requests/charitable choice' is the total number of requests made by an individual based on their faith. The type of request is for an otherwise eligible individual objects to the religious character of a SAMHSA-funded service provider, the individual is entitled to receive services from an alternative provider. In such cases, the state or local agency must provide the individual with alternative services as soon as possible. The alternative provider must be reasonably accessible and have the capacity to provide comparable services to the individual. Such services should be of equal or greater value than the value of the services that the individual would have received from the program to which they had such objection, as defined by the Department of Health. The alternative provider need not be a secular organization. It must simply be a provider to which the recipient has no religious objection. Appropriate state or local governments that administer SAMHSA-funded programs shall ensure that notice of their right to alternative services is provided to all individuals.

t documented on this form.

period (Sunday), regardless

(column e) divided by the total
90% of total treatment capacity.

capacity for non-residential
and not vary week to week. Any
services).
that are filled on the last day

last day of the reporting period
include matched Medicaid services.

regardless of payer source.
service type who are assessed

by population level.
reporting period and the
regulations and require priority
evaluations either immediate
services within 48 hours of the
"P/IV" or the "IV" priority
substance drug use but not using

request should be noted. If an
alternative services from an
available. The alternative
services all have a value that is not less
than that provided by the Division of Behavioral
Health Services. The
request for services is provided to