FORM ORT-1
REVISED 03/2014

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2014

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2011 ANNUAL REPORT FOR OPIATE REPLACEMENT TREATMENT FACILITIES

Mailing Address: _____ (STREET ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Physical Address: _____ (STREET ADDRESS) _____ (CITY) **AL** _____ (ZIP)

County of Location: _____

Facility Telephone: _____ (AREA CODE) & TELEPHONE NUMBER **Facility Fax:** _____ (AREA CODE) & TELEPHONE NUMBER

This reporting period is for January 1, 2011, through December 31, 2011*; or for **partial** year of operation beginning _____ (MONTH DAY) and ending _____ (MONTH DAY) a period of _____ days.

*Data for the agency's fiscal year, other than the time frame specified, may be provided, but no more than 12 months of consecutive data should be reported. ***If there was a change in ownership during the reporting period, data for the full year should be reported by the current owner.***

We hereby affirm and attest that the reported information has been verified, and to the best of our knowledge, the information contained in the following pages of this report is a true and accurate representation of the services, equipment, and utilization of this facility.

PRINTED NAME OF PREPARER	SIGNATURE OF PREPARER	DATE
DIRECT TELEPHONE NUMBER	TITLE OF PREPARER	E-MAIL ADDRESS

A member of administration <u>MUST</u> also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above.

PRINTED NAME OF ADMINISTRATION OFFICIAL	SIGNATURE OF ADMINISTRATION OFFICIAL	DATE
DIRECT TELEPHONE NUMBER	TITLE OF ADMINISTRATION OFFICIAL	E-MAIL ADDRESS

FOR OFFICE USE ONLY

Facility Verified:		Initial Scan:		Completed:	
Entered:		Final Scan:		Audited:	

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OWNERSHIP (check one)

_____ Corporation	_____ Non-Profit Organization	_____ Partnership
_____ Individual	_____ Healthcare Authority	_____ LLC
_____ Joint Venture	_____ Government	_____ Other

Does this facility operate under a management contract? _____ Yes _____ No

Management Firm: _____
NAME

_____
BASE ADDRESS CITY STATE ZIP

List the total patient census on the FIRST day of the reporting period _____

List the total number of admissions during the reporting period _____

List the total number of discharges during the reporting period _____

I. ADMISSIONS

A. Admissions by age and gender

	Male	Female	Total
0-17 Years			
18-34 Years			
35-54 Years			
55-64 Years			
65-74 Years			
75-84 Years			
85+ Years			
Totals			

B. Admissions by race

a. White/Caucasian	
b. Black/African American/Negro	
c. Hispanic/Spanish/Latino	
d. Asian	
e. American Indian/Alaskan Native	
f. Pacific Islander	
g. India	
h. Middle Eastern	
i. Other (specify) _____	
Totals	

C. Admissions by source of payment

a.	Self Pay	_____
b.	Medicaid/SCHIP	_____
c.	Private Insurance	_____
d.	No Charge (charity & other free care)	_____
e.	Other (specify) _____	_____
TOTALS		_____

D. Admissions by source of referral

a.	Criminal Justice/DUI	_____
b.	Healthcare/Community	_____
c.	Self/Family	_____
d.	Other (specify) _____	_____
TOTALS		_____

E. Admissions by primary source of addiction

a.	Heroin	_____
b.	Buprenorphine	_____
c.	Hydrocodone	_____
d.	Oxycodone	_____
e.	Demerol (meperidine)	_____
f.	Dilaudid (hydromorphone)	_____
g.	Fentanyl	_____
h.	Other	_____
	TOTALS	_____

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F. Admissions by county of residence (If unable to determine patient county of residence, fill out section VI on page 8)

County	Methadone Treatment Admissions	Other Modality Admissions	Total Admissions
TOTALS			

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II. Methadone Maintenance Therapy

A. Utilization

	Methadone Maintenance Therapy	Total Patients
1. Patient Census on FIRST day of reporting period	_____	_____
2. Total Admissions	_____	_____
a. Criminal Justice/DUI	_____	_____
b. Healthcare/Community	_____	_____
c. Self/Family	_____	_____
d. Other	_____	_____
3. Total Discharges	_____	_____
a. Completed Treatment	_____	_____
b. Transferred to further treatment	_____	_____
c. Dropped out of treatment (voluntary)	_____	_____
d. Treatment Terminated by facility	_____	_____
e. Other	_____	_____
1. Death	_____	_____
2. Arrest	_____	_____
3. Unknown/Other	_____	_____

B. Length of Stay (based on all active patients on the LAST day of the reporting period)

	Methadone Maintenance Therapy	Total Patients
0-30 Days	_____	_____
30-60 Days	_____	_____
60-90 Days	_____	_____
90-120 Days	_____	_____
120-180 Days	_____	_____
180-365 Days	_____	_____
366 or more Days	_____	_____

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III. DISCHARGES

A. Discharges by Category and Length of Stay

	0-180 days	181-365 days	366 or more days
a. Completed Treatment – Methadone Patients	____	____	____
b. Completed Treatment – Other Patients	____	____	____
c. Transferred to further treatment – Methadone Patients	____	____	____
d. Transferred to further treatment – Other Patients	____	____	____
e. Dropped out of treatment (voluntary) – Methadone Patients	____	____	____
f. Dropped out of treatment (voluntary) – Other Patients	____	____	____
g. Treatment terminated by facility – Methadone Patients	____	____	____
h. Treatment terminated by facility – Other Patients	____	____	____
i. Other			
1. Death – Methadone Patients	____	____	____
2. Death – Other Patients	____	____	____
3. Arrest – Methadone Patients	____	____	____
4. Arrest – Other Patients	____	____	____
5. Unknown/Other – Methadone Patients	____	____	____
6. Unknown/Other – Other Patients	____	____	____
TOTALS	____	____	____

B. Discharges by Modality of Treatment

a. Methadone	_____
b. Buprenorphine	_____
c. Other medication	_____
d. Non-medical	_____
e. Other	_____
TOTAL	_____

C. Discharges by Number of Prior Treatments

a. 0 Prior Treatments	_____
b. 1 or more Prior Treatments	_____
TOTAL	_____

IV. SERVICES OFFERED

Services	Yes	No
a. Drug Testing	_____	_____
b. Individual Counseling	_____	_____
c. Occupational Training/Placement	_____	_____
d. Education Training/Placement	_____	_____
e. Group Counseling	_____	_____
f. Other (specify) _____	_____	_____

V. EXPENSES AND REVENUES

a. Total Revenues	_____
b. Total Expenses	_____
c. Total Bad Debt	_____
d. Total Charity Care	_____

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VI. Admissions by Zip Code of Residence

(Please fill out this section ONLY if your facility currently does not have the capability of filling out section I-F above (admissions by county of residence). The information provided below will NOT be a part of any published dataset, and will be used by the Agency only to assign patients to their county of residence according to their zip code. Make additional copies of this sheet as required to complete the report.)

Zip Code	Methadone Treatment Admissions	Other Modality Admissions	Total Admissions
TOTALS			