Primary Program OTP No:

Program Name:

Program Address:

Primary Clinical Contact for Operations:

Telephone:                         Fax:                            E-mail:

Medication Unit OTP No:

Program Name:

Program Address:

Primary Clinical Contact for Operations:

Telephone:                         Fax:                            E-mail:

Nature of Request:

   **Comments:** (Please justify the use of telecounseling at your organization.)

Patient Considerations:

How will your organization decide whether each patient is an appropriate fit for telecounseling?

   **Comments:**
What policies and procedures will you have in place to ensure that patients understand what telecounseling entails? That the service is voluntary? That the service is patient-centered? When the service should be discontinued? (Please attach any relevant policies or procedural manuals to this application.)

Comments:

What crisis services will be available to this patient at the primary OTP and at the medication unit?

Comments:

What recovery supports will be available to this patient at the primary OTP and at the medication unit?

Comments:

Describe the space in which the person will receive teleconferencing at the medication unit.

Comments:

How will you train your staff to perform telecounseling? Will these staff have to meet any special qualifications (e.g., 3 years counseling experience) How will these staff be supervised?

Comments:

How will primary OTP telecounseling staff and medication unit medical staff communicate any concerns to the medical staff at the primary OTP?

Comments:

Please provide the name and licenses for each person at the primary OTP performing telecounseling with patients at the medication unit. Attach a copy of each practitioner’s curriculum vitae.

Comments:

Please explain the type of tele-equipment you will be using and whether it is compliant with all federal and state regulations (e.g., HIPPA).

Comments:

Do you have any other comments about telecounseling at this organization?

Comments:

Submitted By
Name of Sponsor    Signature of Sponsor    Date    

Name of Medical Director    Signature of Medical Director    Date    

State Response to Request    State Opioid Treatment Authority    Date    

☐ Approved
☒ Denied

Comments:

Federal Response to Request    Center for Substance Abuse Treatment    Date    

☐ Approved
☒ Denied

Comments:

Date of Approval:    /    /    . Telecounseling Expiration Date:    XX/XX/20**

**A continuing telecounseling request must be filed simultaneously with submission of a SMA-162 for SAMHSA OTP recertification.