IMPORTANT

Australian Government
Department of Veterans' Affairs

Prior Approval Request for Treatment of Alcohol and Other Drug Use (AOD)

Please send completed form and supporting documentation to: health.approval@dva.gov.au

This form is to be used for requesting prior financial authorisation to provide treatment relating to substance use to eligible Department of Veterans' Affairs (DVA) clients.

DVA strongly encourages the use of contracted hospitals in the first instance. Treatment at contracted hospitals does not require prior approval, however you can complete this form to confirm whether the requested facility has contractual relationship with DVA, and whether the requested treatment is covered under that contract. Contracted hospitals can be found at http://www.dva.gov.au/providers/hospitals-and-day-procedure-centres

IMPORTANT:

- Residential treatment is not suitable or required for all DVA clients with alcohol and other drug use presentations. Residential rehabilitation treatment programs are suitable for individuals with a long history of chronic alcohol use and who are severely dependent, individuals with alcohol (or other substance) dependence who do not have social networks or supports that would support reduced use or abstinence, and individuals with substance dependence who are unable to support themselves financially.
- Where residential treatment is required, consideration will be given to the availability of LOCAL contracted hospitals in the first instance. 'Local' means in the veteran's local area.
- Consideration will be given to the availability of LOCAL non-contracted residential treatment in the second instance.
- Only under exceptional circumstances will a non-local, non-contracted facility be considered suitable and appropriate for treating the veteran's presenting issue.

There must be a referral attached to this request. This must be from a medical practitioner.

For further information and support to complete this form please contact the Provider Hotline Number: **1800 550 457**.

If you do not have access to email please post the completed form to:
Health Approvals & Home Care team, Department of Veterans' Affairs, GPO Box 9998 Brisbane QLD 4001.

Privacy notice – The privacy and security of personal information is protected by law, including the *Privacy Act 1988*. The DVA collects and uses personal information to deliver government programs to war veterans, serving and former serving members of the Australian Defence Force, Australian Federal Police and their families.

We are collecting this information so that we can process an eligible person's application and provide services to them accordingly. We will only disclose personal information with other parties where we have the consent of the individual, or where the law authorises or requires it. For more information about how we mange personal information, including our privacy policy, see https://www.dva.gov.au/about-us/overview/legal-resources/privacy.

The provider is responsible for ensuring that the client is aware that their personal information is to be forwarded to DVA for determining and/or providing the benefits under relevant legislation. The information will be treated in a confidential manner. However, it may be used for clinical review, audit or management purposes or disclosed to the client's general practitioner.

In assessing whether requests for residential treatment are clinically justified there are certain considerations that DVA will take into account. Please tick No or Yes as appropriate to the items below:

a. **The provider is aware of evidence-based practice guidelines such as the *2021 National Guidelines for the Treatment of Alcohol Problems*.** No ☐ Yes ☐

b. **The facility must provide services in accordance with all relevant Australian Standards and comply with national and state/territory laws, regulations, professional codes, licensing requirements, good industry practice and any relevant industry codes, policies and guidelines including compliance with the National Quality Framework for Drug and Alcohol Treatment Services.** No ☐ Yes ☐

c. **A medical practitioner will be either resident at the facility or provide services on a formalised visiting basis.** No ☐ Yes ☐

d. **Evidence-based treatment must comprise the majority of the whole program offered to clients (if therapy adjuncts such as yoga and exercise are included in the program, their use needs to be justified and cohesive and a minor part of the program).** No ☐ Yes ☐

e. **The facility must gather quantitative evidence of its effectiveness in treating psychological and/or substance use disorders (such as DASS, ASSIST, AUDIT, K10, SDS). Does the program utilise pre, post and follow-up measures for assessing the clinical outcomes achieved?**

Note: If an extension is requested or there is a re-presentation of the same client within 12 months of treatment, the facility will be required to provide outcome measures for the client.

No ☐ Yes ☐

If No, the request **will not** be considered.

f. Discharge summaries must be provided by the facility to treating health professionals. These should include a summary of presenting issues, the progress made by the client, quantitative test results, medication and prescriptions provided, a summary of the participant's current status, and recommendations for follow up treatment.

Will discharge summaries outlining the above be provided? No ☐ Yes ☐

g. **Does the program have an ongoing risk assessment and risk management system?** No ☐ Yes ☐

h. **Does the program have policies and procedures in place to manage a client's unplanned exit from a Treatment Program?** No ☐ Yes ☐

In the event of an unplanned exit from a Treatment Program, the provider must also provide an Unplanned Exit Report to the Entitled Person's Health Professional which should include:

- details of planned re-engagement attempts
- harm reduction advice given to the Entitled Person upon exiting the Treatment Program
- arrangements for transport home or to a safe environment, and
- the Entitled Person's risk assessment, including any details of the Entitled Person's intentions.

DVA Assurance Process – DVA may request, as part of the DVA assurance process, evidence of compliance with the above. Failure to comply will result in the request being declined.

The following information is required for DVA to consider prior approval requests for AOD treatment service.

Referrer's details (must be a medical practitioner)

1. **Referrer name**
2. **Provider number**
3. **Name of referrer's practice/ facility**
4. **Contact number** (including area code if applicable)
5. **Email**
6. **How long has client been a patient?**

Details of facility/provider offering treatment

7. **Name of provider or facility**
8. **Contact person**
9. **Provider number** (if applicable)
10. **Contact number** (including area code if applicable)
11. **Address of facility** Postcode
12. **Email**
13. **ABN**

Entitled person's details

14. **DVA file number**
15. **Surname**
16. **Given name(s)**
17. **Date of birth** (DD/MM/YYYY)
18. **Card type**
    - ☐ Gold
    - ☐ White – Relevant conditions
19. **Does the entitled person have a DVA case manager?**
    - No ☐ Unsure ☐
    - Yes ☐ ▶ Provide details

The information provided should constitute a comprehensive diagnostic assessment.
If there is insufficient space please attach additional details.

20. Current drug use

Type (e.g. alcohol, opioids)	Frequency and quantity	Duration of use at current levels

21. Previous drug usage

Type (e.g. alcohol, opioids)	Frequency and quantity	Duration of use at previous levels

22. Treatment history

Provider type (e.g. medical practitioner)	Treatment type (specific medication, type of therapy e.g. CBT, EMDR)	Period of treatment	Outcome of treatment

23. Current prescribed medications

Medication	Dose	Period of treatment

24. Current mental health conditions/diagnoses

25. Summary of impact of substance use on sociological factors
(e.g. work, family, social life)

26. Clinical justification for admission to an AOD residential facility

27. Justification for why a contracted hospital is not being used

28. Any other identified risks/issues?
(e.g. homelessness, violence)

☐ Homelessness ☐ Mental health ☐ Suicidal thoughts/attempts
☐ Violence/abuse ☐ Self harm ☐ Disrupted relationship

Provide additional information if necessary

29. Provide details of all staff providing treatment, including their qualifications, in the table below.
If there is insufficient space please attach additional details.

Note: As a minimum acceptable standard for provision of DVA AOD programs all staff must have a Certificate IV in AOD treatment, as well as a First Aid certificate and Working With Vulnerable People check. For staff in professional roles such as psychologists and nurses they must be registered with the appropriate regulatory body such as AHPRA.

Name	Role	Relevant Qualifications (e.g. Cert IV, First Aid, WWVP, Diploma, Bachelor Degree, Masters)

Details of services requested

30. Provide the following details
Note: DVA may only be billed for days attended.

	Name of Provider/Program	Length of Program (if applicable) hours/day or no. of days	Start date (if applicable) (DD/MM/YYYY)	End date (if applicable) (DD/MM/YYYY)	Cost	Item number (if applicable)
Assessment					$	
Withdrawal Management (if claiming)					$	
Residential Rehabilitation Accommodation					$	
Dual Diagnosis Treatment					$	
Supported Accommodation					$	
Group Day Programs					$	
Post Discharge Follow up					$	
Counselling					$	
Other (please provide detail)					$	
				Total cost	$	

31. Please **attach** a copy of the facility's program information including a timetable of daily program activities and treatments, as well as **transition program information and activities**. This should include a detailed step-down plan incorporating connection to community supports, assistance with accommodation, regular follow-up, and connection to ongoing treatment (which may include Open Arms individual and/or family interventions). Requests without this information will be considered incomplete and declined.

Additional information

32. Additional relevant information (e.g. details on other identified risk factors, Family Support)

Declaration

33. I declare that:

- ☐ the eligible person has given consent that I can disclose medical information about them to the DVA for the purpose of processing this application.
- ☐ the information contained in this form is correct and accurate to the best of my knowledge.
- ☐ I agree to be contacted about this application should the DVA need to clarify any of the facts or evidence provided in this form.

34. Details of person completing this form

Name

Position

Contact

Date (DD/MM/YYYY)

Please ensure all information provided is clearly written, complete and correct as missing or incorrect information, including clinical justification for request, may delay the processing of your request.

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