ILLINOIS DEPARTMENT OF HUMAN SERVICES
Division of Alcoholism and Substance Abuse
AUTOMATED REPORTING AND TRACKING SYSTEM
HOURLY REPORTING (ASSESSMENT, INTERVENTION, CASE MANAGEMENT, LEVEL I AND LEVEL II, HIV, INTERPRETER)

PROVIDER: [_________]
UNIT: [_________]
PROGRAM: [_________]

SITE NUMBER: [_________]

STAFF ID: [_________________]
SERVICE DATE: [____]/[____]/[____]

PATIENT #1
Funding Code: [_________]
Unique Patient Identifier: [_________________]
Service Type: [____]
Activity Code: [____]
Group ID: [_________]
Start Time: [____]:[____] am/pm
Length of Service: [____] Hrs: [____] Mins: [____]
Collateral ID: [_________________]
Video Counseling: [____]

Medicaid Billing Data
Spend Down: [_________]

TPL Information
TPL Status: [____]
TPL Payer Amount: [_________]

TPL Paid Date: [____]/[____]/[____]

Dedicated Funding Category: SELECT ONLY ONE

☐ D = DCFS
☐ L = Gambling
☐ N = None
☐ O = OMT-STR

PATIENT #2
Funding Code: [_________]
Unique Patient Identifier: [_________________]
Service Type: [____]
Activity Code: [____]
Group ID: [_________]
Start Time: [____]:[____] am/pm
Length of Service: [____] Hrs: [____] Mins: [____]
Collateral ID: [_________________]
Video Counseling: [____]

Medicaid Billing Data
Spend Down: [_________]

TPL Information
TPL Status: [____]
TPL Payer Amount: [_________]

TPL Paid Date: [____]/[____]/[____]

Dedicated Funding Category: SELECT ONLY ONE

☐ D = DCFS
☐ L = Gambling
☐ N = None
☐ O = OMT-STR

EFFECTIVE 07/01/17 – 06/30/18