Questionnaire: PNMI Referral

Office of Behavioral Health PNMI REFERRAL/APPLICATION

1. Marital Status
(Please select one.)
   - ○ Single
   - ○ Married
   - ○ Domestic Partner
   - ○ Divorced
   - ○ Widowed

2. Income Source

3. If no income source has client applied for social security?
(Please select one.)
   - ○ Yes
   - ○ No

   3.1.1. Date of Application:
   3.1.2. Status of Application:

4. Amount

5. What is the consumers MaineCare Status?
(Please select one.)
   - ○ Active MaineCare
   - ○ Applied/Pending
   - ○ Spend Down
   - ○ Other Insurance

   5.3.1. Date applied

   5.4.1. Amount

   5.4.2. Deductible dates

6. Has member applied for Housing Subsidy (BRAP, Shelter + Care, Section 8)?
(Please select one.)
   - ○ Yes
   - ○ No

   6.1.1. Program:

   6.1.2. Date applied
   6.1.3. Status:

7. Referral Source

8. Referent name, phone number, and email address

9. Consumer Area Housing Preference (check all that apply)
(Please select between 1 and 16 items.)
   - ☐ Aroostook
   - ☐ Hancock
   - ☐ Washington
   - ☐ Penobscot
   - ☐ Piscataquis
   - ☐ Kennebec
   - ☐ Somerset

- ☐ Knox
- ☐ Lincoln
- ☐ Sagadahoc
- ☐ Waldo
- ☐ Androscoggin
- ☐ Franklin
- ☐ Oxford
- ☐ Cumberland
- ☐ York

10. Referral is for (Primary PNMI program choice)

11. (Secondary Choice)

12. Reason for referral (Please include symptoms and behaviors (frequency, intensity, and duration) that support the level of care requested)):

13. Does the consumer have any special considerations/needs/accommodations to be considered for this referral? (Please select one.)
    - ○ Yes
    - ○ No

    13.1.1. Please select and explain need:
    (Please select between 1 and 8 items.)
    - ☐ 1:1
    - ☐ Handicap Accessible
    - ☐ Medical Monitoring
    - ☐ Other
    - ☐ On Sex Offender Registry
    - ☐ Needs all male program
    - ☐ Needs all female program
    - ☐ IST/NCR Status

    13.1.1.2.1. Please explain need:

    13.1.1.3.1. Please explain need:

    13.1.1.4.1. Please explain need:

    13.1.1.5.1. Please explain need:

    13.1.1.6.1. Please explain need:

    13.1.1.7.1. Please explain need:

    13.1.1.8.1. Please explain need:

    13.1.1.9.1. Please explain need:

13.2.1. Please explain need:

14. Please note any prior living arrangements and/or periods of homelessness. What worked? What didn't?

15. Does the consumer require ADL assistance?
(Please select one.)
- ○ Yes
- ○ No

15.1.1. What does ADL assistance look like?

16. Assistance or supervision of activities of daily living as needed
(Please select between 1 and 9 items.)
- ☐ Bathing
- ☐ Eating
- ☐ Ambulating
- ☐ Grooming
- ☐ Dressing
- ☐ Toileting
- ☐ Personal Hygiene Activities
- ☐ Performance of incidental household tasks essential to the activities of daily living and to the maintenance of resident health and safety
- ☐ Administration of physician ordered medication

17. Personal supervision or being aware of resident's general whereabouts
(Please select between 1 and 5 items.)
- ☐ Observing or monitoring the resident's general whereabouts
- ☐ Observing or monitoring the resident while on the premises to ensure their health and safety
- ☐ Reminding the resident to carry out activities of daily living
- ☐ Assisting the resident in adjusting to their living environment
- ☐ Specialized community plan-outlines expectations when out in the community

18. Does consumer have their own transportation?
(Please select one.)
- ○ Yes
- ○ No

18.1.1. Please explain

Current Resources and Supports

1. Does consumer have a guardian?
(Please select one.)
- ○ Yes
- ○ No

1.1.1. Select the type of guardian
(Please select one.)
- ○ Public
- ○ Private
- ○ Under Study

1.1.1.4.1. Explain:

1.1.2. Please indicate guardian status
(Please select one.)
- ○ Full
- ○ Limited

1.1.2.3.1. Explain:

1.1.3. Please provide contact information for guardian

2. Does the consumer want the services being requested?
(Please select one.)
- ○ Yes
- ○ No

2.2.1. Explain:

3. Does the consumer have a Rep Payee?
(Please select one.)
- ○ Yes
- ○ No

3.1.1. Rep Payee First and Last Name

3.1.2. Rep Payee Telephone Number

4. Does the consumer have a Case Manager?
(Please select one.)
- ○ Yes
- ○ No

4.1.1. Case manager First and Last Name

4.1.2. Case Management Agency and Telephone Number

5. Does the Consumer have a Primary Care Physician?
(Please select one.)
- ○ Yes ○ No ○ In process, on waitlist

5.2.1. Name of Primary Care Physician

5.2.2. Primary Care Physician Contact Information

6. Family and/or Other Supports?

7. Additional psychosocial information?

8. Does the consumer have family involvement?
(Please select between 1 and 5 items.)
- ☐ Phone Calls
- ☐ Visits
- ☐ Treatment Sessions
- ☐ Other
- ☐ Consumer Refuses

9. Is there family contact information?
(Please select one.)
- ○ Yes
- ○ No

9.1.1. Please provide:

Legal Issues

1. Does the consumer have any current legal issues/charges?
(Please select one.)
- ○ Yes
- ○ No

- ○ No

1.1.1. Explain:

2. Does the consumer have any past legal issues?
(Please select one.)
   - ○ Yes
   - ○ No

2.1.1. Explain:

3. Is the consumer involved with pre-trial?
(Please select one.)
   - ○ Yes
   - ○ No

3.1.1. Explain:

4. Does the consumer have a probation officer?
(Please select one.)
   - ○ Yes
   - ○ No

4.1.1. Please provide contact information for probation officer

5. Does the consumer have conditions of release?
(Please select one.)
   - ○ Yes
   - ○ No

Instructions: Please upload documents

5.1.1. Explain:

6. Does consumer currently have a PTP?
(Please select one.)
   - ○ Yes
   - ○ No

Instructions: Please provide copy of PTP

6.1.1. Explain:

7. Is the consumer involved with the ACT team?
(Please select one.)
   - ○ Yes
   - ○ No

8. Please provide contact information

Diagnosis

1. What is the consumers' current LOCUS score?
Min/Max - 0/100; No decimal places allowed

Instructions: If original date of diagnosis is not known, please enter in the date of the most recent diagnostic assessment

2. Name, credentials and Rater ID of individual completing the LOCUS assessment.

3. Date of diagnosis?
4. Name and credentials of Diagnostician?

5. Does consumer have an Intellectual or Developmental disability diagnosis?
(Please select one.)
   - ○ Yes

- ○ No

6. Are there any areas that are impacting the client's current functioning? (Please select one.)
   - ○ Yes
   - ○ No

   6.1.1. Explain:

   6.2.1. Explain:

7. If yes has the consumer applied for OADS services? (Please select one.)
   - ○ Yes
   - ○ No

   7.1.1. Explain:

   7.2.1. Explain:

8. Has the consumer been approved for OADS services? (Please select one.)
   - ○ Yes
   - ○ No

   8.1.1. Explain:

   8.2.1. Explain:

9. Does consumer have a co-occurring diagnosis? (Please select one.)
   - ○ Yes
   - ○ No

   9.1.1. Explain:

10. Please explain current symptoms:

11. Does consumer have current suicidal ideations? (Please select between 1 and 8 items.)
   - ☐ Yes
   - ☐ No
   - ☐ Ideation
   - ☐ Plan
   - ☐ Means
   - ☐ Intent
   - ☐ Attempt
   - ☐ History of attempts

12. Explain:

13. Does consumer have current homicidal ideations? (Please select between 1 and 8 items.)
   - ☐ Yes
   - ☐ No
   - ☐ Ideation
   - ☐ Plan
   - ☐ Means
   - ☐ Intent
   - ☐ Attempt
   - ☐ History of attempts

☐ History of attempts

14. Explain:

15. Has or is the consumer experiencing psychosis?
(Please select between 1 and 6 items.)
- ☐ Yes
- ☐ No
- ☐ Delusional
- ☐ Paranoid
- ☐ Unable to care for self
- ☐ Other

16. Explain:

17. Has or is the consumer experiencing hallucinations?
(Please select between 1 and 7 items.)
- ☐ Yes
- ☐ No
- ☐ Auditory
- ☐ Olfactory
- ☐ Tactile
- ☐ Taste
- ☐ Visual

18. Explain:

19. Has the consumer experienced depression?
(Please select one.)
- ○ Yes
- ○ No

19.1.1. Has this affected:
(Please select between 1 and 6 items.)
- ☐ Eating
- ☐ Sleeping
- ☐ Energy
- ☐ Isolation
- ☐ Weight Gain
- ☐ Weight Loss

19.1.2. Explain:

20. Are there other areas of risk not previously noted, such as elopement, self-injurious or assaultive behaviors?
(Please select one.)
- ○ Yes
- ○ No

20.1.1. Explain:

21. Does consumer have a co-occurring diagnosis?
(Please select one.)
- ○ Yes
- ○ No

21.1.1. Explain:

22. Substance or Dependence concerns?
(Please select between 1 and 13 items.)
- ☐ Alcohol
- ☐ Cocaine/Crack
- ☐ Marijuana
- ☐ Ecstasy
- ☐ Over the counter medications
- ☐ Sedatives/Hypnotics
- ☐ Opiates/Pain Killers (Heroin, Oxycontin, Oxycodone, others not listed)
- ☐ Tobacco
- ☐ Caffeine
- ☐ Amphetamines/Methamphetamines
- ☐ Benzodiazepines

- ☐ Other street drugs
- ☐ Other

Instructions: Please provide date of onset, current amounts, date of last use

23. Explain:

24. Other pertinent substance use or dependence history
(Please select one.)
    - ○ Yes
    - ○ No

    24.1.1. Explain:

25. Has ASAM been completed?
(Please select one.)
    - ○ Yes
    - ○ No

26. Provide summary of multi-dimensional assessment and date of assessment

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CURRENT AND PRIOR TREATMENT (Mental Health and/or Co-Occurring)

1. Has consumer been hospitalized?
(Please select one.)
    - ○ Yes
    - ○ No

    1.1.1. Please provide Name of hospital(s) and dates

2. Has consumer received outpatient services?
(Please select one.)
    - ○ Yes
    - ○ No

    2.1.1. Please note agency name, provider name and dates of service

3. Please provide any additional information related to inpatient or outpatient services

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Medical History and Updates

1. Please provide medical history to include lab work, know allergies, etc. (Please provide the current medical diagnosis)

2. Please provide any additional medical information, such as:
(Please select between 1 and 6 items.)
    - ☐ Oxygen
    - ☐ CPAP/BiPAP
    - ☐ Sliding scale insulin
    - ☐ Consumer requires hospital bed
    - ☐ Consumer requires first floor accommodation.
    - ☐ Additional durable equipment

3. Explain:

4. Are there visual or hearing impairments?
(Please select one.)
    - ○ Yes
    - ○ No

    4.1.1. Explain:

5. Does the consumer require assistance for visual or hearing impairments?
(Please select one.)
   - ○ Yes
   - ○ No

   Instructions: Explain: Ex.Lights, Sounds, ASL, Interpreter services needed

   5.1.1. Explain:

6. Has the consumer had a brain injury or been diagnosed with a TBI (traumatic brain injury)?
(Please select one.)
   - ○ Yes
   - ○ No

7. Has a referral been completed for the Brain Injury waiver?
(Please select one.)
   - ○ Yes
   - ○ No

   7.1.1. Explain:

8. How does this impact the consumers current functioning?
(Please select one.)
   - ○ Yes
   - ○ No

9. Explain:

10. Please provide current medications, both psychiatric and medical. Please include any recent changes and current prescriber.

11. Please describe consumer's baseline behavior

12. Please describe any concerns for the consumer

13. Please describe any hobbies, interests the consumer has

14. Has consumer had a Maximus/Medxx completed?
(Please select one.)
   - ○ Yes
   - ○ No

   14.1.1. Please provide dates of assessments and results

15. Please list and provide any recent assessments that have been completed within the last three years. This can include assessments from Occupational Therapy, Neuropsychological, Psychosexual, Psychiatric, Psychological, Risk Assessments or any other relevant assessments. (Please include dates and assessor contact information)

Additional Information

1. Where is consumer being referred from?
(Please select one.)
   - ○ DDPC
   - ○ RPC
   - ○ All other psychiatric hospitals
   - ○ IMHU
   - ○ Youth in transition
   - ○ Correctional facility/jail
   - ○ All others in community

2. Does the consumer reside at the address specified on the consumer detail page?
(Please select one.)
   - ○ Yes

- ○ No

2.2.1. Please provide consumer's full current address.

3. Is consumer currently unhoused or experiencing homelessness? (Please select one.)
   - ○ Yes
   - ○ No

4. Please provide consumer's last known full address

5. Please provide known phone number or last known phone number for consumer

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Rules

Instructions: Instructions: To keep this application ACTIVE, please call the Office of Behavioral Health (OBH) as the referent or consumer to follow up every 90 days. Below is the MaineCare rule for Medical Necessity: 10-144 Chapter 101 Department of Health and Human Services MaineCare Benefits Manual Chapter II Section 97 Private Non-Medical Institution Services Established 97.02-2. Medical Necessity Services in PNMI's must be medically necessary, as evidenced by meeting the medical eligibility criteria set forth in this section. A physician or primary care provider must also document in writing that this model of service is medically necessary for the member, and both the physician and the PNMI provider must keep this documentation in the consumer's file. For all PNMI services, this documentation must be completed as part of the prior authorization process conducted by the Department and/or its authorized agent. Additional PNMI provider requirements: Accept all referrals from the Department through the Acentra online portal within three (3) business days of receipt of referral. Note: Section 277of the Bates v. DHHS Consent Decree does not allow for the denial of a referral without the Department's approval. Any such denial, which has not been approved, is a violation of this agreement and may result in termination of this agreement. Contact the consumer being referred and/or the legal guardian within five (5) business days of receipt of this referral. Confirm through the Acentra online portal once contact with consumer or referrant has been made. Admit all individuals to the PNMI within thirty (30) calendar days and submit the prior authorization through the Acentra online portal.
