Questionnaire: CCBHC

CCBHC

1. Is this request a new treatment/episode of care?
(Please select one.)
   - ○ Yes
   - ○ No

2. Does the member require an interpreter?
(Please select one.)
   - ○ Yes
   - ○ No

   2.1.1. What language and dialect will the interpreter need to know?

3. What was the date of referral?
4. Was this person holding for service?
(Please select one.)
   - ○ Yes
   - ○ No

   4.1.1. Since which date was the consumer holding for service:
   4.1.2. Date Case Worker assigned:
   4.1.3. Date seen face to face:

5. Has the member received treatment in a state psychiatric hospital (Riverview, and/or Dorothea Dix Psychiatric Center) within the past 24 months, for a non-excluded DSM 5 diagnosis?
(Please select one.)
   - ○ Yes
   - ○ No

   5.1.1. Provide the dates:

General Questionnaire

Instructions: CLINICAL PRESENTATION

1. Is this request a new treatment/episode of care?
(Please select one.)
   - ○ Yes
   - ○ No

2. Please discuss member's current presentation; symptoms, and behaviors (frequency, intensity, and duration) that support the level of care request at this time:

3. Provide a description of how the provider will use the requested units (breakdown of units) in this requested review period:

4. What has been the progress toward goals?
(Please select one.)
   - ○ None
   - ○ Minimal
   - ○ Moderate
   - ○ Significant

   4.1.1. Please provide barriers to progress and interventions to overcome barriers

   4.2.1. Please provide barriers to progress and interventions to overcome barriers

5. Is member engaged in treatment?
(Please select one.)
   - ○ Yes
   - ○ No

Instructions: REQUIRED – Date of Diagnostic Assessment must be a date in the following format MM/DD/YYYY. Please do not enter a date in any other format.

6. What is the date of the most current diagnostic assessment?
7. Are there any medication changes since last request?
(Please select one.)
   - ○ Yes ○ No ○ N/A

8. What are the symptoms since last review? Please select all that apply

☐ Activities of Daily Living (ADL)	☐ Aggression	☐ Agitation	☐ Appetite Impairments	☐ Anxiety	☐ Auditory Hallucinations	☐ Capacity for Independent Living	☐ Delusions
☐ Has met pharmacological criteria of substance use	☐ Gustatory Hallucinations	☐ Homicidal Ideation	☐ Learning	☐ Impaired control regarding substance use	☐ Memory Impairments	☐ Mood	☐ Mobility
☐ Mood Swings	☐ Paranoia	☐ Olfactory Hallucinations	☐ Physical Aggression	☐ Problem Sexualized Behaviors	☐ Racing Thoughts	☐ Risk/Danger to others	☐ Risk/Danger to self
☐ Risky Use of Substances	☐ Self-Care	☐ Self-Harm	☐ Self-Direction	☐ Tactile Hallucinations	☐ Thought Disorganization / Disturbance	☐ Sensory Hallucinations	☐ Sleep Impairments
☐ Social impairment regarding substance use	☐ Suicidal Ideation	☐ Understanding and use of language	☐ Verbal Aggression	☐ Visual Hallucinations			

Instructions: DISCHARGE PLANNING: A discharge plan should include a specific plan to decrease utilization, refer to appropriate level of care, and indicate the use of natural supports.

9. What is the discharge/transition plan? (explain measurable criteria for discharge or decrease in utilization of units)

10. What is the projected discharge/transition date?

Instructions: GENERAL

11. Select the member"s current living situation:
(Please select one.)

○ Assisted Living Facility	○ Community Residential Facility	○ Dorothea Dix	○ Foster Care
○ Homeless Shelter or on the Streets	○ Hospitalized for Medical Reasons	○ Incarcerated in a State Prison or County Jail	○ Nursing Home
○ Other Psychiatric Inpatient Unit or Facility	○ Own Apartment or Home	○ Residential Crisis unit	○ Residential Treatment Facility (Group Home Arrangement)
○ Riverview Psychiatric Center	○ Supported Apartment	○ School Based	○ Temporarily staying with others
○ Staying With Others	○ Other		

12. Select the member"s current vocational/employment status:
(Please select one.)

○ Clubhouse Transitional Employment	○ Competitively employed full-time (32 or more hours per week)	○ Competitively employed part-time (Less than 32 hours per week)
○ Not employed - looking for work	○ Not employed - not looking for work	○ Self-employed
○ Not Employed - stay home parent	○ Stay-at-home parent of a child under the age of 18	○ Retired
○ Student	○ Veteran	○ Volunteer on a regular basis (in the last 30 days)
○ Volunteer	○ Working with supports full-time (32 or more hours per week)	○ Working with supports part-time (Less than 32 hours per week)

13. Is this member of transition age (16-20 years)?
(Please select one.)
   - ○ Yes
   - ○ No

   13.1.1. What is the member"s current grade level?
   (Please select one.)
      - ○ 9
      - ○ 10
      - ○ 11
      - ○ 12
      - ○ College
      - ○ Technical College
      - ○ Not in school

   13.1.2. In the past three (3) months has attendance at school been an issue for this member?
   (Please select one.)
      - ○ Yes
      - ○ No

   13.1.3. Was this member involved with the Department of Corrections within the past six (6) months?
   (Please select one.)
      - ○ Yes
      - ○ No

14. If the member has a guardian, is the guardian engaged in treatment?
(Please select one.)
- ○ Yes
- ○ No
- ○ N/A

14.2.1. Describe the barriers to engagement:

15. Does the member require an interpreter?
(Please select one.)
- ○ Yes
- ○ No

15.1.1. What language and dialect will the interpreter need to know?

Adult / Child Selection

1. Is this request for an adult or child?
(Please select one.)
○ Adult ○ Child

1.3.1. Date Referral was received (Ages 0-5: Ages 0-5: ASQ-SE was offered)
(Please select one.)
○ Completed ○ Not Completed

1.3.2. Screenings completed:
(Please select one.)
○ Ages 6-17 Pediatric ○ Ages 12-18 PHQ-9M ○ Ages 12-22 CRAFFT 2.1+N (SBIRT) ○ All Ages SDOH: PRAPARE

1.3.2.2.1. Completed by another provider within XX days?
(Please select one.)
- ○ Yes
- ○ No

1.3.2.2.1.1.1. By whom

1.3.2.2.1.1.2. Outcome

1.3.2.2.2. Positive / Negative (choose one)
(Please select one.)
○ Positive ○ Negative

1.3.2.3.1. Positive / Negative (choose one)
(Please select one.)
○ Positive ○ Negative

1.3.2.4.1. Positive / Negative (choose one)
(Please select one.)
○ Positive ○ Negative

1.3.2.5.1. Criteria (Z-Code)
(Please select one.)
○ Experiencing Homelessness (Z59 – Problems related to housing and economic circumstances) ○ Current Involvement with Justice System (Z64 – Problems related to certain psychosocial circumstances) ○ Current Involvement with Child Welfare System (Z63 – Other problems related to primary support group, including family circumstances) ○ Currently in ED/Hospital/Residential (Z65 – Problems related to other psychosocial circumstances) ○ Other not indicated above

1.3.2.5.1.6.1. Please list other relevant Z-Code not listed above

1.3.3. Other Assessments Completed
(Please select between 0 and 5 items.)
□ BioPsychoSocialSpiritual Comprehensive Assessment □ Adaptive Behavior/Functional Assessment Scale (i.e. Vineland, CAFAS, ABAS, etc.) □ CALOCUS-CASii (as indicated) □ Functional Behavioral Assessment (FBA) □ Other

1.3.3.2.1. By whom

1.3.3.2.2. Credentials

1.3.3.2.3. Date Completed

1.3.3.3.1. By whom

1.3.3.3.2. Credentials

1.3.3.3.3. Date Completed

1.3.3.4.1. By whom

1.3.3.4.2. Credentials

1.3.3.4.3. Date Completed

1.3.3.5.1. By whom

1.3.3.5.2. Credentials

1.3.3.5.3. Date Completed

1.3.3.6.1. By whom

1.3.3.6.2. Credentials

1.3.3.6.3. Date Completed

1.3.4. Psychotropic Medications Prescribed
(Please select one.)
- ○ Yes
- ○ No

1.3.4.1.1. Prescriber

1.3.4.1.2. Date

1.3.4.1.3. To treat symptoms of dx

1.3.5. Other Active Services at time of referral (indicate provider)
(Please select one.)
○ Children's ○ ○ ○ ○ Home ○ Multi ○ ○ Children's ○ Rehabilitative ○ ○ Children's ○ Children's ○ ○ ○ ○ ○ ○

Behavioral Health Home Organization (CBHHO)	Targeted Case Management	Outpatient	Medication Management	Home and Community Treatment (HCT)	Multi-Systemic Therapy (MST/MST-PSB)	Functional Family Therapy (FFT)	Children's Assertive Community Treatment (ACT)	Rehabilitative and Community Support (RCS) Services	Day Treatment (School)	Children's Residential Care Facility (CRCF)	Children's Crisis Stabilization Unit (CCSU)	Children's Psychiatric Hospital	Youth Peer Support	Substance Use Disorder Treatment	Hi-Fidelity Wrap-Around	Adolescent DBT	Other

1.3.5.2.1. Indicate Provider

1.3.5.3.1. Indicate Provider

1.3.5.4.1. Outpatient:
(Please select one.)
○ Office ○ Home ○ School

1.3.5.4.2. Indicate Provider

1.3.5.5.1. Indicate Provider

1.3.5.6.1. Indicate Provider

1.3.5.7.1. Indicate Provider

1.3.5.8.1. Indicate Provider

1.3.5.9.1. Indicate Provider

1.3.5.10.1. Rehabilitative and Community Support (RCS) Services
(Please select one.)
○ In home ○ In school ○ Specialized

1.3.5.10.2. Indicate Provider

1.3.5.11.1. Indicate Provider

1.3.5.12.1. Indicate Provider

1.3.5.13.1. Indicate Provider

1.3.5.14.1. Indicate Provider

1.3.5.15.1. Indicate Provider

1.3.5.16.1. Indicate Provider

1.3.5.17.1. Indicate Provider

1.3.5.18.1. Indicate Provider

1.3.5.19.1. Indicate Provider

1.3.6. Preliminary Triage Disposition
(Please select one.)
○ Crisis (Immediate access to Care) ○ Urgent (access to Care within one day) ○ Routine (Access to Care within 10 days)

1.3.7. Initial Assessment Care Disposition
(Please select one.)

Crisis Services	Coordinated Specialty Care (CSC)	Care Coordination	Family Psychoeducation	High-Fidelity Wrap-Around	Youth Peer Support	Family Peer Support	Outpatient Therapy	SUD Treatment	Transitional Care Services	Case Management	Medication Management	In-Home and Community Delivered Behavioral Health Services	Outpatient Services in-school setting	Other behavioral support in school setting (BHP, CHW)
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Procedure Codes

1. Please select all procedure codes that apply:
(Please select between 1 and 28 items.)
- □ 90791 Initial Assessment
- □ 90792 Comprehensive Assessment
- □ 99367 Individualized Treatment Plan
- □ 90832 Outpatient Clinical Services: Individual and Family Therapy Mental Health (Children and Adults)
- □ H0022 Outpatient Clinical Services: Individual and Family Therapy Substance Use (Children and Adults)
- □ H0022 HH Outpatient Clinical Services: Individual and Family Therapy Co-Occurring (Children and Adults)
- □ 90853 Outpatient Clinical Services: Co-occurring capable group therapy (Children and Adults)
- □ H0034 Medication Management – Psychiatric
- □ H0034 HF Medication Management – SUD
- □ T2023 Case management
- □ H2024 Employment Connections and Support for Adults
- □ H0038 HQ Peer-led support and recovery groups
- □ H0023 Recovery Coaching
- □ H0038 Peer support for adults
- □ H0038 HS Peer support for family
- □ H0038 TJ Peer support for youth
- □ H0007 Ambulatory Withdrawal Management
- □ H2031 Clubhouse services, mental health recovery and vocational rehabilitation program
- □ H0039 Assertive Community Treatment (Adult)
- □ H0037 Assertive Community Treatment (Child)
- □ H0022 (w/modifiers) Intensive Outpatient Therapy
- □ H2022 MST
- □ H2022 Q2 MST-PSB
- □ H2022 HK FFT

☐ H2022 HK PPT
☐ H0046 Home, Community, or School Youth Services: Not Otherwise Specified
☐ H2016 Community Rehabilitation and Skills Development
☐ T2023 HK High Fidelity Wraparound Case Management w/in CCBHC
☐ H2041 Coordinated Specialty Care

1.9.1. Is this request a new treatment/episode of care?
(Please select one.)
- ○ Yes
- ○ No

1.9.2. Indicate if this referral is for a MaineCare Funded service or a Non-MaineCare Funded (also known as Grant-Funded) service:
(Please select one.)
- ○ MaineCare Funded
- ○ Non-MaineCare (Grant-Funded)

1.9.2.1.1. Is provider intending to submit for Ancillary Medication Management Contract?
(Please select one.)
- ○ Yes
- ○ No

1.9.2.2.1. Is this member age eighteen (18) or older, or is an emancipated minor?
(Please select one.)
- ○ Yes
- ○ No

1.9.2.2.2. Does member have a primary diagnosis or Schizophrenia, Schizoaffective Disorder; Moderate or Sever Obsessive Compulsive Disorder, Bipolar Disorder, or Major Depressive Disorder?
(Please select one.)
- ○ Yes
- ○ No

1.9.2.2.3. LOCUS Composite Score:
Min/Max - 0/35; No decimal places allowed

1.9.2.2.4. Is the member on two (2) or more psychotropic medications?
(Please select one.)
- ○ Yes
- ○ No

1.9.2.2.5. Has member been referred for psychiatry or medication management services from a primary care provider?
(Please select one.)
- ○ Yes
- ○ No

Instructions: For the purpose of this section, reported history shall mean an oral or written history obtained from the member, a provider, or a caregiver and documented in the clinical record
1.9.2.2.6. Does the member have a documented or reported history of treatment resistant/refractory symptoms?
(Please select one.)
- ○ Yes
- ○ No

Instructions: For the purpose of this section, reported history shall mean an oral or written history obtained from the member, a provider, or a caregiver and documented in the clinical record
1.9.2.2.6.1.1. Please explain

1.10.1. Is this request a new treatment/episode of care?
(Please select one.)
- ○ Yes
- ○ No

1.10.2. Indicate if this referral is for a MaineCare Funded service or a Non-MaineCare Funded (also known as Grant-Funded) service:
(Please select one.)
- ○ MaineCare Funded
- ○ Non-MaineCare (Grant-Funded)

1.10.2.1.1. Is provider intending to submit for Ancillary Medication Management Contract?
(Please select one.)
- ○ Yes
- ○ No

1.10.2.2.1. Is this member age eighteen (18) or older, or is an emancipated minor?
(Please select one.)
- ○ Yes
- ○ No

1.10.2.2.2. Does member have a primary diagnosis or Schizophrenia, Schizoaffective Disorder; Moderate or Sever Obsessive Compulsive Disorder, Bipolar Disorder, or Major Depressive Disorder?
(Please select one.)
- ○ Yes
- ○ No

1.10.2.2.3. LOCUS Composite Score:
Min/Max - 0/35; No decimal places allowed

1.10.2.2.4. Is the member on two (2) or more psychotropic medications?
(Please select one.)
- ○ Yes
- ○ No

1.10.2.2.5. Has member been referred for psychiatry or medication management services from a primary care provider?
(Please select one.)
- ○ Yes
- ○ No

Instructions: For the purpose of this section, reported history shall mean an oral or written history obtained from the member, a provider, or a caregiver and documented in the clinical record
1.10.2.2.6. Does the member have a documented or reported history of treatment resistant/refractory symptoms?
(Please select one.)
- ○ Yes
- ○ No

Instructions: For the purpose of this section, reported history shall mean an oral or written history obtained from the member, a provider, or a caregiver and documented in the clinical record
1.10.2.2.6.1.1. Please explain

Instructions: Section 17
1.11.1. Is this your first CSR?
(Please select one.)
- ○ Yes
- ○ No

1.11.1.1.1. Date of referral:

Instructions: Members have the option to be placed on hold for service if the agency, upon receipt of a referral from any source, has determined that it does not have the capacity to conduct an intake or initial assessment within seven (7) calendar days as required in Sec. 17.03. To be placed on hold for service, providers must offer the member alternatives to being placed on hold for service, including but not limited to giving information on other service providers within a 25-mile radius servicing the area. This information shall be provided in writing. Should members wish to be on hold for service with an agency, the provider will document the member choice and the offering of alternatives in the member's referral record. At this time, the seven (7) calendar day face-to-face requirement will be suspended. Agencies must follow up with members no more than thirty (30) calendar days after being placed on hold to reevaluate their desire to remain on hold for service, which will be documented in the member record. Agencies must continue to follow up with members in successive thirty (30) day increments to reevaluate the member's desire to remain on hold. When the agency has determined it has the capacity to serve the member, it will contact the member immediately and have seven (7) calendar days to conduct the intake or initial assessment.

1.11.1.1.2. Was this person holding for service?
(Please select one.)
- ○ Yes
- ○ No

1.11.1.1.2.1.1. Since which date was the consumer holding for service:
1.11.1.1.2.1.2. Date Case Worker assigned:
1.11.1.1.2.1.3. Date seen face to face:

1.11.1.1.3. Date Case Worker assigned:
1.11.1.1.4. Date seen face to face:

1.11.2. Has the member received treatment in a state psychiatric hospital (Riverview, and/or Dorothea Dix Psychiatric Center) within the past 24 months, for a non-excluded DSM 5 diagnosis?
(Please select one.)
- ○ Yes
- ○ No

1.11.2.1.1. Provide the dates:

1.11.3. Has the member been discharged from a mental health residential facility, within the past 24 months, OR currently resides in a mental health residential facility, for a non-excluded DSM 5 diagnosis?
(Please select one.)
- ○ Yes
- ○ No

1.11.3.1.1. Provide the dates:

1.11.4. Has the member had two or more episodes of inpatient treatment for mental illness, greater than 72 hours per episode, within the past 24 months, for a non-excluded DSM 5 diagnosis?
(Please select one.)
- ○ Yes
- ○ No

1.11.4.1.1. Provide the dates:

1.11.5. Has the member been admitted by a civil court for emergency involuntary psychiatric treatment as an adult (Blue Paper)?
(Please select one.)
- ○ Yes
- ○ No

1.11.5.1.1. Provide the dates:

1.11.6. Is there an uploaded clinical letter from a clinician dated within the past year stating member is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis, that would result in or have significant risk factors of homlessness, criminal justice invlovelment or require a mental health inpatient treatment greater than 72 hours, or residential treatment unless community support program services are provided?
(Please select one.)
- ○ Yes
- ○ No

1.11.6.1.1. Date of clinical letter:
1.11.6.1.2. Name and credentials of clinician who wrote clinical letter:

Instructions: REQUIRED - LOCUS composite score must be a numerical value between 0-35. Only numbers should be entered in this box.
1.11.7. LOCUS Composite Score:
Min/Max - 0/35; No decimal places allowed

Instructions: REQUIRED – Date LOCUS Completed must be a date in the following format MM/DD/YYYY. Please do not enter a date in any other format.
1.11.8. Date LOCUS Completed:
1.11.9. LOCUS Level of Care:
Min/Max - 0/10; No decimal places allowed

1.11.10. Name and credentials of who completed the LOCUS assessment:

1.11.11. LOCUS Rater ID#:

1.11.12. Does the member receive Vocational Rehabilitation Services?
(Please select one.)
- ○ Yes
- ○ No

1.11.13. Does the member currently have a rent subsidy or live in subsidized housing?
(Please select one.)
- ○ Yes
- ○ No

1.11.13.1.1. Please indicate what type of rent subsidy or subsidized housing:
(Please select one.)
- ○ Bridging Rental Assistance Program (B.R.A.P.)
- ○ Building is subsidized
- ○ Section 8
- ○ Shelter Plus Care
- ○ Veteran''s Housing
- ○ Other

1.11.14. Select the Section 17 service type:
(Please select one.)
- ○ Assertive Community Treatment (ACT)
- ○ Community Integration (CI)
- ○ Community Rehabilitation Services (CRS)
- ○ Daily Living Support Services (DLSS)
- ○ Skills Development

1.11.14.1.1. Provide rationale why member requires a multidisciplinary team available seven days per week, twenty four hours per day:

1.11.14.1.2. Has member been receiving a minimum of three contacts from ACT team per week?
(Please select one.)
- ○ Yes
- ○ No

1.11.14.1.2.2.1. Provide rational of why a minimum of three contacts have not occurred per week:

1.11.14.1.3. How are services allowing member to retain community tenure and would require hospitalization or crisis services without the service?

1.11.14.2.1. Has the CI worker facilitated formal and informal opportunities for career exploration during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.11.14.2.1.1.1. Please explain

1.11.14.2.2. Has the CI worker coordinated referrals, and advocated for access by the member to the service(s) and natural support(s) identified in his or her Individual Support Plan during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.11.14.2.2.1.1. Please explain

1.11.14.2.3. Has the CI worker participated in ensuring the delivery of crisis intervention and resolution services during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.11.14.2.3.1.1. Please explain

1.11.14.2.4. Has the CI worker assisted in the exploration of less restrictive alternatives to hospitalization during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.11.14.2.4.1.1. Please explain

1.11.14.2.5. Has the CI worker made face-to-face contact with other professionals, caregivers, or individuals included in the treatment plan in order to achieve continuity of care, coordination of services, and the most appropriate services for the member per their ISP in the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.11.14.2.5.1.1. Please explain

1.11.14.2.6. Has the CI worker contacted the member''s guardian, family, significant other, and providers of services or natural supports to ensure the continuity of care and coordination of services between inpatient and community settings during the last review period?
(Please select one.)
- ○ Yes

- ○ No

1.11.14.2.6.1.1. Please Explain:

1.11.14.2.7. Has the CI worker provided information and consultation with the member receiving Community Support Services, to the member, his or her family, or his or her immediate support system, in order to assist the member to manage the symptoms or impairments of his or her illness with a focus on independence within the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.11.14.2.7.1.1. Please explain

1.11.14.2.8. Has the CI worker assisted the member in restoring and improving communication skills needed to request assistance or clarification from supervisors and co-workers during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.11.14.2.8.1.1. Please explain

1.11.14.2.9. Has the CI worker assisted the member to enhance skills and employment strategies to overcome or address psychiatric symptoms that interfere with seeking, obtaining, and maintaining a job during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.11.14.2.9.1.1. Please explain

1.11.14.2.10. Is this service being provided under an OBH Funded contract for Veteran"s Case Management?
(Please select one.)
- ○ Yes
- ○ No

1.11.14.3.1. Provide rationale why member requires staff availability seven days per week, twenty four hours per day:

1.11.14.3.2. Has the member been receiving a minimum of one contact per day?
(Please select one.)
- ○ Yes
- ○ No

1.11.14.3.2.2.1. Provide rational of why a daily minimum contact has not occurred:

1.11.14.4.1. If provider is a Certified Residential Medication Aide (CRMA), are they administering and supervising medications?
(Please select one.)
- ○ Yes
- ○ No

1.11.14.4.2. If member is accessing a higher level of care, please describe coordination with service provider and non duplication of interventions?

1.11.14.5.1. If provider is a Certified Residential Medication Aide (CRMA), are they administering and supervising medications?
(Please select one.)
- ○ Yes
- ○ No

Instructions: Behavioral Health Homes (BHH)

1.11.15. What tool was completed?
(Please select one.)

○ CANS ○ ASQ ○ CAFAS ○ YOQ ○ LOCUS ○ PECFAS

1.11.15.1.1. Date of CANS assessment:
1.11.15.1.2. Indicate scores two or higher in both of the following sections: Child Behavioral/Emotional Needs AND Life Domain Functioning:

1.11.15.1.1. ASQ Score:

1.11.15.1.2. Date ASQ completed:

1.11.15.2.1. Date CAFAS completed:
1.11.15.2.2. CAFAS Score:

Instructions: REQUIRED - LOCUS composite score must be a numerical value between 0-35. Only numbers should be entered in this box.

1.11.15.4.1. LOCUS Composite Score:
Min/Max - 0/35; No decimal places allowed

Instructions: REQUIRED – Date LOCUS Completed must be a date in the following format MM/DD/YYYY. Please do not enter a date in any other format.

1.11.15.4.2. Date LOCUS Completed:

1.11.15.4.3. LOCUS Level of Care:
Min/Max - 0/10; No decimal places allowed

1.11.15.4.4. LOCUS Rater ID#:

1.11.15.4.5. Name and credentials of who completed the LOCUS assessment:

1.11.15.5.1. PECFAS Score:

1.11.15.5.2. Date PECFAS completed:

1.11.16. What covered services have been provided during the last review period?
- ☐ Care Coordination
- ☐ Comprehensive Case Management
- ☐ Comprehensive Transitional Care
- ☐ Health Promotion
- ☐ Individual and Family Support Services

Instructions: BHH Adult Service Only

1.11.17. Is this your first CSR?
(Please select one.)
- ○ Yes
- ○ No

1.11.17.1.1. Date of referral:

Instructions: Members have the option to be placed on hold for service if the agency, upon receipt of a referral from any source, has determined that it does not have the capacity to conduct an intake or initial assessment within seven (7) calendar days as required in Sec. 17.03. To be placed on hold for service, providers must offer the member alternatives to being placed on hold for service, including but not limited to giving information on other service providers within a 25-mile radius servicing the area. This information shall be provided in writing. Should members wish to be on hold for service with an agency, the provider will document the member choice and the offering of alternatives in the member's referral record. At this time, the seven (7) calendar day face-to-face requirement will be suspended. Agencies must follow up with members no more than thirty (30) calendar days after being placed on hold to reevaluate their desire to remain on hold for service, which will be documented in the member record. Agencies must continue to follow up with members in successive thirty (30) day increments to reevaluate the member's desire to remain on hold. When the agency has determined it has the capacity to serve the member, it will contact the member immediately and have seven (7) calendar days to conduct the intake or initial assessment.

1.11.17.1.2. Was this person holding for service?
(Please select one.)
- ○ Yes
- ○ No

1.11.17.1.2.1.1. Since which date was the consumer holding for service:
1.11.17.1.2.1.2. Date Case Worker assigned:

1.11.17.1.2.1.3. Date seen face to face:

1.11.17.1.3. Date Case Worker assigned:

1.11.17.1.4. Date seen face to face:

1.11.18. Does the member receive Vocational Rehabilitation Services?
(Please select one.)
- ○ Yes
- ○ No

1.11.19. Does the member currently have a rent subsidy or live in subsidized housing?
(Please select one.)
- ○ Yes
- ○ No

1.11.19.1.1. Please indicate what type of rent subsidy or subsidized housing:
(Please select one.)
- ○ Bridging Rental Assistance Program (B.R.A.P.)
- ○ Building is subsidized
- ○ Section 8
- ○ Shelter Plus Care
- ○ Veteran''s Housing
- ○ Other

Instructions: Targeted Case Management (TCM)

1.11.20. Is this request a new treatment/episode of care?
(Please select one.)
- ○ Yes
- ○ No

Instructions: Per OCFS Provider Performance Measure, members should be seen face-to-face within 7 calendar days from the date of referral.

1.11.21. What date was the member referred to services?

1.11.22. How many scores are two or higher in life domain functioning?

1.11.23. How many scores are two or higher in child behavioral/emotional needs?

1.11.24. Does member require referral activities?
(Please select one.)
- ○ Yes
- ○ No

1.11.25. Is member 16 years old and have a diagnosis of ID/DD?
(Please select one.)
- ○ Yes
- ○ No

1.11.26. Does member requiring Monitoring and Follow-Up Activities?
(Please select one.)
- ○ Yes
- ○ No

Instructions: Section 17

1.12.1. Is this your first CSR?
(Please select one.)
- ○ Yes
- ○ No

1.12.1.1.1. Date of referral:

Instructions: Members have the option to be placed on hold for service if the agency, upon receipt of a referral from any source, has determined that it does not have the capacity to conduct an intake or initial assessment within seven (7) calendar days as required in Sec. 17.03. To be placed on hold for service, providers must offer the member alternatives to being placed on hold for service, including but not limited to giving information on other service providers within a 25-mile radius servicing the area. This information shall be provided in writing. Should members wish to be on hold for service with an agency, the provider will document the member choice and the offering of alternatives in the member's referral record. At this time, the seven (7) calendar day face-to-face requirement will be suspended. Agencies must follow up with members no more than thirty (30) calendar days after being placed on hold to reevaluate their desire to remain on hold for service, which will be documented in the member record. Agencies must continue to follow up with members in successive thirty (30) day increments to reevaluate the member's desire to remain on hold. When the agency has determined it has the capacity to serve the member, it will contact the member immediately and have seven (7) calendar days to conduct the intake or initial assessment.

1.12.1.1.2. Was this person holding for service?
(Please select one.)
- ○ Yes
- ○ No

1.12.1.1.2.1.1. Since which date was the consumer holding for service:

1.12.1.1.2.1.2. Date Case Worker assigned:

1.12.1.1.2.1.3. Date seen face to face:

1.12.1.1.3. Date Case Worker assigned:

1.12.1.1.4. Date seen face to face:

1.12.2. Has the member received treatment in a state psychiatric hospital (Riverview, and/or Dorothea Dix Psychiatric Center) within the past 24 months, for a non-excluded DSM 5 diagnosis?
(Please select one.)
- ○ Yes
- ○ No

1.12.2.1.1. Provide the dates:

1.12.3. Has the member been discharged from a mental health residential facility, within the past 24 months, OR currently resides in a mental health residential facility, for a non-excluded DSM 5 diagnosis?
(Please select one.)
- ○ Yes
- ○ No

1.12.3.1.1. Provide the dates:

1.12.4. Has the member had two or more episodes of inpatient treatment for mental illness, greater than 72 hours per episode, within the past 24 months, for a non-excluded DSM 5 diagnosis?
(Please select one.)
- ○ Yes
- ○ No

1.12.4.1.1. Provide the dates:

1.12.5. Has the member been admitted by a civil court for emergency involuntary psychiatric treatment as an adult (Blue Paper)?
(Please select one.)
- ○ Yes
- ○ No

1.12.5.1.1. Provide the dates:

1.12.6. Is there an uploaded clinical letter from a clinician dated within the past year stating member is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis, that would result in or have significant risk factors of homlessness, criminal justice invlovelment or require a mental health inpatient treatment greater than 72 hours, or residential treatment unless community support program services are provided?
(Please select one.)
- ○ Yes
- ○ No

1.12.6.1.1. Date of clinical letter:

1.12.6.1.2. Name and credentials of clinician who wrote clinical letter:

Instructions: REQUIRED - LOCUS composite score must be a numerical value between 0-35. Only numbers should be entered in this box.

1.12.7. LOCUS Composite Score:
Min/Max - 0/35; No decimal places allowed

Instructions: REQUIRED – Date LOCUS Completed must be a date in the following format MM/DD/YYYY. Please do not enter a date in any other format.

1.12.8. Date LOCUS Completed:

1.12.9. LOCUS Level of Care:
Min/Max - 0/10; No decimal places allowed

1.12.10. Name and credentials of who completed the LOCUS assessment:

1.12.11. LOCUS Rater ID#:

1.12.12. Does the member receive Vocational Rehabilitation Services?
(Please select one.)
- ○ Yes
- ○ No

1.12.13. Does the member currently have a rent subsidy or live in subsidized housing?
(Please select one.)
- ○ Yes
- ○ No

1.12.13.1.1. Please indicate what type of rent subsidy or subsidized housing:
(Please select one.)
- ○ Bridging Rental Assistance Program (B.R.A.P.)
- ○ Building is subsidized
- ○ Section 8
- ○ Shelter Plus Care
- ○ Veteran''s Housing
- ○ Other

1.12.14. Select the Section 17 service type:
(Please select one.)
- ○ Assertive Community Treatment (ACT)
- ○ Community Integration (CI)
- ○ Community Rehabilitation Services (CRS)
- ○ Daily Living Support Services (DLSS)
- ○ Skills Development

1.12.14.1.1. Provide rationale why member requires a multidisciplinary team available seven days per week, twenty four hours per day:

1.12.14.1.2. Has member been receiving a minimum of three contacts from ACT team per week?
(Please select one.)
- ○ Yes
- ○ No

1.12.14.1.2.2.1. Provide rational of why a minimum of three contacts have not occurred per week:

1.12.14.1.3. How are services allowing member to retain community tenure and would require hospitalization or crisis services without the service?

1.12.14.2.1. Has the CI worker facilitated formal and informal opportunities for career exploration during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.12.14.2.1.1.1. Please explain

1.12.14.2.2. Has the CI worker coordinated referrals, and advocated for access by the member to the service(s) and natural support(s) identified in his or her Individual Support Plan during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.12.14.2.2.1.1. Please explain

1.12.14.2.3. Has the CI worker participated in ensuring the delivery of crisis intervention and resolution services during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.12.14.2.3.1.1. Please explain

1.12.14.2.4. Has the CI worker assisted in the exploration of less restrictive alternatives to hospitalization during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.12.14.2.4.1.1. Please explain

1.12.14.2.5. Has the CI worker made face-to-face contact with other professionals, caregivers, or individuals included in the treatment plan in order to achieve continuity of care, coordination of services, and the most appropriate services for the member per their ISP in the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.12.14.2.5.1.1. Please explain

1.12.14.2.6. Has the CI worker contacted the member''s guardian, family, significant other, and providers of services or natural supports to ensure the continuity of care and coordination of services between inpatient and community settings during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.12.14.2.6.1.1. Please Explain:

1.12.14.2.7. Has the CI worker provided information and consultation with the member receiving Community Support Services, to the member, his or her family, or his or her immediate support system, in order to assist the member to manage the symptoms or impairments of his or her illness with a focus on independence within the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.12.14.2.7.1.1. Please explain

1.12.14.2.8. Has the CI worker assisted the member in restoring and improving communication skills needed to request assistance or clarification from supervisors and co-workers during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.12.14.2.8.1.1. Please explain

1.12.14.2.9. Has the CI worker assisted the member to enhance skills and employment strategies to overcome or address psychiatric symptoms that interfere with seeking, obtaining, and maintaining a job during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.12.14.2.9.1.1. Please explain

1.12.14.2.10. Is this service being provided under an OBH Funded contract for Veteran''s Case Management?
(Please select one.)
- ○ Yes
- ○ No

1.12.14.3.1. Provide rationale why member requires staff availability seven days per week, twenty four hours per day:

1.12.14.3.2. Has the member been receiving a minimum of one contact per day?
(Please select one.)
- ○ Yes
- ○ No

1.12.14.3.2.2.1. Provide rational of why a daily minimum contact has not occurred:

1.12.14.4.1. If provider is a Certified Residential Medication Aide (CRMA), are they administering and supervising medications?
(Please select one.)

(Please select one.)
- ○ Yes
- ○ No

1.12.14.4.2. If member is accessing a higher level of care, please describe coordination with service provider and non duplication of interventions?

1.12.14.5.1. If provider is a Certified Residential Medication Aide (CRMA), are they administering and supervising medications?
(Please select one.)
- ○ Yes
- ○ No

Instructions: Long-Term Supported Employment (LTSE) Clinical

1.12.15. Employer:

1.12.16. Employer Type:
(Please select one.)
- ○ Community Rehabilitation Provider (CRP)
- ○ Regular
- ○ Non-Provider Business
- ○ Self Employed
- ○ Temp Agency (Non-Provider)
- ○ Not currently employed

1.12.17. Client's Position:

1.12.18. What is the client hourly wage?

1.12.19. Date LOCUS Completed:

1.12.20. LOCUS Composite Score:
Min/Max - 0/35; No decimal places allowed

1.12.21. LOCUS Level of Care:
Min/Max - 0/10; No decimal places allowed

1.12.22. LOCUS Rater ID#:

1.12.23. Name and credentials of who completed the LOCUS assessment:

1.12.24. Is this a competitive employment position as defined by Maine OAMHS MH- LTSE Policy?
(Please select one.)
- ○ Yes
- ○ No

1.12.25. How long has your client been working at this position?

1.12.26. Does your client have plans to change jobs?
(Please select one.)
- ○ Yes
- ○ No

1.12.27. Is client receiving any job development support in addition to MH-LTSE?
(Please select one.)
- ○ Yes
- ○ No

1.12.28. What are the material and substantial duties of this client's job?

1.12.29. What does LTSE support do to help this client?

1.12.30. How many hours a month is the client working?

1.12.31. How many hours of MH-LTSE job support are you providing client per week?

1.12.32. Does the amount of LTSE support equate to more than 25% of the client's actual work hours?
(Please select one.)
- ○ Yes
- ○ No

1.19.1. LOCUS Composite Score:
Min/Max - 0/35; No decimal places allowed

1.19.2. Date LOCUS Completed:

1.19.3. Name and credentials of who completed the assessment:

1.19.4. LOCUS Rater ID#:

Instructions: Section 17

1.20.1. Is this your first CSR?
(Please select one.)
- ○ Yes
- ○ No

1.20.1.1.1. Date of referral:

Instructions: Members have the option to be placed on hold for service if the agency, upon receipt of a referral from any source, has determined that it does not have the capacity to conduct an intake or initial assessment within seven (7) calendar days as required in Sec. 17.03. To be placed on hold for service, providers must offer the member alternatives to being placed on hold for service, including but not limited to giving information on other service providers within a 25-mile radius servicing the area. This information shall be provided in writing. Should members wish to be on hold for service with an agency, the provider will document the member choice and the offering of alternatives in the member's referral record. At this time, the seven (7) calendar day face-to-face requirement will be suspended. Agencies must follow up with members no more than thirty (30) calendar days after being placed on hold to reevaluate their desire to remain on hold for service, which will be documented in the member record. Agencies must continue to follow up with members in successive thirty (30) day increments to reevaluate the member's desire to remain on hold. When the agency has determined it has the capacity to serve the member, it will contact the member immediately and have seven (7) calendar days to conduct the intake or initial assessment.

1.20.1.1.2. Was this person holding for service?
(Please select one.)
- ○ Yes
- ○ No

1.20.1.1.2.1.1. Since which date was the consumer holding for service:

1.20.1.1.2.1.2. Date Case Worker assigned:

1.20.1.1.2.1.3. Date seen face to face:

1.20.1.1.3. Date Case Worker assigned:

1.20.1.1.4. Date seen face to face:

1.20.2. Has the member received treatment in a state psychiatric hospital (Riverview, and/or Dorothea Dix Psychiatric Center) within the past 24 months, for a non-excluded DSM 5 diagnosis?
(Please select one.)
- ○ Yes
- ○ No

1.20.2.1.1. Provide the dates:

1.20.3. Has the member been discharged from a mental health residential facility, within the past 24 months, OR currently resides in a mental health residential facility, for a non-excluded DSM 5 diagnosis?
(Please select one.)
- ○ Yes
- ○ No

1.20.3.1.1. Provide the dates:

1.20.4. Has the member had two or more episodes of inpatient treatment for mental illness, greater than 72 hours per episode, within the past 24 months, for a non-excluded DSM 5 diagnosis?
(Please select one.)
- ○ Yes
- ○ No

1.20.4.1.1. Provide the dates:

1.20.5. Has the member been admitted by a civil court for emergency involuntary psychiatric treatment as an adult (Blue Paper)?
(Please select one.)
- ○ Yes
- ○ No

1.20.5.1.1. Provide the dates:

1.20.6. Is there an uploaded clinical letter from a clinician dated within the past year stating member is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis, that would result in or have significant risk factors of homlessness, criminal justice invlovelment or require a mental health inpatient treatment greater than 72 hours, or residential treatment unless community support program services are provided?
(Please select one.)
- ○ Yes
- ○ No

1.20.6.1.1. Date of clinical letter:
1.20.6.1.2. Name and credentials of clinician who wrote clinical letter:

Instructions: REQUIRED - LOCUS composite score must be a numerical value between 0-35. Only numbers should be entered in this box.
1.20.7. LOCUS Composite Score:
Min/Max - 0/35; No decimal places allowed

Instructions: REQUIRED – Date LOCUS Completed must be a date in the following format MM/DD/YYYY. Please do not enter a date in any other format.
1.20.8. Date LOCUS Completed:
1.20.9. LOCUS Level of Care:
Min/Max - 0/10; No decimal places allowed

1.20.10. Name and credentials of who completed the LOCUS assessment:

1.20.11. LOCUS Rater ID#:

1.20.12. Does the member receive Vocational Rehabilitation Services?
(Please select one.)
- ○ Yes
- ○ No

1.20.13. Does the member currently have a rent subsidy or live in subsidized housing?
(Please select one.)
- ○ Yes
- ○ No

1.20.13.1.1. Please indicate what type of rent subsidy or subsidized housing:
(Please select one.)
- ○ Bridging Rental Assistance Program (B.R.A.P.)
- ○ Building is subsidized
- ○ Section 8
- ○ Shelter Plus Care
- ○ Veteran''s Housing
- ○ Other

1.20.14. Select the Section 17 service type:
(Please select one.)
- ○ Assertive Community Treatment (ACT)
- ○ Community Integration (CI)
- ○ Community Rehabilitation Services (CRS)
- ○ Daily Living Support Services (DLSS)
- ○ Skills Development

1.20.14.1.1. Provide rationale why member requires a multidisciplinary team available seven days per week, twenty four hours per day:

1.20.14.1.2. Has member been receiving a minimum of three contacts from ACT team per week?
(Please select one.)
- ○ Yes
- ○ No

1.20.14.1.2.2.1. Provide rational of why a minimum of three contacts have not occurred per week:

1.20.14.1.3. How are services allowing member to retain community tenure and would require hospitalization or crisis services without the service?

1.20.14.2.1. Has the CI worker facilitated formal and informal opportunities for career exploration during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.20.14.2.1.1.1. Please explain

1.20.14.2.2. Has the CI worker coordinated referrals, and advocated for access by the member to the service(s) and natural support(s) identified in his or her Individual Support Plan during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.20.14.2.2.1.1. Please explain

1.20.14.2.3. Has the CI worker participated in ensuring the delivery of crisis intervention and resolution services during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.20.14.2.3.1.1. Please explain

1.20.14.2.4. Has the CI worker assisted in the exploration of less restrictive alternatives to hospitalization during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.20.14.2.4.1.1. Please explain

1.20.14.2.5. Has the CI worker made face-to-face contact with other professionals, caregivers, or individuals included in the treatment plan in order to achieve continuity of care, coordination of services, and the most appropriate services for the member per their ISP in the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.20.14.2.5.1.1. Please explain

1.20.14.2.6. Has the CI worker contacted the member''s guardian, family, significant other, and providers of services or natural supports to ensure the continuity of care and coordination of services between inpatient and community settings during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.20.14.2.6.1.1. Please Explain:

1.20.14.2.7. Has the CI worker provided information and consultation with the member receiving Community Support Services, to the member, his or her family, or his or her immediate support system, in order to assist the member to manage the symptoms or impairments of his or her illness with a focus on independence within the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.20.14.2.7.1.1. Please explain

1.20.14.2.8. Has the CI worker assisted the member in restoring and improving communication skills needed to request assistance or clarification from supervisors and co-workers during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.20.14.2.8.1.1. Please explain

1.20.14.2.9. Has the CI worker assisted the member to enhance skills and employment strategies to overcome or address psychiatric symptoms that interfere with seeking, obtaining, and maintaining a job during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.20.14.2.9.1.1. Please explain

1.20.14.2.10. Is this service being provided under an OBH Funded contract for Veteran"s Case Management?
(Please select one.)
- ○ Yes
- ○ No

1.20.14.3.1. Provide rationale why member requires staff availability seven days per week, twenty four hours per day:

1.20.14.3.2. Has the member been receiving a minimum of one contact per day?
(Please select one.)
- ○ Yes
- ○ No

1.20.14.3.2.2.1. Provide rational of why a daily minimum contact has not occurred:

1.20.14.4.1. If provider is a Certified Residential Medication Aide (CRMA), are they administering and supervising medications?
(Please select one.)
- ○ Yes
- ○ No

1.20.14.4.2. If member is accessing a higher level of care, please describe coordination with service provider and non duplication of interventions?

1.20.14.5.1. If provider is a Certified Residential Medication Aide (CRMA), are they administering and supervising medications?
(Please select one.)
- ○ Yes
- ○ No

Instructions: Child Assertive Community Treatment (ACT)

1.21.1. Which Level of Care tool has been used?
(Please select one.)
- ○ CAFAS
- ○ PECAFAS
- ○ CANS

1.21.2. What services are being provided to this member by a multidisciplinary team on a 24 hours, seven days per week basis?
(Please select between 1 and 5 items.)
- ☐ Psychiatry
- ☐ Mental Health Therapy
- ☐ Substance Abuse Therapy
- ☐ Case Management
- ☐ Vocational

1.21.3. Is member at risk of hospitalization, or residential treatment, and/or admission to crisis stabilization?
(Please select one.)
- ○ Yes
- ○ No

1.21.4. Is member transitioning from residential treatment?
(Please select one.)
- ○ Yes
- ○ No

1.21.5. Are lower level services being considered at this time?
(Please select one.)
- ○ Yes
- ○ No

1.21.6. Are caregivers engaged in treatment?
(Please select one.)
- ○ Yes
- ○ No

Instructions: Intensive Outpatient Program (IOP)

1.22.1. Members seeking IOP services must be:
(Please select between 1 and 5 items.)
- ☐ Transitioning from a higher level of care (e.g., residential treatment or inpatient psychiatric hospitalization) to a lower level of care when discharge is imminent within thirty (30) days or less
- ☐ At risk of Placement in a residential treatment setting
- ☐ At risk of Involvement in the criminal justice or juvenile justice system
- ☐ At risk of Inpatient psychiatric hospitalization,
- ☐ At risk of Homelessness

1.22.2. Does member Present with a level of clinical acuity that cannot be safely and successfully treated in an outpatient level of care?
(Please select one.)
- ○ Yes
- ○ No

1.22.3. Does member have a primary substance use disorder or a substance use disorder with a co-occurring mental health disorder and meet ASAM Level 2 placement criteria?
(Please select one.)
- ○ Yes
- ○ No

1.22.4. Does member have a primary mental health disorder or a mental health disorder with a co-occurring substance use disorder and exhibit moderate to severe psychiatric symptoms?
(Please select one.)
- ○ Yes
- ○ No

1.22.5. Does member have an Autism Spectrum Disorder (ASD) or an Intellectual Disability and exhibit functional limitations, verbal and/or physical aggression, self-injurious behaviors, severe emotional dysregulation, and other serious problem behaviors?
(Please select one.)
- ○ Yes
- ○ No

1.22.6. Does member have a primary mental health disorder or a co-occurring mental health and substance use disorder and exhibit moderate to severe psychiatric symptoms and has reached at least sixty-five (65) years of age?
(Please select one.)
- ○ Yes
- ○ No

1.22.7. Does member have an Eating Disorder, to include Otherwise Specified Feeding or Eating Disorder and Unspecified Feeding or Eating Disorder
(Please select between 1 and 4 items.)
- ☐ Avoidant/Restrictive Food Intake Disorder
- ☐ Anorexia Nervosa

- ☐ Binge Eating Disorder
- ☐ Bulimia Nervosa

1.22.8. Does member have a primary mental health diagnosis or mental health disorder with a co-occurring substance use disorder (Please select one.)
- ○ Yes
- ○ No

1.22.9. Does member have at least three (3) of the following criteria? (Please select between 1 and 7 items.)
- ☐ Severe emotional dysregulation
- ☐ Chronic suicidality
- ☐ Impulsivity
- ☐ Self-harm
- ☐ Strained interpersonal relationships
- ☐ Inability to engage in appropriate coping skills
- ☐ History of mental health crises and/or psychiatric hospitalizations.

1.22.10. Please select all applicable substances that are current: (Please select between 1 and 15 items.)
- ☐ Alcohol
- ☐ Cocaine / Crack
- ☐ Marijuana / Hashish / THC
- ☐ Heroin / Morphine
- ☐ Non Rx-Methadone
- ☐ Other Opiates and Synthetics
- ☐ PCP
- ☐ Other Hallucinogens LSD, DMT, STP, etc.
- ☐ Methamphetamines
- ☐ Other Amphetamines
- ☐ Other Stimulants
- ☐ Benzodiazepines
- ☐ Other Tranquilizers
- ☐ Barbiturates
- ☐ Other Sedatives and Hypnotics

Instructions: Section 17

1.27.1. Is this your first CSR? (Please select one.)
- ○ Yes
- ○ No

1.27.1.1.1. Date of referral:

Instructions: Members have the option to be placed on hold for service if the agency, upon receipt of a referral from any source, has determined that it does not have the capacity to conduct an intake or initial assessment within seven (7) calendar days as required in Sec. 17.03. To be placed on hold for service, providers must offer the member alternatives to being placed on hold for service, including but not limited to giving information on other service providers within a 25-mile radius servicing the area. This information shall be provided in writing. Should members wish to be on hold for service with an agency, the provider will document the member choice and the offering of alternatives in the member's referral record. At this time, the seven (7) calendar day face-to-face requirement will be suspended. Agencies must follow up with members no more than thirty (30) calendar days after being placed on hold to reevaluate their desire to remain on hold for service, which will be documented in the member record. Agencies must continue to follow up with members in successive thirty (30) day increments to reevaluate the member's desire to remain on hold. When the agency has determined it has the capacity to serve the member, it will contact the member immediately and have seven (7) calendar days to conduct the intake or initial assessment.

1.27.1.1.2. Was this person holding for service? (Please select one.)
- ○ Yes
- ○ No

1.27.1.1.2.1.1. Since which date was the consumer holding for service:

1.27.1.1.2.1.2. Date Case Worker assigned:

1.27.1.1.2.1.3. Date seen face to face:

1.27.1.1.3. Date Case Worker assigned:

1.27.1.1.4. Date seen face to face:

1.27.2. Has the member received treatment in a state psychiatric hospital (Riverview, and/or Dorothea Dix Psychiatric Center) within the past 24 months, for a non-excluded DSM 5 diagnosis? (Please select one.)
- ○ Yes
- ○ No

1.27.2.1.1. Provide the dates:

1.27.3. Has the member been discharged from a mental health residential facility, within the past 24 months, OR currently resides in a mental health residential facility, for a non-excluded DSM 5 diagnosis? (Please select one.)
- ○ Yes
- ○ No

1.27.3.1.1. Provide the dates:

1.27.4. Has the member had two or more episodes of inpatient treatment for mental illness, greater than 72 hours per episode, within the past 24 months, for a non-excluded DSM 5 diagnosis? (Please select one.)
- ○ Yes
- ○ No

1.27.4.1.1. Provide the dates:

1.27.5. Has the member been admitted by a civil court for emergency involuntary psychiatric treatment as an adult (Blue Paper)? (Please select one.)
- ○ Yes
- ○ No

1.27.5.1.1. Provide the dates:

1.27.6. Is there an uploaded clinical letter from a clinician dated within the past year stating member is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis, that would result in or have significant risk factors of homlessness, criminal justice invlovelment or require a mental health inpatient treatment greater than 72 hours, or residential treatment unless community support program services are provided? (Please select one.)
- ○ Yes
- ○ No

1.27.6.1.1. Date of clinical letter:

1.27.6.1.2. Name and credentials of clinician who wrote clinical letter:

Instructions: REQUIRED - LOCUS composite score must be a numerical value between 0-35. Only numbers should be entered in this box.

1.27.7. LOCUS Composite Score:
Min/Max - 0/35; No decimal places allowed

Instructions: REQUIRED – Date LOCUS Completed must be a date in the following format MM/DD/YYYY. Please do not enter a date in any other format.

1.27.8. Date LOCUS Completed:

1.27.9. LOCUS Level of Care:
Min/Max - 0/10; No decimal places allowed

1.27.10. Name and credentials of who completed the assessment:

1.27.11. LOCUS Rater ID#:

1.27.12. Does the member receive Vocational Rehabilitation Services? (Please select one.)
- ○ Yes
- ○ No

1.27.13. Does the member currently have a rent subsidy or live in subsidized housing? (Please select one.)
- ○ Yes
- ○ No

1.27.13.1.1. Please indicate what type of rent subsidy or subsidized housing: (Please select one.)
- ○ Bridging Rental Assistance Program (B.R.A.P.)
- ○ Building is subsidized
- ○ Section 8
- ○ Shelter Plus Care
- ○ Veteran''s Housing
- ○ Other

1.27.14. Select the Section 17 service type: (Please select one.)
- ○ Assertive Community Treatment (ACT)

- ○ Assertive Community Treatment (ACT)
- ○ Community Integration (CI)
- ○ Community Rehabilitation Services (CRS)
- ○ Daily Living Support Services (DLSS)
- ○ Skills Development

1.27.14.1.1. Provide rationale why member requires a multidisciplinary team available seven days per week, twenty four hours per day:

1.27.14.1.2. Has member been receiving a minimum of three contacts from ACT team per week?
(Please select one.)
- ○ Yes
- ○ No

1.27.14.1.2.2.1. Provide rational of why a minimum of three contacts have not occurred per week:

1.27.14.1.3. How are services allowing member to retain community tenure and would require hospitalization or crisis services without the service?

1.27.14.2.1. Has the CI worker facilitated formal and informal opportunities for career exploration during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.27.14.2.1.1.1. Please explain

1.27.14.2.2. Has the CI worker coordinated referrals, and advocated for access by the member to the service(s) and natural support(s) identified in his or her Individual Support Plan during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.27.14.2.2.1.1. Please explain

1.27.14.2.3. Has the CI worker participated in ensuring the delivery of crisis intervention and resolution services during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.27.14.2.3.1.1. Please explain

1.27.14.2.4. Has the CI worker assisted in the exploration of less restrictive alternatives to hospitalization during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.27.14.2.4.1.1. Please explain

1.27.14.2.5. Has the CI worker made face-to-face contact with other professionals, caregivers, or individuals included in the treatment plan in order to achieve continuity of care, coordination of services, and the most appropriate services for the member per their ISP in the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.27.14.2.5.1.1. Please explain

1.27.14.2.6. Has the CI worker contacted the member''s guardian, family, significant other, and providers of services or natural supports to ensure the continuity of care and coordination of services between inpatient and community settings during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.27.14.2.6.1.1. Please Explain:

1.27.14.2.7. Has the CI worker provided information and consultation with the member receiving Community Support Services, to the member, his or her family, or his or her immediate support system, in order to assist the member to manage the symptoms or impairments of his or her illness with a focus on independence within the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.27.14.2.7.1.1. Please explain

1.27.14.2.8. Has the CI worker assisted the member in restoring and improving communication skills needed to request assistance or clarification from supervisors and co-workers during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.27.14.2.8.1.1. Please explain

1.27.14.2.9. Has the CI worker assisted the member to enhance skills and employment strategies to overcome or address psychiatric symptoms that interfere with seeking, obtaining, and maintaining a job during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.27.14.2.9.1.1. Please explain

1.27.14.2.10. Is this service being provided under an OBH Funded contract for Veteran"s Case Management?
(Please select one.)
- ○ Yes
- ○ No

1.27.14.3.1. Provide rationale why member requires staff availability seven days per week, twenty four hours per day:

1.27.14.3.2. Has the member been receiving a minimum of one contact per day?
(Please select one.)
- ○ Yes
- ○ No

1.27.14.3.2.2.1. Provide rational of why a daily minimum contact has not occurred:

1.27.14.4.1. If provider is a Certified Residential Medication Aide (CRMA), are they administering and supervising medications?
(Please select one.)
- ○ Yes
- ○ No

1.27.14.4.2. If member is accessing a higher level of care, please describe coordination with service provider and non duplication of interventions?

1.27.14.5.1. If provider is a Certified Residential Medication Aide (CRMA), are they administering and supervising medications?
(Please select one.)
- ○ Yes
- ○ No

Instructions: Behavioral Health Homes (BHH)

1.28.1. What tool was completed?
(Please select one.)
○ CANS ○ ASQ ○ CAFAS ○ YOQ ○ LOCUS ○ PECFAS

1.28.1.1.1. Date of CANS assessment:

1.28.1.1.2. Indicate scores two or higher in both of the following sections: Child Behavioral/Emotional Needs AND Life Domain Functioning:

1.28.1.1.1. ASQ Score:

1.28.1.1.2. Date ASQ completed:

1.28.1.2.1. Date CAFAS completed:

1.28.1.2.2. CAFAS Score:

Instructions: REQUIRED - LOCUS composite score must be a numerical value between 0-35. Only numbers should be entered in this box.

1.28.1.4.1. LOCUS Composite Score:
Min/Max - 0/35; No decimal places allowed

Instructions: REQUIRED – Date LOCUS Completed must be a date in the following format MM/DD/YYYY. Please do not enter a date in any other format.

1.28.1.4.2. Date LOCUS Completed:

1.28.1.4.3. LOCUS Level of Care:
Min/Max - 0/10; No decimal places allowed

1.28.1.4.4. LOCUS Rater ID#:

1.28.1.4.5. Name and credentials of who completed the LOCUS assessment:

1.28.1.5.1. PECFAS Score:

1.28.1.5.2. Date PECFAS completed:

1.28.2. What covered services have been provided during the last review period?
☐ Care Coordination
☐ Comprehensive Case Management
☐ Comprehensive Transitional Care
☐ Health Promotion
☐ Individual and Family Support Services

Instructions: ADULT SERVICES ONLY For Behavioral Health Homes, providers must conduct an initial face-to-face intake or initial assessment visit within seven (7) calendar days of referral, regardless of source of referral.

1.28.3. Is this your first CSR?
(Please select one.)
○ Yes
○ No

1.28.3.1.1. Date of referral:

Instructions: Members have the option to be placed on hold for service if the agency, upon receipt of a referral from any source, has determined that it does not have the capacity to conduct an intake or initial assessment within seven (7) calendar days as required in Sec. 17.03. To be placed on hold for service, providers must offer the member alternatives to being placed on hold for service, including but not limited to giving information on other service providers within a 25-mile radius servicing the area. This information shall be provided in writing. Should members wish to be on hold for service with an agency, the provider will document the member choice and the offering of alternatives in the member's referral record. At this time, the seven (7) calendar day face-to-face requirement will be suspended. Agencies must follow up with members no more than thirty (30) calendar days after being placed on hold to reevaluate their desire to remain on hold for service, which will be documented in the member record. Agencies must continue to follow up with members in successive thirty (30) day increments to reevaluate the member's desire to remain on hold. When the agency has determined it has the capacity to serve the member, it will contact the member immediately and have seven (7) calendar days to conduct the intake or initial assessment.

1.28.3.1.2. Was this person holding for service?
(Please select one.)
○ Yes
○ No

1.28.3.1.2.1.1. Since which date was the consumer holding for service:
1.28.3.1.2.1.2. Date Case Worker assigned:
1.28.3.1.2.1.3. Date seen face to face:

1.28.3.1.3. Date Case Worker assigned:

1.28.3.1.4. Date seen face to face:

Instructions: ADULT SERVICES ONLY

1.28.4. Does the member receive Vocational Rehabilitation Services?
(Please select one.)
○ Yes
○ No

Instructions: ADULT SERVICES ONLY

1.28.5. Does the member currently have a rent subsidy or live in subsidized housing?
(Please select one.)
○ Yes
○ No

1.28.5.1.1. Please indicate what type of rent subsidy or subsidized housing:
(Please select one.)
○ Bridging Rental Assistance Program (B.R.A.P.) ○ Building is subsidized
○ Section 8 ○ Shelter Plus Care
○ Veteran"s Housing ○ Other

Instructions: Section 17

1.29.1. Is this your first CSR?
(Please select one.)
○ Yes
○ No

1.29.1.1.1. Date of referral:

Instructions: Members have the option to be placed on hold for service if the agency, upon receipt of a referral from any source, has determined that it does not have the capacity to conduct an intake or initial assessment within seven (7) calendar days as required in Sec. 17.03. To be placed on hold for service, providers must offer the member alternatives to being placed on hold for service, including but not limited to giving information on other service providers within a 25-mile radius servicing the area. This information shall be provided in writing. Should members wish to be on hold for service with an agency, the provider will document the member choice and the offering of alternatives in the member's referral record. At this time, the seven (7) calendar day face-to-face requirement will be suspended. Agencies must follow up with members no more than thirty (30) calendar days after being placed on hold to reevaluate their desire to remain on hold for service, which will be documented in the member record. Agencies must continue to follow up with members in successive thirty (30) day increments to reevaluate the member's desire to remain on hold. When the agency has determined it has the capacity to serve the member, it will contact the member immediately and have seven (7) calendar days to conduct the intake or initial assessment.

1.29.1.1.2. Was this person holding for service?
(Please select one.)
○ Yes
○ No

1.29.1.1.2.1.1. Since which date was the consumer holding for service:
1.29.1.1.2.1.2. Date Case Worker assigned:
1.29.1.1.2.1.3. Date seen face to face:

1.29.1.1.3. Date Case Worker assigned:

1.29.1.1.4. Date seen face to face:

1.29.2. Has the member received treatment in a state psychiatric hospital (Riverview, and/or Dorothea Dix Psychiatric Center) within the past 24 months, for a non-excluded DSM 5 diagnosis?
(Please select one.)
○ Yes
○ No

1.29.2.1.1. Provide the dates:

1.29.3. Has the member been discharged from a mental health residential facility, within the past 24 months, OR currently resides in a mental health residential facility, for a non-excluded DSM 5 diagnosis?
(Please select one.)
○ Yes
○ No

1.29.3.1.1. Provide the dates:

1.29.4. Has the member had two or more episodes of inpatient treatment for mental illness, greater than 72 hours per episode, within the past 24 months, for a non-excluded DSM 5 diagnosis?
(Please select one.)
○ Yes
○ No

1.29.4.1.1. Provide the dates:

1.29.5. Has the member been admitted by a civil court for emergency involuntary psychiatric treatment as an adult (Blue Paper)?
(Please select one.)
- ○ Yes
- ○ No

1.29.5.1.1. Provide the dates:

1.29.6. Is there an uploaded clinical letter from a clinician dated within the past year stating member is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis, that would result in or have significant risk factors of homlessness, criminal justice invlovelment or require a mental health inpatient treatment greater than 72 hours, or residential treatment unless community support program services are provided?
(Please select one.)
- ○ Yes
- ○ No

1.29.6.1.1. Date of clinical letter:
1.29.6.1.2. Name and credentials of clinician who wrote clinical letter:

Instructions: REQUIRED - LOCUS composite score must be a numerical value between 0-35. Only numbers should be entered in this box.
1.29.7. LOCUS Composite Score:
Min/Max - 0/35; No decimal places allowed

Instructions: REQUIRED – Date LOCUS Completed must be a date in the following format MM/DD/YYYY. Please do not enter a date in any other format.
1.29.8. Date LOCUS Completed:
1.29.9. LOCUS Level of Care:
Min/Max - 0/10; No decimal places allowed
1.29.10. Name and credentials of who completed the LOCUS assessment:

1.29.11. LOCUS Rater ID#:

1.29.12. Does the member receive Vocational Rehabilitation Services?
(Please select one.)
- ○ Yes
- ○ No

1.29.13. Does the member currently have a rent subsidy or live in subsidized housing?
(Please select one.)
- ○ Yes
- ○ No

1.29.13.1.1. Please indicate what type of rent subsidy or subsidized housing:
(Please select one.)
- ○ Bridging Rental Assistance Program (B.R.A.P.)
- ○ Building is subsidized
- ○ Section 8
- ○ Shelter Plus Care
- ○ Veteran''s Housing
- ○ Other

1.29.14. Select the Section 17 service type:
(Please select one.)
- ○ Assertive Community Treatment (ACT)
- ○ Community Integration (CI)
- ○ Community Rehabilitation Services (CRS)
- ○ Daily Living Support Services (DLSS)
- ○ Skills Development

1.29.14.1.1. Provide rationale why member requires a multidisciplinary team available seven days per week, twenty four hours per day:

1.29.14.1.2. Has member been receiving a minimum of three contacts from ACT team per week?
(Please select one.)
- ○ Yes
- ○ No

1.29.14.1.2.2.1. Provide rational of why a minimum of three contacts have not occurred per week:

1.29.14.1.3. How are services allowing member to retain community tenure and would require hospitalization or crisis services without the service?

1.29.14.2.1. Has the CI worker facilitated formal and informal opportunities for career exploration during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.29.14.2.1.1.1. Please explain

1.29.14.2.2. Has the CI worker coordinated referrals, and advocated for access by the member to the service(s) and natural support(s) identified in his or her Individual Support Plan during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.29.14.2.2.1.1. Please explain

1.29.14.2.3. Has the CI worker participated in ensuring the delivery of crisis intervention and resolution services during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.29.14.2.3.1.1. Please explain

1.29.14.2.4. Has the CI worker assisted in the exploration of less restrictive alternatives to hospitalization during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.29.14.2.4.1.1. Please explain

1.29.14.2.5. Has the CI worker made face-to-face contact with other professionals, caregivers, or individuals included in the treatment plan in order to achieve continuity of care, coordination of services, and the most appropriate services for the member per their ISP in the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.29.14.2.5.1.1. Please explain

1.29.14.2.6. Has the CI worker contacted the member''s guardian, family, significant other, and providers of services or natural supports to ensure the continuity of care and coordination of services between inpatient and community settings during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.29.14.2.6.1.1. Please Explain:

1.29.14.2.7. Has the CI worker provided information and consultation with the member receiving Community Support Services, to the member, his or her family, or his or her immediate support system, in order to assist the member to manage the symptoms or impairments of his or her illness with a focus on independence within the last review period?
(Please select one.)
- ○ Yes

- ○ No

1.29.14.2.7.1.1. Please explain

1.29.14.2.8. Has the CI worker assisted the member in restoring and improving communication skills needed to request assistance or clarification from supervisors and co-workers during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.29.14.2.8.1.1. Please explain

1.29.14.2.9. Has the CI worker assisted the member to enhance skills and employment strategies to overcome or address psychiatric symptoms that interfere with seeking, obtaining, and maintaining a job during the last review period?
(Please select one.)
- ○ Yes
- ○ No

1.29.14.2.9.1.1. Please explain

1.29.14.2.10. Is this service being provided under an OBH Funded contract for Veteran"s Case Management?
(Please select one.)
- ○ Yes
- ○ No

1.29.14.3.1. Provide rationale why member requires staff availability seven days per week, twenty four hours per day:

1.29.14.3.2. Has the member been receiving a minimum of one contact per day?
(Please select one.)
- ○ Yes
- ○ No

1.29.14.3.2.2.1. Provide rational of why a daily minimum contact has not occurred:

1.29.14.4.1. If provider is a Certified Residential Medication Aide (CRMA), are they administering and supervising medications?
(Please select one.)
- ○ Yes
- ○ No

1.29.14.4.2. If member is accessing a higher level of care, please describe coordination with service provider and non duplication of interventions?

1.29.14.5.1. If provider is a Certified Residential Medication Aide (CRMA), are they administering and supervising medications?
(Please select one.)
- ○ Yes
- ○ No