Questionnaire: Coordinated Service Plan (CSP)

CSP Requirement

1.Has there been a recently completed single assessment for which you need to complete the initial CSP?
(Please select one.)
- ○ Yes
- ○ No

1.1.1. Please indicate the date of first meeting about the current CSP
1.1.2. Please indicate the date of the CSP submission
1.1.3. Guardian"s First Name

1.1.4. Guardian"s Last Name

1.1.5. Where is the member currently residing?
(Please select one.)
- ○ Child Residential Care Facility (CRCF)
- ○ Foster Care
- ○ Home
- ○ Long Creek
- ○ Other
- ○ Out of State Child Residential Care Facility (CRCF)
- ○ PRTF
- ○ Psychiatric Hospital
- ○ Shelter

1.1.5.6.1.Please describe.

1.1.5.7.1.Has a return plan been developed?
(Please select one.)
- ○ Yes
- ○ No
- ○ N/A

1.1.6. What is the member"s current physical address? Please only include the street number and street name

1.1.7. Please select the member"s city of residence
(Please select one.)
- ○ Abbot
- ○ Acton
- ○ Addison
- ○ Albion
- ○ Alexander
- ○ Alfred
- ○ Allagash
- ○ Alna
- ○ Alton
- ○ Amherst
- ○ Amity
- ○ Andover
- ○ Anson
- ○ Appleton
- ○ Argyle
- ○ Arrowsic
- ○ Ashland
- ○ Athens
- ○ Auburn

- Augusta
- Aurora
- Avon
- Baileyville
- Bancroft
- Bangor
- Bar Harbor
- Baring
- Bath
- Beals
- Beaver Cove
- Beddington
- Belfast
- Belgrade
- Belmont
- Benedicta
- Benton
- Berwick
- Bethel
- Biddeford
- Bingham
- Birch Harbor
- Blaine
- Blanchard
- Blue Hill
- Boothbay
- Boothbay Harbor
- Bowdoin
- Bowdoinham
- Bowerbank
- Bradford
- Bradley
- Bremen
- Brewer
- Bridgewater
- Bridgton
- Brighton
- Bristol
- Brooklin
- Brooks
- Brooksville
- Brookton
- Brownfield
- Brownville
- Brownville Junction
- Brunswick
- Buckfield
- Bucksport
- Burlington
- Burnham
- Buxton
- Calais
- Cambridge
- Camden
- Canaan
- Canton
- Cape Elizabeth
- Cape Neddick
- Caribou
- Carmel
- Casco
- Castine
- Castle Hill
- Caswell
- Chapman
- Charleston

- Chebeague Island
- Cherryfield
- Chesterville
- China
- Clinton
- Columbia
- Columbia Falls
- Cooper
- Corinna
- Corinth
- Cornish
- Cranberry Isles
- Cumberland
- Cushing
- Cutler
- Dallas Plantation
- Damariscotta
- Danforth
- Dedham
- Deer Isle
- Denmark
- Dennysville
- Detroit
- Dexter
- Dixfield
- Dixmont
- Dover-Foxcroft
- Dresden
- Durham
- Eagle Lake
- East Machias
- East Millinocket
- Eastbrook
- Easton
- Eastport
- Eddington
- Edgecomb
- Eliot
- Ellsworth
- Embden
- Enfield
- Etna
- Eustis
- Exeter
- Fairfield
- Falmouth
- Farmingdale
- Farmington
- Fort Fairfield
- Fort Kent
- Frankfort
- Franklin
- Freedom
- Freeport
- Frenchboro
- Frenchville
- Friendship
- Fryeburg
- Gardiner
- Garland
- Georgetown
- Glenburn
- Gorham
- Gouldsboro
- Grand Isle
- Gray

- Greenbush
- Greene
- Greenville
- Greenwood
- Guilford
- Hallowell
- Hampden
- Hancock
- Hanover
- Harmony
- Harpswell
- Harrington
- Harrison
- Hartland
- Haynesville
- Hebron
- Hermon
- Hiram
- Hodgdon
- Holden
- Hollis
- Hope
- Houlton
- Howland
- Hudson
- Industry
- Island Falls
- Islesboro
- Jackman
- Jay
- Jefferson
- Jonesboro
- Jonesport
- Kenduskeag
- Kennebunk
- Kennebunkport
- Kingfield
- Kittery
- Kittery Point
- Lagrange
- Lakeville
- Lebanon
- Lee
- Leeds
- Levant
- Lewiston
- Liberty
- Limerick
- Limestone
- Limington
- Lincoln
- Lincoln Plantation
- Lincolnville
- Lisbon
- Lisbon Falls
- Litchfield
- Littleton
- Livermore
- Livermore Falls
- Long Island
- Lovell
- Lubec
- Machias
- Machiasport
- Madawaska
- Madison

- Manchester
- Mapleton
- Mars Hill
- Masardis
- Mattawamkeag
- Mechanic Falls
- Medway
- Mexico
- Milbridge
- Milford
- Millinocket
- Milo
- Minot
- Monmouth
- Monroe
- Monson
- Monticello
- Morrill
- Mount Desert
- Mount Vernon
- Naples
- New Canada
- New Gloucester
- New Limerick
- New Portland
- New Sharon
- New Sweden
- New Vineyard
- Newcastle
- Newfield
- Newport
- Newry
- Nobleboro
- Norridgewock
- North Berwick
- North Haven
- North Yarmouth
- Northport
- Norway
- Oakfield
- Oakland
- Ogunquit
- Old Orchard Beach
- Old Town
- Orland
- Orono
- Osborn
- Otis
- Otisfield
- Owls Head
- Oxford
- Palermo
- Palmyra
- Paris
- Parsonsfield
- Passadumkeag
- Patten
- Pembroke
- Penobscot
- Perham
- Perry
- Peru
- Phillips
- Phippsburg
- Pittsfield
- Pleasant Ridge Plantation

- Plymouth
- Poland
- Portage Lake
- Portland
- Pownal
- Presque Isle
- Princeton
- Prospect
- Randolph
- Rangeley
- Raymond
- Readfield
- Richmond
- Ripley
- Robbinston
- Rockland
- Rockport
- Rome
- Roque Bluffs
- Roxbury
- Rumford
- Sabattus
- Saco
- Saint Agatha
- Saint Albans
- Saint Francis
- Sanford
- Sangerville
- Scarborough
- Searsmont
- Searsport
- Sebago
- Sebec
- Sedgwick
- Shapleigh
- Sherman
- Shirley
- Sidney
- Skowhegan
- Smithfield
- Smyrna
- Solon
- Somerville
- Sorrento
- South Berwick
- South Bristol
- South Portland
- South Thomaston
- Southport
- Southwest Harbor
- Springfield
- Standish
- Starks
- Stetson
- Steuben
- Stockholm
- Stockton Springs
- Stoneham
- Stonington
- Stow
- Strong
- Sullivan
- Sumner
- Surry
- Swans Island
- Sweden

- Temple
- Thomaston
- Thorndike
- Topsfield
- Topsham
- Tremont
- Trenton
- Troy
- Turner
- Union
- Unity
- Van Buren
- Vanceboro
- Vassalboro
- Veazie
- Verona Island
- Vienna
- Vinalhaven
- Wade
- Waldoboro
- Wallagrass
- Warren
- Washburn
- Washington
- Waterboro
- Waterford
- Waterville
- Wayne
- Webster Plantation
- Weld
- Wellington
- Wells
- Wesley
- West Bath
- West Gardiner
- West Paris
- Westbrook
- Westfield
- Westmanland
- Westport Island
- Whitefield
- Whiting
- Whitneyville
- Wilton
- Windham
- Windsor
- Winthrop
- Wiscasset
- Woodland
- Woolwich
- Yarmouth
- York

1.1.8. Does the legal guardian reside at the current location of the member? (Please select one.)

- Yes
- No

1.1.8.2.1.Please indicate who the contact is as the member''s location

1.1.8.2.2.Phone number and email of contact at member''s location

1.1.9. First Name of Case Manager

1.1.10.Last Name of Case Manager

1.1.11.Please indicate the type of Case Manager/Provider
(Please select one.)
- ○ BHH
- ○ Child ACT
- ○ HFW
- ○ Section 17
- ○ TCM

1.1.12.Please enter the Case Manager''s telephone number

1.1.13.Please provide the Case Manager''s email address

1.1.14.Please select the name of the Case Manager''s agency
(Please select one.)
- ○ Aroostook County Mental Health Community Health and Counseling
- ○ Kennebec Behavioral Health
- ○ Maine Behavioral Health
- ○ Spurwink
- ○ Other

1.1.14.6.1.Please Explain:

1.1.15.What is the name of the Service Provider/Organization?

1.1.16.What is the status of the CSP?
(Please select one.)
- ○ Initial
- ○ Revision
- ○ Discharge CSP

1.1.16.2.1.Indicate the services the member was deemed eligible for during the Single Assessment
(Please select between 1 and 15 items.)
- ☐ Child Assertive Community Treatment
- ☐ Children's Residential Care Facility IDD (CRCF-IDD)
- ☐ Children's Residential Care Facility MH (CRCF-MH)
- ☐ Enhanced Treatment Foster Care (ETFC)
- ☐ Functional Family Therapy (FFT)
- ☐ High Fidelity Wrap Around (HFW)
- ☐ Home & Community-Based Treatment (HCT)
- ☐ Intensive Outpatient Therapy (IOP)
- ☐ Multi-Systemic Therapy (MST)
- ☐ Multi-Systemic Therapy Problem Sexualized Behavior (MST-PSB)
- ☐ Psychiatric Residential Treatment Facility (PRTF)
- ☐ Rehab & Community Support (RCS) Non-Specialized
- ☐ Rehab & Community Support (RCS) Specialized
- ☐ Therapeutic Intensive Home (TIH)
- ☐ Treatment Foster Care (TFC)

1.1.16.2.1.2.1.Has the family chosen Child Assertive Community Treatment service?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.2.1.1.1.Child Assertive Community Treatment Service: Provider Chosen

1.1.16.2.1.2.1.1.2.Indicate if there are barriers to receiving Child Assertive Community Treatment services in the home
(Please select between 1 and 9 items.)

- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.2.1.2.1.1.2.9.1.Please specify

1.1.16.2.1.2.1.1.3.Does Child Assertive Community Treatment service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)

- ○ Yes
- ○ No

1.1.16.2.1.2.1.1.3.1.1.Have the modifications been made?
(Please select one.)

- ○ Yes
- ○ No

1.1.16.2.1.2.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)

- ○ Yes
- ○ No

1.1.16.2.1.3.1.Has the family chosen Children's Residential Care Facility IDD (CRCF-IDD) service?
(Please select one.)

- ○ Yes
- ○ No

1.1.16.2.1.3.1.1.1.Children's Residential Care Facility IDD (CRCF-IDD) Service: Provider Chosen

1.1.16.2.1.3.1.1.2.Indicate if there are barriers to receiving Children's Residential Care Facility IDD (CRCF-IDD) services in the home
(Please select between 1 and 9 items.)

- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.2.1.3.1.1.2.9.1.Please specify

1.1.16.2.1.3.1.1.3.Does Children's Residential Care Facility IDD (CRCF-IDD) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)

- ○ Yes
- ○ No

1.1.16.2.1.3.1.1.3.1.1.Have the modifications been made?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.3.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.4.1.Has the family chosen Children's Residential Care Facility MH (CRCF-MH) service?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.4.1.1.1.Children's Residential Care Facility MH (CRCF-MH) Service: Provider Chosen

1.1.16.2.1.4.1.1.2.Indicate if there are barriers to receiving Children's Residential Care Facility MH (CRCF-MH) services in the home
(Please select between 1 and 9 items.)
- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.2.1.4.1.1.2.9.1.Please specify

1.1.16.2.1.4.1.1.3.Does Children's Residential Care Facility MH (CRCF-MH) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.4.1.1.3.1.1.Have the modifications been made?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.4.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.5.1.Has the family chosen Enhanced Treatment Foster Care (ETFC) service?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.5.1.1.1.Enhanced Treatment Foster Care (ETFC) Service: Provider Chosen

1.1.16.2.1.5.1.1.2.Indicate if there are barriers to receiving Enhanced Treatment Foster Care (ETFC) services in the home
(Please select between 1 and 9 items.)
- ☐ Cultural and Linguistic
- ☐ Distance to treatment

- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.2.1.5.1.1.2.9.1.Please specify

1.1.16.2.1.5.1.1.3.Does Enhanced Treatment Foster Care (ETFC) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.5.1.1.3.1.1.Have the modifications been made?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.5.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.6.1.Has the family chosen Functional Family Therapy (FFT) service?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.6.1.1.1.Functional Family Therapy (FFT) Service: Provider Chosen

1.1.16.2.1.6.1.1.2.Indicate if there are barriers to receiving Functional Family Therapy (FFT) services in the home
(Please select between 1 and 9 items.)
- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.2.1.6.1.1.2.9.1.Please specify

1.1.16.2.1.6.1.1.3.Does Functional Family Therapy (FFT) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.6.1.1.3.1.1.Have the modifications been made?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.6.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)

(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.7.1.Has the family chosen High Fidelity Wrap Around (HFW) service?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.7.1.1.1.High Fidelity Wrap Around (HFW) Service: Provider Chosen

1.1.16.2.1.7.1.1.2.Indicate if there are barriers to receiving High Fidelity Wrap Around (HFW) services in the home
(Please select between 1 and 9 items.)
- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.2.1.7.1.1.2.9.1.Please specify

1.1.16.2.1.7.1.1.3.Does High Fidelity Wrap Around (HFW) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.7.1.1.3.1.1.Have the modifications been made?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.7.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.8.1.Has the family chosen Home & Community-Based Treatment (HCT) service?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.8.1.1.1.Home & Community-Based Treatment (HCT) Service: Provider Chosen

1.1.16.2.1.8.1.1.2.Indicate if there are barriers to receiving Home & Community-Based Treatment (HCT) services in the home
(Please select between 1 and 9 items.)
- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.2.1.8.1.1.2.9.1.Please specify

1.1.16.2.1.8.1.1.3.Does Home & Community-Based Treatment (HCT) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.8.1.1.3.1.1.Have the modifications been made?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.8.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.9.1.Has the family chosen Intensive Outpatient Therapy (IOP) service?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.9.1.1.1.Intensive Outpatient Therapy (IOP) Service: Provider Chosen

1.1.16.2.1.9.1.1.2.Indicate if there are barriers to receiving Intensive Outpatient Therapy (IOP) services in the home
(Please select between 1 and 9 items.)
- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.2.1.9.1.1.2.9.1.Please specify

1.1.16.2.1.9.1.1.3.Does Intensive Outpatient Therapy (IOP) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.9.1.1.3.1.1.Have the modifications been made?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.9.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.10.1.Has the family chosen Multi-Systemic Therapy (MST) service?
(Please select one.)
- ○ Yes

○ No

1.1.16.2.1.10.1.1.1.Multi-Systemic Therapy (MST) Service: Provider Chosen

1.1.16.2.1.10.1.1.2.Indicate if there are barriers to receiving Multi-Systemic Therapy (MST) services in the home
(Please select between 1 and 9 items.)
- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.2.1.10.1.1.2.9.1.Please specify

1.1.16.2.1.10.1.1.3.Does Multi-Systemic Therapy (MST) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.10.1.1.3.1.1.Have the modifications been made?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.10.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.11.1.Has the family chosen Multi-Systemic Therapy Problem Sexualized Behavior (MST-PSB) service?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.11.1.1.1.Multi-Systemic Therapy Problem Sexualized Behavior (MST-PSB) Service: Provider Chosen

1.1.16.2.1.11.1.1.2.Indicate if there are barriers to receiving Multi-Systemic Therapy Problem Sexualized Behavior (MST-PSB) services in the home
(Please select between 1 and 9 items.)
- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.2.1.11.1.1.2.9.1.Please specify

1.1.16.2.1.11.1.1.3.Does Multi-Systemic Therapy Problem Sexualized Behavior (MST-PSB) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)

○ Yes
○ No

1.1.16.2.1.11.1.1.3.1.1.Have the modifications been made?
(Please select one.)
○ Yes
○ No

1.1.16.2.1.11.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
○ Yes
○ No

1.1.16.2.1.12.1.Has the family chosen Psychiatric Residential Treatment Facility (PRTF) service?
(Please select one.)
○ Yes
○ No

1.1.16.2.1.12.1.1.1.Psychiatric Residential Treatment Facility (PRTF) Service: Provider Chosen

1.1.16.2.1.12.1.1.2.Indicate if there are barriers to receiving Psychiatric Residential Treatment Facility (PRTF) services in the home
(Please select between 1 and 9 items.)
☐ Cultural and Linguistic
☐ Distance to treatment
☐ Environmental barriers
☐ Physical limitations of the home
☐ Provider Availability
☐ Scheduling
☐ Transportation
☐ Other
☐ None

1.1.16.2.1.12.1.1.2.9.1.Please specify

1.1.16.2.1.12.1.1.3.Does Psychiatric Residential Treatment Facility (PRTF) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
○ Yes
○ No

1.1.16.2.1.12.1.1.3.1.1.Have the modifications been made?
(Please select one.)
○ Yes
○ No

1.1.16.2.1.12.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
○ Yes
○ No

1.1.16.2.1.13.1.Has the family chosen Rehab & Community Support (RCS) Non-Specialized service?
(Please select one.)
○ Yes
○ No

1.1.16.2.1.13.1.1.1.Rehab & Community Support (RCS) Non-Specialized Service: Provider Chosen

1.1.16.2.1.13.1.1.2.Indicate if there are barriers to receiving Rehab & Community Support (RCS) Non-Specialized

services in the home
(Please select between 1 and 9 items.)

- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.2.1.13.1.1.2.9.1.Please specify

1.1.16.2.1.13.1.1.3.Does Rehab & Community Support (RCS) Non-Specialized service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)

- ○ Yes
- ○ No

1.1.16.2.1.13.1.1.3.1.1.Have the modifications been made?
(Please select one.)

- ○ Yes
- ○ No

1.1.16.2.1.13.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)

- ○ Yes
- ○ No

1.1.16.2.1.14.1.Has the family chosen Rehab & Community Support (RCS) Specialized service?
(Please select one.)

- ○ Yes
- ○ No

1.1.16.2.1.14.1.1.1.Rehab & Community Support (RCS) Specialized Service: Provider Chosen

1.1.16.2.1.14.1.1.2.Indicate if there are barriers to receiving Rehab & Community Support (RCS) Specialized services in the home
(Please select between 1 and 9 items.)

- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.2.1.14.1.1.2.9.1.Please specify

1.1.16.2.1.14.1.1.3.Does Rehab & Community Support (RCS) Specialized service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)

- ○ Yes
- ○ No

1.1.16.2.1.14.1.1.3.1.1.Have the modifications been made?
(Please select one.)

- ○ Yes

Yes
○ No

1.1.16.2.1.14.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
○ Yes
○ No

1.1.16.2.1.15.1.Has the family chosen Therapeutic Intensive Home (TIH) service?
(Please select one.)
○ Yes
○ No

1.1.16.2.1.15.1.1.1.Therapeutic Intensive Home (TIH) Service: Provider Chosen

1.1.16.2.1.15.1.1.2.Indicate if there are barriers to receiving Therapeutic Intensive Home (TIH) services in the home
(Please select between 1 and 9 items.)
☐ Cultural and Linguistic
☐ Distance to treatment
☐ Environmental barriers
☐ Physical limitations of the home
☐ Provider Availability
☐ Scheduling
☐ Transportation
☐ Other
☐ None

1.1.16.2.1.15.1.1.2.9.1.Please specify

1.1.16.2.1.15.1.1.3.Does Therapeutic Intensive Home (TIH) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
○ Yes
○ No

1.1.16.2.1.15.1.1.3.1.1.Have the modifications been made?
(Please select one.)
○ Yes
○ No

1.1.16.2.1.15.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
○ Yes
○ No

1.1.16.2.1.16.1.Has the family chosen Treatment Foster Care (TFC) service?
(Please select one.)
○ Yes
○ No

1.1.16.2.1.16.1.1.1.Treatment Foster Care (TFC) Service: Provider Chosen

1.1.16.2.1.16.1.1.2.Indicate if there are barriers to receiving Treatment Foster Care (TFC) services in the home
(Please select between 1 and 9 items.)
☐ Cultural and Linguistic
☐ Distance to treatment
☐ Environmental barriers
☐ Physical limitations of the home
☐ Provider Availability

- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.2.1.16.1.1.2.9.1.Please specify

1.1.16.2.1.16.1.1.3.Does Treatment Foster Care (TFC) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.16.1.1.3.1.1.Have the modifications been made?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.2.1.16.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.Indicate the services the member was deemed eligible for during the Single Assessment
(Please select between 1 and 15 items.)
- ☐ Child Assertive Community Treatment
- ☐ Children's Residential Care Facility IDD (CRCF-IDD)
- ☐ Children's Residential Care Facility MH (CRCF-MH)
- ☐ Enhanced Treatment Foster Care (ETFC)
- ☐ Functional Family Therapy (FFT)
- ☐ High Fidelity Wrap Around (HFW)
- ☐ Home & Community-Based Treatment (HCT)
- ☐ Intensive Outpatient Therapy (IOP)
- ☐ Multi-Systemic Therapy (MST)
- ☐ Multi-Systemic Therapy Problem Sexualized Behavior (MST-PSB)
- ☐ Psychiatric Residential Treatment Facility (PRTF)
- ☐ Rehab & Community Support (RCS) Non-Specialized
- ☐ Rehab & Community Support (RCS) Specialized
- ☐ Therapeutic Intensive Home (TIH)
- ☐ Treatment Foster Care (TFC)

1.1.16.3.1.2.1.Has the family chosen Child Assertive Community Treatment service?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.2.1.1.1.Child Assertive Community Treatment Service: Provider Chosen

1.1.16.3.1.2.1.1.2.Indicate if there are barriers to receiving Child Assertive Community Treatment services in the home
(Please select between 1 and 9 items.)
- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.3.1.2.1.1.2.9.1.Please specify

1.1.16.3.1.2.1.1.3.Does Child Assertive Community Treatment service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.2.1.1.3.1.1.Have the modifications been made?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.2.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.3.1.Has the family chosen Children's Residential Care Facility IDD (CRCF-IDD) service?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.3.1.1.1.Children's Residential Care Facility IDD (CRCF-IDD) Service: Provider Chosen

1.1.16.3.1.3.1.1.2.Indicate if there are barriers to receiving Children's Residential Care Facility IDD (CRCF-IDD) services in the home
(Please select between 1 and 9 items.)
- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.3.1.3.1.1.2.9.1.Please specify

1.1.16.3.1.3.1.1.3.Does Children's Residential Care Facility IDD (CRCF-IDD) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.3.1.1.3.1.1.Have the modifications been made?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.3.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.4.1.Has the family chosen Children's Residential Care Facility MH (CRCF-MH) service?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.4.1.1.1.Children's Residential Care Facility MH (CRCF-MH) Service: Provider Chosen

1.1.16.3.1.4.1.1.2.Indicate if there are barriers to receiving Children's Residential Care Facility MH (CRCF-MH) services in the home
(Please select between 1 and 9 items.)
- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.3.1.4.1.1.2.9.1.Please specify

1.1.16.3.1.4.1.1.3.Does Children's Residential Care Facility MH (CRCF-MH) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.4.1.1.3.1.1.Have the modifications been made?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.4.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.5.1.Has the family chosen Enhanced Treatment Foster Care (ETFC) service?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.5.1.1.1.Enhanced Treatment Foster Care (ETFC) Service: Provider Chosen

1.1.16.3.1.5.1.1.2.Indicate if there are barriers to receiving Enhanced Treatment Foster Care (ETFC) services in the home
(Please select between 1 and 9 items.)
- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.3.1.5.1.1.2.9.1.Please specify

1.1.16.3.1.5.1.1.3.Does Enhanced Treatment Foster Care (ETFC) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.5.1.1.3.1.1.Have the modifications been made?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.5.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.6.1.Has the family chosen Functional Family Therapy (FFT) service?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.6.1.1.1.Functional Family Therapy (FFT) Service: Provider Chosen

1.1.16.3.1.6.1.1.2.Indicate if there are barriers to receiving Functional Family Therapy (FFT) services in the home
(Please select between 1 and 9 items.)
- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.3.1.6.1.1.2.9.1.Please specify

1.1.16.3.1.6.1.1.3.Does Functional Family Therapy (FFT) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.6.1.1.3.1.1.Have the modifications been made?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.6.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.7.1.Has the family chosen High Fidelity Wrap Around (HFW) service?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.7.1.1.1.High Fidelity Wrap Around (HFW) Service: Provider Chosen

1.1.16.3.1.7.1.1.2.Indicate if there are barriers to receiving High Fidelity Wrap Around (HFW) services in the home
(Please select between 1 and 9 items.)
- ☐ Cultural and Linguistic
- ☐ Distance to treatment

☐ Distance to treatment
☐ Environmental barriers
☐ Physical limitations of the home
☐ Provider Availability
☐ Scheduling
☐ Transportation
☐ Other
☐ None

1.1.16.3.1.7.1.1.2.9.1.Please specify

1.1.16.3.1.7.1.1.3.Does High Fidelity Wrap Around (HFW) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
○ Yes
○ No

1.1.16.3.1.7.1.1.3.1.1.Have the modifications been made?
(Please select one.)
○ Yes
○ No

1.1.16.3.1.7.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
○ Yes
○ No

1.1.16.3.1.8.1.Has the family chosen Home & Community-Based Treatment (HCT) service?
(Please select one.)
○ Yes
○ No

1.1.16.3.1.8.1.1.1.Home & Community-Based Treatment (HCT) Service: Provider Chosen

1.1.16.3.1.8.1.1.2.Indicate if there are barriers to receiving Home & Community-Based Treatment (HCT) services in the home
(Please select between 1 and 9 items.)
☐ Cultural and Linguistic
☐ Distance to treatment
☐ Environmental barriers
☐ Physical limitations of the home
☐ Provider Availability
☐ Scheduling
☐ Transportation
☐ Other
☐ None

1.1.16.3.1.8.1.1.2.9.1.Please specify

1.1.16.3.1.8.1.1.3.Does Home & Community-Based Treatment (HCT) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
○ Yes
○ No

1.1.16.3.1.8.1.1.3.1.1.Have the modifications been made?
(Please select one.)
○ Yes
○ No

1.1.16.3.1.8.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA

Coordinator?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.9.1.Has the family chosen Intensive Outpatient Therapy (IOP) service?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.9.1.1.1.Intensive Outpatient Therapy (IOP) Service: Provider Chosen

1.1.16.3.1.9.1.1.2.Indicate if there are barriers to receiving Intensive Outpatient Therapy (IOP) services in the home
(Please select between 1 and 9 items.)
- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.3.1.9.1.1.2.9.1.Please specify

1.1.16.3.1.9.1.1.3.Does Intensive Outpatient Therapy (IOP) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.9.1.1.3.1.1.Have the modifications been made?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.9.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.10.1.Has the family chosen Multi-Systemic Therapy (MST) service?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.10.1.1.1.Multi-Systemic Therapy (MST) Service: Provider Chosen

1.1.16.3.1.10.1.1.2.Indicate if there are barriers to receiving Multi-Systemic Therapy (MST) services in the home
(Please select between 1 and 9 items.)
- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

- None

1.1.16.3.1.10.1.1.2.9.1.Please specify

1.1.16.3.1.10.1.1.3.Does Multi-Systemic Therapy (MST) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
- Yes
- No

1.1.16.3.1.10.1.1.3.1.1.Have the modifications been made?
(Please select one.)
- Yes
- No

1.1.16.3.1.10.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
- Yes
- No

1.1.16.3.1.11.1.Has the family chosen Multi-Systemic Therapy Problem Sexualized Behavior (MST-PSB) service?
(Please select one.)
- Yes
- No

1.1.16.3.1.11.1.1.1.Multi-Systemic Therapy Problem Sexualized Behavior (MST-PSB) Service: Provider Chosen

1.1.16.3.1.11.1.1.2.Indicate if there are barriers to receiving Multi-Systemic Therapy Problem Sexualized Behavior (MST-PSB) services in the home
(Please select between 1 and 9 items.)
- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.3.1.11.1.1.2.9.1.Please specify

1.1.16.3.1.11.1.1.3.Does Multi-Systemic Therapy Problem Sexualized Behavior (MST-PSB) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
- Yes
- No

1.1.16.3.1.11.1.1.3.1.1.Have the modifications been made?
(Please select one.)
- Yes
- No

1.1.16.3.1.11.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
- Yes
- No

1.1.16.3.1.12.1.Has the family chosen Psychiatric Residential Treatment Facility (PRTF) service?
(Please select one.)

(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.12.1.1.1.Psychiatric Residential Treatment Facility (PRTF) Service: Provider Chosen

1.1.16.3.1.12.1.1.2.Indicate if there are barriers to receiving Psychiatric Residential Treatment Facility (PRTF) services in the home
(Please select between 1 and 9 items.)
- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.3.1.12.1.1.2.9.1.Please specify

1.1.16.3.1.12.1.1.3.Does Psychiatric Residential Treatment Facility (PRTF) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.12.1.1.3.1.1.Have the modifications been made?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.12.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.13.1.Has the family chosen Rehab & Community Support (RCS) Non-Specialized service?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.13.1.1.1.Rehab & Community Support (RCS) Non-Specialized Service: Provider Chosen

1.1.16.3.1.13.1.1.2.Indicate if there are barriers to receiving Rehab & Community Support (RCS) Non-Specialized services in the home
(Please select between 1 and 9 items.)
- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.3.1.13.1.1.2.9.1.Please specify

1.1.16.3.1.13.1.1.3.Does Rehab & Community Support (RCS) Non-Specialized service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.13.1.1.3.1.1.Have the modifications been made?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.13.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.14.1.Has the family chosen Rehab & Community Support (RCS) Specialized service?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.14.1.1.1.Rehab & Community Support (RCS) Specialized Service: Provider Chosen

1.1.16.3.1.14.1.1.2.Indicate if there are barriers to receiving Rehab & Community Support (RCS) Specialized services in the home
(Please select between 1 and 9 items.)
- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.3.1.14.1.1.2.9.1.Please specify

1.1.16.3.1.14.1.1.3.Does Rehab & Community Support (RCS) Specialized service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.14.1.1.3.1.1.Have the modifications been made?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.14.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.15.1.Has the family chosen Therapeutic Intensive Home (TIH) service?
(Please select one.)
- ○ Yes
- ○ No

1.1.16.3.1.15.1.1.1.Therapeutic Intensive Home (TIH) Service: Provider Chosen

1.1.16.3.1.15.1.1.2.Indicate if there are barriers to receiving Therapeutic Intensive Home (TIH) services in the home
(Please select between 1 and 9 items.)

- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.3.1.15.1.1.2.9.1.Please specify

1.1.16.3.1.15.1.1.3.Does Therapeutic Intensive Home (TIH) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)

- ○ Yes
- ○ No

1.1.16.3.1.15.1.1.3.1.1.Have the modifications been made?
(Please select one.)

- ○ Yes
- ○ No

1.1.16.3.1.15.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)

- ○ Yes
- ○ No

1.1.16.3.1.16.1.Has the family chosen Treatment Foster Care (TFC) service?
(Please select one.)

- ○ Yes
- ○ No

1.1.16.3.1.16.1.1.1.Treatment Foster Care (TFC) Service: Provider Chosen

1.1.16.3.1.16.1.1.2.Indicate if there are barriers to receiving Treatment Foster Care (TFC) services in the home
(Please select between 1 and 9 items.)

- ☐ Cultural and Linguistic
- ☐ Distance to treatment
- ☐ Environmental barriers
- ☐ Physical limitations of the home
- ☐ Provider Availability
- ☐ Scheduling
- ☐ Transportation
- ☐ Other
- ☐ None

1.1.16.3.1.16.1.1.2.9.1.Please specify

1.1.16.3.1.16.1.1.3.Does Treatment Foster Care (TFC) service need to be reasonably modified so the child is able to receive them in the home?
(Please select one.)

- ○ Yes
- ○ No

1.1.16.3.1.16.1.1.3.1.1.Have the modifications been made?
(Please select one.)

(Please select one.)

- ○ Yes
- ○ No

1.1.16.3.1.16.1.1.3.1.1.2.1.Has the family been referred to the DHHS ADA Coordinator?
(Please select one.)

- ○ Yes
- ○ No

1.1.17.Has a crisis plan been developed?
(Please select one.)

- ○ Yes
- ○ No

1.1.17.1.1.Please provide the Crisis Plan

1.1.17.2.1.Identify the reason why a crisis plan has not been developed
(Please select between 1 and 2 items.)

- ☐ Family Refusal
- ☐ Other

1.1.17.2.1.3.1.Please specify

1.1.18.By clicking this box, I am attesting that the family engaged in an informed choice process which led to the chosen services.
(Please select one.)

- ○ I attest