Department of Mental Health
Record Guide
For
Mental Health, Intellectual and Developmental Disabilities, and Substance Abuse Community Providers

2012 Revision

Mississippi Department of Mental Health
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239 North Lamar Suite 1101
Jackson, MS 39201
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Section A
General Information
Purpose

Documentation required in the Mississippi Department of Mental Health (DMH) Record Guide serves as one of the methods for planning and evaluating services and supports provided by agencies and providers certified by the DMH. The intent of the record system outlined in this guide is to help ensure compliance with the DMH Operational Standards.

The emphasis of this Record Guide is on guidance needed to satisfy any and all documentation requirements referenced in the DMH Operational Standards or otherwise needed to ensure documentation of all services provided by agencies certified by DMH. Because of the DMH mandatory data collection and reporting requirements, along with the increasing use of electronic record keeping that many providers are implementing, the need to maintain paper forms is declining. This guide seeks to describe the type and amount of documentation that is necessary and provide a sample of a format with all information needed to satisfy the DMH record keeping requirements. Additional information may be added and the appearance of the form may be changed by the local provider. However, if required data or information is deleted in the process of modifying the form, it will no longer satisfy DMH Operational Standards for record keeping.

General Information

A record must be maintained for all individuals served by the agency/provider and must contain specific mandatory data and information. Additional data or information may be included to ensure that sufficient information is maintained to protect the privacy of all individuals receiving services. Two years of documentation must be maintained in the active record.

The Record Guide is divided into sections that allow the user to identify those forms or data tools required for all individual records, those that are used when the circumstances of the individual receiving services dictates their use, those that are specific to an area of service, and those that are administrative documentation that is not maintained in an individual’s record. For ease of use, there is also an alphabetical listing of all forms/data tools at the end of the Record Guide.

Each area of documentation/record keeping has specific guidance that states the purpose of the form/data tool. Also included in the guidance are references to the DMH Operational Standards, timelines for completion, and specific information regarding the nature and purpose of all forms/data tools.

References to “days” in the Record Guide mean calendar days.

Any section or area of a form that is not applicable must contain a strikethrough line that clearly indicates the item was not overlooked or omitted and that it does not apply to the individual receiving services.
Signatory Authority

Signatures are necessary to verify that information has been correctly and thoroughly shared with individuals receiving services. Signatures are also necessary to create a legally binding document. Forms in the Record Guide require signatures necessary for proper authorization of a particular form. Each signature line provided is clearly marked as to who is expected to sign. All signature lines on all forms must either be signed or marked as "not applicable" if that is the correct response. For example, all of the signature lines provided may not be necessary to document the individuals who participated in development of the Individual Service Plan or the Periodic Staffing/Review of the Individual Service Plan.

Electronic signatures are allowed on any form in the Record Guide.

Signature of the Individual Receiving Services
The individual receiving services must sign for himself or herself unless one of the following conditions applies or is present:

1. The individual is under 18 years of age.
2. A legal representative has been appointed for the person by a court of competent jurisdiction.

Signature of Individual Authorized to Give Consent or Sign in Lieu of the Individual Receiving Services
If one of the conditions stated above applies and the person is unable to sign for himself or herself, the person who is authorized to give consent or sign in lieu of the individual must sign the form(s). If the individual is under 18 years of age, this authorized representative is the parent unless a court ordered (legal) guardian or a conservator has been appointed for the child/youth. If the individual receiving services, regardless of his/her age, has a court ordered (legal) guardian or a conservator, the guardian/conservator must sign all forms on behalf of the individual receiving services. In the case of a court ordered (legal) guardian/conservator, a copy of guardianship/conservatorship papers must be maintained in the record.

Signature of Witness/Credential
In the case of some DMH documentation, a witness must sign in order to verify that the signature(s) are valid, particularly if a person is signing in lieu of the individual receiving services. Forms requiring the signature of a witness will have a signature line provided for the witness. This requirement will be reflected in the guidance for that particular form.

If an individual signs with a mark or an "X," the signature of a witness is required. If the form does not include a line for a witness, the witness will sign next to the mark or "X."

If the witness is an employee of the facility or program, he/she must include his/her credentials (if applicable).

Billing
All questions concerning billing should reference the Medicaid Guidelines issued by the Division of Medicaid, Office of the Governor.
Revisions to the Record Guide

The content of the Record Guide is subject to revision and/or modification at any time by DMH. Certified providers may make comments or suggestions to DMH regarding specific Record Guide issues. Each DMH certified provider must understand they are ultimately responsible for initial and ongoing compliance with all aspects of the DMH Operational Standards irrespective of the content of the Record Guide. The Record Guide and all subsequent revisions will be available on the DMH web site, identified by an effective date.
Section B
Required For All Services

Face Sheet
Medication/Emergency Contact Information
Rights of Individuals Receiving Services
Consent to Receive Services
Acknowledgment of Grievance Procedure
Consent to Release/Obtain Information
Initial Assessment
Individual Service Plan
Record Guide Timelines Reference
Face Sheet

Purpose
The Face Sheet contains relevant data and/or personal information necessary to readily identify the individual receiving services. Information on the Face Sheet is used for routine service provision activities such as scheduling, billing, and reference. It must also include current emergency contact information in order to be used if an emergency occurs while the individual is receiving services.

Timeline
The initial Face Sheet must be prepared at admission as part of the intake process. The Face Sheet must be updated whenever information or data changes or at least annually. When changes in information or data are made or at the annual update, a new/corrected Face Sheet must be placed in the individual record.

Face Sheet Information
Each DMH certified provider must maintain current and accurate data for submission of all reports and data as required by DMH. The Face Sheet can be generated as a report by the agency’s database system once all the data has been entered into the agency’s system. Depending on the specific data collection and reporting system that the agency uses, additional personal information may have to be added to complete the Face Sheet. The Face Sheet must contain all 61 data elements required in the DMH Data Manual.

The face sheet enclosed is an example of an accurate Client Face Sheet, but is not mandatory for use by providers. Provider should reference the DMH Data Manual for applicable codes and should consult with the local provider employee responsible for data submission. Providers can also contact DMH Information Services for additional guidance, 601-359-1288.
# Client Face Sheet

<table>
<thead>
<tr>
<th>Client ID#</th>
<th>New</th>
<th>Change</th>
<th>Intake Date</th>
<th>Intake Status 1-New/2-Renewal</th>
<th>1-Eval only</th>
</tr>
</thead>
</table>

## Intake Type
- 1. Primary
- 2. Collateral
- 3. Unregistered

## Last Name, First, Middle

## County of Residence
- See Back

## Organization Code: 1ε#

## Residential Arrangements
- 1. Private Residence
- 2. Other Independent
- 3. Homeless
- 4. Institution
- 5. Community Program
- 6. Correctional Facility
- 7. Other

## Legal Status
- 1. Voluntary
- 7. Other Legal Status
- 6. Probation/Parole

## Age:

## Veteran Status
- M - Male
- F - Female
- U - Unknown
- N - Not Collected

## Gender
- Y-Yes
- N-No

## Physical Impairments

<table>
<thead>
<tr>
<th>#1</th>
<th>01 Deafness and Blind</th>
</tr>
</thead>
<tbody>
<tr>
<td>#2</td>
<td>02 Deafness/Severe Hearing Loss</td>
</tr>
</tbody>
</table>

## Catchment Area

### County Serviced
- Alcorn
- Tishomingo
- Tippah

## Race
- W Caucasian
- B Black/African American
- I Native American
- A Asian
- K Alaskan Native
- Other

## Hispanic Origin
- C Cuban
- M Mexican
- P Puerto Rican
- O Other Hispanic
- N Not of Hispanic origin
- U Unknown

## Income Source
- 1 Wages/Salary
- 2 Public Assistance
- 3 Retirement/Pension
- 4 Disability Income
- 7 Other

## Employment Status
- 01 Employed-Full Time
- 02 Employed-Part Time
- 03 Employed-Active Military
- 04 Unemployed-Migrant Worker
- 05 Unemployed-Seeking Work
- 06 Unemployed-Not Seeking Work
- 07 Homemaker
- 08 Student/Under 17
- 09 Retired

## Education
- 01-12 Highest Grade
- 16 Associate Degree
- 51 Preschool/Kindergarten
- 52 Special Ed
- 13 GED
- 14 Tech/Trade School
- 15 Some college, no degree

## Marital Status
- 1 Single
- 2 Married
- 3 Divorced
- 4 Widowed
- 5 Unknown
- 6 Separated

## Medicaid Eligibility
- 1 Elig. & Rec. Payment
- 2 Elig. & Not Rec. Payment
- 3 Potentially Eligible
- 4 Determined Ineligible

## SSU/SSDI Eligibility
- 1 Elig. & Rec. Payment
- 2 Elig. & Not Rec. Payment
- 3 Potentially Eligible
- 4 Determined Ineligible

## Number of Household Dependents

## Monthly Household Income Amount

## Household Annual Income Amount

## Disability Category
- 1 Mental Health
- 2 Developmental Disability
- 3 Substance Abuse
- 4 MH/MR
- 5 MR/SA

## Presenting Problem: Choose up to 5 Rank 1-5

## Diagnosis: Axis I

## Diagnosis: Axis II

## Diagnosis: Axis III

## Diagnosis: Axis IV

## Diagnosis: Axis V

## Principal Axis

## Diagnosis: D#1

## Diagnosis: D#2

## Diagnosis: D#3

## Counselor of Record-Staff#

## Date:

## Completed by:

---

DMH Face Sheet  Page 1 of 1  Effective July 2011
Medication/Emergency Contact Information

Purpose
Documentation of medications must be maintained while the individual is receiving services from a DMH certified agency or provider. The Medication/Emergency Contact Information is not to be used for the regular dispensing of medication. An important component is the documentation of all the individual's known allergic and/or adverse reactions. Emergency contact information must be completed to ensure immediate and appropriate response in the event of an emergency.

Timeline
The medications the individual is taking and the emergency contact information are recorded during the initial assessment. The information must be updated when medications are discontinued or added and at least annually.

Updates
The person entering updated information (new medications/changes to existing medications/discontinuing a medication) must write the date the changes were made and initial the form in the designated space. The same form can be used until all spaces for medications are filled. At that time, a new form must be completed to ensure clarity. Any time the emergency contact information changes, a new form must be completed and placed in the individual's record.

Staff Initials/Date Initiated
Each medication entry must be initialed by the person completing the form. If known, enter the date the individual began taking the medication. If this information is unavailable, signify such by entering "NK" in the "Date Initiated" column.

Medication
All sections must be addressed. ALL known and/or reported medications the individual is currently taking must be listed, regardless of type or purpose, including over-the-counter (OTC) medications the individual may be taking. The name of the medical professional prescribing each medication must be listed. All known or reported prescribed medications must be documented. Medication information regarding dosage and frequency must be listed exactly as written on the prescription. If there are no prescribed medications, the person completing the form must write "no meds" and his/her initials.

Date Terminated/Changed/Staff Initials
If a medication dosage or frequency is changed, enter the date in the column. This space is also to be used if a medication is terminated. The staff person entering the information must initial the form.

Allergies/ Adverse Reactions
Each of the individual's known allergies and his/her reactions to them must be documented. Include unusual reactions if applicable. Allergies may include, but not be limited to, medications, insect bites, plants, foods, fragrances/aromas, or anything else that produces an allergic or adverse reaction.
**Medication/Emergency Contact Information**

Name 
ID Number 

Name/Credentials of Staff Initially Completing the form: 

Initial Date of Completion: 

List ALL known and/or reported medications the individual is currently taking regardless of type or purpose to include over-the-counter (OTC) medications (use additional pages, if needed):

<table>
<thead>
<tr>
<th>Staff Initials</th>
<th>Date Initiated</th>
<th>Name of Medication</th>
<th>Prescribed by</th>
<th>Dosage/Frequency</th>
<th>Date Terminated/Changed</th>
<th>Staff Initials</th>
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Known Allergies/Reactions: 

**Emergency Information:**

*In case of emergency (when parent/legal representative cannot be reached) contact:*

Name: 
Phone Number: (primary) __________________________ (secondary) __________________________ 
Address: 
Name of Doctor: 
Doctor's Phone: 
Doctor's Address: 
Hospital Preference: 
Insurance Carrier(s): 
Policy Number(s): 

DMH B2 Medication-Emergency Contact Information-form
Rights of Individuals Receiving Services

Purpose
Each individual who receives services from a DMH certified agency or provider has legal, ethical, and privacy rights that must be protected. DMH certified agencies must maintain documentation showing each individual who receives services has been informed of these rights. This document also informs the individual receiving services of legal circumstances in which the provider will be required to release information concerning his/her treatment/services. After the individual receiving services has been informed of his/her rights, the individual is then offered the opportunity to consent to treatment.

Time Line
Individuals receiving services must be informed of his/her rights at the time of the initial assessment and before services are provided.

Individuals must be informed of his/her rights at least annually, on or before the anniversary date of the current form, as long as the individual continues to receive services.

Intake/Admission Date
The intake/admission date is the original date of intake/admission to the service. This date remains the same from year to year as long as the person is continuously enrolled in the service.

Rights
The rights can be read by or, if necessary, to the individual receiving services and/or to a person who is legally authorized to act on his/her behalf. The rights must be clearly explained to the individual receiving services and/or a person authorized to act on his/her behalf. The individual must be offered a copy of the form to take with them. The original signed copy must be maintained in the record. Providers may omit certain numbers that do not apply to the services being provided.
Rights of Individuals Receiving Services

I, __________________________, began receiving services provided by __________________________ on ____________ and have been informed of the following:

1. My options within the program and of other services available
2. The program's rules and regulations
3. The responsibility of the program to refer me to another agency if this program becomes unable to serve me or meet my needs
4. My right to refuse treatment and withdraw from this program at any time
5. My right not to be subjected to corporal punishment or unethical treatment which includes my right to be free from any forms of abuse or harassment and my right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff
6. My right to voice my opinions, recommendations and to file a written grievance which will result in program review and response without retribution
7. My right to be informed of and provided a copy of the local procedure for filing a grievance/complaint at the local level or with the DMH Office of Consumer Support
8. My right to privacy in respect to facility visitors in day programs and residential programs as much as physically possible
9. My right regarding the program's nondiscrimination policies related to HIV infection and AIDS
10. My right to be treated with consideration, respect, and full recognition of my dignity and individual worth
11. My right to have reasonable access to the clergy and advocates and have access to legal counsel at all times
12. My right to review my records, except when restricted by law
13. My right to fully participate in and receive a copy of my Individual Service Plan/Plan of Care. This includes: 1) having the right to make decisions regarding my care, being involved in my care planning and treatment and being able to request or refuse treatment; 2) having access to information in my clinical records within a reasonable time frame (5 days) or having the reason for not having access communicated to me; and, 3) having the right to be informed about any hazardous side effects of medication prescribed by staff medical personnel
14. My right to retain all Constitutional rights, except when restricted by due process and resulting court order
15. My right to have a family member or representative of my choice notified should I be admitted to a hospital
16. My right to receive care in a safe setting
17. My right to confidentiality regarding my personal information involving receiving services as well as the compilation, storage, and dissemination of my individual case records in accordance with standards outlined by the Department of Mental Health and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if applicable

Additionally, rights for individuals in supervised and residential living arrangements:

18. My right to be provided a means of communicating with persons outside the program
19. My right to have visitation by close relatives and/or significant others during reasonable hours unless clinically contraindicated and documented in my case record
20. My right to be provided with safe storage, accessibility, and accountability of my funds
21. My right to be permitted to send/receive mail without hindrance unless clinically contraindicated and documented in my case record
22. My right to be permitted to conduct private telephone conversations with family and friends, unless clinically contraindicated and documented in my case record

I have been informed of, understand, and have received a written copy of the above information.

<table>
<thead>
<tr>
<th>Individual Receiving Services</th>
<th>Date</th>
<th>Legal Representative</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff/Credentials</td>
<td>Date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DMH B3 Rights of Individuals Receiving Services-form
Consent To Receive Services

Purpose
In addition to all rights of individuals receiving services, each individual must provide his/her consent to receive services from the agency.

Time Line
Individuals receiving services must be informed of and consent to services at the time of the initial intake and before services are provided.

Individuals must provide their consent for services at least annually, on or before the anniversary date of the current consent, as long as the individual continues to receive services.

Consent to Receive Services
This section can be read by, or if necessary, read to the individual receiving services and/or a person who is legally authorized to act on his/her behalf. In either case, the Consent To Receive Services must be clearly explained to the individual receiving services and/or a person authorized to act on his/her behalf. An agency may have to ask an individual to consent for both mental health and IDD services, depending on how the service is defined. Refer to the Operational Standards for listings of services.
**Consent To Receive Services**

<table>
<thead>
<tr>
<th>Name</th>
<th>ID Number</th>
<th>Agency</th>
<th>Service(s)</th>
</tr>
</thead>
</table>

The information which I have provided as a condition of receiving services is true and complete to the best of my knowledge. I consent to receive services as may be recommended by the professional staff. I understand the professional staff may discuss the services being provided to me, and that I may request the names of those involved. I further understand that my failure to comply with therapeutic recommendations of the professional staff may result in my being discharged.

<table>
<thead>
<tr>
<th>Individual/Legal Representative Signature</th>
<th>Staff Signature/Credentials</th>
<th>Date</th>
</tr>
</thead>
</table>
Acknowledgment of Grievance Procedures

Purpose
The provider's grievance and complaint procedures must be provided to the individual and/or legal representative. The information can be read by, or if necessary, read to the individual receiving services and/or a person who is legally authorized to act on his/her behalf.

Time Line
Individuals receiving services must be informed of and provided a copy of the provider's Grievance Procedures at the time of the initial intake and before services are provided. Each individual receiving services must be presented with the provider's Grievance Procedures when they are being asked to give his/her consent to receive services.

Individuals acknowledge receipt of the Grievance Procedures at least annually, on or before the anniversary date of the current acknowledgment, as long as the individual continues to receive services.
Acknowedgment of Grievance Procedures

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID Number</td>
</tr>
<tr>
<td>Agency</td>
</tr>
<tr>
<td>Service(s)</td>
</tr>
</tbody>
</table>

I have been informed of the policies and procedures for reporting a complaint or grievance concerning any treatment or service that I receive.

<table>
<thead>
<tr>
<th>Individual/Legal Representative Signature</th>
<th>Staff Signature/Credentials</th>
<th>Date</th>
</tr>
</thead>
</table>
Consent to Release/Obtain Information

Purpose
Providers must have prior written authorization before information regarding an individual receiving service can be released. A fully executed Consent to Release/Obtain Information must be in place in order to legally exchange, release, or obtain information between individuals, agencies and/or providers. The original Consent to Release/Obtain Information form must always be maintained in the individual’s case record.

Release/Obtain Information
Enter the name and address of the agency from which the action is required.

Complete the Release Information To when requesting a person/provider to send confidential information about an individual to another entity.

Complete the Obtain Information From section when confidential information regarding an individual receiving/requesting to receive services needs to be obtained from another entity.

The specific purpose for which the information is needed must be indicated. If the purpose is not for treatment and/or service coordination, specify the exact reason for obtaining/releasing the information.

Extent/Nature of Information
The specific extent and/or nature of the information to be disclosed must be checked. If ‘Other’ is checked, the specific extent/nature of the disclosure must be described in detail. A generic authorization for the non-specific release of medical or other personal information is not sufficient for this purpose.

Date/Event/Condition
In order to clearly show the point in time when the Consent will expire, the following information must be provided: 1) the month, day, and year, or 2) an event, or; 3) a condition that will deem the Consent form expired meaning no further action can be taken once the specific date/event/condition is satisfied. An example of an event or condition may be, “30 days after discharge or termination of services”.

For children and youth receiving services in a school setting, a date period that covers a specific school year must be used.

Witness
The Consent to Release/Obtain Information requires the signature of a witness. If the witness is an employee of the program, he/she must include his/her credentials (if applicable). If the individual receiving services can only make their mark (for example “X”), place the mark in quotations and write out beside it, John Doe’s Mark substituting individual’s name. This is when a second witness to the individual’s signature is required.
Consent to Release/Obtain Information

I hereby give my consent/permission for:

☐ To release information to:

☐ To obtain information from:

for the specific purpose of:

☐ Treatment
☐ Coordination of Services
☐ Other

The extent and nature of the information to be disclosed/obtained must be indicated (check all that apply):

☐ Evaluations
☐ Case Notes
☐ Substance Abuse Records
☐ Contact Summaries
☐ Identifying Information
☐ Other

☐ Diagnosis/Prognosis/Recommendations
☐ Psychiatric Records
☐ Admission/Discharge Summary
☐ Planning
☐ Individual Service Plan

I understand that I may revoke this consent at any time except to the extent that action has been taken. I further understand that this consent will expire upon

(Specific Date/Event/Condition)

and cannot be renewed without my consent. I understand that to revoke this authorization, I must provide a written request and the revocation will not apply to action or information that has already been released/obtained in response to this authorization. Any information obtained as a result of this release is confidential. State and federal laws and regulations prohibit any entity receiving confidential information from re-disclosing the information to any other entity without the specific written consent of the person to whom it pertains or as otherwise permitted by law and regulations. I understand the information I authorize for release may include information related to history/diagnosis and/or treatment of HIV, AIDS, communicable or sexually transmitted disease, and alcohol/drug abuse or dependency.

By signing below, I acknowledge receipt of a copy of the signed authorization

<table>
<thead>
<tr>
<th>Individual Receiving Services</th>
<th>Date</th>
<th>Legal Representative</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witness/Credentials</td>
<td>Date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Initial Assessment

Purpose
The Initial Assessment is used to document pertinent information that will be used as part of the process for determining what service or combination of services might best meet an individual's stated/presenting need(s). The information gathered is both historical as well as what is currently happening in an individual's life.

*Note- An Initial Assessment is not required for IDD Waiver Services

*Note- The Substance Abuse Specific Assessment must also be completed as part of the intake process if substance abuse services are provided or if substance abuse is suspected.

Timeline
The Initial Assessment is part of the intake process and must be initiated on the first day of service.

See the Record Guide Timeline Reference for additional timeline requirements.

Admission Date
Enter the date the individual was admitted to services.

Assessment Date
Enter the date the Initial Assessment was completed.

Informant
If assessment information is provided by someone other than the individual receiving services, enter the person's name and their relationship to the individual requesting services.

Description of Need
Record the reason(s) the individual gives as to why he/she is seeking services. This must include the onset of condition/symptoms, possible causes, how long the individual has had the condition/symptom(s), and intensity and fluctuations in severity of the needs expressed. The description of need must specifically clarify event(s) that occurred in the individual's life which has caused him/her to seek help or request services. If the use of alcohol and/or other drugs is the reason the individual is seeking services or if there is suspected abuse, the Substance Abuse Specific Assessment must also be completed as part of the intake process.

History
Complete all history sections addressing each area as applicable with information provided by informant. All items in the history sections must be documented in detailed narrative format. Responses of "Yes", "No", "Present", "Not Present", are not acceptable. However, if an entire section does not apply to someone, the recorder can enter "Not Applicable." For example, not
everyone will have a substance abuse/use history; therefore, the section would be marked “Not applicable.”

**Initial Behavioral Observation**
Record observations for all areas listed. All areas must be evaluated. Comments must be included to further explain or clarify the specific observed behaviors.

**Summary/Recommendations**
The person conducting the Initial Assessment must summarize the observations and findings to include an analysis of the individual’s strengths and needs, both expressed and observed. Based on the results of the Initial Assessment, services must be recommended and offered to the individual. Referrals to other appropriate providers must also be offered to the individual.

**Indication of Functional Limitation(s)**
Indicate the life skill areas where there is a functional impairment as a result of the individual’s condition/illness.

**Initial Diagnostic Impression**
Give the written diagnostic impression and DSM or other codes for Axis I, Axis II, Axis III, Axis IV, and Axis V. For MH individuals, all five (5) diagnostic areas must be addressed either with a diagnosis code or an indication of no diagnosis on the axis. For IDD individuals, Axis I, Axis II, and Axis III must be addressed.

**Staff Qualifications**
The Initial Assessment must be completed by an individual with at least a Master’s degree in mental health or intellectual/developmental disabilities, or a related field and who has either (1) a professional license or (2) a DMH credential as a Mental Health Therapist, Intellectual/Developmental Disabilities Therapist or Substance Abuse Therapist (as appropriate to the population being served).

For IDD programs, a QMRP may complete the Initial Assessment.

For Alzheimer’s Day Programs only, the program supervisor must complete the Initial Assessment. A copy of the individual’s current history and physical, signed by an MD or Psychologist must be provided to confirm diagnosis.
Initial Assessment

Name
ID Number
Admission Date
Assessment Date
Time In: Time Out: Total Time:

Informant:  □ Individual receiving services  □ Other  Relationship to individual: 
Date of Birth
Sex:  □ Male  □ Female  Race:

Description of Need

What is your reason for seeking services today?

What specific needs do you currently have?

History

Medical History (Record current medications on the Medication/Emergency Contact Information form):

Allergies
Physical impairments
Surgeries
Special diets
Appetite issues or problems
Sleep issues or problems
Current or chronic diseases (high blood pressure, cancer, etc.)
Applicable family medical history
Other pertinent medical information
**Mental Health History:**

- Previous psychiatric issues
- Previous inpatient psychiatric treatment
- Previous outpatient psychiatric treatment
- Family history of mental illness
- Homicidal behavior
- Suicidal behavior
- Other counseling and/or therapeutic experiences

**Developmental History (Children & youth up to age 21 and everyone with IDD):**

- During pregnancy, did mother use drugs  □ No □ Yes (if yes, indicate which)
  □ alcohol □ cigarettes □ medication

  Describe any problems with the pregnancy or birth

- Birth weight ____________ Birth length ____________

  At what age did the child: Sleep through the night ______ Crawl ______ Walk ______ Say first words ______

  At what age was the child toilet trained ______ Was the child's first year of life easy ______ or difficult ______

  Describe any childhood accidents or injuries

**Traumatic Event Or Exposure History (Note or describe as appropriate):**

- Serious accidents
- Natural disaster
- Witness to a traumatic event
- Sexual assault
- Physical assault (with or without weapon)
- Childhood sexual molestation
- Close friend or family member murdered
- Homeless
- Victim of stalking or bullying
- Other (specify)
**Substance Abuse / Use History:**

<table>
<thead>
<tr>
<th>Age of onset</th>
<th>How much?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patterns of use/abuse:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Resulting circumstances?**

**Family history of alcohol abuse**

**Family history of drug abuse**

*If seeking substance abuse services, the Substance Abuse Questionnaire must be completed and attached during the initial assessment.*

**Social/Cultural History:**

- Immediate household/family configuration
- Marital status
- Relationship with spouse
- Relationship with parents
- Relationship with children
- Relationship with siblings
- Other family background
- Past relationship patterns
- Type of family support available
- Type of social support available
- Types and amounts of social involvement/leisure activities
- Any religious/cultural/ethnic aspects you would like considered
- Current Living Arrangements (type, roommates, perception of safety, satisfaction, goals)
**Educational/Vocational History:**

**Highest grade completed**

If currently in school (child or youth), regular classroom placement?  
- Yes  
- No

List all additional educational services child is receiving

Any repeated grades?  
- No  
- Yes  

Explain:

Suspensions/expulsions?  
- No  
- Yes  

Describe:

Other education issues

Vocational training, if any

Current employment

Previous employment

**Previous Assessment History (if available):**

**Psychological instrument**

Date administered

Results

**Educational instrument**

Date administered

Results

**Speech/Language assessment**

Date administered

Results

**Functional assessment**

Date administered

Results

**Initial Behavioral Observations**

**Speech:**
- Appropriate
- Slowed
- Mechanical
- Rapid
- Other

**Behavior:**
- Appropriate
- Withdrawn
- Bizarre
- Volatile
- Other

**Appearance:**
- Appropriate
- Disheveled
- Unclean
- Inappropriately dressed
- Other

**Mood:**
- Appropriate
- Manic
- Depressed
- Labile
- Irritable
- Other

**Affect:**
- Appropriate
- Flat
- Labile
- Other

**Oriented to:**
- Place
- Time
- Person
- Situation
- Other

**Thought Content:**
- Appropriate
- Incoherent
- Obsessive
- Other

**Memory:**
- Appropriate
- Repressed
- Confused
- Other

**Intelligence:**
- Average
- Above Average
- Below Average

**Judgment/Insight:**
- Appropriate
- Impaired
- Suicidal
- Homicidal
- Other

**Comments:**
Summary/Recommendations:

Indication Of Functional Limitation(s):
(Check Major Life Areas Affected)

| Basic living skills (eating, bathing, dressing, etc.) |
| Instrumental living skills (maintain a household, managing money, getting around the community, taking prescribed medications, etc.) |
| Social functioning (ability to function within the family, vocational or educational function, other social contexts, etc.) |

Initial Diagnostic Impression

<table>
<thead>
<tr>
<th>(Code)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis I</td>
<td></td>
</tr>
<tr>
<td>Axis II</td>
<td></td>
</tr>
<tr>
<td>Axis III</td>
<td></td>
</tr>
<tr>
<td>Axis IV</td>
<td></td>
</tr>
<tr>
<td>Axis V</td>
<td></td>
</tr>
</tbody>
</table>

Signature/Credentials | Date
Individual Service Plan

**Purpose**
Each individual who receives services must have an Individual Service Plan that is based on the identified strengths and needs of the individual, the goals that will help address his/her needs, the services to be provided, and the activities that will take place toward achieving measurable individual outcomes. The individual seeking services must be involved in the development of his/her service plan. For individuals under the age of eighteen (18) or who are unable to effectively participate in the planning process, a parent or legal guardian or a conservator must participate on the individual’s behalf.

The initial Individual Service Plan must be developed during the intake process. The timeline for completion of the Individual Service Plan is determined by the type of service or program the individual is entering.

The Individual Service Plan must be reviewed and revised when goals or objectives are achieved or as needs of the individual change. For service specific requirements, see “Record Guide Timeline Reference.”

**Diagnosis/Diagnoses**
Give the written diagnostic impression and DSM code for Axis I, Axis II, Axis III, Axis IV, and V.

For MH individuals, all five (5) diagnostic areas must be addressed either with a diagnosis code or an indication of no diagnosis on the axis. For IDD individuals, Axis I, Axis II, and Axis III must be addressed.

**Individual Strengths**
List strengths the individual possesses and/or demonstrates that will assist and promote successful achievement and outcomes.

**Individualized Areas of Focus**
Refer to the Initial Assessment to identify symptoms, observable behaviors, clinical problems and elaborate on duration (how long the symptoms/behaviors have been present or observed), frequency (how often the symptoms/behaviors are present or observed), and how the symptoms/observable behaviors create a functional impairment for the individual. Symptoms, behaviors and clinical problems should serve as the focus of treatment and services for individuals.

**Goals**
The individual receiving services establishes the long term goals. Staff helps the individual set short term goals which will contribute to achievement of the long term goal(s).
Services
Services identified and certified as necessary must be provided to the individual. Services to be provided must be determined in conjunction with the identified needs and goals to help ensure needs are met and goals are achieved whenever possible. All services that will be provided in order to achieve the objectives on the Individual Service Plan must be checked.

Objectives/Activities, Criteria/Outcomes, Target Dates
In order to effectively work toward achieving the long term and short term goal(s) identified by the individual receiving services and the staff specific objectives or activities must be measurable. Each objective or activity must have specific criteria or outcomes which clearly indicate an objective has been reached or an activity has been completed. Each objective or activity must be numbered and have a specified target date for achievement or completion.

Case Management/ Community Supports
Community Mental Health Centers certified as DMH (DMH/C) by DMH must provide Case Management/ Community Support Services throughout the CMHC’s catchment area. Case Management/ Community Support Services must be made available to the following populations: adults with serious mental illness, children/youth with serious emotional disturbance, and individuals with intellectual/developmental disabilities. If the individual refuses Case Management/ Community Support Services, the refusal must be documented in writing. Case Management/ Community Support Services must be offered to these specified individuals during the intake process and at a minimum of every twelve (12) months while they remain in services.

Signatory Authority
Each individual who participates in the development of the Individual Service Plan must sign the plan as evidence of his/her participation in plan development. If the Individual Service Plan is developed for adults with a serious mental illness (SMI), individuals with intellectual/developmental disabilities, or children and youth with serious emotional disturbance (SED), a licensed physician, a licensed clinical psychologist, a psychiatric/mental health nurse practitioner, a licensed clinical social worker, Licensed Marriage and Family Therapist, a qualified mental retardation professional (IDD programs only), or Alzheimer’s Day Program Supervisor (for Alzheimer’s Day programs only) must sign the Individual Service Plan, certifying the planned services are medically/therapeutically necessary.
# Individual Service Plan

<table>
<thead>
<tr>
<th>Diagnosis (Axis I-V)</th>
<th>Individual's Strengths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis I</td>
<td></td>
</tr>
<tr>
<td>Axis II</td>
<td></td>
</tr>
<tr>
<td>Axis III</td>
<td></td>
</tr>
<tr>
<td>Axis IV</td>
<td></td>
</tr>
<tr>
<td>Axis V</td>
<td></td>
</tr>
</tbody>
</table>

## Individual Areas of Focus

**Area of Focus:**

Duration:
Frequency:
How does area of focus create functional limitations for the individual?

**Area of Focus:**

Duration:
Frequency:
How does area of focus create functional limitations for the individual?

**Area of Focus:**

Duration:
Frequency:
How does area of focus create functional limitations for the individual?

## Goals

**Long Term Goals:**

**Short Term Goals:**
### Services (check all that apply)

**Emergency/Crisis Services**
- Emergency/Crisis Services
- Intensive Crisis Intervention (C&Y)
- Acute Partial Hospitalization/Comm. Stabilization

**Case Management/Community Supports Services**
- Adult SMI CM/CS
- Children & Youth CM/CS
- IDD CM/CS
- School Based Services
- Mental Illness Management (MIMS)
- Individual Therapeutic Support

**Psychosocial Programs**
- Psychosocial Rehabilitation
- Senior Day Services
- Day Support
- Day Treatment

**Physician Services**
- Nursing Assessment
- Medication Evaluation
- Medication Injection

**Community Living**
- Home and Community Supports
- Therapeutic Foster Care
- Supported Living
- Supervised Living

**Therapeutic Group Homes**
- Transitional Residential
- Halfway House
- Crisis Residential
- Chemical Dependency Units
- Primary Residential
- Crisis Stabilization Units

**Adult Mental Health Services**
- PACT
- Co-Occurring Disorders
- Drop In Services
- Inpatient Referral Services
- Pre-Evaluation Screening
- Consultation and Education
- Alzheimer Services
- Peer Support Services

**C&Y Mental Health Services**
- Prevention/Early Intervention Services
- Family Support & Education Services
- FASD Screening
- Respite Care Services

**IDD Services**
- Early Intervention
- Day Services-Adult
- Prevocational
- Work Activity
- Supported Employment
- Community Respite
- In-Home Respite
- Behavior Support Intervention

**A & D Services**
- Detoxification
- Outreach/Aftercare
- Prevention
- DUI Assessment

**Outpatient Services**
- Outpatient MH
- Outpatient Substance Abuse
- Intensive Outpatient
- Individual Therapy
- Group Therapy
- Family Therapy

**Other**

### Objective/Activities | Criteria/Outcomes | Target Dates
---|---|---

☐ Case Management/Community Support has been offered to me and I choose NOT to participate in Case Management.

Individual Receiving Services | Date | Signature/Credential | Date
---|---|---|---
Parent/Legal Guardian | Date | Signature/Credential | Date

**Physician/Clinical Psychologist/Nurse Practitioner, LCSW, LMFT, QMRP, Alzheimer's Day Program Supervisor**

DMH B8 Individual Service Plan form
# RECORD GUIDE TIMELINES REFERENCE

## INITIAL ASSESSMENT

<table>
<thead>
<tr>
<th>Service</th>
<th>Timeline</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Crisis/Emergency Services, Acute Partial Hospitalization, Crisis Residential and Respite Care for C&amp;Y, and Crisis Stabilization Units</td>
<td>Within 24 hours of admission</td>
<td>Initial Assessment is initiated the first day of service and must be completed within the specified timeline.</td>
</tr>
<tr>
<td>All Community Living &amp; Alzheimer’s Services (unless otherwise specified)</td>
<td>Within 7 days of admission</td>
<td>Initial Assessment is initiated the first day of service and must be completed within the specified timeline.</td>
</tr>
<tr>
<td>Case Management/Community Support Activity Plan</td>
<td>Within 14 days of admission into CM/CS services</td>
<td>Initial Assessment is initiated the first day of service and must be completed within the specified timeline.</td>
</tr>
<tr>
<td>All Outpatient and Support Services (unless otherwise specified)</td>
<td>Within 30 days of admission</td>
<td>Initial Assessment is initiated the first day of service and must be completed within the specified timeline.</td>
</tr>
<tr>
<td>All SAPT Services (Educational Activities/Risk Assessment for TB/HIV/STD &amp; TB/HIV/STD Risk Assessment Interview)</td>
<td>Within 30 days of admission</td>
<td>Assessment is initiated the first day of service and must be completed within the specified timeline.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>NOTE</em> The TB assessment must be completed prior to admission to all services.</td>
</tr>
</tbody>
</table>

## SAPT SPECIFIC ASSESSMENT

<table>
<thead>
<tr>
<th>SAPT Specific Assessment</th>
<th>30 days of admission</th>
<th>Assessment is initiated the first day of service and must be completed within the specified timeline.</th>
</tr>
</thead>
<tbody>
<tr>
<td>All SAPT Services (unless otherwise specified)</td>
<td>30 days of admission</td>
<td>Assessment is initiated the first day of service and must be completed within the specified timeline.</td>
</tr>
<tr>
<td>SAPT Transitional Residential, Primary Residential and Chemical Dependency Units</td>
<td>7 days of admission</td>
<td>Assessment is initiated the first day of service and must be completed within the specified timeline.</td>
</tr>
</tbody>
</table>

## FUNCTIONAL ASSESSMENT

<table>
<thead>
<tr>
<th>Functional Assessment</th>
<th>Between 30 and 60 days after Initial Assessment then annually thereafter</th>
<th>Assessment must be completed within the specified timeline and annually thereafter.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Services for Adults</td>
<td>Between 30 and 60 days after Initial Assessment then annually thereafter</td>
<td>Assessment must be completed within the specified timeline and annually thereafter.</td>
</tr>
</tbody>
</table>

## INDIVIDUALIZED SERVICE PLANS (original)

<table>
<thead>
<tr>
<th>Individuated Service Plans (original)</th>
<th>Within 24 hours from time of admission</th>
<th>Updated as needed but not less than every 30 days.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis/Emergency Services and Respite Care for C&amp;Y</td>
<td>Within 24 hours from time of admission</td>
<td>Updated as needed but not less than every 30 days.</td>
</tr>
<tr>
<td>INDIVIDUALIZED SERVICE PLAN DEVELOPMENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Service</strong></td>
<td><strong>Timeline</strong></td>
<td><strong>Additional Information</strong></td>
</tr>
<tr>
<td>Acute Partial Hospitalization, C&amp;Y</td>
<td>Within 72 hours from time of admission</td>
<td>Updated as needed but not less than every 30 days.</td>
</tr>
<tr>
<td>Crisis Residential and, Crisis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stabilization Units</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Community Living &amp; Alzheimer’s</td>
<td>Within 15 days from date of admission</td>
<td>Updated as needed but not less than annually.</td>
</tr>
<tr>
<td>Services (unless otherwise specified)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Outpatient, Day Programs, Support</td>
<td>Within 30 days from date of admission</td>
<td>Updated as needed but not less than annually.</td>
</tr>
<tr>
<td>Services (unless otherwise specified)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All HCBS Waiver Services (including</td>
<td>Within 30 days from date of admission</td>
<td>ISP must be provided to Support Coordinator by the 15th of the month following the development.</td>
</tr>
<tr>
<td>Supported Employment and Supervised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living Services)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INDIVIDUALIZED SERVICE PLAN REVIEW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service</strong></td>
</tr>
<tr>
<td>Substance Abuse Prevention and</td>
</tr>
<tr>
<td>Treatment Primary Residential</td>
</tr>
<tr>
<td>Treatment and Chemical Dependency</td>
</tr>
<tr>
<td>Units</td>
</tr>
<tr>
<td>Substance Abuse Prevention and</td>
</tr>
<tr>
<td>Treatment Intensive Outpatient, DUI</td>
</tr>
<tr>
<td>and Transitional Residential Treatment</td>
</tr>
<tr>
<td>Children and Youth Community Living</td>
</tr>
<tr>
<td>and Day Treatment</td>
</tr>
<tr>
<td>All Substance Abuse Prevention and</td>
</tr>
<tr>
<td>Treatment (unless otherwise specified)</td>
</tr>
<tr>
<td>Children and Youth Case Management/</td>
</tr>
<tr>
<td>Community Support Activity Plan</td>
</tr>
<tr>
<td>Children and Youth Outpatient</td>
</tr>
<tr>
<td>All Services (unless otherwise specified)</td>
</tr>
<tr>
<td>Case Management/Community Support</td>
</tr>
<tr>
<td>Activity Plan</td>
</tr>
<tr>
<td>Service</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>All Outpatient Therapy, DUI, CDU, SAPT Transitional and Primary</td>
</tr>
<tr>
<td>Residential and Aftercare Therapy, Emergency/Crisis, Case Management,</td>
</tr>
<tr>
<td>C&amp;Y Early Intervention</td>
</tr>
<tr>
<td>Acute Partial Hospitalization, Crisis</td>
</tr>
<tr>
<td>Residential and Respite Care for C&amp;Y, and Crisis Stabilization Units</td>
</tr>
<tr>
<td>Supported Living Services (except Therapeutic Foster Care and Home and Community Supports)</td>
</tr>
<tr>
<td>SAPT Supervised Living and Residential Treatment and IOP Services</td>
</tr>
<tr>
<td>C&amp;Y Day Treatment</td>
</tr>
<tr>
<td>ID/DD Day Services – Adult, Prevocational, and Work Activity</td>
</tr>
<tr>
<td>All Supervised Living</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation, Senior PSR and Day Support</td>
</tr>
</tbody>
</table>

**SAPT AFTERCARE PLAN**

| SAPT Community Living Aftercare Plan and Outpatient Aftercare Plan     | At least seven days prior to discharge | It must be reviewed ninety (90) days after staffing for aftercare services and rewritten annually. |
Section B
As Needed
By Service

Substance Abuse Specific Assessment
Serious Incident Report
Discharge Summary
Service Termination/ Change Summary
Periodic Staffing/Review of the Individual Service Plan
Search and Seizure Report
Physical Restraint/Escort Log
Time Out Log
Readmission Assessment Update
Medical Examination
Documentation of Healthcare Provider Visits
Substance Abuse Specific Assessment

Purpose
This information must be documented if substance abuse services are provided or if substance abuse is suspected. This form must be completed in addition to the Initial Assessment and is applicable to youth and adults. This form should specifically address how substance abuse history has created impairment.

Treatment Modality Abbreviations
OP       Outpatient Services
IOP      Intensive Outpatient Services
PR       Primary Residential
TR       Transitional Residential
CDU      Chemical Dependency Unit
Day TX   Day Treatment

Detailed Drug Problem
This section of the assessment utilizes the codes from the MSAMIS manual. Refer to the manual for an explanation of codes and their use.

Evaluator's Assessment of Attitude
This part of the assessment allows the evaluator to document the individual's level of denial and/or willingness to change with regard to their use of alcohol and other drugs.
### Substance Abuse Specific Assessment

#### Name

#### ID Number

#### Date

#### Time In:  
#### Time Out:  
#### Total:

### Admission Date:

<table>
<thead>
<tr>
<th>Type of Treatment Modality</th>
<th>□ OP</th>
<th>□ IOP</th>
<th>□ PR</th>
<th>□ TR</th>
<th>□ CDU</th>
<th>□ Day TX</th>
</tr>
</thead>
</table>

### Prior Substance Abuse Treatment
(Location, date, completion status, outcome, length of recovery after treatment)

### Legal History
(List all arrests and/or charges, include type of charge, disposition, and relationship to substance abuse if any)

### Is this admission the result of a Criminal Justice referral?  
[ ] Yes  
[ ] No  
If yes, identify referral source below:

### Describe circumstances:

### Name of person to whom reports should be submitted:

### Type(s) of reports requested:

### Are you presently awaiting charges, trial or sentencing?  
[ ] Yes  
[ ] No  
Court Date:

### Explain:

### DUI Offender?  
[ ] First time  
[ ] 2+Offenses  
[ ] Not applicable

### Is the individual’s driver’s license currently suspended?  
[ ] Yes  
[ ] No

### If yes, was the individual enrolled in or referred to a certified DUI Treatment Program?  
[ ] Yes  
[ ] No

### Alcohol and Drug Use History
(Explain use, include age of onset, pattern of use, amount/frequency of use, route of administration)

### Detailed Drug Problem
(For additional Codes see MSAMIS Manual)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th># of Days Past 30</th>
<th>Lifetime Years</th>
<th># of Days Past 30</th>
<th>Lifetime Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>0201</td>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0301</td>
<td>Crack</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0302</td>
<td>Other Cocaine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0401</td>
<td>Marijuana/Hashish</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0501</td>
<td>Heroin/morphine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0601</td>
<td>Methadone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0701</td>
<td>Codeine</td>
<td></td>
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<tr>
<td>0702</td>
<td>Darvocet</td>
<td></td>
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</tr>
<tr>
<td>0703</td>
<td>Oxycodone/Oxycontin</td>
<td></td>
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</tr>
<tr>
<td>0705</td>
<td>Hydromorphone/Dilaudid</td>
<td></td>
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</tr>
<tr>
<td>0901</td>
<td>LSD</td>
<td></td>
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</tr>
<tr>
<td>1001</td>
<td>Methamphetamine/Speed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1101</td>
<td>Amphetamine</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1102</td>
<td>Ritalin</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1301</td>
<td>Alprazolam/Xanax</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>1304</td>
<td>Diazepam/Valium</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1306</td>
<td>Lorazepam/Ativan</td>
<td></td>
<td></td>
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<tr>
<td>1701</td>
<td>Aerosols</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More than 1 substance daily</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
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</tbody>
</table>
Substance Abuse Specific Assessment

Which substance is the major problem? 
How much would you say you've spent on substances during the past 30 days? 
On a scale of 1-5, how important is treatment to you now? 
What was your longest period of abstinence? 
How was abstinence maintained? 

Educational/Vocational History (Explain problems encountered at school/work as a result of substance use)

What is your highest level of education? 
Do you have any difficulties in reading or writing? ☐ Yes ☐ No If yes, explain 

State your means of financial support in the: past 30 days 
past 90 days past year 

Family/Social History (Explain how use has affected family and social relationships. Describe family history of alcohol/other drug use)

Mental Health History

Have you received counseling/help for an issue(s) other than alcohol/drug problem? ☐ Yes ☐ No 
If yes, please explain:

When and from whom did you receive this help?

Evaluator's Assessment of Individual's Attitude Regarding Use of Alcohol and/or Other Drugs

<table>
<thead>
<tr>
<th>Level of denial</th>
<th>None</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willingness to change</td>
<td>None</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
<td>Unsure</td>
</tr>
</tbody>
</table>

Staff Signature/Credential Date
Serious Incident Report

Purpose
All serious incidents involving an individual receiving services or a staff member on agency or program property, at a program-sponsored event, or at any time during the provision of services must be reported and documented. Serious incidents are those of a serious nature that may result or have resulted in injury, death, or legal intervention. Examples include, but are not limited to: death, suicide attempt, elopement of more than twenty-four (24) hours, suspected abuse or neglect, emergency hospitalization, emergency room treatment, incident which may be related to suspected abuse or neglect, incidents in which the cause is unknown or unusual, disaster evacuation and seclusion/restraint.

Timeline
This form must be completed and submitted to the Office of Consumer Support as soon as possible but no later than twenty-four (24) hours after the serious incident OR a report must be made to the Office of Consumer Support by telephone as soon as possible but no more than twenty-four (24) hours or the next working day after the incident and be followed by a completed Serious Incident Report within five (5) working days of the incident.

If a final resolution has not been reached within five (5) working days, the provider must submit the report as required with as much information as is available. The provider must also submit documentation regarding the final resolution when the information becomes available.

Identifying Information
Record the name of the individual involved. A separate form must be submitted for each individual involved. The name of another individual receiving services can not be included on the form.

Date and Time of Incident
Record the month, day and year the incident occurred. Record the time of day the incident occurred.

Program, Agency, Location of Incident
Record the specific agency, program name and the location (city) where the incident occurred. If the incident happened during the provision of in-home services of any type, indicate such on the form.

Staff Involved
If staff were involved in the incident, their name(s) and position/title must be recorded here.

Circumstances under Which the Incident Occurred
Record a detailed account of the incident, all actions taken by staff and/or others and all notified of the incident. Describe in detail how the incident was resolved. Use as many pages as necessary.
Agency Contact
Include the name and phone number of staff the Office of Consumer Support can contact for follow up.

Submission
The Serious Incident Report and all other necessary documentation must either be mailed or faxed to:

Department of Mental Health
Office of Consumer Support
239 North Lamar Street, Suite 1101
Jackson, MS 39201
Fax number: (601) 359-9570
Phone Number: 1-877-210-8513
Serious Incident Report

Name ____________________________
ID Number ________________________
Date _____________________________

Date of Incident ____________________ Time of Incident ________
Agency/Program and Location of Incident _______________________________________
Staff involved
(include position) _____________________________________________________________

Circumstances Under Which The Incident Occurred: Give a detailed description of the incident, including those notified and the final disposition. (Examples of types of serious incidents this form is to be used for are reporting: death, suicide attempt, elopement for more than 24 hours, suspected abuse/neglect, emergency hospitalization, accidents requiring hospitalization, incidents which may be related to suspected abuse/neglect in which the cause is unknown or unusual, disaster, use of seclusion or restraint and disaster evacuation.)

Detailed Description of the Incident (use as many pages as necessary)

Actions and Resolution (use as many pages as necessary)

List dates report submitted to:
DMH/OCS: ____________________ Name of Agency Contact _________________
Agency Director: ______________ Phone Number ________________
Parent/Guardian ________________

Submit all written reports to:
Department of Mental Health
Office of Consumer Support
239 North Lamar Street, Suite 1101
Jackson, MS 39201
Fax: 601-359-9570

Office Use Only ____________________________
Date Received ____________________________ SIR Code ________________________
Discharge Summary

Purpose
When an individual is no longer receiving services from the provider, a Discharge Summary must be completed and placed in the individual’s record. The Discharge Summary must be completed to summarize the services provided, the reason for the discharge from the services, and any referrals made at the time of discharge. It must be noted that additional actions may be necessary in addition to completion of the Discharge Summary in order to close the case.

Timeline
The effective date of the discharge must be documented.

Reason for Discharge
Indicate which category most appropriately describes the reason for discharge.

Referral Information
If the individual was referred to another provider or to other services, this should be indicated by selecting one or more categories that most appropriately describes the service or provider referral(s).

Instructions/Additional Information
If any instructions were provided to the individual or legal representative at the time of discharge, these must be described. Additional information specific to the discharge may be included.
# Discharge Summary

**Name**

**ID Number**

**Date**

## Effective Date of Discharge

## Reason For Discharge:

- [ ] No Treatment Initiated
- [ ] Completion of Service Objectives
- [ ] Noncompliance with treatment recommendations
- [ ] Optimal level of functioning achieved
- [ ] Individual left against medical advice (AMA)
- [ ] Moved from service area
- [ ] Deceased
- [ ] No contact in 12 months
- [ ] Individual requested discharge
- [ ] Other ___________

## Referred To:

- [ ] DMH Psychiatric Hospital
- [ ] Other MS CMHC
- [ ] DMH IDD Facility
- [ ] Private Psychiatric Hospital
- [ ] Other MH Provider
- [ ] Other IDD Provider
- [ ] Other A&D Provider
- [ ] Gen/Hospital/Other Health
- [ ] Self
- [ ] Family/Friend
- [ ] School/Education
- [ ] Employer/EAP
- [ ] Police / Sheriff
- [ ] Courts/Corrections
- [ ] Probation Parole
- [ ] Self Help Program
- [ ] Voc Rehab/Job Placement
- [ ] Licensed Personal Care Home
- [ ] Private PRTF
- [ ] Private ICF/MR
- [ ] Other __________

## Discharge Instructions provided to

- [ ] Individual
- [ ] Legal Representative

## Discharge Instructions/Additional Information:

__________________________

__________________________

**Signature/Credentials**

**Date**
Service Termination/Change Summary

Purpose
Documentation must be provided and maintained when an individual receiving services transfers between services or between service provider staff. The Service Termination/Change Summary serves to document an individual’s change(s) of service(s) with the current provider which may include transfers from one program or service area to another, as well as transfers from one staff member to another.

Service Termination/Change Information
The individual completing the Service Termination/Change Summary must provide as much information as necessary to clearly describe the transfer that is taking place. It must be documented if the transfer is expected to be temporary or permanent, with dates provided when appropriate or available.

Date of Transfer
The date must indicate the point at which the transfer will become effective. One Service Termination/Change Summary can be used for more than one service change that all become effective the same date. Separate forms must be used for transfers that have different effective dates.

Signatory Authority
The staff member authorizing the change must sign and date the form.
# Service Termination/Change Summary

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>ID Number</td>
</tr>
<tr>
<td>Date</td>
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</table>

<table>
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<tr>
<th>Effective Date of Service Termination/Change</th>
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<table>
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<tr>
<th>Service Termination is expected to be</th>
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<tbody>
<tr>
<td>☐ Temporary</td>
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<tr>
<td>☐ Permanent</td>
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<table>
<thead>
<tr>
<th>Reasons for Service Termination/Change (Check all that apply):</th>
</tr>
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<tbody>
<tr>
<td>☐ Change in Diagnosis</td>
</tr>
<tr>
<td>☐ Change in Symptoms</td>
</tr>
<tr>
<td>☐ Change in Service Activities</td>
</tr>
<tr>
<td>☐ Change in Treatment Recommendations</td>
</tr>
<tr>
<td>☐ Appropriate for Less Intensive Service</td>
</tr>
<tr>
<td>☐ Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>List Service(s) Discontinued</th>
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</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th>List Service(s) Initiated</th>
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</table>

## Service Staff Change

<table>
<thead>
<tr>
<th>From (staff name/credential)</th>
<th>To (staff name/credential)</th>
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</table>

<table>
<thead>
<tr>
<th>Service Change Instructions or Information:</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Signature/Credentials</th>
<th>Date</th>
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</table>
Periodic Staffing/Review of the Individual Service Plan

Purpose
The Periodic Staffing/Review of the Individual Service Plan (ISP) is used to document periodic review and revision in order to remain continuously current with regard to the goals and outcomes the individual receiving services is seeking to achieve. As with the original ISP, all reviews, revisions, or rewrites of the ISP must be a collaborative effort with the individual and/or legal representative and the appropriate staff.

Timelines
Review and revision must occur whenever the individual receiving services experiences a change in his/her life that impacts the goals of their current ISP. Life changes can be expected to be initially reported in progress notes and may be in one or more of the areas listed below. At a minimum, the ISP must be reviewed and revised/rewritten annually.

Changes
Any or all changes in the following areas since the last ISP review must be documented in specific detail:

- Change in diagnosis
- Change in symptoms
- Change(s) in service activities
- Change(s) in household
- Change(s) in treatment/treatment recommendations
- Other significant life change

Plan Modification
After documenting any and all changes that have occurred since the last ISP review, careful consideration should be given to the impact these changes have made on the ISP in terms of the needs expressed goals and outcomes being pursued by the individual. The ISP should be modified or rewritten if needed to ensure ongoing progress toward achievement of the individual’s ISP goals. If the ISP needs to be rewritten, there must be involvement of the treatment team and the Physician, Psychologist, Nurse Practitioner, Licensed Marriage and Family Therapist, Qualified Mental Retardation Professional (IDD programs only) or Alzheimer’s Day Program Supervisor (Alzheimer’s Day programs only) to determine medical necessity.

Signatory Authority
Each individual who participates in the staffing/Review of the Individual Service Plan must sign the Periodic Staffing/Review of the ISP form as evidence of his/her participation in the staffing/Review process.
Periodic Staffing/Review of the Individual Service Plan

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>ID Number</td>
<td></td>
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<tr>
<td>Current Date</td>
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<tr>
<td>Date of Last ISP/Review</td>
<td></td>
</tr>
<tr>
<td>Time In</td>
<td>Time Out</td>
</tr>
</tbody>
</table>

- Change in diagnosis since last review
- Change in symptoms since last review
- Change(s) in service activities since last review
- Change(s) in household since last review
- Change(s) in treatment/service recommendations since last review
- Other significant life change(s) since last review

Comments/Recommendations

Plan Modification □ No □ Yes □ Rewrite Plan
If yes, make additions/ modifications to the existing plan

Individual Receiving Services

Staff Signatures/Credentials

Staff Signatures/Credentials

Signature of Parent/Legal Guardian (if applicable)

Date

Date

Date

Date

DMH B14 Periodic Staffing of ISP-form
Purpose
The form serves as documentation that a search of an individual and/or his/her possessions and/or space was conducted by a DMH certified provider. A separate form must be completed for each individual receiving services who is included in the search.

Reason for the Search
Explain the specific reason the search was conducted.

Description of Search
Describe, in detail, all aspects of the search. Indicate the type of search conducted. Document the specific location (room, building, program area, other), specific items searched, method of search, and duration of search.

Items Seized
List all of the items seized as a result of the search. Specify source or location of items seized if items were seized from more than one location or source.

Staff Involvement
The staff person who authorized the search is to sign the form and list his/her credentials and position title. The same is true for any other staff involved in or witnessing the search.
# Search and Seizure Report

<table>
<thead>
<tr>
<th>Name</th>
<th>ID Number</th>
<th>Date</th>
<th>Time</th>
<th>AM</th>
<th>PM</th>
</tr>
</thead>
</table>

**Reason for Search**

**Description of Search**

**Type of Search**
- [ ] Person
- [ ] Room
- [ ] Locker
- [ ] Possessions
- [ ] Other ________________

**Location** ________________

**List of Items Seized and Source(s) of Items**

**Staff Involvement**

**Authorized By** ________________ Signature/credentials/position title

**Conducted By** ________________ Signature/credentials/position title

**Other person(s) involved in or witnessing the search (signature/credential/position title):**

---

DMH B15 Search and Seizure Report-form
Physical Restraint/Escort Log

Purpose
When an individual is physically restrained or physically escorted away from a service or living area due to inappropriate behavior, the intervention must be documented.

Identifying Information
Enter the name and record number of the individual being restrained or escorted.

Presenting Need
The time, date and detailed description of the events necessitating a restraint/escort must be documented. Describe in detail the individual’s behavior and the type of restraint/escort used. All staff physically involved in the restraint/escort must be documented. Describe all other attempts to de-escalate the individual’s behavior. If less restrictive methods of de-escalation are bypassed, explain staff reasoning. The supervisory staff person must document the face-to-face assessments provided during the restraint/escort, including the time the assessments began and ended. List all dates the individual was restrained/escorted within the last thirty (30) days. Indicate any treatment recommendations and date Individual Service Plan was modified (if necessary.) The primary staff implementing the restraint/escort must sign the documentation. Staff who witnessed but did not participate in the restraint/escort must also sign the finalized log.

Requirements
Physical Restraints/Escort can not be utilized more than three (3) times in a thirty (30) day period unless a Behavior Support Plan has been developed and approved by the program’s Clinical Director and ordered by a physician or other licensed practitioner. Physical Restraint/Escort can not be used as part of a standing order or on an as needed basis. If an individual is placed in a physical restraint or is physically escorted, the treating physician must be consulted within twenty-four (24) hours. A supervisory or senior staff person must physically observe the individual being restrained as soon as possible but within one (1) hour of initiation of the intervention. An individual can not be restrained for longer than one (1) hour. A physical assessment of the restrained individual must be made at least every twenty (20) minutes.

Timeline
Documentation of the physical assessments must take place when they occur. The form must be completed in its entirety by the end of the working day in which the intervention took place.
Physical Restraint/Escort Log

Name ____________________________
ID Number ____________________________
Date ____________________________

Time intervention began: AM/PM
ended: AM/PM

Describe the precipitating events necessitating restraint/escort:

Describe the behavior warranting restraint/escort:

Describe type of restraint/escort used:

List all staff members (regardless of position) that were involved in restraint/escort:

Describe ineffective/less restrictive alternatives attempted prior to restraint/escort:

Describe individual’s behavior during restraint/escort:
Supervisory staff person’s face-to-face assessment of the individual’s mental and physical well being during restraint/escort:

<table>
<thead>
<tr>
<th>Time 1&lt;sup&gt;st&lt;/sup&gt; assessment began:</th>
<th>AM/PM</th>
<th>Ended:</th>
<th>AM/PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time 2&lt;sup&gt;nd&lt;/sup&gt; assessment began:</td>
<td>AM/PM</td>
<td>Ended:</td>
<td>AM/PM</td>
</tr>
<tr>
<td>Time 3&lt;sup&gt;rd&lt;/sup&gt; assessment began:</td>
<td>AM/PM</td>
<td>Ended:</td>
<td>AM/PM</td>
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</table>

Signature/credentials of supervisor staff:

Date(s) individual restrained in the last 30 days:

Is a Behavior Support Plan warranted?  □ Yes  □ No

Name of treating physician consulted: ______________________ Date: _______ Time: _______

Treatment Recommendations:

Date Individual Service Plan Modified:

Signature of Staff Implementing Restraint/Escort

Signature(s) of Other Staff Witness(es)
Time Out Log

Purpose
When an individual is placed in time out due to inappropriate behavior, the intervention must be documented.

Identifying Information
Enter the name and record number of the individual being placed in time out.

Presenting Need
The time, date and detailed description of the events necessitating the time out must be documented. Describe in detail the individual’s behavior. All staff physically involved in the time out must be documented. Describe all other attempts to de-escalate the individual’s behavior. If less restrictive methods of de-escalation are bypassed, explain staff reasoning. Document the visual assessments provided during the time out. Indicate any treatment recommendations and date Individual Service Plan was modified (if necessary.) The primary staff implementing the restraint/escort must sign the documentation. Staff who witnessed but did not participate in the restraint/escort must also sign the finalized log.

Requirements
The use of time out must be justified and approved in the Individual Service Plan. Prior to the use of time out, there must be a written Behavior Support Plan, which is developed in accordance with the Individual Service Plan, and must be approved by the program’s clinical director. An individual cannot be placed in timeout for more than one (1) hour. The individual must be visually observed by staff during time out at least once every twenty (20) minutes.

Timeline
Documentation of visual assessments is made at the time of each observation. The form must be completed in its entirety by the end of the working day in which the time out took place.
<table>
<thead>
<tr>
<th>Time Out Log</th>
<th>Name</th>
<th>ID Number</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time intervention began:</td>
<td>AM/PM</td>
<td>ended:</td>
<td>AM/PM</td>
</tr>
<tr>
<td>Describe the precipitating events necessitating time out</td>
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<tr>
<td>Describe the behavior warranting time out</td>
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<tr>
<td>Describe ineffective/less restrictive alternatives attempted prior to time out</td>
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<tr>
<td>Describe individual's behavior during time out, based on visual assessments</td>
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<tr>
<td>Does the Individual Service Plan require modification?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Signature of Staff Implementing Time Out</td>
<td></td>
<td>Signature of Staff Observing Time Out</td>
<td></td>
</tr>
<tr>
<td>Signature/credentials of Supervisory Staff</td>
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</table>
Readmission Assessment Update

Purpose
When an individual has been discharged from an agency or provider and seeks to resume services, it is necessary to complete a Readmission Assessment Update as part of the readmission process to update information that has changed regarding the individual’s needs and status.

Instructions
Update identifying information and description of need. Document any changes relating to the individual’s history occurring during the lapse of service.

Description of Need
Record the reason(s) the individual is seeking services.

Status Updates
Any changes relating to individual’s status areas (medical, mental health, substance abuse/use, social/cultural, educational/vocational) that have occurred during the gap in service must be documented in detailed narrative format. Responses of “Yes”, “No”, “Present”, “Not Present” are not acceptable.

Indication of Functional Limitation(s)
An assessment must be conducted and the results documented for the major life areas specified for each individual seeking readmission to services.

Staff Requirement
The Readmission Assessment Update must be completed by an individual with at least a Master’s degree in mental health or intellectual/developmental disabilities, or a related field and who has either (1) a professional license or (2) a DMH credential as a Mental Health Therapist or Intellectual/Developmental Disabilities Therapist (as appropriate to the population being served), a QMRP (IDD programs only), LMFT, or Alzheimer’s Day Program Supervisor (Alzheimer’s Day Programs only).
# Readmission Assessment Update

<table>
<thead>
<tr>
<th>Name</th>
<th>ID Number</th>
<th>Readmission Date</th>
</tr>
</thead>
</table>

**Informant:**
- Individual receiving services
- Other

**Relationship to individual:**

## DESCRIPTION OF NEED

**What is your reason for seeking services today?**

**What specific needs are you currently having?**

**Why was the record closed?**

## Status Updates

**Medical Status**
- Record current medications on the Medication/Drug Use Profile:
  - Allergies
  - Physical impairments
  - Surgeries
  - Special diets
  - Appetite issues or problems
  - Sleep issues or problems
  - Current or chronic diseases (high blood pressure, cancer, other)
  - Other pertinent medical information
**Mental Health Status:**

- Recent psychiatric issues
- Homicidal behavior
- Suicidal behavior
- Other counseling and/or therapeutic experiences

**Traumatic Event Or Exposure Status (Note Or Describe As Appropriate):**

- Serious accidents
- Natural disaster
- Witness to a traumatic event
- Sexual assault
- Physical assault (with or without weapon)
- Close friend or family member murdered
- Homeless
- Victim of stalking or bullying
- Other (specify)

**Substance Abuse / Use Status:**

- Use or abuse by the individual
  - Age of onset _________
  - Patterns of use/abuse: How much? _________
  - How often? _________
  - Methods of use: smoke □ snort □ inject □ insert □ inhale □
- Resulting circumstances?

**NOTE:** If the individual is being readmitted for substance abuse services, the Substance Abuse Specific Assessment must be completed and attached during the Readmission Assessment.
### Social/Cultural Status:

- Immediate household/family configuration

- Marital status

- Relationship with family members

- Type of family support available

- Type of social support available

- Types and amounts of social involvement/leisure activities

- Any religious/cultural/ethnic aspects that should be considered

### Educational/Vocational Status:

- Highest grade completed

- If currently in school (child or youth), regular classroom placement? □ Yes □ No

  List all additional educational services child is receiving

  - Any repeated grades? □ No □ Yes Explain:
  - Suspensions/expulsions? □ No □ Yes Describe:
  - Other education issues

- Vocational training, if any

- Current employment

- Previous employment

- Comments:

### Indication Of Functional Limitation(s):

(Check Major Life Areas Affected)

- Basic living skills (eating, bathing, dressing, etc.)

- Instrumental living skills (maintain a household, managing money, getting around the community, taking prescribed medications, etc.)

- Social functioning (ability to function within the family, vocational or educational function, other social contexts, etc.)

 Signature/Credentials

 Date
Medical Examination

The DMH Operational Standards require that each individual served in any DMH certified supervised and residential living program must have a documented Medical Examination in the individual’s record. This requirement also applies for individuals attending Senior Psychosocial Rehabilitation programs. The examination must take place within 72 hours of admission, but not more than 30 days prior to admission and be conducted by a licensed physician, certified nurse practitioner or certified physician’s assistant. No individual may remain in the program unless a medical examination is completed and documented.

Components of the medical examination and report include but are not limited to:

- Individual’s personal information
- Physician’s information (name, contact information, other)
- Examination information (blood pressure, pulse, height, weight, current diagnosis, current medications, statement of freedom from communicable disease, physical and dietary limitations, and allergies)

The medical examination report must be signed by a licensed physician/nurse practitioner/ certified physician’s assistant.
# Medical Examination

**Physician’s Name:**

**Date of Evaluation:**

**Physician’s Address:**

**Physician’s Phone #:**

**Person Receiving Evaluation:**

**DOB:**

**Age:**

<table>
<thead>
<tr>
<th>Check</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Head</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Fontanelle</td>
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<td>3. Skin</td>
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<tr>
<td>4. Lymph Nodes</td>
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<tr>
<td>5. Facies</td>
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<tr>
<td>6. Eyes a. Right</td>
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<td>b. Left</td>
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<td>7. Ears a. Right</td>
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<td>b. Left</td>
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<td>8. Nose</td>
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<tr>
<td>9. Mouth</td>
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<td>10. Teeth &amp; Gums</td>
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<tr>
<td>11. Tongue</td>
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<td>12. Pharynx &amp; Palate</td>
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<td>13. Neck</td>
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<td>14. Thorax</td>
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<td>15. Heart</td>
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<td>16. Lungs</td>
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<td>17. Abdomen</td>
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<td>18. Breasts</td>
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<td>19. Genitals</td>
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<tr>
<td>20. Spine</td>
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<td>21. Extremities</td>
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<tr>
<td>22. Neurological</td>
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<tr>
<td>a. Cranial</td>
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<td>b. Reflexes</td>
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<tr>
<td>c. Neuromuscular</td>
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<tr>
<td>d. Stain &amp; Gait</td>
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<td>e. Mood/Behavior</td>
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<tr>
<td>23. Urine</td>
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<tr>
<td>24. CBC</td>
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**Current Medications:**

**Special Dietary Requirements:**

Based upon the results of this examination and the additional information provided, this person is sufficiently free from disease and does not have any health conditions that would create a hazard for other people.

**Physician Signature**

**Date**
Documentation of Healthcare Provider Visits

Purpose
This form is available to ensure that programs are assisting individuals in accessing routine healthcare services.

Timelines
This form must be completed each time the individual interacts with a healthcare provider of any type.

Name/Type of Healthcare Provider
List the name and type of the healthcare provider. List the credential(s) of the provider. Types of healthcare providers are physicians, nurses, pharmacists, optometrists, etc.

Reason for Visit
Provide a detailed description of why the individual is meeting with the healthcare provider.

Outcomes/Results
Provide a detailed description of the outcome of the meeting with the healthcare provider. This includes any diagnosis(es), procedures conducted during the visit, and any procedures/follow-up required. If a procedure of any type is scheduled, provide the date.

Medications
Medications ordered or changed must be documented on the Medication Profile Form.

Change(s) in Existing Prescriptions
If the healthcare provider changes a currently prescribed medication(s), provide the same information as required above and include the reason for the change(s). Update the Medication/Emergency Contact Information form as needed.
# Documentation of Healthcare Provider Visits

<table>
<thead>
<tr>
<th>Name of Health Care Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Health Care Provider:</td>
</tr>
</tbody>
</table>

**Reason for Visit:**

**Outcomes/Results**

- **Diagnosis(es) (if applicable):**
- **Procedure(s) conducted:**
- **Procedure(s) ordered:**  
  - **Date:**

**Describe any needed follow up, including dates:**

**Source of Information**

- Provider/ Staff participated in the visit
- Family/ Guardian participated in the visit and provided results of the visit to the program
- Provider assisted with access to healthcare but did not participate in the visit
- Release of records completed
- Records requested from healthcare provider

---

**Staff Signature/Credential**  
**Date**
Section C
Emergency/Crisis Services

Emergency/Crisis Contact Log
Acute Partial Hospitalization/Acute Community Stabilization Services Daily Service Log/Activity Summary Note
Individual Crisis Support Plan
Emergency/Crisis Contact Log

Purpose
All emergency/crisis contacts, both face-to-face and by telephone, must be documented. This is a requirement for all providers of emergency/crisis services (mobile crisis response).

Identifying Information
Record the name and case number (if applicable) of the individual receiving services. Contacts may be provided to individuals who are not currently receiving services from the provider.

Presenting Need
The time and date the individual and/or family member/legal guardian or other interested party contacted the provider must be documented. In the event of a face-to-face contact, the location of the contact must be documented. The factors indicating a need for emergency services must be documented to include as much detail as possible. All parties involved in the emergency/crisis must be identified.

Action Taken by Staff
Include the steps taken to assess and resolve the emergency/crisis. Record whether or not significant others were notified. If they were not, indicate why that notification was not made.

Resolution
Describe the condition of the individual at the last face-to-face contact and/or termination of the phone call. Services to which the individual and/or family were referred must be documented.
<table>
<thead>
<tr>
<th>Name</th>
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<tr>
<td>ID Number</td>
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<thead>
<tr>
<th>Date</th>
<th>Time</th>
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</table>

<table>
<thead>
<tr>
<th>Type of Contact</th>
<th>Face-to-Face</th>
<th>Telephone</th>
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<tbody>
<tr>
<td></td>
<td>Location of Face-to-Face</td>
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</table>

**Indi viduals Involved:**

**Presenting Need** (include factors indicating a need for emergency services)

- 
- 
- 
- 

**Action(s) Taken by Staff** (include notification of others or rationale for deciding not to notify)

- 
- 
- 
- 

**Resolution**

<table>
<thead>
<tr>
<th>Condition of the Individual/Family or Interested Party at Conclusion of Emergency/Crisis</th>
<th>Referrals Made by Staff</th>
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**Staff/Credentials**
Acute Partial Hospitalization/Acute Community Stabilization Services Daily Service Log/Activity Summary Note

Purpose
Documentation must be maintained when an individual receives Acute Partial Hospitalization/Acute Community Stabilization (APH/ACS) Services. There must be documentation of medical supervision and follow along to include on-going evaluation of the medical status of the individual. Support services for families and significant others must be documented. Discharge criteria and follow-up planning must be documented.

Identifying Information
Record the name, record number, date of service and total amount of time the individual received the service.

Services
Indicate which services were provided during the day by checking the appropriate box, specify the time the service began and ended and list the name of the staff providing the service.

Therapeutic Activities Provided
List all activities the individual participated in during the day, specify the time the activity began and ended and list the name of the staff providing the service.

Daily Summary Note
The Master’s level staff must summarize the progress of the individual receiving services as it relates to the Individual Service Plan.

Timeline
APH/ACS Services must be documented daily with a summary note that records services provided.

APH/ACS Services must be provided at a minimum of three (3) days per week for a minimum of four (4) hours per day (excluding transportation time) and must be available twelve (12) months per year.
<table>
<thead>
<tr>
<th>Services</th>
<th>Check</th>
<th>Time In</th>
<th>Time Out</th>
<th>Name of Service Provider</th>
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<tbody>
<tr>
<td>Medical Supervision</td>
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<tr>
<td>Nursing</td>
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<tr>
<td>Intensive Psychotherapy</td>
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<td>Individual Therapy</td>
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<td>Group Therapy</td>
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<td>Family Therapy</td>
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<tr>
<th>Therapeutic Activities Provided</th>
<th>Activity</th>
<th>Time In</th>
<th>Time Out</th>
<th>Name of Activity Coordinator</th>
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<table>
<thead>
<tr>
<th>Daily Summary Note</th>
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Signature/Credential
Individual Crisis Support Plan

Purpose
Each Case Management Support Plan must include an individualized Crisis Support Plan for all individuals at risk of crisis, frequent users of inpatient services or individuals that are transitioning from a more restrictive environment to the community.

Identifying Information
Record the individual’s name, record number, date the plan was developed and the local toll-free crisis phone number.

Treatment Information
Record the individual’s diagnosis as indicated on the Individual Service Plan. Explain relevant history and current potential for crisis situation. List all medications the individual is currently prescribed. Explain what may be a potential trigger for the individual to regress into a crisis situation.

Action Steps
List the action steps the individual, crisis response team and family (if indicated) will take in the event the individual is experiencing a crisis at home or in the community. Include who is responsible for initiating the response with their phone number.

Requirements
The Crisis Support Plan must be developed by the team of individuals who will have responsibilities for implementing the Plan in the event of a crisis. Each of these individual team members must sign the Crisis Support Plan where indicated.

The Crisis Support Plan identifies what could go wrong and how people should respond. Crisis planning includes opportunities for family and team members to practice crisis response by simulating a crisis in a safe, controlled environment. The Crisis Support Plan must include who will notify who and when. The Crisis Support Plan must be portable in the sense that all team members must have a copy to refer to when needed. The Individual receiving services should also maintain a copy of the plan for reference.
# Individual Crisis Support Plan

**Name**

ID Number

Date Plan Developed

Toll-free Crisis Phone Number

## Diagnosis:

## Current Medications:

## Relevant History and Potential Crisis:

## Known Triggers:

<table>
<thead>
<tr>
<th>Action Steps for Home</th>
<th>Person(s) Responsible and Phone Number(s)</th>
<th>Action Steps for Community Locations (specify)</th>
<th>Person(s) Responsible and Phone Number(s)</th>
</tr>
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Signature of IRS Date

Signature/Position Date

Signature/Position Date

Signature/Position Date
Section D
Case Management/Community Support Services

Case Management/Community Support Activity Plan
Case Management/Community Support Progress Note
Case Management/Community Support
Activity Plan

Purpose
The Case Management/Community Support Activity Plan identifies the individual's strengths and resources that can contribute to the achievement of the individual's personal goals. The Activity Plan documents the individual's personal goals, the action steps needed to achieve those goals and case management support needed to assist with goal achievement.

The development of an individual's Case Management/Community Support Activity Plan includes an assessment of the individual's strengths and needs and must be a collaborative effort of the individual, the individual's parent(s) and/or legal representative (when appropriate), and staff members involved in service delivery and resource development. By signing the Activity Plan, each of these individuals is confirming their active participation in development of the Activity Plan and the support needed to assist the individual in achievement of their goals.

For those providers who are certified to participate in the Wraparound Approach (National Wraparound Initiative), the Individualized Support Plan that is a part of the Wraparound process can be used in lieu of the Case Management/Community Support Activity Plan.

Strengths
Strengths are those qualities, characteristics, or personal and family resources that can and do play a valuable and distinctive role in helping the individual achieve their goals. Document the individual's strengths as seen by the individual, the individual's parent(s) and/or legal representative (when appropriate), and the case manager. Strengths should be clearly stated or described and must be reflected in action steps.

Areas of Need
Areas of Need are assessed by the individual and/or legal representative and the case manager and can include relevant information from other appropriate sources. For purposes of the Activity Plan, there are four broad areas of need, including Health, Home, Purpose and Community. Individuals may have needs in any or all of these areas.

Current Status
For each area of need, record the current status of the individual in the most specific, measurable terms possible. Prompts are suggested for each of the four areas of need to help make the Activity Plan more specific. A description of the individual’s current status should be objective and non-judgmental.

Personal Goals
Document the individual's goals for each area of need as identified by the individual and case manager. Indicate which goals were developed by the individual, by the case manager, or by both. Goals must be measurable, clearly stated, and time-specific, not to exceed one year. Personal goals should be stated in the individual's own words whenever possible.
Action Steps
Action Steps are those specific activities that need to be accomplished in order to achieve the goal(s) in each area of need. The Action Steps are those things that the individual will either complete or actively participate in with the assistance/support of the case manager and other relevant resources. In some situations, Action Steps may need to be completed in sequence. Indicate who is primarily responsible for making sure each Action Step is accomplished. Each Action Step must include a target date for each step to be accomplished.

Level of Case Management/Community Support
The Level of Case Management/Community Support is primarily based on the intensity or severity of the Current Status in each area of need identified in conjunction with the nature and quantity of the Action Steps needed to achieve each Personal Goal. In determining the Level of Case Management/Community Support, Areas of Need may need to be prioritized on the basis of the individual’s immediate health and/or safety.

School Input (C&Y only)
Give the name of the school official providing information. Information can be obtained by face to face contact, written report or telephone contact.

Measurable Goals
In order to measure progress or lack of progress, goals and actions steps should be measurable and should result in a positive outcome for the individual. Include timelines when appropriate to increase measurability.
# Case Management/Community Support Activity Plan

<table>
<thead>
<tr>
<th>Strengths/Vision</th>
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</table>

## Area of Need: Health *(dental, medical, medication, substance abuse, adaptive equip, therapy, behavior supports, other)*

<table>
<thead>
<tr>
<th>Current Status</th>
<th>Personal Goal</th>
<th>Action Steps</th>
<th>Date Goal Achieved</th>
</tr>
</thead>
</table>

## Area of Need: Home *(money management, benefits, living arrangements, clothing, personal care, child care, rent, other)*

<table>
<thead>
<tr>
<th>Current Status</th>
<th>Personal Goal</th>
<th>Action Steps</th>
<th>Date Goal Achieved</th>
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</thead>
</table>
### Area of Need: Purpose
(employment assistance, education, vocational training, early intervention, other)

<table>
<thead>
<tr>
<th>Current Status</th>
<th>Personal Goal</th>
<th>Action Steps</th>
<th>Date Goal Achieved</th>
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</thead>
</table>

### Area of Need: Community
(social supports, interpersonal, protective care, support group, counseling, legal assistance, other)

<table>
<thead>
<tr>
<th>Current Status</th>
<th>Personal Goal</th>
<th>Action Steps</th>
<th>Date Goal Achieved</th>
</tr>
</thead>
</table>

### Level of Case Management/Community Support (circle one)

- High
- Moderate
- Low
- Follow Along

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<thead>
<tr>
<th>ID/DD only</th>
<th>Potential/Temporary</th>
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<tr>
<td>In Date:</td>
<td>Out Date:</td>
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<table>
<thead>
<tr>
<th>Individual receiving services</th>
<th>Date</th>
<th>CM/CS Specialist/ Credentials</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Input By (For C&amp;Y only)</td>
<td>Parent/Legal Guardian</td>
<td>Date</td>
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</table>
Case Management/ Community Support
Progress Note

Purpose
For individuals receiving Case Management/Community Support (CM/CS) services, the progress made toward achieving their individual goals must be periodically documented in the form of progress notes completed by the DMH Credentialled Case Management/Community Support Specialist.

If a child or youth is participating in the Wraparound Approach (National Wraparound Initiative) and has an Individualized Wraparound Support Plan, the Case Management/Community Support Progress Note must be used to document Wraparound progress.

Timelines
Each contact with the individual receiving services or any collateral source must be documented in a progress note, dated, and signed by the DMH Credentialled Case Manager/Community Support Specialist. The documented status of progress in these notes will be used to revise, modify, or rewrite the individual’s Case Management/Community Support Activity Plan as progress is made or circumstances change requiring the plan to be modified or rewritten.

Need(s) Addressed
Each progress note must reference one or more Areas of Need from the Activity Plan and Individual Service Plan and provide current information as to the level of support provided to address that need. Needs must be addressed individually and not be combined.

Summary of Actions
Each CM/CS progress note must list, describe, and/or summarize the specific case management actions toward addressing the need(s) that have taken place since the previous note.

Result of Action Steps
Each CM/CS progress note must list, describe, and/or summarize the results of the specific actions that have taken place since the previous note.

Next Steps
Those next steps to be taken toward achieving the individual’s personal goals to address or resolve needs must be listed or described. These action steps or activities should include an indication or measure regarding the time by which the activity or action will be completed. These action steps are primarily those that the individual will accomplish with the assistance and support of the case management/community support specialist or other resources as needed. Each action step must be identified as being the responsibility of the individual or the Case Management/Community Support Specialist or both. The next planned visit must include the scheduled date and time of the visit. The visit must be documented in the next progress note or the progress note must include an explanation as to why the visit did not
take place.

**Progress toward Case Management/Community Support Activity Plan Goals**

Specific, measurable progress toward the achievement of the personal goals identified in the Case Management/Community Support Activity Plan must be documented in each Case Management/Community Support Progress Note.
<table>
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<tr>
<th>Case Management/Community Support Progress Note</th>
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<tbody>
<tr>
<td>Name</td>
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<td>ID Number</td>
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<td>Date</td>
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<td>Time In</td>
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<td>Time Out</td>
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<td>Total Time</td>
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<th>Need(s) Addressed</th>
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<th>Summary of Actions</th>
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<tr>
<th>Result(s) of Action Steps</th>
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<tr>
<th>Next Steps &amp; Responsible Party (must include date and time of next planned visit)</th>
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<tr>
<th>Progress Toward CM/CS Activity Plan Goals</th>
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Section E
Psychosocial Programs

- Psychosocial Rehabilitation Services Progress Note
- Senior Psychosocial Rehabilitation Services Progress Note
- Psychosocial Rehabilitation/ Day Support Progress Note
- Day Treatment Progress Note
Purpose
Providers must maintain documentation to verify each individual's monthly progress on the areas of need identified on his/her Individual Service Plan. A version of the progress note is provided for each type of Psychosocial Rehabilitation Service.

Time
Record the appropriate amount of time provided each day. Indicate if an individual is absent or if it is a weekend or holiday.

Monthly Summary
Daily participation is summarized at the end of each month and must address the individual's objectives identified on his/her Individual Service Plan.

Area of Focus
Areas of focus are identified on the Individual Service Plan and activities must be specific to the area of focus.

Summary of Objective/Activity
Provide a summary of each therapeutic activity addressed.

Result of Objective/Activity
An assessment of the progress or lack of progress toward the areas of focus and the objectives addressed must be stated in measurable terms.

Next Step
List or describe specific plans for the future therapeutic activity. Because many of the activities may appear to be repetitive in nature, “Next Step” must be described in terms of frequency, quality, consistency, and/or across multiple settings.
### Psychosocial Rehabilitation Progress Note

#### Monthly Summary

<table>
<thead>
<tr>
<th>Area of Focus</th>
<th>Summary of Objective/Activity</th>
<th>Result of Objective/Activity</th>
<th>Next Step</th>
</tr>
</thead>
</table>

#### Unit Summary Activities

<table>
<thead>
<tr>
<th>Kitchen</th>
<th>Snack Bar</th>
<th>Clerical</th>
<th>Thrift Store</th>
<th>Maintenance</th>
<th>Other</th>
</tr>
</thead>
</table>

#### Signature/Credentials

Date

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DMH E1a PSR Progress Note-form
# Senior Psychosocial Rehabilitation Progress Note

## Monthly Summary

<table>
<thead>
<tr>
<th>Area of Focus</th>
<th>Summary of Objective/Activity</th>
<th>Result of Objective/Activity</th>
<th>Next Step</th>
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**Signature/Credentials**  

**Date**

---

**Name**  

**ID Number**  

**Month/Year**
## Psychosocial Rehabilitation/Day Support Progress Note

| Day of the month | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|-----------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Time In         |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Time Out        |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Total           |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |

### Monthly Summary

<table>
<thead>
<tr>
<th>Area of Focus</th>
<th>Summary of Objective/Activity</th>
<th>Result of Objective/Activity</th>
<th>Next Step</th>
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Day Treatment Progress Note

Purpose
Day Treatment Services require that progress be documented on a weekly basis with a monthly summary of overall progress toward meeting the needs and achieving the objectives specified in the Individual Service Plan.

Identifying Information
Identifying information must include the name of the DMH-certified Day Treatment program in which the child/youth is enrolled.

Service Provision Information
Record the date services were provided and the total time for each day.

Objectives
Due to the intensive nature of Day Treatment, no more than two objectives should be monitored for progress at a time. As objectives are achieved, they can be replaced with additional objectives as warranted or as indicated by the most current Individual Service Plan. Progress or lack of progress on each objective should be stated in concrete, measurable terms, along with an indication of any recommended changes in treatment or service activities.

Signatory Authority
Each weekly progress note and monthly summary requires the signature of the Master’s level Day Treatment Specialist. Credentials must be included with the signature.

Monthly Summary
At the end of the month, a summary of progress or lack of progress toward achieving the stated objective(s) must be recorded.
# Day Treatment Progress Note

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<thead>
<tr>
<th>Name</th>
<th>ID Number</th>
<th>Program Name</th>
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</table>

## Attendance during month of [Month] year of [Year]

| Days | 1   | 2   | 3   | 4   | 5   | 6   | 7   | 8   | 9   | 10  | 11  | 12  | 13  | 14  | 15  | 16  | 17  | 18  | 19  | 20  | 21  | 22  | 23  | 24  | 25  | 26  | 27  | 28  | 29  | 30  | 31  |
|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Time In |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| Time Out|     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| Total Time |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |

## Weekly Dates

<table>
<thead>
<tr>
<th>Objective 1:</th>
<th>Objective 2:</th>
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### 1st Week

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### 2nd Week

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### 3rd Week

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### 4th Week

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### 5th Week

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## Monthly Summary

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<th>Signature/Credential</th>
<th>Supervisor Signature/Credential</th>
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</table>
Section F
Community Living Services
Section F
Community Living:
Supported Living Option

Supported Living Progress Note
ID/DD Waiver Home and Community Supports
  Activity Plan
ID/DD Waiver Home and Community Supports
  Activity Note
ID/DD Waiver Home and Community Supports
  Service Agreement
Supported Living Progress Note

Purpose
Supported Living Progress Note is to be maintained by providers of Supported Living Services for each individual. The activities listed on the progress note should correspond to the objectives/activities specified on the Individual Service Plan. The Supported Living Progress Note is also used to verify activities/supports provided to recipients of supported living services.

Timeline
Each contact the service provider has with the individual receiving services must be documented in a Progress Note at the time the contact is made.

Nature of the Note
The Progress Note must clearly document the purpose of the contact, the activity (banking, paying bills, shopping, cleaning, etc.) and what is accomplished.
<table>
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<tr>
<th>Date</th>
<th>Activity</th>
<th>Signature/Credentials</th>
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</table>
**ID/DD Waiver Home and Community Supports**

**Activity Plan**

**Purpose**
The purpose of the Activity Plan is to document the outcomes an individual would like to achieve as a result of participating in Home and Community Supports.

**General**
The activities must be developed based on the Plan of Care Outcomes and the individual's choices/desires.

Use as many pages as necessary to capture and document pertinent information. If the Activity Plan is revised or changed, document the changes on the current Activity plan, sign and date the form and send it to the appropriate ID/DD Waiver Support Coordinator.

**Outcomes**
List the outcomes the individual would like to achieve through Home and Community Supports. Outcomes can be in the areas of any aspect of a person’s life that enables him/her to participate in meaningful activities and community integration. Outcomes can be specific or general depending on the individual’s interests and need(s) for assistance/support.

**Individual’s Activities**
List and number the activities which the individual will participate in to assist him/her in meeting his/her stated outcomes. These must be individualized for each person and be specific to the activity(ies) which will help the individual achieve/maintain the desired outcome.
ID/DD Waiver
Home and Community Supports
Activity Plan

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Specific Activities</th>
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</table>

Name ____________________________
ID Number ________________________

Page of

Individual/Legal Representative Signature
Agency Representative Signature/Credentials

Date ____________________________
Date ____________________________

DMH F2 ID-DD Waiver HCS Activity Plan-form 87
ID/DD Waiver Home and Community Supports Activity Note

Purpose
Programs must document each individual's progress toward stated outcomes as well as the times the individual arrives at and leaves the program each day.

Timelines
Staff must complete the required information during the time the service is being provided. Notes for any given month must be in the individual's record no later than the 10th of the following month.

Activities addressed
The activities included in the Activity Note must reflect the activities listed in the Activity Plan for Home and Community Supports. This includes the activities of the individual as well as anything staff did to assist/support the individual in the stated activity. Activities should relate to a stated outcome.

Day/Date
The staff person is to list both the day of the week and the 3-part date services are provided. Document the number of units provided to each individual each day. Staff must list the exact time the service began and ended. Indicate if the time is a.m. or p.m.

See Contact Summary for Additional Information
The provider checks this box if there is information which is pertinent to the individual but cannot be adequately/appropriately captured in the Activity Note. The Contact Note must be attached to the Activity Note.

Individual/Legal Representative Signature
The individual/legal representative must sign the form to verify the services/activities documented took place.

Staff Signature
Staff must sign the form to verify the services documented were provided on the day indicated. If more than one staff person assists an individual during the day, the staff person who signs the form is responsible for ensuring all activities took place as reported by other staff. Only one staff signature is required.
<table>
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<tr>
<th>Activity</th>
<th>Day/Date</th>
<th>Day/Date</th>
<th>Day/Date</th>
<th>Day/Date</th>
<th>Day/Date</th>
<th>Day/Date</th>
<th>Day/Date</th>
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</thead>
</table>

- **See Contact Summary for Additional Information**

- **Time Service Began** (use a.m. and p.m.)
- **Time Service Ended** (use a.m. and p.m.)
- **Units Provided**
- **Individual/Legal Rep. Signature**
- **Staff Signature**
ID/DD Waiver Home and Community Supports Service Agreement

Purpose
The individual's provider(s) inform the person about the services that can and cannot be provided through Home and Community Supports (HCS).

Timelines
The Service Agreement is reviewed with the individual prior to or at the time the provider begins providing services and at least annually thereafter. Providers must send signed copies of the Service Agreement to the individual's Support Coordinator by the 15th of the month following the month it is signed.
**ID/DD Waiver Home and Community Supports Service Agreement**

<table>
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<tr>
<th>Name</th>
<th>Medicaid Number</th>
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1. I understand Home and Community Supports (HCS) will, to the greatest extent possible, be scheduled on a regular basis to meet my unique needs, as identified on the Activity Plan. Only the amount of Home and Community Supports authorized on the Plan of Care will be provided. If a change in the amount is needed, I will contact my Support Coordinator.

2. I understand Home and Community Supports can be provided in my home and/or in the community and either with or without my parent/legal representative present, depending upon my identified support needs.

3. I understand HCS staff cannot be responsible for caring for others who may be in the house. HCS staff is only responsible for the person who is enrolled in the ID/DD Waiver. Also, the HCS staff person is not responsible for caring for pets. I cannot receive HCS at a staff person's home.

4. If a scheduled Home and Community Supports visit must be canceled (e.g. because of a doctor's appointment, I am ill, my family will be out of town, etc.), it is my responsibility to notify the provider as soon in advance of the cancellation as possible. I understand that three (3) cancellations for which no notice is given will result in a review of the Plan of Care to determine if Home and Community Supports are still necessary and appropriate.

5. I understand the HCS staff person will complete all forms necessary to document the provision of Home and Community Supports. I or my parent/legal representative will be asked to initial an Activity Note each time Home and Community Supports are provided to verify that the HCS staff indeed provided the amount of service documented. I further understand initializing false or fraudulent documentation is against the law.

6. I understand that the receipt of Home and Community Supports is voluntary. I may decline services by notifying my Support Coordinator.

7. I understand services may be terminated according to the provisions in the ID/DD Waiver Enrollment Agreement.

8. I understand if services are to be terminated, I will be notified as soon as possible. The Support Coordinator will assist me in locating other service options, if available. If I disagree with services being terminated, I may file an appeal according to established procedures. The services will not change until the outcome of the appeal is determined. If termination of services is due to the environment or persons in the environment posing a risk to the HCS staff, I cannot continue to receive services pending the outcome of the appeal.

9. Should any problems arise regarding the provision of Home and Community Supports, I will notify my ID/DD Waiver Support Coordinator immediately.

10. I understand Home and Community Supports cannot be provided on an overnight basis outside of my legal residence.

11. I understand HCS staff cannot provide medical treatment of any sort, as defined in the Mississippi Nurse Practice Act Rules and Regulations.

12. Home and Community Supports staff cannot accompany a minor child on a medical visit without the parent/legal representative.
ID/DD Waiver Home and Community Supports
Service Agreement

13. The ID/DD Waiver does not allow HCS staff to be a parent or legal guardian, a step parent of a minor, or a spouse or relative or anyone else who resides in the same home or who is normally expected to provide care.

14. Relatives who are not the parent or legal guardian, a step parent of a minor, or a spouse, relative or anyone else who resides in the same home or who is normally expected to provide care may be approved to provide Home and Community Supports. They must be employed by a DMH certified provider and meet the same qualifications for employment as staff who are unrelated. The employing provider must receive prior approval from the Director of the Bureau of Intellectual and Developmental Disabilities at the DMH before a relative can provide Home and Community Supports.

I understand the above information and the circumstances under which Home and Community Supports can be provided.

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<tr>
<th>Individual/Legal Representative</th>
<th>Authorized Provider Representative/Credential</th>
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Date

Date
Section F
Community Living:
Supervised & Residential Living Options

Supervised Living Activity Summary
Telephone/Visitation Agreement
Community Living Substance Abuse Aftercare Plan
Community Living TB/HIV/STD Risk Assessment Interview
Community Living Educational Activities/Risk Assessment for TB/HIV/STD
Seclusion Behavior Management Log
Supervised Living Activity Summary

Purpose
The purpose of the Activity Summary is to document the activities to support outcomes an individual would like to achieve as a result of participating in Supervised Living.

These activities will be based on identified areas of support/assistance as well as the desires and choices of the individual/legal representative.

General
The activities must be developed based on the Individual Service Plan.

As a part of ongoing needs assessment, additional outcomes may be identified depending on the individual's desires and should be incorporated into the activities.

Individual's Activities
Activities should be individualized for each person and be specific to help the individual achieve/maintain the desired outcome. Activities should correspond to each identified outcome.
## Supervised Living Activity Summary

### Participation during month of ___________ year of ___________

| Days | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Present |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |

### Weekly Dates | Activities to Support: | Activities to Support:

#### 1st Week
- **Date**: ___________
  - **Signature/Credential**: ___________

#### 2nd Week
- **Date**: ___________
  - **Signature/Credential**: ___________

#### 3rd Week
- **Date**: ___________
  - **Signature/Credential**: ___________

#### 4th Week
- **Date**: ___________
  - **Signature/Credential**: ___________

#### 5th Week
- **Date**: ___________
  - **Signature/Credential**: ___________

### Monthly Summary
- **Signature/Credential**: ___________
TelephoneNumber/Visitation Agreement

Purpose
Individuals receiving services in a group setting have the right to privacy as it pertains to the acknowledgement of their presence in the program with regard to visitors as much as physically possible. Individuals receiving services also have the right to determine from whom they will accept phone calls and/or visitation. The fully executed Telephone/Visitation Agreement serves to allow acknowledgement of the individual's presence in the program to those listed in and according to the terms detailed in the Agreement.

Timeline
The Telephone/Visitation Agreement must be completed upon admission/re-admission to any program certified by DMH. The Agreement must be reviewed or updated upon the request of the individual receiving services.

Telephone Calls
Check only the box that applies. If the individual agrees to accept all telephone calls regardless of source, the first box should be checked. If the individual agrees to only accept calls from specific individuals, the second box should be checked and the name(s), phone number, and relationship of those individuals must be documented.

Visits
Check only the box that applies. If the individual agrees to accept all visitors, the first box should be checked. If the individual agrees to only accept visits from specific individuals, the second box should be checked and the name(s), phone number, and relationship of those individuals must be documented.

Staff and Facility-specific Visitors
By signing the Telephone/Visitation Agreement, the individual receiving services also acknowledges their understanding that the program cannot be held responsible for disclosures made by other individuals who may enter the premises.
# Telephone/Visitation Agreement

While a resident at [Name of Program]

I give consent to receive phone calls and visits from those specific persons named in the sections below and who are outside the program/facility for support and coordination of my treatment services.

- I agree to have my participation in this program acknowledged and accept telephone calls from any individuals.
- I agree to have my participation in this program acknowledged and accept telephone calls only from the following named individuals:

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<th>Name</th>
<th>Telephone Number(s)</th>
<th>Relationship</th>
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- I agree to accept any individual as a visitors.
- I agree to accept as visitors the following named individuals only:

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<tr>
<th>Name</th>
<th>Telephone Number(s)</th>
<th>Relationship</th>
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I understand this consent will expire upon my discharge from the program. I may revoke this consent at any time except to the extent that action has already taken place.

I understand that interns and delivery/maintenance people enter the premises on occasion and I will not hold the service provider staff responsible for any visitors that may disclose my presence in this program.

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<thead>
<tr>
<th>Individual Receiving Services</th>
<th>Date</th>
<th>Authorized Representative</th>
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<tr>
<th>Signature/Credential</th>
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<th>Relationship to Individual</th>
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Community Living Substance Abuse Aftercare Plan

Purpose
The Aftercare Plan is used as a tool to assist an individual in making plans to engage in activities and access resources designed to help/support him/her in maintaining recovery.

Strengths/Challenges
Record the strengths and challenges related to maintaining recovery that the individual identifies.

Statement of Need
Record any needs identified by the individual in the areas listed.

Individualized Objectives
All Aftercare Plans must have individualized objectives and they must be measurable. For example, what does the individual wish to accomplish or achieve while in Aftercare Services?

Objectives
Objectives 1 and 2 are required for all Aftercare Plans. Check each item that applies.

Referrals to Other Sources
In order to remain in recovery, individuals may require assistance from other resources. The provider is to assist in accessing any needed resources. The Aftercare Plan is used to document the resources needed to assist the individual. Indicate where the individual is referred and also document when they are scheduled, where, the time, and with whom.
# Community Living Substance Abuse Aftercare Plan

<table>
<thead>
<tr>
<th>Name</th>
<th>ID Number</th>
<th>New Admission</th>
<th>Readmission</th>
<th>Rewrite</th>
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<th>Strengths/Challenges</th>
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## Statement of Need

A. Vocational

B. Psychological

C. Medical

D. Social

E. Educational

F. Legal

G. Transportation

H. Housing

I. Family/other support
**Measurable Objectives**

**Individualized Objective(s)**

**Objective 1** To maintain sobriety-oriented support:

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<tbody>
<tr>
<td>a)</td>
<td>Individual will attend 90 AA/NA meetings in 90 days</td>
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<tr>
<td>b)</td>
<td>In lieu of objective a), individual will attend</td>
<td>AA/NA meetings weekly AND/OR</td>
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<td>c)</td>
<td>Individual will obtain a sponsor</td>
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<tr>
<td>d)</td>
<td>Individual will talk to sponsor at least</td>
<td>times weekly</td>
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**Objective 2** To participate actively in Aftercare for at least two (2) years

| a) | Individual will attend all Aftercare meetings |   |
| b) | Individual will continue to work on Twelve Steps of Recovery by completing steps |   |

**Referrals to Other Community Resources**

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>Parenting Classes</th>
<th>Voc-Rehab</th>
<th>Food Stamps</th>
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<tbody>
<tr>
<td>Medicaid</td>
<td>Medical Care</td>
<td>Aftercare</td>
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**Evidence-based Recovery Program (Reality Therapy)**

**Other:**

**Appointments Scheduled**

1. Date _______________ Time ___________ Agency ___________ Location ___________ Contact Person ___________

2. Date _______________ Time ___________ Agency ___________ Location ___________ Contact Person ___________

3. Date _______________ Time ___________ Agency ___________ Location ___________ Contact Person ___________

**I understand and agree to participate in the recommended Aftercare Service.**

<table>
<thead>
<tr>
<th>Individual Receiving Services</th>
<th>Aftercare Counselor/Credential</th>
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<tbody>
<tr>
<td>Parent/Legal Guardian</td>
<td>Primary Counselor/Credential</td>
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</table>

DMH F7 Community Living Substance Abuse Aftercare Plan-form
Community Living TB/HIV/STD Risk Assessment Interview

Purpose
Individuals receiving Community Living substance abuse services must be interviewed to assess whether the individual is at risk for TB, HIV and STD.

Timeline
The risk assessment interview must be completed and documented within (30) days from the date of admission for all substance abuse treatment services with the exception of the TB portion of the interview which must be completed at the time of admission to treatment.

Interview
Record the yes, no, or other responses of the individual to Questions 1-11 on the risk assessment.
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever lived on the street or in a shelter?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Have you ever been incarcerated?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Have you ever been told that you have a positive HIV test? (test for the AIDS virus)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Have you ever been diagnosed with or treated for tuberculosis (TB)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Has anybody you know or have lived with been diagnosed with TB in the past year?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. a. Within the last month, have you had any of the following symptoms lasting for more than 2 weeks? If yes, please check items below.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Drenching night sweats</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Coughing up blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Losing weight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Shortness of breath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Lumps or swollen glands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Diarrhea lasting more than one week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. b. Are you now living with someone with any of the following?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Coughing up blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Drenching night sweats</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Active TB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Have you ever used needles to shoot drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Have you used cocaine, coke or crack?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Have you ever engaged in any of the following high-risk behaviors: unprotected vaginal, anal or oral sex with multiple partners, anonymous partners, or men who have sex with men?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Have you been diagnosed with or treated for hepatitis and/or a sexually transmitted disease?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:

Staff Signature/Credentials  
Date
# Residential Educational Activities / Risk Assessments for TB/HIV/STD

<table>
<thead>
<tr>
<th>Educational Activities</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HIV/AIDS Information (modes of transmission and universal precautions)</td>
<td></td>
</tr>
<tr>
<td>2. Sexually Transmitted Diseases (STDS)</td>
<td></td>
</tr>
<tr>
<td>3. Tuberculosis</td>
<td></td>
</tr>
<tr>
<td>4. MS Implied Consent Law</td>
<td></td>
</tr>
</tbody>
</table>

## HIV Risk Assessment

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Completion of Risk Assessment</td>
<td></td>
</tr>
<tr>
<td>2. Provided HIV Prevention Counseling</td>
<td></td>
</tr>
<tr>
<td>3. Provided HIV Testing (voluntary)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>4. Provided Post-Test Counseling (if testing is conducted)</td>
<td></td>
</tr>
</tbody>
</table>

## Tuberculosis Risk Assessment

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Completion of Tuberculosis Risk Assessment (results indicate further action if action is taken)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>2. Completion of Skin Test (results indicate further action)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>3. Completion of X-ray (results indicate further action)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>4. Referred for Tuberculosis Treatment</td>
<td></td>
</tr>
</tbody>
</table>

I have received the educational information and all risk assessments listed above.

---

<table>
<thead>
<tr>
<th>Individual Receiving Services</th>
<th>Date</th>
<th>Staff Signature/Credentials</th>
<th>Date</th>
</tr>
</thead>
</table>

---

F9 Community Living AD Educational Activities - Risk Assessments - form 105
Seclusion Behavior Management Log

Purpose
The DMH only allows seclusion to be used in a Crisis Stabilization Unit (CSU) and only in accordance with the order of a physician or other licensed independent practitioner, as permitted by State licensure rules/regulations governing the scope of practice of the independent practitioner. Programs utilizing Seclusion as part of an approved Individual Service Plan (ISP) must document all aspects of the Seclusion intervention using the Seclusion Behavior Management Log. There must be a written Behavior Support Plan developed in accordance with the ISP and with signature approval by the Clinical Director.

Timeline
The Seclusion Behavior Management Log must be completed during the Seclusion intervention in order to accurately record all aspects of the intervention. Each written order for Seclusion must be limited to four (4) hours. After the original order expires, a physician or licensed independent practitioner as provided above must see and assess the individual in Seclusion before issuing a new order. Staff must observe the individual in seclusion every 15 minutes and record the observation.

Completion of the Log
The time the Seclusion intervention began and ended must be documented.

The precipitating event(s) and behavior(s) causing the Seclusion intervention to be implemented must be documented in detail.

The less-restrictive interventions that were implemented prior to the use of Seclusion must be documented in detail.

Visual observation by staff while the individual is in Seclusion and a description of the individual’s behavior while in Seclusion must be documented in detail.

Staff Signatures
The Seclusion Behavior Management Log must be signed by both the staff person implementing the Seclusion and the staff person observing the Seclusion.
<table>
<thead>
<tr>
<th>Time Intervention Began:</th>
<th>Ended:</th>
<th>Date:</th>
</tr>
</thead>
</table>

**Precipitating Events Necessitating Seclusion:**

**Behavior Warranting Intervention:**

**List all Staff (regardless of position) that were involved in seclusion:**

**Ineffective Less Restrictive Alternatives Attempted Prior to Intervention:**

**Description of Individual's Behavior During Seclusion:**

**Signature of Staff Implementing Seclusion**

**Signature of Other Staff Witness(es)**

**Physician or Other Licensed Practitioner's Evaluation of the Need for Seclusion (within one hour of onset):**

**Signature of Physician or other Licensed Practitioner**

<table>
<thead>
<tr>
<th>15 Minute Observations Indicated by Staff Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
</tr>
<tr>
<td>5.</td>
</tr>
<tr>
<td>6.</td>
</tr>
<tr>
<td>7.</td>
</tr>
<tr>
<td>8.</td>
</tr>
<tr>
<td>9.</td>
</tr>
<tr>
<td>10.</td>
</tr>
<tr>
<td>11.</td>
</tr>
<tr>
<td>12.</td>
</tr>
</tbody>
</table>
Section G
Mental Health Services

Pre-Evaluation Screening
Violence Risk Assessment for Certified Holding Facility
Suicide Risk Assessment for Certified Holding Facility
Pre-Evaluation Screening

Purpose
The Pre-Evaluation Screening is required under Mississippi civil commitment statues and includes gathering of information pertaining to the individual age 14 and above to be used by the Chancery, Family and/or Youth Court in determining the need of civil commitment.

Type of Court
Specify Chancery, Family or Youth Court

County
Record the name of County where the affidavit was filed and where the Pre-Evaluation Screening is being conducted.

Case Number
Record the number issued by the Clerk of the Chancery, Family or Youth Court.

Legal Charges Pending
If legal charges are pending, the pre-evaluation screening cannot be conducted. All charges must be resolved before the pre-evaluation screening process is allowed to proceed.

Name of Affiant
Record the name and other specified information of the individual who filed the affidavit with the Chancery Clerk’s office requesting a civil commitment.

Family Contact
Record the name of the family member (i.e. mother, father, sister, wife, husband, brother, son, daughter, etc.) to contact in cases of emergency. This may be the same individual named as the affiant.

Person with Legal Custody
If the individual being screened is between the ages of 14 years and 17 yrs. and 11 months, or has a legal guardian, or has a conservator, record the name of the person who has legal responsibility for the individual being evaluated.

Describe Physical Appearance
Provide a description of the individual’s physical appearance including such things as excessive amount of make-up, inappropriate dress for the season, failure to make eye contact, or other significant physical characteristics.
Behaviors Exhibited by Respondent
Use the prompts listed on the form, mark whether or not the individual being evaluated has or is currently exhibiting behaviors or characteristics specific to each category. Be specific in describing how the individual's behavior is in relation to the prompts selected.

Child/Adolescent Conduct Disturbance
This section is specifically designed for child/adolescents.

Developmental Disability
This section is to be completed when the individual being evaluated has a documented diagnosis of mental retardation or a developmental disability. In absence of a diagnosis, it should be noted if responses provided during the pre-screening by the individual or from the family member who has accompanied the individual indicate the possibility that there may be a diagnosis of mental retardation or a developmental disability.

Other
Complete this section if any of the indicators listed or if any other disorders are applicable to the individual being screened.

Signature/Credentials
The Pre-Evaluation Screening must be conducted by qualified staff of a regional Community Mental Health Center (CMHC) and performed in accordance with current Mississippi civil commitment statutes.
Pre-Evaluation Screening

Name ____________________________

ID Number ________________________
Social Security Number ____________ Date of Birth ______

Time In ______ Time Out ______ Total Time ______

IN THE ____________________________ COURT OF ____________________________
(COUNTY ____________________________)

CASE NO. ____________________________

Respondent having been evaluated and pre-screened for commitment pursuant to M.C.A. Section 41-21-67,
Region ______ Mental Health Center offers the following: Legal Charges Pending: Yes □ No □

PERSONAL INFORMATION

Race ______ Marital Status □ Single □ Married □ Divorced □ Widowed Sex □ Male □ Female

Interpretive Aids Needed □ NO □ YES (sign language, Spanish, Braille, other)

Address ____________________________

__________________________________

County of Residence ____________________________

Name of Spouse/Next of Kin ____________________________

MEDICAID# ____________________________ MEDICARE # ____________________________

Family Physician ____________________________

EDUCATION (Circle Highest Grade Completed) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 GED Currently Enrolled: □

OCCUPATION: ____________________________ PRESENTLY EMPLOYED: □ Yes □ No

EMPLOYER: ____________________________ LENGTH OF EMPLOYMENT: _______ years _______ months

HOUSEHOLD COMPOSITION (Mark All That Apply)

□ Lives Alone □ With Siblings □ With Parent(s) □ Homeless □ With Children
□ With Spouse □ With Relatives □ With Legal Guardian □ With Others □ In Group Home

NUMBER OF DEPENDENT(S): _______ □ Unknown (Explain) ____________________________

NAME OF AFFIANT (Person Filing Papers)

Name: ____________________________ Relationship: ____________________________ Phone: (H) _______ (W) _______

Address: ____________________________ City ____________ State ______ Zip Code ______
<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone: (H)</th>
<th>(W)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
</tbody>
</table>

**PERSON WITH LEGAL CUSTODY, GUARDIANSHIP, AND/OR CONSERVATORSHIP**  
☐ Not applicable (N/A)

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone: (H)</th>
<th>(W)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
</tbody>
</table>

**MEDICAL HISTORY INFORMATION**

**PREVIOUS MENTAL HEALTH HOSPITALIZATION, SERVICE, A&D TREATMENT**  
(List Where and When)

**CURRENT MEDICATIONS**  
(List Names and Dosage)

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
</tr>
</thead>
</table>

**COMPLIANT WITH MEDICATIONS:**  
☐ Yes  ☐ No  ☐ Unknown

**DESCRIBE PHYSICAL APPEARANCE:**

**ALLERGIES:**
☐ Yes  ☐ No  ☐ Unknown  If Yes, Explain

**PREVIOUS SURGERY:**
☐ Yes  ☐ No  ☐ Unknown  If Yes, Explain

**CONCURRENT PHYSICAL CONDITIONS**  
(Mark all that apply)

- ☐ Physical Disability  
- ☐ (list required aids i.e. wheelchair, white cane, support cane, oxygen, etc.)  
- ☐ Diabetes  
- ☐ Emphysema/Cold  
- ☐ Hypertension  
- ☐ S.T.D.  
- ☐ Contagious Disease  
- ☐ Other Chronic Illness  
- ☐ (Please State)  
- ☐ Hepatitis  
- ☐ None known

Elaborate on acute medical conditions of conditions marked (if needed)

DMH G1 Pre-Evaluation Screening - form  
112
<table>
<thead>
<tr>
<th>NAME</th>
<th>ID Number</th>
</tr>
</thead>
</table>

**BEHAVIORS EXHIBITED BY RESPONDENT**
Also consider information from affiant and/or affidavit.
(Mark appropriate answer and/or write in additional pertinent descriptions.)

**History or Present Danger to Self**

- [ ] Yes
- [ ] No

(if Yes, mark appropriate statement(s) below)

- [ ] Thoughts of suicide
- [ ] Suicide gesture
- [ ] Inability to care for self
- [ ] Other

Describe:

**History or Present Danger to Others**

- [ ] Yes
- [ ] No

(if Yes, mark appropriate statement(s) below)

- [ ] Thoughts to harm others
- [ ] Attempts to harm others
- [ ] Felt like killing someone
- [ ] Other

Describe:

**Failure to Care for Self**

- [ ] Yes
- [ ] No

(if Yes, mark appropriate statement(s) below)

Failure or inability to provide necessary:

- [ ] Food
- [ ] Clothing
- [ ] Shelter
- [ ] Safety
- [ ] Medical care for self
- [ ] Other

Describe:

**Antisocial/Criminal Behavior**

- [ ] Yes
- [ ] No

(if Yes, mark appropriate statement(s) below)

- [ ] Frequent lying
- [ ] Destroys property
- [ ] Arrests
- [ ] Imprisoned
- [ ] Uses multiple aliases
- [ ] Other

Describe:

**Drug Use/Abuse**

- [ ] Yes
- [ ] No
- [ ] Unknown

(if Yes, mark appropriate statement(s) below)

- [ ] Has abused
- [ ] Is abusing
- [ ] Cocaine
- [ ] Marijuana
- [ ] Has required hospitalization
- [ ] Other

Describe:

**Alcohol Use/Abuse**

- [ ] Yes
- [ ] No
- [ ] Unknown

(if Yes, mark appropriate statement(s) below)

- [ ] Drinking problem suspected
- [ ] D.T.'s
- [ ] Job loss
- [ ] Currently under the influence of alcohol (BAL, if available)
- [ ] High-risk behavior occurs primarily when under the influence of alcoholic beverages, including beer.
- [ ] Other

Describe:
<table>
<thead>
<tr>
<th>NAME</th>
<th>ID Number</th>
</tr>
</thead>
</table>

### Depressive-Like Behaviors
- □ Yes  □ No  (If Yes, mark appropriate statement(s) below)
  - □ Sadness
  - □ Fatigue
  - □ Crying
  - □ Poor Concentration
  - □ Feelings of worthlessness
  - □ Thoughts/threats of suicide
  - □ Other

Describe:

### Manic-Like Behavior
- □ Yes  □ No  (If Yes, mark appropriate statement(s) below)
  - □ Euphoria
  - □ Hyperactivity
  - □ Irritability
  - □ High Risk Behaviors
  - □ Sleep disturbance
  - □ Extravagance with money

Describe:

### Dementia-Like Characteristics
- □ Yes  □ No  (If Yes, mark appropriate statement(s) below)
  - □ Confusion
  - □ Wanders Off
  - □ Disorientation
  - □ Over talkativeness and/or pressured speech
  - □ Impaired Abstract Thinking
  - □ Significant short-and/or long term memory

Describe:

### Psychotic-Like Behavior
- □ Yes  □ No  (If Yes, mark appropriate statement(s) below)
  - □ Poor personal hygiene
  - □ Loose Association
  - □ Incoherence
  - □ Unmanageable
  - □ Suspiciousness
  - □ Illusions
  - □ Bizarre or obscene acts
  - □ Talks often
  - □ Wanders off
  - □ Illusions
  - □ Delusions
  - □ Confusion
  - □ Forgetfulness
  - □ Emotional turmoil
  - □ Irritability
  - □ Hallucinations
  - □ Poor judgment

Describe:

### ADDITIONAL INFORMATION

### Child/Adolescent Conduct Disturbance
(Shallow Behavior or During Childhood)
- □ Yes  □ No  □ Unknown  (If Yes, mark appropriate statement(s) below)
  - □ Theft
  - □ Fire-setting
  - □ Aggression
  - □ Arrest/detainment
  - □ Refusal to attend school
  - □ Possession/Use of weapons
  - □ Other

- □ Cruelty to people
  - □ Cruelty to animals
  - □ Destruction of property
  - □ Combative/ness/aggression
  - □ Running away
  - □ Defiance of authority and rules
  - □ Frequent lying
  - □ Reported sexual or physical abuse/neglect
<table>
<thead>
<tr>
<th>NAME</th>
<th>ID NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disability</td>
<td>☐ Yes ☐ No ☐ Unknown (If Yes, mark appropriate statement(s) below)</td>
</tr>
<tr>
<td>☐ History of special education placement</td>
<td>☐ Documented IQ score below a 70</td>
</tr>
<tr>
<td>☐ Inability to care for self or activities of daily living</td>
<td>☐ Significantly sub-average intellectual functioning before age 18</td>
</tr>
<tr>
<td>☐ Substantial limitations in adaptive skills (communication, self-care, home living, social skills, community use, self-direction health and safety, leisure and work)</td>
<td></td>
</tr>
<tr>
<td>☐ Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th>☐ Yes ☐ No ☐ Unknown (If Yes, mark appropriate statement(s) below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Anxiety ☐ Panic ☐ Eating disturbance ☐ Sexual problems ☐ Impulsive behaviors</td>
<td></td>
</tr>
<tr>
<td>☐ Obsessive behaviors ☐ Other</td>
<td></td>
</tr>
</tbody>
</table>

**RECOMMENDATIONS**

Recommend Examination for Commitment: ☐ Yes ☐ No

If yes, is outpatient commitment currently an option for the respondent? ☐ Yes ☐ No Explain:

If no, explain why outpatient commitment is not an option for the Respondent:

**SPECIFIC RECOMMENDATIONS**

*(Include Treatment Options)*

<table>
<thead>
<tr>
<th>Screener/Credentials</th>
<th>Date</th>
<th>Print Name</th>
</tr>
</thead>
</table>
Violence Risk Assessment for Certified Holding Facility

Purpose
A DMH approved Violence Risk Assessment must be conducted on each individual who is being housed in a DMH certified Holding Facility. The results of the Violence Risk Assessment will determine if a follow-up assessment by a nurse or physician is needed or if immediate violence prevention protocols must be initiated.

Timeline
The Violence Risk Assessment must be conducted immediately upon arrival of an individual at the Holding Facility.

Signature/Credentials
The Violence Risk Assessment must be conducted by the designated Screening Officer of the Holding Facility.
<table>
<thead>
<tr>
<th>FEMALE □</th>
<th>MALE □</th>
<th>Most serious charge:</th>
</tr>
</thead>
</table>

**Scoring Instructions:** Collect information about each of the 10 risk factor items on the checklist using examples given. Place a check in the box to indicate the degree of likelihood that the risk factor applies to this individual. Use the following indicator scale:

- **No:** Does not apply to this person  
- **Yes:** Definitely applies to a severe degree  
- **Maybe:** Applies/present to a moderately severe degree  
- **Do not know:** Too little information to answer

**Results:** If 5 or more questions are checked YES or MAYBE, notify supervisor and other Holding Facility staff. Initiate proper safety protocols.

1. **Previous and/or current violence**  
   Physical attack, including with various weapons, towards another individual with intent to inflict severe physical harm. "Yes" means individual has committed at least 3 moderately violent aggressive acts or 1 severe violent act. "Maybe/moderate" means less severe aggressive acts such as kicks, blows and shoving not resulting in severe harm to the victim.

2. **Previous and/or current threats (verbal/physical)**  
   Verbal: Statements, yelling, other that involve threat of inflicting physical harm  
   Physical: Movements and gestures that warn of physical attack

3. **Previous and/or current substance abuse**  
   History of abusing alcohol, medication and/or other substances including abuse of solvents, glue, similar. "Yes" means extensive abuse/dependence with reduced occupational/educational functioning, reduced health and/or reduced participation in leisure activities.

4. **Previous and/or current major mental illness**  
   Individual has or has had a psychotic disorder (schizophrenia, delusional disorder, psychotic affective disorder, other)

5. **Personality Disorder**  
   Eccentric (schizoid, paranoid), impulsive, uninhibited (emotionally unstable, antisocial) types

6. **Shows lack of insight into illness and/or behavior**  
   Degree to which individual lacks insight into his/her mental illness regarding medication, social consequences of behavior related to illness or personality disorder

7. **Expresses suspicion**  
   Expresses verbal or nonverbal suspicion towards others; appears to be "on guard" toward environment/surroundings

8. **Shows lack of empathy**  
   Appears emotionally cold, without sensitivity towards others’ thoughts or emotional situations

9. **Unrealistic planning**  
   Unrealistic plans for future. Unrealistic expectation of support from family and professional/social network. Assess ability to cooperate with/follow plans.

10. **Future stress situations**  
    Ability to cope with future stress; ability to tolerate boundaries, physical proximity to possible victims of violence, substance use, homelessness, violent environment, easy access to weapons, other.
Suicide Risk Assessment for Certified Holding Facility

Purpose
A DMH approved Suicide Risk Assessment must be conducted on each individual who is being housed in a DMH certified Holding Facility. The results of the Suicide Risk Assessment will determine if a follow-up assessment by a nurse or physician is needed or if immediate suicide prevention actions must be instituted.

Timeline
The Suicide Risk Assessment must be conducted immediately upon arrival of an individual at the Holding Facility.

Signature/Credentials
The Suicide Risk Assessment must be conducted by the designated Screening Officer of the Holding Facility.
Suicide Risk Assessment for Certified Holding Facility

Detainee's Name

Date of Birth

Date and Time

Name of Facility

Screening Officer

<table>
<thead>
<tr>
<th>FEMALE ☐</th>
<th>MALE ☐</th>
<th>Most serious charge:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check YES or NO for each numbered item below. Each YES response requires support documentation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personal Data Questions</th>
<th>YES</th>
<th>NO</th>
<th>Support Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Individual lacks support of family of friends</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Individual has a history of drug or alcohol abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Individual is very worried about problems other than legal issues (financial, family, medical condition, other)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Individual has experienced a significant loss within the last 6 months (loss of job or relationship, death of a close family member)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Individual is expressing feelings of hopelessness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Individual is thinking about killing himself/herself</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Individual has previous suicide attempt(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Attempt occurred within last month</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total number of YES checks**

**Officer's/Staff's Comments/Impressions:**

**Action:** If total number of YES checks is 4 or more or if item # 6 is checked or if screener believes it is necessary, notify the supervisor and initiate Constant Watch for the individual.

Supervisor Notified ☐ Yes ☐ No

Constant Watch Initiated ☐ Yes ☐ No

Signature of Screening Officer

Badge Number

Medical/Mental Health Personnel Actions (to be completed by medical/MH staff):
Section H
Alzheimer’s and Other Dementia Services

Life Story Narrative
Life Story Narrative

Purpose
As Alzheimer’s disease progresses, the individual loses developmental skills and abilities and appears to “move backward in time.” A Life Story gives those around them the ability to assist and be with them as they remember the past and work through the stages of the disease. The Life Story Narrative should include specific details about pertinent events and the lifestyle of the individual. Traumatic events that occurred in the individual’s life or family should also be included in the narrative.

Timeline
The Life Story Narrative must be completed as part of the initial assessment process and must be included in the individual’s record. Program staff must review the individual’s narrative prior to initial contact with the individual. The Life Story Narrative must also be reviewed whenever the Individual Service Plan is reviewed.

Narrative Completion
The Program Supervisor is responsible for completing the narrative and should ask the family and/or responsible party for assistance in completing the narrative. All those individuals who participate in developing the Life Story Narrative must sign where indicated.

List any significant traumatic events in the “Other” section of the narrative that coincides with the time of life that the trauma occurred. For example, if the individual had a sibling to die in early childhood, list that in the “Other” section of the “Childhood” narrative. If the individual had a stillborn baby or suffered miscarriages, include that information in the “Other” section of the “Young Adulthood” narrative.
**Life Story Narrative**

**Childhood (Birth - 12 years)**

- **Birth date and birth place:**
- **Parents and grandparents:**
- **Brothers and Sisters:**
- **Birth Order:**
- **Friends:**
- **Significant relatives:**
- **House (s) lived in:**
- **Towns lived in:**
- **Church (s) attended and activities:**
- **Schools attended:**
- **Early education events:**
- **Interest/activities/sports/games/etc:**

**Pets:**

**Other:**
<table>
<thead>
<tr>
<th>Adolescence (13-21 years)</th>
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<tbody>
<tr>
<td>Name and location of school(s):</td>
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<tr>
<td>Favorite/least favorite classes:</td>
</tr>
<tr>
<td>Friends/relationships:</td>
</tr>
<tr>
<td>Interests/hobbies/activities/sports/etc:</td>
</tr>
<tr>
<td>Behavior problems:</td>
</tr>
<tr>
<td>First Job:</td>
</tr>
<tr>
<td>Church (s) attended and activities:</td>
</tr>
<tr>
<td>School(s) attended:</td>
</tr>
<tr>
<td>House(s) lived in:</td>
</tr>
<tr>
<td>Town (s) lived in:</td>
</tr>
<tr>
<td>Pets:</td>
</tr>
<tr>
<td>Specific happy/sad events:</td>
</tr>
<tr>
<td>Other:</td>
</tr>
<tr>
<td>Life Story Narrative</td>
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<td>----------------------</td>
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</table>

**Young Adulthood (21-39 years)**

- College and work: ____________________________
- Military Service: ____________________________
- Marriage(s)/Relationship(s): ____________________________
- Family: ____________________________
- Clubs/community involvement: ____________________________
- Church(s) attended and activities: ____________________________
- First home: ____________________________
- Other Homes: ____________________________
- Interests/hobbies/sports: ____________________________
- Town(s) lived in: ____________________________
- Pets: ____________________________
- Specific happy/sad events: ____________________________
- Other: ____________________________
<table>
<thead>
<tr>
<th><strong>Life Story Narrative</strong></th>
<th>Name ____________________________</th>
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<tr>
<td>ID Number</td>
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<tr>
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**Middle Age (40-65 years)**

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<tbody>
<tr>
<td><strong>Family Role:</strong></td>
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<tr>
<td><strong>Marriage(s)/Relationship(s):</strong></td>
<td></td>
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<tr>
<td><strong>Family:</strong></td>
<td></td>
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<tr>
<td><strong>Grandchildren:</strong></td>
<td></td>
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<tr>
<td><strong>Clubs/community involvement:</strong></td>
<td></td>
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<tr>
<td><strong>Church (s) attended and activities:</strong></td>
<td></td>
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<tr>
<td><strong>Homes lived in:</strong></td>
<td></td>
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<tr>
<td><strong>Interests/hobbies/sports:</strong></td>
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<tr>
<td><strong>Town(s) lived in:</strong></td>
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<td><strong>Pets:</strong></td>
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<td><strong>Specific happy/sad events:</strong></td>
<td></td>
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<tr>
<td><strong>Other:</strong></td>
<td></td>
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</tbody>
</table>
**Life Story Narrative**

<table>
<thead>
<tr>
<th>Name</th>
<th>ID Number</th>
<th>Date</th>
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</table>

Later Years (66+ years)

<table>
<thead>
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<th>Work Role:</th>
<th>Family Role:</th>
<th>Marriage(s)/Relationship(s):</th>
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</table>

<table>
<thead>
<tr>
<th>Family:</th>
<th>Grandchildren:</th>
<th>Clubs/community involvement:</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Life achievements and accomplishments:</th>
<th>Church (s) attended and activities:</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Homes lived in:</th>
<th>Interests/hobbies/sports:</th>
</tr>
</thead>
</table>

<table>
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<tr>
<th>Town(s) lived in:</th>
<th>Pets:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Specific happy/sad events:</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questions to Enrich the Story</td>
<td></td>
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<tr>
<td>-------------------------------</td>
<td></td>
</tr>
<tr>
<td>1. How would the individual have enjoyed spending holidays? (New Year’s Eve, Christmas, Fourth of July, Memorial Day, etc.)?</td>
<td></td>
</tr>
<tr>
<td>2. What are their favorite books/music/artists/athletes/movies stars, etc?</td>
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</tr>
<tr>
<td>3. If the individual was stuck on a desert island, what three (3) things would they wish to have with them? (Assume there is food, drink, and shelter.)</td>
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<tr>
<td>4. How would the person’s desk, kitchen shelves/drawers, tool box, etc., be organized?</td>
<td></td>
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<tr>
<td>5. Would he/she have looked at life thinking the glass is half-full (optimist) or half-empty (pessimist)?</td>
<td></td>
</tr>
<tr>
<td>6. Where did he/she travel?</td>
<td></td>
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<tr>
<td>7. What special skills did he/she have?</td>
<td></td>
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<tr>
<td>8. What special awards did he/she acquire?</td>
<td></td>
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</tbody>
</table>

**Other**
Section I
Children and Youth Services

FASD Screening Form
MAP Team Case Summary
FASD Screening Form

Purpose
Mississippi is seeking to identify children who might have physical, mental, behavioral and/or learning disabilities that can be attributed to prenatal exposure to alcohol. Fetal Alcohol Spectrum Disorders (FASD) is the umbrella term used to describe the range of effects that may be present when prenatal alcohol exposure occurs. Through use of an FASD screening tool based on nationally-accepted criteria, children can be identified who need to be referred for an FASD diagnostic evaluation. The FASD screening process may be conducted by a case manager, a therapist, or other children’s mental health professional.

It should be noted that the FASD screening process does NOT result in a diagnosis of any kind. FASD screening is only a tool that can indicate the need to pursue FASD diagnostic evaluation.

Timelines
Children ages birth to 18 must be screened using the FASD Screening Form during the intake process or within 6 months of the completion of the initial intake process. Youth ages 18 to 24 may also be screened if there is indication of prenatal alcohol exposure. If a child’s initial FASD screening result is negative, the screening process must be repeated at the first annual record review to determine if additional information regarding maternal alcohol history has been obtained that might change the result of the initial FASD screen.

FASD Screening Criteria
The result of the FASD screening process will either be positive (needs to be referred for diagnosis) or negative (does not warrant diagnostic evaluation at this time). If at least one of the 4 possible indicators is true or present, the screening result is positive. If none of the 4 indicators is true or present, the screening result is negative.

Confirmed Prenatal Alcohol or Drug Exposure
The items listed are to identify possible sources of information/confirmation regarding prenatal alcohol or drug exposure. For FASD screening purposes only, prenatal drug exposure would result in a positive FASD screen because of the statistically high incidence of individuals using drugs who also use alcohol. Final determination of prenatal alcohol exposure will always be made by the diagnosing physician.

Sibling who already has a diagnosis of an FASD
Existing FASD research shows an increasing incidence of FASD in subsequent births to a mother of a child with an FASD. If one biological sibling has an FASD diagnosis, all of the biological siblings will need to be referred for an FASD diagnostic evaluation.
Previous diagnosis of an FASD
This item is included in order to address/include those children who may have been diagnosed with an FASD in another state or in another system. Best medical practice and a case staffing can be used to determine if the child could benefit from further FASD diagnostic evaluation or assessment.

Face Rank of 3 or 4 on the FAS Photographic Tool
This item applies only if the "FAS Facial Photographic Analysis Software" developed by the FAS Diagnostic and Prevention Network at the University of Washington, Seattle was used. The resulting facial rank and date would be entered as shown.

Screening Results
With consent obtained from the parent/legal guardian, children who receive a positive FASD screen must be referred for a diagnostic evaluation to the Child Development Clinic at the University of Mississippi Medical Center or other multi-disciplinary children's clinic qualified to diagnose FASD. Appointment date should be recorded on the form as indicated. Date and reason must be recorded if the parent(s)/legal guardian declined to pursue diagnostic evaluation.
# FASD Screening Form

**Name**

**Date of Birth**

**Case Number**

**Screening Date**

**Children who meet at least one of the following 3 criteria will be referred for diagnostic evaluation. (Check all that apply)**

- [ ] **1. Confirmed Prenatal Alcohol or Drug Exposure (check all that apply)**
  - Mother’s self-report of alcohol or drug use during pregnancy
  - Reliable informant reported alcohol or drug use by mother
  - Child placed in child protective custody at birth due to mother’s alcohol or drug condition
  - Medical, birth or hospital records indicate this child was delivered intoxicated or with a high blood alcohol level
  - Documentation in the child’s chart or a legal record
  - Other:

- [ ] **2. Sibling who already has a diagnosis of an FASD** (if more than one sibling, provide information on each)
  - Source of information (parent, child, record, other)
  - Date of diagnosis
  - Diagnostic Clinic

- [ ] **3. Previous diagnosis of an FASD**
  - Source of information (parent, child, record, other)
  - Date of diagnosis
  - Diagnostic Clinic

## Screening Results

- [ ] **Negative for Risk**  Child is **not** referred for diagnosis. No further action is needed.

- [ ] **Positive for Risk**  Child is referred to diagnostic clinic for diagnostic evaluation.

  Parent(s)/legal guardian agree to diagnostic evaluation: Yes ________  No ________

  If No, reason(s) for declining diagnostic evaluation:

  **Date forms faxed to diagnostic clinic**

  **Name & Location of diagnostic clinic:**

  **Date of diagnostic appointment**

## Periodic Review of Negative for Risk Result:

**Signature/Credentials**

**Date**
MAP Team Case Summary

Purpose
Making a Plan (MAP) Teams address the needs of children/youth with Serious Emotional Disturbance (SED) who require services from multiple agencies and multiple program systems and who can be diverted from inappropriate institutional placement. All Community Mental Health Centers must document participation in at least two MAP Teams in their region.

Timeline
If DMH flexible funds are utilized, a MAP Team Case Summary form must be completed for each child/youth and submitted to the DMH, Division of Children & Youth Services by the 10th of each quarter; January 10th for October – December, April 10th for January – March, July 10th for April – June and October 10th for July – September along with the MAP Team Monthly Reporting form.

Identifying Information
To ensure confidentiality, the child/youth’s ID number (CMHC or other provider) is entered on the MAP Team Case Summary in place of the child/youth’s name.

Referral Information
All questions in all sections must be answered with as much detail as possible in order to justify the need for MAP Team intervention. Space is provided for the specific recommendations of the MAP Team after all aspects of the case have been considered by the team.
MAP Team Case Summary

<table>
<thead>
<tr>
<th>MAP Team Name</th>
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<tbody>
<tr>
<td>ID Number</td>
<td></td>
</tr>
<tr>
<td>SED Dx</td>
<td></td>
</tr>
<tr>
<td>ID/DD (Axis II) Dx</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Race</td>
</tr>
<tr>
<td>Transitional Needs?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Why was this child/youth's case referred to the MAP Team?

Why is this child/youth considered to be at-risk for an institutional mental health placement?

Recommendations of the MAP Team

If MAP Team flexible funds will be used for this child/youth, indicate the estimated amount agreed upon by the Team.

If MAP Team flexible funds will be used for this child/youth, how will the use of these funds keep the child/youth in the community in a manner that makes it possible for the child/youth to be diverted from an inappropriate 24-hour institutional mental health placement?

Signature of MAP Team Coordinator/Credentials

Date
Section J
Intellectual/ Developmental Disabilities Services

Early Intervention Activity Plan
Early Intervention Activity Note
ID/DD Work Activity Note
ID/DD Waiver Activity Plan
ID/DD Waiver Activity Note
Supported Employment Inventory
Supported Employment Activity Note
ID/DD Waiver In-Home Nursing Service Agreement
ID/DD Waiver In-Home Nursing Respite Activity Plan
ID/DD Waiver In-Home Nursing Respite Activity Note
ID/DD Community Respite Activity Plan
ID/DD Community Respite Activity Note
ID/DD POC Outcomes for Activity Plans
ID/DD Waiver Service Authorization
ID/DD Services Contact Summaries
ID/DD Waiver Behavior Support/Intervention Medical Information
ID/DD Waiver Functional Behavior Assessment
ID/DD Waiver Medical Verification for Behavior Support/ Intervention Services
ID/DD Waiver Behavior Support/Intervention Plan
ID/DD Waiver Behavior Support/Intervention Note
Early Intervention Activity Plan

Purpose
Providers must document the outcomes an individual would like to achieve through the receipt of Early Intervention Services. The Activity Plan lists the areas of support/assistance needed in order to achieve stated outcomes.

Programs that use First Steps documentation do not have to use the Early Intervention Plan Activity and Note.

General
The activities must be developed as part of the Individual Service Plan/Individualized Family Service Plan process.

Use as many pages as necessary to capture and document pertinent information.

Outcomes
List the outcomes to be achieved through the provision of Early Intervention Services. Outcomes can be in various areas of development including cognitive, social, and motor skills. Outcomes can be specific or general depending on the child and his/her need(s) for assistance/support. Outcomes can relate to achievements as well as areas in which the child needs to continue or maintain skills.

Individual's Activities
List the activities the child will participate in to assist him/her in meeting identified outcomes. These must be individualized for each child and be specific to the activity(ies) which will help him/her achieve or maintain desired outcomes. Activities should correspond to each identified outcome.
# Early Intervention Activity Plan

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Specific Activities</th>
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</table>

**Legal Representative Signature**

**Staff Signature/Credentials**

**Date**
Early Intervention Activity Notes

Purpose
An individual's progress toward meeting stated outcomes must be documented using the Early Intervention Activity Notes.

Programs that use First Steps documentation do not have to use the Early Intervention Plan Activity and Note.

Activities
Each day, the provider must indicate the activities from the Activity Plan that the child participated in and/or completed. The provider must establish a key to indicate varying levels of assistance/support needed for each activity, success, partial success, etc. Not every activity addressed on the Activity Plan will be addressed every day.

Weekly Summary
At the end of each week, an authorized staff person summarizes the week's activities in the "Weekly Summary" section and signs and dates the form.
# Early Intervention Activity Note

## Week 1

<table>
<thead>
<tr>
<th>Dates:</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
<th>#4</th>
<th>#5</th>
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**Staff Signature/Credential**

**Weekly Summary:**

**Date:**

## Week 2

<table>
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<tr>
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**Staff Signature/Credential**

**Weekly Summary:**

**Date:**

## Week 3

<table>
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<th>Dates:</th>
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**Staff Signature/Credential**

**Weekly Summary:**

**Date:**
# Early Intervention Activity Note

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<table>
<thead>
<tr>
<th>Staff Signature/Credential</th>
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<table>
<thead>
<tr>
<th>Week 5</th>
<th>Activities</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Staff Signature/Credential</th>
<th>Weekly Summary:</th>
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<tbody>
<tr>
<td>Date:</td>
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</table>

**Key:**
ID/DD Work Activity Note

Purpose
The purpose of the Activity Note is to document an individual's progress toward meeting stated outcomes.

General
Outcomes and activities must be based on the Individual Service Plan. Not every activity addressed on the Individual Service Plan will be addressed every day.

Monthly Summary
At the end of each month, an authorized staff person summarizes the activities in which the individual participated in the "Monthly Summary" section of the note. Staff then signs and dates the form.
# ID/DD Work Activity Note

<table>
<thead>
<tr>
<th>Name</th>
<th>ID Number</th>
<th>Program Name</th>
</tr>
</thead>
</table>

## Dates & times of attendance during the month of: [ ] in the year of: [ ]

| Days | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Present | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] |

### Weekly Dates

#### 1st Week

- **Date:** [ ]
- **Signature/Credential:** [ ]

#### 2nd Week

- **Date:** [ ]
- **Signature/Credential:** [ ]

#### 3rd Week

- **Date:** [ ]
- **Signature/Credential:** [ ]

#### 4th Week

- **Date:** [ ]
- **Signature/Credential:** [ ]

#### 5th Week

- **Date:** [ ]
- **Signature/Credential:** [ ]

### Monthly Summary

**Signature/Credential:** [ ]

---

DMH J3 IDDD Work Activity Note-form  

141
ID/DD Waiver Activity Plan

Purpose
The purpose of the Activity Plan is to document the outcomes an individual would like to achieve as a result of participating in Prevocational Service or Day Services-Adult.

General
The Activity Plan must be developed based on the Plan of Care Outcomes for Activity Plans, the required functional assessment, areas of support/assistance and desires identified by the individual/legal guardian. The functional skills assessment must address: mobility, activities of daily living, communication, money management, and community integration.

Use as many pages as necessary to capture and document pertinent information. If the Activity Plan is revised/changed, document the changes on the current Activity plan. The Plan must be signed and dated. The provider should send a copy of the Plan to the appropriate Support Coordinator.

Outcomes
List outcomes the individual would like to achieve through Prevocational Services and Day Services-Adult. Outcomes can be in the areas of any aspect of a person’s life that enables him/her to participate in meaningful activities, community integration and job skill development. Outcomes can be specific or general depending on the individual’s interests and need(s) for assistance/support.

Individual’s Activities
List and number activities the individual will participate in to assist him/her in meeting his/her stated outcomes. Activities must be individualized for each person and be specific to what will help the individual achieve/maintain his/her desired outcomes.
# ID/DD Waiver Activity Plan

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<th>Service</th>
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<th>Date</th>
<th>Page of</th>
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<tr>
<th>Outcomes</th>
<th>Specific Activities</th>
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</tbody>
</table>

**Individual/Legal Representative Signature**  
**Staff Signature/Credentials**  
**Date**
ID/DD Waiver Activity Note

Purpose
Programs must document each individual's progress toward stated. It is also used to document participation in community activities and job exploration.

Time of Service
Each day the individual attends the program, the provider must document the exact time he/she arrives at and departs from the program (this does not include travel time to and from the program). The amount of time the individual attends the program must be documented in the "Total Time" space at the end of the day.

Activities
Each day, the provider must indicate the activities on the Activity Note that the individual participated in and/or completed. The provider must establish a key to indicate varying levels of assistance/support needed for each activity, success, partial success, etc. Not every activity addressed on the Activity Plan will be addressed every day.

Weekly Summary
At the end of each week, an authorized staff person summarizes the week's activities in the "Weekly Summary" section and signs and dates the form.

Documentation of Community Integration/Job Exploration Activities
This section of the form is used to document the individual's participation in chosen community integration/job exploration activities for the month. The provider must enter the date and day of the week and indicate the activity which took place as well as the location. Staff must sign and provide their credentials for each entry.
# ID/DD Waiver Activity Note

| Day of Month | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 | 1 |
| Time In     |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Time Out    |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |

**Total Time**

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<tr>
<th>Week 1 Date:</th>
<th>Activities</th>
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</table>

**Staff Signature/Credential**

**Weekly Summary:**

| Date: |

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<tr>
<th>Week 2 Date:</th>
<th>Activities</th>
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<tbody>
<tr>
<td>Time in</td>
<td>Time out</td>
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**Staff Signature/Credential**

**Weekly Summary:**

| Date: |

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<tr>
<th>Week 3 Date:</th>
<th>Activities</th>
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<tbody>
<tr>
<td>Time in</td>
<td>Time out</td>
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<td>Mon</td>
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</tbody>
</table>

**Staff Signature/Credential**

**Weekly Summary:**

| Date: |
**ID/DD Waiver**  
**Activity Note**

<table>
<thead>
<tr>
<th>Week 4 Date:</th>
<th>Activities</th>
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<tbody>
<tr>
<td>Time in</td>
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<td>Time out</td>
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**Staff Signature/Credential**

**Weekly Summary:**

**Date:**

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<tr>
<th>Week 5 Date:</th>
<th>Activities</th>
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<tbody>
<tr>
<td>Time in</td>
<td>#1</td>
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<td>Time out</td>
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**Staff Signature/Credential**

**Weekly Summary:**

**Date:**

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## Community Integration/Job Exploration Activities

<table>
<thead>
<tr>
<th>Date</th>
<th>Day of Week</th>
<th>Activity</th>
<th>Location</th>
<th>Staff Signature/Credentials</th>
</tr>
</thead>
</table>

**Monthly Summary:**

**Key:**

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146
Supported Employment Inventory

Purpose
The Supported Employment Inventory is used to assess the supports/assistance a person needs to obtain and maintain employment. This information provides information to serve as the basis in searching for jobs for an individual.

Areas in Which Support/Assistance May Be Required (describe each)
Areas in which a person may need support/assistance are listed. Address each area with the person and describe/list any pertinent information for each area. If an individual does not require any assistance in an area, list his/her strengths or other pertinent information in that section.
Supported Employment Inventory

<table>
<thead>
<tr>
<th>Name</th>
<th>ID Number</th>
<th>Date</th>
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</thead>
</table>

Areas in Which Support/Assistance May Be Required (describe each)

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<thead>
<tr>
<th>Employment Interest</th>
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<tbody>
<tr>
<td>Communication</td>
</tr>
<tr>
<td>Grooming/Hygiene</td>
</tr>
<tr>
<td>Interpersonal/Social</td>
</tr>
<tr>
<td>Interview Skills</td>
</tr>
<tr>
<td>Application Process</td>
</tr>
<tr>
<td>Transportation</td>
</tr>
<tr>
<td>Time Management</td>
</tr>
<tr>
<td>Follows Rules</td>
</tr>
<tr>
<td>Changes in Routine</td>
</tr>
<tr>
<td>Accepts Criticism</td>
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<tr>
<td>Behavior</td>
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<tr>
<td>Express Opinions</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

Name/Credentials of Staff Completing Inventory  Date
Supported Employment Activity Note

Purpose
Programs must document each individual’s progress toward stated outcomes as well as the times Supported Employment Services begin and end each day.

General
The staff person must complete the required information during the time the service is being provided.

Notes for any given month must be in the individual’s record no later than 10th of the following month.

Activities
The activities included in the Supported Employment Activity Notes must reflect the activities listed on the Individual Service Plan. This includes the activities of the individual as well as anything staff did to assist/support the individual in the stated activity. Activities should relate to a stated outcome.

See Contact Summary for Additional Information
The provider checks this box if there is information which is pertinent to the individual but cannot be adequately/appropriately captured in the Activity Notes. The Contact Summary must be attached to the Activity Notes.

Time Service Began/Ended
Staff must list the exact time the service began and ended. Indicate if the time is a.m. or p.m.

Required Signature
The individual/legal representative must sign the form to verify the services/activities documented each day took place.

Staff must sign the form to verify the services documented were provided. The staff person who actually provides the service must sign the form, not supervisory staff.
<table>
<thead>
<tr>
<th>Activity</th>
<th>Day/Date</th>
<th>Day/Date</th>
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</thead>
</table>

- See Contact Summary for Additional Information

- Time Service Began (use a.m. and p.m)
- Time Service Ended (use a.m. and p.m)
- Total Time
- Individual/Legal Rep. Signature
- Staff Signature
ID/DD Waiver In-Home Nursing Respite Service Agreement

Purpose
The individual's provider(s) informs the person about the services that can and cannot be provided through In-Home Nursing Respite.

Timelines
The Service Agreement is reviewed with the individual prior to or at the time the provider begins providing the service and at least annually thereafter. Providers must send a signed copy of the Service Agreement to the individual's Support Coordinator by the 15th of the month following the month it is signed.
ID/DD Waiver In-Home Nursing Respite Service Agreement

1. I understand In-Home Nursing Respite services will, to the greatest extent possible, be scheduled on a regular basis to meet my unique needs, as identified on the Activity Plan. Only the amount of In-Home Nursing Respite authorized on the Plan of Care will be provided. If a change in the amount is needed, I will contact my Support Coordinator.

2. I understand In-Home Nursing Respite can be provided in my home and/or in the community (on a limited basis) and either with or without my parent/legal guardian present, depending upon my identified support needs.

3. I understand the nurse cannot be responsible for caring for others who may be in the house. The nurse is only responsible for the person who is enrolled in the ID/DD Waiver. Also, the nurse is not responsible for caring for pets. I cannot receive In-Home Nursing Respite in the nurse's home.

4. If a scheduled time for In-Home Nursing Respite must be canceled (e.g. because of a doctor's appointment, I am ill, my family will be out of town, etc.), it is my responsibility to notify the nurse as soon as possible. I understand that three (3) cancellations for which no notice is given will result in a review of the Plan of Care to determine if In-Home Nursing Respite services are still necessary and appropriate.

5. I understand the In-Home Nursing Respite staff person will complete all forms necessary to document the provision of In-Home Nursing Respite. I or my parent/legal representative will be asked to initial the Activity Note each time In-Home Nursing Respite services are provided to verify that the provider indeed provided the amount of service indicated. I further understand initialing false or fraudulent documentation is against the law.

6. I understand that the receipt of In-Home Nursing Respite services is voluntary. I may decline services by notifying my Support Coordinator.

7. I understand services may be terminated according to the provisions in the ID/DD Waiver Enrollment Agreement.

8. I understand if services are to be terminated, I will be notified as soon as possible. The Support Coordinator will assist me in locating other service options, if available. If I disagree with services being terminated, I may file an appeal according to established procedures. The services will not change until the outcome of the appeal is determined. If termination of services is due to the environment or persons in the environment posing a risk to the In-Home Nursing Respite staff person, I cannot continue to receive services pending the outcome of the appeal.

9. Should any problems arise regarding the provision of In-Home Nursing Respite, I will notify my ID/DD Waiver Support Coordinator immediately.

10. I understand medical treatment provided by nurses must be according to the Mississippi Nurse Practice Act Rules and Regulations. Non-nursing staff cannot provide medical treatment of any sort.

11. The ID/DD Waiver does not allow In-Home Nursing Respite staff to be a parent or legal guardian, a step parent of a minor, or a spouse or relative or anyone else who resides in the same home or who is normally expected to provide care.

12. Relatives who are not the parent or legal guardian, a step parent of a minor, or a spouse, relative or anyone else who resides in the same home or who is normally expected to provide care may be approved to provide In-Home Nursing Respite. They must be employed by a DMH certified agency and meet the same qualifications for employment as staff who are unrelated. The employing agency must receive prior approval from the Director of the Bureau of Intellectual and Developmental Disabilities at the DMH before a relative can provide In-Home Nursing Respite.

I understand the above information and the circumstances under which In-Home Nursing Respite can be provided.

Individual/Legal Representative ___________________________ Date ____________

Authorized Agency Representative ___________________________ Date ____________
ID/DD Waiver In-Home Nursing Respite Activity Plan

Purpose
The purpose of the In-Home Nursing Respite Activity Plan is to document the outcomes an individual would like to achieve as a result of participating in In-Home Nursing Respite as well as the activities necessary to achieve the desired outcome.

General
The Activity Plan must be developed in conjunction with a nursing care plan as required by the Nurse Practice Act Rules and Regulations. It must be developed before services begin and be signed by the individual/legal representative. He/she must be offered a copy of the Activity Plan each time it is revised or rewritten.

In-Home Nursing Respite is provided by a licensed nurse.

Outcomes
List the outcomes the individual would like to achieve through In-Home Nursing Respite. Outcomes are listed on the Plan of Care Outcomes and can be in the areas of activities of daily living, housekeeping directly related to the individual’s health and welfare and the use of adaptive equipment. Additional outcomes can be added at any time, depending on the individual’s desires for In-Home Nursing Respite. Outcomes can be specific or general depending on the family’s need for relief from constant care giving and the individual’s interests and need(s) for assistance/support.

Specific Activities
List the activities which the individual will participate in to assist him/her in meeting his/her stated outcomes and which provide relief for the family from constant care giving. These must be individualized for each person and be specific to the activity(ies) which will help the individual achieve/maintain the desired outcomes.
ID/DD Waiver
In-Home Nursing Respite Activity Plan

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<tr>
<th>Outcomes</th>
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Name ____________________________
ID Number _______________________

Individual/Legal Representative Signature ____________________________
Date ____________________________

Agency Representative Signature/Credentials ____________________________
Date ____________________________

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ID/DD Waiver In-Home Nursing Respite Activity Note

Purpose
The provider must document on the In-Home Nursing Respite Note services provided and time spent in service provision with individual receiving services.

General
Nurses are governed by the Mississippi Board of Nursing and the Mississippi Nurse Practice Act and Rules and Regulations. For purposes of the ID/DD Waiver, the note must have information sufficient enough to justify the time spent providing the service. Additionally, the note must identify the time services began and the time they ended. The individual/legal representative receiving the services must be able to sign the note to verify the services documented were indeed provided during the times indicated.

The form provided contains all of the information required for the ID/DD Waiver.
<table>
<thead>
<tr>
<th>Provider's Signature</th>
<th>Date</th>
<th>Time In</th>
<th>Time Out</th>
<th>Total Time</th>
<th>Individual/Legal Representative's Signature</th>
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</table>

Notes
ID/DD Waiver Community Respite Activity Plan

Purpose
The purpose of the Activity Plan is to document the outcomes an individual would like to achieve as a result of participating in Community Respite as well as the activities necessary to achieve the desired outcomes.

General
The Activity Plan must be developed by the provider with the Plan of Care Outcomes for Activity Plan form and the individual/legal representative before services begin. The individual/legal representative must sign the Activity Plan before it is implemented. Use as many pages as necessary to ensure all information is included. The individual must be offered a copy of the Activity Plan each time it is revised or rewritten.

Outcomes
List the outcomes intended to be achieved during Community Respite. Outcomes are based on the Plan of Care Outcomes for Activity Plan and any interests or needs the individual want. Outcomes can be in the areas of activities of daily living, socialization and leisure activities as well as anything else the individual desires. Outcomes can be specific or general depending on the individual’s interests and need(s) for assistance/support in the areas listed above.

Individual Activities
List the activities which the individual will participate in to assist him/her in meeting his/her stated outcomes. These must be individualized for each person and be specific to the activity(ies) which will help the individual achieve/maintain the desired outcomes.
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<tr>
<th>Outcomes</th>
<th>Specific Activities</th>
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Individual/Legal Representative Signature

Date

Agency Representative Signature/Credentials

Date
ID/DD Waiver Community Respite Activity Note

Purpose
Programs must document each individual’s progress toward stated.

Timelines
Staff must complete the required information during the time the service is being provided.

Activities addressed
The activities included on the Activity Note must reflect the activities listed on the Activity Plan developed from the Plan of Care Outcomes. This includes the activities of the individual as well as anything staff did to assist/support the individual in the stated activity. Activities should relate to a stated outcome.

See Contact Summary for Additional Information
The provider checks this box if there is information which is pertinent to the individual that cannot be adequately/appropriately captured in the Activity Notes. The Contact Note must be attached to the Activity Notes.

Time Service Began/Ended
Staff must list the exact time the service began and ended. Indicate if the time is a.m. or p.m.

Individual/Legal Representative Signature
The individual/legal representative must sign the form to verify the services/activities documented took place.

Staff Signature
Staff must sign the form to verify the services documented were provided on the day indicated. If more than one staff person assists an individual during the day, the staff person responsible for ensuring all activities took place signs the note. Only one staff signature is required.
## ID/DD Waiver Community Respite Activity Note

<table>
<thead>
<tr>
<th>Activity</th>
<th>Day/Date</th>
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</table>

- See Contact Summary for Additional Information
- Time Service Began (use a.m. and p.m)
- Time Service Ended (use a.m. and p.m)
- Total Time
- Individual/Legal Rep. Signature
- Staff Signature
ID/DD Waiver Plan of Care Outcomes for Activity Plan

Purpose
The purpose of this form is to ensure the provider of each service a person is approved to receive is providing services/supports necessary for the individual to achieve the outcomes listed for the service(s) on the individual’s Plan of Care.

General
For each service an agency is authorized to provide, the Support Coordinator will provide the “Plan of Care Outcomes for Activity Plans.” These outcomes are listed on each individual’s Plan of Care for each service he/she receives. The outcomes are used by the provider to develop each individual’s Activity Plan which outlines specific activities necessary to reach the desired outcome(s) for each service.

Timelines
This form accompanies the Service Authorization when it is initially sent to an agency and at least annually thereafter. As updates are needed, they are sent to the provider who is responsible for updating the Activity Plan.

Signature of Support Coordinator
The Support Coordinator signs and dates the form to verify the information is accurate and forwards it to the provider.

Signature of Authorized Agency Representative
An authorized agency representative must sign and date the form to verify receipt and review of the outcomes and as an assurance that the outcomes will be addressed fully in the provider’s Activity Plan.
### ID/DD Waiver
#### Plan of Care Outcomes for Activity Plan

<table>
<thead>
<tr>
<th>Individual's Name</th>
<th>Medicaid Number</th>
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<table>
<thead>
<tr>
<th>Service</th>
<th>Outcome of Service/Support</th>
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**Support Coordinator Signature**  
**Date**

*By signing this form I assure the Plan of Care Outcomes for Activity Plans have been reviewed and incorporated into the agency's Activity Plan(s) for the above named individual.*

---

**Authorized Agency Representative**  
**Date**
ID/DD Waiver Service Authorization

Purpose
To inform a provider what type and amount of ID/DD Waiver service(s) they are authorized to provide to an individual and the begin and end dates for the authorization.

The provider receives this form from the Support Coordinator.

General
Initially and when updated, the Support Coordinator sends the most current Interdisciplinary Summary and Recommendations Report from the Diagnostic and Evaluation Team with the Service Authorization.

Timelines
No service can begin before the start date on the Service Authorization. Before any services can begin, the provider must review the Interdisciplinary Summary and Recommendations Report from the Diagnostic and Evaluation Team and document the review in a Contact Summary in the individual’s record.

The Support Coordinator must issue the Service Authorization(s) to the providers chosen by the individual and listed on the Plan of Care within five (5) days of receipt of the approved certification/change(s) from the BIDD.

1. Initial Certification/Readmission – The Support Coordinator will issue Service Authorization(s) within five (5) days of receipt of the approved initial certification/readmission request.

2. Changes – If, during the individual’s certification year, there is a change in the type/amount of service a person receives, the Support Coordinator will send the provider an updated Service Authorization indicating there are changes within five (5) days of receipt of the Plan of Care from the BIDD. The Service Authorization will have the new type(s) and/or amount(s) of services being authorized along with the end date of the previously authorized type(s) and/or amount(s) of service.

2. Recertification – Annually, within five (5) days of receiving an individual’s approved recertification, the Support Coordinator issues a new Service Authorization to the provider(s) reflecting the services and the amount(s) of service(s) the agency is authorized to provide. The effective date of the Service Authorization will be the individual’s certification begin date and the end date will be the certification lock-in end date.

If the Support Coordinator does not receive a signed copy of the Service Authorization from an agency within ten (10) days, the Support Coordinator will ask the individual if he/she would like to be referred to another provider. At that time, the Support Coordinator sends the agency a Service Authorization with an end date for the service(s).

Another Service Authorization is issued for the next agency chosen. The start date for that agency must be no sooner than the end date of the previous Service Authorization.

Start and End Dates
All service amounts/frequencies will have an authorized start and end date. Service Authorizations are valid only for the dates listed on the form. The end date cannot exceed the person’s current certification lock-in end date, regardless of the authorized start date.
1. Authorized Start Date
   a. The date of the individual’s certification, regardless of type
   b. Date changes to the Plan of Care are approved by BIDD

2. End Date
   a. Initial/readmission/recertification – The certification lock-in end date
   b. Changes – The day the BIDD approves changes to the Plan of Care
   c. When a service is terminated

If at any time a person chooses to change providers, the Service Authorization will be effective on the 1st day of the month following the request. (ex: Change in provider is requested July 12th; the Service Authorization will have an effective date of August 1st and the end date will be the individual’s certification lock-in end date).

Exceptions:
   a. Suspected abuse or neglect or other situations in which the individual’s health and welfare are at risk
   b. The individual is not receiving/has not received the particular service during the month in which the change in provider is requested.

Signature of Authorized Agency Representative
An authorized agency representative must sign and date the form to verify the information is accurate and return a copy to the appropriate Support Coordinator BEFORE services can begin.
# ID/DD Waiver
## Service Authorization

### To:

Name of Agency  

### From:

Support Coordination Department  

### Re:

Individual's Name  

### Individual's Address and Phone Number

- [ ] Change in type(s)/amount(s) of service

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Service</th>
<th>Amount</th>
<th>Frequency</th>
<th>Authorized Start Date</th>
<th>End Date</th>
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</table>

### ID/DD Waiver Support Coordinator Comments/Information


### Can the agency provide the service(s) requested?  
- [ ] Yes  
- [ ] No

### Agency Comments


### Signature of Authorized Agency Representative  

[Signature]  

Date

---

To Be Completed by Support Coordinator

Date Received from Agency  

Support Coordinator Signature
ID/DD Services Contact Note

Purpose
Programs must document activities/events that take place with/for an individual that cannot be adequately captured in the Activity Note.

General
A single form can be used for one or more days, depending on the amount of information. The amount of space per contact is not limited to a single space per day; use as many as necessary to adequately document the information.
## ID/DD Services Contact Notes

<table>
<thead>
<tr>
<th>Date</th>
<th>Notes</th>
<th>Signature/Credentials</th>
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ID/DD Waiver Medical Verification for Behavior Support/Intervention Services

Purpose
A physical evaluation must be conducted by a licensed physician to rule out any underlying medical conditions that may be causing the behavior to occur (abscessed tooth, ulcer, etc.).

Timeline
The physical evaluation cannot be more than thirty (30) days old at the time Behavior Support/Intervention Services begin.

Instructions
The Support Coordinator and provider must work together to assist the individual and/or family in getting the form completed by a physician/nurse practitioner.

Before any behavior support/intervention services takes place, a licensed physician/nurse practitioner must determine the following:

1. The individual presents no symptoms of physical illness that should receive medical treatment before beginning Behavior Support/Intervention Services

2. The individual presents no symptoms of mental illness that should receive medical treatment before beginning Behavior Support/Intervention Services

3. If there are any special medical precautions to follow during the implementation of a Behavior Support/Intervention Plan.

The licensed physician/nurse practitioner is also asked to indicate, based on his/her examination/observation of the individual if the individual:

1. Can participate in a behavior intervention/support program

2. Requires any medical treatment that must be successfully completed prior to the implementation of Behavior Support/Intervention Services

3. Cannot receive Behavior Support/Intervention because of medical reasons.

Record Maintenance
Both the Support Coordinator and Behavior Support/Intervention provider must maintain a copy of this form in the individual's record.
ID/DD Waiver Medical Verification for Behavior Support/Intervention Services

<table>
<thead>
<tr>
<th>Individual’s Name:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Healthcare Provider’s Name:</td>
<td>Office Phone:</td>
</tr>
<tr>
<td>Healthcare Provider’s Address:</td>
<td></td>
</tr>
</tbody>
</table>

Proposed Intervention:


Healthcare Provider: Please initial to indicate your agreement or disagreement with each of the items listed below. If you are in disagreement with any of the statements, please summarize on the reverse side of this form your reasons for disagreeing, as well as your recommendations and/or treatment plans.

<table>
<thead>
<tr>
<th>Agree</th>
<th>Disagree</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>There is no medical reason that this individual cannot participate in the proposed intervention.</td>
</tr>
<tr>
<td></td>
<td>This individual presents no symptoms of physical illness that should receive medical treatment prior to starting the proposed intervention.</td>
</tr>
<tr>
<td></td>
<td>This individual presents no symptoms of mental illness that should receive medical treatment prior to starting the proposed intervention.</td>
</tr>
<tr>
<td></td>
<td>There are no special medical precautions to follow during the implementation of the proposed intervention.</td>
</tr>
</tbody>
</table>

Based upon my knowledge of this individual:

- He/she can participate in the proposed intervention.
- He/she requires medical treatment that must be successfully completed prior to starting the proposed intervention.
- He/she cannot participate in the proposed intervention for medical reasons.

Signature of Healthcare Provider/Credentials __________________________        Date __________

J16 ID-DD Waiver Medical Verification for BSI-form 169
ID/DD Waiver Functional Behavior Assessment

Purpose
To assess where the behavior(s) occurs, any antecedent(s) of the behavior(s), consequences(s) of the behavior(s), factor(s) that may be maintaining the behavior(s), frequency of the behavior(s), and how the behavior(s) impacts the person’s environment and life.

Requirements
This form can be completed using both the interview with the individual, family, others, and direct observation. However, observation and interaction must comprise the majority of how the data/information is gathered. All components must be addressed.

Submission of Documentation
The Behavior Support/Intervention provider must submit a complete copy of the Functional Behavior Assessment to the Support Coordinator along with a copy of the Assessment Summary/Recommendations form. The Support Coordinator will not issue a Service Authorization for Behavior Support/Intervention Services until all required has been submitted to and approved by The Bureau of Intellectual/Developmental Disabilities.
ID/DD Waiver Functional Behavior Assessment

Respondents(s): ____________________________  Interviewer/Credentials: ____________________________

I. Description of Behavior(s)

A. What are the behavior(s) of concern? For each, define the topography (how it is performed), frequency (how often it occurs per day, week, or month), duration (how long it lasts when it occurs), and intensity (the magnitude of the behavior - low, medium, high - and if it causes harm).

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<tr>
<th>Behavior:</th>
<th>Topography</th>
<th>Frequency</th>
<th>Duration</th>
<th>Intensity</th>
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<th>Topography</th>
<th>Frequency</th>
<th>Duration</th>
<th>Intensity</th>
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<th>Behavior:</th>
<th>Topography</th>
<th>Frequency</th>
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<th>Intensity</th>
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<th>Behavior:</th>
<th>Topography</th>
<th>Frequency</th>
<th>Duration</th>
<th>Intensity</th>
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</table>


B. Which of the behaviors described above occur together (e.g., occur at the same time; occur in a predictable chain; occur in response to the same situation)?

__________________________

__________________________

__________________________
II. Ecological Events That May Affect the Behavior(s)

A. What medications is the person taking (if any), and how do you believe these may affect his/her behaviors?

B. What medical complications (if any) does the person experience that may affect his/her behavior (e.g., asthma, allergies, rashes, sinus infections, seizures, etc.)?

C. Describe the sleep cycles of the individual and the extent to which these cycles affect his/her behavior.

D. Describe the eating routines and diet of the person and the extent to which these routines may affect his/her behavior.

E. Briefly list below the person’s typical daily schedule of activities.

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>6:00 am</td>
<td>3:00 pm</td>
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<tr>
<td>7:00 am</td>
<td>4:00 pm</td>
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<tr>
<td>8:00 am</td>
<td>5:00 pm</td>
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<tr>
<td>9:00 am</td>
<td>6:00 pm</td>
</tr>
<tr>
<td>10:00 am</td>
<td>7:00 pm</td>
</tr>
<tr>
<td>11:00 am</td>
<td>8:00 pm</td>
</tr>
<tr>
<td>12:00 pm</td>
<td>9:00 pm</td>
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<tr>
<td>1:00 pm</td>
<td>10:00 pm</td>
</tr>
<tr>
<td>2:00 pm</td>
<td>11:00 pm</td>
</tr>
</tbody>
</table>

F. Describe the extent to which you believe the activities that occur during the day are predictable for the person. (e.g., when to get up, eat dinner, shower, go to school/work, etc.)?

G. About how often does the person get to make choices about activities, reinforcers, etc.? In what areas does the person get to make choices (e.g., food, clothing, social companions, leisure activities, etc.)?

H. Describe the variety of activities performed on a typical day (exercise, community activities, etc.)
### I. How many other people are in the setting (work/school/home)? Do you believe that the density of people or interactions with other individuals affect the targeted behaviors?

---

### J. If the person is attending a day program, what is the staffing pattern? To what extent do you believe the number of staff, training of staff, quality of social contacts with staff, etc., affect the targeted behaviors?

---

### K. If not attending a day program, describe some typical interactions of the person with others in the home or other environments.

---

### L. Are the tasks/activities presented during the day boring or unpleasant for the person, or do they lead to results that are preferred or valued?

---

### M. If the person attends a day program, what outcomes are monitored regularly by staff (frequency of behaviors, skills learned, activity patterns)?

---

### N. If the person does not attend a day program, how do people in the home or other environments monitor outcomes?

---

### III. Events and Situations that Predict Occurrences of the Behavior(s)

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>A.</td>
<td>Time of Day: When is the behavior(s) most likely and least likely to occur?</td>
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<tr>
<td></td>
<td>Most Likely</td>
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<td></td>
<td>Least Likely</td>
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<tr>
<td>B.</td>
<td>Setting: Where is the behavior most likely and least likely to occur?</td>
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<tr>
<td></td>
<td>Most Likely</td>
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<tr>
<td></td>
<td>Least Likely</td>
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<tr>
<td>C.</td>
<td>Control: With whom is the behavior most likely and least likely to occur?</td>
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<td></td>
<td>Most Likely</td>
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<tr>
<td></td>
<td>Least Likely</td>
</tr>
<tr>
<td>D.</td>
<td>What activity is most likely and least likely to produce the behavior(s)?</td>
</tr>
<tr>
<td></td>
<td>Most Likely</td>
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<tr>
<td></td>
<td>Least Likely</td>
</tr>
<tr>
<td>E.</td>
<td>Are there particular situations, events, etc., that are not listed previously that “set off” the behavior(s) that cause concern (particular demands, interruptions, transitions, delays, being ignored, etc.)?</td>
</tr>
<tr>
<td>F.</td>
<td>What would be the one thing you could do that would be most likely to make the undesirable behavior(s) occur?</td>
</tr>
</tbody>
</table>
Name:

IV. Function of the Undesirable Behavior(s)

A. Review each of the behaviors listed in Part I and define the function(s) you believe the behavior serves for the person (i.e., what does he/she get and/or avoid by doing the behavior?).

<table>
<thead>
<tr>
<th>Behavior</th>
<th>What does he/she get?</th>
<th>What does he/she avoid?</th>
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</table>

B. Describe the person's most typical response to the following situations:

1. Is the above behavior(s) more likely less likely unaffected if you present him/her with a difficult task?
2. Is the above behavior(s) more likely less likely unaffected if you interrupt a desired event (eating ice cream, watching TV, etc.)?
3. Is the above behavior(s) more likely less likely unaffected if you deliver a "stern" request/command/reprimand?
4. Is the above behavior(s) more likely less likely unaffected if you are present but do not interact with him/her?
5. Is the above behavior(s) more likely less likely unaffected if the routine is changed?
6. Is the above behavior(s) more likely less likely unaffected if something the person wants is present but he/she cannot get to it (i.e., a desired object that is out of reach)?
7. Is the above behavior(s) more likely less likely unaffected if he/she is alone?
V. Efficiency of the Undesirable Behavior(s)

A. What amount of physical effort is involved in the behavior(s) (e.g., prolonged intense tantrums - vs- simple verbal outbursts, etc.)?

B. Does engaging in the behavior(s) result in a “payoff” (getting attention, avoiding work) every time? Almost every time? Once in a while?

C. How much of a delay is there between the time the person engages in the behavior(s) and gets the “payoff”? Is it immediate, a few seconds, or longer?

VI. Primary Method(s) Used by the Person to Communicate

A. What are the general expressive communication strategies used by or available to the person in the following situations?

<table>
<thead>
<tr>
<th>Request attention</th>
<th>Request Help</th>
<th>Request preferred food/objects/activities</th>
<th>Show you something/someplace</th>
<th>Indicate physical pain</th>
<th>Indicate confusion</th>
<th>Protest/reject situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex speech</td>
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<tr>
<td>Multiple words</td>
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<tr>
<td>One word utterances</td>
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<tr>
<td>Complex signing</td>
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<tr>
<td>Simple signs</td>
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<td>Echolalia</td>
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<tr>
<td>Pointing</td>
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<td>Leading</td>
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<tr>
<td>Grab/Reach</td>
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<tr>
<td>Increased movement</td>
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<tr>
<td>Moves away</td>
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<td>Moves closer</td>
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<td>Fixed gaze</td>
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<td>Facial expressions</td>
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<td>Aggression</td>
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<td>Self injury</td>
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<td>Eye movements</td>
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<td>Augmentative</td>
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<td>communication</td>
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</table>
Name:

B. With regard to receptive communication:
   1. Does the person follow requests or instructions? If so approximately how many?

   2. Is the person able to imitate physical models for various tasks or activities?

   3. Does the person respond to signed or gestural requests or instructions?

   4. How does the person indicate yes or no?

VII. Events, Actions, and Objects Perceived as Positive by the Person?
A. In general, what are the things (events/activities/objects/people) that appear to be reinforcing or enjoyable for the person?

VIII. Functional Alternative Behaviors Known by the Person?
A. What socially appropriate behaviors/skills does the person perform that may be ways of achieving the same function(s) as the behavior(s) of concern?

   B. What things can you do to improve the likelihood that a teaching session will occur smoothly?

   C. What things can you do that would interfere with or disrupt a teaching session?

IX. History of the Undesirable Behavior(s) and Programs that Have Been Attempted.

<table>
<thead>
<tr>
<th></th>
<th>Behavior</th>
<th>How long has this been a problem?</th>
<th>Programs</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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</table>
Purpose
The provider must submit a summary of the results of the Functional Behavior Assessment to the Support Coordinator. Additionally, the provider must make recommendations regarding the amount of service estimated to be necessary to successfully implement the Behavior Support Plan.

Timeline
The provider must complete the form after completing the Functional Behavior Assessment. Within ten (10) days of completing the Functional Behavior Assessment this form, along with the Functional Behavior Assessment and Behavior Support Plan, must be submitted to the Support Coordinator for review before any direct Behavior Support Intervention Services can be authorized. The Bureau of Intellectual/Developmental Disabilities must authorize the service.
### ID/DD Waiver Behavior Support/Intervention Assessment Summary/Recommendations

<table>
<thead>
<tr>
<th>Date</th>
<th>Assessment Procedure</th>
<th>Location</th>
<th>Conducted By</th>
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</table>

The individual listed above received the following assessments:

Based upon the conducted assessments, the following behaviors were most prominent:

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Function</th>
<th>Location</th>
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<tbody>
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</table>

The results of the assessment(s) reflect that the behavior(s) demonstrated by this individual present a risk to the health and welfare of the individual and/or others.

- [ ] DO  
- [ ] DO NOT

These risks, if any, are presented below:

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Risk to Self</th>
<th>Risk to Others</th>
</tr>
</thead>
<tbody>
<tr>
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Based upon the above information, it is suggested that behavior support/intervention services **ARE NOT** warranted.

Based upon the above information, it is suggested that behavior support/intervention services **ARE** warranted.

It is anticipated that approximately __ hours for __ months will be required to implement this intervention.

Provider Signature/Credentials  

Date
ID/DD Waiver Behavior Support/Intervention Plan

Purpose
The Behavior Support/Intervention Plan is developed based on the assessment(s) used to evaluate the behavior(s).

General
The Behavior Support/Intervention Plan must be developed before the intervention can begin. All areas indicated on the form must be addressed and the signatures must be obtained before services begin.

Timelines
A copy of the Behavior Support/Intervention Plan along with the Functional Behavior Assessment and Summary/Recommendations must be submitted to the Support Coordinator within ten (10) days of completion.

Signatures
The following signatures must be obtained by the provider after completion of the Behavior Support/Intervention Plan:

The parent/legal guardian, if appropriate, and the individual receiving services, indicating they agree with the contents of the Plan and consent for its implementation,

The behavior support/interventionist, agreeing to implement the plan as written and to notify the individual/family before making any changes or modifications,

The Executive Director and Supervisor of the program the individual attends (if the Plan is to be implemented in such a setting), indicating he/she agrees with the content of the plan and will support the interventionist as necessary. Also, he/she is agreeing to allow appropriate staff to be trained by the interventionist to ensure the plan continues to be successful after the interventionist has ceased providing services.
### ID/DD Waiver Behavior Support/Intervention Plan

<table>
<thead>
<tr>
<th>Initiation Date:</th>
<th>Estimated Completion Date:</th>
<th></th>
</tr>
</thead>
</table>

**Scheduled dates for review:**

**Behavior(s) to be addressed:**

**Are medications prescribed for this behavior(s)?**

- Yes ☐
- No ☐

If yes, list name(s) and dosage(s):

**Reduction Criteria:**

**Implementation Schedule:**

**Materials:**

**Outcome(s):**

---

I agree with the contents of this Plan and give consent for its implementation. I have received a copy of the plan. I understand the behavior management techniques that will be used with this program. I may terminate the program at any time.

**Parent/Guardian**

Date

**Individual**

Date

I agree to implement the Plan contained on the following page(s). If any modifications are necessary, I will contact the family before making any changes. I will ensure staff are trained before terminating my services.

**Behavior Support/Interventionist/Credentials**

Date

I agree to the contents of this Plan and will support the Interventionist as needed to ensure implementation of the Plan. Appropriate staff will receive training to ensure the Plan continues, as needed, after the Interventionist terminates services.

**Executive Director**

Date
## ID/DD Waiver Behavior Support/Intervention Plan

<table>
<thead>
<tr>
<th>Name</th>
<th>ID Number</th>
<th>Date</th>
</tr>
</thead>
</table>

### Steps and Methods

<table>
<thead>
<tr>
<th>When this behavior occurs:</th>
<th>The Interventionist will:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

J19 ID-DD Waiver Behavior Support-Intervention Plan-form 161
<table>
<thead>
<tr>
<th>Risk Containment Strategies (least to most pattern of intrusiveness)</th>
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</table>
ID/DD Waiver Behavior Support/Intervention Note

Purpose
Each time the interventionist provides services, he/she must document the activities on the Behavior Support/Intervention Note.

General
This includes all time spent conducting the Functional Behavior Assessment, implementing the intervention, training family members and/or staff how to maintain the desired behavior(s), and providing follow-up services. Only time spent with the person or in training others how to implement the intervention may be billed. Time spent completing paperwork cannot be billed to Medicaid.

The form is designed to allow the provider to document three (3) visits with the person. The identifying information at the top of the form must be completed. Each time the provider provides services, he/she must:

1. Document the time the service began and the time the service ended
2. Indicate the total time provided
3. Write a summary or note about the activities during that time
4. Have the individual/legal representative sign the form upon completion of the visit
5. Provider signs the form

This form is in addition to documentation used for monthly data collection.
<table>
<thead>
<tr>
<th>Provider's Signature</th>
<th>Date</th>
<th>Time In</th>
<th>Time Out</th>
<th>Total Time</th>
<th>Individual/Guardian Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notes</td>
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</table>

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<th>Total Time</th>
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</thead>
<tbody>
<tr>
<td>Notes</td>
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</tbody>
</table>
Section K
Substance Abuse
Prevention and
Treatment-
Rehabilitation Services

Outpatient Educational Activities/Risk Assessments for TB/HIV/STD
Outpatient TB/HIV/STD Risk Assessment Interview
Outpatient Substance Abuse Aftercare Plan
Outpatient Educational Activities/Risk Assessments for TB/HIV/STD

Purpose
All individuals receiving substance abuse treatment services must receive educational information on HIV/AIDS, STD, TB, Mississippi's Implied Consent Law, an HIV Risk Assessment, HIV Prevention Counseling, and TB Risk Assessment.

Applicability
Under each section, if any of the numbered items does not apply, document as "not applicable."

Educational Activities: HIV/AIDS, STDs, TB, MS Implied Consent
Record the month/day/year that the individual receiving services is provided with educational information regarding the topics listed in lines 1-4. Provide the actual date that each activity was provided.

HIV Risk Assessment
Line 1 Record month/day/year that the HIV Risk Assessment was completed for the individual receiving outpatient substance abuse services.

Line 2 Record the month/day/year that the individual received HIV prevention counseling.

Line 3 If as a result of the HIV Risk Assessment or at the individual's request further action was taken with the individual receiving services, then check "Yes". Record the month/day/year the individual was provided voluntary HIV testing. Check "No" if further action is not warranted.

Line 4 Record the month/day/year when the individual receiving services received a post-test individual HIV counseling session, if applicable.

TB Risk Assessment
Line 1 Record the month/day/year that the TB Risk assessment was completed for the individual.
Check "Yes" if further action will be taken.
Check "No" if results of risk assessment indicate that no further action appears warranted.

Line 2 Record month/day/year when the skin test was administered to the individual.
Check "Yes" if further action will be taken after the skin test.
Check "No" if results of skin test indicate that no further action appears warranted.

Line 3 Record month/day/year that individual received an x-ray to determine their TB status.
Check "Yes" if further action will be taken after the x-ray.
Check "No" if results of x-ray indicate that no further action appears warranted.

Line 4 Record month/day/year when the individual was referred for treatment for tuberculosis. If not applicable, record this in the "date completed" section.
Individual Receiving Services Signature/Date
After receiving all applicable educational activities/risk assessments, the individual receiving outpatient substance abuse services must sign and date the form where indicated.

Staff Signature/Credentials/ Date
After the individual has received all applicable educational activities/risk assessments, the staff person responsible for verifying the administration of these educational activities/risk assessments must sign, date, and record their credentials.
### Outpatient Educational Activities/Risk Assessments for TB/HIV/STD

<table>
<thead>
<tr>
<th>Educational Activities</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HIV/AIDS Information (modes of transmission and universal precautions)</td>
<td></td>
</tr>
<tr>
<td>2. Sexually Transmitted Diseases (STDS)</td>
<td></td>
</tr>
<tr>
<td>3. Tuberculosis</td>
<td></td>
</tr>
<tr>
<td>4. MS Implied Consent Law</td>
<td></td>
</tr>
</tbody>
</table>

### HIV Risk Assessment

1. Completion of Risk Assessment

2. Provided HIV Prevention Counseling

3. Provided HIV Testing (voluntary) Yes  No

4. Provided Post-Test Counseling (if testing is conducted)

### Tuberculosis Risk Assessment

1. Completion of Tuberculosis Risk Assessment – Do results indicate further action? Yes No

2. Completion of Skin Test – Do results indicate further action? Yes No

3. Completion of X-ray – Do results indicate further action? Yes No

4. Referred for Tuberculosis Treatment

I have received the educational information and all risk assessments listed above.

<table>
<thead>
<tr>
<th>Individual Receiving Services</th>
<th>Date</th>
<th>Staff Signature/Credentials</th>
<th>Date</th>
</tr>
</thead>
</table>
Outpatient TB/HIV/STD Risk Assessment Interview

Purpose
Individuals receiving outpatient substance abuse services must be interviewed to assess whether the individual is at risk for TB, HIV and STD.

Interview
Record the yes, no, or other responses of the individual to Questions 1-11 on the Risk Assessment.
# Outpatient TB/HIV/STD Risk Assessment Interview

<table>
<thead>
<tr>
<th>1. Have you ever lived on the street or in a shelter?</th>
<th>□ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Have you ever been incarcerated?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>3. Have you ever been told that you have a positive HIV test? (test for the AIDS virus)</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>4. Have you ever been diagnosed with or treated for tuberculosis (TB)?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>5. Has anybody you know or have lived with been diagnosed with TB in the past year?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>6. a. Within the last month, have you had any of the following symptoms lasting for more than 2 weeks? If yes, please check items below.</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>□ Fever □ Drenching night sweats □ Coughing up blood</td>
<td></td>
</tr>
<tr>
<td>□ Losing weight □ Shortness of breath □ Lumps or swollen glands</td>
<td></td>
</tr>
<tr>
<td>□ Diarrhea lasting more than one week</td>
<td></td>
</tr>
<tr>
<td>b. Are you now living with someone with any of the following?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>□ Coughing up blood □ Drenching night sweats □ Active TB</td>
<td></td>
</tr>
<tr>
<td>7. Have you ever used needles to shoot drugs?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>8. Have you used cocaine, coke or crack?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>9. Have you ever engaged in any of the following high-risk behaviors: unprotected vaginal, anal or oral sex with multiple partners, anonymous partners, or men who have sex with men?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>10. Have you been diagnosed with or treated for hepatitis and/or a sexually transmitted disease?</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

**Comments:**

---

Staff Signature/Credentials: ___________________________ Date: ___________________________
Outpatient Substance Abuse Aftercare Plan

Purpose
The Aftercare Plan is used as a tool to assist an individual in making plans to engage in activities and access resources designed to help/support him/her in maintaining recovery.

Strengths/Challenges
Record the strengths and challenges the individual identifies that are related to maintaining recovery.

Statement of Need
Record any needs identified by the individual in the areas listed.

Individualized Objectives
All Aftercare Plans must have individualized objectives and they must be measurable. For example, what does the individual wish to accomplish or achieve while in Aftercare Services?

Objectives
Objectives 1 and 2 are required for all Aftercare Plans. Check each item that applies.

Referrals to Other Sources
In order to remain in recovery, individuals may require assistance from other resources. The provider is to assist in accessing any needed resources. The Aftercare Plan is used to document the resources needed to assist the individual, to where referrals are made, location(s) and time(s) of the appointments, and who the individual is to meet with.
# Outpatient Substance Abuse Aftercare Plan

**Name**

**ID Number**

<table>
<thead>
<tr>
<th>Time In</th>
<th>Time Out</th>
<th>Total Time</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>New Admission</th>
<th>Readmission</th>
<th>Rewrite</th>
</tr>
</thead>
</table>

**Date**

**Strengths/Challenges**

- 
- 
- 
- 
- 

**Statement of Need**

<table>
<thead>
<tr>
<th>A. Vocational</th>
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<tr>
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<tr>
<td>B. Psychological</td>
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<td>---------------</td>
</tr>
<tr>
<td>C. Medical</td>
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<td>---------------</td>
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<tr>
<td>D. Social</td>
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<td>E. Educational</td>
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<td>F. Legal</td>
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<td>G. Transportation</td>
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<td>H. Housing</td>
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<tr>
<td>I. Family/other support</td>
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</tbody>
</table>
Measurable Objectives

Individualized Objective(s)

Objective 1 To maintain sobriety-oriented support:
   a) Individual will attend 90 AA/NA meetings in 90 days
   b) In lieu of objective a), individual will attend AA/NA meetings weekly AND/OR
      After objective a) is completed, individual will attend AA/NA meetings weekly
   c) Individual will obtain a sponsor
   d) Individual will talk to sponsor at least times weekly

Objective 2 To participate actively in Aftercare for at least two (2) years
   a) Individual will attend all Aftercare meetings
   b) Individual will continue to work on Twelve Steps of Recovery by completing steps

Referrals to Other Community Resources

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>Parenting Classes</th>
<th>Voc-Rehab</th>
<th>Food Stamps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>Medical Care</td>
<td>Aftercare</td>
<td></td>
</tr>
<tr>
<td>Evidence-based Recovery Program (Reality Therapy)</td>
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<tr>
<td>Other:</td>
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</tbody>
</table>

Appointments Scheduled

1. Date _______ Time _______ Agency __________________
   Location __________________ Contact Person __________
2. Date _______ Time _______ Agency __________________
   Location __________________ Contact Person __________
3. Date _______ Time _______ Agency __________________
   Location __________________ Contact Person __________

I understand and agree to participate in the recommended Aftercare Service.

Individual Receiving Services ____________________________
Parent/Legal Guardian ____________________________
Aftercare Counselor/Credential ____________________________
Primary Counselor/Credential ____________________________
Section L
Administrative Information

FASD Data Tool: Sections A, B, and C
Therapeutic Foster Care Contact Log
Disaster, Fire, and COOP Drills for all Programs
Substance Abuse Monthly Capacity Management and Waiting List Reports
MAP Team Report
DMH Plan of Compliance Template
FASD Data Tool: Sections A, B, and C

Purpose
DMH is collecting data on Fetal Alcohol Spectrum Disorders (FASD) screening and diagnosis of children ages birth to 18. The FASD Data Tool must be fully completed and submitted to DMH Division of Children and Youth Services monthly for every child that is screened for FASD.

Timelines
Sections A and B of the FASD Data Tool must be submitted by the 10th of each month for all the children who were screened during the previous month. Section C: Positive Screen Data must be completed and submitted monthly for every child who screens positive with all the current information regarding diagnostic evaluation status, diagnostic appointments scheduled and completed with diagnostic results indicated.

Screening Results
If a child is screened at Initial Intake and the result is a negative screen, the child must be re-screened in six months to ensure that the screening results are accurate and based on sufficient family history or other information that might be available. All children who screen positive must be referred for an FASD diagnostic evaluation. If the parent/guardian declines to allow the child to receive the diagnostic evaluation, this must be documented in Section C and the child’s Individual Service Plan must be modified to include a plan for follow-up with the parent/guardian to provide information and education regarding the potential benefit to the child as a result of the diagnostic evaluation.
## FASD Data Tool: Sections A and B

### CMHC/Agency

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<th>County</th>
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<table>
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<tr>
<th>Case Number</th>
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<table>
<thead>
<tr>
<th>Person completing form</th>
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</table>

<table>
<thead>
<tr>
<th>Phone number</th>
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</table>

### Section A: Demographic Data

1. Date FASD Screening Completed: (mm/dd/yyyy)

2. Gender
   - □ Male
   - □ Female

3. Date of birth: (mm/dd/yyyy)

4. Is the child Hispanic or Latino?
   - □ YES
   - □ NO

5. What is the child's racial background? (Select one or more)
   - □ Alaska Native
   - □ American Indian
   - □ Asian
   - □ Black or African American
   - □ Native Hawaiian or Other Pacific Islander
   - □ White

6. Does the child currently live in a single parent household?
   - □ YES
   - □ NO

7. The child currently lives with:
   - □ Both biological parents
   - □ Both foster parents
   - □ Both adoptive parents
   - □ Relative, non-foster parent (specify)
   - □ Non-Relative (specify)

8. Number of times has the child moved or been placed in the last year?

### Section B: Screening Results

Which of the criteria in item 9 or 10 apply to this child? (Check all that apply)

9. □ Negative for risk - no screening criteria met

10. Positive for risk – one or more of the following applies:
   - □ Confirmed prenatal alcohol or drug exposure
   - □ Sibling previously diagnosed with an FASD
   - □ Previous diagnosis of an FASD

If screening result is Positive for risk, FASD Data Tool Section C must be completed
### Section C: Positive Screen Data

11. Diagnostic Evaluation Plan (Positive Screen)
   - ☐ Parent/guardian agrees to diagnostic evaluation
   - ☐ Parent/guardian declines diagnostic evaluation. Reason:

12. Date referral forms were faxed to the Diagnostic Clinic for an appointment: (mm/dd/yyyy)

13. Diagnostic evaluation appointment date (mm/dd/yyyy)

14. Date diagnostic evaluation was completed (mm/dd/yyyy)

15. Date written diagnostic report was completed (mm/dd/yyyy)

16. Did the child receive an FASD diagnosis? ☐ NO ☐ YES

17. Diagnoses the child received as a result of the diagnostic evaluation (check ALL that apply):

   - Fetal Alcohol Syndrome (FAS)
   - Partial Fetal Alcohol Syndrome (P-FAS)
   - Fetal Alcohol-related Neurodevelopmental Effect (FANDE)
   - Alcohol-Related Neurodevelopmental Disorder (ARND)
   - Alcohol-Related Birth Defects (ARBD)
   - Fetal Alcohol Spectrum Disorders (FASD): NOS
   - Post Traumatic Stress Disorder
   - Closed Head Injury
   - Congenital Birth Defect
   - Autism Spectrum Disorder
   - ADHD
   - Learning Disability/Dyslexia
   - Mood Disorder
   - Other:
   - Other:
   - Other:
Therapeutic Foster Care Contact Log

Purpose
The Therapeutic Foster Care (TFC) Specialist must document face-to-face contact with TFC parents including home visits. Documentation must be maintained that each TFC home has no more than one child/youth with serious emotional disturbance (SED) in the home at one time.

Timeline
Documentation of at least one family session per month with the foster parent(s) must be maintained.
<table>
<thead>
<tr>
<th>Date</th>
<th>Type of Contact (in-home, monthly group, meeting, other)</th>
<th>Total # of children/youth in the home</th>
<th>Total # of children/youth with SED in the home</th>
<th>Staff Signature/Credential</th>
</tr>
</thead>
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Disaster, Fire, and COOP Drills for all Programs

Purpose
Each provider certified by the DMH must maintain an emergency/disaster response plan for each service location/site for responding to natural disasters and manmade disasters (fires, bomb threats, utility failures and other threatening situations such as workplace violence). Providers must maintain a Continuity of Operations Plan (COOP) describing how operations will continue in the event of a natural or manmade disaster. Each location/site must document proof of implementation of these written plans as evidenced by written reports of scheduled and conducted fire, disaster, and COOP drills.

Timeline
- **Disaster drills** must be conducted and documented at least quarterly.
  - Disaster drills must rotate the nature of the event for the drill based on each facility and program’s emergency/disaster plan.

- **Fire drills** must be conducted and documented at least monthly.
  - Fire drills for supervised living residential treatment service must be conducted on a rotating schedule across all three shift schedules.

- **COOP drills** must be conducted and documented at least annually.

General Information
Each provider is responsible for developing a report that will document all aspects of each type of drill in order to ensure the safety of all persons involved in the drill. Elements to be recorded in each drill report include but are not limited to:

- Name and location of the program
- Type/nature of the drill
- Date of the drill
- Time the drill began
- Time the drill ended
- Nature of the event (tornado, bomb, hurricane, other) for a disaster drill – must rotate quarterly based on potential hazards
- Number of participants
- Names of staff participating
- Assessment of the drill that addresses elements of the emergency/disaster or COOP plan as well as the behavior of those participating in the drill
- Signature and title of the staff person completing the report

Providers are welcome to contact the Division of Disaster Preparedness and Response at 601-359-1288 for technical assistance in the development of drill reports.
Fire and Disaster Drill Report Form

Date of Drill: ___________________________ Time of Drill: ___________________________

Type of Drill:
- Fire (quarterly for day programs, monthly for residential programs)
- Disaster (quarterly for all programs)
- COOP (annually for all programs)

Type of Disaster: ___________________________

(Continuity of Operations Plan) disaster type must rotate each quarter through all applicable disasters

Exact Start Time of Drill: ___________________________ Exact End Time of Drill: ___________________________

Amount of Time to Complete Drill: ___________________________

Number of Participants (not staff): ___________________________

Staff Participating in Drill:

- ____________________________
- ____________________________
- ____________________________
- ____________________________
- ____________________________
- ____________________________
- ____________________________

Written assessment of general performance on the drill:
(please be specific about actions that took place during the drill)

Signature of Staff Member Preparing Report: ___________________________
Purpose
All substance abuse programs must give first priority to the acceptance and treatment of pregnant women. Substance abuse programs must also provide treatment to IV drug users. Written documentation of placement or assessment and referral of pregnant women and IV drug users must be maintained and reported to the DMH.

Timeline
Pregnant women must be admitted to a program for treatment within forty-eight (48) hours of an initial contact. IV drug users must be placed in substance abuse treatment programs within forty-eight (48) hours of an initial contact. Reports must be submitted to the Office of Consumer Reports by the 10th working day of the month following the reporting period.

The program must monitor and complete the process of securing the most appropriate program for pregnant women and IV drug users. If the most appropriate program has not been secured by the end of a reporting month, the report must be sent to the Office of Consumer Supports indicating where the individual is in the process. The program must continue to submit the information on the individual each month until he/she is admitted into the appropriate program.
# Emergency Placement for Pregnant Women

**Timeline:** within 48 hours of initial contact

<table>
<thead>
<tr>
<th>Client Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name</strong></td>
</tr>
<tr>
<td><strong>Address</strong></td>
</tr>
<tr>
<td><strong>Telephone Number</strong></td>
</tr>
<tr>
<td><strong>Other Contact Information</strong></td>
</tr>
</tbody>
</table>

**Fax or Email to Office of Consumer Supports:**
Office of Consumer Support
Fax Number: (601)359-9570
Mshelpline@dmh.state.ms.us

_**Date Submitted to DMH**_
## Emergency Placement for IV Drug Users

Timeline: within 48 hours of initial contact

<table>
<thead>
<tr>
<th>Date</th>
<th>Time of Contact</th>
<th>Type of Contact</th>
<th>Facility Name</th>
</tr>
</thead>
</table>

### Client Information

<table>
<thead>
<tr>
<th>Name</th>
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<table>
<thead>
<tr>
<th>Address</th>
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<table>
<thead>
<tr>
<th>Telephone Number</th>
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</table>

<table>
<thead>
<tr>
<th>Other Contact Information</th>
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</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### Fax or Email to Office of Consumer Supports:

Fax Number: (601)359-9570
Mshelpline@dmh.state.ms.us

Date Submitted to DMH
<table>
<thead>
<tr>
<th>Substance Abuse Capacity Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timeline within 7 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>

- At 90% capacity
- No longer at 90% capacity

Fax or Email to Office of Consumer Supports:
Office of Consumer Support
Fax Number: (601)359-9570
Mshepline@dmh.state.ms.us
MAP Team Report

Purpose
Making a Plan (MAP) Teams address the needs of children/youth with serious emotional disorder (SED) who require services from multiple agencies and multiple program systems and who can be diverted from inappropriate institutional placement. MAP Teams are a significant piece of the statewide System of Care for children/youth with serious emotional/behavioral disorders. Quarterly reports are required for data collection purposes.

Timelines
The MAP Team Reporting form must be completed and submitted to the DMH, Division of Children & Youth Services by the 10th of each quarter; January 10th for October – December, April 10th for January – March, July 10th for April – June, and October 10th for July – September.

Case Summaries
If MAP Team grant funds are used, Case Summary forms for each child/youth reviewed must be submitted with the MAP Team Report. Cash requests will not be processed without this information.
# MAP Team Report

## Referral Information

1. Number of **new cases** reviewed

2. Number of children/youth in DHS custody (of the new cases only)

3. Number of follow-ups from previous quarter

4. Number of children/youth not Medicaid eligible

5. Number of referrals from **new cases** only:

<table>
<thead>
<tr>
<th>Mental Health Center in your county</th>
<th>Mental Health Center Region-Wide</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHS - Family &amp; Children’s Services</td>
<td>Youth Court</td>
</tr>
<tr>
<td>Therapeutic Group Home</td>
<td>Therapeutic Foster Care</td>
</tr>
<tr>
<td>Acute Psychiatric Hospital</td>
<td>Psychiatric Residential Tx Facility</td>
</tr>
<tr>
<td>Local School District</td>
<td>Parent(s)</td>
</tr>
<tr>
<td>Faith-Based Agency/Church</td>
<td>A.O.P</td>
</tr>
<tr>
<td>MYPAC</td>
<td>College/University</td>
</tr>
<tr>
<td>Substance Abuse Residential Facility</td>
<td>Other (specify)</td>
</tr>
</tbody>
</table>

## MAP Team Member Participation

Check the following agencies that were represented at your MAP Team Meeting(s) for the quarter

<table>
<thead>
<tr>
<th>Families/Parents (Local Family Partners – must be parent(s) or primary caregiver(s) of a child/youth with SED. Use MS Families As Allies Partners when available.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Mental Health Center</td>
</tr>
<tr>
<td>Youth Court</td>
</tr>
<tr>
<td>Vocational Rehabilitation</td>
</tr>
<tr>
<td>Boys &amp; Girls Club</td>
</tr>
<tr>
<td>Substance Abuse Residential Facility</td>
</tr>
<tr>
<td>Youth Villages</td>
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<tr>
<td>Faith-based Agency/Church</td>
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<tr>
<td>DHS – Family &amp; Children Services</td>
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<tr>
<td>Local School District</td>
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<tr>
<td>Health Department</td>
</tr>
<tr>
<td>Law Enforcement</td>
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<tr>
<td>A. O. P.</td>
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<tr>
<td>MYPAC</td>
</tr>
<tr>
<td>Other (specify)</td>
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</tbody>
</table>
Required Plan of Compliance

**Purpose**
All DMH Certified Providers must submit a Plan of Compliance in response to findings included in a DMH Written Report of Findings. This template must be utilized by providers.

**Timeline**
The plan must be completed within the timeframe stated in the DMH Written Report of Findings.

**Finding**
Reference the DMH Operational Standard included in the DMH Written Report of Findings.

**Program/Service**
Reference the program or service (if there is not a specific physical location for the program) included in the DMH Written Report of Findings.

**Corrective Action Steps**
Outline the action steps the provider will put in place to correct the findings. Do not include justification. *A request for a waiver of a DMH Operational Standard is not considered a corrective action step.*

**Time Line**
Include the implementation date and estimated date of completion for each corrective action.

**Plan for Continued Compliance**
Outline the plan for how the agency will continue to comply with DMH Operational Standards and the identified correction action plan(s).
Required Plan of Compliance

Plan of Compliance

Please complete all requested information and mail completed form to:
Division of Certification
MS Department of Mental Health
239 North Lamar Street, Suite 1101
Jackson, MS 39201

In lieu of mailing the form, you may e-mail the completed electronic form to:

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Phone:</th>
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<tbody>
<tr>
<td>Provider Contact Person for follow-up:</td>
<td>Fax:</td>
</tr>
<tr>
<td></td>
<td>Email:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Finding (DMH Standard Number)</th>
<th>Program/Service/Record</th>
<th>Corrective Action(s)</th>
<th>Time Line</th>
<th>Plan for Continued Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Implementation Date:</td>
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<td>Projected Completion Date:</td>
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