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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CONTENTS

Section A
General Information

2012 DMH Operational Standards Record Guide

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 Recieve 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

Client ID# | **New** | **Change** | **Intake Date** | **Intake Status** ☐ 1-New 2-Readmit 1-Eval only

Intake Type ☐
1. Primary
2. Collateral
3. Unregistered

Last Name, First, Middle

Maiden Name/Alias-Nickname

County of Residence ☐
See Back

Referred From: ☐
See Back

Program Record ☐
See Back

Address

Organization Code: 104

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:

Living Arrangements ☐
1 Lives Alone
2 Lives w/Relatives
3 Lives w/non-Relatives

Home Phone #

Work Phone#

Social Security#

Birth Date

Emergency contact and phone number:

Veteran Status ☐
Y-Yes
N-No

Gender ☐
M - Male
F - Female
U - Unknown
N - Not Collected

Physical Impairments
#1 ☐☐ #2 ☐☐

01 Deafness and Blind
02 Deafness/Severe Hearing Loss
03 Blind/Severe Vision Loss
04 Nonambulatory
05 Ambulatory w/Assistance
06 Unable to Communicate Verbally
07 Brain Injury
08 Major Medical Condition
97 Other
98 Unknown
99 N/A

Catchment Area ☐
County Serviced
20 Alcorn
30 Tishomingo
40 Prentiss
50 Tippah

Education ☐☐
01-12 Highest Grade
51 Preschool/Kindergarten
52 Special ED
13 GED
14 Tech/Trade School
15 Some college, no degree
16 Associate Degree
17 Bachelor's Degree
18 Master's Degree
19 Ph.D.
98 Unknown
99 None

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

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_____
8 Unknown
9 None
☐

Medicaid Eligibility ☐
1 Elig. & Rec. Payment
2 Elig. & Not Rec. payment
3 Potentially Eligible
4 Determined Ineligible
8 Unknown
9 N/A

SSI/SSDI Eligibility ☐
1 Elig. & Rec. Payment
2 Elig. & Not Rec. Payment
3 Potentially Eligible
4 Determined Ineligible
8 Unknown
9 N/A

Number of Household Dependents ☐

Monthly Household Income Amount
$_____

Household Annual Income Amount
$_____

Is Client SMI or SED?
SMI ☐ SED ☐
Y - Yes N-No

Employment Status
01 Employed-Full Time
02 Employed-Part Time
03 Employed-Active Military
04 Season/Migrant Worker
05 Unemployed-Seeking Work
06 Unemployed-Not Seeking Work
07 Homemaker
08 Student/Under 17
09 Retired
10 Disabled
11 Correctional Inmate
97 Other_____
98 Unknown
☐☐

Payer Code
#1 ☐ #2 ☐
#3 ☐ See Back

Disability Category ☐
1 Mental Health
2 Develop Disability
3 Substance Abuse
4 MH/MR
5 MH/SA
6 MR/SA
7 MH/MR/SA
8 Unknown

Primary Focus ☐
1 MH
2 DD/MR
3 A&D

EAP Name & Address

Primary Source of Payment

Medicaid #

Date Eligibility

Medicare #

Date Eligibility

Presenting Problem Choose up to 5 Rank 1-5

Please see back and fill in the problems below. Rank selection entering your choices from left to right, highest to lowest.

☐ ☐ ☐ ☐ ☐

Responsible Party Information
Name:
Address:
Relationship to Client:

Ins. Name:
Ins Id#: Grp#
Policy Owner:

Ins Name:
Ins Id# Grp#:
Policy Owner:

Diagnosis	Axis I	Axis II	Axis IV	Axis V	Principal Axis
Dx#1					#1 ☐ #2 ☐
Dx #2			Counselor of Record-Staff#		
Dx #3		Completed by: Date:			

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):

Staff Initials	Date Initiated	Name of Medication	Prescribed by	Dosage/ Frequency	Date Terminated/ Changed	Staff Initials

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): _____

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

Name _____

ID Number _____

I, _____ (Name) began receiving services provided by _____ (Name of Provider)

on _____ (Intake/Admission Date) 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.

Individual Receiving Services	Date	Legal Representative	Date
Staff/Credentials	Date		

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

Name _____

ID Number _____

Agency _____

Service(s) _____

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.

Individual/Legal Representative Signature	Staff Signature/Credentials	Date

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.

Acknowledgment of Grievance Procedures

Name _____

ID Number _____

Agency _____

Service(s) _____

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

Individual/Legal Representative Signature	**Staff Signature/Credentials**	**Date**

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

Name _____

ID Number _____

Date _____

I hereby give my consent/permission for _____
(Agency Name and Address)

❑ To release information to: _____
(Agency/Person Name/Title and Address)

❑ To obtain information from: _____
(Agency/Person Name/Title and Address)

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

Individual Receiving Services	Date	Legal Representative	Date
Witness/Credentials	Date		

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:

Age of onset ____

Patterns of use/abuse:

How much? _____

How often? _____

Methods of use: *smoke* ❑ *snort* ❑ *inject* ❑ *insert* ❑ *inhale* ❑

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

(Code)

Axis I _____ _____
_____ _____

Axis II _____ _____
_____ _____

Axis III _____ _____
_____ _____

Axis IV _____ _____
_____ _____

Axis V _____ _____

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

Name	
ID Number	
Date of Admission	
Date Plan Developed	
Date of Review Meeting	

Diagnosis (Axis I-V)	**Individual's Strengths**
Axis I	
Axis II	
Axis III	
Axis IV	
Axis V	

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		Date	

RECORD GUIDE TIMELINES REFERENCE

INITIAL ASSESSMENT		
Service	**Timeline**	**Additional Information**
All Crisis/Emergency Services, Acute Partial Hospitalization, Crisis Residential and Respite Care for C&Y, and Crisis Stabilization Units	Within 24 hours of admission	Initial Assessment is initiated the first day of service and must be completed within the specified timeline.
All Community Living & Alzheimer's Services (unless otherwise specified)	Within 7 days of admission	Initial Assessment is initiated the first day of service and must be completed within the specified timeline.
Case Management/Community Support Activity Plan	Within 14 days of admission into CM/CS services	Initial Assessment is initiated the first day of service and must be completed within the specified timeline.
All Outpatient and Support Services (unless otherwise specified)	Within 30 days of admission	Initial Assessment is initiated the first day of service and must be completed within the specified timeline.
All SAPT Services (Educational Activities/Risk Assessment for TB/HIV/STD & TB/HIV/STD Risk Assessment Interview)	Within 30 days of admission ***NOTE*** The TB assessment must be completed prior to admission to all services.	Assessment is initiated the first day of service and must be completed within the specified timeline.
SAPT SPECIFIC ASSESSMENT		
All SAPT Services (unless otherwise specified)	Within 30 days of admission	Assessment is initiated the first day of service and must be completed within the specified timeline.
SAPT Transitional Residential, Primary Residential and Chemical Dependency Units	Within 7 days of admission	Assessment is initiated the first day of service and must be completed within the specified timeline.
FUNCTIONAL ASSESSMENT		
Outpatient Services for Adults	Between 30 and 60 days after Initial Assessment then annually thereafter	Assessment must be completed within the specified timeline and annually thereafter.
INDIVIDUALIZED SERVICE PLANS (original)		
Crisis/Emergency Services and Respite Care for C&Y	Within 24 hours from time of admission	Updated as needed but not less than every 30 days.

INDIVIDUALIZED SERVICE PLAN DEVELOPMENT		
Service	**Timeline**	**Additional Information**
Acute Partial Hospitalization, C&Y Crisis Residential and, Crisis Stabilization Units	Within 72 hours from time of admission	Updated as needed but not less than every 30 days.
All Community Living & Alzheimer's Services (unless otherwise specified)	Within 15 days from date of admission	Updated as needed but not less than annually.
All Outpatient, Day Programs, Support Services (unless otherwise specified)	Within 30 days from date of admission	Updated as needed but not less than annually.
All HCBS Waiver Services (including Supported Employment and Supervised Living Services)	Within 30 days from date of admission	ISP must be provided to Support Coordinator by the 15th of the month following the development.
INDIVIDUALIZED SERVICE PLAN REVIEW		
Substance Abuse Prevention and Treatment Primary Residential Treatment and Chemical Dependency Units	Be reviewed as needed but at a minimum every 15 days	
Substance Abuse Prevention and Treatment Intensive Outpatient, DUI and Transitional Residential Treatment	Be reviewed as needed but at a minimum every 30 days	
Children and Youth Community Living and Day Treatment	Be reviewed as needed but at a minimum every 30 days	
All Substance Abuse Prevention and Treatment (unless otherwise specified)	Be reviewed as needed but at a minimum every 90 days	
Children and Youth Case Management/Community Support Activity Plan	Be reviewed as needed but at a minimum every 6 months	
Children and Youth Outpatient	Be reviewed as needed but at a minimum every 6 months	
All Services (unless otherwise specified)	The ISP must be reviewed and revised when necessary. The plan must be rewritten at least annually.	
Case Management/Community Support Activity Plan	The CM/CSAP must be review when necessary. The plan must be rewritten at least annually.	

PROGRESS/ACTIVITY/CONTACT NOTES		
Service	**Timeline**	**Additional Information**
All Outpatient Therapy, DUI, CDU, SAPT Transitional and Primary Residential and Aftercare Therapy, Emergency/Crisis, Case Management, C&Y Early Intervention	Each contact	Progress Note must be completed for each contact made with the individual.
PROGRESS/ACTIVITY/CONTACT NOTES		
Acute Partial Hospitalization, Crisis Residential and Respite Care for C&Y, and Crisis Stabilization Units	At least daily	A Daily Summary based on documentation throughout the day.
Supported Living Services (except Therapeutic Foster Care and Home and Community Supports)	At least weekly	A Weekly Summary based on daily contact documentation must be completed.
SAPT Supervised Living and Residential Treatment and IOP Services	At least weekly	A Group Progress Note must be completed.
C&Y Day Treatment	At least weekly	A Weekly Summary based on daily contact documentation must be completed.
ID/DD Day Services – Adult, Prevocational, and Work Activity	At least weekly	A Weekly Summary based on daily contact documentation must be completed.
All Supervised Living	At least monthly	A Monthly Summary based on daily contact documentation must be completed.
Psychosocial Rehabilitation, Senior PSR and Day Support	At least monthly	A Monthly Summary based on daily contact documentation must be completed.
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:

Type of Treatment Modality ❑OP ❑IOP ❑PR ❑TR ❑CDU ❑Day TX

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)

	# of Days Past 30		Lifetime Years			# of Days Past 30		Lifetime Years	
0201 = Alcohol					0901 = LSD				
0301 = Crack					1001 = Methamphetamine/Speed				
0302 = Other Cocaine					1101 = Amphetamine				
0401 = Marijuana/Hashish					1102 = Ritalin				
0501 = Heroin/morphine					1301 = Alprazolam/Xanax				
0601 = Methadone					1304 = Diazepam/Valium				
0701 = Codeine					1306 = Lorazepam/Ativan				
0702 = Darvocet					1701 = Aerosols				
0703 = Oxycodone/Oxycontin					More than 1 substance daily				
0705 = Hydromorphone/Dilaudid					Other:				

Substance Abuse Specific Assessment

Name _____

ID Number _____

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

Level of denial	None	Low	Moderate	High	Unsure
Willingness to change	None	Low	Moderate	High	Unsure

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

Name _____

ID Number _____

Date _____

Effective Date of Service Termination/Change _____

Service Termination is expected to be ❑ Temporary ❑ Permanent

Reasons for Service Termination/ Change (Check all that apply):

❑ Change in Diagnosis ❑ Change in Symptoms ❑ Change in Service Activities

❑ Change in Treatment Recommendations ❑ Appropriate for Less Intensive Service

❑ Other _____

List Service(s) Discontinued

List Service(s) Initiated

Service Staff Change

From	**To**
(staff name/credential)	**(staff name/credential)**

Service Change Instructions or Information:

_____ _____

Signature/Credentials Date

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

Name _____

ID Number _____

Current Date _____

Date of Last ISP/Review _____

Time In _____ **Time Out** _____ **Total** _____

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 Date

_____ _____
Staff Signatures/Credentials Date

_____ _____
Staff Signatures/Credentials Date

_____ _____
Signature of Parent/Legal Guardian (if applicable) Date

Search and Seizure Report

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

Name _____

ID Number _____

Date _____

Time AM PM

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):

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 deescalate 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:

Time 1st assessment began: _____ AM/PM Ended: _____ AM/PM

Time 2nd assessment began: _____ AM/PM Ended: _____ AM/PM

Time 3rd assessment began: _____ AM/PM Ended: _____ AM/PM

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 deescalate 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.

Time Out Log

Name _____

ID Number _____

Date _____

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

Describe the precipitating events necessitating time out

Describe the behavior warranting time out

Describe ineffective/less restrictive alternatives attempted prior to time out

Describe individual's behavior during time out, based on visual assessments

Does the Individual Service Plan require modification? Yes ❑ No ❑

Signature of Staff Implementing Time Out

Signature of Staff Observing Time Out

Signature/credentials of Supervisory Staff

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

Name _____

ID Number _____

Readmission Date _____

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:** _____

Height:		Temperature:		Blood Pressure:	General Appearance:
Weight:		Head Circumference:			

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

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

Name _____

ID Number _____

Date _____

Name of Health Care Provider: _____

Type of Health Care Provider: _____

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.

Emergency/Crisis Contact Log

Name

ID Number

Date | **Time**

Type of Contact ☐ **Face-to-Face** ☐ **Telephone**

Location of Face-to-Face

Individuals 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

Condition of the Individual/Family or Interested Party at Conclusion of Emergency/Crisis	**Referrals Made by Staff**

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.

Acute Partial Hospitalization/ Acute Community Stabilization Services Daily Service Log/Activity Summary Note

Name _____

ID Number _____

Date _____

Total Time

Services	Check	Time In	Time Out	Name of Service Provider
Medical Supervision				
Nursing				
Intensive Psychotherapy				
Individual Therapy				
Group Therapy				
Family Therapy				

Therapeutic Activities Provided

Activity	Time In	Time Out	Name of Activity Coordinator

Daily Summary Note

_____

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:**

Action Steps for Home	**Person(s) Responsible and Phone Number(s)**	**Action Steps for Community Locations (specify)**	**Person(s) Responsible and Phone Number(s)**

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

Name _____

ID Number _____

Date _____

Strengths/Vision

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

Current Status	Personal Goal	Action Steps	Date Goal Achieved

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

Current Status	Personal Goal	Action Steps	Date Goal Achieved

Area of Need: Purpose (employment assistance, education, vocational training, early intervention, other)			
Current Status	**Personal Goal**	**Action Steps**	**Date Goal Achieved**

Area of Need: Community (social supports, interpersonal, protective care, support group, counseling, legal assistance, other)			
Current Status	**Personal Goal**	**Action Steps**	**Date Goal Achieved**

Level of Case Management/Community Support (circle one)				**ID/DD only**	**Potential/Temporary**	
High	**Moderate**	**Low**	**Follow Along**		In Date:	Out Date:

Individual receiving services	Date	CM/CS Specialist/ Credentials	Date
School Input By (For C&Y only)		Parent/Legal Guardian	Date

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 Credentialed 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 Credentialed 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.

Case Management/ Community Support Progress Note

Name _____

ID Number _____

Date _____

Time In _____ Time Out _____ Total Time _____

Need(s) Addressed	
Summary of Actions	
Result(s) of Action Steps	
Next Steps & Responsible Party (must include date and time of next planned visit)	
Progress Toward CM/CS Activity Plan Goals	

_____

Signature/Credential

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

Psychosocial Rehabilitation Services 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

Name _____

ID Number _____

Month/Year _____

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

Area of Focus	Summary of Objective/Activity	Result of Objective/Activity	Next Step

Unit Summary Activities

Kitchen	Snack Bar	Clerical	Thrift Store	Maintenance	Other

Signature/Credentials **Date**

Senior Psychosocial Rehabilitation Progress Note

Name _____

ID Number _____

Month/Year _____

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

Area of Focus	Summary of Objective/Activity	Result of Objective/Activity	Next Step

Signature/Credentials **Date**

Psychosocial Rehabilitation/Day Support Progress Note

Name _____

ID Number _____

Month/Year _____

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

Area of Focus	Summary of Objective/Activity	Result of Objective/Activity	Next Step

Signature/Credentials **Date**

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

Name _____

ID Number _____

Program Name

Attendance 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
Time In																															
Time Out																															
Total Time																															

Weekly Dates	**Objective 1:**	**Objective 2:**
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	Supervisor Signature/Credential

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.

Supported Living Progress Note

Name _____

ID Number _____

Date	Activity	Signature/ Credentials

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

Name _____

ID Number _____

Page ____ of ____

Outcomes	Specific Activities

_____
Individual/Legal Representative Signature

_____
Agency Representative Signature/Credentials

_____
Date

_____
Date

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.

ID/DD Waiver
Home and Community Supports
Activity Note

Name: _____

ID Number: _____

Activity	Day/Date	Day/Date	Day/Date	Day/Date	Day/Date	Day/Date	Day/Date
■ 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

Name _____ **Medicaid Number** _____

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 initialing 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 be 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.

Individual/Legal Representative	Authorized Provider Representative/Credential
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

Name _____

ID Number _____

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	

Telephone/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

Name _____

ID Number _____

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:

Name	Telephone Number(s)	Relationship

☐ I agree to accept any individual as a visitors.

☐ I agree to accept as visitors the following named individuals only:

Name	Telephone Number(s)	Relationship

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.

_____ _____

Individual Receiving Services Date Authorized Representative Date

_____ _____

Signature/Credential Date Relationship to Individual

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

Name _____

ID Number _____

_____

	New Admission		Readmission		Rewrite

Date

Strengths/Challenges

_____

_____

_____

_____

_____

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:							
		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							
	Mental Health		Parenting Classes		Voc-Rehab		Food Stamps
	Medicaid		Medical Care		Aftercare		
	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.

Individual Receiving Services	Aftercare Counselor/Credential
Parent/Legal Guardian	Primary Counselor/Credential

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.

Community Living TB/HIV/STD Risk Assessment Interview

Name _____

ID Number _____

Time In _____ **Time Out** _____ **Total Time** _____

1.	Have you ever lived on the street or in a shelter?	❑Yes	❑No
2.	Have you ever been incarcerated?	❑Yes	❑No
3.	Have you ever been told that you have a positive HIV test? (test for the AIDS virus)	❑Yes	❑No
4.	Have you ever been diagnosed with or treated for tuberculosis (TB)?	❑Yes	❑No
5.	Has anybody you know or have lived with been diagnosed with TB in the past year?	❑Yes	❑No
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.	❑Yes	❑No
	❑Fever ❑Drenching night sweats ❑Coughing up blood		
	❑Losing weight ❑Shortness of breath ❑Lumps or swollen glands		
	❑Diarrhea lasting more than one week		
b.	Are you now living with someone with any of the following?	❑Yes	❑No
	❑Coughing up blood ❑Drenching night sweats ❑Active TB		
7.	Have you ever used needles to shoot drugs?	❑Yes	❑No
8.	Have you used cocaine, coke or crack?	❑Yes	❑No
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?	❑Yes	❑No
10.	Have you been diagnosed with or treated for hepatitis and/or a sexually transmitted disease?	❑Yes	❑No

Comments:

Staff Signature/Credentials _____ Date _____

Residential Educational Activities/ Risk Assessments for TB/HIV/STD

Name _____

ID Number _____

Time In _____ Time Out _____ Total Time _____

Educational Activities	Dates
1. HIV/AIDS Information (modes of transmission and universal precautions)	
2. Sexually Transmitted Diseases (STDS)	
3. Tuberculosis	
4. MS Implied Consent Law	
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 (results indicate further action if action is taken) ❑Yes ❑No	
2. Completion of Skin Test(results indicate further action) ❑Yes ❑No	
3. Completion of X-ray (results indicate further action) ❑Yes ❑No	
4. Referred for Tuberculosis Treatment	
I have received the educational information and all risk assessments listed above.	

Individual Receiving Services	Date	Staff Signature/Credentials	Date

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.

Seclusion Behavior Management Log

Name of Individual Being Placed in Seclusion

Time Intervention Began: Ended: Date:

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

15 Minute Observations Indicated by Staff Signature

1.	**7.**
2.	**8.**
3.	**9.**
4.	**10.**
5.	**11.**
6.	**12.**

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
Type of Court (Name 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 _____

NAME	ID Number

FAMILY CONTACT ❒ Unknown (Explain) _____

Name: _____ Relationship: _____ Phone: (H) _____ (W) _____

Address: _____ City _____ State _____ Zip Code _____

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

Name: _____ Relationship: _____ Phone: (H) _____ (W) _____

Address: _____ City _____ State _____ Zip Code _____

MEDICAL HISTORY INFORMATION

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

_____

_____

_____

_____

CURRENT MEDICATIONS (*List Names and Dosage*)

Name	*Dosage*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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. wheel chair, white cane, support cane, oxygen, etc.)

❒ Diabetes	❒ Emphysema/Cold	❒ Heart Condition	❒ Seizures
❒ Hypertension	❒ S.T.D.	❒ TB	❒ Cancer
❒ Contagious Disease	❒ Other Chronic Illness	❒ (Please State) _____	
❒ Hepatitis	❒ None known		

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

NAME	ID Number

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 ❒ Threats of suicide ❒ Plan for suicide ❒ Pre-occupation with death
❒ Suicide gesture ❒ Suicide attempts ❒ Family history of suicide ❒ Self-mutilation
❒ Inability to care for self ❒ High risk behavior ❒ Provoking harm to self from others
❒ Other _____

Describe: _____

History or Present Danger to Others ❒ Yes ❒ No *(If Yes, mark appropriate statement(s) below)*

❒ Thoughts to harm others ❒ Threats to harm others ❒ Plans to harm others
❒ Attempts to harm others ❒ Stalking ❒ Has harmed others
❒ Felt like killing someone ❒ Inability or unwillingness to care for dependents
❒ 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 _____

Antisocial/Criminal Behavior ❒ Yes ❒No *(If Yes, mark appropriate statement(s) below)*

❒ Frequent lying ❒ Stealing ❒ Running away from home ❒ Excessive fighting
❒ Destroys property ❒ Fire setting ❒ Cruelty to others ❒ Cruelty to animals
❒ Arrests ❒ Gang membership ❒ Brandishing weapons ❒ Convictions
❒ Imprisoned ❒ Uses multiple aliases ❒ Exhibitionism ❒ Family desertion
❒ Identify any legal charges which may be pending _____

❒ Other _____

Describe: _____

Drug Use/Abuse ❒ Yes ❒No ❒ Unknown *(If Yes, mark appropriate statement(s) below)*
❒ Has abused ❒ Is abusing ❒ Narcotics ❒ Amphetamines ❒ Barbiturates ❒ Hallucinogens
❒ Cocaine ❒ Marijuana ❒ Absenteeism ❒ Job loss ❒ Arrests
❒ Has required hospitalization ❒ Family problems due to drug use ❒ Currently under the influence of drugs

❒ Other _____

Describe: _____

Alcohol Use/Abuse ❒ Yes ❒No ❒ Unknown *(If Yes, mark appropriate statement(s) below)*

❒ Drinking problem suspected ❒ Intoxicated Now ❒ Has required hospitalization
❒ D.T.'s ❒ Black-outs ❒ Absenteeism
❒ Job loss ❒ Arrests/DUI ❒ Family problems due to drinking
❒ 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: _____

NAME	ID Number

Depressive-Like Behaviors ❒ Yes ❒No *(If Yes, mark appropriate statement(s) below)*

❒ Sadness ❒ Fatigue ❒ Low Energy ❒ Loss of interest ❒ Extreme Withdrawal
❒ Crying ❒ Poor Concentration ❒ Weight loss or gain ❒ Guilt feelings
❒ Feelings of worthlessness ❒ Hopelessness about the future ❒ Hypoactive
❒ Thoughts/threats of suicide ❒ Sudden drop in grades or change in friends (especially in adolescents)

❒Other _____

Describe:
_____

Manic-Like Behavior ❒ Yes ❒No *(If Yes, mark appropriate statement(s) below)*

❒ Euphoria ❒ Hyperactivity ❒ Grandiosity ❒ Over talkativeness and/or pressured speech
❒ Irritability ❒ High Risk Behaviors ❒ Sleep disturbance ❒ Extravagance with money

❒ Other
_____

Describe:
_____

Dementia-Like Characteristics ❒ Yes ❒No *(If Yes, mark appropriate statement(s) below)*

❒ Confusion ❒ Wanders Off ❒ Disorientation ❒ Impaired Abstract Thinking
❒ Poor Concentration ❒Gets Lost ❒ Impaired Judgment ❒ Significant short-and/or long term memory
❒ Decline in activities of daily living *(Consider age of respondent)*

❒ Other
_____

Describe:
_____

Psychotic-Like Behavior ❒ Yes ❒No *(If Yes, mark appropriate statement(s) below)*

❒ Poor personal hygiene ❒ Loose Association ❒ Suspiciousness ❒ Bizarre or obscene acts
❒ Withdrawn ❒ Incoherence ❒ Unmanageable ❒ Flat or inappropriate affect
❒ Talks often ❒ Wanders off ❒ Illusions ❒ Disorientation (time, place, people)
❒ Delusions ❒ Confusion ❒ Forgetfulness ❒ Poor judgment
❒ Doesn't make sense ❒ Irritability ❒ Hallucinations
❒ Emotional turmoil ❒ Disorganized speech or behavior

❒ Other
_____

Describe:
_____

ADDITIONAL INFORMATION

Child/Adolescent Conduct Disturbance ❒ Yes ❒ No ❒ Unknown *(If Yes, mark appropriate statement(s) below)*
(Current Behavior or During Childhood)

❒ Theft ❒ Fire-setting ❒ Cruelty to people ❒ Cruelty to animals ❒ Destruction of property
❒ Aggression ❒ Arrest/detainment ❒ Combativeness/aggression ❒ Sexual high risk behavior
❒ Refusal to attend school ❒ Running away ❒ Defiance of authority and rules
❒ Possession/Use of weapons ❒ Frequent lying ❒ Reported sexual or physical abuse/neglect
❒ Other

NAME	ID NUMBER

Developmental Disability ❒ Yes ❒ No ❒ Unknown (*If Yes, mark appropriate statement(s) below*)

❒ History of special education placement
❒ Documented IQ score below a 70
❒ Inability to care for self or activities of daily living
❒ Significantly sub-average intellectual functioning before age 18
❒ Substantial limitations in adaptive skills (*communication, self-care, home living, social skills, community use, self-direction health and safety, leisure and work)*
❒ Other _____

Other ❒ Yes ❒ No ❒ Unknown (*If Yes, mark appropriate statement(s) below*)

❒ Anxiety ❒ Panic ❒ Eating disturbance ❒ Sexual problems ❒ Impulsive behaviors
❒ Obsessive behaviors ❒ Other _____

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)

_____

_____

_____

_____

_____ _____

Screener/Credentials Date Print Name

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.

Violence Risk Assessment for Certified Holding Facility

Detainee's Name _____

Date of Birth _____

Date _____

Name of Facility _____

Screening Officer _____

FEMALE ☐ **MALE** ☐ | **Most serious charge:**

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.	☐ **No** ☐ **Maybe** ☐ **Yes** ☐ **Do not know**
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	☐ **No** ☐ **Maybe** ☐ **Yes** ☐ **Do not know**
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.	☐ **No** ☐ **Maybe** ☐ **Yes** ☐ **Do not know**
4. Previous and/or current major mental illness Individual has or has had a psychotic disorder (schizophrenia, delusional disorder, psychotic affective disorder, other)	☐ **No** ☐ **Maybe** ☐ **Yes** ☐ **Do not know**
5. Personality Disorder Eccentric (schizoid, paranoid), impulsive, uninhibited (emotionally unstable, antisocial) types	☐ **No** ☐ **Maybe** ☐ **Yes** ☐ **Do not know**
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	☐ **No** ☐ **Maybe** ☐ **Yes** ☐ **Do not know**
7. Expresses suspicion Expresses verbal or nonverbal suspicion towards others; appears to be "on guard" toward environment/surroundings	☐ **No** ☐ **Maybe** ☐ **Yes** ☐ **Do not know**
8. Shows lack of empathy Appears emotionally cold, without sensitivity towards others' thoughts or emotional situations	☐ **No** ☐ **Maybe** ☐ **Yes** ☐ **Do not know**
9. Unrealistic planning Unrealistic plans for future. Unrealistic expectation of support from family and professional/social network. Assess ability to cooperate with/follow plans.	☐ **No** ☐ **Maybe** ☐ **Yes** ☐ **Do not know**
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.	☐ **No** ☐ **Maybe** ☐ **Yes** ☐ **Do not know**

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 _____

FEMALE ☐ **MALE** ☐ | **Most serious charge:**

Check YES or NO for each numbered item below. Each YES response requires support documentation

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

Name _____

ID Number _____

Date _____

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: _____

Life Story Narrative

Name _____

ID Number _____

Date _____

Adolescence (13-21 years)

Name and location of school (s): _____

Favorite/least favorite classes: _____

Friends/relationships: _____

Interests/hobbies/activities/sports/etc: _____

Behavior problems: _____

First Job: _____

Church (s) attended and activities: _____

School(s) attended: _____

House(s) lived in: _____

Town (s) lived in: _____

Pets: _____

Specific happy/sad events: _____

Other:

Life Story Narrative

Name _____

ID Number _____

Date _____

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: _____

Life Story Narrative

Name _____

ID Number _____

Date _____

Middle Age (40-65 years)

Work Role: _____

Family Role: _____

Marriage(s)/Relationship(s): _____

Family: _____

Grandchildren: _____

Clubs/community involvement: _____

Church (s) attended and activities: _____

Homes lived in: _____

Interests/hobbies/sports: _____

Town(s) lived in: _____

Pets: _____

Specific happy/sad events: _____

Other: _____

Life Story Narrative

Name _____

ID Number _____

Date _____

Later Years (66+ years)

Work Role: _____

Family Role: _____

Marriage(s)/Relationship(s): _____

Family: _____

Grandchildren: _____

Clubs/community involvement: _____

Life achievements and accomplishments: _____

Church (s) attended and activities: _____

Homes lived in: _____

Interests/hobbies/sports: _____

Town(s) lived in: _____

Pets: _____

Specific happy/sad events: _____

Other: _____

Life Story Narrative

Name _____

ID Number _____

Date _____

Questions to Enrich the Story

1. How would the individual have enjoyed spending holidays? (New Year's Eve, Christmas, Fourth of July, Memorial Day, etc.)?

2. What are their favorite books/music/artists/athletes/movies stars, etc?

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.)

4. How would the person's desk, kitchen shelves/drawers, tool box, etc., be organized?

5. Would he/she have looked at life thinking the glass is half-full (optimist) or half-empty (pessimist)?

6. Where did he/she travel?

7. What special skills did he/she have?

8. What special awards did he/she acquire?

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 of 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

MAP Team Name					
ID Number					
SED Dx					
ID/DD (Axis II) Dx					
Age		**Race**		**Sex**	
Transitional Needs? ☐ **Yes** ☐ **No**					

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

Name _____

ID Number _____

Date _____

Page of

Outcomes	Specific Activities

_____ _____ _____

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

Name _____

ID Number _____

Week 1	Activities				
Dates:	#1	#2	#3	#4	#5
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Staff Signature/Credential	Weekly Summary:				
Date:					

Week 2	Activities				
Dates:	#1	#2	#3	#4	#5
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Staff Signature/Credential	Weekly Summary:				
Date:					

Week 3	Activities				
Dates:	#1	#2	#3	#4	#5
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Staff Signature/Credential	Weekly Summary:				
Date:					

Early Intervention Activity Note

Name _____

ID Number _____

Week 4	Activities				
Dates:	#1	#2	#3	#4	#5
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Staff Signature/Credential	Weekly Summary:				
Date:					

Week 5	Activities				
Dates:	#1	#2	#3	#4	#5
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Staff Signature/Credential	Weekly Summary:				
Date:					

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

Name _____

ID Number _____

Program Name

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	**Objective 1:**	**Objective 2:**
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	

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

Name _____

ID Number _____

Date _____

Service _____

Page of

Outcomes	Specific Activities

_____ _____ _____

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

Name _____

ID Number _____

Service _____

Day of 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 Time																															

Week 1 Date:			Activities				
	Time in	Time out	#1	#2	#3	#4	#5
Mon							
Tues							
Wed							
Thurs							
Fri							
Staff Signature/Credential			Weekly Summary:				
Date:							

Week 2 Date:			Activities				
	Time in	Time out	#1	#2	#3	#4	#5
Mon							
Tues							
Wed							
Thurs							
Fri							
Staff Signature/Credential			Weekly Summary:				
Date:							

Week 3 Date:			Activities				
	Time in	Time out	#1	#2	#3	#4	#5
Mon							
Tues							
Wed							
Thurs							
Fri							
Staff Signature/Credential			Weekly Summary:				
Date:							

ID/DD Waiver Activity Note

Name _____

ID Number _____

Week 4 Date:			Activities				
	Time in	Time out	#1	#2	#3	#4	#5
Mon							
Tues							
Wed							
Thurs							
Fri							
Staff Signature/Credential			Weekly Summary:				
Date:							

Week 5 Date:			Activities				
	Time in	Time out	#1	#2	#3	#4	#5
Mon							
Tues							
Wed							
Thurs							
Fri							
Staff Signature/Credential			Weekly Summary:				
Date:							

Community Integration/Job Exploration Activities

Date	Day of Week	Activity	Location	Staff Signature/Credentials

Monthly Summary:

Key:

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

Name _____

ID Number _____

Date _____

Areas in Which Support/Assistance May Be Required (describe each)
Employment Interest
Communication
Grooming/Hygiene
Interpersonal/Social
Interview Skills
Application Process
Transportation
Time Management
Follows Rules
Changes in Routine
Accepts Criticism
Behavior
Express Opinions
Other

_____ _____

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.

Supported Employment Activity Note

Name: _____

ID Number: _____

Activity	Day/Date	Day/Date	Day/Date	Day/Date	Day/Date	Day/Date	Day/Date
■ 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 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 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

Name _____

ID Number _____

Page of

Outcomes	Specific Activities

_____
Individual/Legal Representative Signature

_____
Agency Representative Signature/Credentials

_____
Date

_____
Date

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.

ID/DD Waiver In-Home Nursing Respite Activity Note

Name _____

ID Number _____

Page of

Provider's Signature	Date	Time In	Time Out	Total Time	Individual/Legal Representative's Signature

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.

ID/DD Waiver Community Respite Activity Plan

Name _____

ID Number _____

Outcomes	Specific Activities

_____
Individual/Legal Representative Signature

_____
Agency Representative Signature/Credentials

_____
Date

_____
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

Name: _____

ID Number: _____

Activity	Day/Date	Day/Date	Day/Date	Day/Date	Day/Date	Day/Date	Day/Date
■ 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

Individual's Name	Medicaid Number

Service	Outcome of Service/Support

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 types(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: _____ From: _____

Name of Agency — Support Coordination Department

Re: _____ _____

Individual's Name — ID/DD Waiver Support Coordinator

_____ _____

Medicaid Number — ID/DD Waiver Support Coordinator Phone/e-mail

_____

_____

Individual's Address and Phone Number

☐ Change in type(s)/amount(s) of service

Procedure Code	Service	Amount	Frequency		Authorized Start Date	End Date
			---	---		
			---	---		
			---	---		
			---	---		
			---	---		
			---	---		
			---	---		

ID/DD Waiver Support Coordinator Comments/Information

Can the agency provide the service(s) requested? ☐ **Yes** ☐ **No**

Agency Comments

_____ _____

Signature of Authorized Agency Representative — **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

Name _____

ID Number _____

Service _____

Date	Notes	Signature/ Credentials

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

Individual's Name: _____

Healthcare Provider's Name: _____ **Office Phone:** _____

Healthcare Provider's Address: _____

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.

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

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**

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

Name _____

Assessment Date(s) _____

ID Number _____

DOB _____ Sex ☐M ☐F

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).

Behavior:

Topography	Frequency	Duration	Intensity

Behavior:

Topography	Frequency	Duration	Intensity

Behavior:

Topography	Frequency	Duration	Intensity

Behavior:

Topography	Frequency	Duration	Intensity

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)?

Name:

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.

6:00 am		3:00 pm	
7:00 am		4:00 pm	
8:00 am		5:00 pm	
9:00 am		6:00 pm	
10:00 am		7:00 pm	
11:00 am		8:00 pm	
12:00 pm		9:00 pm	
1:00 pm		10:00 pm	
2:00 pm		11:00 pm	

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.)

Name:

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)

A. Time of Day: When is the behavior(s) most likely and least likely to occur?

Most Likely

Least Likely

B. Setting: Where is the behavior most likely and least likely to occur?

Most Likely

Least Likely

C. Control: With whom is the behavior most likely and least likely to occur?

Most Likely

Least Likely

D. What activity is most likely and least likely to produce the behavior(s)?

Most Likely

Least Likely

E. 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.)?

F. What would be the one thing you could do that would be most likely to make the undesirable behavior(s) occur?

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?).

Behavior	What does he/she get?	What does he/she avoid?

Behavior	What does he/she get?	What does he/she avoid?

Behavior	What does he/she get?	What does he/she avoid?

Behavior	What does he/she get?	What does he/she avoid?

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?

Name:

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?

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

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.

	Behavior	How long has this been a problem?	Programs	Effect
1.				
2.				
3.				
4.				
5.				

ID/DD Waiver Behavior Support/Intervention Assessment Summary/Recommendations

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

Name _____

ID Number _____

Date _____

Agency _____

The individual listed above received the following assessments:

Date	Assessment Procedure	Location	Conducted By

Based upon the conducted assessments, the following behaviors were most prominent:

Behavior	Function	Location

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:

Behavior	Risk to Self	Risk to Others

	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

Name _____

ID Number _____

Date _____

Page of

Initiation Date:	Estimated Completion Date:

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

Name _____

ID Number _____

Date _____

Page of

Steps and Methods

When this behavior occurs:	The Interventionist will:

ID/DD Waiver Behavior Support/ Intervention Plan

Name _____

ID Number _____

Date _____

Page of

Risk Containment Strategies
(least to most pattern of intrusiveness)

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.

ID/DD Waiver Behavior Support/Intervention Note

Provider's Signature	Date	Time In	Time Out	Total Time	Individual/Guardian Initials

Notes

Provider's Signature	Date	Time In	Time Out	Total Time	Individual/Guardian Initials

Notes

Provider's Signature	Date	Time In	Time Out	Total Time	Individual/Guardian Initials

Notes

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

Name _____

ID Number _____

Time In _____ Time Out _____ Total Time _____

Educational Activities	Date Completed
1. HIV/AIDS Information (modes of transmission and universal precautions)	
2. Sexually Transmitted Diseases (STDS)	
3. Tuberculosis	
4. MS Implied Consent Law	
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.	

Individual Receiving Services	Date	Staff Signature/Credentials	Date

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

Name _____

ID Number _____

Time In _____ Time Out _____ Total Time _____

1.	Have you ever lived on the street or in a shelter?	❑Yes	❑No
2.	Have you ever been incarcerated?	❑Yes	❑No
3.	Have you ever been told that you have a positive HIV test? (test for the AIDS virus)	❑Yes	❑No
4.	Have you ever been diagnosed with or treated for tuberculosis (TB)?	❑Yes	❑No
5.	Has anybody you know or have lived with been diagnosed with TB in the past year?	❑Yes	❑No
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.	❑Yes	❑No
	❑ Fever ❑ Drenching night sweats ❑ Coughing up blood		
	❑ Losing weight ❑ Shortness of breath ❑ Lumps or swollen glands		
	❑ Diarrhea lasting more than one week		
b.	Are you now living with someone with any of the following?	❑Yes	❑No
	❑ Coughing up blood ❑ Drenching night sweats ❑ Active TB		
7.	Have you ever used needles to shoot drugs?	❑Yes	❑No
8.	Have you used cocaine, coke or crack?	❑Yes	❑No
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?	❑Yes	❑No
10.	Have you been diagnosed with or treated for hepatitis and/or a sexually transmitted disease?	❑Yes	❑No

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 _____

Time In _____ Time Out _____ Total Time _____

	New Admission		Readmission		Rewrite

Date

Strengths/Challenges

_____

_____

_____

_____

_____

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:					
		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

	Mental Health		Parenting Classes		Voc-Rehab		Food Stamps
	Medicaid		Medical Care		Aftercare		
	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.

Individual Receiving Services	Aftercare Counselor/Credential
Parent/Legal Guardian	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 _____

County _____

Case Number _____

Person completing form _____

Phone number _____

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 ☐ One biological parent
   ☐ Both foster parents ☐ One foster parent
   ☐ Both adoptive parents ☐ One adoptive parent
   ☐ 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

FASD Data Tool: Section C

CMHC/Agency _____

County _____

ID Number _____

Person Completing Form _____

Phone number _____

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.

Therapeutic Foster Care Contact Log

Foster Parent's Name _____

Foster Parent's Case Number _____

Date	Type of Contact (in-home, monthly group, meeting, other)	Total # of children/youth in the home	Total # of children/youth with SED in the home	Staff Signature/ Credential

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) _____ **Type of Disaster:** _____

COOP (annually for all programs) _____

(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 : _____

Substance Abuse Monthly Capacity Management and Waiting List Reports

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

Date _____
Time of Contact _____
Type of Contact _____
Facility Name _____

Client Information	
Name	
Address	
Telephone Number	
Other Contact Information	

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

Date _____
Time of Contact _____
Type of Contact _____
Facility Name _____

Client Information	
Name	
Address	
Telephone Number	
Other Contact Information	

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

Substance Abuse Capacity Management

Timeline within 7 days

Facility Name _____

Date _____

- ❑ 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
Mshelpline@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

MAP Team _____

Months/Quarter

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:

	Mental Health Center in your county		Mental Health Center Region-Wide
	DHS - Family & Children's Services		Youth Court
	Therapeutic Group Home		Therapeutic Foster Care
	Acute Psychiatric Hospital		Psychiatric Residential Tx Facility
	Local School District		Parent(s)
	Faith-Based Agency/Church		A.O.P
	MYPAC		College/University
	Substance Abuse Residential Facility		Other (specify)

MAP Team Member Participation

Check the following agencies that were represented at your MAP Team Meeting(s) for the quarter

	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.)		
	Community Mental Health Center		DHS – Family & Children Services
	Youth Court		Local School District
	Vocational Rehabilitation		Health Department
	Boys & Girls Club		Law Enforcement
	Substance Abuse Residential Facility		A. O. P.
	Youth Villages		MYPAC
	Faith-based Agency/Church		Other (specify)

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 <u>all</u> 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:**

Provider Name:		**Phone:**	
Provider Contact Person for follow-up:		**Fax:**	
		Email:	

Finding (DMH Standard Number)	Program/Service/ Record	Corrective Action(s)	Time Line	Plan for Continued Compliance
			Implementation Date: Projected Completion Date:	
			Implementation Date: Projected Completion Date:	
			Implementation Date: Projected Completion Date:	
			Implementation Date: Projected Completion Date:	