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

2015 Revision

Mississippi Department of Mental Health
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Section A
General Information

2015 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 single case 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. All completed documentation should be present in the individual's record no later than the 10th day of the following month to the service delivered unless more stringent timelines are required by DMH.

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.

Each form has specific guidance that states the purpose of the form/data tool. Also included in the guidance are references to the DMH Operational Standards 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.**

The legal guardian or conservator of an individual receiving service(s) must review and sign the paperwork required in order for an individual to receive services.

Should the individual's legal guardian or conservator choose to delegate his/her responsibility and signatory authority to another individual for the completion of daily paperwork (including delegating signature authority to the individual being served), DMH will accept the signature of that individual. The legal guardian or conservator must provide **written documentation** of such delegation and to whom the signatory authority is being delegated. This must be maintained in the individual's record. Daily signature authority cannot be delegated to the service provider. However, the legal guardian or conservator must continue to sign annual paperwork, such as the Consent for Services and Individual Service Plan.

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 or position.

Billing

All questions concerning billing should reference the funding source. Questions concerning Medicaid 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 Records

Face Sheet

Consent to Receive Services

Rights of Individuals Receiving Services

Acknowledgment of Grievance Procedure

Consent to Release/Obtain Information

Initial Assessment

Trauma History

Medication/Emergency Contact Information

Individual Service Plan

Individual Crisis Support Plan

Support Implementation Plan for Recovery/ Resiliency

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Progress Note

Weekly Progress Note

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.

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 and/or at least annually. When changes in information or data are made, or at the annual update, a new/corrected Face Sheet must be dated and 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 44 data elements required in the DMH Manual of Uniform Data Standards.

The required elements of the Face Sheet are provided on the following page. Providers should reference the DMH Manual of Uniform Data Standards for applicable codes and should consult with the agency employee responsible for data submission. Providers can also contact DMH Division of Information Services for additional guidance, 601-359-1288.

Required Data Elements for Face Sheet

1. Record transaction type (add, change, delete)
2. Organization code
3. Unique client ID within organization
4. Client status
5. Admission date (most recent) to organization
6. Admission type (primary, collateral, unregister)
7. Admission referral category
8. Admission referral organization code (DMH only)
9. Legal status of client at admission
10. Client last name
11. Client first name
12. Client maiden name (if applicable)
13. Social Security Number (unique client identifier)
14. Birth date
15. Age of client (calculated from birth date)
16. Sex
17. Race
18. Hispanic origin
19. Education level: last grade completed
20. Marital status
21. County of residence prior to admission
22. Living arrangement
23. Type of residence
24. Employment status
25. Primary source of household income
26. Household annual income amount
27. No. of persons in household dependent on income
28. Is the individual pregnant?
29. Eligibility for SSI/SSDI
30. Eligibility for Medicaid
31. Expected principle source of payment
32. Veteran status
33. Physical impairment (1 of 2)
34. Physical impairment (2 of 2)
35. Presenting problem (1 of 2)
36. Presenting problem (2 of 2)
37. Treatment category (MH, IDD, SA, dual)
38. Primary treatment category (if dual)
39. Is client seriously mentally ill (Y/N)

40. Is client seriously emotionally disturbed child?
41. Medicaid number
42. State ID (generated by CDR upon 1st submission)
43. Client receives integrated treatment
44. Indicates whether client receives ACT/PACT Assertive Community Treatment

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 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 and the limits of confidentiality must be clearly explained to the individual receiving services and/or a person authorized to act on his/her behalf.

Signatures
If the individual receiving services is unable to sign and the form is being signed by a court ordered (legal) guardian/conservator, a copy of guardianship/conservatorship papers must be maintained in the record.

The Consent to Receive Services, Rights of Individuals Receiving Services and Acknowledgment of Grievance forms can be combined into one document as long as space is included in the document for signature or initials of the individual receiving services or legal guardian to acknowledge each separate action.

Consent To Receive Services

Name _____

ID Number _____

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.

I understand that I have the freedom of choice to receive services in a setting that is integrated in and supports full access to the greater community; and is a setting that facilitates individual choice regarding services and supports, and who provides them.

I understand that State and federal laws and regulations prohibit any entity receiving confidential information from redistributing 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 that confidential information may be released without my consent when necessary for continued treatment; when release is necessary for the determination of eligibility for benefits, compliance with statutory reporting requirements, or other lawful purpose; if you communicate to the treating physician, psychologist, master social worker or licensed professional counselor an actual threat of physical violence against a clearly identified or reasonably identifiable potential victim or victims; in compliance with reporting requirements under state law of incidents of suspected child abuse or neglect, or by court order.

Individual/Legal Representative Signature	Staff Signature/Credentials	Date

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 during the intake process 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, read 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. Signed documentation of receipt must be maintained in the record. Providers may omit #18-22 if those service types are not provided by the agency.

The Consent to Receive Services, Rights of Individuals Receiving Services and Acknowledgment of Grievance forms can be combined into one document as long as space is included in the document for signature or initials of the individual receiving services or legal guardian to acknowledge each separate action.

Rights of Individuals Receiving Services

Name _____

ID Number _____

I, _____ began receiving services provided by _____
Name — Name of Provider

on _____ and have been informed of the following:
Intake/Admission Date

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 at the local level or with the DMH Office of Consumer Support
8. My right to privacy and confidentiality in respect to facility visitors in day programs, residential treatment programs, and community living 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 or Activity Plan. 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 case 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 treatment 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		

Acknowledgment of Grievance Procedures

Purpose

The provider's grievance procedures must be provided to the individual and/or legal representative during the intake process. 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. A copy of the Grievance Procedures given to the individual receiving services should be attached and kept with the signed form.

The Consent to Receive Services, Rights of Individuals Receiving Services and Acknowledgment of Grievance forms can be combined into one document as long as space is included in the document for signature or initials of the individual receiving services or legal guardian to acknowledge each separate action.

# Acknowledgment of Grievance Procedures	**Name** _____ **ID Number** _____

I have been informed of the policies and procedures for reporting a 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 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. Staff must 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.

The actions, conditions and limits of the consent must be clearly explained to the individual receiving services and/or to a person who is legally authorized to act on his/her behalf.

The provider must clearly explain the conditions under which confidential information may be released without consent. Confidential information may be released without consent when necessary for continued treatment; when release is necessary for the determination of eligibility for benefits, compliance with statutory reporting requirements, or other lawful purpose; if you communicate to the treating physician, psychologist, master social worker or licensed professional counselor an actual threat of physical violence against a clearly identified or reasonably identifiable potential victim or victims; in compliance with reporting requirements under state law of incidents of suspected child abuse or neglect or by court order.

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. A second witness to the individual’s signature is required in this case.

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
❑ Progress Notes
❑ Substance Abuse Records
❑ Contact Summaries
❑ Identifying Information
❑ Other _____
❑ Diagnosis/Prognosis/Recommendations
❑ Psychiatric Records
❑ Admission/ Discharge Summary
❑ Activity Plan
❑ 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, Individual or Legal Representative 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 redistributing 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 diseases and alcohol/drug abuse or dependency.

I understand that confidential information may be released without my consent when necessary for continued treatment; when release is necessary for the determination of eligibility for benefits, compliance with statutory reporting requirements, or other lawful purpose; if you communicate to the treating physician, psychologist, master social worker or licensed professional counselor an actual threat of physical violence against a clearly identified or reasonably identifiable potential victim or victims; in compliance with reporting requirements under state law of incidents of suspected child abuse or neglect or by court order.

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 ID/DD Waiver or 1915(i) Services. The ID/DD Evaluation performed by the Diagnostic and Evaluation team to determine eligibility for the ID/DD Waiver or the 1915(i) Community Support Program takes the place of the Initial Assessment.

Responses of "No" or "Not Present", are acceptable. If an entire section does not apply to someone, the recorder can enter "Not Applicable." However, if the answer is "Yes" or "Present", then additional narrative and explanation is required.

Timeline

The Initial Assessment is part of the intake process. See the Record Guide Timeline Reference for additional timeline requirements.

Admission Date

Enter the date the individual was admitted to service(s).

Assessment Date

Enter the date the Initial Assessment was started.

Informant

If assessment information is provided by someone other than the individual receiving services, enter the person's relationship to the individual requesting services. A Consent to Release/ Obtain Information must be completed if applicable.

Legal Information

If individual has a legal guardian record name and contact information.

Confidentiality

Mark yes if limits of confidentiality are discussed with individual/guardian. If not, mark no with an explanation.

Description of Need

Record the reason(s) the individual gives as to why he/she is seeking services, current needs, goals etc.

Social / Cultural

Complete social information, current living situation, and family history sections as applicable with information provided by the informant.

History

Complete the history section as applicable with information provided by informant.

The *developmental history section* should be completed for Children and Youth up to age 21 and all individuals with IDD.

The *educational/vocational history section*, *special communication needs section*, *the previous assessment history section, current legal status section and history of legal charges section* should be completed for all individuals.

The *school functioning section* and *additional information section* should be completed for all Children and Youth up to age 21.

The *educational information section*, *history of learning difficulties section, employment section and military section* should be completed for adults.

All items in the history sections must be completed. Responses of "No" or "Not Present", are acceptable. If an entire section does not apply to someone, the recorder can enter "Not Applicable." However, if the answer is "Yes" or "Present", then additional narrative and explanation is required.

Medical History

Complete the primary care physician information, additional medical information and previous medication sections as applicable with information provided by informant.

All items in the history sections must be completed. Responses of "No" or "Not Present", are acceptable. If an entire section does not apply to someone, the recorder can enter "Not Applicable." However, if the answer is "Yes" or "Present", then additional narrative and explanation is required.

Individual Mental Health History

Complete the outpatient mental health, psychiatric hospitalization/ residential treatment and substance use sections as applicable with information provided by informant.

All items in the history sections must be completed. Responses of "No" or "Not Present", are acceptable. If an entire section does not apply to someone, the recorder can enter "Not Applicable." However, if the answer is "Yes" or "Present", then additional narrative and explanation is required.

Initial Behavioral Observation

Record observations for all areas listed. <u>All areas</u> must be evaluated. Comments must be included to further explain or clarify the specific observed behaviors.

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.

The Child and Adolescent Functional Assessment Scale (CAFAS) is required for all children/youth receiving mental health services. The CAFAS must be completed within 60 days for all children/youth receiving mental health services.

An approved functional assessment is required for all adults receiving mental health services. An approved functional assessment must be completed within 60 days for all adults receiving mental health services. DMH will review and approve a functional assessment for use with the adult SMI population.

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.

Initial Diagnostic Impression

Give the written diagnostic impression and appropriate codes.

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: Age: Gender: Race/Ethnicity:

LEGAL INFORMATION

Name of Guardian / Custodian:	Guardianship Documentation Verified: ☐ Yes ☐ No
Guardian / Custodian Address:	Guardian / Custodian Phone Number:

CONFIDENTIALITY

Were the limits of confidentiality reviewed with Individual and/or Guardian? ☐ Yes ☐ No
If NO, please explain.

DESCRIPTION OF NEED

What is your reason for seeking services today?

What specific needs do you currently have?

What are your hopes / dreams / goals?

What previous coping skills have been helpful in the past?

Description / Perception of difficulties according to the INDIVIDUAL?

Description / Perception of difficulties according to the FAMILY / GUARDIAN?

SOCIAL / CULTURAL

Social Information

Primary / Family / Marital / Significant Other support systems:

Friendship / Social / Peer support relationships:

Meaningful Activities:

Community Supports / Self-Help Groups (AA, NA, NAMI, etc.):

Social / Interpersonal relationships:

Cultural / Ethnic / Spiritual interests, supports, needs:

Community Needs (social supports, interpersonal, protective care, support groups, counseling, legal assistance, other):

Living Situation

Current Living Situation:

What are your views on your current living arrangements (strengths and concerns)?

Individuals Living in Household

Individual	Relationship to Client	Age	Quality of Relationship According to the person (circle one)
			Good Fair Poor
			Good Fair Poor
			Good Fair Poor
			Good Fair Poor
			Good Fair Poor

Secondary Household (Minor Only)

Individual	Relationship to Client	Age	Quality of Relationship
			Good Fair Poor
			Good Fair Poor
			Good Fair Poor
			Good Fair Poor

(For minors only) Are there family members that live in both households? (If yes, list names below)

Additional Family Members involved in care/support (i.e., parents or siblings not living in primary or secondary households):

Family Financial Concerns / Household Needs (money management, benefits, living arrangements, clothing, personal care, child care, rent, other)

Family History

Is there any family history of :

If yes, list below:	Parent	Sibling	Other
Alcohol Abuse			
Substance Use			
Mental Health Issues			
Health Problems			
Disability			
Legal Issues			

HISTORY

Developmental History

(Complete only for Children & Youth up to age 21 and everyone with ID/DD)

During pregnancy, did mother use drugs?

Describe any problems with the pregnancy or birth:

What was birth weight and length?

At what age did the child:

Sleep through the night?	Crawl?	Walk?	Say first words?	Toilet trained?

Was the child's first year of life difficult, easy, other?

Describe any childhood accidents or injuries:

Educational / Vocational History (Complete for all)
Education / Vocation Needs (employment assistance, education, vocational training, early intervention, other)
Barriers to learning:

Special Communication Needs (Complete for all)			
Special Communication Needs:			
	TDD / TTY Device		Assistive Listening Device [s]:
	Sign Language Interpreter		Language Interpreter Services Needed: Other spoken Language:
	Other:		

School Functioning (Children & Youth up to age 21)	
Name of school:	Current grade or equivalence:
Does client receive Special Education Services? □ Yes □ No	

	Multiple disabilities (not deaf-blind)		Orthopedic Impairment		Traumatic Brain Injury
	Emotional Disturbance (SBH)		Other Health Impairment		Deafness (hearing impairment)
	Intellectual Disability (MH)		IEP/IFSP Established		Visual Impairment
	Specific Learning Disability		Current Behavior Plan:		

Additional Information (Children & Youth up to age 21)			
Comments on Educational Classification / Placement (please indicate if client is home schooled, in gifted program, etc.):			
Grades:	Attendance:	Previous Grade Retentions:	Suspensions / Expulsions:
Other Academic / School Concerns:			

Educational Information (Adults Only)		
High School:	Highest Grade Completed:	Vocational Program and Year Completed:
College Attended:	College Years Completed:	Degree / Major:

History of Learning Difficulties (Adults Only) (including performance / behavioral problems due to alcohol and other drugs used)	
	Learning Disability / Type:
	Developmental Disabilities:

	Special School Placement:
	Other:

Previous Assessment History (If available)

□ Yes □ No	Psychological Instrument: Name_____ Date Administered_____ Results:	
□ Yes □ No	Educational Instrument: Name_____ Date Administered_____ Results:	
□ Yes □ No	Speech/Language Assessment: Name_____ Date Administered_____ Results:	
□ Yes □ No	Functional Assessment: Name_____ Date Administered_____ Results:	

Employment (Adults only)

Current Employment: □ Yes □ No	Name of Employer:
Is Individual satisfied with job: □ Yes □ No	Position Type:
If Unemployed, last date worked:	Number of Jobs in last 5 years:
Reason for Unemployment:	Comments (include performance/behavioral problems due to A&D use):

Are you experiencing financial problems?

Are you having difficulty maintaining occupational functioning?

Are you having difficulty with working relationships?

Military (Adults only)

Military Status:	Date of Discharge:	Type of Discharge:

Describe the branch of service, any pertinent duties, and any trauma experienced during service as applicable:

Are you receiving services from Veterans Affairs?

Contact Name: Phone Number:

Current Legal Status

□ No Current Legal Status Reported	Number of arrests in the past 30 days:

Detentions:

Awaiting Charges:
Substance Use Related Legal Issues:
Conditional Release:
Civil Commitment: Number of Days for Civil Commitment:_____
Court Ordered to Treatment:
Drug Court:
Probation/Parole: Name of Officer: Officer's Phone Number:
Domestic Relations Court Issues (i.e., custody, protective services, restraining orders):
Child Support Enforcement Order:
Court Issues:

History of Legal Charges

□ No History of Legal Charges Reported
List and Date Most Recent Legal Charges: Dates: Charges:

Convictions □ Yes □ No	Explanation / Description:
Incarcerations □ Yes □ No	Explanation / Description:

History of Legal Charges as an Adult:
History of Juvenile Legal Charges:
Juvenile Court Involvement:
DHS Involvement with Family: DHS Caseworker Name: DHS Caseworker's Phone Number:
Guardian Ad Litem (GAL) or Court Appointed Special Advocate (CASA) Assigned to Family:

MEDICAL HISTORY

□ No Known Drug Allergies

Allergies (include food/drug reactions):	Onset Date:	Reaction:

(For women only) Are you pregnant?

Physical Impairments:

Surgeries (include date of surgery):

Special Diets:

Appetite Issues:

Sleep Issues:

Current or Chronic Diseases (high blood pressure, cancer, etc.):

Other Pertinent Medical Information:

Primary Care Physician Information

Primary Care Physician (PCP):	Date of Last Physician Visit:
Other Prescribing Physicians:	Reason for Last Physician Visit:

Additional Medical Information

Immunizations (current, not current, needed):
Flu:
Tetanus-Diphtheria:
Others:

When did you last receive:

Routine Physical Exam:	Eye Exam (every 2 years):	Pelvic Exam / Pap Smear (Females 21 & up):
Blood pressure:	Dental Exam (yearly):	Mammogram (Females 40 & up):
Diabetes:	Colon (age 50 & up):	Breast exam (Females 20 & up):
Cholesterol:	Osteoporosis:	Prostate (Males 50 & up):

Refer for Medical Evaluation – Site, Resources, Follow Up, Instructions, Appointments:

Service: Provider Name: Date: Time: Location:	Service: Provider Name: Date: Time: Location:

Additional Medical History or Health and Safety Issues:

Health Needs (dental, medical, medication, substance use, adaptive equipment, therapy, behavior support, other):

Previous Medication (Prescription / OTC / Herbal)
(Record current medications on the Medication / Emergency Contact Information Form)

Medication	Directions to Patient	Comments

Adverse Reactions to Medications:

INDIVIDUAL MENTAL HEALTH HISTORY

Previous or Current Diagnoses:

Mental Health Needs:

Outpatient Mental Health Treatment Agency		
□ None Reported		
Treatment Agency	Dates of Service	Consent to Communicate

Psychiatric Hospitalizations / Residential Treatment			
□ None Reported			
Treatments	Reason (suicidal, depressed, etc.)	Dates of Service	Consent to Communicate

Substance Use History				
Substances Used (list separately):	Age of Onset:	How Much:	How Often:	Method of Use:

Resulting Circumstances:
Recovery Needs:

Initial Behavioral Observations	
General Observations	Appearance:
	Build:
	Demeanor:
	Eye Contact:
	Activity:
	Speech:

Thought Content	Delusions:
	Other:
Perception	Hallucinations:
	Other:
Thought Process	
Mood	
Affect	
Behavior	
Cognition	Impairment of:
Other Observations:	
Attempts of Suicide:	
Attempts / Acts of Self-Harm:	
Attempts / Acts of Violence / Homicide to others:	

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.)

SUMMARY / RECOMMENDATIONS

INITIAL DIAGNOSTIC IMPRESSION

Codes:	Description:

SIGNATURES / CREDENTIALS

X	Date:	X	Date:
X	Date:	X	Date:

Trauma History

Purpose

The Trauma History is a screening tool designed to determine whether or not an individual receiving services has experienced trauma in the past. This tool is not a standardized measure and there are no scoring guidelines. This assessment should be administered in an interview format that allows the clinician to explain questions in a developmentally appropriate manner to ensure the client understands what is being asked. The interview process also allows the clinician to observe nonverbal responses to questions that might indicate a trauma response such as anxiety, fear, avoidance, shame, etc.

General

The timeline for completion of the Trauma History is determined by the type of service or program the individual is entering.

All individuals receiving services must complete a trauma history questionnaire. Outpatient Services must complete the trauma history questionnaire within 30 days, Day programs must complete the trauma history questionnaire within 3 days of admission. Primary Residential Services within 5 days of admission to the services. Crisis Stabilization Services must complete the trauma history questionnaire within 48 hours. Results of trauma history questionnaire should be incorporated into ISP and subsequent services.

The Trauma History Assessment is not a tool for gathering information or details about the traumatic event. The clinician should maintain a neutral tone when asking each question. If the client indicates he/she has experienced an event, then the therapist only asks at what age the traumatic event(s) started and ended. If the client offers more information, the clinician captures that content but does not attempt to elicit more details than offered, challenge nor process the information shared.

If the client reports a positive trauma history, the clinician asks the client to identify the trauma that is most distressing at that time. The identified trauma is then incorporated into the Individual Service Plan and subsequent services and can be referred to when administering formal trauma assessments.

Trauma History

Name _____

ID Number _____

Date _____

Time In: Time Out: Total:

Please indicate if any of the following have happened to you and how it may have affected you.

Have you ever seen or been in a really bad accident?

Has someone close to you ever been so badly injured or sick that s/he almost died?

Has someone close to you ever died?

Have you ever been so sick that you or the doctor thought you might die?

Have you ever been unexpectedly separated from someone who you depend on for love or security for more than a few days?

Has someone close to you ever tried to kill or hurt him/herself?

Has someone ever physically hurt you or threatened to hurt you?

Trauma History

Name _____

ID Number _____

Have you ever been mugged or seen someone you care about get mugged?

Has anyone ever kidnapped you?

Have you ever been attacked by a dog or other animal?

Have you ever seen or heard people physically fighting or threatening to hurt each other? (In or outside of the family)?

Have you ever witnessed a family member who was arrested or in jail?

Have you ever had a time in your life when you did not have a place to live or enough food?

Has someone ever made you see or do something sexual? Or have you seen or heard someone else being forced to do sex acts?

Have you ever watched people using drugs, like smoking drugs or using needles?

Staff Signature/Credential _____ 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 intake process. 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/discontinuation of a medication) must write the date the changes were made and sign 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 Signature/Date Initiated

Each medication entry must be signed 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 prescribed. If there are no prescribed or OTC medications, the person completing the form must write "no prescription or OTC meds" and his/her initials.

Date Terminated/Changed/Staff Signature

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 discontinued. The staff person entering the information must sign 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: _____

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

Known Allergies/Reactions:

Emergency Information:

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

Name:

Phone Number: **(primary)** _____ **(secondary)** _____

Address:

Primary Doctor:

Doctor's Phone:

Doctor's Address:

Hospital Preference:

Insurance Carrier(s):

Policy Number(s):

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/ receiving 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, legal guardian or conservator must participate in planning on the individual's behalf.

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 but at least annually. For service specific requirements, see "Record Guide Timeline Reference."

Individual Strengths

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

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).

Identified Barriers

List barriers that may prevent the individual from achieving successful outcomes. Barriers must include but are not limited to functional impairments in basic living skills, instrumental living skills or social skills, as indicated by an assessment instrument/ approach approved by DMH.

Individualized Areas of Need

Refer to the Initial Assessment to identify symptoms, observable behaviors, clinical areas of need 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 areas of need should serve as the focus of treatment, services and supports for individuals.

Interventions, Criteria/Outcomes, Initiation and Target Dates

In order to effectively work toward achieving the long term and short term goal(s) identified by the individual receiving services, the objectives and interventions must be measurable. Each objective and intervention must have specific criteria or outcomes which clearly indicate an objective has been reached or an intervention has been completed. Each intervention must be

numbered, assigned to a service area (eg. Peer Support Services, Therapy Services, Community Support Services, etc) and have a specified target date for achievement or completion. Services identified and certified as necessary must be provided to the individual. **All services that the individual is receiving must be indicated in relation to an objective/ intervention.**

Diagnosis

Give the written diagnosis and appropriate codes for the individual receiving services.

Community Supports

Community Support Services must be made available to the following populations: adults with serious mental illness and children/youth with serious emotional disturbance. If the individual refuses Community Support Services, the refusal must be documented in writing. 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 Psychologist, a Psychiatric/Mental Health Nurse Practitioner, a Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Counselor, Physician Assistant 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:_____ Admission Date:_____ Date of Plan Implementation_____

☐ New ☐ Re-Write ☐ Addendum

INDIVIDUAL'S STRENGTHS

LONG TERM GOALS	SHORT TERM GOALS

IDENTIFIED BARRIERS
(Based on Functional Assessment)

INDIVIDUAL'S AREAS OF NEED

INDIVIDUALIZED PLAN FOR SERVICES

Objective #1:

Interventions	Service Area Assigned	Criteria / Outcomes for Completion	Initiation Date:	Target Date:
1.				
2.				
3.				

Objective #2:

Interventions	Service Area Assigned	Criteria / Outcomes for Completion	Initiation Date:	Target Date:
1.				
2.				
3.				

Objective #3:

Interventions	Service Area Assigned	Criteria / Outcomes for Completion	Initiation Date:	Target Date:
1.				
2.				
3.				

DIAGNOSIS

Primary Diagnosis(es)	
Secondary Diagnosis(es)	

Community Support has been offered to me and I choose:

☐ **YES**, I do want to participate (see Support Implementation Plan for Recovery/ Resiliency)

_____(initials of individual receiving services)

☐ **NO**, I do NOT want to participate

_____ (initials of individual receiving services)

_____	_____	_____	_____
Individual Receiving Services	Date	Parent / Legal Guardian	Date

_____	_____	_____	_____
Signature / Credentials	Date	Signature / Credentials	Date
_____	_____	_____	_____
Signature / Credentials	Date	Signature / Credentials	Date
_____	_____	_____	_____
Signature / Credentials	Date	Signature / Credentials	Date
_____	_____	_____	_____
Signature / Credentials	Date	Signature / Credentials	Date
_____	_____	_____	_____
Signature / Credentials	Date	Signature / Credentials	Date

_____ _____

Physician / Clinical Psychologist / Nurse Practitioner, LCSW, LMFT, LPC, PA, Alzheimer's Day Program Supervisor — Date

Individual Crisis Support Plan

Purpose
Providers must develop an Individualized Crisis Support Plan for each individual receiving services in all populations served, including SMI, SED, IDD and Substance Use Disorders.

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 within 30 days of admission for all individuals receiving services except those individuals admitted through crisis services. Crisis Support Plans must be developed for individuals admitted through crisis services within 72 hours of admission.

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. The Plan development team members must have at least a Bachelor's degree in mental health or a related field and 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 Individual Receiving Services	Date	Signature/Position	Date
Signature/Position	Date	Signature/Position	Date

Support Implementation Plan for Recovery/Resiliency

Purpose

The Support Implementation Plan for Recovery/Resiliency should be completed with the Individual Receiving Services and is used as a tool to assist the individual in making plans to engage in activities and access resources designed to help support him/her in achieving and maintaining recovery/resiliency. The Support Implementation Plan for Recovery/ Resiliency replaces the previous Community Support Plan and the Substance Abuse Recovery Support Plan. This plan is meant to be a flexible document that expounds upon the information provided in the Individual Service Plan (ISP). This documentation is required for individuals receiving Community Supports Services, Recovery Supports Services and Peer Support Services but can be used in conjunction with any individual's ISP.

The Support Implementation Plan for Recovery and Resiliency must be developed within 30 days of admission for all individuals receiving services.

The Support Implementation Plan for Recovery and Resiliency must be developed by the team of individuals who will have responsibilities for implementing the Plan during service delivery. The Plan development team members must have at least a Bachelor's degree in mental health or a related field and must sign the Support Implementation Plan for Recovery and Resiliency where indicated.

Needs Statement from ISP

Record the individual's Needs Statement from their Individual Service Plan.

Recovery/Resiliency Goal from the ISP

Record the individual's Recovery/Resiliency Goal from the Individual Service Plan.

Objectives:

All Support Implementation Plans for Recovery/Resiliency must have individualized objectives and they must be measurable. Record what the individual hopes to accomplish or achieve while receiving Support Services.

Strategies:

Describe the strategies or activities that the individual will complete to achieve the desired outcome.

Who is responsible?

Who is responsible for assisting with the completion of these objectives? This can be the individual themselves, a natural support, or a staff member. Record the person or persons responsible.

Target completion date

Explain how often activities will be conducted and the expected completion date.

Signatures

The date, signature, and credentials (if applicable) of all persons responsible for completing objectives should be recorded.

Support Implementation Plan for Recovery/ Resiliency

Name:_____

ID Number:_____

Needs Statement from ISP:

Recovery/ Resiliency Goal from ISP:

Objectives:

Strategies:

Who is responsible:

Target Completion Date:

_____	_____	_____	_____
Individual Receiving Services	Date	Parent / Legal Guardian	Date
_____	_____	_____	_____
Direct Service Provider/ credential	Date	Direct Service Provider/ credential	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 for adults and every six months for children and youth.

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 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 Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Counselor, Physicians Assistance 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

Progress Note

Purpose
All programs must document single therapeutic support interventions and activities that take place with/for an individual. The Progress Note can also be used “as needed” to provide supplemental documentation that cannot be adequately captured in the Weekly Progress Note.

Location
Document the location where services were provided.

Time
Document the time services began and ended along with the total amount of time services were provided.

General
Providers must document therapeutic interventions and activities (such as outpatient therapy, community support services, supported and supervised living services) utilizing the SAP format.

Summary should address the summary of activities related to the service being provided for each contact/ service event.

Assessment should address the progress made, or lack of progress made, toward the goals and objectives on the plan directing the treatment, services and/or supports for the individual (ex. ISP).

Plan should address the plan for future activities related to the service. This can include staff or individual activities.

Signatures
Staff completing the Progress Note must sign and date the form at the end of each note. The signature of a supervisor is not required but can be used to document supervision of provisionally credentialed staff.

Progress Note

Name _____

ID Number _____

Service Type _____

Day / Date	Location	Time Began (am/pm)	Time Ended (am/pm)	Total Time

S:

A:

P:

Provider Signature/Credentials

Supervisor Signature (if applicable)

Day / Date	Location	Time Began (am/pm)	Time Ended (am/pm)	Total Time

S:

A:

P:

Provider Signature/Credentials

Supervisor Signature (if applicable)

Weekly Progress Note

Purpose
Providers must maintain documentation to verify each individual's weekly and monthly progress toward the areas of need identified on his/her Individual Service Plan.

Time
Document the time services began and ended along with the total amount of time services were provided. Indicate if an individual is absent or if it is a weekend.

Weekly Documentation
The provider must document in SAP format the activities an individual participates in or completes during the week. All activities must be listed including, community integration, job exploration, therapeutic activities, etc. Activities should be related and documented to an individual's goals/objectives/outcomes stated on the Individual Service Plan.

Staff completing the Weekly Progress Note must sign and date the form at the end of each week.

Monthly Summary
At the end of the month, a summary of progress or lack of progress toward goals/objectives/outcomes must be documented utilizing the SAP format.

Staff completing the Weekly Progress Note must sign and date the form at the end of the month. For Day Treatment Services and Psychosocial Rehabilitation Services, the Supervisor may use this form as part of the documentation of the required monthly supervision.

Weekly Progress Note

Name _____

ID Number _____

Service _____

Attendance during 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
Time In																															
Time Out																															
Total Time																															

Weekly Dates	**Summary of Objective/Activity**
1st Week	**Objective(s):**
	S: A: P:
Date:	**Signature/Credential:**
2nd Week	**Objective(s):**
	S: A: P:
Date:	**Signature/Credential:**

3rd Week	**Objective(s):**
	S: A: P:
Date:	**Signature/Credential:**
4th Week	**Objective(s):**
	S: A: P:
Date:	**Signature/Credential:**
5th Week	**Objective(s):**
	S: A: P:
Date:	**Signature/Credential:**
Monthly Summary	S: A: P:
Date:	**Staff Signature/Credential:**
Date:	**Supervisor Signature/Credential:**

Section C
As Needed

Initial Assessment and Crisis Contact Summary

Readmission Assessment Update

Serious Incident Report

Medical Examination

Documentation of Healthcare Provider Visits

Self-Administration Medication Log

Telephone/ Visitation Agreement

Search and Seizure Report

Physical Restraint/Escort Log

Time Out Log

Seclusion Behavior Management Log

Service Termination/ Change Summary

Provider Discharge Summary

Initial Assessment and Crisis Contact Summary for Emergency/ Crisis Contacts

Purpose

The Initial Assessment and Contact Log for Emergency/Crisis Contacts is used to document the provision of emergency/crisis contacts with individuals seeking services from a CMHC who are not already receiving other mental health services from the CMHC.

Identifying Information

Record the name of the individual receiving crisis services. Issue and record a client identification number. The Date of Contact will also be the Date of Admission. Enter the individual's Social Security and Medicaid numbers. Record the time the contact began and ended. Indicate the type of crisis service delivered (Mobile Crisis Services, Telephone Emergency/ Crisis, or Walk-in Emergency/ Crisis). If the contact was made Face to Face, include the location where the contact took place and if the contact was made by phone, include the phone number of the caller. List by relationship any other individuals involved with the emergency/ crisis or any referral source (i.e. sister).

Presenting Need

Document the reason(s) the individual is seeking emergency/crisis services.

Actions Taken by Staff

Document the steps taken to assess and resolve the emergency/crisis. Record if anyone was contacted on behalf of the individual in crisis. If no one else was notified, indicate why it was not necessary.

Initial Behavioral Observations

Document the staff's impressions of the individual's behaviors. Include additional comments at the end of the section.

Resolution

Document the condition of the individual at the end of the contact; indicate where the individual and/or family were referred and if a subsequent appointment was made for the individual at the CMHC, note the date and time of the appointment.

Required Data

This information is required by the Department of Mental Health and is to be submitted to the Central Data Repository. If you are unable to obtain this information, please mark as "unknown." The staff person responding to the individual in crisis and documenting the contact must sign this form and include their professional credentials.

Initial Assessment and Crisis Contact Summary for Emergency/Crisis Contacts

Name:_____

ID Number:_____

Contact/ Admit Date:_____

Medicaid #:_____ **SS#**_____

Time In: **Time Out:** **Total Time:**

Type of Contact:

□ Mobile Crisis Service Location: _____

□ Telephone Emergency/ Crisis Number: _____

□ Walk-in Emergency/ Crisis

Others Involved:

Presenting Needs (the factors indicating a need for Emergency/Crisis Services)

Actions Taken by Staff:

Initial Behavioral Observations

Speech: ☐ Appropriate ☐ Slowed ☐ Mechanical ☐ Rapid ☐ Other

Behavior: ☐ Appropriate ☐ Withdrawn ☐ Bizarre ☐ Volatile ☐ Other

Appearance: ☐Appropriate ☐Disheveled ☐Unclean ☐ Inappropriately dressed ☐Other ☐ Phone Contact

Mood: ☐ Appropriate ☐Manic ☐Depressed ☐Labile ☐Irritable ☐Other

Affect: ☐Appropriate ☐Flat ☐Labile ☐Other

Oriented to: ☐Place ☐Time ☐Person ☐Situation ☐Other

Thought Content: ☐Appropriate ☐Incoherent ☐ Obsessive ☐ Delusional ☐ Paranoid ☐Other

Memory: ☐ Appropriate ☐ Repressed ☐ Confused ☐ Other

Intelligence: ☐ Average ☐ Above Average ☐ Below Average

Judgment/Insight: ☐ Appropriate ☐ Impaired ☐ Suicidal ☐ Homicidal ☐ Other

Hallucinations: ☐ Auditory ☐Visual ☐Tactile ☐ Other

Comments:

Resolution

Condition of the Individual at Conclusion of Contact	Referrals Made by Staff Appointment at CMHC Date: Time:

Required Data

(Please mark as Unknown if Information is Unavailable)

Birth Date:	Age:	Gender:
Race:	Education Level:	Marital Status:
County of Residence:	Living Arrangement:	Type of Residence:
Employment Status:	Legal Status:	Primary Income Source:
Annual Income:	# in Household:	SSI/SSDI Eligibility:
Veteran Status:	Physical Impairments:	Service Code:
Staff Signature/Credentials:		

Readmission Assessment Update

Purpose
When an individual has been discharged from a provider agency and seeks to resume services within one year of the discharge date, a Readmission Assessment Update may be utilized instead of the Initial Assessment 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.

The Child and Adolescent Functional Assessment Scale (CAFAS) is required for all children/youth receiving mental health services. The CAFAS must be completed within 60 days for all children/youth receiving mental health services.

An approved functional assessment is required for all adults receiving mental health services. An approved functional assessment must be completed within 60 days for all adults receiving mental health services. DMH will review and approve a functional assessment for use with the adult SMI population.

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) 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:

LEGAL INFORMATION	
Name of Guardian / Custodian:	Guardianship Documentation Verified: □ Yes □ No
Guardian / Custodian Address:	Guardian / Custodian Phone Number:

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

(For women only) Are you pregnant?

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?

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**

Serious Incident Report

Date of Report: The date this report was written

Date of Incident: The date the incident occurred

Time of Incident: The time the incident occurred; make sure to check am or pm

Provider Name: The name of the Provider (example: Region X Mental Health)

Program Name: The Name of the specific program within the Provider agency (example: Golden Rainbows PSR). In some instances the Provider Name may actually be the Program; for instance with a smaller private Provider.

Service: The name of the specific Service for which the Program is certified. (example: Psychosocial Rehabilitation Services)

Reported by: The name of the person completing the incident report. If the incident was reported to the person completing the form, the names of the initial reporter(s) will be included in the **Description of Incident**, **Person(s) Involved in Incident** and **Witnesses** sections.

Event Codes:

- **SU** Suicide attempt, or Completed Suicide
- **EMG** Treatment received at an Emergency Room. Do not include trips to Emergency Room that do not result in treatment
- **SR** Any Seclusion or Restraints
- **ACL** An unexpected absence from a community living program
- **ABN** Any abuse or neglect of an individual receiving services, either suspected or confirmed
- **WKV** Any workplace violence occurring on the property of a certified Provider, or at a Provider sponsored event
- **ELP** Elopement of an individual receiving services
- **DIS** Any Disaster that effects the normal functioning of a certified Provider. Do not include reports of Disaster Drills.
- **MED** Any confirmed Medication Errors

INJ Any serious injuries sustained by an individual receiving services. Minor injuries need not be reported. Injuries resulting in fractures, stitches or sutures (or preliminary x-rays to determine extent of injury) are considered serious.

EVC Any event that requires evacuation of the premises. Do not include drills.

OTH Any incident that is deemed serious by the Provider, but is not listed above. Details should be given in the Description of Incident section.

Description of Incident:

Give as detailed an account as possible of the incident in the space provided.

Person(s) Involved In Incident:

List first and last names (if known) of all individuals involved in the incident. This should include all alleged victims and alleged perpetrators (if applicable). Use the provided check boxes to indicate whether or not the individual(s) is on the ID/DD waiver.

Witnesses: List the names of any verified or potential witnesses to the incident.

Possible Contributing Factors:

List any identified possible contributing factors to the incident. (example: a wet floor that resulted in a fall which caused a hip fracture)

Consequences/Follow Up Actions:

List any actions that the Provider has taken since the incident occurred to lessen the chances of it happening again. Any disciplinary actions that have been taken should also be included (example: Administrative Leave)

Any and all authoritative bodies to which this incident has been reported and the dates of those reports. (example: Department of Health, 12/3/12; Attorney General's Office, 12/4/12)

Has A Report Been Made Within the Agency:

Mark "yes" here to acknowledge that a report of the incident has been made to the proper authoritative body within the agency. For example, the agency may have a Risk Management Department to which all incidents should be reported internally. Or, if the agency does not have a formal Risk Management Department, mark "yes" if a report has been made to the Executive Director.

If yes, to whom has the Report of Incident been made?

Provide the names and positions of each person to whom the incident has been reported.

At the time of this report, is the Agency conducting an Internal Investigation?

Mark “yes” if the agency is conducting its own internal investigation.

If yes, is the Agency’s Investigation Active or Closed?

If the investigation is ongoing, mark “Active.” If the investigation has been completed, mark “closed.”

Is this a high visibility Incident?

Visibility refers to the likelihood that the incident will be reported by the media. If there is a good possibility that the incident will be reported in the media, check “yes.”

Serious Incident Reporting Form

Date of Report:	**Date of Incident:**	**Time of Incident:** ☐ **am** ☐ **pm**
Provider Name:		
Program Name:	**Service:**	
Reported By:		

Event Codes (Check All That Apply)

☐ **SU** Suicide (Attempt or Completed)	☐ **EMG** Emergency Room Treatment	☐ **SR** Seclusion/Restraint
☐ **ACL** Absence from Community Living	☐ **ABN** Abuse/Neglect	☐ **WKV** Workplace Violence
☐ **ELP** Elopement	☐ **DIS** Disaster	☐ **MED** Medication Error
☐ **INJ** Injury	☐ **EVC** Evacuation	☐ **OTH** Other (describe below in narrative)

Description of Incident:

Individual(s) Involved In Incident (include case # with name if known)	Is this individual on the ID/DD Waiver? □ **Yes** □ **No**
	If yes, was Support Coordination notified? □ Yes □ No

Witnesses:

Possible Contributing Factors:

Consequences/Follow Up Actions:

Any and all authoritative bodies to which this incident has been reported and the dates of those reports.

Has a Report of Incident been made within the agency? □ **Yes** □ **No**

If yes, to whom has the Report of Incident been made?

_____	_____
Name	Position
_____	_____
Name	Position
_____	_____
Name	Position

At the time of this report, is the Agency conducting an Internal Investigation? □ **Yes** □ **No**

If yes, is the Agency's Investigation Active or Closed?

Is this a high visibility Incident? □ **Yes** □ **No**

Medical Examination

The DMH Operational Standards require that each individual served in any DMH certified supervised living and residential treatment program must have a documented Medical Examination in the individual's record. This requirement also applies to individuals attending Senior Psychosocial Rehabilitation programs. The examination must take place within 72 hours of admission or 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 Examination:				DOB	
				Age	
Height:		Temperature:		Blood Pressure:	
Weight		Head Circumference:		General Appearance:	

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 and 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. Stand and 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.

_____ _____

Signature of Healthcare Provider Date

Documentation of Healthcare Provider Visits

Purpose
This form ensures that Supervised Living Services and Therapeutic Group Home Services providers are assisting individuals in accessing routine healthcare services. This form is required for Supervised Living Services and Therapeutic Group Home Services but can be used by any service provider to document access to routine healthcare.

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/ Emergency Contact Information 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

Self-Administered Medication Observation Log

Purpose
This form should be used to document all medications that are self-administered in day programs and in all Supervised Living settings. This form is not intended for use by nurses administering medication.

Identifying Information
Enter the name and ID number of the individual.

Documentation
The provider must enter all required information.

Signature
The signature of the staff completing the log must be included. Two or more medications, administered at the same time, can be signed with a single signature on a diagonal line across rows. Signatures must be original and cannot be typed.

Self-Administered Medication Observation Log

Name _____

ID Number _____

Program _____

Time/ Date	Medication	Dosage	Individual Signature	Staff Observation Signature/ Credential

Telephone/Visitation Agreement

Purpose

Individuals receiving services 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. This form is required for Substance Abuse Residential Treatment programs, Supervised Living programs and Crisis Stabilization programs.

Timeline

The Telephone/Visitation Agreement must be completed upon admission/re-admission when required. 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 receiving services from: _____

(Provider)

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

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 Escort Log

Purpose
When an individual is 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 escorted.

Presenting Need
The time, date and detailed description of the events necessitating an escort must be documented. Describe in detail the individual's behavior and the type of escort used. All staff physically involved in the 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 escort, including the time the assessments began and ended. List all dates the individual was 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 escort must sign the documentation. Staff who witnessed but did not participate in the escort must also sign the finalized log.

Requirements
Physical Escort cannot 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 Escort cannot be used as part of a standing order or on an as needed basis. If an individual is physically escorted, the treating physician must be consulted within twenty-four (24) hours.

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 Escort Log

Name _____

ID Number _____

Date _____

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

Describe the precipitating events necessitating escort:

Describe the behavior warranting escort:

Describe type of escort used:

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

Describe ineffective/less restrictive alternatives attempted prior to escort:

Describe individual's behavior during escort:

Supervisory staff person's face-to-face assessment of the individual's mental and physical well being during 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 de-escalate the individual's behavior. If less restrictive methods of de-escalation are bypassed, explain staff reasoning. Document the visual assessments provided during the time out. Indicate any treatment recommendations and date Individual Service Plan was modified (if necessary.) The primary staff implementing the restraint/escort must sign the documentation. Staff who witnessed but did not participate in the restraint/escort must also sign the finalized log.

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

Timeline
Documentation of visual assessments is made at the time of each observation. The form must be completed in its entirety by the end of the working day in which the time out took place.

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

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	**ID#**
	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.**

Service Termination/Change Summary

Purpose

Documentation must be provided and maintained when an individual receiving services transfers between services or between service staff within a provider agency. 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.
For example: if an individual receives Service A and Service B and will no longer receive Service A- a Service Termination/ Change Summary must be completed for Service A.

Service(s) initiated must be part of the Individual Service plan. If they are not on the ISP at the time of change, a revision to the ISP must be completed and certified by those with signatory authority and signed by the individual receiving services or legal representative.

Service Termination/Change Information

The staff member 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 _____

❑ **Service Termination**
❑ **Service Change**

Effective Date of Service Change/Termination: _____

Service Termination or Change 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
❑ Change in Service Staff
❑ 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

Provider Discharge Summary

Purpose

When an individual is no longer receiving services from the agency, 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 provider agency, and any referrals made at the time of discharge.

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 and individual receiving information must sign to acknowledge. Additional information specific to the discharge may be included.

If the individual participates in the ID/DD Waiver program, a copy of this form must be provided to the Individual's Support Coordinator within 5 days of discharge.

Provider Discharge Summary

Name _____

ID Number _____

Date _____

Effective Date of Discharge _____

Reason For Discharge:

- ❑ Evaluation Only
- ❑ Treatment Completed
- ❑ Provider Terminated Treatment
- ❑ Individual Referred Elsewhere
- ❑ Other _____
- ❑ Moved from service area
- ❑ Deceased
- ❑ No contact in 12 months
- ❑ Individual requested discharge

Referred To:

- ❑ DMH Behavioral Health Program
- ❑ Other MS CMHC
- ❑ DMH IDD Program
- ❑ 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/IDD
- ❑ Other_____

Discharge Instructions provided to ❑ Individual ❑ Legal Representative

Discharge Instructions/Additional Information:

_____ _____

Individual/Legal Representative Date

_____ _____

Signature/Credentials Date

Section D
Day Service Programs

Acute Partial Hospitalization Services Summary Note

Acute Partial Hospitalization Services Summary Note

Purpose
Documentation must be maintained when an individual receives Acute Partial Hospitalization 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 in SAP format as it relates to the Individual Service Plan.

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

Acute Partial Hospitalization Services 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

S

A

P

_____

Signature/Credential

Section E
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 intellectual or 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 Master's level staff of a regional Community Mental Health Center (CMHC) that has completed the Pre-Evaluation Screening Training approved by DMH. The Pre-Evaluation Screening must be 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	❒ (Other) _____	
❒ Hepatitis	❒ None known		

Elaborate on acute medical conditions of 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 F
Alzheimer's and Other Dementia Services

Life Story Narrative

Life Story Narrative

Purpose

As Alzheimer's disease progresses, individuals lose 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 G
Children and Youth Services

FASD Screening Form

FASD Data Tool

Therapeutic Foster Care Contact Log

MAP Team Report

MAP Team Case Summary

Wraparound Facilitation Individual Support Plan

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 Community Support Specialist, a therapist, or other children's mental health credentialed staff.

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

Timelines

Children ages birth to 18 must be screened using the FASD Screening Form 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. The screening does not need to be repeated. However, in the event a child's initial FASD screening result is negative, and additional information regarding possible maternal alcohol history is obtained, the result of the initial screening must be revised on the initial FASD Screening Form to reflect this change.

FASD Screening Criteria

The results 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 <u>at least one</u> of the following 3 possible indicators as listed on the screening form is true or present, the screening result is positive. If none of the 3 indicators is true or present, the screening result is negative.

1. 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.

2. 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.

3. Previous diagnosis of an FASD

A screening should be positive for 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.

Screening Results

With consent obtained from the parent/legal guardian, children ages birth to seven (7) who receive a positive FASD screen should 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. Children older than age seven (7) who screen positive for risk may be referred to a multidisciplinary FASD diagnostic provider.

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

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 and receives a positive result.

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 and received a positive result. 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

Children ages birth to 18 must be screened using the FASD Screening Form within 6 months of the completion of the initial assessment. Youth ages 18 to 24 may also be screened if there is indication of prenatal alcohol exposure. The screening does not need to be repeated. However, in the event a child's initial FASD screening result is negative, and additional information regarding possible maternal alcohol history is obtained, the result of the initial screening must be revised on the initial FASD Screening Form to reflect this change.

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) placed 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

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 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)

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 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 <u>institutional</u> 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

Wraparound Facilitation

Overview of Wraparound

Wraparound is an approach to individualized care planning encompassing the concept of wrapping services and supports around children, youth and families, utilizing both clinical treatment services and natural supports. Wraparound is built on the collective action of a committed group of family, friends, community, professionals, and cross-system supports mobilizing resources and talents from a variety of sources. This results in the creation of an Individualized Support Plan that is the best fit between the family vision and story, strengths, needs, team mission, and strategies.

Target Population

Wraparound facilitation is for children/youth with serious emotional disturbances (SED) who have highly complex needs and/or have multiple agency involvement and are at risk of out-of-home placement. With ratios of 1 Wraparound Facilitator to 10 families and youth, youth can be diverted from residential placements and served in their communities and homes.

Key Elements of the Wraparound Process

Grounded in a Strengths Perspective

Strengths are defined as interests, talents, and unique contributions that make things better for the family and youth. Within an entire process that is grounded in a strengths perspective, the family story is framed in a balanced way that incorporates family strengths rather than a focus solely on problems and challenges. A strengths perspective should be overt and easily recognized, promoting strengths that focus on the family, team, and community, while empowering and challenging the team to use strengths in a meaningful way.

Driven by Underlying Needs

Needs typically define the underlying reasons why behaviors happen in a situation. In a needs-driven process, the set of underlying conditions (needs) that cause a behavior and/or situation to exist are both identified and explored in order to understand why a behavior and/or situation happened. These needs would be identified across family members in a range of life areas beyond the areas defined by the system. These underlying conditions would be articulated with overt agreement with the family and all team members about which to select for action or attention first. The process involves flexibility of services and supports that will be tailored to meet the needs of the family and youth.

Supported by an Effective Team Process

Wraparound is a process that requires active investment by a team, comprised of both formal and informal supports willing to be accountable for the results. Measurable target outcomes are derived from multiple team member perspectives. The team's overall success is demonstrated by how much closer the family is to their vision and how well the family needs have been addressed.

Determined by Families

A family-determined process includes both youth and caregivers with the family having the authority to determine decisions and resources. Families are supported to live a life in a community rather than in a program. The critical process elements of this area include access, inclusion, voice, and

ownership. Family access is defined as inclusion of people and processes in which decisions are made. Inclusion in decision making implies that families should have influence, choice and authority over services and supports identified in the planning process. This means that they should be able to gain more of what is working and less of what they perceive as not working. Family voice is defined as feeling heard and listened to, and team recognition that the families are important stakeholders in the planning process. Therefore, families are critical partners in setting the team agenda and making decisions. Families have ownership of the planning process in partnership with the team when they can make a commitment to any plans concerning them. In Wraparound, the important role of families is confirmed throughout the duration of care.

Wraparound Facilitation

Wraparound Facilitation is the creation and facilitation of a child and family team for the purpose of developing a single plan of care to address the needs of youth with complex mental health challenges and their families. The child and family team will meet regularly to monitor and adjust the plan of care if necessary or if progress is not being made. Wraparound facilitation is intended to serve individuals with serious mental health challenges that exceed the resources of a single agency or service provider, experience multiple acute hospitals stays, are at risk of out-of-home placement or have been recommended for residential care. Individuals who have had interruptions in the delivery of services across a variety of agencies due to frequent moves, failure to show improvement, lack of previous coordination by agencies providing care, or reasons unknown can also be served through wraparound facilitation.

Wraparound facilitation must be provided in accordance with high fidelity (as outlined below) and quality wraparound practice.

1. Services comprised of a variety of specific tasks and activities designed to carry out the wraparound process, including:

    a. Engaging the family;
    b. Assembling the child and family team;
    c. Facilitating a child and family team meeting at a minimum every thirty (30) days;
    d. Facilitating the creation of a plan of care, which includes a plan for anticipating, preventing and managing crisis, within the child and family team meeting;
    e. Working with the team in identifying providers of services and other community resources to meet family and youth needs;
    f. Making necessary referrals for youth;
    g. Documenting and maintaining all information regarding the plan of care, including revisions and child and family team meetings;
    h. Presenting plan of care for approval by the family and team;
    i. Providing copies of the plan of care to the entire team including the youth and family/guardian;
    j. Monitoring the implementation of the plan of care and revising if necessary to achieve outcomes;
    k. Maintaining communication between all child and family team members;
    l. Monitoring the progress toward needs met and whether or not the referral behaviors are decreasing;
    m. Leading the team to discuss and ensure the supports and services the youth and family are receiving continue to meet the caregiver and youth’s needs;

n. Educating new team members about the wraparound process; and
o. Maintaining team cohesiveness.

2. Child and family team membership must include:

   a. The wraparound facilitator;
   b. The child's service providers, any involved child serving agency representatives and other formal supports, as appropriate;
   c. The caregiver/guardian;
   d. Other family or community members serving as informal supports, as appropriate; and
   e. Identified youth, if age nine (9) or above, unless there are clear clinical indications this would be detrimental. Such reasons must be documented clearly throughout the record.

3. Wraparound facilitation is limited to one hundred (100) units (15 minute unit) per state fiscal year and eight (8) units per day.

4. Provider requirements

   a. Wraparound facilitators and supervisors of the process must have completed and show evidence of completion of the Introduction to Wraparound 3-day training.
   b. Wraparound facilitators and supervisors must participate in ongoing coaching and training as defined by the Division of Medicaid and the Department of Mental Health.
   c. The provider organization providing Wraparound facilitation must be participating in the wraparound certification process through the Division of Medicaid or its designee.
   d. Providers must ensure case load size for each wraparound facilitator of no more than ten (10) cases.

Wraparound Facilitation Additional Documentation Requirements

All contacts, specific tasks and activities must be documented in Progress Note and filed in the child/youth's record.

Wraparound Facilitation
Individualized Support Plan

Youth Name (First, MI, Last):		Client #:	TAN #:	Date:
Guardian Name:	**DOB:**	**Phone:**	**Address:**	
☐ Initial ☐ Review ☐ Discharge		**Start Date:**	**Target Completion Date**:	

Vision/Mission/Strengths

Family Vision/Preference Statement:		
Team Mission:		
Strengths/Abilities: Youth, Family Members, & Team		

Client Name	Case #
Crisis Plan	
Diagnosis:	
Medications:	
Brief History:	
Triggers:	
Potential Crisis:	
Action Steps for home and school to meet Identified Needs re: Potential Crisis:	
Persons Responsible and phone numbers:	
Crisis Debriefing after Resolution:	

Client Name	**Case #**

Needs Statements/Strategies

Needs Statement 1		Start Date: End Date/Duration:
Outcome:		

Life Domain Area of need:

☐Family ☐Residence ☐Social ☐Education/Vocation

☐Medical/Physical Health ☐Community ☐Psychological/Emotional/Behavioral

☐Safety ☐Basic Physical Needs ☐Financial ☐Leisure/Recreation

Youth Strategies	

Parent/Guardian/Community Strategies:

Strategy Completion Date:	**Strategy Discontinue Date:**	**Reason for Discontinuation:**

Client Name		Client #
Needs Statement 2		Start Date: End Date/Duration:
Outcome:		

Life Domain Area of need:

☐Family ☐Residence ☐Social ☐Education/Vocation

☐Medical/Physical Health ☐Community ☐Psychological/Emotional/Behavioral

☐Safety ☐Basic Physical Needs ☐Financial ☐Leisure/Recreation

Youth Strategies	

Parent/Guardian/Community Strategies:

Strategy Completion Date:	Strategy Discontinue Date:	Reason for Discontinuation:

Client Name		Client #
Needs Statement 3		**Start Date:** **End Date/Duration:**
Outcome:		

Life Domain Area of need:

☐Family ☐Residence ☐Social ☐Education/Vocation

☐Medical/Physical Health ☐Community ☐Psychological/Emotional/Behavioral

☐Safety ☐Basic Physical Needs ☐Financial ☐Leisure/Recreation

Youth Strategies	

Parent/Guardian/Community Strategies:

Strategy Completion Date:	**Strategy Discontinue Date:**	**Reason for Discontinuation:**

Client Name		**Client #**
Needs Statement 4		**Start Date:** **End Date/Duration:**
Outcome:		

Life Domain Area of need:

☐Family ☐Residence ☐Social ☐Education/Vocation

☐Medical/Physical Health ☐Community ☐Psychological/Emotional/Behavioral

☐Safety ☐Basic Physical Needs ☐Financial ☐Leisure/Recreation

Youth Strategies	

Parent/Guardian/Community Strategies:

Strategy Completion Date:	**Strategy Discontinue Date:**	**Reason for Discontinuation:**

Client Name		Client #
Team Contacts/Resources		
Support Name/Signature	**Contact and Organization**	**Role**

Discharge

Support Summary:

Further Recommendations:

Youth Signature:	Date:
Parent/Guardian Signature:	Date:
Wraparound Facilitator Signature:	Date:
Supervisor Signature:	Date:
Other Signature (Name/Relationship):	Date:
Other Signature (Name/Relationship):	Date:

Case # _____

Wraparound Team Meeting

Wraparound team for _____ and Family

Date: _____ Start – End Time: _____

* I am aware that everything said in this meeting is confidential. Confidentiality means that what we discuss is private and should not be discussed outside of this meeting or with others not involved in this family's Wraparound process. By signing, I agree to preserve the confidentiality of all information discussed. I agree that this information will be used for the purposes outlined in the Wraparound planning process only. I understand that if any abuse or neglect is disclosed in this process, mandated reports will be made.

Name of Family Team Member*	**Role, Agency, or Relationship to Youth**	**Phone Number(s)**	***To be filled out by Wrap Facilitator*: Release authorized?**
	Wrap Facilitator		
			Y or N
			Y or N
			Y or N
			Y or N
			Y or N
			Y or N
			Y or N
			Y or N
			Y or N

"*<u>Wraparound</u>* is a family centered, community-oriented, strengths-based, highly individualized planning process aimed at helping people achieve important outcomes by helping them meet their unmet needs both within and outside of formal human services systems, while they remain in their neighborhoods and homes, whenever possible" (wraparoundsolutions.com).

Section H
Intellectual/ Developmental Disabilities Services

IDD Activity Plan

IDD Service Note

IDD Waiver Service Authorization

IDD Waiver Home and Community Supports Service Agreement

IDD Waiver In-Home Nursing Service Agreement

IDD Waiver In-Home Nursing Respite Service Note

IDD Employment Profile

IDD Waiver Job Discovery Profile

IDD Waiver Functional Behavior Assessment

IDD Request for Behavior Support and/or Crisis Support Services

IDD Waiver Medical Verification for Behavior Support/Crisis Intervention Services

IDD Waiver Behavior Support Plan

IDD Waiver Behavior Support Quarterly Review Report

IDD Waiver Request for Additional Behavior Support Services

IDD Waiver Request for Additional Crisis Support Services

IDD Waiver Request for Crisis Intervention Services

IDD Waiver Crisis Intervention Plan

IDD Waiver Crisis Intervention Daily Service Note

IDD Waiver Crisis Intervention Log- Episodic

IDD Waiver Request for Additional Crisis Intervention Services

IDD Activity Plan

Purpose

The purpose of the Activity Plan is to document the outcomes a person would like to achieve as a result of participating in the service as well as the activities that will assist in meeting the stated outcomes. The following services must use an Activity Plan for each service provided:

- Community Respite
- Day Habilitation
- Day Services-Adult
- Home and Community Supports
- Host Homes
- In-Home Nursing Respite
- Prevocational Services
- Supervised Living
- Supported Employment
- Supported Living
- Work Activity

General

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 Activity Plan must be signed and dated by the Program Supervisor.

Timelines

Activity Plans must be developed within 30 days of the date of admission to the service. It must be revised as needed but at least annually thereafter. The provider must send a copy of the Activity Plan to the appropriate Support Coordinator by the 15th of the month following the month it is developed.

Outcomes

List outcomes the person would like to achieve through participation in the service. Outcomes can be in the areas or any aspect of a person's life that enable him/her to participate in meaningful activities, community integration and job skill development. Outcomes can be specific or general depending on the person's interests and need(s) for assistance/support.

Person's Activities

List and number activities the person 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 him/her achieve/maintain his/her desired outcomes.

IDD Activity Plan

Name: _____

Medicaid #: _____

Agency: _____

Service: _____

Page **of**

Outcomes	Specific Activities to Reach Outcomes

_____ _____

Person/Legal Representative Signature **Date**

_____ _____

Staff Signature/Credentials **Date**

IDD Service Notes

Purpose

IDD Service Notes are used to document activities that take place during the provision of services. Documentation must be detailed and specific to each person's Activity Plan. Staff activities toward the provision of services must also be documented. A single form can be used for one (1) or two (2) days, depending on the amount of information; use as many pages as necessary to adequately document the information each day/time services are provided. For example, if a person goes out to participate in a community activity, two (2) notes may be necessary for that day: one (1) for program site activities and one (1) for community activities.

General

Indicate the person's name, Medicaid number (or other ID number if the person does not receive Medicaid), the name of the service and the name of the agency providing the service. Document the date of service, the time it begins (using a.m./p.m.), the time it ends (using a.m./p.m.), and the total time spent providing services. Staff providing the service must sign indicating his/her credentials and date the form.

IDD Service Notes replace Activity Notes. IDD Service Notes are required for the following IDD services:

- Behavior Support *(Each time services are provided. A separate form for detailed observation may be used if desired.)*
- Community Respite *(Each time services are provided.)*
- Day Habilitation *(Daily)*
- Day Services-Adult *(Daily)*
- Early Intervention *(Each time services are provided.)*
- Home and Community Supports *(Each time services are provided.)*
- Host Homes *(Daily)*
- Job Discovery *(Each time services are provided.)*
- Prevocational Services *(Daily)*
- Supervised Living *(Daily - There must be a Service Note for each shift.)*
- Supported Employment *(Each time services are provided.)*
- Supported Living *(Each time services are provided.)*
- Work Activity *(Daily)*

IDD Service Notes must reflect who, what, when, where, how and why for activities each day/ time services are provided. The following must be specifically addressed:

- Activities in which the person chose to participate
- When and where all activities occurred *(at the program site, in the community[list the specific location of the activity], in the home)*
- How and why activities were completed *(this relates activities back to the person's Activity Plan)*
- What worked well about the activity(ies) and what the person liked
- What did not work well about the activity(ies) and what the person did not like
- Strategies or instructions staff followed during the provision of services
- Progress toward meeting stated outcomes

IDD Service Notes must also be used to document the following:

- When supports are not provided according to the Activity Plan
- Why a person chose not to participate in an activity
- Unusual events/circumstances
- Why a person is absent on any given day
- Phone calls or interaction with family or other providers/entities on behalf of the person

Service notes can be written or typed. Use as much space as necessary to completely document all activities.

Timelines

IDD Service Notes must be completed the day services are provided and be in the person's record no later than the 10th day of the month following the month service are provided.

IDD Service Note

Name: _____ Medicaid #: _____

Service: Agency:

Date: Begin Time: End Time: Total Time: Location(s):

Person's Activities	Staff's Activities
(Who, What, When, Where, How, Why)	
Staff Signature/ Credentials	

Date: Begin Time: End Time: Total Time: Location(s):

Person's Activities	Staff's Activities
(Who, What, When, Where, How, Why)	
Staff Signature/ Credentials	

IDD Waiver Service Authorization

Purpose

To inform a provider what type and amount of IDD 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.

IDD Waiver
Service Authorization

To: _____ **From:** _____

Name of Agency — Support Coordination Department

Re: _____ _____

Individual's Name — IDD Waiver Support Coordinator

_____ _____

Medicaid Number — IDD 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**

IDD Waiver Home and Community Supports Service Agreement

Purpose

The Home and Community Supports (HCS) Service Agreement outlines the allowable activities, rules and procedures regarding the provision of the service. The agreement indicates supports and/or activities that can and cannot be provided by staff when services are rendered.

General

The provider is responsible for reviewing the form with the person/legal representative. Both the staff person and person/legal representative must sign form to indicate agreement to adhere to the requirements in order to receive services.

Timelines

The provider reviews the Home and Community Supports Service Agreement with the person/legal representative prior to or at the time the provider begins providing services and at least annually thereafter. A signed document must be maintained in the person's record and the person/legal representative must be given a copy to keep.

IDD Waiver Home and Community Supports
Service Agreement

Name:	**Medicaid Number:**
	Agency:

1. Home and Community Supports (HCS) will meet the support needs identified in the Plan of Services and Supports and Activity Support Plan. Only the amount of Home and Community Supports authorized in the Plan of Services and Supports will be provided. If a change in the amount is needed, the Support Coordinator must be contacted.
2. HCS can be provided in the home and/or in the community and either with or without a parent/legal representative present, depending upon identified support needs.
3. HCS staff cannot be responsible for caring for others who may be in the home. HCS staff is only responsible for the person who is enrolled in the IDD Waiver. Also, the HCS staff person is not responsible for caring for pets.
4. HCS cannot be provided at a staff person's home.
5. If a scheduled HCS visit must be canceled (e.g. because of a doctor's appointment, illness, going out of town, etc.), the provider must be notified as soon in advance of the cancellation as possible. Three (3) cancellations for which no notice is given will result in a review of the Plan of Services and Supports to determine if Home and Community Supports are still necessary and appropriate.
6. Receipt of HCS is voluntary. Services can be declined by notifying the Support Coordinator.
7. If HCS are terminated because of failure to adhere to the IDD Waiver Enrollment Agreement or the HCS Service Agreement, notification will be sent as soon as possible. The Support Coordinator will assist in locating other service options, if available. There are established procedures for filing an appeal of the decision. 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 person, services may or may not continue pending the outcome of the appeal.
8. Should any problems arise regarding the provision of HCS, the Support Coordinator is to be notified immediately.
9. HCS cannot be provided on an overnight basis outside of the legal residence.
10. HCS cannot be provided out of the state of Mississippi.
11. HCS staff cannot provide medical treatment of any sort, as defined in the Mississippi Nurse Practice Act Rules and Regulations.
12. HCS staff cannot accompany a minor child on a medical visit without the parent/legal representative.
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 not normally expected to provide care may be approved to provide HCS. 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 request and receive prior approval from the DMH Review Committee before a relative can provide Home and Community Supports.

ID/DD Waiver Home and Community Supports
Service Agreement

15. If approved to provide the service, a relative may only provide up to 172 hours of Home and Community Supports per month.
16. HCS cannot be provided in a school setting.
17. HCS providers cannot do personal errands or have interactions with their family and friends during the provision of services.
18. Behavior Support is the only IDD Waiver service that may be provided and billed for during the provision of HCS.

The above information has been reviewed and the circumstances under which Home and Community Supports can be provided are understood.

Person/Legal Representative Signature	**Agency Representative Signature/Credentials**
Date	**Date**

IDD Waiver In-Home Nursing Respite Service Agreement

Purpose

The In-Home Nursing Respite Service Agreement outlines the allowable activities, rules and procedures regarding the provision of the service. The agreement indicates supports and/or activities that can and cannot be provided by staff when services are rendered.

General

The provider is responsible for reviewing the form with the person/legal representative. Both the staff person and person/legal representative must sign form to indicate agreement to adhere to the requirements in order to receive services.

Timelines

The provider reviews the In-Home Nursing Respite Service Agreement with the person/legal representative prior to or at the time the provider begins providing services and at least annually thereafter. A signed document must be maintained in the person's record and the person/legal representative must be given a copy to keep.

IDD Waiver In-Home Nursing Respite
Service Agreement

Name:	**Medicaid Number:**
	Agency:

1. In-Home Nursing Respite (IHNR) services will meet the support needs identified in the Plan of Services and Supports and Activity Support Plan. Only the amount of In-Home Nursing Respite authorized in the Plan of Services and Supports will be provided. The Support Coordinator must be contacted if a change in the amount is needed.
2. IHNR is provided by either a Licensed Practical Nurse (LPN) or Registered Nurse (RN). The service is intended to be temporary (short-term) and provide periodic relief to the primary caregiver. IHNR services are not available to anyone living alone, in a Supervised or Supported Living setting or any other type of staffed residence.
3. IHNR is provided in the family home either with or without a parent/legal guardian present, depending upon identified support needs. The nurse may accompany the person to doctor appointments. Minors must also be accompanied by a parent.
4. IHNR services cannot be provided in the nurse's or any of his/her relatives' homes.
5. Nurses are NOT responsible for caring for others who may be in the home. The nurse is only responsible for the person who is enrolled in the IDD Waiver. Also, the nurse is not responsible for caring for pets.
6. If a scheduled time for IHNR must be canceled (e.g. because of a doctor's appointment, illness, going out of town, etc. the nurse must be notified as soon in advance of the cancellation as possible. Three (3) cancellations for which no notice is given will result in a review of the Plan of Services and Supports to determine if IHNR services are still necessary and appropriate.
7. It is understood that the IHNR 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 Service Note each time IHNR services are provided to verify that the provider provided the amount of service indicated. It is understood that initialing false or fraudulent documentation is against the law.
8. If a decision is made to terminate IHNR services because of failure to adhere to the IDD Waiver Enrollment Agreement or the IHNR Service Agreement, notification will be sent as soon as possible. The Support Coordinator will assist in locating other service options, if available. There are established procedures for filing an appeal. 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 IHNR staff person, services may or may not continue, depending on the situation.
9. Should any problems arise regarding the provision of IHNR, the Support Coordinator shall be notified immediately. The receipt of IHNR services is voluntary. The service may be declined at any time by notifying the Support Coordinator.
10. Medical treatment provided by nurses must be completed according to the Mississippi Nurse Practice Act Rules and Regulations. Any questions regarding nurses and their scope of practice must be addressed directly to the Mississippi Board of Nursing.
11. Documentation from a physician stating nursing services are medically necessary must be obtained before IHNR services can be approved.
12. Behavior Support is the only IDD Waiver service that may be provided and billed for during the provision of IHNR.

The above information has been reviewed and the circumstances under which In-Home Nursing Respite Services can be provided are understood.	
Person/Legal Representative Signature	**Agency Representative/Credentials**
Date	**Date**

IDD Waiver In-Home Nursing Respite Service Note

Purpose

The provider must document on the In-Home Nursing Respite Service Note time spent in service provision with the person receiving supports. In-Home Nursing Respite Service Notes must reflect activities and strategies written in the Activity Plan.

General

Nurses are governed by the Mississippi Board of Nursing and the Mississippi Nurse Practice Act and Rules and Regulations. For purposes of the IDD Waiver, the In-Home Nursing Respite Service Note must have information sufficient enough to justify the time spent providing the service. The In-Home Nursing Respite Service Note must identify the time services began, the time they ended (indicating a.m./p.m.) and the total amount of time spent providing services. The person/legal representative must sign the note verifying the services documented were provided during the times indicated.

In-Home Nursing Respite Service Notes must be completed during service provision. The nurse completing the In-Home Nursing Respite Service Note signs and dates it at the completion of the shift.

Timelines

In-Home Nursing Respite Service Notes must be in the person's record no later than the 10th day of the month following the month they were completed.

IDD Waiver In-Home Nursing Respite Service Note

Name _____

Agency _____

ID Number _____

Page of

Provider's Signature/Credentials	Date (m/d/yr)	Time In (am/pm)	Time Out (am/pm)	Total Time	Individual/Legal Representative's Signature

Notes

IDD Employment Profile

Purpose

The IDD Employment Profile is used for people who have not had or who do not wish to participate in Job Discovery. The IDD Employment Profile is used to determine a person's skills, interests and preferences as they relate to a career path or field of employment. This information serves as the basis of job searching for the person.

General

Information gathered is used to determine the best job fit for someone. The Employment Specialist/Job Coach is to use this information when assisting a person in locating a job. The information can be relayed to potential employers in order to help facilitate obtaining a job in which the person can be satisfied and successful.

Information to Be Gathered

Address each area with the person and/or someone who knows him/her best if he/she does not speak using words. This information can be gathered by the Program Supervisor or a Direct Support Staff person.

Timelines

The IDD Employment Profile is to be completed within thirty (30) days of enrollment in a Supported Employment program and is to be updated if a person loses/changes jobs. The purpose of the update is to ensure any changes in the information are reflected. For instance, a person may find after working for several months that he/she likes a more interactive work environment than when he/she first started or he/she may gain skills that would need to be reflected when looking for another job. The IDD Employment Profile must be in the person's record by the 10th of the month following the month in which it is completed.

ID/DD Waiver/IDD Community Support Program

The IDD Employment Profile must be submitted to the person's ID/DD Waiver Support Coordinator or IDD Community Support Program Targeted Case Manager by the 15th of the month following the month it is completed. The information gathered from the IDD Employment Profile may be used to update the Plan of Services and Supports and generate new outcome(s) for the person. A Team Meeting may be necessary and provider staff will be required to attend.

IDD Employment Profile

Name: _____
ID Number: _____
Date: _____
Provider Agency: _____

Availability:

☐ Weekdays ☐ Evenings ☐ Full time (40 hours/week)
☐ Weekends ☐ Part-time (at least 20 hrs/week) ☐ Less than part-time (less than 20 hrs/week)

Transportation:

☐ Needs transportation ☐ Needs assistance/training to access public transportation
☐ Can access public transportation ☐ Family/neighbor/friend/co-worker will transport

Financial Situation:

☐ Income must not affect benefits ☐ Financial ramifications not an obstacle
☐ Is concerned/would like more information about increased income effect on SSI/SSDI

Time awareness:

☐ Cannot tell time ☐ Understands break and lunch
☐ Can tell exact time ☐ Can tell time to the hour
☐ Must have digital clock/watch to tell time ☐ Can tell time with analog clock/watch

Lifting ability:

☐ 0-5 lbs. ☐ 10-20 lbs.
☐ 20+ lbs. ☐ Cannot lift

Endurance (hours per day):

☐ 2-4 hrs, many breaks ☐ 2-4 hrs, few breaks
☐ 5-8 hrs, many breaks ☐ 5-8 hrs, few breaks

Preferred work area (check all that apply):

☐ Small area/one room ☐ Several rooms
☐ Building-wide ☐ Building and grounds

Mobility:

☐ Walks without assistance ☐ Requires adaptations/assistance to walk/stand
☐ Uses a wheelchair/must be pushed ☐ Uses a wheelchair/can self-navigate

Supervision (check all that apply):

☐ Requires one-on-one supervision/all times ☐ Can be unsupervised for 30 minutes
☐ Can be unsupervised for 60 minutes ☐ Does not require immediate supervision
☐ Prefers to work alone ☐ Likes to be a part of a team of 3 or less
☐ Likes to work in larger groups

Adapt to change/ability to follow rules:

☐ Accepts change ☐ Is confused by change ☐ Does not like change
☐ Prefers routine tasks ☐ Prefers variety of tasks ☐ Flexible
☐ Follows variety of rules ☐ Must have assistance to follow rules

Multitask (check all that apply):

☐ Can complete 1-3 tasks in sequence independently ☐ Can complete 1-3 tasks in sequence with assistance
☐ Can complete 4-6 tasks in sequence independently ☐ Can complete 4-6 tasks in sequence with assistance
☐ Can complete more than 7 tasks independently ☐ Can complete more than 7 tasks with assistance

Self-initiation:

☐ Always requires prompting to move to next step ☐ Will ask for next step 25% of the time
☐ Will ask for next step 25%-50% of the time ☐ Will ask for next step more than 50% of the time

Benefits desired (check all that apply):

☐ None ☐ Vacation ☐ Vision
☐ Medical ☐ Dental

IDD Employment Profile

Name: _____
ID Number: _____
Date: _____
Provider Agency: _____

Interactions/Preferred Work Environment (check all that apply):

- ☐ Friendly, talkative co-workers
- ☐ Helps others (co-workers, customers)
- ☐ Receives satisfaction from completing tasks
- ☐ Prefers a relaxed work site
- ☐ Would like to advance in the company
- ☐ Prefers few interactions with co-workers
- ☐ Prefers busy, high demand work site
- ☐ Prefers very quiet work site
- ☐ Requires recognition for a job well done

Person has expressed interest in:

Things done to earn money in the past:

Short term jobs(less than 90 days):

Volunteer or internship experiences:

Describe favorite employment experience (if applicable):

Describe work skills the person already has:

How does the person get around in their community:

What are the person's hobbies and interests:

IDD Employment Profile

Name: _____
ID Number: _____
Date: _____
Provider Agency: _____

What are the person's conditions (non- negotiations) for employment at this time:

What are the person's potential contributions to offer to employers:

Staff signature/credentials	

IDD Waiver Job Discovery Profile

Purpose

The Job Discovery Profile is developed as a result of the Job Discovery Process and contains information that provides a full and accurate picture of the person.

General

The Job Discovery Profile should be written in positive, person-first language that portrays the person in the best light possible. While a specific form is not required, all elements listed below must be addressed.

Part I

Identification information *(birthdate, gender, address, phone number(s), Medicaid Number, Social Security Number, place of residence, name of parent/legal representative, address and phone number, if different than the person's, marital status, additional agencies involved with the person and what they provide and/or agencies involved with the family and what they provide.)*

Living Arrangements

a. Family members involved in the person's life, including extended family in the local area
b. Names, ages and employment (if applicable) of the people living in the home/residence (if applicable)
c. Residential history
d. Description of neighborhood
e. Location of neighborhood in the community
f. Transportation used by person, family, staff
g. General commercial areas (shopping , industry, services) near the home

Education and Specialized Training History

a. School, dates of attendance, degree/Certificate of Completion/Occupational Diploma, reason if not completed
b. Vocational training, internships, special trainings, sheltered workshops, other day programs, dates, locations, name of entity, special skills developed, level of interest in these activities
c. Work History (list most recent first), business, dates, job title, pay, responsibilities, reason(s) for leaving

Part II

Person and Family

a. Brief summary
b. Typical routine
c. Family (or staff, as appropriate) supports
d. Family (staff) and person's needs for daily routine support
e. Physical and health related issues

Educational Experiences

a. Overall educational experiences
b. Academic services
c. Community recreation activities/participation
d. Vocational experiences and activities

Employment and Related Activities

a. Informal work performed at home for others
b. Formal chores and responsibilities
c. Entrepreneurial activities
d. Internships, structured work experiences, sheltered work, other day programs, volunteering
e. Wage employment
f. General areas of previous work interest

Life Activities and Experiences

a. Friends and social groups
b. Personal activities including hobbies, done at home
c. Family/friend activities, including hobbies, done at home
d. Personal activities, including hobbies, done in the community
e. Family/friend activities, including hobbies, done in the community
f. Specific events and activities that are of crucial importance

Skills, Interests and Conditions in Life Activities

a. Domestic/home skills
b. Community participation skills
c. Recreation/leisure skills
d. Academic skills
e. Physical fitness skills
f. Arts and Talents
g. Communication skills
h. Social skills
i. Mobility skills
j. Sensory skills (sight, hearing, smell, touch)
k. Vocational skills
l. Personal care needs

Connections for Employment

a. Potential connectors in family (or staff, as appropriate)
b. Potential connectors among friends, neighbors, and work colleagues
c. Potential connection sites in community relationships
d. Potential connections through clubs, organizations, or groups (such as church or school)
e. List of local employers (determined by proximity, relationships, interest areas, etc.)

Part III

Conditions for Success

a. General conditions for participant
b. General conditions for family (or staff, as appropriate)
c. Conditions for task performance
d. Instructional strategies
e. Environmental conditions
f. Supervisory strategies
g. Supports needed for successful task performance
h. Conditions to be avoided

Interests Toward an Aspect of the Job Market

a. General personal interest
b. General family interests (or staff, as appropriate)
c. Activities participant engages in without being expected to do so
d. General areas of current work interest
e. Specific areas of past work experience

Contributions

a. Strongest positive personality characteristics
b. Most reliable strengths regarding performance
c. Best current and potential skills to offer to potential employers
d. Credential training, certifications, and recognized skills
e. Possible sources for recommendations
f. Resources/financial assets

Challenges

a. Areas potentially needing matching to employment sites
b. Areas potentially needing negotiation with local employers
c. Physical/health restrictions
d. Habits and routines
e. Challenges related to disability – need for accommodation and disclosure
f. Financial issues
g. Transportation issues

Potential Employer List

List businesses, addresses and types of each business.

Signatures

The Job Discovery Profile must be signed by the person/legal representative, Job Discovery staff, and his/her program director.

Timelines

The Job Discovery Profile is to be completed no more than three (3) months from the date of the person's referral to the Job Discovery agency. It is to be in the record by the 10th of the month following the month it is completed.

IDD 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.

General

This assessment is completed by the Behavior Support Consultant using interviews with the person, family, others, and direct observation. Observation of youth can occur in the school setting, but actual Behavior Support Services cannot occur in the school.

All components must be addressed.

After the Functional Behavior Assessment is complete, the Behavior Consultant indicates at the end of the form the amount of Behavior Support services that will be necessary.

The results of the Functional Behavior Assessment may yield that a formal Behavior Support Plan is not necessary. However, training of individuals (staff, family, others) who interact with the person may be the appropriate course of action. If this is the case, indicate the amount of training needed to adequately address the behavior in all appropriate settings.

Timelines

The Functional Behavior Assessment must be completed within ninety (90) days of approval of the Behavior Support Evaluation.

Submission of Documentation

If a Behavior Support Plan is warranted, the Functional Behavior Assessment must be submitted with it to the appropriate ID/DD Waiver Support Coordinator who then submits them both to BIDD for approval. The amount of service anticipated to be needed is included on the Functional Behavior Assessment.

If a Behavior Support Plan is not warranted, but training of individuals who interact with the person is, this is to be indicated on the Functional Behavior Assessment and be submitted to the appropriate ID/DD Waiver Support Coordinator who will submit the request to BIDD.

IDD 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 and Topography:	**Frequency**	**Duration**	**Intensity**

Behavior and Topography:	**Frequency**	**Duration**	**Intensity**

Behavior and Topography:	**Frequency**	**Duration**	**Intensity**

Behavior and 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)?

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 person 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.)

I. How many other people are in the setting (work/school/home)? Do you believe that the density of people or interactions with other persons 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?

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?

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 or a place	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.				

X. Summary/ Recommendations

Based on the Functional Behavior Assessment, the following action(s)/behavior(s) were discovered:

Behavior	Function	Location

The results of the assessment(s) reflect that the action(s)/behavior(s) demonstrated by the person pose a risk to the health and welfare of the person and/or others.	Yes	No

If a risk(s) exist, list them below:		
Behavior	Risk to Self	Risk to Others

Based upon the above information, it is suggested that Behavior Support services ***ARE*** warranted	
Based upon the above information, it is suggested that Behavior Support services ***ARE NOT*** warranted	

It is anticipated that approximately		hours for		months will be required to implement
the Behavior Support Plan.				

Behavior Support Consultant Signature/Credentials	**Date**

Request for IDD Waiver Behavior Support and/or Crisis Support Services

Purpose

The form must be completed when a person requests Behavior Support or Crisis Support. The form is submitted by the IDD Waiver Support Coordinator with input from the chosen Behavior Support or Crisis Support provider.

General

Indicate the amount of service being requested, the person's diagnoses, medications, targeted behaviors, the frequency of behaviors and the last occurrence and the environment(s) where the behavior(s) occurred. The form must reflect whether or not the person has received the service in the past. If the answer is yes, the previous provider and dates services were provided must be indicated.

The request for each service must be tailored to the service and the justification must support the definition of the service as indicated in the DMH Operational Standards.

Timelines

If a person is admitted to ***Crisis Support*** services prior to the service being approved on his/her Plan of Care, the Support Coordinator has five (5) days to submit a request to the BIDD for approval. Behavior Support services cannot be provided prior to BIDD approval.

The Support Coordinator submits the form electronically to the BIDD.

IDD Waiver Request for Behavior Support and/or Crisis Support

Name:		Date:	
Medicaid #:		Regional Program:	
Support Coordinator:		SC Phone Number:	
Service(s) Requested:		Provider Requested:	
Diagnoses:			
Current Medications:			
Target Behavior(s):			
Frequency of behavior(s):			
Date of last occurrence of behavior(s):			
Environment(s) where behavior(s) occur:			
Desired goal/outcome of service:			

Has the person received the service(s) before?	Yes	No
If so, list dates and provider(s) and outcomes/goals achieved:		
Source(s) of Information:		

Support Coordinator Signature/Credentials **Date**

Medical Verification for IDD Waiver
Behavior Support and Crisis Intervention Services

Purpose

A physical evaluation must be conducted by a licensed physician or nurse practitioner to rule out any underlying medical conditions that may be causing the behavior(s) to occur (for example, an abscessed tooth, ulcer, ear ache etc.).

General

IDD Waiver Behavior Support

This form is to be completed during the Behavior Support evaluation process. During the Behavior Support Consultant's initial meeting with the person/legal representative and service provider(s), if applicable, the rationale for the form is explained. The person/legal representative/service provider is responsible for ensuring the form is completed by a physician or nurse practitioner. The physical evaluation cannot be more than ninety (90) days old at the time Behavior Support Services begin.

IDD Waiver Crisis Intervention

A person must see a physician/nurse practitioner as soon as feasible after the provision of IDD Waiver Crisis Intervention Services to determine if there are any physical/medication factors that may be contributing to the crisis behaviors. The IDD Waiver Crisis Intervention Services provider is responsible for working with the person/legal representative and/or other service providers to have the form completed as soon as possible, but not to exceed ten (10) days after the provision of IDD Waiver Crisis Intervention Services.

Timelines

The IDD Waiver Behavior Support/IDD Waiver Crisis Intervention provider must maintain a copy of this form in the person's record. It must be placed in there no later than the 10th of the month following the month it is signed by the physician/nurse practitioner. A copy must be forwarded to the Support Coordinator no later than the 15th of the month following the month it is completed.

Medical Verification for IDD Waiver
Behavior Support and Crisis Intervention Services

Person's Name:			
Healthcare Provider's Name:		**Office Phone:**	
Healthcare Provider's Address:			

Proposed Behavior Support/Crisis Intervention Service:

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 person cannot participate in the proposed Behavior Support/Crisis Intervention Services.
		This person presents no symptoms of physical illness that should receive medical treatment prior to starting/continuing Behavior Support/Crisis Intervention services.
		This person presents no symptoms of mental illness that should receive medical treatment prior to starting Behavior Support/Crisis Intervention services.
		There are no special medical precautions to follow during the implementation of Behavior Support/Crisis Intervention services.

Based Upon My Knowledge of This Person:

	He/she can participate in the proposed Behavior Support/Crisis Intervention services.
	He/she requires medical treatment that must be successfully completed prior to starting Behavior Support/Crisis Intervention services.
	He/she cannot participate in the proposed Behavior Support/Crisis Intervention services for medical reasons.

Signature of Healthcare Provider/Credentials		**Date**

IDD Waiver Behavior Support Plan

Purpose

The Behavior Support Plan is developed by the Behavior Support Consultant based on the assessment(s) used to evaluate the person's actions or behavior(s).

General

All areas indicated on the Behavior Support Plan must be addressed:

- Background information
- Summary of the Functional Behavior Assessment
- Tracking and reduction strategies
- Objectives
- Staff instructions for implementing the plan

The Behavior Support Plan must indicate the total number of Behavior Support hours necessary for implementation of the plan and an estimated date of completion. Hours must be broken out between the Behavior Support Consultant and Behavior Support Specialist when applicable.

Signatures

The following signatures must be obtained by the provider after completion and review of the Behavior Support Plan:

The parent/legal representative, if appropriate, and the person receiving services, indicating they agree with the contents of the Behavior Support Plan and consent for its implementation,

The Behavior Support Consultant agreeing to implement the plan as written and to notify the person/family/legal representative before making any changes or modifications,

The Behavior Support Specialist (when applicable) agreeing to implement the plan and collect data to report to the Behavior Support Consultant as indicated in the plan,

The Director or Supervisor of the program the person attends (if the Behavior Support Plan is to be implemented in such a setting), indicating he/she agrees with the content of the Behavior Support Plan and will provide support as necessary. Also, he/she is agreeing to allow appropriate staff to be trained by the Behavior Support Consultant and/or a Behavior Support Specialist to ensure the plan continues to be successful after the Consultant/Specialist has ceased providing services,

Prior to being submitted to the Support Coordinator, the Behavior Support Plan must be approved by a licensed clinician or person with a BCBA Credential.

Timelines

The Behavior Support Plan must be completed within ten (10) days of completion of the Functional Behavior Assessment.

A copy of the Behavior Support Plan along with the Functional Behavior Assessment must be submitted to the Support Coordinator within ten (10) days of completion. The Support Coordinator will submit the documentation to BIDD for review.

The Plan must be approved before services can begin. The Plan must be reviewed at least quarterly.

A copy must be in the person's record no later than the 10th day of the month following the month it is developed.

IDD Waiver Behavior Support Plan

Name:		**Behavior Consultant:**	
Medicaid #:		**Agency:**	
Address:		**Contact Number:**	
		Email Address:	
		Phone Number:	

Background	
Reason for Referral:	
History:	
Psychiatric Diagnoses:	

Summary of Functional Behavior Assessment		
Target Identification Methods:		
Description of Assessment Procedures:		
Target Behavior(s) and Definitions:	Behavior(s)	Definitions

Behavioral Findings:	Behavioral Description	Antecedents	Consequences
Relevant Findings from Physiological Issues/Illness/Injury Assessment:			
Relevant Findings from Environmental and Setting Assessment:			
Relevant Findings from Communicative Functions:			
Hypothesis and Summary of Behavior Function(s):			
Baseline Data:			
Replacement Behaviors Identified:			

Tracking and Reduction

Behavior Reduction:	
Baseline Data:	
Treatment Expectation:	
Replacement/ Alternative Behavior:	
Review Criteria:	

Behavior Reduction:	
Baseline Data:	
Treatment Expectation:	
Replacement/ Alternative Behavior:	
Review Criteria:	
Behavior Reduction:	
Baseline Data:	
Treatment Expectation:	
Replacement/ Alternative Behavior:	
Review Criteria:	

Objective(s)	
1.	
2.	
3.	
4.	

Staff Instructions	
Preventive Measures:	
Replacement Behavior/Alternative Skill Training:	
Consequence Strategies:	
Procedural Safeguards:	
Medication Side Effects of Concern:	
References:	

Recommendation(s)			
Total Hours Requested:		Estimated Completion Date:	
Behavior Support Consultant Hours per Month:		Number of Months:	
Estimated Behavior Specialist Hours per Month:		Number of Months:	

Agreements and Signatures

I agree with the content 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.

Person:		Date:	
Parent/Legal Representative:		Date:	

I agree to implement the Plan as described. If any modifications are necessary, I will contact the family before making any changes. I will ensure staff is trained before terminating my services.

Behavior Support Consultant:		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.

Program Director:		Date:	
Approved by:		Date:	
License Number or Credential:			

IDD Waiver Behavior Support
Quarterly Review Report

Purpose
The Behavior Support Consultant must complete a Quarterly Review Report to be submitted for approval to the Behavior Services Oversight Team for each quarter services are provided. The report reflects the supports provided and the amount of progress made during that particular quarter.

General
Based on data gathered during each quarter, the Behavior Support Consultant composes a report that reflects the elements required on the form.

The Behavior Support Quarterly Review Report must be signed and dated by the Behavior Support Consultant and his/her Clinical Supervisor before being submitted to the appropriate Support Coordinator.

The Support Coordinator will submit the report electronically to BIDD. The Behavior Services Oversight Team will review the report and return it to the Support Coordinator. The Support Coordinator will return the approved report to the Behavior Support Consultant.

Timelines
The Quarterly Review Report is to be completed at the end of each three (3) months of service to the person. It is to be submitted to the Support Coordinator by the 15th of the month following the month it is completed.

IDD Waiver Behavior Support Quarterly Review Report

Name:		**Date of Report:**
Medicaid Number:		
Behavior Consultant:		
Behavior Specialist:		
Support Coordinator:		
Service Dates:	BSP Approved:	Implemented:
	Last Reviewed:	Estimated Completion:
Describe any changes in behavior, medication (include prescribing doctor) and/or diagnosis:		
Explain reasons for changes:		
Target Behaviors:		

Locations of Behavior Support Plan implementation: □ Home □ Day Program □ Community □ Place of Employment	Behavior Support Plan structure: □ Modeling □ Reinforcement/Consequences □ Training for staff/family □ One-on-one supervision □ Redirection & blocking □ Verbal Prompting □ Environmental accommodations □ Other:

Include a chart indicating baseline data or data collected for previous review as well as a brief narrative to describe the chart/data:

IDD Waiver Behavior Support
Quarterly Review Report

Name:	**Date of Report:**
Medicaid Number:	

Include a chart indicating most recently recorded data as well as a brief narrative to describe the chart/data.

Provide a narrative to explain the progress demonstrated in the above charts

Summary/Future Goals:

Behavior Consultant Signature and Credentials — Date

Behavior Consultant Signature and Credentials — Date

Clinical Supervisor Signature and Credentials — Date

BSOT Approval

IDD Waiver Request for Additional Behavior Support Services

Purpose

When additional Behavior Support Services are deemed necessary by the Behavior Support Consultant, a Request for Additional Behavior Support Services form must be submitted for approval.

General

The Behavior Support Consultant indicates the amount of service needed, the targeted behaviors, the number of Behavior Support hours that have been used thus far, how they were used and includes justification for the additional hours being requested. The desired goal(s) or outcome(s) must be included.

The form and any attached documentation are submitted to the appropriate Support Coordinator for submission to the BIDD for review.

IDD Waiver Request for <u>Additional</u> Behavior Support Services

(use as many pages as necessary)

Name:		Date:	
Medicaid #:		Regional Program:	
Behavior Consultant:		B.C. Phone Number:	
# Hours Requested:		# Hours already utilized:	
Targeted behavior(s):			
Justification for additional services: (why hours are needed and how they will be used)			
Desired goals/outcomes:			

❖BIDD/BSOT USE ONLY❖

Approved	Disapproved
BSOT/BIDD Signature/Credentials:	
Date:	

IDD Waiver Request for Additional Crisis Support Services

Purpose
When additional Crisis Support Services are deemed necessary by the Program Supervisor, a Request for Additional Crisis Services form must be submitted for approval.

General
The Program Supervisor indicates the additional number of days needed, the targeted behaviors, the number of days that have been used thus far, how they were used and includes justification for the additional days being requested. The desired goal(s) or outcome(s) must be included.

The form and any attached documentation are submitted to the appropriate Support Coordinator for submission to the BIDD for review. The maximum number of days of Crisis Support someone may receive without additional approval is thirty (30).

IDD Waiver Request for <u>Additional</u> Crisis Support Services

(use as many pages as necessary)

Name:		Date:	
Medicaid #:		Regional Program:	
Program Supervisor		Phone Number:	
# Days Requested:		# Days already utilized:	
Targeted behavior(s):			
Justification for additional services: (why days are needed and how they will be used)			
Desired goals/outcomes:			

❖BIDD/BSOT USE ONLY❖

Approved	Disapproved
BSOT/BIDD Signature/Credentials:	
Date:	

Request for IDD Waiver
Crisis Intervention Services

Purpose

The form must be completed when a person requests IDD Waiver Crisis Intervention services. The form is submitted to BIDD for approval by the Behavior Services Oversight Team.

General

The IDD Waiver Crisis Intervention Services provider notifies the Support Coordinator that services have been utilized. The provider completes the form. It must be signed by the Clinical Supervisor of the IDD Waiver Crisis Intervention Services Team.

Timelines

If a person receives Crisis Intervention services prior to the service being approved on their Plan of Care/Plan of Services and Supports, the Support Coordinator has five (5) days from the date services were provided to work with the provider to get it completed and submit it to BIDD for approval.

IDD Waiver Request for Crisis Intervention Services

Name:	**Date of Request:**
Medicaid Number:	**Regional Program:**
Support Coordinator:	**Phone Number:**
Provider Agency:	**Phone Number:**
Diagnoses:	
Current Medications:	
Target Behavior(s):	
Frequency of behavior(s):	**Date of last occurrence of behavior(s):**
Environment(s) where behavior(s) occur(red):	
Desired goal/outcome of service:	

Has the person received the service(s) before?	**☐Yes**	**☐No**
If so, list dates, provider(s), outcomes/goals achieved and why service ended:		
Source(s) of Information:		

Clinical Supervisor/Credentials **Date**

Approved		Disapproved
BSOT Signature/Credentials		**Date**

IDD Waiver
Crisis Intervention Plan

Purpose
The IDD Waiver Crisis Intervention Plan is developed for people who utilize IDD Waiver Crisis Intervention Services.

General
A Crisis Intervention Plan is developed for someone for whom the service is on his/her approved Plan of Care and staff/family know his/her potential crisis(es), as well as for those people who have experienced a crisis and received IDD Waiver Crisis Intervention Services. The person can either have received the service on an episodic basis or it can be for someone who requires the service on a 24/7 basis, depending on the nature of the crisis and the person's individual circumstances.

The IDD Waiver Crisis Intervention Plan is used to provide a plan for use in mitigating and intervening in a person's individual crisis situation. There can be multiple types of crises addressed on a single plan. Describe the person's relevant history in regard to the presenting crisis(es) and the known trigger(s) for said crisis(es). The IDD Waiver Crisis Intervention Team and the person/legal representative, Support Coordinator and providers, if applicable, then work to develop the IDD Waiver Crisis Intervention Plan that can be implemented in the home, the community, a day program or some combination of sites.

In addition to the case record, copies of the IDD Waiver Crisis Intervention Plan are to be maintained in all settings where it may be implemented and the IDD Waiver Crisis Intervention Team is to train all individuals who may have to implement components of the IDD Waiver Crisis Intervention Plan.

The IDD Waiver Crisis Intervention Team also provides a Team member's name and phone number to contact in case of a crisis which cannot be resolved by implementing the IDD Waiver Crisis Intervention Plan.

It is signed by the person/legal representative, the IDD Waiver Crisis Intervention Team Clinical Supervisor, by IDD Waiver Crisis Team staff who is primarily responsible for implementation, if applicable, a staff of another provider(s) who may have to implement the plan as well other IDD Waiver Crisis Intervention Team staff who may have to implement the IDD Waiver Crisis Intervention Plan.

Timelines
The IDD Waiver Crisis Intervention Plan must be developed within five (5) days of the provision of or referral for IDD Waiver Crisis Intervention Services.

Copies of the IDD Waiver Crisis Intervention Plan must be sent to all applicable parties no more than five (5) days following development. It must be in the person's record no later than the 10th of the month following it is developed.

IDD Waiver Crisis Intervention Plan	**Name:** _____ **Medicaid Number:** _____ **Provider Agency:**

Crisis Intervention Team Contact:	Phone number:

Relevant History and Potential Crisis Situation(s):	Current Medications

Known Triggers:

Action Steps for Home	Action Steps for Community Locations (specify location(s))	Action Steps for Day Programs
Person/Legal Guardian Signature/Date	Crisis Intervention Team Clinical Supervisor Signature/Credentials/Date	Responsible Crisis Intervention Team Staff Signature/Credentials/Date
Other Provider Signature/Credentials/Date	Other Responsible Crisis Intervention Team Staff Signature/Credentials/Date	Other Responsible Crisis Intervention Team Staff Signature/Credentials/Date

IDD Waiver
Crisis Intervention Daily Service Note

Purpose
This form is used during the provision 24/7 daily IDD Waiver Crisis Intervention Services.

General
The IDD Waiver Crisis Intervention Daily Service Note must include analysis of the behaviors and contributing factors, progress in implementing the IDD Waiver Crisis Intervention Plan, providing direct supervision or support, counseling and training family members and/or staff how to remediate the current crisis and prevent its reoccurrence.

The form is designed to be a running document that allows staff to document activities/events that take place during the provision of IDD Waiver Crisis Intervention Services on a 24/7 basis. The time services begin as well as when they end must be documented. Use a.m./p.m. Notes should run from the time the service actually begins on any given day until 11:59 p.m. Notes for the next day begin at 12:00 a.m. and end on the day and time the person leaves the service. There must be notes from all shifts detailing the person's activities (meal times, leisure activities, personal hygiene activities, attendance at a day program, etc.) as well as reactions to implementation of the IDD Waiver Crisis Intervention Plan.

Timelines
IDD Waiver Crisis Intervention Daily Service Notes must be in the person's record no later than the 10th of the month following they month they were completed.

IDD Waiver Crisis Intervention Daily Service Note

Name _____

Agency _____

Medicaid #: _____

Page **of**

Staff Signature/Credentials	Date (m/d/yr)	Time In (am/pm)	Time Out (am/pm)	Total Time

Notes

IDD Waiver Crisis Intervention Log - Episodic

Purpose

The IDD Waiver Crisis Intervention Log – Episodic is used to document the provision of IDD Waiver Crisis Intervention Services as they occur episodically, not in the provision of 24/7 IDD Waiver Crisis Intervention Services.

General

Document the name, Medicaid number, time services began, time services ended, and the total amount of time in service provision. The location(s) where services are provided must be listed. This could be in the person's home, in a community location, at a program site or a combination of more than one (1) site. List the names of the people involved in the situation and their relationship to the person. If someone else receiving services is involved, simply list his/her relationship to the person. For example, list "another person participating in the program" rather than Bob Smith.

Describe in detail the nature of the situation which required IDD Waiver Crisis Intervention services. This could include elopement, damage to property, self, others, etc. This is the justification for the provision of services.

Describe in detail the action(s) taken to address the situation before the arrival of Crisis Intervention staff. This includes information about what staff/family/others did to intervene in or mitigate the crisis.

Describe action(s) taken by Crisis Intervention staff to resolve the crisis. This could include counseling, the use of Mandt© techniques, removal from the situation to another setting, etc.

Describe in detail the final resolution of the crisis. Indicate the person's condition at the end of the crisis. Part of the resolution of the crisis may be that the person is removed from the setting for an extended period of time that may cover one or more days. Also document if referrals were made to other agencies, which agencies, the reason for referral and the appointment time, if applicable.

Indicate if the ID/DD Waiver Crisis Intervention Plan was implemented as written or if, as a result of the current situation, it requires revision. If this is the first time services have been provided, indicate the need for an IDD Waiver Crisis Intervention Plan.

The staff who provided IDD Waiver Crisis Intervention Services sign and date the form upon completion. Even though there is only one line for staff signature/credentials, if more than one (1) staff participated in the event, include their signature and credentials also.

Timelines

The IDD Waiver Crisis Intervention Log – Episodic must be completed each time services are provided. If it is the first time services are being provided, the Clinical Supervisor must notify

the person's IDD Waiver Support Coordinator to request from BIDD that it be added to the person's IDD Waiver Plan of Care/Plan of Services and Supports within five (5) days of the provision of IDD Waiver Crisis Intervention Services. The justification for the need for services is documented on the IDD Waiver Request for Crisis Intervention Services form. The provider completes the IDD Waiver Request for Crisis Intervention Services form and submits it to the Support Coordinator who will then submit it to BIDD for review by the Behavior Services Oversight Team.

If this is not the first time the services have been used, the provider completes the IDD Waiver Crisis Intervention Log and submits a copy to the Support Coordinator.

All IDD Waiver Crisis Intervention Logs must be in the person's record no later than the 10th of the month following the month they are completed.

IDD Waiver Crisis Intervention Log
(Episodic)

Name:

Medicaid Number:

Date	Time Began	Time Ended	Total Time

Location(s) where services provided:

People Involved and Relationship:

Situation Requiring Support
(Use as much space as needed)

Action(s) Prior to Crisis Intervention Staff Arrival
(Use as much space as needed)

Action(s) of Crisis Intervention Staff
(Use as much space as needed)

Resolution
(Use as much space as needed)

Crisis Plan Implemented ☐ Crisis Plan Requires Revision ☐ Crisis Plan Needed ☐

Staff Signature/Credentials **Date**

Clinical Supervisor Signature/Credentials **Date**

IDD Waiver Request for Additional Crisis Intervention (24/7) Services

Purpose
When additional Crisis Support Services on a 24/7 basis are deemed necessary by the Program Supervisor, a Request for Additional Crisis Intervention Services form must be submitted for approval.

General
The Program Supervisor indicates the additional number of days needed, the targeted behaviors, the number of days that have been used thus far, how they were used and includes justification for the additional days being requested. The desired goal(s) or outcome(s) must be included.

The form and any attached documentation are submitted to the appropriate Support Coordinator for submission to the BIDD for review. The maximum number of days of Crisis Support someone may receive without additional approval is seven (7).

IDD Waiver Request for <u>Additional</u> Crisis Intervention (24/7) Services

(use as many pages as necessary)

Name:		Date:	
Medicaid #:		Regional Program:	
Program Supervisor		Phone Number:	
# Days Requested:		# Days already utilized:	
Targeted behavior(s):			
Justification for additional services: (why days are needed and how they will be used)			
Desired goals/outcomes:			

❖BIDD/BSOT USE ONLY❖

Approved	Disapproved
BSOT/BIDD Signature/Credentials:	
Date:	

Section I
Substance Abuse Prevention and Treatment-Rehabilitation Services

Educational Activities/Risk Assessments for TB/HIV/STD

Substance Abuse Monthly Capacity Management and Waiting List Report

Risk Assessment Interview & Educational Activities for TB/HIV/STDs

Purpose

All individuals receiving substance use treatment services (i.e., Outpatient/Intensive Outpatient Services, Primary/Transitional Residential Services, Withdrawal Management Services, Opioid Treatment Services, Recovery Support Services, DUI Diagnostic Assessment Services) must receive a TB and HIV Risk Assessment Interview as well as educational information on HIV/AIDS, TB, STDs, and Hepatitis.

Applicability

Under each section, if any of the items do not apply, document as "not applicable."

Risk Assessment Interview for TB/HIV/STDs Form

The staff should verbally administer the interview questions and mark the individual's responses on the Risk Assessment Interview Form. Staff should indicate any additional information in the comments section. After completion on the Assessment Interview, Staff should sign with credentials and date the form.

Educational Activities & Risk Assessments for TB/HIV/STDs Form

Educational Activities

Lines 1-4: Record the month/day/year and total amount of time spent on each education topic. A minimum of one hour of HIV Prevention Education is required for all individuals in treatment at funded Substance Abuse Block Grant HIV Early Intervention Services programs (SABG HIV-EIS). Educational activities can be conducted in group and/or individual sessions.

HIV Risk Assessment, Testing, & Counseling

Line 1 Record month/day/ year that the Risk Assessment Interview was completed for the individual receiving substance use treatment services. Total Time is not applicable for Line 1 item.

Line 2 Record the month/day/year and total time that the individual received HIV pre-test counseling. This is applicable to all individuals receiving treatment services, even if they opt out of HIV testing. For SABG HIV-EIS, a minimum of 30 minutes pre-testing counseling is required.

Line 3 Record YES if the individual received HIV testing and the month/day/year the individual was tested. Record NO if the individual receiving services opts-out of testing. An Opt-Out form must be completed if NO is marked. Indicate the month/day/year the Opt-Out form was completed and signed by the individual. Total Time is not applicable for Line 3 items.

Line 4 Record the month/day/year and total time the individual receiving services was provided post-test counseling. Post-test counseling can only be provided IF testing was conducted. For SABG HIV-EIS, a minimum of 30 minutes of post-test counseling is required, with 60 minutes for a reactive HIV test.

Tuberculosis Risk Assessment, Testing, & Referral

Line 1 Record the month/day/year the Risk Assessment Interview was completed for the individual receiving primary substance use treatment services.
Check YES if results indicate further action is needed.
Check NO if results of risk assessment do not indicate that further action is warranted.
If an individual is determined to be high risk, the individual cannot be admitted to treatment until testing confirms the individual does not have TB.

Line 2 If further testing is not required, document as “not applicable.”
If Skin Test is completed, 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 If further testing is not required, document as “not applicable.”
If X-ray testing is required, 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 If further treatment is not required, document as “not applicable.”
If TB treatment is required, record month/day/year when the individual was referred for treatment for tuberculosis.

Individual Receiving Services Signature/Date

After receiving all applicable risk assessments/educational activities, the individual receiving substance use treatment services must sign and date the form where indicated.

Staff Signature/Credentials/Date

After the individual has received all applicable risk assessments/educational activities, the staff person responsible for verifying the administration of these risk assessments/educational activities must sign, date, and record their credentials.

Risk Assessment Interview for TB/HIV/STDs

Name _____

ID Number _____

Date

1.	Have you ever tested positive, been diagnosed with, or treated for tuberculosis (TB)?	❑Yes	❑No
2.	Has anybody you know or have lived with been diagnosed with or tested positive for TB in the past year?	❑Yes	❑No
3.	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.		❑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?		❑No
	❑ Coughing up blood ❑ Drenching night sweats ❑ Active TB		
4.	Have you ever been told that you have a positive HIV test? (test for the AIDS virus)	❑Yes	❑No
5.	Do you have a history of IV drug usage?	❑Yes	❑No
6.	Have you used cocaine (I.E., powder, crack...etc.)?	❑Yes	❑No
7.	Have you ever engaged in unprotected vaginal, anal or oral sex with multiple partners and/or anonymous partners?	❑Yes	❑No
8.	Have any of your current or previous sex partners used IV drugs or been HIV positive?	❑Yes	❑No
9.	Have you ever been paid to have sex or to exchange sex for food, shelter, etc.?	❑Yes	❑No
10.	Have you ever been the victim of sexual assault?	❑Yes	❑No
11.	Have you ever used alcohol or drug before or during sex?	❑Yes	❑No
12.	Have you been diagnosed with or treated for hepatitis and/or a sexually transmitted disease?	❑Yes	❑No
13.	Have you ever lived on the street or in a shelter?	❑Yes	❑No
14.	Have you ever been incarcerated or in jail?	❑Yes	❑No
15.	Have you had a blood transfusion prior to 1992?	❑Yes	❑No
16.	Were you born between the years 1945 and 1965?	❑Yes	❑No

Comments:

_____ _____

Staff Signature/Credentials Date

Educational Activities & Risk Assessments for TB/HIV/STDs

Name

ID Number

Educational Activities	**Date Completed**	**Total Time**
1. HIV/AIDS Information (minimum of 1 hour required for funded SABG HIV-EIS programs) (including modes of transmission, universal precautions and other preventative measures, current treatments and how to access them)		
2. Sexually Transmitted Diseases (STDs) (including modes of transmission, precautions to take against contraction, progression of diseases, current treatment resources and how to access them)		
3. Tuberculosis (including modes of transmission, current treatment resources and how to access them)		
4. Hepatitis (including modes of transmission, precautions to take against contraction, current treatments and how to access them)		

HIV Risk Assessment, Testing, & Counseling			**Date Completed**	**Total Time**
1. Completion of Risk Assessment Interview				
2. Provided HIV Pre-Test Counseling (minimum of 30 minutes)				
3. Provided HIV Testing				
	❑Yes			
	❑No	❑ Opt-out form completed for refusal of testing on:		
4. Provided Post-Test Counseling if testing was conducted (minimum of 30 minutes; 60 minutes for a reactive HIV test)				

Tuberculosis Risk Assessment, Testing, & Referral	**Date Completed**
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	

By signing, you acknowledge receipt of the educational information and all risk assessments listed above.

Individual Receiving Services	**Date**	**Staff Signature/Credentials**	**Date**

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

To assist with appropriate referrals and placement, all residential programs must report to DMH when the census of the program exceeds 90% capacity and when the census drops below 90% capacity. Report should be submitted to the Office of Consumer Support by fax or the Bureau of Alcohol and Drug Services by email within 24 hours of crossing the 90% threshold.

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 Support by fax or the Bureau of Alcohol and Drug Services by email 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 Support by fax or the Bureau of Alcohol and Drug Services by email 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.

Substance Abuse Capacity Management

Timeline within 24 hours

Facility Name _____

Date _____

- ❑ At 90% capacity
- ❑ No longer at 90% capacity

Fax or Email to:

Office of Consumer Support
Fax Number: (601)359-9570
Or
Bureau of Alcohol and Drug Services
Email: deeannalechtenberg@dmh.state.ms.us

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:

Office of Consumer Support
Fax Number: (601)359-9570
Or
Bureau of Alcohol and Drug Services
Email: deeannalechtenberg@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:

Office of Consumer Support
Fax Number: (601)359-9570
Or
Bureau of Alcohol and Drug Services
Email: deeannalechtenberg@dmh.state.ms.us

_____
Date Submitted to DMH

Section J Administrative Information

Disaster Preparedness and Response Guidance

Disaster, Fire, and COOP Drills for all Programs

DMH Plan of Compliance Template

DISASTER PREPAREDNESS AND RESPONSE
Guidance for Operational Standards

This document contains guidance to assist your program with compliance with The Mississippi Department of Mental Health Operational Standards for Disaster Preparedness and Response as well as the Continuity of Operations Plan (COOP). By using this guidance, you will be more likely to meet the required elements for each standard listed. This guidance is not meant to be copied and pasted into your Policy and Procedures Manual, but is simply a guide to assist you in meeting the agency's standards.

Beneath each standard (**in bold**) you will find guidance that will assist you in meeting the desired outcome of that standard. Some of the standards require completion of certain tasks. For example, in the introduction to the emergency/disaster response plan section you must have a plan for each site that is "reviewed by the governing body". You must have in your plan a statement that the plan will be reviewed by the governing body, how often, and how you will document this.

If you have specific questions regarding these standards, please contact The Mississippi Department of Mental Health, Office of Incident Management at 601-359-6652 or send email questions to randy.foster@dmh.state.ms.us.

Rule 13.9.A **Providers must develop and maintain an emergency/disaster response plan for each service location/site, approved by the governing body, for responding to natural disasters, manmade disasters (fires, bomb threats, utility failures and other threatening situations, such as workplace violence). The plan should identify which events are most likely to affect the location/site. For example, the location/site is located near an airport, railroad, nuclear power plant, typical path of tornado, earthquake zone, coastal region, etc. This plan must address at a minimum:**

- You must have a plan for each service location/site. Each plan may have many of the same elements as other sites, but each site is a little bit different and the plan should reflect those differences.
- This plan must be approved by your governing authority; you must have documentation of this in meeting minutes.
- Each program should have as a part of the plan a response for each type of identified threat
    - Natural events such as tornado, hurricane, wild fire, etc.
    - Man-made events such as bomb threats, work place violence, etc.

To accurately assess the hazards that each location/site might be vulnerable to, it is suggested that you complete a Hazard Vulnerability Analysis (HVA) or contact the county to obtain county level HVA info. Please see attachment A for more information on how to conduct a HVA.

1. **Lines of authority and Incident Command**

   Identify who will be in charge for the whole agency and for each location/site in the event of an emergency/disaster. An organizational chart would be helpful here in the event that the identified person is not available.

2. **Identification of a Disaster Coordinator**

   Please designate one person that will act as your Disaster Coordinator. This individual will be in charge of making sure the plan is accurate and up to date, drills are conducted appropriately, and that the agency and each location are prepared to respond.

3. **Notification and plan activation**

   This section must contain what triggers activation of the plan, who officially activates the plan, and once the plan has been activated how staff and individuals who receive services are notified of the event. Part of this section should be notification to DMH, and local emergency personnel that need to be notified based on the nature of the event (Fire, Police, DEQ, Emergency Management, etc.).

4. **Coordination of planning and response activities with local and state emergency management authorities**

   Your agency and programs must coordinate with the local emergency response agencies. Typically, these are the local Fire Department, local Police Department, and local Emergency Management Agency. There may be other response agencies, such as non-profit agencies or other state/local agencies, which you may benefit from coordinating with as well. Each of these agencies may benefit from having a copy of your emergency/disaster response plan for review, comment and reference.

5. Assurances that staff will be available to respond during an emergency/disaster

You must have sufficient staff to continue the essential functions of the agency. You should identify how you will ensure that the needed staff is available to handle those responsibilities. This section should also address how your agency will ensure that staff is available to respond to community needs during an event.

6. Communication with individuals receiving services, staff, governing authorities, and accrediting and/or licensing entities

Outline how you will notify individuals receiving services, staff, your governing authorities, and your accrediting and/or certifying entities that an event has occurred, your plan has been activated, and to what extent and for how long your services will be affected.

7. Accounting for all persons involved (staff and individuals receiving services)

When the event occurs and directly affects your program, outline how you will make sure all of those present at the time of the event, both staff and individuals receiving services, are safe and accounted for. This could be done with attendance logs, lists of those staff that may be traveling, or other means of accounting for everyone. There must be a method to account for each individual.

8. Conditions for evacuation

Outline conditions that would cause you to evacuate your facility. A fire would be an example, but there are others as well such as power failure, sewage and/or water failure, foreseen unsafe conditions (hurricane, etc.), gas leaks (must comply with EMA directives regarding evacuation for gas leaks) and others. You should address all of those here.

9. Procedures for evacuation

Outline procedures for evacuation. Here you should identify the different types of evacuation as well. For example, the evacuation of your location for a fire is a different type of evacuation than leaving the location and area due to weather or chemical exposure. This section should also address the plan if the decision is made to shelter in place.

10. Conditions for agency closure

Under what conditions would your agency close? Some reasons might include damage to the facility, prolonged utility outage, infrastructure failure, and others.

11. Procedures for agency closure

If the conditions have been met for agency closure, what is the procedure? Who has the authority to order the agency closure? Who will be responsible for notification procedures?

12. Schedules of drills for the plan

Drills are required to be held on a schedule to ensure that staff is prepared in the event of an actual emergency/disaster. This schedule is the minimum requirement; more drills should be conducted if they are deemed necessary. The minimum schedule of drills should be as follows:

Quarterly fire drills for day programs

Monthly fire drills for residential programs, conducted on a rotating schedule within the following time frames:

7 a.m. to 3 p.m.
3 p.m. to 11 p.m.
11 p.m. to 7 a.m.

Quarterly disaster drills, rotating the nature of the event for the drill based on the emergency/disaster plan, for each facility and program.

Annual drill of Continuity of Operations Plan for the agency.

Drills should be unannounced as much as possible to ensure they are as real as possible.

13. **The location of all fire extinguishing equipment, carbon monoxide detectors (if gas or any other means of carbon monoxide emission is used in facility) and alarms/smoke detectors**

    In your plan you should have a map that shows the location of these items or a written description of the location of these items. The physical presence of these items in these locations will be checked on site visit.

14. **The identified or established method of annual fire equipment inspection**

    All fire equipment must be inspected on a set schedule, usually annually and by a professional from either the Fire Department or the equipment company. The method of inspection and documentation of inspection must be outlined here.

15. **Escape routes and procedures that are specific to location/site and the type of disaster(s) for which they apply.**

    A copy of the escape routes must be in the emergency/disaster response plan for reference. These signs should be posted in visible locations, oriented to the location in the building, with a route for evacuation specific to that location.

CONTINUITY OF OPERATIONS PLAN REVIEW

***Understand that this Continuity of Operations Plan (COOP) is for the agency as a whole, not for specific sites/locations. Only 1 COOP is required for the agency. Each site should be provided a copy of the agency's COOP.**

Rule 13.9.B Providers must develop and maintain a Continuity of Operations Plan, approved by the governing body, for responding to natural disasters, manmade disasters, fires, bomb threats, utility failures and other threatening situations, such as workplace violence. This plan must address at a minimum:

The following standards address your Continuity of Operations Plan (COOP). This plan is in place in the event that an emergency/disaster occurs. This plan ensures that essential functions can continue no matter what type of event occurs. Your governing body should approve this plan and any changes to it. Please note that the following standards are the minimum this plan should address.

1. **Identification of provider's essential functions in the event of emergency/ disaster**

   What are the essential functions of your agency? These are functions that your program's clients would need even during an emergency/disaster. Some examples could be medications, individual therapies, residential treatment, or any other number of services.

2. **Identification of necessary staffing to carry out essential functions**

   List the staff members (not specific names, but positions) that your agency will need to ensure that the essential functions will continue. List the capacity in which these individuals will serve and backup staff if these individuals are not available.

3. **Delegations of authority**

   Who has the authority to assign tasks and duties? A COOP organizational chart that shows minimal staff and responsibilities in the event that the COOP Plan is activated, might be useful here.

4. **Alternate work sites in the event of location/site closure**

   You have identified essential functions and you must identify an alternate location for those functions to continue if your location/site is not able to provide those functions. These sites must be identified and named with memorandum of agreements (MOA) or understanding (MOU) in place with the location if needed. It is not sufficient to simply state that you will find a location if needed at the time of the event.

5. **Identification of vital records and their locations**

   If you have vital records for staff or individuals served, those are to be identified here along with the location of those records. Vital records may include case record, personnel records and financial records for agency. This does not have to include all records, but should include any records essential to continuing operations.

6. **Identification of systems to maintain security of and access to vital records.**

   How will you maintain the security of these vital records during the event? Buildings may be compromised, the records may need to be transported to other locations, and the security and confidentiality of those records is important and must be addressed here. How are your records backed-up and how often does this back-up occur?

Rule 13.9.C Copies of the Emergency/Disaster Response Plans and the Continuity of Operations Plan must be maintained on-site for each location/site and at the agency's administrative offices.

You must have copies on site of both the Emergency/Disaster Response Plans and the Continuity of Operations Plan at each location/site. This ensures that in any event, the staff at every location have access to the needed materials to follow these plans. These will be checked during the site visit for each program.

Rule 13.9.D Any revisions to the Emergency/Disaster Response Plans and the Continuity of Operations Plan must be documented and approved by the agency's governing body. Any revisions must be communicated in writing to all staff.

Any changes to either plan must be reviewed and approved by the governing body and evidence of this must be documented in the meeting minutes. You should note in the plan itself that these plans will be reviewed by your governing body. These minutes will be reviewed by the site visit team. All staff must be notified of any changes to these plans.

Rule 13.9.E All locations/sites must document, utilizing the standardized DMH form, implementation of the written plans for emergency/disaster response and continuity of operations. This documentation of implementation must include, but is not limited to the following:

1. **Quarterly fire drills for day programs**

   For day programs, you must conduct a fire drill in each of the four quarters of the year:
   Jan-Mar, Apr-Jun, Jul-Sept, and Oct-Dec.

2. **Monthly fire drills for residential programs, conducted on a rotating schedule within the following time frames:**

   7 a.m. to 3 p.m.
   3 p.m. to 11 p.m.
   11 p.m. to 7 a.m.

   For residential programs, you must conduct a monthly fire drill rotating between the timeframes listed. For example: Jan – 7A-7P, Feb 3P-11P, Mar 11P-7A.

   This schedule would meet the minimum requirements of each shift participating in one drill each quarter. It may be beneficial for each shift to have a drill each month, but it is not required.

3. **Quarterly disaster drills, rotating the nature of the event for the drill based on the emergency/disaster plan, for each facility and program.**

   There must be one drill each quarter for those disasters identified in the HVA. These drills should be rotated to address the types of events most likely to occur based on the HVA.

4. **Annual drill of Continuity of Operations Plan for the agency.**

   On an annual basis (on or before the date of the previous drill), you must conduct a drill for your Continuity of Operations Plan. You should conduct this drill to test each level of the plan including activating essential

staff, movement of vital records, and activating agreement with alternate site location. This drill should be documented and kept on file for review.

PLEASE SEE ATTACHMENT B FOR FURTHER GUIDANCE ON DRILLS AND MONITORING OF DRILLS

Rule 13.9.F **All supervised living, residential treatment programs, and/or Crisis Stabilization Units must maintain current emergency/disaster preparedness supplies to support individuals receiving services and staff for a minimum of seventy-two (72) hours post event. At a minimum, these supplies must include the following:**

1. **Non-perishable foods**
2. **Manual can opener**
3. **Water**
4. **Flashlights and batteries**
5. **Plastic sheeting and duct tape**
6. **Battery powered radio**
7. **Personal hygiene items.**

For supervised living programs and residential substance abuse treatment programs, you must keep on site at a minimum the items above. Any other items that are viewed as necessary should also be kept on site in the event of an emergency/disaster. These will be viewed on site by the site visit team. Please be sure to monitor expiration dates as expired products will be viewed as missing by the site visit team. You must list all items that you plan to keep on site for such events in the Emergency/Disaster Response Plan. It is up to the program to determine the right amount to provide these items for the clients on site.

Rule 13.9.G **All supervised living, residential treatment programs, and/or Crisis Stabilization Units must have policies and procedures that can be implemented in the event of an emergency that ensure medication, prescription and nonprescription, based on the needs of the individuals in the program and guidance of appropriate medical staff is available for up to seventy-two (72) hours post-event.**

Each program must have policies and procedures that state they will not only have seventy-two (72) hour supply of all prescription and non-prescription medication for each resident, but they must also have appropriate staff available to administer those medications.

ATTACHMENT A – Hazard Vulnerability Analysis (HVA)

- An HVA is conducted to determine the risks associated with probable or possible disasters or events.
- An HVA identifies the events most likely to affect your organization and the probable impact if they do occur
- Depending on the evaluated level of preparedness, the facility must take necessary steps to ensure they are prepared to meet the challenges presented by the hazards

There are Four Areas of Concern: Natural, Technological, Human, and Hazmat Events

These should be broken out into each individual type of event (i.e. tornado, fire, etc.)

Items to address for each event type:

- Probability
  - What is the known risk this will happen
    - Low – Rare
    - Moderate – Unusual
    - High – High Potential or Have Experienced
  - Use of historical data about previous events can help predict the likelihood

- Response
  - How long would it take to have an on-scene response
  - How big will that response be
  - Historical evaluation of response success

- Human Impact
  - Potential for staff death or injury
  - Potential for patient death or injury

- Property Impact
  - Cost and time to replace/repair
  - Cost to set up temporary replacement
  - Time to recover

- Business Impact
  - Business interruption
  - Employees and/or patients unable to report to work
  - Interruption of critical supplies
  - Financial impact/burden

- Preparedness
  - Status of current plans (how ready are you for each type of event)
  - Frequency of drills
  - Availability of alternate sources for critical supplies/services

- Internal Resources
  - Types and amount of supplies on hand and will they meet the need
  - Staff availability

- External Resources
  - Types of agreements with community agencies
  - Coordination with local and state agencies
  - Coordination with nearby health care facilities
  - Coordination with treatment specific facilities
  - Community resources

ATTACHEMENT B – Disaster, Fire, and COOP Drill Guidance

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 situation 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 for all supervised living and/or residential programs and quarterly for all day programs.
    - Fire drills for residential programs 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 report formats 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
- 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 Office of Incident Management at 601-359-6652 for technical assistance in the development of drill reports.

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 for all supervised living and/or residential programs and quarterly for all day programs.
  - 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

Program Name_____

Date of Drill_____

Time of Drill (am/pm)_____

Type of Drill :

☐ **Fire** (quarterly for day programs, monthly for residential programs)

☐ **Disaster** (quarterly for all programs) **Type of Disaster:** _____
(Disaster type must rotate each quarter through all applicable disasters)

☐ **COOP** (annual for all programs)

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 :

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.

Deficiencies related to Chapters 13, 32 and/or 34 of the DMH Operational Standards must be corrected within 30 days of the date of this letter.

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 and supporting documentation 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 and supporting documentation to the Division of Certification. For contact information call #601-359-1288.**

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:	