DMH

Mississippi Department of Mental Health

Supporting a Better Tomorrow...One Person at a Time

ALCOHOL AND DRUG
ADDICTION
SERVICES

BEHAVIORAL HEALTH
SERVICES

INTELLECTUAL AND
DEVELOPMENTAL
DISABILITY SERVICES

Mississippi Department of Mental Health
Record Guide
for
Mental Health, Intellectual and Developmental Disabilities, and Substance Use Disorders Community Providers

2022 Revision

Mississippi Department of Mental Health
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Mississippi Department of Mental Health
www.dmh.ms.gov

Section A
General Information

2022 DMH Operational Standards Record Guide

Purpose

The required documentation elements outlined in the Mississippi Department of Mental Health (DMH) Record Guide serve as one of the methods for planning and evaluating services and supports provided by agency providers certified by DMH. The emphasis of the record-keeping system outlined in this guide is on the guidance needed to satisfy the documentation requirements referenced in the DMH Operational Standards document and which is otherwise needed to ensure documentation of all services and supports provided by agencies certified by DMH.

The intent of the DMH Record Guide is to help agency providers ensure compliance with the record keeping aspects referenced in the DMH Operational Standards document.

Because of DMH mandatory data collection and reporting requirements, along with the use of electronic record keeping and electronic health records, the need to maintain paper forms is declining. Therefore, while the documentation elements outlined in this guide (*as applicable to the services and supports offered by the agency provider)* are required, the actual forms contained in this guide are not necessarily a requirement. It is not the intent of this guide to necessitate providers making immediate substantive modifications to their existing electronic health records system. Rather, this guide seeks to describe the necessary documentation elements which are required to satisfy DMH record keeping requirements as outlined in the DMH Operational Standards document and which are otherwise required to document all services and supports provided by the DMH-certified agency and to provide a sample format for this purpose.

Providers utilizing the forms contained in this guide to satisfy DMH Operational Standards record keeping requirements may modify and customize these forms as they see fit. However, if any documentation element of a form is deleted, the form may no longer satisfy the DMH Operational Standards record keeping requirements.

General Information

A single case record must be maintained for all people 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 people receiving services. Two years of documentation must be maintained in the active record. All completed documentation should be present in the person's record no later than the 10th day of the following month the service was delivered unless more stringent timelines are required by DMH.

The Record Guide is divided into sections that allow the user to identify documentation requirements and/or data tools required for all individual records, those that are used when the circumstances of the person 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 a person'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 paper 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 person receiving services.

Signatory Authority

Signatures are necessary to verify that information has been correctly and thoroughly shared with people 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 the signature lines provided may not be necessary to document the people 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 Person Receiving Services

The person receiving services must sign for himself or herself unless one of the following conditions applies or is present:

1. The person is under 18 years of age.
2. A legal representative has been appointed for the person by a court of competent jurisdiction.
3. If a person cannot physically sign or is not mentally/cognitively able to understand the form, a parent or next of kin can sign if they indicate they are signing as such. Physical, mental, or cognitive ability to sign and understand the form must be determined by a medical doctor or psychologist. Documentation must be maintained in the record.

Signature of Person Authorized to Give Consent or Sign in Lieu of the Person 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 person must sign the form(s). If the person 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 person receiving services, regardless of his/her age, has a court ordered (legal) guardian or a conservator, the parent/legal representative must sign all forms on behalf of the person 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 parent/legal representative of a person receiving service(s) must review and sign the paperwork required for a person to receive services.

Should the person's parent/legal representative choose to delegate his/her responsibility and signatory authority to another individual for the completion of daily paperwork (including delegating signature authority to the person being served), DMH will accept the signature of that individual. The parent/legal representative must provide **written documentation** of such delegation and to whom the signatory authority is being delegated. This must be maintained in the person's record. Daily signature authority cannot be delegated to the service provider. However, the parent/legal representative 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 to verify that the signature(s) are valid, particularly if a person is signing in lieu of the person 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 a person 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.

Section B
Required For All
Records

Individual Profile-Face Sheet

Consent to Receive Services

Rights of Persons Receiving Services

Acknowledgment of Grievance Procedure

Consent to Release/Obtain Information

Medication/Emergency Contact Information

Consent to Release Information Form for HIE *(only for participating DMH/C providers)*

Individual Profile/Face Sheet (Client Entry Form for WITS)

Purpose

The Individual Profile/Face Sheet (Client Entry Form for WITS) contains relevant data and/or personal information necessary to readily identify the person receiving services. The data elements on this form are required to be entered into the Web Infrastructure for Treatment Services (WITS) or agency provider's Electronic Health Record (EHR) system and should be printed and updated as needed. Information is used for routine service provision activities such as scheduling, billing, and reference.

Timeline

The Individual Profile/Face Sheet (Client Entry Form for WITS) data must be completed at admission as part of the intake process. The data must be updated whenever information or changes occur and/or at least annually. When changes in information or data are made, or at the annual update, a new/corrected Individual Profile/Face Sheet (Client Entry Form for WITS) must be dated and placed in the person's record.

Individual Profile/Face Sheet (Client Entry Form for WITS) Information

Each DMH certified agency provider must maintain current and accurate data for submission of all reports and data as required by DMH Rule 2.5.D. The data can be generated as a report by the agency provider's database system once all the required data elements have been entered into the agency provider's system. Depending on the specific data collection and reporting system that the agency provider uses, additional personal information may have to be added to complete the Individual Profile/Face Sheet.

The required elements of the Individual Profile/Face Sheet (Client Entry Form for WITS) are provided on the form itself. Agency providers should reference the DMH Manual of Web Infrastructure for Treatment Services (WITS) and consult with the agency provider's employee responsible for data submission. The DMH WITS system documentation information is located on the DMH website.

Individual Profile/Face Sheet (Client Entry Form for WITS)

Agency _____   **Facility** _____

First Name_____   **Last Name** _____

Provider Client ID _____   **DOB** _____   **SSN** _____

Gender _____   **Ethnicity**   **Race** (Check One or More)

Veteran Status:
    No
    Not Collected
    Unknown
    Yes

Citizenship
    United States Citizen
    Non United States Citizen

Ethnicity:
Puerto Rican
Mexican
Cuban
Other specific Hispanic
Not Hispanic or Latino
Hispanic or Latino- specific
origin not specified
Unknown

Race:
Alaska Native
American Indian
Asian
Black or African American
Native Hawaiian or Other
Pacific Islander
Other Race
Unknown
White

Address _____

City _____   **ZIP** _____   **Address County** _____

Address Type _____   **Residence County** _____

Source of Referral
    Alcohol/Drug Abuse Care Provider
    Court/County Justice
    Court/Criminal Justice – Diversionary Program
    Court/Criminal Justice – DUI/DWI
    Court/Criminal Justice – Not Applicable
    Court/Criminal Justice – Not Collected
    Court/Criminal Justice – Other
    Court/Profile Justice – Other Court
    Court/Criminal Justice – Other Recognized Legal Entity
    Court/Criminal Justice – Prison
    Court/Criminal Justice – Probation/Parole
    Court/Criminal Justice – State/Federal Court
    Court/Criminal Justice – Unknown
    Crisis/Respite Program
    Employer/EAP
    Home
    Individual (includes self-referral)
    Nursing Home
    Other Community Referral
    Other Health Care Provider
    Other IDD Facility
    Personal Care Home
    School (Educational)
    Veterans Administration (VA)
    Unknown

Initial Contact
    By Appointment
    Community Service Patrol
    Other
    Phone
    Walk-in

Initial Contact Date _____
Intake Date _____

Pregnant   **Due Date** _____
    Yes
    No
    Not Applicable
    Unknown

HIV Positive
    Yes
    No
    Unknown

Injection Drug User
    Yes
    No
    Denies

Presenting Problem
_____

Admission Date _____

Outcome Measure Date _____   SA   Mental Health   IDD

Codependent/Collateral
    Yes
    No

Education status
    None, never attended school
    First grade
    Second grade
    Third grade
    Fourth grade
    Fifth grade
    Sixth grade
    Seventh grade
    Eighth grade
    Ninth grade
    Tenth grade
    Eleventh grade
    Twelfth grade, High School Graduate or GED
    One Year of College
    Two Years of College or Associate's Degree
    Three Years of College
    Bachelor's Degree
    Some Post Graduate Study
    Master's Degree
    Graduate or Professional School - Doctoral Study, Med School, Law School, etc.
    Technical trade school
    Kindergarten
    Special Education Class
    Unknown

Primary Diagnosis

_____

Secondary Diagnosis

_____

Mental Health:
SMI/SED Status
    At risk for SED (optional)
    Not SMI or SED
    SED
    SMI
    Unknown

School Attendance (last 3 months)
    Attending School Regularly: 5 Days or Less Absent
    Home Schooled
    Not Applicable
    Not Attending School Regularly: 6 Days or More Absent
    Not Available

Employment Status
    Full Time
    Not in Labor Force- Disabled
    Not in Labor Force- Homemaker
    Not in Labor Force- Inmate of Institution
    Not in Labor Force- Not Collected
    Not in Labor Force- Other
    Not in Labor Force- Retired
    Not in Labor Force- Student
    Not in Labor Force- Unknown
    Part Time
    Unemployed
    Unknown

Living Situation
    Dependent Living
    Homeless
    Independent Living
    Unknown

Is Client Indigent
    Yes
    No

# of Arrests in Past 30 Days _____

Program _____

Program Start Date _____

Tertiary Diagnosis

_____

Days on Wait List _____

Mental Health Legal Status
    Involuntary- civil
    Involuntary- civil, sexual
    Involuntary- Criminal
    Involuntary- Juvenile Justice
    Not Applicable
    Not Collected
    Unknown
    Voluntary – others (parents, guardians, etc.)
    Voluntary – self

Substance Use Disorder
Co-Occuring SA and MH Problem
> Yes
> No
> Unknown

# of times the client has attended a self-help program in the 30 days preceding the date of reference (admission or discharge) to treatment services. Includes attendance at AA, NA, and other self-help/mutual support groups focused on recovery from substance abuse and dependence.
> No attendance in the past month
> 1-3 times in past month
> 4-7 times in past month
> 8-15 times in past month
> 16-30 times in past month
> Some attendance in past month,
> but frequency unknown
> Unknown

Health Insurance
> Blue Cross/Blue Shield
> Health Maintenance Organization (HMO)
> Medicaid
> Medicare
> None
> Other (e.g., Tricare, Champus)
> Private Insurance
> Unknown

Marital Status
> Divorced
> Never Married
> Now Married
> Separated
> Unknown
> Widowed

# of Prior SA Tx Episodes _____

Medication Assisted Tx
> Yes
> No
> Unknown
> Not Applicable

Source of Income
> Disability
> None
> Other
> Public Assistance
> Retirement/Pension
> Unknown
> Wages/Salary

Primary Payment Source
> Blue Cross/Blue Shield
> Medicaid
> Medicare
> No Charge
> Other
> Other Government Payments
> Other Health Insurance Companies
> Self-Pay
> Unknown

See options below and complete for each substance:

	Substance	Frequency	Method	Detailed Drug Code
Primary	_____	_____	_____	_____
Secondary	_____	_____	_____	_____
Tertiary	_____	_____	_____	_____

At what age did the client **FIRST** use the substances indicated above (if unknown, enter 97)
Primary _____   Secondary _____   Tertiary _____

Substance (Type one of these options above)
None
Alcohol
Cocaine/Crack
Marijuana/Hashish/THC   Heroin
Non-Prescription Methadone Other Opiates and
Synthetics PCP
Other Hallucinogens Methamphetamine
Other Amphetamines

Other Stimulants
Benzodiazepines
Other Non-Benzodiazepine Tranquilizers
Barbiturates
Other Non-Barbiturates Sedatives or
Hypnotics Inhalants
Over-the-Counter
Other
Unknown

Frequency (Type one of these options above)
- No use in the past month
- 1-3 times in the past month
- 1-2 times in the past week
- 3-6 times in the past week
- Daily
- N/A
- Unknown

Method (Type one of these options above)
- Oral
- Smoking
- Inhalation
- Injection (IV or Intramuscular)
- Other
- N/A
- Unknown

Detailed Drug Code (Type one of these options above)

- Alcohol
- Crack
- Other Cocaine
- Marijuana/Hashish
- Heroin
- Non-Prescription Methadone
- Codeine
- Propoxyphene (Darvon)
- Oxycodone (Oxycotin)
- Meperidine (Demerol)
- Hydromorphone (Dilaudid)
- Other Opiates or Synthetics
- Pentazocine (Talwin)
- Hydrocodone (Vicodin)
- Tramadol (Ultram)
- Buprenorphine
- PCP or PCP Combination
- LSD
- Other Hallucinogens
- Methampetamine/Speed
- Amphetamine
- Methylenedioxymethamphetamine (MDMA, Ecstasy)
- Other Amphetamines
- Other Stimulants
- Methylphenidate (Ritalin)
- Alprazolam (Xanax)
- Chordiazepoxide (Librium)
- Clorazepate (Tranxene)
- Diazepam (Valium)

- Flurazepam (Dalmane)
- Lorazepam (Ativan)
- Triazolam (Halcion)
- Other Benzodiazepines
- Flunitrazepam (Rohypnol)
- Clonzazepam (Klonopin, Rivotril)
- Meprobamate (Miltown)
- Other Tranquilizers
- Phenobarbital
- Secobarbital/Amobarbital (Tuinal)
- Secobarbital (Seconal)
- Other Barbiturate Sedatives
- Ethchlorvynol (Placidyl)
- Glutethimide (Doriden)
- Methaqualone
- Other Non-Barbiturate Sedatives
- Other Sedatives
- Aerosols
- Nitrites
- Other Inhalants
- Solvents
- Anesthetics
- Diphenhydramine
- Other Over-the-Counter
- Diphenylhydantoin/Phenytoin (Dilantin)
- Other Drugs
- GHB/GBL (Gamma-Hydroxybutyrate, Gamma-Butyrolactone)
- Ketamine (Special K)

Consent to Receive Services

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

Timeline
People receiving services must be informed of and consent to services at the time of the admission and before services are provided.

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

For ID/DD Waiver Support Coordination and IDD Targeted Case Management Services, people must provide their consent for services at least annually, before the end of the person's certification period.

For IDD providers, people must provide their consent at the time the Activity Support Plan is developed and annually thereafter.

Consent to Receive Services
This section can be read by, or if necessary, read to the person 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 person receiving services and/or a person authorized to act on his/her behalf.

Signatures
If the person 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 Persons 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 person 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 if I refuse all of the therapeutic recommendations of the professional staff I may be discharged and referred to another agency that can meet my needs.

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 services; when release is necessary for the determination of eligibility for benefits, compliance with statutory reporting requirements, or other lawful purpose; if I communicate to the treating physician, psychologist, master social worker, licensed professional counselor or other credentialed professional 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.

_____   _____
Person/Parent/Legal Representative Signature   **Date**

_____   _____
Staff Signature/Credentials   **Date**

Rights of Persons Receiving Services

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

Timeline
People receiving services must be informed of his/her rights during the admission process and before services are provided.

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

For ID/DD Waiver Support Coordination and IDD Targeted Case Management Services, people must be informed of their rights at least annually, before the end of the person's certification period.

For IDD agency providers, people must be informed of their rights at the time the Activity Support Plan is developed and annually thereafter.

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 person 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 person receiving services and/or a person authorized to act on his/her behalf.   The person must be offered a copy of the form to take with them. Signed documentation of receipt must be maintained in the record.

The Consent to Receive Services, Rights of Persons 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 person receiving services or legal guardian to acknowledge each separate action.

<table>
<tr><td rowspan="2"><h1>Rights of Persons Receiving Services</h1></td><td>**Name** _____</td></tr>
<tr><td>**ID Number** _____</td></tr>
</table>

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

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

1. My options within the program and of other services available regardless of cultural barriers and limited English proficiency
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, neglect, exploitation 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 service location 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 personal worth
11. My right to have reasonable access to the clergy and advocates and always have access to legal counsel
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 Services and Supports or Activity Support 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
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 safe storage, accessibility, and accountability of my funds
21. My right to send/receive mail without hindrance unless clinically contraindicated and documented in my case record (for residential services and support programs)
22. My right to conduct private telephone conversations with family and friends, unless clinically contraindicated and documented in my case record
23. My right to information about my rights in a manner that is understandable regardless of any challenges with vision, hearing, or cognition

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

_____   _____   _____   _____
Person Receiving Services/Parent   Date   Legal Representative   Date

_____   _____
Staff/Credentials   Date

Acknowledgment of Grievance Procedures

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

Timeline
Persons receiving services must be informed of and provided a copy of the provider's Grievance Procedures at the time of the admission and before services are provided. Each person receiving services must be presented with the agency provider's Grievance Procedures when they are being asked to give his/her consent to receive services.

Persons acknowledge receipt of the Grievance Procedures at least annually, on or before the anniversary date of the current acknowledgment, as long as the person continues to receive services. A copy of the Grievance Procedures given to the person receiving services should be attached and kept with the signed form.

For ID/DD Waiver Support Coordination and IDD Targeted Case Management Services, the person must sign the acknowledgment at least annually, before the end of the person's certification period.

For IDD agency providers, the person must sign the acknowledgment at the time the Activity Support Plan is developed and annually thereafter.

The Consent to Receive Services, Rights of Persons 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 person 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.

_____   _____
Person/Parent/Legal Representative Signature   **Date**

_____   _____
Staff Signature/Credentials   **Date**

Consent to Release/Obtain Information

Purpose
Agency providers must have prior written authorization before information regarding a person receiving service can be released. A fully executed Consent to Release/Obtain Information must be in place in order to exchange, release, or obtain information legally between people and/or agency providers. The original Consent to Release/Obtain Information form must always be maintained in the person's case record and completed as needed.

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

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

Complete the Obtain Information From section when confidential information regarding a person 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 show clearly 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 person receiving services and/or to a person who is legally authorized to act on his/her behalf.

The agency 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 services; when release is necessary for the determination of eligibility for benefits; compliance with statutory reporting requirements, or other lawful purpose; if the person communicates to the treating physician, psychologist, master social worker, or

licensed professional counselor, or other credentialed professional 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 person 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 person's name. A second witness to the person's signature is required in this case.

Consent to Release/Obtain Information

This consent form is to be completed as needed.

Name _____

ID Number _____

Date _____

I hereby give my consent/permission for _____

(Agency Provider 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 Support Plan
    Individual Service Plan/ Plan of Services &
❑ Supports

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, Person 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 services; 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

_____   _____   _____   _____
Person Receiving Services/Parent   Date   Legal Representative   Date

_____   _____
Witness/Credentials   Date

Medication/Emergency Contact Information

Purpose
Documentation of medications must be maintained while the person is receiving services from a DMH certified agency or provider. (This excludes IDD Support Coordination and IDD Targeted Case Management records.) 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 person'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 person is taking, and the emergency contact information are recorded during the admission 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 person's record.

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

Current Medication
All sections must be addressed. ALL known and/or reported medications the person is currently taking must be listed, regardless of type or purpose, including over-the-counter (OTC) medications the person 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.

Previous Medications/ Dietary Needs
Previously prescribed or taken medications listed (including any adverse reactions as reported by the person) any special dietary needs.

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 person'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:

Date Initially Completed:

CURRENT MEDICATIONS

List ALL known and/or reported medications the person 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:

PREVIOUS MEDICATIONS

Medication	Directions	Comments (to include adverse reactions if applicable)

Special Dietary Needs *(if applicable)***:**

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):

Consent to Release Information - Mississippi Health Information Exchange (HIE) Participation
(For Participating DMH/C Providers Only)

Purpose
This form is designed solely for DMH/C providers who participate in the Mississippi Health Information Exchange (HIE).

<u>DMH/C providers who take part in the Mississippi Health Information Exchange (HIE) may utilize this form as a guide for obtaining a person's informed consent to participate in the Mississippi HIE system.</u>

The Mississippi Health Information Exchange (HIE) is intended to facilitate the flow of clinical and health data among participating treatment providers to improve quality of care and promote efficiencies in service provision.

Extent/Nature of Information
Persons who consent to participate in the Mississippi HIE are consenting that their Protected Health Information (PHI) may be accessed by and made available to other healthcare providers through a HIPAA-compliant and secure Mississippi Health Information Exchange (HIE) system unless consent is revoked. Participation in the HIE is optional. The person's treatment is not conditioned upon the person's PHI being available in the HIE. The person's participation in the HIE allows the provider agency to receive notification when the person has been hospitalized or has presented to an emergency department; it allows the notifying healthcare provider access to the person's clinical records and allows the agency and the notifying healthcare provider to share healthcare information, including (but not limited to) Protected Health Information (PHI).

Date/Event/Condition
A person's informed consent to participate in the Mississippi Health Information Exchange (HIE) includes the following stipulations, as designated on the consent form.

- Consent may be revoked at any time except to the extent that action has already been taken.
- To revoke authorization, the Person 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.
- Discharge from the provider agency results in automatic revocation of this consent.

Any information obtained due to 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.

Witness
The *Consent to Release Information - Mississippi Health Information Exchange (HIE) Participation* form requires the signature of a witness. If the witness is an employee of the program, the employee's credentials must be included (if applicable). If the person receiving services can only make the person's mark (for example "X"), place the mark in quotations and write out beside it, "INSERT NAME's Mark," (using the person's name). A second witness to the person's signature is required in this event.

Consent to Release Information - **Mississippi Health Information Exchange (HIE) Participation**

(For Participating DMH/C Providers Only)

Name _____

ID Number _____

Date _____

Consent to Mississippi Health Information Exchange (HIE) Participation:

Mississippi Health Information Exchange (HIE) is intended to facilitate the flow of clinical and health data among treatment providers to improve quality of care and promote efficiencies in service provision. By providing consent below, I, the undersigned, agree that notification will be provided to this agency when I arrive at an emergency department. I, the undersigned, consent and understand that my Protected Health Information (PHI) may be accessed by and made available to other healthcare providers through a HIPAA-compliant and secure Mississippi Health Information Exchange (HIE) unless I revoke consent. I further understand that my treatment is not conditioned upon my PHI being available in the HIE. I understand that participation in the HIE allows this agency to receive notification when I have been hospitalized or have presented to an emergency department; it allows the notifying healthcare provider access to my clinical records and allows this agency and the notifying healthcare provider to share healthcare information, including (but not limited to) PHI.

- I understand that I may revoke this consent at any time except to the extent that action has already been taken.
- I understand that to revoke this authorization, the 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.
- I understand that discharge from this agency results in automatic revocation of this consent.

Additional Consent to Release Information – General Information:

Any information obtained due to 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 services; when release is necessary for the determination of eligibility for benefits, compliance with statutory reporting requirements, or other lawful purpose; if an actual threat of physical violence against a clearly identified or reasonably identifiable potential victim or victims is communicated to the treating physician, psychologist, master social worker or licensed professional counselor or other credentialed professional; in compliance with reporting requirements under state law of incidents of suspected child abuse or neglect or by court order.

(Check one below):

❑ I **DO** give consent to participate in the Mississippi HIE as outlined above.

❑ I **DO NOT** give consent to participate in the Mississippi HIE as outlined above.

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

_____   _____   _____   _____
Person Receiving Services/Parent   Date   Legal Representative   Date

_____   _____
Witness/Credentials   Date

Section C
Required For All
Mental Health and
Substance Use Records

Initial Assessment

Trauma History

Individual Service Plan

Individual Crisis Support Plan

Recovery Support Plan

Periodic Staffing/ Review of the Individual Service Plan

Progress Note

Weekly Progress Note

Readmission Assessment Update

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 a person's stated/presenting need(s). The information gathered is both historical as well as what is currently happening in a person's life.

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 and must be completed within the service specific timeline requirements.

Admission Date
Enter the date the person 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 person receiving services, enter the person's relationship to the individual requesting services. A Consent to Release/ Obtain Information must be completed if applicable.

Guardianship Information
If a person has a legal guardian, record name and contact information.

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

Description of Need
Record the reason(s) the person gives as to why he/she is seeking services, current needs, goals etc. If substance use disorder is indicated in this section, one (1) of the three (3) Substance Use Disorder Level of Care Placement Assessment options must be completed.

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 persons with IDD.

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

The *employment section* should be completed for adults at the time of the assessment.

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 additional medical information 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.

Mental Health History

Complete the outpatient mental health and psychiatric hospitalization/ residential treatment 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 person seeking admission to services.

An approved functional assessment by the Division of Children and Youth Services is required for all children and youth receiving mental health services. The approved functional assessment must be completed within 30 days of admission and at least every six (6) months thereafter for all children and youth receiving mental health services or with timelines as required by the service.

An approved functional assessment is required for all adults receiving mental health services. An approved functional assessment must be completed within 30 days for all adults receiving mental

health services or within timelines as required by service. DMH will review and approve a functional assessment for use with the adult SMI population.

An approved functional assessment is required for all persons receiving substance use disorder services. DMH will review and approve a functional assessment for use with the SUD population.

Summary/Recommendations

The person conducting the Initial Assessment must summarize the observations and findings to include an analysis of the person's strengths and needs, both expressed and observed. Based on the results of the Initial Assessment, services must be recommended and offered to the person. Referrals to other appropriate providers must also be offered to the person. Observations, findings and recommendations should support a life of recovery related to the following dimensions:

Health- managing one's disease; making informed, healthy choices that support physical and emotional well-being

Home- having a stable and safe place to live

Community- having relationships and social networks that provide support, friendship, love and hope

Purpose- conducting meaningful daily activities to participate in society

Initial Diagnostic Impression

Give the written diagnostic impression and appropriate codes.

Staff Qualifications

The Initial Assessment must be completed by an individual that meets the current requirements of the DMH Operational Standards, with at least a master's degree in addictions, mental health, 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 Addictions Therapist (as appropriate to the population being served).

For Alzheimer's Day Programs only, the program supervisor must complete the Initial Assessment. A copy of the person'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: ☐ Person Receiving Services   ☐ Other: Relationship to Person_____

Does the person seeking services have an Outpatient Commitment Order? ☐ Yes   ☐ No

Does the person seeking services meet the DMH "Codependent" status? (seeking services based on the mental health or substance use, behavioral problems, of another person, and it is affecting them negatively) ☐ Yes   ☐ No

GUARDIANSHIP INFORMATION

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

Is the family involved with the Department of Human Services or Child Protection Services? ☐ Yes   ☐ No

If yes, has a consent to release information been obtained?   ☐ Yes   ☐ No
If yes, please explain and indicate the name of the assigned case worker: _____

CONFIDENTIALITY

Were the limits of confidentiality reviewed with Person 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?
(Include a description/perception of difficulties according to the person seeking services and any applicable family members/legal guardian.)

Is the reason for seeking services today only related to mental health or substance use?

☐ Yes   ☐ No
If yes, one (1) of the three (3) Substance Use Disorder Level of Care Placement Assessment options must be completed.

What previous coping skills have been helpful in the past?

Thoughts of Suicide: ☐ Yes *(If yes, explain)*   ☐ No

Attempts of Suicide: ☐ Yes *(If yes, explain)* ☐ No

Thoughts of Homicide: ☐ Yes *(If yes, explain)* ☐ No
(Indicate the need for "duty to warn")

Acts of Self-Harm: ☐ Yes *(If yes, explain)* ☐ No

SOCIAL / CULTURAL

Identification of Support Systems:
(Address family relationships, interpersonal relationships, and community support systems)

Meaningful Activities, Cultural / Ethnic / Spiritual interests, Supports:
(Address hobbies, leisure activities, etc.)

Living Situation

What is your current living arrangement (strengths and concerns)? Who lives with you? What are your views on your current arrangement?

Does the person meet the DMH "Parenting" Classification? ☐ Yes *(if yes, list the age(s) of dependent(s)* ☐ No
(Parenting Classification - Mother or Father of dependent(s) under the age of five; and their dependent(s) will be accompanying them in the agency's SUD Residential Treatment program during the current treatment experience.)

Needs Related to Living Situation
(money management, benefits, living arrangements, clothing, personal care, child care, rent, other)

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

During pregnancy, did mother use alcohol or other drugs? ☐ Yes ☐ No

Describe any problems with the pregnancy or birth:

Were there any developmental issues? ☐ Yes ☐ No *(If yes, explain)*

Describe any childhood accidents or injuries:

Education
(Complete for Children & Youth up to age 21 and Adults)

Select the person's current or highest level of education completed:
□ None, never attended grade school □ Kindergarten □ 1st Grade □ 2nd Grade □ 3rd Grade □ 4th Grade □ 5th Grade □ 6th Grade □ 7th Grade □ 8th Grade □ 9th Grade □ 10th Grade □ 11th Grade □ 12th Grade □ High School Graduate or GED □ 1-year of College □ 2-years of College or Associates Degree □ 3-years of College □ Bachelor's degree □ Some Post Graduate Study □ Master's degree □ Graduate or Professional School (Doctoral Study, Med School, Law School, etc.) □ Technical Trade School

Name of school:

Does child/youth receive Special Education Services?
□ Yes *(If yes, complete release of information to obtain a copy of the current Individualized Education Plan (IEP))*
□ No

Additional Information (Children & Youth up to age 21)
Educational Issues/ Needs (grades, attendance, suspensions, expulsions)

Employment *(adults only)*

Are you employed? □ Yes   □ No

If no, do you want to be employed?

If yes, which of the following occupational codes best describes your current employment situation:
☐ Healthcare Worker   ☐ First Responder   ☐ Frontline Worker   ☐ Sales   ☐ Farm Owners/Laborers   ☐ Service/Household   ☐ Executive/Managerial   ☐ Professional   ☐ Educator/Teacher   ☐ Counselor/Therapist   ☐ Office Support   ☐ Other (*Please provide description.*): _____

Employment Barriers/ Related Needs?

Current Legal Status
Has the person ever been incarcerated, in a juvenile detention, jail, or prison? □ Yes □ No If yes, when?
Has the person been involved with the legal system? □ Yes   □ No

Any involvement within the past twelve months? □ Yes □ No	
Arrests: □ Yes □ No	If yes, indicate type and number of arrest(s):
Number of arrests in the past 30 days:	
Pending Charges: □ Yes □ No	If yes, indicate type and number of pending charges:
Substance Use Related Legal Issues:	
Is this person currently on parole and/or probation? □ Yes □ No If applicable, indicate to whom reports should be submitted: _____	

MEDICAL HISTORY	
Appetite Issues:	
Sleep Issues:	
Current or Chronic Diseases	□ high blood pressure □ diabetes □ thyroid □ other _____
Family History	□ high blood pressure □ diabetes □ thyroid □ other _____
Additional Medical History or Health and Safety Issues:	
Health-Related Needs:	

MENTAL HEALTH HISTORY
Previous Assessment History
Have psychological, educational or functional assessments been completed in the last twelve months? □ Yes *(If yes, complete release of information to obtain a copy of the applicable assessment.)* If yes, indicate type of assessment_____ □ No
Previous or Current Diagnoses:

Mental Health Needs:

Family History of Psychiatric or Substance Use Disorder(s) □ Yes □ No If yes, please describe.	

Outpatient Behavioral Health Agency

□ None Reported

Treatment Agency	Services Received	Dates of Service	Has Consent to Release Information Been Requested?
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No

Psychiatric Hospitalizations / Residential Treatment

□ None Reported

Treatments	Reason (suicidal, depressed, etc.)	Dates of Service	Has Consent to Release Information Been Requested?
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No

Initial Observations

General Observations	**Appearance:** □ Appropriate □ Disheveled □ Unclean □ Other _____
	Speech: □ Appropriate □ Slow □ Mechanical □ Rapid □ Other _____
	Affect: □ Appropriate □ Flat □ Labile □ Other _____
Delusions:	□ N/A

	□ Description:
Hallucinations:	□ N/A □ Description:
Mood	□ Appropriate □ Manic □ Depressed □ Labile □ Irritable □ Other _____
Orientation	□ Person □ Place □ Time □ Situation □ Other _____

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

Health:

Home:

Community:

Purpose:

Other:

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 a person 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 person 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 person is entering.

All persons receiving services must complete a trauma history questionnaire. Outpatient Services must complete the trauma history questionnaire within 30 days of admission; Day programs must complete the trauma history questionnaire within 30 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 of admission. 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 person indicates he/she has experienced an event, then the therapist only asks at what age the traumatic event(s) started and ended. If the person 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 person reports a positive trauma history, the clinician asks the person 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:

The clinician and/or person are permitted to only answer questions that are appropriate or applicable.

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

Do you have trauma concerns that you wish to address during this experience? □ Yes □ No

If yes, please elaborate on those concerns.

Have you ever experienced any of the following? □ Yes □ No

□ **Physical Abuse** □ **Emotional Abuse** □ **Sexual Abuse** □ **Neglect** □ **Domestic Violence** □ **Military Service** □ **Natural Disaster** □ **Other**

If yes, when, by whom (if applicable), and what has been the effect on you?

Have you ever done any of the following to someone? □ Yes □ No

□ **Physical Abuse** □ **Emotional Abuse** □ **Sexual Abuse** □ **Neglect** □ **Domestic Violence** □ **Other**

If yes, when, to whom (if applicable), and what has been the effect on you?

Did you ever receive counseling for any of the above □ Yes □ No   **If so, when, and where?**

Have you ever served in the military, law enforcement or as a first responder?   □ Yes   □ No

If yes, indicate the capacity in which you served.

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?

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

Individual Service Plan

Purpose
Each person who receives services must have an Individual Service Plan that is based on the identified strengths and needs of the person, the goals that will help address his/her needs, the services to be provided, and the activities that will take place toward achieving measurable person-centered outcomes. The person seeking/receiving services must be involved in the development of his/her service plan. For persons 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 person's behalf.

The timeline for completion of the Individual Service Plan is determined by the type of service or program the person is entering.

The Individual Service Plan must be reviewed and revised when goals or objectives are achieved, as needs of the person change, or according to specific service requirements but at least annually.

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

Goals
The person receiving services establishes the long term goals. Staff helps the person set short term goals which will contribute to achievement of the long term goal(s).

Identified Barriers
List barriers that may prevent the person 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 person. Symptoms, behaviors and clinical areas of need should serve as the focus of treatment, services and supports for people.

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 person 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 person. **All services that the person is receiving must be indicated in relation to an objective/intervention.**

<u>**Alcohol and Drug Providers**</u>**: The Treatment Formulation section of the Placement Assessment is the foundation of the Individualized Service Plan development. If a person has a Risk Rating of a 2 or above, in any Dimension on the Placement Assessment, there should be an objective on the ISP addressing that Dimension.**

Diagnosis
Give the written diagnosis and appropriate codes for the person 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 person refuses Community Support Services, the refusal must be documented in writing. Community Support Services must be offered to these specified persons during the intake process and at a minimum of every twelve (12) months while they remain in services.

Signatory Authority
Each person 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), persons with intellectual/ developmental disabilities, children and youth with serious emotional disturbance (SED), or persons with a substance use disorder, a licensed Physician, a licensed Psychologist, a Psychiatric/Mental Health Nurse Practitioner, a Licensed Clinical Social Worker, Licensed Master 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

Community Support has been offered to me and I choose:

☐ **YES**, I do want to participate _____ (initials of person receiving services) **[see Recovery Support Plan]**	☐ **NO**, I do NOT want to participate _____ (initials of person receiving services)

LONG TERM GOALS *(include hopes/dreams/goals)*	**SHORT TERM GOALS**

PERSON'S STRENGTHS

IDENTIFIED BARRIERS
(Based on Functional Assessment)

PERSON'S AREAS OF NEED

Area of needed support/observable behaviors/symptoms: How do needs/behaviors/symptoms create functional limitations for the person?	Duration: Frequency:

INDIVIDUALIZED PLAN FOR SERVICES

Objective #1:

Interventions	Service Area Assigned	Criteria / Outcomes for Completion	Initiation Date:	Target Date:

Objective #2:

Interventions	Service Area Assigned	Criteria / Outcomes for Completion	Initiation Date:	Target Date:

Objective #3:

Interventions	Service Area Assigned	Criteria / Outcomes for Completion	Initiation Date:	Target Date:

DIAGNOSIS

Primary Diagnosis(es)	
Secondary Diagnosis(es)	

_____ _____ _____ _____
Person 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, LMSW, LMFT LPC, PA, Alzheimer's Day Program Supervisor	Date		

Individual Crisis Support Plan

Purpose
Agency providers must develop an Individualized Crisis Support Plan for persons receiving services in the following priority groups:
- Persons discharged from an inpatient psychiatric facility;
- Persons discharged from an institution;
- Persons discharged or transferred from Crisis Stabilization Services; and,
- Persons referred from Crisis Response Services.

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

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

Action Steps
List the action steps the person, crisis response team and family (if indicated) will take in the event the person 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 persons receiving services in the above priority groups except those persons admitted through crisis services. Crisis Support Plans must be developed for persons admitted through crisis services within 72 hours of admission.

The Crisis Support Plan must be developed by the team of persons who will have responsibilities for implementing the Plan in the event of a crisis. The Plan development team members must meet the requirements per the current DMH Operational Standards to have at least a master's degree in a related field along with the applicable license or credential for required signature on 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 person 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 Person Receiving Services/Parent/ Legal Representative	Date	Signature/Position	Date
Signature/Position	Date	Signature/Position	Date

Recovery Support Plan

Purpose
The Recovery Support Plan should be completed with the person receiving services and is used as a tool to assist the person in making plans to engage in activities and access resources designed to help support him/her in achieving and maintaining recovery/resiliency.

The Recovery Support Plan replaces the previous Community Support Plan, Individual Recovery Action 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 persons receiving Community Support Services and Peer Support Services but can be used in conjunction with any person's ISP. The Recovery Support Plan must be developed within 30 days of admission for all persons receiving services.

The Recovery Support Plan 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 Recovery Support Plan where indicated. If a staff is implementing the plan and does not have a bachelor's degree, he/she should sign the plan along with his/her supervisor who must have at least a bachelor's degree in mental health or a related field.

Needs Statement from Initial Assessment and ISP
Record the person's needs statement from their Initial Assessment and Individual Service Plan.

Long Term Goal(s) from the ISP
Record the person's Long-Term Goal(s) from the Individual Service Plan. Long term goals are ones that the person will achieve over a longer period of time (e.g., 2-3 years).

Short Term Goal
Short term goals are the small steps the person will take to accomplish long term goals. Short term goals are measurable and written in positive terms. Short term goals are ones that the person will achieve in the near future (e.g., less than 12 months)

Individual Strengths
List strength(s) from the Individual Service Plan that the person possesses and/or demonstrates that will assist and promote successful achievement of goals. Strengths are qualities that the person and natural supporter brings to treatment that help increase the likelihood of achievement of goals. Strengths are recorded from the ISP as needed to support the goals and objectives.

Barriers:

List barriers from the Individual Service Plan that may prevent the person from achieving goals. What is getting in the way of the person achieving their goal/challenges?

Objectives:

All Recovery Support Plans must have individualized objectives and they must be measurable, achievable/action oriented, reasonable and have a target date of completion. Record what the person will do, change, or accomplish in order to achieve their goal.

Strategies/Interventions and target dates:

The intervention should describe who, what, when and why. Who on the team or support system will provide the service, what specific service and intervention will be provided, the schedule of the service (frequency and duration) and identify the purpose/intent/impact of the intervention.

Signatures

The date, signature, and credentials (if applicable) of all persons responsible for completing objectives should be recorded. Additionally, everyone who participates in the development of the Recovery Support Plan must sign the plan as evidence of his/her participating in plan development.

Reminder: If a staff member is implementing the plan and does not have a bachelor's degree, he/she should sign the plan along with his/her supervisor who must have at least a bachelor's degree in mental health or a related field.

Recovery Support Plan

Name: _____

ID Number: _____

Need Statement(s) from Initial Assessment and ISP

Long Term Goal(s) from ISP

Short Term Goals

Strengths to Draw Upon (from ISP)	**Barriers which Interfere (from ISP)**

Objectives (what you hope will change for the person as a result of services)

Strategies (actions by staff, family, other natural supports to assist person in achieving specific objective)

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

_____ _____ _____ _____
Direct Service Provider   Date   Direct Service Provider   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 person 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 person and/or legal representative and the appropriate staff.

Timelines
Review and revision must occur whenever the person 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 person. The ISP should be modified or rewritten if needed to ensure ongoing progress toward achievement of the person'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 person 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

Person Receiving Services _____ Date _____

Staff Signatures/Credentials _____ Date _____

Staff Signatures/Credentials _____ Date _____

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

Progress Note

Purpose
All programs must document single therapeutic support interventions and activities that take place with/for a person. 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 person (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
Agency providers must maintain documentation to verify each person'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 a person is absent or if it is a weekend.

Weekly Documentation
The agency provider must document in SAP format the activities a person 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 a person'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.

For Day Treatment Services and Psychosocial Rehabilitation Services, the Supervisor may use this form as part of the documentation of the required 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:	Staff Signature/Credential:
Date:	Supervisor Signature/Credential:

Readmission Assessment Update

Purpose
When a person has been discharged from an agency provider 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 person's needs and status.

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

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

Status Updates
Any changes relating to a person'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 person seeking readmission to services.

An approved functional assessment by the Division of Children and Youth Services is required for all children and youth receiving mental health services. The approved functional assessment must be completed within 30 days of admission and at least every six (6) months thereafter for all children and youth receiving mental health services or with timelines as required by the service.

An approved functional assessment is required for all adults receiving mental health services. An approved functional assessment must be completed within 30 days for all adults receiving mental health services. DMH will review and approve a functional assessment for use with the adult SMI population.

An approved functional assessment is required for all people receiving substance use disorder services. DMH will review and approve a functional assessment for use with the SUD 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).

<table>
<tr><td rowspan="3"># Readmission Assessment Update</td><td>**Name** _____</td></tr>
<tr><td>**ID Number** _____</td></tr>
<tr><td>**Readmission Date** _____</td></tr>
</table>

Informant:　❑ Person receiving services　　❑ Other　Relationship to person:

LEGAL INFORMATION	
Name of Parent/Legal Representative:	Parent/Legal Representative Documentation Verified: □ Yes　□ No
Parent/Legal Representative Address:	Parent/Legal Representative 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 Use Status:

Use or abuse by the person

   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**

Section D
As Needed

Initial Assessment and Crisis Contact Summary

Medical Examination

Documentation of Healthcare Provider Visits

Self-Administration Medication Observation Log

Telephone/ Visitation Agreement

Search and Seizure Report

Physical Escort Log

Seclusion Behavior Management Log

Initial Assessment and Crisis Contact Summary for Crisis Response Contacts

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

Identifying Information
Record the name of the person receiving crisis services. Issue and record a person identification number. The Date of Contact will also be the Date of Admission. Enter the person'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 Crisis Response, or Walk-in Crisis Response). 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 person 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 person in crisis. If no one else was notified, indicate why it was not necessary.

Initial Behavioral Observations
Document the staff's impressions of the person's behaviors. Include additional comments at the end of the section.

Resolution
Document the condition of the person at the end of the contact; indicate where the person and/or family were referred and if a subsequent appointment was made for the person with the provider, 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 Web Infrastructure for Treatment Services (WITS). If you are unable to obtain this information, please mark as "unknown." The staff person responding to the person in crisis and documenting the contact must sign this form and include their professional credentials.

Initial Assessment and Crisis Contact Summary for Crisis Response Contacts

Name: _____
ID#: _____
Contact/Admit Date: _____
Medicaid #: _____ SS#: _____
Time In: _____ Time Out: _____ Total Time: _____

_____

Contact Type:
Location: _____ Phone Number: _____

☐ Mobile Crisis Service   ☐ Telephone Crisis Response   ☐ Walk-in Crisis Response

_____

Others Involved (Names and Relationships where applicable)**:** _____
_____
_____

Current Presentation (i.e., Why are Crisis Response Services needed?) _____
_____
_____
_____
_____
_____

Actions Taken by Staff: _____
_____
_____
_____
_____
_____

Initial Behavioral Observations:

Speech: ☐ Appropriate   ☐ Slowed   ☐ Pressured   ☐ Mechanical   ☐ Slurred   ☐ Tangential   ☐ Other: _____
Behavior: ☐ Appropriate   ☐ Withdrawn   ☐ Atypical   ☐ Hostile   ☐ Agitated   ☐ Guarded   ☐ Other: _____

_____

Observation Type: ☐ Phone Call Only   ☐ In-person

_____

Appearance: ☐ Appropriate   ☐ Disheveled   ☐ Inappropriate Dress   ☐ Unsanitary   ☐ Other: _____

_____

Mood: ☐ Appropriate   ☐ Euthymic   ☐ Depressed   ☐ Euphoric   ☐ Irritable   ☐ Anxious   ☐ Angry

_____

Affect: ☐ Appropriate   ☐ Flat   ☐ Blunted   ☐ Labile   ☐ Other: _____

_____

Oriented to: ☐ Place   ☐ Time   ☐ Person   ☐ Situation   ☐ None

_____

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

_____

Memory: ☐ Appropriate   ☐ Impaired   **Intelligence:**   ☐ Below Average   ☐ Average   ☐ Above Average   ☐ N/A

_____

Judgment/Insight: ☐ Good   ☐ Fair   ☐ Poor   ☐ Impaired   ☐ N/A

Are you currently experiencing **Hallucinations?**   ☐ Yes   ☐ No ; If YES,   ☐ Auditory   ☐ Visual   ☐ Tactile

_____

Is the person currently **Suicidal?**   ☐ Yes   ☐ No; If YES,   ☐ Ideation   ☐ Plan   ☐ Intent   ☐ Self-Harm

Comments: _____

_____

Is the person currently **Homicidal?**   ☐ Yes   ☐ No; If YES,   ☐ Ideation   ☐ Plan   ☐ Intent   ☐ Aggressive

Comments: _____

RESOLUTION	
Status of Person at Conclusion of Crisis Contact:	**Referrals:**
	Appointment with Provider: Date: Time:

Required Data
(Please note "Unknown" if information is Unavailable at time of Assessment)

DOB:	**Age:**	**Sex at Birth:**
Race/Ethnicity:	**Education Level:**	**Marital Status:**
County of Residence:	**Current Living Arrangements:**	**Type of Residence/Dwelling:**
Employment Status:	**Any current/pending criminal charges:**	**Primary Source of Income:**
Annual Gross Income:	**# Living in household:**	**SSI/SSDI Eligibility:**
Veteran Status:	**Physical/Cognitive Impairments:**	**Service Code:**

Additional Comments:

Staff Signature/Credentials:
Date:

Medical Examination

The DMH Operational Standards require that each person served in any DMH certified supervised living and residential treatment program must have a documented Medical Examination in the person's record. 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 person 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:

- Person'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.

For ID/DD Waiver, the medical exam obtained as part of the admission process can be used for up to one year from the date of the exam.

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, Shared Supported Living Services, Supported Living Services and Therapeutic Group Home Services providers are assisting people 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 person 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 person 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**
❑ **Person/Parent/Legal Representative 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.

Forms can be prepared or generated by the pharmacy for up to one month for regularly prescribed medication. Agencies must have policies and procedures to account for changes to medications mid cycle. Signatures must be original at the time of observation.

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

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	Person Signature	Staff Observation Signature/ Credential

Telephone/Visitation Agreement

Purpose
People 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. People 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 person's presence in the program to those listed in and according to the terms detailed in the Agreement. This form is required for Substance Use Residential Treatment programs, Supervised Living programs, Shared Supported 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 person receiving services.

Telephone Calls
Check only the box that applies. If the person agrees to accept all telephone calls regardless of source, the first box should be checked. If the person 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 person agrees to accept all visitors, the first box should be checked. If the person 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 person 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 visitor.

☐ 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.

_____   _____
Person Receiving Services/Parent   Date   Legal/Authorized Representative   Date

_____   _____
Signature/Credential   Date   Relationship to Person

Search and Seizure Report

Purpose
The form serves as documentation that a search of a person and/or his/her possessions and/or space was conducted by a DMH certified provider. A separate form must be completed for each person 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 a person is physically escorted away from a service or living area due to inappropriate behavior, the intervention must be documented. A physical escort is the temporary holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing a person who is acting out to walk to a safe location.

Identifying Information
Enter the name and record number of the person being escorted.

Presenting Need
The time, date and detailed description of the events necessitating an escort must be documented. Describe in detail the person'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 person'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 person 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 a person 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

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 person's behavior during escort:

Supervisory staff person's face-to-face assessment of the person'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) person 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 Escort

_____

Signature(s) of Other Staff Witness(es)

_____

_____

_____

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.

Seclusion cannot be used for persons who have IDD.

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 person in seclusion before issuing a new order. Staff must observe the person 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 person is in seclusion and a description of the person'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 Person 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 Person's Behavior During Seclusion:

Signature of Staff Implementing Seclusion	Signature of Other Staff Witness(es)

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

Signature of Physician or other Licensed Practitioner

15 Minute Observations Indicated by Staff Signature	
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

Section E
Day Service Programs

Acute Partial Hospitalization Services Summary Note

Acute Partial Hospitalization Services Summary Note

Purpose
Documentation must be maintained when a person 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 person. 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 person 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 person 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 person 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 F
Mental Health Services

Adult Making A Plan (AMAP) Case Summary

Adult Making A Plan (AMAP) Monthly Reporting

Crisis Stabilization Services Daily Note

Adult Pre-Evaluation Screening

Youth Pre-Evaluation Screening

Violence Risk Assessment for Certified Holding Facility

Suicide Risk Assessment for Certified Holding Facility

Adult Making A Plan (AMAP) Case Summary

Purpose

Adult Making a Plan (AMAP) Teams address the needs of adults with serious mental illness who require services from multiple agencies and multiple program systems due to multiple/frequent in-patient treatment admissions or commitments. The purpose of the AMAP Team is to develop and implement new and different systems of wrap-around support in order to treat people in the community rather than an institutional setting. All Community Mental Health Centers must document participation in at least one AMAP Team in their region.

Documentation

If DMH funds are utilized to assist people referred to the AMAP Team, all questions in all sections of the Case Summary form must be answered in as much detail as possible in order to justify the need for AMAP Team intervention.

The AMAP Case Summary form must be completed, attached to the Mobile Crisis Response Team (M-CeRT) cash request, and submitted to the Department of Mental Health.

AMAP Team Case Summary Form	Name: _____ Date of Review _____

Why was this person referred to the AMAP Team? *(How many inpatient tx/over what period of time)*

Why was this person considered to be at-risk?

Recommendations of the team (include how they differ from past interventions) :

If DMH funds will be used for this person, indicate estimated amounts for each recommended service/support agreed upon by the team.

If DMH funds will be used for this person, how will the use of these funds maintain this person in his/her home and community? How will the service/support continue after the use of DMH funds?

Signature of AMAP Team Coordinator _____

Adult Making A Plan (AMAP) Monthly Report

Purpose

Adult Making a Plan (AMAP) Teams address the needs of adults with serious mental illness who require services from multiple agencies and multiple program systems due to multiple/frequent in-patient treatment admissions or commitments. The purpose of the AMAP Team is to develop and implement new and different systems of wrap-around support in order to treat people in the community rather than an institutional setting.

Documentation

Document the county where the AMAP meeting was held and the month the meeting took place. Document the number of each staff representing the agencies involved with the AMAP Team. Have each team member sign the attendance log and write the name of their agency on the same line.

The AMAP Monthly Reporting form must be completed, attached to the Mobile Crisis Response Team (M-CeRT) cash request, and submitted to the Department of Mental Health.

AMAP Team Monthly Reporting	County _____ Month _____

Monthly Reporting Forms must be submitted to the Department of Mental Health. Case summary forms, for each adult reviewed, must be submitted with the monthly reporting form. Cash requests will not be processed without this information.

Referral Information

1. Number of cases reviewed _____

2. Number of follow-ups from previous month _____

3. Number of referrals from:

    _____ Mental Health Center in your county   _____ Mental Health Center Region-Wide

    _____ Mental Health Center (other Region)   _____ Chancery Court/Clerk

    _____ MDMH State Hospital   _____ Sheriff's Department

    _____ Crisis Stabilization Unit   _____ Police Department

    _____ Behavioral/Mental Health Court   _____ Family Member(s)

    _____ Other

AMAP Team Member Participation

Please indicate, using a checkmark, which of the following agencies that were represented at your AMAP Team Meeting(s) for the month.

_____ Community Mental Health Center   _____ MDMH State Hospital

_____ Chancery Court   _____ Crisis Stabilization Unit

_____ Sheriff's Department   _____ Police Department

_____ Families   _____ Individual Receiving Services

_____ NAMI   _____ Other *please identify

AMAP Team Member Participation

Attendance Log

Team Member   Agency Represented

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Crisis Stabilization Services
Daily Activity/Daily Progress Summary Note

Purpose
Documentation must be maintained when a person receives Crisis Stabilization Services. Each therapeutic activity must be documented along with a summary of progress for each day the person receives services. All psychiatric care, nursing services and mental health therapy will be documented in the Individualized Progress Note format.

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

Therapeutic Activities Provided
Indicate the nature of the therapeutic activities being provided, specify the time the activity began and ended and list the name of the staff leading the services.

Daily Summary Note
A Master's level therapist must summarize the progress of the person receiving services as it relates to the Individual Service Plan.

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

Crisis Stabilization Services (i.e. counseling, therapy, recreational, education, and social/interpersonal activities) can be provided seven (7) days per week but must at a minimum be;

        a. Provided five (5) days per week.
        b. Provided five (5) hours per day.
        c. Provided two (2) hours per day for children/youth enrolled and attending school full time.

Crisis Stabilization Services Daily Activity/Daily Summary Note	Name _____
	ID Number _____
	Date _____
	Total Time

Therapeutic Activities Provided

Activity	Time In	Time Out	Name of Activity Coordinator

Daily Summary Note

_____

Signature/Credential

Youth and Adult Pre-Evaluation Screening

Purpose

The Pre-Evaluation Screening is required under Mississippi Civil Commitment Statutes. The Pre-Evaluation Screening must take place prior to the Civil Commitment Exam and can only be completed by staff from a Community Mental Health Center. The Pre-Evaluation Screening is used to gather information pertaining to a person to be used by the Chancery, Family and/or Youth Court in determining the need for civil commitment.

Timeline

The Pre-Evaluation Screening must take place within 48 hours after an affidavit has been filed in Chancery, Family and/or Youth Court.

General

The Pre-Evaluation Screening must be filled out as completely as possible. Do not leave any spaces blank. If you are unable to gather certain information then make a notation in that space. Information can be gathered from informants, the person and the person's record.

The Adult Pre-Evaluation is to be used with people 18 years and older. The Youth Pre-Evaluation is to be used with people 14 – 17 years of age.

Once the Pre-Evaluation Screening is completed, recommend to the court if a Civil Commitment Exam should take place. If you recommend that the Civil Commitment Exam does not need to take place, indicate on the form why and list appropriate referrals that have been made or should be made. Include any additional comments that you think are pertinent to the court.

A copy of the completed form must be kept in the person's record.

Signature

The staff member completing the Pre-Evaluation Screening must sign the report to include credentials.

Youth Pre-Evaluation Screening

Date:	Time In:	Time Out:	Interview Location:

Individuals Present:

Interpretative Aids/Assisted Devices:	Pending Felony Charges: ☐ Yes ☐ No

Case Number:	CMHC Region:
In the court of County	Voluntary CSU Admission Sought: ☐ Yes ☐ No
Mobile Crisis Involvement: ☐ Yes ☐ No	

Advise the following to the *Respondent:* Information from this interview will be reported on a standardized form and submitted to the chancery court and civil commitmentexaminers. You have the right to refuse to participate. Other sources of information including a review of your legal medical records and interviews with family member and the affiant requesting commitment will be included in this report.

Respondent Demographics

Name:	DOB:	Age: Gender: Race:
Social Sec #: Medicaid #:		Medicare#:
Home Address:		Phone Number:
Does the respondent have a legal guardian or conservator: ☐ Yes ☐ No		
Guardian/Conservator Contact Information		
Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other		

Affiant Demographics

Affiant Name:	Relation to Respondent:
Phone Number:	Home Address:
Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other	

Respondent Psychosocial Information

Current Living: ☐Alone ☐Family ☐Friends ☐Assisted Living ☐Homeless ☐Other/Describe:	
Does the Respondent currently have stable and independent living arrangements: ☐ Yes ☐ No	
Current Grade in School:	Name of School:
History of IEP or 504C: ☐ Yes ☐ No Date of most recent IEP or 504C:	
Juvenile Justice Involvement: ☐ Yes ☐ No	Describe
Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other	

Psychiatric History

Current Psychotropic Medications: Dosage & Date/Time Last Taken: Is the medication helpful or problematic:	
Psychiatric Hospitalizations: Has the Respondent had 2 or more psychiatric hospital or emergency admissions in the past 12 months: ☐ Yes ☐ No	Locations/Dates:
Outpatient Treatments:	Locations/Dates:
Psychological Testing:	Provider/Dates:
Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other	

Medical Status & Treatment History

Current Medications (not listed above):	Dosage & Date/Time Last Taken:	Is the medication helpful or problematic: .

Known Medication Allergies:

Currently Under Physician Care For:	Physician's Name:
Conditions Treated In The Past:	Provider/Dates:
Medical Hospitalization History:	Physical Disabilities:

Current Communicable Diseases:

☐ HIV/AIDS　　☐Hepatitis A　　☐Hepatitis B　　☐Hepatitis C　　☐TB(Tuberculosis)

☐ MRSA　　☐Influenza　　☐Head Lice　　☐Scabies　　☐Body Lice　　☐STIs　　☐Other

Currently Pregnant: ☐ Yes　　☐ No

Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Developmental Disability

Pregnancy/Delivery Complications: ☐ Yes ☐ No	Describe:
Met Developmental Milestones on Time: Walked ☐　Talked ☐　Crawled ☐　Toilet Trained ☐　Feeding ☐	If no, describe:
History of Special Education Ruling: ☐ Yes ☐ No	If yes, describe:
Documented IQ below 70: ☐ Yes ☐ No	If yes, describe:
Documented sub-average intellectual functioning before age 18: ☐ Yes　☐ No	If yes, describe:
Documented Adaptive Functioning Deficits: ☐ Yes ☐ No	If yes, describe:

Specific Observed Adaptive Functioning Deficits:

Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Mental State Exam

Oriented to Date:　**Time:**　　**Place:** *Cue for three words (provide words)
President:
Counting Response:
Word Recall:
Completed Written Command: ☐ Yes　　☐ No　　If no, describe:
What do you understand the reason for our meeting today to be?
Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Psychiatric Symptoms Past Month

Respondent(R)　Informant(I)

Mood Symptoms	R	I	Mood Symptoms	R	I	Behavioral Symptoms	R	I
☐ Depressed mood/Appears Sad	☐	☐	☐ Dizzy	☐	☐	☐ Attempts to "Annoy" Others	☐	☐
☐ Enjoys Very Little	☐	☐	☐ Shaking/Trembling	☐	☐	☐ Defies Requests	☐	☐
☐ Cries Frequently	☐	☐	☐ Excessive Sweating	☐	☐	☐ Angry & Resentful	☐	☐
☐ Decrease in Appetite	☐	☐	☐ Shortness of Breath	☐	☐	☐ Sullen	☐	☐
☐ Increase in Appetite	☐	☐	☐ Tingling in Hands or Feet	☐	☐	☐ Irritable	☐	☐

Psychiatric Symptoms Past Month

Mood Symptoms continues	R	I	Mood Symptoms continues	R	I	Behavioral Symptoms continues	R	I
☐ Fatigued or Underactive (without reason)	☐	☐	☐ Headache	☐	☐	☐ Tantrums	☐	☐
☐ Difficulty Sleeping	☐	☐	**Behavioral Symptoms**	**R**	**I**	☐ Lying	☐	☐
☐ Nightmares/Nigh Terrors	☐	☐	☐ Impulsive	☐	☐	☐ Cheating	☐	☐
☐ Withdrawn From Peers	☐	☐	☐ Fails to Finish Tasks	☐	☐	☐ Steals	☐	☐
☐ Bullied or Rejected by Peers	☐	☐	☐ Talks Excessively	☐	☐	☐ Physically Harms People	☐	☐
☐ Engages in Self Harm	☐	☐	☐ Loud	☐	☐	☐ Physically Harms Animals	☐	☐
☐ Talks About Killing Self Wishes to die	☐	☐	☐ Blurts Words/Interrupts	☐	☐	☐ Destroys Property	☐	☐
☐ Clings to Adults/Dependent	☐	☐	☐ Difficulty Sitting Still, Restless	☐	☐	☐ Sets Fires	☐	☐
☐ Fears Specific Situations or Objects Describe:	☐	☐	☐ Fidgets	☐	☐	☐ Threatens Others	☐	☐
☐ Reports Fearing School	☐	☐	☐ Easily Distracted	☐	☐	☐ Physical Fights With Peers	☐	☐
☐ Worries	☐	☐	☐ Disorganized	☐	☐	☐ Skips School	☐	☐
☐ Tense	☐	☐	☐ Forgetful/Misplaces Belongings	☐	☐	☐ Used a Weapon	☐	☐
☐ Stomach Aches or Pains	☐	☐	☐ Loses Temper Frequently	☐	☐	☐ Delinquent Peers	☐	☐
☐ Heart Palpitations	☐	☐	☐ Argues with Adults ☐ Home ☐ School	☐	☐			

Psychiatric Symptoms Past Month

Respondent(R) Informant(I)

Thought Disorder Symptoms	R	I		R	I
☐ Hallucinations	☐	☐	☐ Absence of emotions	☐	☐
☐ Auditory ☐Visual ☐Olfactory	☐	☐	☐ Absence of speech	☐	☐
☐ Tactile ☐Gustatory	☐	☐	☐ Absence of movement	☐	☐
Specific Hallucinations:	☐	☐	☐ Lack of Hygiene	☐	☐
☐ Delusions	☐	☐	☐ Lack of eating/feeding	☐	☐
☐Persecutory ☐Grandiose ☐Paranoid ☐ Other	☐	☐			
Specific Delusions:					
Obsessive/Compulsive Symptoms					
Obsessive Thoughts ☐Yes ☐No	☐	☐	Obsessive Thoughts ☐Yes ☐No	☐	☐
Severity: ☐Mild ☐Moderate ☐Severe	☐	☐	Severity: ☐Mild ☐Moderate ☐Severe	☐	☐
Specific Obsessions:	☐	☐	Specific Obsessions:	☐	☐

Trauma History

Trauma Exposure ☐Yes ☐No (type/approx. Date) Click here to enter text.				
Trauma Triggers:				
Environmental	☐ Crowding	☐Room checks	☐Confusing signs	☐ Slamming doors
	☐ Leaving bedroom door open	☐ Dark room	☐ Too hot or too cold	☐ Noise

Interpersonal	☐ Lack of privacy	☐ Being approached by men or women	☐Arguments	☐People Yelling
	☐ Confined spaces	☐Being touched	☐ People too close	Contact with Family
	☐ Being stared at	☐ Being ignored	☐Feeling pressured	☐ Being ordered to do something
	☐ Being approached by women	☐ Being Teased/picked on	☐ Tall or large people	☐ Smells
				☐ People focusing on my symptoms
Other Triggers	☐ Taste ☐ Time of Day	☐ sounds ☐ Sights	☐ Sensations/textures	☐ Wringing hands
Warning Signs of Emotional escalation	☐ Heart Pounding	☐ Shortness of Breath	☐ Breathing Hard	☐ Wringing hands
	☐ Clenching teeth	☐ Flushed/red face	☐ Crying	☐ Clenching fists
	☐ Bouncing legs	☐ Singing	☐ Can't sit still	☐ Cursing/swearing
	☐ Sweating	☐ Rocking	☐ Pacing	☐ Giggling

Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Suicide Assessment

	Friend or Family Member Completed Suicide:
Prior Attempts:	
Approximate Date:	Approximate Date:
Method of attempt:	Method of suicide:

Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Behaviors Exhibited by Respondent

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:

Violence Risk Assessment

Current thoughts about harming another person   ☒ Yes   ☐ No

If yes, whom:
If yes, how long have you had these thoughts
If yes, specific plan:
Access to means to carry out plan:

Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Violence Risk Factors Present

Present	Unknown		Present	Unknown	
☐	☐	Male sex	☐	☐	Substance Abuse
☐	☐	Suspiciousness/Perception of hidden threat	☐	☐	Comorbid MI & Substance Use Dx
☐	☐	Early offense history	☐	☐	Anger
☐	☐	Psychopathy (PCL:SV>12)	☐	☐	Antisocial Personality Diagnosis
☐	☐	Violent Fantasies	Frequency, type, recency		
☐	☐	Previous violence against other people	Frequency, severity, type		
☐	☐	Childhood physical abuse	Frequency, severity		

Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Substance Use

Do you currently use?

	Past Use	Amount	Frequency	Age of Initiation
Caffeine				
Nicotine				
Alcohol				
Marijuana				
Opioids				
Amphetamines				
Hallucinogenic				
Prescription Medication				
Over the counter medication				

History of legal charges related to substance use?   ☐ Yes   ☐ No | Describe:

Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Physical Appearance

	Attire	**Hair**	**Nails**	**Skin**	
☐ Glasses	☐ Appropriate for occasion	☐ Clean	☐ Clean	☐ Clean	☐ Bruised
☐ Contacts	☐ Appropriate for weather	☐ Dirty	☐ Dirty	☐ Dirty	☐ Cuts/Scrapes
☐ Hearing Aids	☐ Clean	☐ Disheveled	☐	☐ Tattoos Describe:	
	☐ Dirty	☐ Styled			
	☐ Torn/worn through		☐	☐ Sores	
	☐ Other		☐		

Teeth	Unusual alterations or distinguishing features:
☐ Clean	
☐ Dirty	
☐ Decay	
☐ Missing	

Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Behavioral Observations

Motor Activity

Diminished	Normal	Excessive	Unusual	
☐ Frozen	☐ Purposeful	☐ Restless	☐ Other	
☐ Catatonic	☐ Coordinated	☐ Squirming		
☐ Almost motionless	☐ Other	☐ Fidgety		
☐ Little animation		☐ Constant movement		
☐ Psychomotor retardation		☐ Hyperactive		
☐ Slowed reaction time		☐ Other		
☐ Other				

Speech

Slowed	Normal	Pressured	Verbose	Unusual
☐ Minimal response	☐ Initiates	☐ Excessively wordy	☐ Over productive	☐
☐ Unspontaneous	☐ Alert/responsive	☐ Expansive	☐ Long winded	
☐ Sluggish	☐ Productive	☐ Rapid	☐ Nonstop	
☐ Paucity	☐ Animated	☐ Fast	☐ Frequent run ons	
☐ Impoverished	☐ Spontaneous	☐ Rushed	☐ Flight of ideas	
☐ Single word answers	☐ Smooth	☐ Other	☐ Hyper verbal	
☐ Other	☐ Other		☐ Other	

Thought Process				
Attention	Insight	Preoccupations		
☐ Normal	☐ Good	☐ Somatic	☐ Self	
☐ Unengaged	☐ Fair	☐ Children	☐ Finances	
☐ Distractible	☐ Poor	☐ Spouse/Sig Other	☐ Other	
☐ Hyper vigilant	☐ No insight	☐ Job		
☐ Hyper focused				
		Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other		
Affect				
☐ Flat	☐ Blunted	☐ Constricted	☐ Normal	☐ Broad
Facial Expression				
☐ Vacant				
☐ Blank				
☐ Strained				
☐ Pained				
☐ Grimacing				
☐ Smiling				
☐ Other				

Summary & Recommendations

Additional Comments:

Based on the data gathered for the current Pre-Evaluation Screening:

☐ It is **NOT** recommended that this respondent receive a civil commitment exam.

- Current available information indicates that present symptomatology is due to

  ☐Dementia ☐Intellectual/Developmental Disability ☐ Epilepsy ☐Chemical Dependency ☐Mental Illness

☐ It **IS** recommended that this respondent receive a civil commitment exam. Based on the data available for the current Pre-Screening Evaluation the following symptomatology cannot be managed/treated in a less restrictive environment:

1)

2)

3)

4)

** Must Complete Referral Page for appropriate supports and services for all individuals that receive a Pre-Evaluation Screening regardless of recommendation status. It is important to document that the individual was evaluated for appropriateness to the indicated intensive services and supports for current or future treatment planning.

** If the interviewer determines that there is not enough information or evidence at this time to evaluate the individual for diversion or appropriateness of referral to intensive services or supports, please notate in the comments section above.

_____
Interviewer's Signature-Credentials

_____
Interviewer's Agency

_____
County where affidavit was filed.

Referrals

Please refer to the 2021 Community Transition Guide for updated referral contact information

Respondent's County of Residence: _____

Was a referral made to a Crisis Stabilization Unit (CSU)? ☐ Yes ☐ No

    Which CSU? _____

    Was the Respondent accepted at the CSU? ☐ Yes ☐ No

        If *No,* what was the denial reason: _____

Does the Respondent's Family have stable and independent living arrangements?

    If *No,* then refer to CHOICE Housing Program

    Referral Date: _____

    CHOICE Referral Staff Contact: _____

    Resolution: _____

Has the Respondent had 2 or more psychiatric hospital or emergency admissions in the past 12 months? OR

Does the Respondent present with significant and major psychiatric symptoms (e.g., suicidality, psychosis) and has not benefited from traditional outpatient services?

    If *Yes,* then refer to ICSS

    Referral Date: _____

    ICSS Staff Contact: _____

    Resolution: _____

Is Respondent between 15-30 years old? ☐ Yes ☐ No
Is this the Respondent's first episode of psychosis? ☐ Yes ☐ No
If the answer is *Yes* to both, then refer to NAVIGATE First Episode Psychosis Service

    Referral Date: _____

    NAVIGATE Staff Contact: _____

    Resolution: _____

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Adult Pre-Evaluation Screening

Date:	Time In:	Time Out:	Interview Location:

Individuals Present:

Interpretative Aids/Assisted Devices:	Pending Felony Charges: ☐ Yes ☐ No

Case Number:	CMHC Region:

In the _____ court of _____ County	Voluntary CSU Admission Sought: ☐ Yes ☐ No

Mobile Crisis Involvement: ☐ Yes ☐ No	

Advise the following to the *Respondent:* Information from this interview will be reported on a standardized form and submitted to the chancery court and civil commitment examiners. You have the right to refuse to participate. Other sources of information including a review of your legal medical records and interviews with family member and the affiant requesting commitment will be included in this report.

Respondent

Name:	DOB:	**Age:** **Gender:** **Race:**

Social Sec #:	Medicaid #:	Medicare#:

Home Address:	Phone Number:

Respondent resides with minor children: ☐ Yes ☐ No	Name & Ages of Children:
Respondent resides has visitation rights to minor children: ☐ Yes ☐ No	Name & Ages of Children:
Respondent resides has legal guardian/conservator: ☐ Yes ☐ No	Name & Ages of Children:

Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Affiant

Affiant Name:	Relation to Respondent:
Phone Number:	Home Address:

Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Respondent Psychosocial Information

Current Living: ☐Alone ☐Family/Friends ☐Assisted Living ☐Homeless ☐Other/Describe:
Does the Respondent currently have stable and independent living arrangements: ☐ Yes   ☐ No

Housing:	Dwelling:	Marital Status:	Home Address:

Employed: ☐ Yes ☐ No Employer/Position:	Length of Job:

If unemployed (most recent job?):	Highest Level of Education Completed:

Religious Preference or Practice:

Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Psychiatric

Current Psychotropic Medications:	Dosage & Date/Time Last Taken:	Is the medication helpful or problematic:

Psychiatric Hospitalizations: Has the Respondent had 2 or more psychiatric hospital or emergency admissions in the past 12 months: ☐ Yes ☐ No	Locations/Dates: Enter Location and Date
Outpatient Treatments:	Locations/Dates:
Psychological Testing:	Provider/Dates:

Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Medical Status & Treatment

Current Medications (not listed above):	Dosage & Date/Time Last Taken:	Is the medication helpful or problematic:

Known Medication Allergies:

Currently Under Physician Care For:	Physician's Name:
Conditions Treated in The Past:	Provider/Dates:
Medical Hospitalization History:	Physical Disabilities:

Current Communicable Diseases:

☐ HIV/AIDS ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ TB(Tuberculosis)

☐ MRSA ☐ Influenza ☐ Head Lice ☐ Scabies ☐ Body Lice ☐ STIs ☐ Other

Currently Pregnant: ☐ Yes ☐ No

Source of Information: ☐ Respondent ☐ Affiant ☐ Chart Review ☐ Other

Developmental Disability

History of Special Education Ruling: ☐ Yes ☐ No	If yes, describe:
Documented IQ below 70: ☐ Yes ☐ No	If yes, describe:
Documented sub-average intellectual functioning before age 18: ☐ Yes ☐ No	If yes, describe:
Documented Adaptive Functioning Deficits: ☐ Yes ☐ No	If yes, describe:

Specific Observed Adaptive Functioning Deficits:

Source of Information: ☐ Respondent ☐ Affiant ☐ Chart Review ☐ Other

Mental State Exam

Oriented to Date: **Time:** **Place:** *Cue for three words (provide words)
President:
Counting Response:
Word Recall:
Completed Written Command: ☐ Yes ☐ No If no, describe:
What do you understand the reason for our meeting today to be?

Source of Information: ☐ Respondent ☐ Affiant ☐ Chart Review ☐ Other

Psychiatric Symptoms Past

Respondent(R) Informant(I)

Depressive Symptoms	R	I	Anxiety Symptoms	R	I	Somatic Symptoms	R	I
☐ Depressed mood most of the day	☐	☐	☐ Worry	☐	☐	☐ Headaches	☐	☐
☐ Lack of Interest/Pleasure	☐	☐	☐ Restlessness	☐	☐	☐ Chest Discomfort/Pain	☐	☐
☐ Appetite Change or Sig Weight Change	☐	☐	☐ Easily Fatigued	☐	☐	☐ Faintness	☐	☐
☐ Insomnia (Difficulty Falling Asleep)	☐	☐	☐ Irritability	☐	☐	☐ Hot or Cold Flashes	☐	☐
☐ Feelings of Worthlessness	☐	☐	☐ Muscle Tension	☐	☐	☐ Stomach Aches/Pains	☐	☐
☐ Fatigue or Loss of Energy	☐	☐	☐ Difficulty Concentrating	☐	☐	☐ Heart Palpitations	☐	☐
☐ Diminished Concentration	☐	☐	☐ Sleep Disturbance	☐	☐	☐ Dizziness or Vertigo	☐	☐

Psychiatric Symptoms Past

Respondent(R) Informant(I)

	R	I		R	I		
☐ Indecisiveness	☐	☐	☐ Other	☐	☐	☐Shaking/Trembling	☐
☐ Hypersomnia (Sleeping Excessively)	☐	☐				☐Tingling in hands or feet	☐
☐ Recurrent Thoughts of Death	☐	☐				☐Excessive Sweating	☐
☐ Motor Retardation	☐	☐				☐ Other	☐ ☐
☐ Motor Agitation	☐	☐					
☐ Feelings of Hopelessness	☐	☐					
☐ Other	☐	☐					

Mania & Hypomania Symptoms	R	I		R	I
☐ At least 1 week	☐	☐	☐More talkative than usual	☐	☐
☐ 4 consecutive days < weeks	☐	☐	☐ Excessive involvement in activities with high potential for painful consequences	☐	☐
☐ Flight of ideas/racing thoughts	☐	☐	☐Distractibility	☐	☐
☐ Decreased need for sleep	☐	☐	Persistent elevated, or irritable mood and significant increases in goal directed activity ☐Yes ☐No	☐	☐
☐ Increased self-esteem of Grandiosity	☐	☐			

Thought Disorder Symptoms	R	I		R	I
☐ Hallucinations	☐	☐	☐ Absence of emotions	☐	☐
☐ Auditory ☐Visual ☐Olfactory	☐	☐	☐Absence of speech	☐	☐
☐ Tactile ☐Gustatory	☐	☐	☐Absence of movement	☐	☐
Specific Hallucinations:	☐	☐	☐ Lack of Hygiene	☐	☐
☐ Delusions	☐	☐	☐Lack of eating/feeding	☐	☐
☐Persecutory ☐Grandiose ☐Paranoid ☐ Other	☐	☐			
Specific Delusions:					

Obsessive Compulsive Symptoms					
Obsessive Thoughts ☐Yes ☐No	☐	☐	Compulsive Behaviors ☐Yes ☐No	☐	☐
Severity: ☐Mild ☐Moderate ☐Severe	☐	☐	Severity: ☐Mild ☐Moderate ☐Severe	☐	☐
Specific Obsessions:	☐	☐	Specific Compulsions:	☐	☐

Trauma History

Trauma Exposure ☐Yes ☐No (type/approx. Date)

Trauma Triggers:

Environmental	☐ Crowding	☐ Room checks	☐ Confusing signs	☐ Slamming doors
	☐ Leaving bedroom door open	☐ Dark room	☐ Too hot or too cold	☐ Noise
Interpersonal	☐ Lack of privacy ☐ Confined spaces	☐ Being approached by men or women ☐ Being touched	☐ Arguments ☐ People too close	☐ People Yelling ☐ Contact with Family ☐ Being ordered to do something
	☐ Being stared at	☐ Being ignored	☐ Feeling pressured ☐ People focusing on my symptoms	
	☐ Being approached by women	☐ Being Teased/picked on ☐ Tall or large		☐ Smells
Other Triggers	☐ Taste ☐ Time of Day	☐ sounds ☐ Sights	☐ Sensations/textures	☐ Wringing hands
Warning Signs of Emotional escalations	☐ Heart Pounding ☐ Clenching teeth ☐Bouncing legs ☐ Sweating	☐ Shortness of Breath ☐ Flushed/red face ☐Singing ☐ Rocking	☐ Breathing Hard ☐ Crying ☐ Can't sit still ☐ Pacing	☐ Wringing hands ☐ Clenching fists ☐Cursing/swearing ☐ Giggling

Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Suicide Assessment

Prior Attempts:	Friend or Family Member Completed Suicide:
Approximate Date:	Approximate Date:
Method of attempt:	Method of suicide:
	Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

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: _____

Violence Risk Assessment

Current thoughts about harming another person ☐ Yes ☐ No
If Yes, whom:
If yes, how long have you had these thoughts?
If yes, specific plan:
Access to means to carry out plan:
Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Violence Risk Factors Present

Present	Unknown		Present	Unknown	
☐	☐	Male sex	☐	☐	Substance Abuse
☐	☐	Suspiciousness/Perception of hidden threat	☐	☐	Comorbid MI & Substance Use Dx
☐	☐	Early offense history	☐	☐	Anger
☐	☐	Psychopathy (PCL:SV>12)	☐	☐	Antisocial Personality Diagnosis
☐	☐	Violent Fantasies	Frequency, type, recency		
☐	☐	Previous violence against other people	Frequency, severity, type		
☐	☐	Childhood physical abuse	Frequency, severity		
			Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other		

Substance Use

Do you currently use?

	Past Use	Amount	Frequency	Age of Initiation
Caffeine				
Nicotine				
Alcohol				
Marijuana				
Opioids				
Amphetamines				
Hallucinogenic				
Prescription Medication				
Over the counter medication				

History of legal charges related to substance use? ☐ Yes ☐ No	Describe:
Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other	

Physical Appearance

	Attire	Hair	Nails	Skin	
☐ Glasses	☐ Appropriate for occasion	☐ Clean	☐ Clean	☐ Clean	☐ Bruised
☐ Contacts	☐ Appropriate for weather	☐ Dirty	☐ Dirty	☐ Dirty	☐ Cuts/Scrapes
☐ Hearing Aids	☐ Clean	☐ Disheveled	☐	☐ Tattoos Describe:	
	☐ Dirty	☐ Styled			
	☐ Torn/worn through		☐	☐ Sores	
	☐ Other		☐		

Teeth	Unusual alterations or distinguishing features:
☐ Clean	
☐ Dirty	
☐ Decay	
☐ Missing	

Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Behavioral Observations

Motor Activity

Diminished	Normal	Excessive	Unusual	
☐ Frozen	☐ Purposeful	☐ Restless	☐ Other	
☐ Catatonic	☐ Coordinated	☐ Squirming		
☐ Almost motionless	☐ Other	☐ Fidgety		
☐ Little animation		☐ Constant movement		
☐ Psychomotor retardation		☐ Hyperactive		
☐ Slowed reaction time		☐ Other		
☐ Other				

Speech

Slowed	Normal	Pressured	Verbose	Unusual
☐ Minimal response	☐ Initiates	☐ Excessively wordy	☐ Over productive	☐
☐ Unspontaneous	☐ Alert/responsive	☐ Expansive	☐ Long winded	
☐ Sluggish	☐ Productive	☐ Rapid	☐ Non stop	
☐ Paucity	☐ Animated	☐ Fast	☐ Frequent run-ons	
☐ Impoverished	☐ Spontaneous	☐ Rushed	☐ Flight of ideas	
☐ Single word answers	☐ Smooth	☐ Other	☐ Hyper verbal	
☐ Other	☐ Other		☐ Other	

Thought Process

Attention	Insight	Preoccupations		
☐ Normal	☐ Good	☐ Somatic	☐ Self	
☐ Unengaged	☐ Fair	☐ Children	☐ Finances	
☐ Distractible	☐ Poor	☐ Spouse/Sig Other	☐ Other	
☐ Hyper vigilant	☐ No insight	☐ Job		
☐ Hyper focused				

Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other

Behavioral Observations				
Affect				
☐ Flat	☐ Blunted	☐ Constricted	☐ Normal	☐ Broad
Facial Expression				
☐ Vacant				
☐ Blank				
☐ Strained				
☐ Pained				
☐ Grimacing				
☐ Smiling				
☐ Other				
		Source of Information: ☐Respondent ☐Affiant ☐Chart Review ☐Other		

Summary & Recommendations

Additional Comments:

Based on the data gathered for the current Pre-Evaluation Screening:

☐ It is **NOT** recommended that this respondent receive a civil commitment exam.

- Current available information indicates that present symptomatology is due to:
  ☐ Dementia ☐Intellectual/Developmental Disability ☐ Epilepsy ☐Chemical Dependency ☐Mental Illness

☐ It **IS** recommended that this respondent receive a civil commitment exam. Based on the data available for the current Pre-Screening Evaluation the following symptomatology cannot be managed/treated in a less restrictive environment:

1)

2)

3)

4)

** Must Complete Referral Page for appropriate supports and services for all individuals that receive a Pre-Evaluation Screening regardless of recommendation status. It is important to document that the individual was evaluated for appropriateness to the indicated intensive services and supports for current or future treatment planning.
** If the interviewer determines that there is not enough information or evidence at this time to evaluate the individual for diversion or appropriateness of referral to intensive services or supports, please notate in the comments section above.

_____
Interviewer's Signature-Credentials

_____
Interviewer's Agency

_____
County where affidavit was filed.

<u>Referrals</u>

Please refer to the 2021 Community Transition Guide for updated referral contact information

Respondent's County of Residence: _____

Was a referral made to a Crisis Stabilization Unit (CSU)? ☐ Yes ☐ No

    Which CSU? _____

    Was the Respondent accepted at the CSU? ☐ Yes ☐ No

        If *No,* what was the denial reason: _____

Does the Respondent have stable and independent living arrangements?

    If *No,* then refer to CHOICE Housing Program

    Referral Date: _____

    CHOICE Referral Staff Contact: _____

    Resolution: _____

Is the Respondent currently employed?

    If *No,* then refer to Supported Employment Program

    Referral Date: _____

    Supported Employment Staff Contact: _____

    Resolution: _____

Has the Respondent had 2 or more psychiatric hospital or emergency admissions in the past 12 months? <u>OR</u>

Does the Respondent present with significant and major psychiatric symptoms (e.g., suicidality, psychosis) and has not benefited from traditional outpatient services?

    If *Yes,* then refer to PACT or ICORT (dependent on Respondent's county of residence)

    Referral Date: _____

    PACT/ICORT Staff Contact: _____

    Resolution: _____

Is Respondent between 15-30 years old? ☐ Yes ☐ No
Is this the Respondent's first episode of psychosis? ☐ Yes ☐ No
If the answer is *Yes* to both, then refer to NAVIGATE First Episode Psychosis Service

    Referral Date: _____

    NAVIGATE Staff Contact: _____

    Resolution: _____

Intensive Community Supports by County

All Regions have ICSS and Supported Employment

Counties	Intensive Community Support	Operational	Counties	Intensive Community Support	Operational
Adams	ICORT	Yes	Lincoln	ICORT	No
Alcorn	PACT	Yes	Lowndes	ICORT	Yes
Amite	ICORT	Yes	Madison	PACT	Yes
Attala	ICSS	Yes	Marion	ICORT	Yes
Benton	ICSS	Yes	Marshall	ICORT	Yes
Bolivar	ICORT	Yes	Monroe	ICSS	Yes
Calhoun	ICORT	Yes	Montgomery	ICSS	Yes
Carrol	ICSS	Yes	Neshoba	ICSS	Yes
Chickasaw	ICSS	Yes	Newton	ICORT	Yes
Choctaw	ICORT	Yes	Noxubee	ICORT	Yes
Claiborne	ICORT	Yes	Oktibbeha	ICORT	Yes
Clarke	ICORT	Yes	Panola	ICORT	Yes
Clay	ICORT	Yes	Pearl River	ICORT	Yes
Coahoma	ICORT	Yes	Perry	PACT	Yes
Copiah	ICORT	No	Pike	ICORT	Yes
Covington	ICORT	Yes	Pontotoc	ICSS	Yes
DeSoto	PACT	Yes	Prentiss	PACT	Yes
Forrest	PACT	Yes	Quitman	ICORT	Yes
Franklin	ICORT	Yes	Rankin	PACT	Yes
George	ICORT	Yes	Scott	ICORT	Yes
Greene	ICSS	Yes	Sharkey	ICSS	Yes
Grenada	PACT	Yes	Simpson	ICORT	No
Hancock	PACT	Yes	Smith	ICORT	Yes
Harrison	PACT	Yes	Stone	ICSS	Yes
Hinds	PACT & ICORT	Yes Yes	Sunflower	ICSS	Yes
Holmes	PACT	Yes	Tallahatchie	ICORT	Yes
Humphreys	ICSS	Yes	Tate	ICORT	Yes
Issaquena	ICSS	Yes	Tippah	PACT	Yes
Itawamba	PACT	Yes	Tishomingo	PACT	Yes
Jackson	ICORT	Yes	Tunica	ICORT	Yes
Jasper	ICSS	Yes	Union	ICSS	Yes
Jefferson	ICORT	Yes	Walthall	ICORT	Yes
Jefferson Davis	ICORT	Yes	Warren	PACT	Yes
Jones	ICORT	Yes	Washington	ICORT	Yes
Kemper	ICSS	Yes	Wayne	ICSS	Yes
Lafayette	ICORT	Yes	Webster	ICORT	Yes
Lamar	ICORT	Yes	Wilkinson	ICORT	Yes
Lauderdale	PACT	Yes	Winston	ICORT	Yes
Lawrence	ICORT	Yes	Yalobusha	ICORT	Yes
Leake	ICORT	Yes	Yazoo	PACT	Yes
Lee	PACT	Yes			
Leflore	PACT	Yes			

Updated 06/01/2021

Violence Risk Assessment for Certified Holding Facility

Purpose
A DMH approved Violence Risk Assessment must be conducted on each person 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 a person 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 person. 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 person with intent to inflict severe physical harm. "Yes" means person 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 Person 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 person 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 person 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. Person lacks support of family of friends			
2. Person has a history of drug or alcohol abuse			
3. Person is very worried about problems other than legal issues (financial, family, medical condition, other)			
4. Person has experienced a significant loss within the last 6 months (loss of job or relationship, death of a close family member)			
5. Person is expressing feelings of hopelessness			
6. Person is thinking about killing himself/herself			
7. Person 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 person.

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 G
Alzheimer's and Other Dementia Services

Life Story Narrative

Life Story Narrative

Purpose
As Alzheimer's disease progresses, people lose developmental skills and abilities and appear 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 person. Traumatic events that occurred in the person'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 person's record. Program staff must review the person's narrative prior to initial contact with the person. 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 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 person had a sibling to die in early childhood, list that in the "Other" section of the "Childhood" narrative. If the person had a stillborn baby or suffered miscarriages, include that information in the "Other" section of the "Young Adulthood" narrative.

<table>
<tr><td rowspan="4"><h1>Life Story Narrative</h1></td><td>**Name** _____</td></tr>
<tr><td>**ID Number** _____</td></tr>
<tr><td>**Date** _____</td></tr>
<tr><td></td></tr>
</table>

Childhood (Birth - 12 years)

Birth date and birthplace: _____

Parents and grandparents: _____

Brothers and Sisters: _____

Birth Order: _____

Friends: _____

Significant relatives: _____

Home(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: _____

<table>
<tr><td rowspan="4"><h1>Life Story Narrative</h1></td><td>**Name** _____</td></tr>
<tr><td>**ID Number** _____</td></tr>
<tr><td>**Date** _____</td></tr>
<tr><td></td></tr>
</table>

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 person 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 person 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 H
Children and Youth Services

MAP Team Case Summary

MAP Team Report

Therapeutic Foster Care Contact Log

Wraparound Plan of Care

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

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
	Child Protective 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		Child Protective 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)

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

Wraparound Plan of Care

Purpose

Each individual who is receiving wraparound must have a Wraparound Plan of Care. (The Crisis Management Plan is considered a part of the Wraparound Plan of Care.) The Wraparound plan is a product resulting from the team process representing the best fit between all of the activities of the process including: family story, vision, team mission, strengths, needs, and strategies that move a family closer to their vision.

The timeline for completion for the initial plan is 30 days from the enrollment date at the first Child and Family Team Meeting (CFTM). The Crisis Management Plan is completed within 24 hours of enrollment and adjusted at the first CFTM.

The plan must be reviewed, updated and revised every 30 days at Child and Family Team Meetings. Wraparound Plans of Care can only be modified in a Child and Family Team Meeting with the family and team present.

Family Vision

The family vision is a statement using the family's words to describe what they hope to achieve. The statement should be positive, future-focused, and about the whole family. It can start with the phrase, "Life will be better when…"

Team Mission

The child and family team develops the mission together of what they hope to accomplish as team.

Functional Strengths for all Team Members

Each person that is on the child and family team (including the youth, all family members living in home with the youth, all informal supports, all formal supports, and all wraparound staff) should have strengths on the plan. Strengths should indicate how a person uses the strength so that it can be applied to strategies, tasks, and action steps in the crisis plan.

Need Statement

Needs in wraparound are the set of conditions causing a behavior or situation to occur or not occur and explain the underlying reasons why behaviors or situations happen. Need statements should address what an individual needs to know, feel, or understand. These statements should be empowering to the individual. The plan should have one statement for the youth and need statement(s) for other family members as needed. The review section is used to note how close a person is to having the need met.

Outcome Statement

Outcome statements should address the reason the youth was referred. The outcome statements for other family members should address how referral behaviors impacted them. The outcome statements should be measurable and include a baseline. The outcomes will be tracked using the "Outcome Statement Review" section.

Brainstormed Options to Meet Need

These are options that the family can choose from to meet the needs. These are only developed through a brainstorming process during the Child and Family Team Meeting. There should be a range of formal services, informal supports, and Evidence Based Practices (EBP) for the family to choose from.

Mandates, Challenges/Barriers, Tasks to Address Mandates or Challenges

Mandates are tasks that a family must complete due to other system involvement (youth court, CPS and/or education) Challenges/Barriers may be related to difficulty assessing needed supports and/or services due to location (e.g. lack of evidence based intervention in an area) or situation (e.g. lack of transportation). Use the Tasks to Address Mandates or Challenges if needed to address extenuating circumstances. If any of these areas do not apply, please mark N/A on the plan.

Strategy

Indicate an intervention, service, community support, or any unique steps to meet the need. (Add as many strategies as necessary with associated tasks)

Task

Tasks should be specific to how a strategy will be carried out. Tasks should address who, what, when, where, and how in regards to a strategy. Tasks can be assigned to anybody on a Child and Family Team and should be connected to an individual's strengths.

Crisis Management Plan

Diagnosis

Please provide the diagnosis of the individual

Potential Crisis

This section should include all of the safety risks in each area and address the reason for referral to wraparound. Also, list any crisis situations identified by the family (past and current)

Relevant History

Give a brief history to provide context to safety risks and challenges for the individual and family. Include things that work and do not work that have been used in the past.

Triggers

Please list all things that happen that can contribute to a crisis in each area of the individual's life.

Action Steps

Steps should range from least intrusive to more intensive. Proactive steps include steps that team members can take to prevent crisis from happening and are often directly linked to responses to triggers. Reactive steps include specific actions that team members can take when crisis actually occurs to address safety. Alternatives to emergency services and professional intervention should be included as options to try first. Action steps should include connections to coping skills and strengths that have already been identified.

Wraparound Plan of Care

*[*This form is ONLY used for children and youth receiving Wraparound Facilitation Services.]*

Date of Child and Family Team Meeting _____

Youth Name	**Guardian Name**	
Wraparound Phase	**Start Date**	**Target Discharge**
Primary Diagnosis(es)	**Secondary Diagnosis(es)**	
Family Contact Number	**Meeting Address**	
Facilitator Name	**Facilitator Contact Number**	

Family Vision:

Rating and Review:

Team Mission:

Rating and Review:

<u>Functional Strengths for Youth, Family, and other Team Members</u>

Need Statement		Start Date
		End Date
		Discontinued Date
Rating and Review		
Outcome Statement: (as related to referral Behavior)		
Outcome Statement Review		

Brainstormed options to meet need:

Mandates:

_____

Challenges/Barriers:

_____

Tasks to address Mandates or challenges:

Prioritized Strategy:	Start Date

| | Achieved Date |
| | Discontinued Date |

| **Tasks**: | |
| | |

Prioritized Strategy:	Start Date
	Achieved Date
	Discontinued Date

| **Tasks**: | |
| | |

Prioritized Strategy:	Start Date
	Achieved Date
	Discontinued Date

Tasks:

Prioritized Strategy:	Start Date
	Achieved Date
	Discontinued Date

Tasks:

Prioritized Strategy:	Start Date
	Achieved Date
	Discontinued Date

Tasks:

Prioritized Strategy:		Start Date
		Achieved Date
		Discontinued Date

Tasks:

(Add additional strategies as needed)

Need Statement		Start Date
		End Date
		Discontinued Date
Rating and Review		
Outcome Statement (as related to referral Behavior)		
Outcome Statement Review		

Brainstormed options to meet need:

Mandates:

Prioritized Strategy:	Start Date
	Achieved Date
	Discontinued Date

> **Tasks**:

Prioritized Strategy:	Start Date
	Achieved Date
	Discontinued Date

> **Tasks**:

| **Prioritized Strategy:** | Start Date |
| | Achieved Date |

	Discontinued Date

Tasks:

Prioritized Strategy:	Start Date
	Achieved Date
	Discontinued Date

Tasks:

Prioritized Strategy:	Start Date
	Achieved Date
	Discontinued Date

Tasks:

Prioritized Strategy:	Start Date
	Achieved Date
	Discontinued Date

Tasks:

(Add additional strategies as needed)

Date of Next Meeting:

Is the family ready to transition? Yes or No
Include reason and comments:

Additional team members to engage:

CRISIS MANAGEMENT PLAN

Youth Name (First, MI, Last):		File #:	Date:

Guardian Name:	DOB:	Phone:	Address:

Diagnosis

Primary:

Secondary:

Potential Crisis: (Include all current safety risks, reason for referral should be reflected)

Home:

School:

Community:

Relevant History:

Triggers:

Home:

School:

Community:

Action Steps: (Steps should range from least intrusive to more intensive. Proactive steps include steps that team members can take to prevent crisis from happening and are often directly linked to responses to triggers. Reactive steps include specific actions that team members can take when crisis actually occurs to Improve safety. Alternatives to emergency services and professional intervention should be included as options to try first. Action steps should include connections to coping skills and strengths that have already been identified.)

Home:

Proactive Steps

Reactive Steps

School:

Proactive Steps

Reactive Steps

Community:

Proactive Steps

Reactive Steps

Persons responsible and phone numbers:

Signature Page (See Child and Family Team Sign-In Sheet for all team members signatures):

Youth:_____Date:_____

Parent/Legal Representative:_____ Date:_____

Wraparound Staff/Position/Credentials:

_____ Date:_____

_____ Date:_____

_____ Date: _____

Section I
Intellectual/ Developmental Disabilities Services

IDD Plan of Services and Supports

IDD Activity Support Plan

IDD Service Note

IDD Assistance with Medication Skills Checkoff Manual

IDD Staffing Worksheets

ID/DD Waiver/IDD CSP Service Authorization

ID/DD Waiver Home and Community Supports Service Agreement

ID/DD Waiver In-Home Respite Service Agreement

ID/DD Waiver In-Home Nursing Respite Service Agreement

ID/DD Waiver In-Home Nursing Respite Service Note

IDD Employment Profile

ID/DD Waiver Job Discovery Profile

ID/DD Request for Behavior Support and/or Crisis Support Services

ID/DD Waiver Medical Verification for Behavior Support/Crisis
    Intervention Services

ID/DD Waiver Functional Behavior Assessment

ID/DD Waiver Behavior Support Plan

ID/DD Waiver Justification for Behavior Support Services

ID/DD Waiver Behavior Support Plan Quarterly Review Report

ID/DD Waiver Request for Additional Behavior Support Services

ID/DD Waiver Request for Additional Crisis Support Services

ID/DD Waiver Request for Crisis Intervention Services

ID/DD Waiver Crisis Intervention Plan

ID/DD Waiver Crisis Intervention Daily Service Note

ID/DD Waiver Crisis Intervention Log – Episodic

ID/DD Waiver Request for Additional Crisis Intervention Services

Plan of Services and Supports

General

The Plan of Services and Supports (PSS) is the person-centered plan for persons with intellectual/development disabilities (IDD) and Autism receiving IDD services. The PSS is to be developed by Support Coordinators, IDD Targeted Case Managers, Transition Coordinators and providers of non-Waiver/non-IDD Community Support Program (CSP) services.

If a person is enrolled in ID/DD Waiver or IDD Community Support Program and receives another non-Waiver or non-CSP funded IDD Service, the Support Coordinator/Targeted Case Manager should include the non-Waiver/non-CSP IDD Service in the non-Waiver or non-CSP Service section of the PSS and assign outcomes to the IDD Service (as appropriate).

If a person is not enrolled in either ID/DD Waiver or IDD Community Support Program and only receives non-Waiver/non-CSP IDD Service(s), the provider is responsible in developing the PSS.   If the person receives both non-Waiver Supervised Living and non-Waiver/non-CSP Employment Related Services (former Work Activity or Supported Employment), the residential provider is in charge of developing the PSS and including the other support services in the PSS meeting. If the person only receives non-Waiver/non-CSP Employment Related Services, the Employment Related Services provider is responsible in developing the PSS.

Copies of PSSs must be available to support staff at all times.

Timelines

Support Coordinators and IDD Targeted Case Managers: The PSS must be revised and submitted to the IDD Community Services Office within 45 days of a person's recertification date.

Non-Waiver/non-CSP Providers: The PSS is to be completed annually or within 45 days of admission to a service. It is to be kept in the person's file for Department of Mental Health (DMH) review.

PLAN OF SERVICES AND SUPPORTS INSTRUCTIONS

Plan of Services and Supports Overview

The Plan of Services and Supports (PSS) document reflects a person's vision of their desired life. It includes a description of the person's strengths, what is important to and for them, and supports necessary to live their best life. The PSS contains the outcomes that lead to the development of a person's supports and services. The outcomes indicate what a person wants their life to look like. The PSS is developed by the person with the involvement of others identified by the person, such as family, friends, and service providers, and is facilitated by the person's ID/DD Waiver Support Coordinator (SC), IDD Community Support Program Targeted Case Manager (TCM), or a Regional Program's Transition Coordinator (TC) or other certified IDD Provider (as applicable). The planning team uses the PSS as a guide to developing needed paid supports and services as well as natural and unpaid supports from the community. It is the fundamental document used to assist the person in achieving their desired outcomes and thus their best life. The PSS meeting and the 4th Quarterly

meeting can be combined.

Plan of Services and Supports Format
The PSS document begins with the Overview section and is divided into six (6) parts:
Overview
I.   Essential Information
II.   Personal Profile
III.   Person Centeredness
IV.   Signatures
V.   Shared Planning
VI.   Activity Support Plans (developed by service providers after PSS is approved)

Overview
The Overview section is completed by the SC/TCM/TC to provide basic information. In the Type box, choose the Type of PSS being submitted: Initial, Recertification, or Change Request. The Effective Date for initials and change requests is the effective date the person is proposed to begin service(s) or when the change in service takes effect. The Effective Date for recertification is the begin date of the recertification period. The Comment section is used to explain any exceptions to the normal timelines or for an unusual circumstance. Any requested changes to the PSS or change requests since the last Recertification must be addressed in the comment section. Please review current PSS for any temporary changes which may be expiring, and address as needed. For CSP, the TCM only PSS should include in the comment section the reason the person is TCM only, for example, Joe is still in school until August or DSA provider of choice has no opening but will notify TCM when available. Another general example, the PSS was submitted out of timeline due to the person's illness.

Part I
Essential Information (EI)
This part is completed prior to the Plan of Services and Supports meeting. For the person's first PSS, the Essential Information should be gathered during a conversation with the person/legal representative/family member either via phone or in person. The SC/TCM will keep the Essential Information current throughout the year. Address each section for which information is available, regardless of whether or not it is a required section to be completed through the LTSS system. For example, the Employment Section is not required for submission of the PSS to IDD Community Services Office. However, it must be completed if the person is eighteen (18) years old or above.

Parts II – IV
Personal Profile, Person-Centeredness, and Signatures
These parts contain information that will be gathered during the PSS meeting. Each member of the person's planning team must contribute information that will best help others learn about the person and how to support them.

Part V
Shared Planning – Outcomes
Ideas for outcomes must be developed during the PSS meeting. Outcomes are to be person centered, reflect the broad goals of the person, and not be centered on a service or needed support. (example: If a person uses a wheelchair and is concerned about mobility, the Outcome will address the person going where they want)

Part VI
Activity Support Plans (ASP)
Activity Support Plans are developed by providers, based on the outcomes developed in Part V-Shared Planning, after they receive the IDD Community Services Office approved PSS and Service Authorization from the SC/TCM.

Information Gathering

The Plan of Services and Supports should paint a picture of the focus person's life. The person is the expert on his/her life and should contribute as much information as possible. Other team members should consist of the supports in the person's life that are closest and know him/her the best. All providers that work closely with the person are required to contribute to the PSS. The PSS should help the team understand the person, what the person wants and needs, and how best to support him/her to live the life he/she desires.

With the focus person's permission, information is also obtained from others with whom the person interacts. These supports may not be able to attend the PSS meeting but can contribute information prior to the meeting via the SC/TCM/TC. This information is gathered over the phone and documented in planning notes along with the date the conversation took place. The SC/TCM/TC is responsible for sharing this information at the planning meeting.

Person Centered Thinking Skills© (PCT) developed by *The Learning Community* will be used during the planning meeting to gather information. The Person Centered Thinking skills provide a structure for gathering information during a conversation rather than simply having a question/answer session. With the SC/TCM/TC acting as the facilitator and the person acting as co-facilitator of the planning meeting, the team must work together to obtain all the information that goes in the PSS.

*******Always remember to ask "why," especially when people give yes/no answers. "Why" provides an important avenue of exploring topics further. ********

Person Centered Thinking Skills© (PCT) are used as a way to gather information during the PSS meeting. The skills can also be useful throughout a person's certification year to gather and organize information. The PCT Skills include:

- The Relationship Map©
- Important To and For©
- Working and Not working©
- 4+1 Questions©
- Communication Chart©
- Good Day/Bad Day©
- Routines and Rituals©
- 2 Minute Drill©
- The Donut©
- Matching Profile©
- Learning Log©

> *Write the person's name and date of the PSS meeting at the top of each Skill or note page. SCs/TCM/TCs must submit their notes/ PCT Skills© forms to IDD Community Services Office as attachments to the PSS. Providers must maintain theirs in the person's record for IDD Community Services Office review.*

The SC/TCM/TC and all providers are responsible for taking notes during the planning meeting. Notes can be written on flip chart paper, the PCT Skills© forms or regular paper depending on what is comfortable for the person and team. SCs/TCMs/TCs are not required to provide copies of their notes/ PCT Skills© forms to providers. Providers must have their own notes/ PCT Skills© forms to be able to develop Activity Support Plans for the outcomes they are responsible for implementing. Notes/ PCT Skills© forms will be used by the IDD Community Service Office to monitor PSSs and Activity Support Plans.

Completing the PSS

The following instructions and examples should be used as a guide to develop the PSS. *The examples do not encompass all items required in each section.* Instructions are organized in the

sequence in which they appear in the PSS document. Once the PSS is approved by IDD Community Services Office, everyone on the team will receive a complete copy of the plan – including the Essential Information.

Part I: Essential Information
This part of the PSS should be completed by the Support Coordinator/Targeted Case Manager/Transition Coordinator prior to the PSS meeting. The information should be obtained through a conversation(s) with the person/legal representative/family either via phone or in person. The Essential Information can also be completed with staff if they are the ones most likely to have any of the current information. Certain items can be completed prior to the planning meeting but must be reviewed with the person's team at the beginning of the meeting. At the beginning of the PSS meeting, the following items must be reviewed:
- Medications
- Back-up and Emergency Plans
- Risk assessment
- Employment
- Behavior Supports *(If a person has a Behavior Support Plan, it must be reviewed and documented in the notes/ PCT Skills forms and be attached to the PSS.)*

- *Contact Information -* Complete the identification information for the person and his/her family members. The person's address must be entered in the Personal Profile section of LTSS.

- In the Family Contact Information, include any family members that will not be listed in the "Natural Supports" section. The Emergency Contact is to be entered in the Personal Profile section of LTSS.

- **ID/DD Waiver/IDD Community Support Program Supports**
  Depending upon the program, this section includes ID/DD Waiver Supports or IDD Community Support Program Supports as well as those not funded by either program. ***This section should not be generic definitions of services or include medical/institutional terminology. It must be specific to the person and contain enough information and justification to support the services a person is approved to receive*** – the **why, when and how**. The information listed below must be included in the PSS.

ID/DD Waiver Supports	IDD Community Support Program Supports
• List the services/supports provided through the ID/DD Waiver along with all the necessary contact information for each agency *(email address is required)* Use the email address of the staff member who is most likely the appropriate staff to receive alerts from LTSS	• List the services/supports provided through the IDD CSP along with all the necessary contact information for each agency *(email address is required)*
• Indicate the frequency of the service/support (hours per day, month or year)	• Indicate the frequency of the service/support (hours per day, month or year)
• Describe in detail*: WHEN* the person uses the service; *HOW* the person utilizes the service; and <u>WHY</u> the person needs the service/support.	• Describe in detail: WHEN the person uses the service; HOW the person utilizes the service; and WHY the person needs the service/support.
	• Include a set schedule if there is one or the times services are usually provided

ID/DD Waiver Supports	IDD Community Support Program Supports
• Include a set schedule if there is one or the times services are usually provided • If the service is Home and Community Supports or In Home Respite, indicate if a family member is providing the service, their relationship to the focus person, and how many hours per month they provide • All direct support professionals (DSPs) must be reflected on the Relationship Map	• All direct support professionals (DSPs) must be reflected on the Relationship Map
Non-Waiver Agency Supports	**Non-IDD CSP Program Supports**
• List the agencies that provide services/supports to the person through avenues other than the ID/DD Waiver along with all the necessary contact information for each agency • Provide a brief summary of how, when and why the support is used • Examples of non-Waiver agency supports are Vocational Rehabilitation, Physical Therapy, Community Support Services, Counseling, etc. All supports listed here must also be reflected on the Relationship Map.	• List the agencies that provide services/supports to the person through avenues other than the IDD CSP along with all the necessary contact information for each agency • Provide a brief summary of how, when and why the support is used • Examples of IDD CSP agency supports are Vocational Rehabilitation, Physical Therapy, Counseling, etc. All supports listed here must be reflected on the Relationship Map.

- **Natural Supports**
    - ✓ List the people who provide unpaid supports to the focus person.

    - ✓ Include family, friends, neighbors, people who support the person in the community and anyone else the person wishes to include. This could include those that provide support through a church, job or a volunteer program.

    - ✓ Include names (first and last) of the natural support rather than "family" or "friends" since this section will pre-populate the Shared Planning section in LTSS.

    - ✓ Indicate the natural support's relationship to the person, their phone number and how and when they provide support to the person. This must include how often the natural support sees or speaks with the person and what they do together. If the phone number is unavailable, enter 000-000-0000.

    - ✓ All natural supports listed here must be reflected on the Relationship Map.

    - ✓ People listed in the center section of the Relationship Map should be reflected in the PSS. If they do not support the person regularly or never but the person wants them on the map, document this information somewhere on the Relationship Map page.

- **Medical Information**

  ✓ List the physician(s) who provide services/supports to the focus person and their specialty area such as general practitioner, dentist, neurologist, ophthalmologist, etc.

  ✓ Provide the physician's contact information.

  ✓ All medical agency services/supports listed here must be reflected on the Relationship Map.

  ➢ **Medications**
  - List all of the current medications the person is taking including over-the-counter medicines.

  - For each medication, indicate the dosage and frequency the person is taking, the physician who prescribed the medication and the reason for taking it. (www.rxlist.com is a good resource for understanding medications and their usage**)**

  - If it is an over-the-counter medication, indicate why they need it or the condition for which it is taken.

  - Indicate if the medicine is used as a psychotropic medication

  ✓ List any chronic health or physical conditions the person has. ***Chronic health or physical conditions are ongoing conditions that the person has lived with and will continue to live with for the foreseeable future.*** (Ex: diabetes, cerebral palsy, hypertension, epilepsy, etc.) Also indicate any diagnoses that are not listed in the evaluation section.

  ✓ The ***history of health problems/issues or addresses any illnesses the person experienced in the past but that are not affecting their health and welfare presently.*** Include any surgeries or procedures the person has undergone that may affect his/her current situation. (Ex: stroke, heart attack, cancer, removal of organs, no seizures experienced in 5 years, etc.) Also indicate any historical diagnoses that are not listed in the evaluation section.

  ✓ Current limitations on physical activities are usually supported by a doctor's note. The SC/TCM/TC is to upload the note into the attachments section of the PSS module under "Other." It may be that a person can only lift a certain amount of weight due to a hurt back or are temporarily restricted from certain activities due to medical issues. (This section does not include Cerebral Palsy, wheelchair, walker or crutches, etc.)

  ✓ ***If the person was ever admitted to a facility (***Ex: ICF/IID, Nursing Facility, Rehabilitation Facility, Behavioral Health Facility, etc.) indicate when, where and why they were admitted and the circumstances surrounding discharge.

  ✓ List the dates of the most recent physical and dental exams.

  ✓ List anything the person may be allergic to and indicate how he/she reacts to the allergen.

- **Medical and Mental Health Support Needs**

  - ✓ If the person has experienced any physical complaints or other medical issues during the past year, provide a summary of the issue(s) and the outcome. This is where the SC/TCM/TC can list anything that may have come about as a result of a physical exam during the past year.

  - ✓ List any special medical items necessary for the person to live comfortably. Indicate the equipment or treatment and *when, why and how* it is used and who is responsible. (Examples: Baclofen pump, G-tube, Peg-tube, oxygen, disposable adult briefs, ventilator, blue pads, Epi-pen, etc.) (Example: Mary is allergic to bees. She keeps an Epi-pen with her at all times.)

  - ✓ If the person is receiving Mental Health support services, provide a description of the services/support, when and why the support is needed and how it benefits the person.

- **Communication and Equipment/Technology**

  - ✓ Indicate the person's method of communication. (Do they use words or gestures to speak?)

  - ✓ Describe supports needed for communication (what communication devices, sign language, etc.)

  - ✓ Describe any adaptive equipment or assistive technology supports the person uses and why. (Examples: wheelchair, lifts, hospital bed, hearing aids, walker, bath chair, adaptive forks or knives)

  - ✓ Indicate how the equipment is maintained and who is responsible.

  - ✓ Describe the back-up plan for power outages if medical equipment is used.

- **Risk Assessment**

  The Support Coordinator /Targeted Case Manager/Transition Coordinator completes the Risk Assessment Tool with the focus person, his/her family or legal representative, and providers before the meeting. It will be reviewed at the meeting and all pertinent information will be included in the PSS. List the date(s) the Risk Assessment Tool was completed, any identified risks and the strategies for avoiding identified risks (Resolution) for each**.** If a person has any modification or restriction of their rights, it must be associated with an identified risk. If the person has no identified risks, write "none" in this section and on the Risk Assessment Tool and upload it to LTSS.

- **Back-Up and Emergency Plans**

  - ✓ Indicate what will happen if the provider does not show up – this includes all services that go to the person's home, not just in-home services.

  - ✓ Indicate the actions to take if the day program, work or other activity is canceled or closed.

✓ Indicate the actions to take when disasters occur – this refers not only to natural disasters but also to emergencies, issues with housing, staff not being available, issues with evacuation, etc.

✓ These plans must include the name and phone number of who the person is to call.

✓ Plan for future living arrangements – where will a person live in the future or where will they go if something happens to their home or people they live with.

- **Family and Current Living Arrangements**

  ✓ Indicate the current living arrangement for the focus person (at home with parents, at home with siblings, in a supervised living setting, in an apartment with/without a roommate, etc.).

  ✓ State with whom the person lives, and the age, occupation and health condition of everyone living in the home. Provide information about the level of support each individual living in the home provides to the person.

  ✓ Include ALL family listed on the Relationship Map and the amount of support they provide to the person (Example: Aunt Mary lives in Chicago and sees Sue twice a year.)

  ✓ If the person resides in a group home, indicate the roommates' first names.

  ✓ If the person resides alone or in a group home, indicate the extent of the support/interaction he/she has with family as well as the information above.

- **Education**

  ✓ Indicate the current school, if applicable. List the name of the last school attended (if known). Indicate if he/she received a certificate of completion or a diploma and the date (an estimate of May 31st and the year of graduation is appropriate).   If a person is under the age of 21 and not in school, indicate in the notes the reason(s) why.

Employment and Volunteer Activities

  ✓ If the person currently has a job, indicate where he/she is employed, when he/she began, the days and hours he/she works, and provide a summary of the work duties. If the person's schedule varies, the SC/TCM/TC can choose the days and times the person generally works. ** Estimate the begin date if necessary. Indicate such in the notes.

  ✓ If the person was previously employed, indicate where he/she worked as well as the end date and the reason he/she is no longer employed at that location. Estimate dates and days, if not known, and indicate such in the notes.

  ✓ If a person is not employed, indicate why in the "Duties" column. Employment MUST be addressed at all meetings for people ages eighteen (18) and older and be documented in the PCT Skills/Notes.

- ✓ If the person volunteers somewhere in the community, indicate where, the begin date, the days and hours he/she volunteers and what duties are performed while volunteering. List as many places as applicable. If exact begin dates are not known or if the schedule varies, estimate in this section and indicate such in the notes.

- ✓ If the person volunteered in the past, provide the necessary information, if available. Estimate dates and days, if not known, and indicate such in the notes.

- ✓ If the person has never volunteered, please indicate such in the notes.

- **Previous and Current Behavior Supports**

  This section includes any and all information regarding ***current or past actions*** that providers would need to know to support the person.

  - ✓ If the person is currently or has previously received services to assist in correcting inappropriate actions, indicate what the actions are/were, when they occur or occurred and what was done or is being done to eliminate or change the actions, if necessary.

  - ✓ ***If the person has a Behavior Support Plan in place, indicate there is a plan being implemented and upload a copy of the plan with the PSS.***

  - ✓ If the person currently does things out of the ordinary but they do not need a Behavior Support Plan, list those actions and specifics, if known.

- **Serious Incidents During the Past Year**

  Write a summary of any serious incidents that occurred during the past certification year. Include information regarding the incident(s) that occurred and how the incident(s) was resolved or the outcome(s) of the incident(s). Indicate if the PSS was changed as a result of the incident.

- **Evaluation Information**

  - ✓ Record the person's current ICAP score and level, the date the assessment was conducted, and who conducted it.

  - ✓ Indicate the date of the most recent Psychological Evaluation and who conducted the evaluation.

  - ✓ List the diagnoses given as a result of the evaluation.

  - ✓ If there are any diagnoses on Axis I or III, ask which, if any, are still relevant and list them in the Chronic Medical Conditions section, History of Health Problems/Issues section, or Medical Needs section, depending on the nature of the diagnosis.

- **Essential Information Completed By**

  The SC/TCM/TC completes this section by indicating the person/legal representative/family that provided the information, his/her name, and the date completed. The SC/TCM/TC can indicate in the Notes who else may have provided information for completion of the Essential Information. This person should be listed in the section "Contributors Not at Meeting" if they are not at the actual meeting.

The Planning Meeting

The Support Coordinator/Targeted Case Manager /Transition Coordinator is responsible for facilitating the planning meeting for persons in ID/DD Waiver or IDD Community Support Program. Good facilitation is crucial to complete the Personal Profile. The Personal Profile must be reflective of the person and the supports needed to make sure he/she lives the best life possible. The more information that is elicited during the planning meeting, the stronger the plan will be to support the person. This will entail asking questions to draw information out of the person/team rather than asking yes/no questions. In some cases, subjects or ideas may need to be challenged or teased out to determine a way to change something or make something new and different happen that is important to or for the focus person. *If optimistic discontent is not created, change will not occur.*

✓ The key to a good person centered plan is asking "why" when gathering information and understanding the "why" when reviewing the PSS.

✓ Remember the plan belongs to the person and is about what they want for their life rather than what the family and providers think is best for them. Plan WITH the person rather than FOR the person.

✓ The plan must always be current and reflect what is happening in the person's life. The person must be aware of the process for requesting changes and updates to their PSS throughout the year and not just at the annual planning meeting in order for the document to always be current. Requests for change should be made to the Support Coordinator/Targeted Case Manager. The person/legal representative must make the request. Providers can inform the Support Coordinator/Targeted Case Manager of issues that may be occurring, but the request for additional services must come from the person/legal representative. The process must be explained during the planning meeting, so all team members are aware of the process.

✓ The Personal Profile is written in the present tense rather than describing what has happened in the past or what may happen in the future.

✓ Using people's first names in a PSS makes the plan more person centered. It is their plan and they know the people supporting them and their relationship to the support person.

✓ The PSS must be written in plain language so that it is easily understood by the person and everyone else on their team. Medical or institutional terminology must be avoided.

✓ Pay attention to behaviors as well as words. People often speak louder with actions than with words. Sometimes people tell us what they think we want to hear rather than how they really feel or what they really think. By reading a person's behaviors, these things can be figured out.

✓ The Person Centered Thinking Skills© provide a guide for gathering information through a regular conversation rather than a question/answer session. People are more likely to contribute information if they feel comfortable and are not being pressured with answering questions. Make sure everyone at the meeting is included in all aspects of the conversation.

✓ All information included in the Personal Profile section must come directly from the notes or Person Centered Thinking Skills forms written during the meeting; however not all information gathered will always go into the Personal Profile. Some information may not be appropriate to include in the person's PSS.

- Examples: negative things about the person stated at the meeting; discussions at the meeting that may have not been positive or were hot topics; information gathered/offered that may not be important to know or do, etc. However, these things should be reflected in your notes so that you know they were discussed and can follow up on them at a more appropriate time.

✓ Information should be recorded as it is expressed during the meeting. When the SC/TCM/TC writes the Personal Profile, he/she organizes the information and determines where it belongs in the PSS. If information is expressed in a negative manner, the SC/TCM/TC should use the "Reframing Reputations" Skill© when writing the information in the PSS. Negatives must be re-worded in the PSS to make them factual, yet not stereotypical or clinical. (Example: "Amy is attention seeking." Could be "Amy wants alone time with staff.")

✓ The SC/TCM/TC is responsible for organizing the information discussed during the planning process and developing the PSS. The PSS should not be a copy of the PCT Skills©/notes taken during the meeting. Information is gathered using the skills, but it does not necessarily belong under that section of the PSS. It may be more appropriate in another section of the PSS.

- Example: Bad Day Skill© – a person says "last minute changes" can cause them to have a bad day. If something has an effect on a person and how they act, that is information that could go under the Important TO or Important FOR section of the PSS. Same with Dislikes – if a person dislikes something, why and what happens? Is this something that is Important To or For them?

✓ Information in the Personal Profile must be in the form of a sentence. (Example: "Spot is important to Mary because he is her constant companion:" not just "Spot.")

✓ For people who do not use words to speak, write what a support person may think the focus person would say or do. (Example: "Suzy says she thinks Mary would say playing with Spot is working for her.")

✓ Once a PSS is developed and implemented, the SC/TCM (not the Transition Coordinator) is responsible for keeping the PSS document current and ensuring all team members have the most recent information.

✓ If/when changes or revisions are made to the PSS during the certification year, all team members must agree and will then receive an updated copy of the PSS from the SC/TCM.

✓ Throughout the planning process, it is recognized that sometimes difficult choices may have to be made. Teams are encouraged to be creative in overcoming obstacles such as limited funding, isolated geographical locations and limited community resources in order to support the person in meeting their desired outcomes.

✓ All information included in the PSS must be written in complete sentences and include "WHY" – For example, someone says attending the day program is important to him/her. WHY is it important to him/her? Is it because they see their friends there?

Part II: Personal Profile

The Personal Profile is the core of the person's plan and contains the most vital information – an image of the person and the supports needed to make sure he/she lives his/her best life possible. ***Good facilitation and participation of all team members is crucial to completing the Personal Profile.***

A.   Introduction: Great Things about _____

The Introduction is written with positive, person-first language to introduce the focus person. It emphasizes the positive qualities identified by the person and others that know him/her best. Written correctly, the Introduction should capture the person's spirit and provide a clear impression of the person's admirable qualities and present his/her "positive reputation." It should be worded as if you were introducing the person to someone new.

> ▪ Example: Mary has a dynamic personality. She has a great sense of humor and loves to make people laugh. Mary is very passionate about things that are important to her such as her dog Spot. She is a loyal friend. Mary loves a challenge and will not give up until she has done what she set out to do.

B.   Hopes and Dreams

This section describes the hopes and dreams of the focus person at this time in their life. The PSS must reflect the true hopes and dreams of the person and not just what the team believes is obtainable. No hope or dream should go unacknowledged or be dismissed just because team members believe it is unattainable. These must be the person's hopes and dreams. Hopes and dreams should not be tied to health or welfare.

  Ask the questions:
> ✓ What would he/she like to accomplish?
> ✓ Where does he/she want to go?
> ✓ What does he/she hope to have one day?
> ✓ What would he/she like to learn to do?
> > ▪ Example: Mary wants to live in an apartment with her best friends, Kimberly and Susan. Mary hopes that one day she will get the chance to go to Washington and meet the president.

C.   Important TO and Important FOR

Recognizing what is important TO and important FOR a person is the fundamental Person Centered Thinking Skill©. When planning with a person, focus on what is important to the person as well as what is important for them (health and safety). The goal is to balance what is important to/for the person so that they can live a good life.

IMPORTANT TO:

These are things in life that are special to the person. This section must include things, when present (or if applicable), that are likely to contribute to a good day, or when absent, are likely to contribute to a bad day. The following areas MUST be addressed:

> > ✓ Relationships
> > ✓ Things to do and have
> > ✓ Community Integration (places to go)
> > ✓ Rhythm and pace of life
> > ✓ Rituals and Routines
> > ✓ Status or control over one's life (choices, decisions, options)
> > ✓ Anything else the person wishes to include

> > Tips:
> > • Do not include items the team thinks are or should be important to the

person. This is just what the person thinks.

- Remember there is a difference between what someone "likes" and what is "important to" the person. "Likes" can be included in the section "Things People Need to Know and Do to Support the Person and Keep Them Healthy and Safe" or "Strengths."

IMPORTANT FOR:
These are things that are necessary in a person's life to ensure their health and welfare. The following areas MUST be addressed but not limited to:

- ✓ Things pertaining to issues of health (prevention, treatment, diet, exercise, physical health, mental health, etc.)
- ✓ Issues of safety
- ✓ Support needs
- ✓ Medical conditions
- ✓ What is necessary to help the person be a valued and contributing member of their community

Examples:

Important to Mary	*Important for Mary*
It's important to spend time with best friends, Kimberly and Susan, to laugh and have fun.	*Spending time with Abby, Sam, and her friends is important for Mary, so she has good relationships and supports*
Spot (puppy) is important to Mary because he is her constant companion.	*It is important for Mary not to be rushed so she doesn't forget things and become upset.*
It's important to Mary to choose where she and Suzy (HCS provider) eat lunch and shop so she has some say in what she does.	*Being with Suzy is important for Mary. With Suzy, she gets to go do things without her parents.*
It's important to Mary to not be rushed; she will forget things and become upset.	*Taking care of Spot is important for Mary. It gives her a sense of responsibility and she takes it very seriously*

D.   Working/Not Working
This section provides a snapshot of what is currently working and not working in a person's life from multiple perspectives. Things that may occur in the future or that need to be prevented are not recorded here. All team members must look through the lenses of the focus person and not just their own. Each service must have its own section and the information working and not working must be relevant to that service/support being provided. Topics addressed MUST include but are not limited to:

- ✓ *Living arrangement (where and with whom)*
- ✓ *Relationships (family, friends, providers, anyone else)*
- ✓ *What the person does for fun*
- ✓ *Where they like to go and what they like to do in the community*
- ✓ *How the person spends his/her days (include school, day program, job, volunteering, retirement activities, etc.)*
- ✓ *The amount of control the person has over life choices (Example: churches, activities, clothes, time they go to bed at night, etc.)*
- ✓ *Any plans developed to support the person in addition to the PSS, when applicable. (Example: a Behavior Support Plan, doctor ordered diet, any plans written for restrictions/limitations.)*

Addressing **ALL** of the items indicated above from each team member's perspective allows the team to think through how to support the person rather than jumping straight to the "fix" for the person.

The "Not Working" section shows different perspectives which leads to questions as to why something is occurring. In these cases, the information may show up here and in the "Questions/Things to Figure Out" section.

Examples: The examples listed below do not encompass all items required to be addressed.

- **Perspectives:**
  - ✓ Person's perspective – list things the person says are working and not working in his or her life as related to ALL areas listed above. If the person cannot use words to speak, the team may all contribute. Indicate who says what they think Mary would say is working/not working from her perspective.

Mary's perspective	
Working	*Not Working*
Mary thinks taking care of Spot is working. She likes playing with him and feeding him.	*Not being able to decide what she wants to eat for lunch at the day program is not working for Mary. She doesn't like some of the food they serve.*
Spending time doing fun things with Suzy like getting nails done, going to eat Mexican food, and walking at the park is working for Mary.	*Having to sit next to Steve at the day program is not working. He gets on her nerves with his loud mouth.*
Mary is happy learning to play games on the computer. She thinks this is working well.	*Suzy not being around enough isn't working for Mary. She misses Suzy when she is gone and thinks they don't get to spend enough time together.*

  - ✓ Family's perspective - list things family members see as working and not working for the person regarding the topics listed above. Family members must look through the lenses of the person as well as their own. Ideas/subjects should not be listed in a negative fashion, nor should they violate the person's rights.

Abby (mom) and Sam's (dad) perspective	
Working	*Not Working*
Suzy spending time with Mary and taking her places she wants to go is working.	*Not having enough HCS hours to do more things with Suzy on the weekends is not working.*
It is working that Mary gets to do new activities and experience new things at the day program.	*The weight Mary has gained from eating too many sweets is not working. It is not good for her health and wellbeing.*
Mary being able to do things for herself like getting ready to go to the day program is working out well.	*Mary not having a job in the community so she can be around more people and make money isn't working.*

  - ✓ Provider's perspective - list things the provider(s) see as working and not working for the person regarding the support(s) they are providing. Providers

must look through the lenses of the person as well as their own. Each service/support should have a separate working/not working perspective. Ideas/subjects should not be listed in a negative fashion, nor should they violate the rights of the person. The provider should say "why" something is not working.

XYZ Agency; HCS; Suzy's perspective	
Working	*Not Working*
It is working that Mary takes good care of Spot. She loves him so much.	Not enough HCS hours to do more things with Mary isn't working.
Mary and I having fun together laughing and singing in the car is working well for her and me.	It's not working that Mary doesn't have more opportunities to make new friends.
The schedule Abby and I have worked out for me to support Mary works well for everyone.	Mary always asking to go get ice cream isn't working. Her mother says she has gained a lot of weight. I don't like telling her no though.

XYZ Agency; DSA; Dan's perspective	
Working	*Not Working*
Mary learning to use the computer to play games is working well. She is very good on the computer.	Mary wanting to do everything in the kitchen and not allowing others to have a chance isn't really working.
It is working that Mary keeps the day program calendar up to date. She always knows what is going on.	It's not working that Mary doesn't want to get off the van when returning from community activities.
Mary eating lunch with her best friends Kimberly and Susan works well for her.	Sitting next to Steve during certain activities doesn't seem to be working for Mary. He gets on her nerves.

E. Things People Need to Know (and do) to Support the Person and Keep Them Healthy and Safe

This section includes information/instructions others need to know and do to support the person. The Things People Need to Know section is a summary of the PSS. The information should not focus on services but rather on a description of the person and supports necessary for them to have a good life. It should be detailed and specific and be written so it is easy to understand and clearly explains how to provide supports. Any information can be recorded in this section including but must include the following: inappropriate actions, means of communication, routines, likes, dislikes, coping strategies, relationships, fears or concerns and what to do about them, movement and mobility, seizures, medications, feeding rituals or instructions, identified risks and any modifications/limitations to the person's rights, treatments and interventions, special considerations, etc. Think about it from a provider's perspective and what they would need to know and do to support someone they just met. ***A provider should be able to know what to do for or with someone and when, how and WHY***. This may be the only part of the PSS a DSP reads.

Examples:
- ✓ Actions that are not appropriate or may cause problems:
  - ▪ Example: John will hit staff or other people in the program when he doesn't get his way.

✓ Special considerations that relate directly to the person
  ▪ Example: Remind Ryan not to get in other people's faces when talking to them.
✓ Person's fears or concerns
  ▪ Example: Sam is afraid of the dark. Always make sure the nightlight is on before turning out his light at bedtime.
✓ Movement and mobility - include any approaches, supplies or devices that are used to accomplish movement and mobility; movement patterns and/or habits
  ▪ Example: Lizzie uses a power wheelchair to get around. The chair needs to be charged every night. When she goes to the mall, Walmart or out to eat, Lizzie takes her manual wheelchair and needs to be pushed.
✓ Routines - include routines for the morning, bathing, evening, etc.
  ▪ Example: Dottie has a bed bath every other morning and a shower the other days. Dottie does not like having her face wet, so staff use a special shower chair that reclines to keep the water out of her face.

F. Strengths

This section focuses on what the person can do for him/herself or can do with assistance. Indicate the person's abilities to perform specific activities. This should be a description of the person rather than a list of their positive qualities. The description reflects the person's abilities and likes. Use complete sentences.

  ▪ Example: Mary has the ability to control her emotions. She likes to make her own decisions. Mary manages her money with the assistance of Sam. She will let you know when she doesn't like something or isn't excited about doing something. Mary uses the microwave to cook popcorn when she watches movies. She gets herself ready for the day program in the morning and does her nighttime routine on her own. She loves to ride her bike around the neighborhood.

G. Referrals

Describe any referrals necessary for the person. Indicate who will make the referral and by when. (Examples: VR, MH, therapy, etc.)

H. Questions/Things to figure out

This section is a place to record things the team does not know about the person and/or questions left unanswered at the end of the planning meeting. More times than not, the team will not know all the necessary information or the answers to all questions.

✓ *Where are we missing information?*
✓ *What do we need to know more about?*
✓ *What do we need to figure out to make something happen or how to better support the person?*
✓ *Always include who will be responsible for following through with getting more information regarding the issue or what they will do. Also include the timeline. If a staff person is responsible, then this information will also go in the person's Activity Support Plan for that specific service.*
  ▪ Example: Mary wants to swim more often. Where is a place that has a pool that can accommodate a person who uses a wheelchair? – Shelly from DSA will look into this

Part III - Person-Centeredness

All services and supports provided must be person centered. People with disabilities have rights that cannot be violated and must be protected. Each person must be given choices regarding the services

and supports they need to live a good life. Each of the following must be addressed in the PSS and there must be a statement associated with each answer:

✓ Information on what services are available must be presented to the person/legal representative/family in an understandable manner in order for them to make an informed decision on which service(s) they wish to utilize. Explain each applicable service and how it is used.

✓ Information on all certified providers must be presented to the person/legal representative/family in an understandable manner in order for them to make an informed decision on which provider(s) to utilize.

✓ Information regarding different living environments/arrangements must be presented to the person/legal representative/family in an understandable manner in order to choose the best living environment/arrangement for the person. Some people living at home with families may not know there are other options. People already living in the community need to know there are other places to live if they are not happy where they are.

✓ If the person chooses to live in a group setting, there must be documentation that they were given a choice of roommates.

✓ Unless the person is a minor (under the age of 18) or has a legal guardian/representative (with legal documentation), they should be given control over their personal resources.
   ▪ Example: access to money, access to health and wellness, emotional support, spirituality, social supports, etc. If a person's family assists them with making choices or budgeting their money, please indicate this information.

✓ Documentation must be maintained indicating the *person is given a choice of activities in their day program and home settings.* Examples must be provided of what the person chooses to do.
   ▪ Example: arts and crafts, where to go eat, where to go look for a job; where to shop, etc.

✓ According to the HCBS Final Rule, any limitations or restrictions must be addressed in the person-centered plan (for IDD - the Plan of Services and Supports). Limitations and/or restrictions limit a person's movement, daily activities, choices, access, or functions. Placing limitations and/or restrictions on a person often results in the person losing an object or not getting to do something they enjoy. Positive reinforcement is not present when restrictions are in place. If a person has a limit or restriction, there must be a plan in place supporting the necessity of the restriction/limitation and how it is to be used. The plan must include the specific circumstances it will be used in, the fading techniques of the plan and the consent of the person/legal representative to implement the plan. If there is a doctor's note supporting a special diet or other health items, a copy of the medical or a doctor's note must be attached to the PSS. If the person has a Behavior Support Plan, it must be attached to the PSS. Limitations and/or restrictions will also be addressed by the service provider(s) on the Activity Support Plan.
   ▪ Examples of limitations/restrictions: visitors not allowed; having items taken away for certain reasons; food choices not allowed; being limited to a special diet; being told when to eat or sleep.

Part IV – Signatures
Everyone at the PSS planning meeting must sign the Signature Page to indicate they participated in developing the PSS. If the person served or any other person present at the Planning Meeting was unable or unwilling to sign the Signature Page, it must be documented on the Signature Page the

person was present and why he/she did not sign. *Each team member's signature indicates a promise being made to the focus person to work on making their life better by supporting their outcomes.* The signature page also serves to hold those team members accountable for implementing their part of the PSS. If someone did not attend the planning meeting but still contributed information via the SC/TCM/TC, their name and relationship to the person must be indicated in the appropriate section along with the date the information was provided to the SC/TCM/TC. The SC/TCM/TC signs the document last indicating they are responsible for monitoring the implementation of the PSS. The signature page must be uploaded into the LTSS system along with the Skills/Notes from the planning meeting in the attachments section of the PSS module.

Part V - Shared Planning

The Shared Planning section of the Plan of Services and Supports indicates specific outcomes a person wishes to achieve in order to lead the life they desire. *Outcomes are developed by the person and his/her team based on <u>what is important TO them</u> according to the information collected and written in the Personal Profile section of the PSS.* The person may want to change an aspect of his/her life, learn to do something new, or continue doing something that is currently working in their life.

✓ Outcomes are not directed by the services/supports a person receives but rather by the life they wish to live. Outcomes direct the services and supports to be provided. Outcomes are not services a person receives or specific details written on how to support them. They are general statements about living life.

- *Outcomes must be measurable:*
  ✓*Can you see it?*
  ✓*Can you count it?*

- The Support Coordinator/Targeted Case Manager/Transition Coordinator may choose to use the "Person Centered PSS Outcome Worksheet" to record ideas or recommendations for outcomes as agreed upon at the meeting. The form is optional.

- *All outcomes must be written using the following formula:*
  Name + action verb + what/where + so that/in order to = expected results

✓ The "Desired Outcomes" is where each outcome idea developed during the meeting is recorded. *The SC/TCM/TC writes the outcomes after the meeting based on the ideas discussed during the meeting.*

✓ The "Provider Services" column indicates who is responsible for completing activities related to each outcome. This may include more than one provider and/or service. *Natural supports can also be responsible for supporting outcomes.* If a natural support is going to support an outcome their name will be pre-populated from the Natural Supports section of the PSS in the LTSS system.

✓ The "How Often" column indicates how often activities will be completed while working towards the outcome. The timeframe must indicate if the activity will be completed daily, weekly or monthly. If activities are to be completed weekly or monthly, the number of times of participation/support must be included. The start and end dates will be pre-populated by the LTSS system to reflect the dates of the person's current certification year.

Examples:

Outcome	Desired Outcomes	Provider Services	How Often	Start Date	End Date
1	Mary participates in arts and crafts in order to make things to give to her family and friends.	XYZ Agency/HCS, DSA	3 x per week	10/1/15	9/30/16
2	Mary attends church so that she can worship God and see her friends in Sunday School.	XYZ Agency, HCS XYZ Agency, DSA Abby and Sam	2 x per week	10/1/15	9/30/16
3	Mary feeds and walks Spot in order to ensure he is healthy and well cared for.	XYZ Agency, HCS Abby and Sam	Daily	10/1/15	9/30/16
4	Mary eats out, shops, gets her nails done and does other things in order to enjoy herself and be a part of her community.	XYZ Agency, HCS XYZ Agency, DSA Abby	4 x per week	10/1/15	9/30/16

The Plan of Services and Supports should always be a complete, current snapshot of a person's life. Everyone's life changes all the time. The people who receive supports are no different. Health changes, friends come and go, jobs change, life changing events happen. The plan should always be updated to reflect those changes in order to know the person and what is currently happening in his/her life.

Planning with a person using Person Centered Thinking Skills© and practices allows you to dig deeper, ask more questions, and find out more about a person than ever before. <u>Always ask "WHY"??</u> Plans and outcomes are truly individualized. People we support will begin communicating with us and letting us help him/her live the life they want. Only when people see change do they believe it.

Revisions to the Plan of Services and Supports

The PSS is a fluid document that is meant to be revised throughout the year as a person's situation changes. Revisions can be made to any section of the PSS. Providers can also ask for changes to a PSS regarding the Shared Planning Section. An outcome may be accomplished, or a new outcome may need to be added. Additionally, they may have information regarding an item in the Essential Information Section that may need to be updated. The person/legal representative must agree to all changes either in writing, or via a witness hearing the request. The person/legal representative and all current service providers must get a copy of the revised PSS.

Due to changing needs, there could be instances when all members of the team must come together during the person's certification year to review/revise the PSS. For example, a person could have a change in medical condition and new services must be requested, the Personal Profile must be updated, and the Shared Planning must be revised. Other examples could include someone moving from their family home to Supervised Living. A new PSS meeting would need to be held to involve the new provider and new outcomes may need to be developed. The revised PSS and signature page would be sent to everyone who attended the meeting.

Recertification Plans of Services and Supports

For recertification Plans of Services and Supports, the SC/TCM may take a copy of the current PSS to the PSS meeting. It can be used as the basis of the conversation. The Skills to be used at each meeting will vary from person to person. The SC/TCM must use their judgement to determine which Skills may be necessary to gather additional information. The Relationship Map is the only required Skill to be used for recertifications. If other skills are not utilized, each section of the PSS must be initialed and dated by the SC/TCM. All Skills including the Relationship Map, notes taken at the PSS

meeting, and/or copy of previous PSS with notes and sections initialed and dated must be uploaded in attachments to the recertification PSS.

All elements of the Essential Information should be kept current throughout the year. Before the PSS meeting, the Support Coordinator/TCM can review the elements with the person/legal representative/service providers to ensure they are up-to-date. However, the following elements of the Essential Information must be reviewed at the PSS meeting to ensure they are, indeed, current:

       Medical Information
       Medications
       Back-up and Emergency Plans
       The Risk Assessment
       Employment
       Behavior Supports (if applicable)
       Any restrictions

All sections of the Part II: The Personal Profile should be reviewed to ensure all sections are accurate and current. All questions in the Person Centeredness Section must be addressed. The Shared Planning Section is to be updated/changed according to information gathered during the PSS meeting. Everyone who attends the recertification PSS meeting must get a copy of the revised PSS.

Providers should bring copies of their Activity Support Plans to the meeting to review, also. The provider has 30 days from receipt of the PSS to complete revisions the Activity Support Plan. It must be submitted to the SC/TCM by the 15th of the month following the month it is developed.

The Plan of Services and Supports Instructions include person centered concepts, principles and materials used with permission from The Learning Community for Person Centered Practices. Find out more at www.learningcommunity.us. Support Development Associates, Inc. also contributed to development of the PCT Skills©.

Plan of Services and Supports   Status: Program Type: ID/DD

Overview

Active: Created Date:
PSS Type: Initial/Recertification/Change   Effective Date:
Service Type   End Date:

Comments:

Part I - Essential Information

Contact Information

Legal First Name: Medicaid #
Legal Last Name: Initial Certification Date:
Legal Middle Name: Home Phone:
Preferred Name: Cell Phone:
Date of Birth: Email:
Address: Support Coordinator/TCM

Family Contact

First Name: Phone:
Last Name: Fax:
Middle Name: Email:
Contact Type: Address:

First Name: Phone:
Last Name: Fax:
Middle Name: Email:
Contact Type: Address:

First Name: Phone:
Last Name: Fax:
Middle Name: Email:
Contact Type: Address:

ID/DD Waiver Supports

Service Information

Service Type: PSS Service:
Frequency Type: Units per month:
Hours per Month: Rate:
Minutes: Costs:
How/When Support is Used:

Provider Information
Provider Name: Provider Number:

Contact Name: Phone:

Address: Email address

Service Information

Service Type: PSS Service:
Frequency Type: Units per month:
Hours per Month: Rate:
Minutes: Costs:
How/When Support is Used:

Provider Information
Provider Name: Provider Number:

Contact Name: Phone:

Address: Email address

PSS Costs

Annual Waiver Plan Services Total:
Annual 1915(i) Services Total:
Total PSS Budget:

Non – Waiver Agency Supports

Agency	Contact Name	Phone Number:	Non-Waiver Agency Support	How/When Support Provided

Natural Supports

Are there natural supports? Yes/No

Support Person	Relationship	Support Role	Phone Number

Medical Information

Physician	Specialty	Address	Phone

Medications

Medications required?

Medication:	Physician:	Dosage	Frequency	Reason(s) Prescribed	Psychotropic Y/N

Recent Physical and Health Conditions

Recent Physical Complaints and/or Health Conditions

Chronic health conditions?	Yes	No	Description:
History of health problems/issues?	Yes	No	Description:
Current limitations or restrictions on physical activities?	Yes	No	Description:
Any serious illnesses and/or hospitalizations in the past year including ER visits?	Yes	No	Description:
Admissions to ICF/IID, Mental Health Facilities, Rehabilitation Facilities or other inpatient care?	Yes	No	Description: *(when, where, why)*

Latest Exam Dates

Date of my last physical exam:	Date of my last dental exam:
Estimated/approximate date?	Estimated/Approximate date?
Examination Results	Examination Results

Allergies:

Reactions:

Medical Support Needs and Mental Health Support Needs

Medical Support Needs   Mental Health Support Needs

.

Communication, Adaptive Equipment, Assistive Technology and/or Modifications

Method(s) of communication:

Describe supports needed for communication (if any):

Describe any adaptive equipment or assistive
technology supports used:
How is equipment maintained? Who is responsible?

What is the back-up plan for power outages if medical
equipment is used?
Describe any environmental modifications necessary:

Risk Assessment
Date Created: Risk: Resolution

Back-up and Emergency Plans
Steps to take if the provider does not show up:

Steps to take if the day program/work or other activity
is canceled, closes or you have to
leave for some other reason:

Steps to take when a natural disaster occurs:

Plan for future living arrangements if something were
to happen to the primary caregiver:

Family and Current Living Arrangements

Education

Current School   Year

Last School
Attended: Year

Type of
Diploma/Certificate: Year:

Employment History

Was {name} ever
employed?   Yes   No

Reason why
{name} isn't
working:

Volunteer Activities

Did {name} ever
volunteer?   Yes   No

Behavior Supports

Previous and Current Behavior Supports:

Serious Incidents During the Past Year

Evaluation Information

Current ICAP Date:	Current ICAP Score
Who Completed the ICAP	Current ICAP Service Level
Previous ICAP Date	Previous ICAP Score
Who Completed the ICAP?	Previous ICAP Service Level
Psychological Date:	
Examiner Name:	Examiner Agency:
Primary DSM Code	
Secondary DSM Code(s)	

Essential Information completed by:

Person:	Legal Guardian:
Support Coordinator/Credentials:	Additional Contributors:
Date Reviewed:	

Part II – Personal Profile

Great Things About {name}

Hopes and Dreams

Important To/For

Important TO	Important FOR

Working/Not Working
Perspectives

Things that work	Things That Do Not work
_____'s Perspective:	_____'s Perspective:
Family's Perspective	Family's Perspective
Family's Perspective	Family's Perspective
Provider's Perspective	Provider's Perspective
Provider's Perspective	Provider's Perspective

Need to Know & Strengths

Things People Need to Know to Support {name} and Keep Him/Her Healthy and Safe

{Name} 's Strengths

Questions/Things to Figure Out

Question   **Person Responsible**

Are any referrals needed?

Yes   No   Explain:

Part III – Person Centeredness

Choice, Control, Restrictions/Limitations

Were you given a choice of service(s)?	Yes	No	Please describe:
Were you given a choice of provider(s)?	Yes	No	Please describe:
Were you given a choice of living setting(s)?	Yes	No	Please describe:
Were you given a choice of roommate(s)?	Yes	No	Please describe:
Do you have control of your personal resources?	Yes	No	Please describe:
Are you given a choice of activities in your living setting? *(including where you want to go in the community)*	Yes	No	Please describe:
Are you given a choice of activities in your day program setting? *(including where you want to go in the community)*	Yes	No	Please describe:
Do you have any restrictions or limitations set by staff? *(including visitors and food)*	Yes	No	Please describe:

Contributors Not at Meeting

Support Person	Relationship	Date contributed

Signatures

Type	Name	Services	Signature Name	Signature Date

Part IV - Shared Planning

Desired Outcome	Supports	How Often	Start Date	End Date

IDD Activity Support Plan

Purpose
The purpose of the Activity Support Plan (ASP) is to document activities and strategies/support instructions to be completed in order for a person to work towards reaching their desired outcomes as documented in the Plan of Services and Supports. Staff should be able to read a person's ASP and know exactly how to provide services and supports to that person.

General
An ASP is required for each service a person receives with the exception of Behavior Support, Crisis Support, Crisis Intervention and Job Discovery. Providers are responsible for developing the ASP with the person and legal/representative after the development of the Plan of Services and Supports (PSS). The ASP is tailored to the outcomes developed during a person's PSS meeting. Each service will have a separate ASP regardless of whether or not the same provider is providing more than one service.

The Support Coordinator/IDD Targeted Case Manager must ensure all ASPs are consistent and include activities that were identified to meet the outcomes developed during the PSS meeting. If the Support Coordinator/IDD Targeted Case Manager finds the ASP does not reflect what was discussed at the PSS meeting, he/she can return it to the provider for revision.

Copies of ASPs must be available to support staff at all times.

Outcome Statement
Providers write the outcome statements from the Shared Planning section of the PSS that pertain to the service/support they provide. The outcome statement must be written word for word as stated on the person's PSS. Outcomes may be on more than one ASP if both services can provide support in reaching the outcome.

Person's Support Activities
Support Activities are written in short phrases or sentence to describe the various activities the support staff will use to assist the person in meeting his/her stated outcomes. Providers should consider the type of support appropriate for the service and ensure the support provided is included under at least one of the outcomes. Support activities are person-centered and vary according to the person's support needs. Support Activities include some sort of action word, related to the desired outcome being addressed and support being provided. Activities are things that can be seen and/or counted. There will likely be multiple support activities for each outcome.

Strategies/Support Instructions
The Strategies/Support Instructions describe how supports will be provided based on the person's choices and preferences. The strategies/support instructions will provide detailed directions for staff to follow when completing support activities with the person. The strategies/support instructions may include what the person likes to do, the type of support needed, specific directions for staff to follow, teaching steps, what is needed for success. The information must be very detailed and specific to each person and each outcome. Risks from the PSS and any

modification/limitation to the person's rights based on an identified risk must be addressed in the Support Instructions. If/when the limitations/restrictions are identified or are no longer needed, the provider must discuss with Support Coordinator/Targeted Case Manager to determine if changes are needed in the PSS. Risks and need for limitations/restrictions must be discussed at least annually.

Frequency – How Often Service Supports the Outcome
The frequency each service supports the outcome must be discussed at the PSS meeting with outcome development. If the PSS assigns multiple services and/or non-Waiver/non-CSP Supports and/or natural supports to a single outcome, the How Often section on the PSS indicates the total number of times the outcome will be supported by those assigned. The Activity Support Plan How Often/When section must indicate the number of times that particular service will support the outcome.

Timelines
For ID/DD Waiver and IDD CSP providers, Activity Support Plans must be developed with the person/legal guardian (if applicable) within thirty (30) days of receipt of the person's PSS. The ASP is to be submitted to the appropriate Support Coordinator/Targeted Case Manager by the 15th of the month following development. It must be reviewed and/or revised at least annually, as changes are needed or whenever the person wishes to revise it.

Other IDD services – The Activity Support Plan is to be developed with the person/legal guardian (if applicable) within 30 days of the date of the PSS and be in the person's record no later than the 10th of the month following development. It must be reviewed and/or revised at least annually, as changes are needed or whenever the person wishes to revise it.

The Support Coordinator/IDD Targeted Case Manager must ensure all ASPs are consistent and include activities that were identified to meet the outcomes developed during the PSS meeting. If the Support Coordinator does not feel the ASP reflects what was discussed in the PSS meeting, he/she can send it back and request clarification.

The ASP must be reviewed and/or revised at least annually, as changes are needed or whenever the person wishes to revise it.

Questions/Things to Figure Out
List questions/ideas/things discussed in the PSS meeting and assigned to the person/provider that need to be addressed but cannot be decided upon at the meeting or that require research or additional information to figure out. There must be a person responsible assigned to address each item. There must also be timelines for accomplishing the activity.

Signatures
The ASP is developed with the person/legal representative and signed at the time of development/review. Staff developing the plan with the person/legal representative sign (including credentials) and date the plan.

IDD Activity Support Plan

Name: _____ Medicaid #: _____ Agency: _____ Service: _____

(Use as much space as necessary)

Outcome Statement	List the support activities for each desired outcome	Support Instructions Describe how supports need to be tailored to the person's preferences and profile	How often or by when?

IDD Activity Support Plan

Name: _____ Medicaid #: _____ Agency: _____ Service: _____

Questions/Things to Figure Out (use as many lines as necessary)				
1.	**Person Responsible:**		**By when:**	
2.	**Person Responsible:**		**By when:**	

Signatures
Person: **Date:**
Legal Representative: **Date:**
Provider 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 Support Plan. Staff activities toward the provision of services must also be documented. 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 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 day services are provided)*
- Crisis Support *(Daily Service Note or ICF Note or Daily Log)*
- Day Services Adult *(Each day services are provided)*
- Host Homes *(Daily)*
- Home and Community Supports *(Each time services are provided.)*
- In Home Respite *(Each time services are provided)*
- Job Discovery *(Each time services are provided)*
- Prevocational Services *(Each day services are provided)*
- Shared Supported Living *(Daily – There must be a Service Note for each shift)*
- Supervised Living *(Daily - There must be a Service Note for each shift.)*
- Behavior Supervised Living *(Service Note every two hours while the person is awake and in the home. Overnight entries can be every four hours.)*
- Medical Supervised Living *(Service note for each shift. Nursing notes are recorded separately at each time of nursing intervention/treatment)*
- Supported Employment *(Each time services are provided.)*
- Supported Living *(Each time services are provided.)*

Exception for the following services:
- In Home Nursing Respite (Refer to In-Home Nursing Respite Service Note)
- Crisis Intervention (Refer to Crisis Intervention Daily Service Note)

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
- 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 Support*

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
- 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 Support 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.

Service notes must be signed by the person writing the note with credentials and date.

The Center for Medicare and Medicaid Services (CMS) requires verification of service provision for Home and Community Supports or In Home Respite Services. Therefore, service notes for Home and Community Supports or In Home Respite must also include the person/responsible party's signature. "Responsible party" for purpose of verifying service provision is someone who is available in the home to verify service provision if the person is unable to do so.

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: _____

Provider must record the person's activities and the support activities provided by staff. Describe choices offered. Address outcomes supported (Who, What, When, Where, How, Why)
Community Integration Location(s)

Staff Signature/Credentials _____ Date _____

(Applies to In Home Respite or Home and Community Support Services <u>only</u>.)

Person/Responsible Party Signature _____ Date _____

IDD Assistance with Medications
Skills Check-Off Manual

Purpose
Providers have the option to allow non-licensed personnel to assist a person with medication usage after the non-licensed personnel completes certain training requirements described below. The Assistance with Medications Skills Check-Off Manual is completed by a nurse after the non-licensed personnel demonstrates skills learned through the eLearn Course.

General
Providers must clearly address Rule 13.8.C. in their agency's policies and procedures and state if they allow or do not allow non-licensed personnel to assist a person with medication usage. The Assistance with Medication Usage course is designed to provide training to non-licensed personnel who will be helping people they support take their medications safely. Non-licensed personnel are only allowed to assist a person with medication usage after he/she completes a two-step training process prior to assisting the person with medication and annually thereafter. Part one is an online eLearn course, *Assistance with Medication Usage,* that teaches how to safely and responsibly help people in using their medications. Each non-licensed staff must complete the online eLearn course offered through IntellectAbility's Learning Management System (LMS) which results in a certificate of completion. The second part of the course consists of a practical examination conducted by the agency's nurse to ensure staff can safely assist with medication usage. Each non-licensed staff must successfully demonstrate skills learned through the training as the nurse completes the Skills Check-Off Manual. Agency nurse(s) who observe skill demonstration and complete the Skills Check-Off Manual must also complete the *Assistance with Medication Usage* eLearn Course prior to beginning to assess non-licensed personnel and annually thereafter.

Each provider must have assigned staff as LMS Administrator(s). The LMS Administrator(s) will set up user accounts for staff needing access to the *Assistance with Medication Usage* eLearn course. Contact IntellectAbility at LearnHelp@ReplacingRisk.com to request training and access for LMS Administrator(s) and for technical support with the *Assistance with Medication Usage* eLearn course.

* Note throughout the Skills Check-Off Manual, it refers to the Medication Usage Record (MUR). The MUR is the DMH Self-Administration Medication Observation Log (located in Section D of the DMH Record Guide).

Timelines
All non-licensed personnel assisting people with medication usage must complete the Assistance with Medication Usage Course (both steps – eLearn course and skills demonstration) prior to assisting a person with medication usage and at least annually thereafter. A copy of the certificate of completion from the eLearn course *Assistance with Medication Usage* must be kept in personnel record for both non-licensed staff and agency nurse(s) conducting the skills assessment and training documented in his/her training records. A copy of the completed nurse review from the Skills Check Off Manual must also be kept in the non-licensed staff's personnel file and the training documented in training records.

Mississippi Assistance with Medication Usage by Non-licensed Personnel

Skills Check off Manual

Mississippi Assistance with Medication Usage by Non-licensed Personnel

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Skills Check off Manual

This manual was developed to help the non-licensed person safely and appropriately assist a person to take their medication. It is part 2 of the Mississippi Assistance with Medication Usage Training Program. The first part is a three lesson eLearn program that must be successfully completed before proceeding with Part 2.

Safety is most important. There are standard procedures in this lesson that anyone assisting with medications should follow.

After learning about assisting with medications online in the lessons delivered there you will demonstrate your knowledge of Assistance with Medication Usage by performing the actions in this manual while being observed by a nurse. It is crucial that you can competently perform these basics before moving on to the task of actually assisting people with their medication. You must have a strong foundation to build on.

First, study the procedures for assisting with medications. You must be competent in understanding how each medication route is to be delivered. You will need to know these by heart, because you won't have a "cheat sheet" while helping a person to take their medication. After you feel comfortable that you can assist a person with all of these different types of medication routes, a nurse will watch you to be sure that you do every step in order. Some medication you will not administer very often, such as vaginal creams. If a person is required to take any of these infrequently used medications in the future, you would definitely need to review the procedure before helping a person.

The nurse will sign a check off sheet indicating that you are competent to assist with medications. The nurse will re-evaluate you again every year or more often to make sure you are still assisting with medications safely. If your nurse suspects you are not following the original protocol and cutting corners, he or she may watch you at more frequent intervals. Anytime the nurse does not find you qualified to assist safely with medications or follow procedures properly, he or she may tell you that you can no longer assist with medications. You will be required to repeat training as the nurse deems appropriate. It is the nurse's responsibility to keep the person safe and to make sure you are following all procedures and safety measures.

* Note throughout the Skills Checkoff Manual, it refers to the Medication Usage Record (MUR). The MUR is the DMH Self-Administration Medication Observation Log (Section D in the DMH Record Guide).

Check Off – Handwashing

Person being reviewed: _____   **Date:** _____

Correctly Performed	Incorrectly Performed	Task
☐	☐	Turn on the faucet and adjust the water temperature to warm or cool.
☐	☐	Wet your hands thoroughly.
☐	☐	Apply liquid soap.
☐	☐	Lather soap by rubbing your hands together.
☐	☐	Rub lather on to your palms, the back of your hands, between your fingers and under your nails. Continue to scrub for a minimum of 20 seconds.
☐	☐	Rinse your hands well under running water, removing all soap.
☐	☐	Use a clean paper towel to turn off the water. Then throw away the paper towel.
☐	☐	Use a clean paper towel to dry your hands.
☐	☐	Moisturize your hands often to prevent excessive dryness and cracking which could allow bacteria to enter your body.

Comments from observing nurse

☐ **Person is competent to assist with this task**   ☐ **Person is not competent to assist with this task**

_____   _____
Signature of observing nurse   **Date**

Check Off – Hand Sanitizing

Person being reviewed: _____ **Date:** _____

Correctly Performed	Incorrectly Performed	Task
		Task
☐	☐	Apply enough hand sanitizer to your hands to keep them wet for at least 20 seconds or per manufacturer recommendations.
☐	☐	Rub your hands together.
☐	☐	Rub on to your palms, the back of the hands, between the fingers and under the nails.
☐	☐	Rub your hands together until all sanitizer is gone and your hands are dry, or 20 seconds.
☐	☐	If your hands become visibly soiled or sticky, they must be washed with soap and water.
☐	☐	Moisturize your hands frequently to prevent excessive dryness and cracking which could allow bacteria to enter the body.

Comments from observing nurse

☐ Person is competent to assist with this task   ☐ Person is **not** competent to assist with this task

_____   _____

Signature of observing nurse   Date

Check Off – Pharmacy Labels

Person being reviewed: _____ Date: _____

Correctly Performed	Incorrectly Performed	Task
		Task
☐	☐	Identifies the name of the person.
☐	☐	Identifies the name of the medication.
☐	☐	Identifies the medication dosage.
☐	☐	Identifies the medication directions.
☐	☐	Identifies any special instructions on the label.

Comments from observing nurse

☐ **Person is competent to assist with this task**   ☐ **Person is not competent to assist with this task**

_____   _____
Signature of observing nurse   Date

Check Off – Oral Pills and Capsules

Person being reviewed: _____ Date: _____

Correctly Performed	Incorrectly Performed	Task
☐	☐	Choose a quiet, private area to assist with medication.
☐	☐	Gather the necessary materials to assist with medication. ☐ Medication cups or other receptacles to drop the medication into ☐ A glass of water
☐	☐	Help the person to the medication area.
☐	☐	Assist the person to wash their hands or use hand sanitizer if it is safe to do so.
☐	☐	Choose the person's medication usage record (MUR).
☐	☐	Choose the person's medication from the locked storage area.
☐	☐	Match the person's name with their picture.
☐	☐	Check the medication usage record to see if any vital signs need to be measured before the person takes their medication.
☐	☐	Wash your hands before preparing medication.
☐	☐	Match the pharmacy label with the MUR. The pharmacy label and MUR must match for the right person, the right medication, the right dosage, the right time, and the right route.
☐	☐	If using a blister pack, pop the medication out into a cup or the person's hand, taking care not to break the medication.
☐	☐	If using a sachet pack, tear or cut the packet open. If cutting, cleanse the scissors with alcohol. Pour the pills from the pack into a cup or the person's hand.
☐	☐	Assist the person to raise their hand to their mouth to take the medication if needed.
☐	☐	Give a drink of water with each pill. Observe that the person is actually swallowing the medication and not holding in their cheek or under the tongue.
☐	☐	Document on the MUR that you assisted the person with their medication.
☐	☐	Return the medications to the locked storage area.
☐	☐	Clean up the area and sanitize the table or countertop.
☐	☐	Wash your hands.
☐	☐	If you will not be helping anyone else with their medications, return the MUR to its storage area.

Comments from observing nurse

☐ **Person is competent to assist with this task** ☐ **Person is not competent to assist with this task**

_____
Signature of observing nurse

_____
Date

Check Off - Crushing Medication (Silent Knight)

Person being reviewed: _____ **Date:** _____

Correctly Performed	Incorrectly Performed	Task
☐	☐	Choose a quiet, private area to assist with medication.
☐	☐	Gather the necessary materials to assist with medication. ☐ Gloves ☐ Clean paper towel or dish to place medication lid on
☐	☐	Help the person to the medication area if needed.
☐	☐	Assist the person to wash their hands or you may use hand sanitizer if it is safe to do so.
☐	☐	Choose the person's medication usage record (MUR).
☐	☐	Choose the person's medication from the locked storage area.
☐	☐	Match the person's name with their picture.
☐	☐	Wash your hands before preparing medication.
☐	☐	Match the pharmacy label with the MUR for the right person, the right medication, the right dosage, the right time and the right route. Do this for each medication.
☐	☐	Put on gloves.
☐	☐	Place all pills into a pill crusher bag in a single layer.
☐	☐	Place the bag into the crusher.
☐	☐	Pull down on the handle of the Silent Knight.
☐	☐	Shake bag to rearrange pills as needed.
☐	☐	Continue crushing until all medication is a fine powder.
☐	☐	Pour into a container so you can mix it in an appropriate food
☐	☐	Open any capsules and place in the container
☐	☐	Mix the medication in pudding, applesauce, yogurt, etc. Mix with a small amount of food so that the person can eat it all. Generally a tablespoon or two is enough.
☐	☐	Open capsules if needed and pour into medicine cup
☐	☐	Clean up the area and sanitize the table or countertop and the Silent Knight.
☐	☐	Remove gloves and wash your hands.

Comments from observing nurse

☐ **Person is competent to assist with this task**   ☐ **Person is not competent to assist with this task**

_____   _____

Signature of observing nurse   **Date**

Check Off – Oral Liquids

Person being reviewed: _____ **Date:** _____

Correctly Performed	Incorrectly Performed	Task
☐	☐	Choose a quiet, private area to assist with medication.
☐	☐	Gather the necessary materials to assist with medication. ☐ Medication cups or other receptacles to hold and measure the medication ☐ A glass of water
☐	☐	Help the person to the medication area if needed.
☐	☐	Assist the person to wash their hands or use hand sanitizer if it is safe to do so
☐	☐	Choose the person's medication usage record (MUR).
☐	☐	Choose the person's medication from the locked storage area.
☐	☐	Match the person's name with their picture.
☐	☐	Check the medication usage record to see if any vital signs need measured before the person takes their medication.
☐	☐	Wash your hands before preparing the medication.
☐	☐	Match the pharmacy label with the MUR. The pharmacy label and MUR must match for the right person, the right medication, the right dosage, the right time, and the right route.
☐	☐	Measure the liquid in a medication cup or a medication spoon. Hold the cup or spoon at eye level so that you are measuring the correct amount.
☐	☐	Mix the medication into another liquid such as juice or water if prescribed.
☐	☐	Assist the person to raise their hand to their mouth to take the medication if needed.
☐	☐	Give a sip of water between each different liquid medication.
☐	☐	Document on the MUR that you assisted the person with their medication.
☐	☐	Return the medications to the locked storage area.
☐	☐	Clean up the area and sanitize the table or countertop.
☐	☐	Wash your hands.
☐	☐	If you will not be helping anyone else with their medications, return the MUR to its storage area.

Comments from observing nurse

☐ **Person is competent to assist with this task**   ☐ **Person is not competent to assist with this task**

_____   _____

Signature of observing nurse   **Date**

Check Off - Topical Medications

Person being reviewed: _____ Date: _____

Correctly Performed	Incorrectly Performed	**Task**
☐	☐	Choose a quiet, private area to assist with medication.

☐	☐	Gather the necessary materials to assist with medication.
		  ☐ Gloves
		  ☐ Clean paper towel or dish to place medication lid on

☐	☐	Help the person to the medication area if needed.
☐	☐	Assist the person to wash their hands or you may use hand sanitizer if it is safe to do so.
☐	☐	Choose the person's medication usage record (MUR).
☐	☐	Choose the person's medication from the locked storage area.
☐	☐	Match the person's name with their picture.
☐	☐	Wash your hands before preparing medication.
☐	☐	Match the pharmacy label with the MUR for the right person, the right medication, the right dosage, the right time and the right route. Do this for each medication.
☐	☐	Put on gloves.
☐	☐	Position the person and expose the area that medication is to be applied to. Make sure that privacy for the person is maintained.
☐	☐	Cleanse the area that the medication will be applied to with the prescribed cleanser.
☐	☐	Use mild soap and water if no specific cleanser is prescribed.
☐	☐	Put the amount of medication needed on your fingers or hand. Only get out the amount of medication that is needed. Never put your hand back into a container without changing gloves first.
☐	☐	Spread the medication around the area and rub in thoroughly. Observe the area and report any changes to the nurse.
☐	☐	Remove gloves and wash hands.
☐	☐	Document on the MUR that you assisted the person with their medication.
☐	☐	Return the medications to the locked storage area.
☐	☐	Clean up the area and sanitize the table or countertop.
☐	☐	Wash your hands.
☐	☐	If you will not be helping anyone else with their medications, return the MUR to its storage area.

Comments from observing nurse

☐ **Person is competent to assist with this task**   ☐ **Person is not competent to assist with this task**

_____

Signature of observing nurse

_____

Date

Check Off – Eye Drops

Person being reviewed: _____ **Date:** _____

Correctly Performed	Incorrectly Performed	Task
☐	☐	Choose a quiet, private area to assist with medication.
☐	☐	Gather the necessary materials to assist with medication. ☐ Gloves ☐ Clean paper towel or dish to place medication lid on
☐	☐	Help the person to the medication area if needed.
☐	☐	Assist the person to wash their hands or you may use hand sanitizer if it is safe to do so.
☐	☐	Choose the person's medication usage record (MUR).
☐	☐	Choose the person's medication from the locked storage area.
☐	☐	Match the person's name with their picture.
☐	☐	Wash your hands before preparing medication.
☐	☐	Match the pharmacy label with the MUR. The pharmacy label and MUR must match for the right person, the right medication, the right dosage, the right time, and the right route.
☐	☐	Put on gloves.
☐	☐	Ask the person to sit or lie down.
☐	☐	Shake the drops if needed. Take the lid off the eye drop bottle and place it on the paper towel or dish.
☐	☐	Gently pull the lower lid down to form a pouch.
☐	☐	Put one drop into the pouch
☐	☐	Have the person gently close their eye. Provide them with a tissue in case the eye waters.
☐	☐	Remove gloves and wash hands.
☐	☐	Document on the MUR that you assisted the person with their medication.
☐	☐	Return the medications to the locked storage area.
☐	☐	Clean up the area and sanitize the table or countertop.
☐	☐	Wash your hands.
☐	☐	If you will not be helping anyone else with their medications, return the MUR to its storage area.

Comments from observing nurse

☐ **Person is competent to assist with this task**   ☐ **Person is not competent to assist with this task**

_____
Signature of observing nurse

_____
Date

Check Off – Ear Drops

Person being reviewed: _____ Date: _____

Correctly Performed	Incorrectly Performed	Task
☐	☐	Choose a quiet, private area to assist with medication.
☐	☐	Gather the necessary materials to assist with medication. ☐ Gloves ☐ Clean paper towel or dish to place medication lid on
☐	☐	Help the person to the medication area if needed.
☐	☐	Assist the person to wash their hands or you may use hand sanitizer if it is safe to do so.
☐	☐	Choose the person's medication usage record (MUR).
☐	☐	Choose the person's medication from the locked storage area.
☐	☐	Match the pharmacy label with the MUR. The pharmacy label and MUR must match for the right person, the right medication, the right dosage, the right time, and the right route.
☐	☐	Match the person's name with their picture.
☐	☐	Wash your hands before preparing medication.
☐	☐	Verify into which ear(s) the medication is to be administered
☐	☐	Put on gloves.
☐	☐	Ask the person to sit or lie down.
☐	☐	Shake the drops, if needed. Take the lid off the ear drop bottle and place it on paper towel or dish.
☐	☐	Gently pull the ear up and back to straighten the ear canal.
☐	☐	Put in the correct number of drops.
☐	☐	Have the person remain with their head leaned over for 5 minutes.
☐	☐	Document on the MUR that you assisted the person with their medication.
☐	☐	Return the medications to the locked storage area.
☐	☐	Clean up the area and sanitize the table or counter top.
☐	☐	Wash your hands.
☐	☐	If you will not be helping anyone else with their medications, return the MUR to its storage area.

Comments from observing nurse

☐ **Person is competent to assist with this task**   ☐ **Person is not competent to assist with this task**

Signature of observing nurse

Date

Check Off – Nasal Spray

Person being reviewed: _____   Date: _____

Correctly Performed	Incorrectly Performed	Task
☐	☐	Choose a suitable area to assist with medications.
☐	☐	Gather the necessary materials to assist with medication. ☐ Gloves ☐ Clean paper towel or dish to place medication lid on
☐	☐	Help the person to the medication area if needed.
☐	☐	Assist the person to wash their hands or you may use hand sanitizer if it is safe to do so.
☐	☐	Choose the person's medication usage record (MUR).
☐	☐	Choose the person's medication from the locked storage area.
☐	☐	Match the person's name with their picture.
☐	☐	Wash your hands before preparing medication.
☐	☐	The pharmacy label and MUR must match for the right person, the right medication, the right dosage, the right time and the right route. If it doesn't match, contact the nurse.
☐	☐	Put on gloves.
☐	☐	Ask the person to sit down and lean the head slightly forward.
☐	☐	Have the person blow their nose. Discard the tissue.
☐	☐	Shake the drops if needed. Take the lid off the nasal spray bottle and place it on paper towel or dish.
☐	☐	Insert the tip of the bottle inside the nose. Aim the tip toward the back of the nose. Press your finger along the opposite side of the nose to close.
☐	☐	Firmly squeeze the bottle to deliver one spray. Have the person inhale in the spray if able.
☐	☐	Ask the person to lean their head back for 2 minutes so that the medication does not run out. Ask them to not blow their nose for at least 15 – 30 minutes after the spray.
☐	☐	Repeat the procedure in the other side of the nose if prescribed for both sides.
☐	☐	If the tip of the nasal spray becomes soiled, wipe clean with a clean, damp cloth.
☐	☐	Document on the MUR that you assisted the person with their medication.
☐	☐	Return the medications to the locked storage area.
☐	☐	Clean up the area and sanitize the table or countertop.
☐	☐	Wash your hands.
☐	☐	If you will not be helping anyone else with their medications, return the MUR to its storage area.

Comments from observing nurse

☐ **Person is competent to assist with this task**   ☐ **Person is not competent to assist with this task**

_____   _____

Signature of observing nurse   **Date**

Check Off – Metered Dose Inhaler

Person being reviewed: _____   **Date:** _____

Correctly Performed	Incorrectly Performed	Task
☐	☐	Choose a quiet, private area to assist with medication.
☐	☐	Gather the necessary materials to assist with medication. ☐ Gloves ☐ Clean paper towel or dish to place medication lid on
☐	☐	Help the person to the medication area if needed.
☐	☐	Assist the person to wash their hands or you may use hand sanitizer if it is safe to do so.
☐	☐	Choose the person's medication usage record (MUR).
☐	☐	Choose the person's medication from the locked storage area.
☐	☐	Match the person's name with their picture.
☐	☐	Wash hands before preparing medication.
☐	☐	The pharmacy label and MUR must match for the right person, the right medication, the right dosage, the right time and the right route.
☐	☐	Place the mouthpiece on the canister so that it looks like an "L". If the mouthpiece is already attached to canister, there is no need for this step.
☐	☐	Shake the canister well for about 20 seconds.
☐	☐	If the medication is a powder, turn the dial to a new dose.
☐	☐	Ask the person to inhale, then to exhale completely and not breathe in.
☐	☐	Place the canister mouthpiece inside the person's lips.
☐	☐	If you are helping with a canister spray, ask the person to breathe in through their mouth as you spray the medication.
☐	☐	If you are helping with a powder form, ask the person to inhale the medication through their mouth.
☐	☐	After the person inhales, ask them to hold their breath for a few seconds, then exhale slowly.
☐	☐	If a second spray is required, wait one minute before the second puff.
☐	☐	Document on the MUR that you assisted the person with their medication.
☐	☐	Return the medications to the locked storage area.
☐	☐	Clean up the area and sanitize the table or countertop.

Correctly Performed	Incorrectly Performed	Task
		Task
☐	☐	Wash hands.
☐	☐	If you will not be helping anyone else with their medications, return the MUR to its storage area.

Comments from observing nurse

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☐ **Person is competent to assist with this task**   ☐ **Person is not competent to assist with this task**

_____   _____

Signature of observing nurse   **Date**

Check Off – Metered Dose Inhaler with a Spacer

Person being reviewed: _____ Date: _____

Correctly Performed	Incorrectly Performed	Task
☐	☐	Choose a quiet, private area to assist with medication.
☐	☐	Gather the necessary materials to assist with medication. ☐ Gloves ☐ Clean paper towel or dish to place medication lid on
☐	☐	Help the person to the medication area.
☐	☐	Assist the person to wash their hands or use hand sanitizer if it is safe to do so.
☐	☐	Choose the person's medication usage record (MUR).
☐	☐	Choose the person's medication from the locked storage area.
☐	☐	Match the person's name with their picture.
☐	☐	Wash your hands before preparing medication.
☐	☐	Match the pharmacy label with the MUR. The pharmacy label and MUR must match for the right person, the right medication, the right dosage, the right time, and the right route.
☐	☐	Place the mouthpiece on the canister so that it looks like an "L".
☐	☐	If the mouthpiece is already attached to canister, there is no need for this step.
☐	☐	Shake the canister well for about 20 seconds.
☐	☐	Insert the mouthpiece of the metered dose inhaler into the spacer device. A spacer device looks like a small tunnel.
☐	☐	Ask the person to inhale, then to exhale completely and not breathe in.
☐	☐	Place the other end of the spacer inside the person's lips.
☐	☐	Ask the person to breathe in through their mouth as you spray the medication.
☐	☐	After the person inhales, ask them to hold their breath for a few seconds, then exhale slowly.
☐	☐	If a second spray is required, wait one minute before the second puff.
☐	☐	Document on the MUR that you assisted the person with their medication.
☐	☐	Return the medications to the locked storage area.
☐	☐	Clean up the area and sanitize the table or countertop.
☐	☐	Wash your hands.
☐	☐	If you will not be helping anyone else with their medications, return the MUR to its storage area.

Comments from observing nurse

☐ **Person is competent to assist with this task**   ☐ **Person is not competent to assist with this task**

Signature of observing nurse   **Date**

Check Off – Nebulizer Medications

Person being reviewed: _____ **Date:** _____

Correctly Performed	Incorrectly Performed	Task
☐	☐	Choose a suitable area to assist with medications.
☐	☐	Gather the necessary materials to assist with medications. ☐ Gloves ☐ Clean paper towel or dish to place medication lid on
☐	☐	Help the person to the medication area if needed.
☐	☐	Assist the person to wash their hands or you may use hand sanitizer if it is safe to do so.
☐	☐	Choose the person's medication usage record (MUR).
☐	☐	Choose the person's medication from the locked storage area.
☐	☐	Match the person's name with their picture.
☐	☐	Wash your hands before preparing medication.
☐	☐	The pharmacy label and MUR must match for the right person, the right medication, the right dosage, the right time and the right route.
☐	☐	Place the nebulizer machine on a firm surface. The person may want to sit in a comfortable chair since the entire treatment may take five minutes or more.
☐	☐	Attach the tubing to the nebulizer machine.
☐	☐	Attach a mask or a mouthpiece to the tubing. For people who cannot or will not use the mouthpiece for 5-10 minutes, a mask is the best choice.
☐	☐	Twist the top off of the nebulizer medication and squeeze into the nebulizer cup.
☐	☐	Place the mask on the person or hand them the mouthpiece to hold and turn on the machine.
☐	☐	Have the person breathe normally.
☐	☐	Every 2-3 minutes, gently tap the side of the medicine cup to make sure all of the medication is being used in the bottom of the cup.
☐	☐	When the machine stops producing mist, the treatment is done.
☐	☐	Take the tubing off the machine, roll up and secure.
☐	☐	Take the medication cup apart.
☐	☐	Wash the medication cup and the mask or hand held device in warm soapy water.
☐	☐	Rinse well and allow the pieces to air dry on a clean cloth.

Correctly Performed	Incorrectly Performed	Task
		Task
☐	☐	Wipe the machine with a damp cloth.
☐	☐	Document on the MUR that you assisted the person with their medication.
☐	☐	Return the medications to the locked storage area.
☐	☐	Clean up the area and sanitize the table or countertop.
☐	☐	Wash your hands.
☐	☐	If you will not be helping anyone else with their medications, return the MUR to its storage area.

Comments from observing nurse

☐ **Person is competent to assist with this task**   ☐ **Person is not competent to assist with this task**

_____
Signature of observing nurse

_____
Date

Check Off – Skin Patch

Person being reviewed: _____ Date: _____

Correctly Performed	Incorrectly Performed	Task
☐	☐	Choose a suitable, private area to assist with medications.
☐	☐	Gather the necessary materials to assist with medications. ☐ Gloves ☐ Clean paper towel or dish to place medication container on
☐	☐	Help the person to the medication area if needed.
☐	☐	Assist the person to wash their hands or you may use hand sanitizer if it is safe to do so.
☐	☐	Choose the person's medication usage record (MUR).
☐	☐	Choose the person's medication from the locked storage area.
☐	☐	Match the person's name with their picture.
☐	☐	Wash your hands before preparing medication.
☐	☐	The pharmacy label and MUR must match for the right person, the right medication, the right dosage, the right time and the right route. If it doesn't match, contact the nurse. Do this for each medication.
☐	☐	Position the person and expose the area where the medication is to be applied. Make sure that privacy for the person is maintained.
☐	☐	Cleanse the area where the medication will be applied with soap and water and dry thoroughly. An alcohol swab may also be used to cleanse the area. Cleansing to remove all oils and lotions is important to allow the patch to stick well to the skin.
☐	☐	Put on gloves and remove the previous patch.
☐	☐	Remove the new patch from the package. Remove the covering over the patch. Do not touch the medication part of the patch.
☐	☐	Apply the patch to the cleansed area. Hold the palm of your hand firmly on the patch for 1 minute to allow the adhesive to fully stick.
☐	☐	Document on the MUR that you assisted the person with their medication. Follow the information provided in the documentation guideline.
☐	☐	Return the medications to the locked storage area.
☐	☐	Clean up the area and sanitize the table or countertop.
☐	☐	Wash your hands.
☐	☐	If you will not be helping anyone else with their medications, return the MUR to its storage area.

Comments from observing nurse

☐ **Person is competent to assist with this task**   ☐ **Person is not competent to assist with this task**

_____   _____
Signature of observing nurse   **Date**

Check Off – Rectal Suppositories

Person being reviewed: _____ Date: _____

Correctly Performed	Incorrectly Performed	Task
☐	☐	Assist the person with this type of medication in their bedroom. Help the person to this location, if needed.
☐	☐	Gather the necessary materials to assist with medications. ☐ Gloves ☐ Water soluble lubricant
☐	☐	Assist the person to wash their hands or they may use hand sanitizer if it is safe to do so.
☐	☐	Choose the person's medication usage record (MUR).
☐	☐	Choose the person's medication from the locked storage area.
☐	☐	Match the person's name with their picture.
☐	☐	Wash your hands before preparing medication.
☐	☐	The pharmacy label and MUR must match for the right person, the right medication, the right dosage, the right time and the right route.
☐	☐	Tell the person what you are going to do. Ask or assist them to pull their underwear down to the knees.
☐	☐	Assist the person to lie on their bed on their side. Only expose the buttocks and keep all other body areas covered with a sheet or by draping their clothing. Make sure that privacy for the person is maintained.
☐	☐	Apply gloves.
☐	☐	Remove the suppository from the foil or plastic packaging.
☐	☐	Apply water soluble lubricant to the suppository.
☐	☐	Spread the buttocks gently apart. Insert the suppository with your finger. Insert the rounded end into the anus and up into the rectum. Hold the buttocks together to keep the person from pushing out the suppository.
☐	☐	Remove gloves and clean up used supplies. Dispose of used wrappers and gloves in the trash can.
☐	☐	Wash hands.
☐	☐	Assist the person to pull up underwear if needed and adjust other clothing as needed.
☐	☐	Wash hands.
☐	☐	Document on the MUR that you assisted the person with their medication.
☐	☐	Return the medications to the locked storage area.
☐	☐	If you will not be helping anyone else with their medications, return the MUR to its storage area.

Comments from observing nurse

☐ **Person is competent to assist with this task**   ☐ **Person is not competent to assist with this task**

_____   _____

Signature of observing nurse   **Date**

Check Off – Vaginal Creams

Person being reviewed: _____   **Date:** _____

Correctly Performed	Incorrectly Performed	Task
☐	☐	Assist the person with this type of medication in their bedroom. Help the person to this location, if needed.
☐	☐	Gather the necessary materials to assist with medications. ☐ Gloves ☐ Water soluble lubricant
☐	☐	Assist the person to wash their hands or they may use hand sanitizer if it is safe to do so.
☐	☐	Choose the person's medication usage record (MUR).
☐	☐	Choose the person's medication from the locked storage area.
☐	☐	Match the person's name with their picture.
☐	☐	Wash your hands before preparing medication.
☐	☐	The pharmacy label and MUR must match for the right person, the right medication, the right dosage, the right time and the right route.
☐	☐	Tell the person what you are going to do. Ask or assist them to remove their underwear.
☐	☐	Assist the person to lie on their bed on their back. Ask them to spread their legs apart. Only expose the pelvic area and keep all other body areas covered with a sheet or by draping their clothing. Make sure that privacy for the person is maintained.
☐	☐	Apply gloves.
☐	☐	Select the pre-filled applicator or pull up the correct amount of cream into the applicator according to specific medication instructions.
☐	☐	Apply plenty of water soluble lubricant to the applicator to reduce discomfort for the person.
☐	☐	Spread the labia gently apart. Locate the vagina. Insert the applicator gently into the vagina.
☐	☐	Push the opposite end of the applicator slowly so the medication is moved from the applicator into the vagina.
☐	☐	Gently remove the applicator. If the applicator is reusable, lay aside for cleansing.
☐	☐	Remove gloves and clean up used supplies. Dispose of used wrappers and gloves in the trash can.
☐	☐	Assist the person to put on underwear and adjust other clothing as needed.
☐	☐	Wash hands.
☐	☐	Cleanse the reusable applicator according to instructions from the medication label or the nurse. Allow to dry before storing away.

Correctly Performed	Incorrectly Performed	**Task**
☐	☐	Document on the MUR that you assisted the person with their medication.
☐	☐	Return the medications to the locked storage area.
☐	☐	If you will not be helping anyone else with their medications, return the MUR to its storage area.

Comments from observing nurse

☐ **Person is competent to assist with this task**   ☐ **Person is not competent to assist with this task**

_____
Signature of observing nurse

_____
Date

Check Off – Vaginal Suppository

Person being reviewed: _____ **Date:** _____

Correctly Performed	Incorrectly Performed	Task
☐	☐	Assist the person with this type of medication in their bedroom. Help the person to this location, if needed.
☐	☐	Gather the necessary materials to assist with medications. ☐ Gloves ☐ Water soluble lubricant
☐	☐	Assist the person to wash their hands or they may use hand sanitizer if it is safe to do so.
☐	☐	Choose the person's medication usage record (MUR).
☐	☐	Choose the person's medication from the locked storage area.
☐	☐	Match the person's name with their picture.
☐	☐	Wash your hands before preparing medication.
☐	☐	The pharmacy label and MUR must match for the right person, the right medication, the right dosage, the right time and the right route.
☐	☐	Tell the person what you are going to do. Ask or assist them to remove their underwear.
☐	☐	Assist the person to lie on their bed on their back. Ask them to spread their legs apart. Only expose the pelvic area and keep all other body areas covered with a sheet or by draping their clothing. Make sure that privacy for the person is maintained.
☐	☐	Apply gloves.
☐	☐	Remove the suppository from the foil or plastic packaging.
☐	☐	Apply water-soluble lubricant to the suppository.
☐	☐	Spread the labia gently apart. Locate the vagina. Insert the suppository into the vagina with your finger.
☐	☐	Remove gloves and clean up used supplies. Dispose of used wrappers and gloves in the trash can.
☐	☐	Wash hands.
☐	☐	Assist the person to put on underwear and adjust other clothing as needed.
☐	☐	Wash hands.
☐	☐	Document on the MUR that you assisted the person with their medication.
☐	☐	Return the medications to the locked storage area.
☐	☐	If you will not be helping anyone else with their medications, return the MUR to its storage area.

Comments from observing nurse

☐ **Person is competent to assist with this task**   ☐ **Person is not competent to assist with this task**

_____
Signature of observing nurse

_____
Date

MS Assistance with Medication Usage - Final Review

Support Person's Name:

_____

☐ This was an initial evaluation ☐ This was an annual review ☐ This was a periodic review

I attest that I have observed this person performing the above medication assistance tasks and have determined them to be:

☐ Competent in all tasks ☐ Not competent in any task ☐ Competent in tasks as individually noted on each check off sheet

Additional comments or recommendations:

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[                                                                    ]
[                                                                    ]
[                                                                    ]
[                                                                    ]
[                                                                    ]
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_____
(Nurse's Signature)

_____   _____
(Nurse's Name)   Date

IDD Staffing Worksheets

Purpose
The IDD Staffing Worksheets are used to calculate the number of staffing hours required for Supervised Living, Shared Supported Living, Prevocational Services, and Day Services Adult through the ID/DD Waiver and/or IDD Community Support Program (CSP). Staffing must also be accounted for people receiving Supported Living in a Supervised Living home either by adding person receiving Supported Living to IDD Staffing Worksheets for Supervised Living, decreasing Supervised Living staff hours prior to spreadsheet by hours provided for Supported Living, or by providing separate staff for persons receiving Supported Living.

General
The amount of staffing hours required for Supervised Living, Shared Supported Living, Prevocational Services or Day Services Adult through the ID/DD Waiver or IDD Community Support Program (CSP) is determined by the level of support for people served based on the Inventory for Client and Agency Planning (ICAP). For ID/DD Waiver, the ICAP Support Level is determined by an independent contractor and is documented on each person's Service Authorization sent to the provider from the Support Coordinator. For IDD CSP, the Targeted Case Manager uses the most current ICAP on the Service Authorization. There are two worksheets required to determine the staffing needed for each service at each setting. Be sure to open the appropriate tab at the bottom of the page for the service in which you are determining the staffing requirement.

Worksheet to Determine Required Staff Hours
The *Worksheet to Determine Required Staff Hours* uses the ICAP Support Level as indicated on the person's Service Authorization from the Support Coordinator or Targeted Case Manager to calculate the number of staff hours required. Data is entered for one week. A week is defined as Sunday through Saturday. Once the information is entered about each person enrolled in the service, the ICAP Support Level he/she requires, and the approved hours of attendance, the worksheet calculates the required number of staffing hours for the persons served at that setting.

Staffing Schedule Worksheet
The provider completes the *Staffing Schedule Worksheet* to list each staff and hours worked per week for that specific service and setting to compile the total weekly staff hours at that setting. A week is defined as Sunday through Saturday. Total weekly staff hours on the *Staffing Schedule Worksheet* must meet or exceed the number of staffing hours required on the *Worksheet to Determine Required Staff Hours*.

Timelines
The provider is responsible for completing both worksheets for each setting and keeping them up to date. The worksheets must be changed as staff schedules change or person(s) receiving the service or terminating from the service change. Note ICAP Support Levels on the person's Service Authorization must be checked with each person's recertification and the staffing worksheets updated as needed.

Staffing Schedule for SUPERVISED LIVING Homes
(complete and submit one worksheet per home with the Staff Hour worksheet)

Provider Name

Date Submitted

Anticipated Compliance Date

Program Name

Home Address

	Staff	Supervised Living Work Hours
	TOTAL	
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		

Note 1: 'Week' is defined as Sunday through Saturday.

Note 2: Only hours when the staff is in the home, awake, and available to provide care may be listed.

Note 3: If anyone in the home is approved for the medical rate, there must be a CNA-level staff in the home whenever that member is present.

Staffing Schedule for SHARED SUPPORTED LIVING Sites
(complete and submit one worksheet per home with the Staff Hour worksheet)

Provider Name

Date Submitted
Anticipated Compliance Date

Program Name
Home Address

	Staff	Supervised Living Work Hours
	TOTAL	
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		

Note 1: 'Week' is defined as Sunday through Saturday.

Note 2: Only hours when the staff is on-ste, awake, and available to provide care may be listed.

Staffing Schedule for DAY SERVICES Programs
(complete and submit one worksheet per location with the Staff Hour worksheet)

Provider Name

Date Submitted
Anticipated Compliance Date

Program Name
Program Address

Week Ending

	Staff	Day Services Work Hours		Providing Direct Care	Transporting to/ from Program	Other Non-Billable
	TOTAL					
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						
32						
33						
34						
35						

Note 1: The sum of hours reported for providing direct care, transporting people to and from the program, and performing other non-billable tasks (such as set-up, clean-up, or recordkeeping) must be equal to total reported Work Hours (the cells will turn red if they do not).

Note 2: 'Week' is defined as Sunday through Saturday.

Staffing Schedule for PREVOCATIONAL SERVICES Programs
(complete and submit one worksheet per location with the Staff Hour worksheet)

Provider Name

Date Submitted
Anticipated Compliance Date

Program Name
Program Address

Week Ending

	Staff	Day Services Work Hours		Providing Direct Care	Transporting to/ from Program	Other Non-Billable
	TOTAL					
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						
32						
33						
34						
35						

Note 1: The sum of hours reported for providing direct care, transporting people to and from the program, and performing other non-billable tasks (such as set-up, clean-up, or recordkeeping) must be equal to total reported Work Hours (the cells will turn red if they do not).

Note 2: 'Week' is defined as Sunday through Saturday.

Worksheet to Determine Required Staff Hours for
SUPERVISED LIVING Homes
(complete and submit one Staff Hour worksheet per home with accompanying Staffing Schedule worksheet for the home)

Provider Name

Date Submitted
Anticipated Compliance Date

Program Name
Home Address

Approved Home Size

Supervisor Name
Supervisor Hire Date
Supervisor Qualifications

	Person	Assigned Level (1-5, Behavioral, or Medical)
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

Required Weekly Staff Hours   **0**

Note 1: This worksheet does not replace any other requirements outlined in the DMH Operational Standards or a person's PSS (for example, staff must be present and awake whenever anyone is in the home).

Note 2: 'Week' is defined as Sunday through Saturday.

Note 3: Only hours when the staff is in the home, awake, and available to provide care may be counted towards meeting the requirement.

Note 4: If anyone in the home is approved for the medical rate, there must be a CNA-level staff in the home whenever that member is present.

Worksheet to Determine Required Staff Hours for
SHARED SUPPORTED LIVING Sites
(complete and submit one Staff Hour worksheet per site with accompanying Staffing Schedule worksheet)

Provider Name

Date Submitted
Anticipated Compliance Date

Program Name
Site Address

	Person	Assigned Level (1-5)
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

Required Weekly Staff Hours 0

Note 1: This worksheet does not replace any other requirements outlined in the DMH Operational Standards or a person's PSS (for example, staff must be available and awake whenever anyone is present).

Note 2: 'Week' is defined as Sunday through Saturday.

Note 3: Only hours when the staff is on-site, awake, and available to provide care may be counted towards meeting the requirement.

Worksheet to Determine Required Staff Hours for
DAY SERVICES Programs
(complete and submit one Staff Hour worksheet per location with accompanying Staffing Schedule worksheet)

Provider Name

Date Submitted
Anticipated Compliance Date

Program Name
Program Address

Week Ending

| | Person | Assigned Level (1-5 or 1915i) | Hours of Attendance | | | | | |
			Mon.	Tues.	Wed.	Thurs.	Fri.	Total
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
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31								
32								
33								
34								
35								
36								
37								
38								
39								
40								
41								
42								

Worksheet to Determine Required Staff Hours for
DAY SERVICES Programs
(complete and submit one Staff Hour worksheet per location with accompanying Staffing Schedule worksheet)

Provider Name

Date Submitted
Anticipated Compliance Date

Program Name
Program Address

Week Ending

| | Person | Assigned Level (1-5 or 1915i) | Hours of Attendance | | | | | |
			Mon.	Tues.	Wed.	Thurs.	Fri.	Total
43								
44								
45								
46								
47								
48								
49								
50								
51								
52								
53								
54								
55								
56								
57								
58								
59								
60								
61								
62								
63								
64								
65								
66								
67								
68								
69								
70								
71								
72								
73								
74								
75								

Required Weekly Staff Hours   **0**

Note 1: This worksheet does not replace any other requirements outlined in the DMH Operational Standards or a person's PSS (for example, community-based services cannot exceed three people per staff).

Note 2: 'Week' is defined as Sunday through Saturday.

Note 3: Only hours when the staff is actively engaged in billable Day Services activities may be counted towards meeting the requirement (for example, time spent transporting people to and from the program, on set-up and clean-up, or on recordkeeping activities cannot be counted).

Worksheet to Determine Required Staff Hours for
PREVOCATIONAL SERVICES Programs
(complete and submit one Staff Hour worksheet per location with accompanying Staffing Schedule worksheet)

Provider Name

Date Submitted
Anticipated Compliance Date

Program Name
Program Address

Week Ending

	Person	Assigned Level (1-5 or 1915i)	Hours of Attendance					Total
			Mon.	Tues.	Wed.	Thurs.	Fri.	
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
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22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34								
35								
36								
37								
38								
39								
40								
41								
42								

Worksheet to Determine Required Staff Hours for
PREVOCATIONAL SERVICES Programs
(complete and submit one Staff Hour worksheet per location with accompanying Staffing Schedule worksheet)

Provider Name

Date Submitted
Anticipated Compliance Date

Program Name
Program Address

Week Ending

	Person	Assigned Level (1-5 or 1915i)	Hours of Attendance					Total
			Mon.	Tues.	Wed.	Thurs.	Fri.	
43								
44								
45								
46								
47								
48								
49								
50								
51								
52								
53								
54								
55								
56								
57								
58								
59								
60								
61								
62								
63								
64								
65								
66								
67								
68								
69								
70								
71								
72								
73								
74								
75								

Required Weekly Staff Hours   0

Note 1: This worksheet does not replace any other requirements outlined in the DMH Operational Standards or a person's PSS (for example, community-based services cannot exceed three people per staff).

Note 2: 'Week' is defined as Sunday through Saturday.

Note 3: Only hours when the staff is actively engaged in billable Day Services activities may be counted towards meeting the requirement (for example, time spent transporting people to and from the program, on set-up and clean-up, or on recordkeeping activities cannot be counted).

ID/DD Waiver/IDD CSP Service Authorization

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

Documentation to be Sent to the Provider with a Service Authorization
1. Initially and when updated, the Support Coordinator/Targeted Case Manager sends the most current Interdisciplinary Summary from the Diagnostic and Evaluation Team with the Service Authorization. If there is no Interdisciplinary Summary, the psychological evaluation and social summary are sent to the provider.

2. The Support Coordinator also sends the most current Medical Evaluation.

3. If the person receives In-Home Nursing Respite, the most recent In-Home Nursing Respite Physician Recommendation Form is sent.

4. Plans of Services and Support must also accompany an initial certification, recertification, readmission, change or addition/deletion of a service.

5. Date stamp any information received from the Support Coordinator to show evidence that required timelines are met.

Timelines
No service can begin before the start date on the Service Authorization. The Support Coordinator/Targeted Case Manager must issue the Service Authorization(s) to the providers chosen by the person and listed on the Plan of Services and Support within five (5) days of receipt of the approved certification/change(s) from the IDD Community Services Office.

1. Initial Certification/Readmission – The Support Coordinator/Targeted Case Manager will issue

   Service Authorization(s) within five (5) days of receipt of the Overall Decision and approval of the initial certification/readmission request. The Overall Decision provides the initial start date of the service authorization.

2. Changes – If, during the person's certification year, there is a change in the type/amount of service a person receives, the Support Coordinator/Targeted Case Manager will send the provider an updated Service Authorization, within five (5) days of receipt of the approved Plan of Services and Supports from the IDD Community Services Office. The Change in Type(s)/Amount(s) of Service box is marked to alert the provider that there are changes. 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.

3. Recertification – Annually, within five (5) days of receiving an individual's Overall Decision and approved recertification, the Support Coordinator/ Targeted Case Manager 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/Targeted Case Manager does not receive a signed copy of the Service Authorization from an agency within ten (10) days of the date it is sent, the Support Coordinator/

Targeted Case Manager will ask the individual if he/she would like to be referred to another provider. At that time, the Support Coordinator/Targeted Case Manager 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.

Person's Authorized Address

The Authorized Address is where the person lives. The address must be updated if a person moves from one residence to another. If a person lives in a Supervised Living arrangement, the Authorized Address cannot be updated until the Support Coordinator has spoken with the person and the person has indicated that he/she agreed to the move and was able to choose his/her roommates. At that time, the Support Coordinator will issue a Service Authorization for the new address. If a provider does not have a Service Authorization for the new address, the service is not authorized and billing cannot take place. The Support Coordinator marks the Change in Address box on the Service Authorization.

Person's Support Level

The person's Support Level is determined by his/her score on the most recent ICAP. For ID/DD Waiver, Support Coordination must use the most recent ICAP completed by the Independent Contractor. Support Levels of 1 & 2 are low support, 3 is moderate support, and a 4 & 5 are high support as indicated on the following chart:

General Description	ICAP Levels	Support Level	Degree of Support
Fairly independent, may need intermittent support with living activities like cooking and cleaning	9	1	Low
May need assistance getting ready for the day, household chores, accessing places in their community, purchasing groceries	7 & 8	2	Low
Moderate support needs, may need reminders to complete daily living activities such as bathing, may use alternative means for communication	5 & 6	3	Medium
Extensive support needs, likely medical and behavior support, physical assistance with daily life activities	3 & 4	4	High
Requires constant support, significant hands on assistance with daily life activities, support with communication, and maintain health and safety	1 & 2	5	High

Procedure Codes and Modifiers

For each service listed, the Support Coordinator/Targeted Case Manager will provide the procedure code and 1st, 2nd, and, if needed 3rd modifiers, as applicable to the service. The 1st modifier will always be U3 for ID/DD Waiver and U7 for CSP, which is the modifier that identifies the service(s) as being ID/DD Waiver or IDD CSP and not another waiver/program. The 2nd modifier reflects the person's Support Level as determined by the ICAP, which is used to determine the reimbursement rate for each level of service.

EXAMPLE

Service	Procedure Code	Modifier #1 (will always be the 1st modifier)	Modifier #2	Modifier #3
Shared Supported Living, low support, (levels 1 & 2)	H0043	U3	None	None Needed
Shared Supported Living, moderate support (level 3)	H0043	U3	TF	
Shared Supported Living, high support (levels 4 & 5)	H0043	U3	TG	

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 person's certification, regardless of type (initial/readmission/ recertification)
    b. Date changes to the Plan of Services and Supports are approved by the IDD Community Services Office
2. End Date
    a. Initial/readmission/recertification – The certification lock-in end date
    b. Changes – The day before the IDD Community Services Office approval of changes to the Plan of Services and Supports
    c. When a service is terminated

It is recommended change in service(s) begin the first of the following month so provider(s) can make appropriate changes in staff/records/billing. If at any time a person chooses to change providers of in home services, the Support Coordinator can obtain documentation of the amount of services provided thus far in the month and issue a Service Authorization to the new agency with the remaining authorized amount of service.

Signatures

1.   The Support Coordinator/Targeted Case Manager sign the form and indicate the date it was sent to the provider.

2.   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/ Targeted Case Manager BEFORE services can begin.

3.   The Support Coordinator/Targeted Case Manager signs and dates the form when it is received from the agency.

Service Authorization

To: _____ **From:** _____
   Name of Agency   **Support Coordination/**
                                         Targeted Case Management Department

Re: _____   _____
   Person's Name   **Support Coordinator/Targeted Case Manager**

   _____   _____
   Medicaid Number   **Support Coordinator/Targeted Case Manager**
                                         Phone & E-mail

_____
Person's Authorized Address and Phone Number

☐ **Change in type(s)/amount(s) of service**   ☐ **Change in authorized address for Supervised/Shared Supported Living**

Person's Support Level:	1 or 2	3	4 or 5

Procedure Code	Modifier(s)			Service	Amount	Frequency		Authorized Start Date	End Date
	1st	2nd	3rd						

Support Coordinator/Targeted Case Manager Comments/Information:

_____   _____
Date Sent to Agency   **Support Coordinator/Targeted Case Manager**
                                   Signature

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

Agency Comments

_____   _____
Date   **Signature of Authorized Agency Representative**

To Be Completed by Support Coordinator/Targeted Case Manager
Upon Receipt from Authorized Agency Representative

_____   _____
Date Received from Agency   **Support Coordinator/Targeted Case Manager**

ID/DD 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, at the same time the Activity Support Plan is completed. A signed document must be maintained in the person's record and the person/legal representative must be given a copy to keep.

ID/DD Waiver Home and Community Supports
Service Agreement

Name: _____ **Medicaid Number:** _____

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 PSS will be provided. If a change in the amount is needed, the Support Coordinator must be contacted. A Change Request PSS must be submitted and approved and provider notified through a Service Authorization prior to the change in hours.

2. The intent of HCS is to assist the person gain access to the community. HCS can be provided in the home and in the community and either with or without a parent/legal representative present, depending upon identified support needs. If the person does not utilize community participation, HCS is not the appropriate service.

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 ID/DD 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. HCS may be terminated according to the provisions in the ID/DD Waiver Enrollment Agreement.

7. If a decision is made to terminate HCS, 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 might 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 staff cannot provide medical treatment of any sort, as defined in the Mississippi Nurse Practice Act Rules and Regulations.

11. Home and Community Supports staff cannot accompany a minor child on a medical visit without the parent/legal representative.

12. HCS staff cannot provide services to someone who is in a hospital or any other facility being reimbursed by Medicaid, Medicare or private insurance.

13. Home and Community Supports cannot be provided in a school setting.

14. A relative may provide no more than 172 hours HCS per month and must be identified in the PSS.

15. Home and Community Supports providers cannot do personal errands or have interactions with their family and friends during the provision of services.

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**

ID/DD Waiver In-Home Respite Service Agreement

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

ID/DD Waiver In-Home Respite Service Agreement

Name: _____ **Medicaid Number:** _____

1. In-Home Respite (IHR) will meet the support needs identified in the Plan of Services and Supports and Activity Support Plan. Only the amount of In-Home Respite 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. A Change Request PSS must be submitted and approved and provider notified through a Service Authorization prior to the change in hours.

2. In-Home Respite is to be provided in the home. The provider can take the person on short (1-2 hour) community outings to get out of the house for a short period, but community participation cannot be the purpose of the service.

3. In-Home Respite staff cannot be responsible for caring for others who may be in the home. In-Home Respite staff is only responsible for the person who is enrolled in the ID/DD Waiver. Also, the In-Home Nursing Respite staff person is not responsible for caring for pets.

4. If a scheduled In-Home Respite 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 In-Home Respite is still necessary and appropriate.

5. In-Home Respite may be terminated according to the provisions in the ID/DD Waiver Enrollment Agreement.

6. If a decision is made to terminate In-Home Respite, 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 In-Home Respite staff person, services might continue pending the outcome of the appeal.

7. Should any problems arise regarding the provision of In-Home Respite, the Support Coordinator is to be notified immediately.

8. In-Home Respite staff cannot provide medical treatment of any sort, as defined in the Mississippi Nurse Practice Act Rules and Regulations.

9. In-Home Respite staff cannot accompany anyone on a medical visit.

10. A relative may only provide up to 172 hours of IHR per month and must be identified in the PSS.

11. In-Home Respite providers cannot do personal errands or have interactions with their family and friends during the provision of services.

The above information has been reviewed and the circumstances under which In-Home Respite can be provided are understood.

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

_____   _____
Date   **Date**

ID/DD 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, at the same time the Activity Support Plan is completed. A signed document must be maintained in the person's record and the person/legal representative must be given a copy to keep.

ID/DD 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. A Change Request PSS must be submitted and approved and provider notified through a Service Authorization prior to changing hours.

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.

3. IHNR can only be approved for persons who require skilled nursing care. The need for medication administration alone is not a justification for IHNR.

4. IHNR is provided in the family home either with or without a parent/legal guardian present, depending upon identified support needs.

5. IHNR services cannot be provided in the nurse's or any of his/her relatives' homes.

6. 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 ID/DD Waiver. Also, the nurse is not responsible for caring for pets.

7. 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.

8. It is understood that the IHNR staff person will complete all forms necessary to document the provision of IHNR. 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 signing false or fraudulent documentation is against the law.

9. If a decision is made to terminate IHNR services because of failure to adhere to the ID/DD 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 and those will be provided. The services will not change until the outcome of any appeal is determined. If the environment or persons in the environment pose a risk to the IHNR staff person, he/she/the agency does not have to continue providing services.

10. Should any problems arise regarding the provision of IHNR, notify the Support Coordinator immediately to avoid possible interruption of services.

11. 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.

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 Signature/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 Support 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 ID/DD 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	Person/Legal Representative's Signature
Notes					

IDD Employment Profile

Purpose
The IDD Employment Profile is used for people who currently do not have a job 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 community job or becoming self -employed. 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.

If a person referred to a Supported Employment provider already has a job, this form would not need to be completed. It would be completed at such time as when the person desires a new job or is terminated from his/her current job.

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 Employment Staff, 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   ☐ Does not adapt to 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

<table>
<tr>
<td rowspan="2"><h1>IDD
Employment Profile</h1></td>
<td>

Name: _____

ID Number: _____

Date: _____

Provider Agency: _____
</td>
</tr>
</table>

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

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

Person has expressed interest in:

Things done to earn money in the past:

Short term jobs(less than 90 days):

Describe any interactions/services from MDRS (include dates and activities)

Volunteer or internship experiences:

Describe favorite employment experience (if applicable):

Describe work skills the person already has:

How does the person get around in the community:

IDD Employment Profile

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

What are the person's hobbies and interests:

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

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

Staff signature/credentials	

ID/DD 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. A facilitation meeting will be held prior to starting the Discovery Process.

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. The PSS can be used to gather some of this information.)*

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

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

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 and dated 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. Submit to the Support Coordinator by the 15th of the month following the month it is developed.

ID/DD Waiver Request for Behavior Support and/or Crisis Support Services

Purpose
The form must be completed when a person requests a Behavior Support or Crisis Support Services. The form is submitted by the ID/DD Waiver Support Coordinator with input from the person, family, providers, and the chosen Behavior Support or Crisis Support provider.

General
Indicate the 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 Services and Supports, the Support Coordinator has five (5) days to submit a request to IDD Community Services Office for approval. Behavior Support services cannot be provided prior to IDD Community Services Office approval.

ID/DD 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 reason(s) services are provided:			
Source(s) of Information:			

_____   _____
Support Coordinator Signature/Credentials   **Date**

Medical Verification for ID/DD 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
ID/DD 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.

ID/DD Waiver Crisis Intervention
A person must see a physician/nurse practitioner as soon as feasible after the initiation of ID/DD Waiver Crisis Intervention Services to determine if there are any physical/medication factors that may be contributing to the crisis behaviors. The ID/DD 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 initiation of ID/DD Waiver Crisis Intervention Services.

Timelines
The ID/DD Waiver Behavior Support/ID/DD 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 ID/DD 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**

ID/DD Waiver Functional Behavior Assessment

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

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 be provided in the school and be billed to Medicaid.

All components must be addressed.

The Recommendations sections contains information indicating if the Behavior Support Consultant recommends a Behavior Support Plan is warranted, staff training only is warranted, or no Behavior Support Services are needed. It also indicates information regarding any referrals that may need to be made or other recommendations that can assist the person/family.

Timelines
The Functional Behavior Assessment must be completed within ninety (90) days of IDD Community Services Office approval for Behavior Support Services or within fifteen (15) days of approval of Behavioral Supervised Living.

Submission of Documentation
The ID/DD Waiver Functional Behavior Assessment must be submitted to the Support Coordinator along with the Behavior Support Plan and Justification for Behavior Support Services within ten (10) days of completion of the Behavior Support Plan. The Support Coordinator then submits all documentation to IDD Community Services Office for review.

If the ID/DD Waiver Functional Behavior Assessment indicates a Behavior Support Plan is not warranted, but training of staff and other individuals who interact with the person is, indicate such on the Justification for Behavior Support Services.

If the ID/DD Waiver Functional Behavior Assessment indicates neither a Behavior Support Plan nor training is necessary, submit the completed ID/DD Waiver Functional Behavior Assessment to the appropriate Support Coordinator within ten (10) days of completion, along with a narrative indicating that Behavior Support Services were not warranted as per the assessment.

ID/DD Waiver Functional Behavior Assessment	Name:			
	Assessment Date(s):			
	ID Number:			
	DOB:		Sex:	❏M ❏F

Respondents(s):	Behavior Consultant/Credentials/Agency:

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) <u>more likely</u> <u>less likely</u> <u>unaffected</u> if you present him/her with a difficult task?

2. Is the above behavior(s) <u>more likely</u> <u>less likely</u> <u>unaffected</u> if you interrupt a desired event (eating ice cream, watching TV, etc.)?

3. Is the above behavior(s) <u>more likely</u> <u>less likely</u> <u>unaffected</u> if you deliver a "stern" request/command/reprimand?

4. Is the above behavior(s) <u>more likely</u> <u>less likely</u> <u>unaffected</u> if you are present but do not interact with him/her?

5. Is the above behavior(s) <u>more likely</u> <u>less likely</u> <u>unaffected</u> if the routine is changed?

6. Is the above behavior(s) <u>more likely</u> <u>less likely</u> <u>unaffected</u> 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) <u>more likely</u> <u>less likely</u> <u>unaffected</u> 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

Recommendations:

Behavior Support Consultant/Credentials   **Date**

ID/DD Waiver Behavior Support Plan

Purpose
The Behavior Support Plan is developed by the Behavior 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

Signatures
The following signatures must be obtained by the Behavior Support Consultant 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 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 Interventionist (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 Interventionist to ensure the plan continues to be successful after the Consultant/Specialist has ceased providing services.

Timelines
The Behavior Support Plan must be completed within thirty (30) days of completion of the Functional Behavior Assessment.

A copy of the Behavior Support Plan, along with the Functional Behavior Assessment and Justification for Behavior Support Services, must be submitted to the Support Coordinator within ten (10) days of completion of the Behavior Support Plan. The Support Coordinator will submit the documentation to IDD Community Services Office for review. The Behavior Support Plan must be approved before services can begin. The Behavior Support 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 approved by IDD Community Services Office.

ID/DD Waiver Behavior Support Plan

Name:		**Behavior Consultant:**	
Medicaid #:		**Agency:**	
Address:		**Contact Number:**	
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 Description	Antecedents	Consequences
Behavioral Findings:			
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:	
Intervention Expectation:	
Replacement/ Alternative Behavior:	
Review Criteria:	

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

Behavior Reduction:	
Baseline Data:	
Intervention 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:	

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:	
Person/Legal Representative:		Date:	

I agree to implement the Plan as described. If any modifications are necessary, I will contact the person/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 Consultant/Interventionist as needed to ensure implementation of the Plan. Appropriate staff will receive training to ensure the Plan continues, as needed, after the Consultant/Interventionist terminates services.			
Program Director:		Date:	

<u>Signature of</u> Behavior
Consultant/Credential _____   Date: _____

ID/DD Waiver Justification for Behavior Support Services

Purpose
The provider uses the ID/DD Waiver Justification for Behavior Support Services to justify the type and amount of Behavior Support Services needed.

General
Based upon the Functional Behavior Assessment and Behavior Support Plan, indicate the amount of Behavior Support Services needed to change/modify targeted behaviors or whether or not only staff training is needed to change/modify targeted behaviors.

Timelines
The Justification for Behavior Support Services is submitted along with the Functional Behavior Assessment and Behavior Support Plan to the appropriate Support Coordinator within ten (10) days of initiation of the Behavior Support Plan. It must be maintained in the person's record. The SC then submits all documentation to IDD Community Services Office for review.

ID/DD Waiver Justification for Behavior Support Services

Name: _____   **Medicaid Number:** _____

Agency: _____

Based upon the Functional Behavior Assessment completed _____ it is recommended
that Behavior Support services are warranted.
(date)

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

OR

Based upon the Functional Behavior Assessment completed, _____ it is recommended
(date)

that direct Behavior Support services are not warranted but there is a need for ***staff training***

It is anticipated that approximately _____ hours will be required to adequately train staff to manage
identified behaviors.

_____   _____
Behavior Support Consultant   **Date**
Signature/Credentials

ID/DD Waiver Behavior Support Plan
Quarterly Review Report

Purpose
The Behavior Consultant must complete a Behavior Support Plan Quarterly Review Report 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 Consultant composes a report that reflects medication changes, target behavior(s), information about Behavior Support Plan implementation, and narrative information about baseline data or data from the previous Quarterly Review Report as well as narrative information about the current quarter's data.

The report includes next steps to be taken in implementation of the Behavior Support Plan. Next steps could include actions such as continuing with the Behavior Support Plan as it is written or modifying it to meet any changing needs. Modifications can be made to the intervention, intervention techniques, target behaviors, training needs, timelines, etc.

The Behavior Support Quarterly Review Report must be signed and dated by the Behavior Consultant and be filed in the person's record by the 10th of every month. IDD Community Services Office staff will review the Quarterly Reports through Support Coordination records in the Long Term Services and Supports (LTSS) system.

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.

ID/DD Waiver Behavior Support Plan
Quarterly Review Report

Name:	Date of Report:

Medicaid Number:

Behavior Consultant:

Behavior Specialist:

Support Coordinator:

Behavior Support Plan Approved:

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:

Describe baseline data or data collected for previous review as well as a narrative of the previous review:

ID/DD Waiver Behavior Support Plan
Quarterly Review Report

Name:	Date of Report:

Medicaid Number:

Include a narrative of the current quarter's data.

Next Steps:

_____   _____
Behavior Consultant Signature /Credentials   Date

ID/DD Waiver Request for __Additional__ Behavior Support Services

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

General
The Behavior Consultant indicates the amount of service needed, the target behaviors, the number of Behavior Support service 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 the most recent Quarterly Review Report are submitted to the appropriate Support Coordinator for submission to the IDD Community Service Office for review.

ID/DD Waiver Request for <u>Additional</u> Behavior Support Services

(Use as many pages as necessary and attach most recent Quarterly Review Report)

Name:		**Date:**	
Medicaid #:		**Agency:**	
Behavior Consultant:		**Phone Number:**	
# Additional Hours Requested:		**# Hours utilized to date:**	

Target behavior(s):	
Justification for additional services: (why hours are needed and how they will be used)	
Desired goals/outcomes:	

ID/DD Waiver Request for <u>Additional</u> Crisis Support Services

Purpose

Crisis Support Services can be provided for up to thirty (30) days per a person's certification year. If 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 IDD Community Services Office for review. The maximum number of days of Crisis Support someone may receive without additional approval is thirty (30).

ID/DD Waiver Request for <u>Additional</u> Crisis Support Services

(use as many pages as necessary)

Name:		Date:	
Medicaid #:		Regional Program:	
Program Supervisor:		Phone Number:	
Additional # Days Requested:		# Days utilized to date:	

Targeted behavior(s):	
Justification for additional services: **(why days are needed and how they will be used)**	
Desired goals/outcomes:	

Request for ID/DD Waiver
Crisis Intervention Services

Purpose
The form must be completed when a person requests ID/DD Waiver Crisis Intervention services.

General
Crisis Intervention Services are approved on an individual's Plan of Services and Supports when there is a reasonable expectation, based on past occurrences or immediate situational circumstances in which the individual is at risk of causing physical harm to him/herself, causing physical harm to others, damaging property, eloping, or being unable to control him/herself in a manner that allows participation in usual activities of daily life.   The provider will be chosen at the time the service is approved on the Plan of Services and Supports; therefore, if a crisis arises, the provider can be dispatched immediately.

If a need for Crisis Intervention arises whereby a provider must provide immediate assistance, but the service is not yet on the Plan of Services and Supports, the provider and Support Coordinator must work together to gather justification for the need for the service and submit this form to IDD Community Services Office for review. The request must be submitted to IDD Community Services Office within five (5) days of the initiation of Crisis Intervention services.

Crisis Intervention can be requested for up to seven (7) days or 168 hours. If additional services are deemed to be necessary, the provider must submit the ID/DD Waiver Request for Additional Crisis Intervention Services from to the Support Coordinator who will then submit it to IDD Community Services Office for review.

The ID/DD 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 ID/DD Waiver Crisis Intervention Services Team.

Timelines
If a person receives Crisis Intervention services prior to the service being approved on their 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 the form completed and submit it to IDD Community Services Office for approval.

ID/DD Waiver Request for Crisis Intervention Services

Name:		**Date of Request:**	
Medicaid Number:		**Regional Program:**	
Support Coordinator:		**Phone Number:**	

# of Days/Hours Being Requested:
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**

ID/DD Waiver
Crisis Intervention Plan

Purpose
The ID/DD 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 ID/DD 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 ID/DD 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 ID/DD Waiver Crisis Intervention Team and the person/legal representative, Support Coordinator and providers, if applicable, then work to develop the ID/DD 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 ID/DD Waiver Crisis Intervention Plan are to be maintained in all settings where it may be implemented and the ID/DD Waiver Crisis Intervention Team is to train all individuals who may have to implement components of the ID/DD Waiver Crisis Intervention Plan.

The ID/DD 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 ID/DD Waiver Crisis Intervention Plan.

It is signed by the person/legal representative, the ID/DD Waiver Crisis Intervention Team Clinical Supervisor, by ID/DD 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 ID/DD Waiver Crisis Intervention Team staff who may have to implement the ID/DD Waiver Crisis Intervention Plan.

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

Copies of the ID/DD 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 the month it is developed. The Crisis Intervention Plan must be submitted to the Support Coordinator by the 15th of the month following the month it is developed.

ID/DD 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

ID/DD Waiver
Crisis Intervention Daily Service Note

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

General
The ID/DD Waiver Crisis Intervention Daily Service Note must include analysis of the behaviors and contributing factors, progress in implementing the ID/DD 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 ID/DD 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 ID/DD Waiver Crisis Intervention Plan.

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

ID/DD 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				

ID/DD Waiver Crisis Intervention Log - Episodic

Purpose

The ID/DD Waiver Crisis Intervention Log – Episodic is used to document the provision of ID/DD Waiver Crisis Intervention Services as they occur episodically, not in the provision of 24/7 ID/DD 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 ID/DD 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, the ID/DD Waiver Crisis Intervention Plan must be developed within five (5) days.

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

All ID/DD 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.

ID/DD 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**

ID/DD Waiver Request for <u>Additional</u> Crisis Intervention Services

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

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

Timelines
The form and any attached documentation are submitted to the appropriate Support Coordinator for submission to the IDD Community Services Office for review. The maximum number of hours of Crisis Intervention someone may receive without additional approval is 168 hours.

ID/DD Waiver Request for <u>Additional</u> Crisis Intervention Services

Name:		Date:	
Medicaid #:		Agency:	
Behavior Consultant:		Phone Number:	

# Additional hours requested:		OR	# Additional days requested	
# Hours utilized to date:			# Additional Days utilized to date:	

Target behavior(s):	
Justification for additional services: **(why hours/days are needed and how they will be used)**	
Desired goals/outcomes:	

Section J
Substance Use
Disorder Services

Risk Assessment Interview & Educational Activities
    for TB/HIV/STDs/Hepatitis
Emergency Placement for IV Drug Users
Emergency Placement for Pregnant Women
LOC Intake and Placement Assessment – Comprehensive
LOC Placement Assessment – Non-Comprehensive
Subsequent LOC Placement Assessment Template
LOC Placement Addendum
Problem Detailed – Specific Drug Code

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

Purpose
All people 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 person'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 people 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 person 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 person received HIV pre-test counseling. This is applicable to all persons 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 person received HIV testing and the month/day/year the person was tested. Record NO if the person 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 person. Total Time is not applicable for Line 3 items.

Line 4   Record the month/day/year and total time the person 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 person 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 a person is determined to be high risk, the person cannot be admitted to treatment until testing confirms the person 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 person.
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 person 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 person was referred for treatment for tuberculosis.

Person Receiving Services Signature/Date

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

Staff Signature/Credentials/Date

<u>After</u> the person 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/Hepatitis	**Name** _____

Name _____

ID Number _____

Date _____

#	Question	Yes	No
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

#	Question	Yes	No
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/Hepatitis

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.

Person Receiving Services/   **Date**   **Staff Signature/Credentials**   **Date**
Parent/Legal Representative

Emergency Placement for IV Drug Users **Timeline: within 48 hours of initial contact**	**Date** _____ **Time of Contact** _____ **Type of Contact** _____ **Facility Name** _____

Note: This form is to be used per the current DMH Operational Standard for *Services to People Who Use IV Drugs*.

Person Information	
Name	
Address	
Telephone Number	
Other Contact Information	

Fax or Email:

Office of Consumer Support
Fax Number: (601)359-9570

_____
Date Submitted to DMH

Emergency Placement for Pregnant Women

Timeline: within 48 hours of initial contact

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

Note: This form is to be used per the current DMH Operational Standard for *Services to Pregnant Women*.

Person Information	
Name	
Address	
Telephone Number	
Other Contact Information	

Fax or Email:

    Office of Consumer Support
    Fax Number: (601)359-9570

                                                  Date Submitted to DMH

Level of Care Intake & Placement Assessment

Purpose

This document serves as a Guidance to the three (3) Level of Care (LOC) Placement Assessments option. One (1) of the following three (3) assessment options is required for persons presenting with Substance Use or Co-occurring Disorders.

- Substance Use Disorder Intake & Level of Care Placement Assessment (Comprehensive) – replaces the DMH requirements for the Initial Assessment & Placement Assessment. This all-inclusive comprehensive assessment does not have to be combined with any other assessment(s). This assessment can be used for MH Only persons but is not required. If this is the selected assessment for MH Only, various components in the Treatment Formulation and Disposition sections are not required.
- Substance Use Disorder Level of Care Placement Assessment (Non-Comprehensive) – is required in addition to using the Initial Assessment. This option is only applicable to providers choosing to continue using the original Initial Assessment. These two assessments, when administered concurrently, supplement each other.
- Substance Use Disorder Level of Care Placement Addendum – The Initial Assessment and the Substance Use Disorder Level of Care Placement Addendum must be completed if the provider opts to use one of the alternate Placement Assessments approved by DMH. *The approved alternate Placement Assessments are as follow:
    - Dimensional Assessment for Patient Placement Engagement and Recovery-3 (DAPPER-3)
    - Level of Care Index- 3 (LOC-3)
      *Providers are responsible for purchasing the copyrights of these tools prior to embedding into an Electronic Health Record (EHR) system.

The Substance Use Disorders Level of Care (LOC) Intake and Placement Assessment is used to document pertinent information that will be used as part of the process for determining what service, combination of services, or level of care placement might best meet an persons stated/presenting need(s). The information gathered is both historical as well as what is currently happening in an person's life. This assessment will allow for the gathering of sufficient multidimensional information and matching of needed services to justify the need for placement in a particular level of care. This comprehensive biopsychosocial assessment, risk/severity rating, and immediate need profile is necessary to ensure persons are receiving personized, adaptable, and interdisciplinary care that incorporates both inpatient, outpatient, and/or ongoing continuing care.

This LOC Intake and Placement Assessment is required for persons with Substance Use and Co-Occurring (Mental Health and Substance Use) Disorders. Providers are at liberty to collect information from the person by way of interview or questionnaire (i.e, person can complete assessment items in the lobby or take home and return).

Responses of "No" or "Not Present", are acceptable. If an entire section does not apply to someone, the clinician can enter "Not Applicable." However, if the answer is "Yes" or "Present",

then additional narrative and/or explanation is required.

Timeline
The Intake & Placement Assessment is part of the intake process and must be completed within the service specific timeline requirements.

Admission Date
Enter the date the person was admitted to service(s).

Assessment Date
Enter the date the Intake & Placement Assessment was started.

Informant
If assessment information is provided by someone other than the person receiving services, enter the person's relationship to the person requesting services. The informant can be a combination of persons (i.e., the person seeking services and their spouse; child and parent/legal representative, etc.). A Consent to Release/Obtain Information must be completed if applicable.

Codependent
The person seeking services not based on their mental health or substance use related behaviors but based on another person's mental health or substance use related behaviors and it has a negative impact on them.

Child Protection Services
The person seeking services is either in the custody of CPS and/or have an open case with CPS.

Description of Need
Record the reason(s) the person gives as to why he/she is seeking services, current needs, goals etc. If the person is only seeking Substance Use Disorder services, the completion of one of the three (3) Substance Use Disorder LOC Placement Assessment options is required. If the person is only seeking Mental Health services, and the Provider chooses to use the *Substance Use Disorders Intake & Level of Care Placement Assessment (Comprehensive)* Dimension 1 can be skipped. The completion of the other dimensions (Dimension 2, 3, 4, 5, and 6) are required. If the person is seeking Substance Use only services, and/or Co-Occurring MH & SU services, the completion of ALL Dimensions are required.

Placement Assessment
This is the diagnostic admission criteria section for persons who have a mental health disorder or a substance use disorder. Whether it is during an intake or follow-up assessment, all six dimensions are evaluated, both independently and/or interactively, to determine what risks and needs are most pressing for the person in his or her current situation.

Dimension 1: Acute Intoxication and/or Withdrawal Potential
This dimension assesses the person's alcohol, tobacco, and other drug use or addictive behavior history, including onset and pattern of progression, past sequelae, and past treatment episodes including past successes and barriers to success. This dimension also assesses the need for stabilization of acute intoxication. When concerning withdrawal, this dimension assesses what

type and intensity of withdrawal management services are needed. Withdrawal Management can be provided at any level that is medically appropriate, provided that the person is kept from his or her work if there is a known or suspected concern for public safety.

*Various elements within this Dimension can be skipped for persons not seeking or in need of Substance Use Disorder Services.

Substance Use Problem Code: Indicate one (1) detailed drug code in Primary, Secondary, Tertiary, and/or Other Substance Use Code (as applicable). Reference the DMH website for the complete detailed drug code list: http://www.dmh.ms.gov/wp-content/uploads/2020/04/MS-DMH-DW-Data-Set-Code-Values_03182021.pdf

Frequency of Use: Indicate frequency of use at the time the person was actively using (prior to confinement in an institution, etc.)

Dimension 2: Biomedical Conditions and Complications
This dimension assesses the need for physical health services, including whether there are needs for acute stabilization and/or ongoing disease management for a chronic physical health condition.

Pregnancy Status: Gather details on person's due date (weeks gestation at the time of assessment), if and where the person is receives prenatal care, include doctor's name, and have them sign a consent for Release of Information.

Medical History: Complete the additional medical information 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.

Medication: Obtain a list of the medications the person is presently taking for any reason. Note: Medication information can be gathered separately (i.e., Medication/Emergency Contact form) to avoid duplication.

Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications (Mental Health)
This dimension assesses the need for mental health services. This dimension specifically references mental health conditions, including trauma-related issues and conditions such as post-traumatic disorders, and substance related mental health conditions. If the emotional, behavioral, cognitive signs and symptoms are part of the addiction (i.e. mood swings because the person is using "uppers" and "downers"), then the needs in this dimension 3 may be safely addressed as part of addiction treatment. On the other hand, if mood swings relate to a current bipolar disorder, then additional mental health services are warranted.

This dimension also identifies five (5) subcategories known as Risk Domains. These include: 1) Danger/Lethality, 2) Interference with Addiction and Recovery Efforts, 3) Social Functioning, 4) Ability for Self-Care, and 5) Course of Illness.

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.

Mental Health History: Complete the outpatient mental health and psychiatric hospitalization/ residential treatment sections as applicable with information provided by informant.

Trauma History: If the person indicates "yes" to any of the questions in this section, the completion of a more in-depth Trauma Assessment is required within 30 days of admission. The DMH Trauma History Questionnaire or an alternate (DMH approved) evidenced-based trauma screener can be used for a more thorough trauma assessment.

*DMH approves the Post Traumatic Stress Disorder Checklist for DSM-5 (PCL-5) as an alternate Trauma Assessment. http://traumadissociation.com/pcl5-ptsd

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

Dimension 4: Readiness to Change

This dimension assesses the degree of need for motivational enhancement services to engage a person and begin a recovery process. This dimension assesses stages of change thus moving the criteria beyond the concepts of "denial" and "resistance to treatment." It is not unusual for person to be ambivalent about whether they have a mental health/substance use problem. The intent here is to assess the person's stage of change so treatment approaches and intensity can be tailored to the assessed stage of change.

Assessing an person's readiness for change with a 0-10 scale is one of several strategies that can facilitate communication about self-management of presenting problem. Persons need to feel confident that they can make changes that will positively affect their health, mental health, or substance dependence. Many persons have only experienced failure in making changes in this area of their life and doubt their ability to effectively influence their presenting problem. Clinicians can increase persons' confidence by emphasizing how small, incremental steps can improve their circumstance. Use the general and/or SUD related questions to assess persons' readiness for change.

*DMH approves of the University of Rhode Island Change Assessment (URICA) as an alternate evidenced-based Readiness to Change Assessment for a more specific Readiness to Change screening.

Dimension 5: Relapse, Continued Use, or Continued Problem Potential

This dimension assesses the need for relapse prevention services. If the person has not achieved a period of recovery from which to relapse, this dimension assesses the potential for continued use for substance use disorders, or continued problem potential to include attention to gambling and or co-occurring mental health, trauma, and cognitive conditions that add to the

patient's difficulty maintaining stability and making progress in recovery.

Dimension 6: Recovery and Living Environment
This dimension assesses the need for specific personized family or significant other support and services. It also assesses the need for housing, financial, vocational, educational, legal, arrest, transportation, or childcare services.

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 persons with IDD.

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

The *employment section* should be completed regardless if a person is working at the time of the assessment (assists in determining need).

If there is an indication that the person is a DUI offender in the *arrest history section,* the SASSI Assessment must be completed.

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 clinician can enter "Not Applicable." However, if the answer is "Yes" or "Present", then additional narrative and explanation is required.

Treatment Formulation & Summary (Risk Rating System)
The option boxes ☐ provided in the Treatment Formulation section of the three (3) LOC Placement assessments are examples of risk severities in each Dimension. The more checked boxes ☐ presumes a higher risk rating. This is optional as these examples are provided for Clinical Use Only.

In the 0-4 rating system, the higher number indicates a greater level of intensity.

Risk Rating 0: Indicates a non-issue or very low-risk issue. The person would present no current risk and any chronic issues would be mostly or entirely stabilized. Considered full functioning; no severity; no risk in this dimension. Further indicating no need for specific services in this dimension.

Risk Rating 1-4: Indicates various level of functioning, severity, and the level of risk in this dimension. Further indicating the of range of specific services needed in the treatment plan to match the person's functioning and severity in this dimension.

Risk Rating 1: Indicates a mildly difficult issue, or present minor signs and symptoms. Any existing chronic issues or problems would be able to be resolved in a short period of time.

Risk Rating 2: Indicates moderate difficulty in functioning. However, even with moderate impairment, or somewhat persistent chronic issues, relevant skills, or support systems maybe present.
> Note: A Risk Rating of 2 or higher in Dimension 3 requires a Risking Rating in MH Dimensions 4, 5, & 6 also.

Risk Rating 3: Indicates a serious issue or difficulty coping within a given dimension. An person presenting at this level of risk may be considered near "imminent danger."

Risk Rating 4: Indicate issues of utmost severity. The person present with critical impairments in coping and functioning, with signs and symptoms, indicating an "imminent danger" concern, which would require immediate services.
> Note: A Risk Rating of 4 in Substance Use Dimensions 4, 5, & 6 requires a Sub-Risk Rating Score of A or B.

Sub-Risk Rating A: indicates there is no immediate action required. No engagement or motivational enhancement strategies or services are needed to be mentioned in the Treatment Plan.

Sub-Risk Rating B: indicates immediate action is required. Further engagement or motivational enhancement strategies or services are needed to be mentioned in the Treatment Plan

Imminent Danger: Imminent danger is important when considering and substantiating the need for placement into residential levels of care. In accordance to ASAM Criteria, the following three (3) elements must be present when qualifying an person's situation as imminent danger:
1) A strong probability that certain behaviors or events will occur (i.e. continued substance use, relapse to use; non-adherence with medication requirements; being victimized or harming others).
2) The likelihood that these behaviors will present a significant risk of serious adverse consequences to the person and/or others (i.e. life-threatening medical complications associated with continued use or non-adherence to medication requirements; a continued pattern of driving while intoxicated).
3) The likelihood that such adverse events will occur in the near future.

Dimension 3 (is the ONLY Dimension) identifies five (5) subcategories known as Risk Domains. These include: 1) Danger/Lethality, 2) Interference with Addiction and Recovery Efforts, 3) Social Functioning, 4) Ability for Self-Care, and 5) Course of Illness.

Comment(s)/Summary/Recommendation(s)

The clinician conducting the LOC Intake & Placement Assessment must summarize the observations and findings to include an analysis of the person's strengths and needs, both expressed and observed. Based on the results of the Initial Intake & Placement Assessment, services must be recommended and offered to the person. Referrals to other appropriate providers must also be offered to the person. Observations, findings, and recommendations should support a life of recovery related to the six dimensions. The risk rating, comments and

summaries recorded in the Treatment Formulation section permits the assessor space to express their prudent clinical judgement on how they arrived at the recommended LOC and how medical necessity was determined. Medical necessity (in this context) pertains to necessary care for one's biopsychosocial severity; the extent and severity of problems in all six multidimensional assessment areas of an person's life.

Indication of Functional Limitation(s)
An assessment must be conducted, and the results documented for the major life areas specified for each person seeking admission 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 30 days for all children/youth receiving mental health services or within timelines as required by service.

An approved functional assessment is required for all adults receiving mental health services. An approved functional assessment must be completed within 30 days for all adults receiving mental health services or within timelines as required by service. DMH will review and approve a functional assessment for use with the adult SMI population.

The DLA-20 A/D is the approved functional assessment for use within the SUD population. The DLA-20 A/D is required for all transitional aged youth and adults (age 16 and up) receiving substance use disorder services. The DLA-20 A/D must be completed within timelines according to the service(s) received for all persons receiving substance use services.

Initial Diagnostic Impression
Provide a written diagnostic impression with appropriate diagnostic code(s). Note: The DSM 5 does not separate out MH and SU disorders. Indicate the primary diagnosis first. This was separated to help clinicians differentiate MH and SU disorders.

Assessed Level of Care Recommendation
Movement through Levels of Care depends on an person's progress in treatment. Progress made during the treatment episode may justify movement to a less intensive level of care. Likewise, lack of progress or worsening of problems may indicate movement to a more intensive level of care or a transfer to a program offering the same level of care but different services (i.e. transfer from a Level 3.5 Co-Occurring Capable to a Level 3.5 Co-Occurring Enhanced Level of Care).

Disposition: Select one (1) of the Level of Care placement number below that offer the most appropriate level of care/service that can provide the service intensity needed to address the person's current functioning/severity; and/or the service needed.

Level of Care Recommendation	
Level 0.5	**Early Intervention Services**
Level 1	**Outpatient Services**

Level 1-WM	**Ambulatory Detox w/o Extended On-Site Monitoring**
Level 1.0	**OTP- Opioid Treatment Services** *NOTE: This is not a level of care but rather a service of employing agonist or antagonist medications in any level of care.*
Level 2.1	**Intensive Outpatient Treatment Services**
Level 2.5	**Partial Hospitalization**
Level 2-WM	**Ambulatory Detox with Extended On-Site Monitoring**
Level 3.1	**Clinically Managed Low Intensity (Transitional) Residential Treatment Services**
Level 3.1-WM	**Clinically Managed Residential Withdrawal Management**
Level 3.3	**Clinically Managed Population Specific High Intensity Residential Services**
Level 3.5	**Clinically Managed High Intensity Residential Treatment Services**
Level 3.7	**Medically Monitored Intensive Residential Treatment Services**
Level 3.7-WM	**Medically Monitored Intensive Residential Treatment Services**
Level 4	**Medically Managed Intensive Inpatient Services**
Level 4-WM	**Medically Managed Intensive Inpatient Services**

Level 0.5: Early Intervention Services
Assessment and education for at-risk persons who do not meet diagnostic criteria for substance use disorder. Such interventions include Screening, Brief Intervention, Referral and Treatment (SBIRT); risk advice; and education.

Level 1: Outpatient Services
Less than 9 hours of services/week(adults); less than 6 hours/week (adolescent) for recovery or motivational enhancement therapies/strategies.

Level 1: WM Ambulatory Detox without Extended On-Site Monitoring
Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment recovery.

Level 1.0: OTP- Opioid Treatment Services
This is not a level of care but rather a service of employing agonist or antagonist medications in any level of care.
Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder.

Level 2.1: Intensive Outpatient Treatment Services
9 or more hours of service/week (adults); 6 or more hour/week (adolescents) to treat multidimensional instability

Level 2.5: Partial Hospitalization
20 or more hours of service/week for multidimensional instability not requiring 24-hour care

Level 2-WM: Ambulatory Detox with Extended On-Site Monitoring
Moderate withdrawal with all day withdrawal management support and supervision; at night, has supportive family or living situation; likely to complete withdrawal.

Level 3.1: Clinically Managed Low Intensity (Transitional) Residential Treatment Services
24-hour structure with available trained personnel; minimum of five (5) hours of clinical service/week

Level 3.2-WM: Clinically Managed Residential Withdrawal Management
Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.

Level 3.3: Clinically Managed Population-Specific High-Intensity Residential Services (not designated for adolescent populations)
24-hour support setting to meet the needs of people with cognitive difficulties, who need specialized personized treatment services (who need a slower pace and could not otherwise make use of the more intensive Level 3.5 milieu). Level 3.3 is not a step-down residential level. It is qualitatively different from other residential levels of care. The cognitive impairments manifested in persons most appropriately treated in Level 3.3 services can be due to aging, traumatic brain injury, acute but lasting injury, or due to illness.

Level 3.5: Clinically Managed High Intensity Residential Treatment Services (Adults)
24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community.

Level 3.5: Clinically Managed Medium Intensity Residential Treatment Services (Adolescents)
24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community.

Level 3.7: Medically Monitored Intensive Residential Treatment Services
24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3. 16 hour/day counselor ability.

Level 3.7-WM: Medically Monitored Intensive Residential Treatment Services
Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, nursing monitoring.

Level 4: Medically Managed Intensive Inpatient Services
24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3. Counseling available to engage person in treatment.

Level 4-WM: Medically Managed Intensive Inpatient Services
Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.

Level of Care Placement Summary
Indicate the Level of Care that offers the most appropriate level of care/services that can provide

the service intensity needed to address the person's current functioning/severity; and/or the service needed. i.e. housing, vocational training, transportation, language interpreter.

Admitted Level of Care
Indicate the level of care the person will be admitted into.

Referral to Level of Care
Indicate the level of care the person needs that the assessing agency cannot offer. Indicate the name of the agency or the level of care that the referral was made out for. If the most appropriate level or service is not utilized, indicate the most appropriate placement or service available

Reason for Difference
Possible reasons: service not available, provider judgement, person preference; person is on waiting list for appropriate level of care; service available, but no payment source; geographic accessibility; family responsibility; language barrier; not listed (specify reason if examples are not fitting).

Anticipated Outcome If Service Cannot Be Provided
Possible reasons: Person risk an admission into an acute care setting; Risk discharge to street; Risk continued stay in acute care facility; Risk incarceration or other legal challenges; Person may drop out/leave AMA until next crisis; or Other (Specify).

Person Signature
The collection of the person (person receiving services) signature is an acknowledgment that the person participated in the assessment and that the questions were presented in a language the person could understand. Additionally, it's an acknowledgment that the person reviewed and understands the determination of the Level of Care and their respective placement decision with the clinician. The signature does not indicate nor imply that the person reviewed and was privy to all clinical information included in the intake document, such as the clinical hypotheses. A signature from the person is *not* required but strongly encouraged to avoid potential legal ramifications.

Staff Qualifications
The Initial Assessment must be completed by an person 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 Alzheimer's Day Programs only, the program supervisor must complete the Initial Assessment. A copy of the person's current history and physical, signed by an MD or Psychologist must be provided to confirm diagnosis.

However, interpretation of such information must be within the assessor's scope of practice. Consultation with the interdisciplinary team is required whenever the assessor is outside his or her scope of practice and expertise. For example, a counselor can gather a history of withdrawal but would need nursing or medical consultation to determine the severity of withdrawal and the

matched level of withdrawal management.

Subsequent Assessments
In the Substance Use Treatment domain, persons must be re-assessed at every step-down or step-up in Level of Care and every 14 days in Residential Services, every 90 days in Outpatient and every 30 days in Intensive Outpatient (to coincide with periodic staffing requirements).

Please adhere to the Subsequent Assessment Profile template for the required components. Record of subsequent assessments can be kept in a Progress Note labeled "Re-Assessment" or "LOC Re-Assessment".

Reference
Mee-Lee, D., Shulman, G. D., Miller, M. M., & Provence, S. M. (2013). The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. Third Edition. Chevy Chase, Maryland: American Society of Addiction Medicine, Inc.

Level of Care Intake & Placement Assessment *Comprehensive*	Name: _____ ID Number: _____ Initial Assessment Date: _____ Admission Date: _____ Time In: _____ Time Out: _____ Total Time: _____

Informant: ☐ Person Receiving Services   ☐ Other: Relationship to Person_____

Is person seeking services Codependent status? (Is the person seeking services based on the mental health or substance use, behavioral problems, of another person, and it is affecting them negatively?)

☐Yes ☐No   If Yes, Explain: _____

PLACEMENT ASSESSMENT

DIMENSION 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL

Does the person appear to be intoxicated or experiencing withdrawal at the time of assessment? ☐Yes ☐No
If yes, assess the person's intoxication, withdrawal potential, and living environment risk factors below:

Intoxication	Current Intoxication: ☐None ☐Mildly ☐Very ☐Extremely
	Physical Signs and Symptoms of Intoxication: *(indication of vital signs, gait, speech, coordination)* ☐Normal ☐Mild ☐Moderate ☐Severe ☐Life Threatening
	Mental Signs and Symptoms of Intoxication: ☐Oriented, alert, normal mental functioning ☐Mild disturbance of mood, cognition, function ☐Moderate disturbance of mood, cognition, function ☐Severe disturbance of mood, cognition, function ☐Life Threatening, disoriented, clouded consciousness, or psychotic
Withdrawal Potential	Physical Signs and Symptoms of Withdrawal: *(vital signs, tremor, sweats, Central Nervous System or Gastrointestinal Intestinal problems)* ☐Normal ☐Mild ☐Moderate ☐Severe ☐Life Threatening
	Mental Signs and Symptoms of Withdrawal: ☐Oriented, alert, normal mental functioning ☐Mild anxiety, agitation, depression, dysfunction ☐Moderate anxiety, agitation, depression, dysfunction ☐Severe anxiety, agitation, depression, dysfunction ☐Life Threatening, suicidal, psychotic, disoriented, hallucinating
	History of Withdrawal Problems: ☐No prior history of withdrawal problems ☐History of minor problems ☐History of moderate problems ☐History of severe problems ☐History of Life-Threatening withdrawal problems
Modifications Needed	Ability to cope/tolerate current intoxication or withdrawal symptoms: ☐Fully ☐Mild difficulty ☐Moderate difficulty ☐Severe difficulty ☐Unable to tolerate or cope
	Current living environment supportive of person and his/her Withdrawal Management needs:

	□Full assistance □Some/partial assistance □Unreliable □No one to assist □Toxic

Have you ever been treated for an Alcohol or Drug use/problem? □Yes □No

If answered yes to the Substance Use question above, gather additional information and summarize (the onset, possible causes, duration, intensity & fluctuations of severity):

Prior Treatment for Substance Use Disorder?

00 = None   01 = 1 Previous   02 = 2 Previous   03 = Unknown

If 1 or 2 (Previous) is indicated above, provide more details.
When: _____   Where: _____

Level of Care (i.e., Detox Only, Intensive Outpatient, Outpatient, Residential, Hospital Inpatient): _____

Type of Discharge (*Did they complete treatment?*) _____

Optional for MH reporting

Is the person receiving **Medication-Assisted Opioid Therapy**: □Yes □No □Not Applicable

*Is the person interested in receiving MAT services? □Yes □No

Is the person receiving **Methadone**: □Yes □No □Not Applicable □Not Collected (for MH-only persons)

<div align="center">

Current Substance Problem Code (Detailed Drug Code)

</div>

Indicate one (1) detailed drug code in Primary, Secondary, and/or Tertiary Substance Use Code (as applicable) below:
*Reference the DMH website for complete code list: http://www.dmh.ms.gov/wp-content/uploads/2020/04/MS-DMH-DW-Data-Set-Code-Values_03182021.pdf

		Substance Use I Code _____
Primary	*Route of Administration:*	□ Oral □ Smoking □ Inhalation □ Injection *(priority population)* □ Suppositories □ Other □ Unknown □ NA
	Frequency of Recent Use	(At the time you were using the substance, what was your frequency? □ No use past month □ 1-3x past month □ 1-2x week past month □ 3-6s week past month □ 1x daily past month □ 2-3x daily past month □ 4+x daily past month □ Unknown □ NA
	Age at First Use:	Age at first use of Problem Substance I:
		Substance Use II Code _____
Secondary	*Route of Administration:*	□ Oral □ Smoking □ Inhalation □ Injection *(priority population)* □ Suppositories □ Other □ Unknown □ NA
	Frequency of Recent Use	(At the time you were using the substance, what was your frequency? □ No use past month □ 1-3x past month □ 1-2x week past month □ 3-6s week past month □ 1x daily past month □ 2-3x daily past month □ 4+x daily past month □ Unknown □ NA
	Age at First Use	Age at first use of Problem Substance II:
		Substance Use III Code _____
Tertiary	*Route of Administration:*	□ Oral □ Smoking □ Inhalation □ Injection *(priority population)* □ Suppositories □ Other □ Unknown □ NA

	Frequency of Recent Use	(At the time you were using the substance, what was your frequency? ☐ No use past month ☐ 1-3x past month ☐ 1-2x week past month ☐ 3-6s week past month ☐ 1x daily past month ☐ 2-3x daily past month ☐ 4+x daily past month ☐ Unknown ☐ NA
	Age at First Use	Age at first use of Problem Substance III:
	List Other Drug Use Code ____	
	Route of Administration:	☐ Oral ☐ Smoking ☐ Inhalation ☐ Injection *(priority population)* ☐ Suppositories ☐ Other ☐ Unknown ☐ NA
Other Drug Use	*Frequency of Recent Use*	(At the time you were using the substance, what was your frequency? ☐ No use past month ☐ 1-3x past month ☐ 1-2x week past month ☐ 3-6s week past month ☐ 1x daily past month ☐ 2-3x daily past month ☐ 4+x daily past month ☐ Unknown ☐ NA
	Age at First Use	Age at first use of Problem Substance:

How much money would you say you've spent on substances during the past 30 days?

Family History of Alcohol and/or Other Drugs:

Person Nicotine Use:

☐ Smoke ☐ Oral (*tobacco*) ☐ Vape ☐ Nicotine Gum
Age of first use:

Frequency of Use:

☐ Current every day ☐ Current someday ☐ Former smoker ☐ Never smoked ☐ Smoker, status unknown

DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS

Person Sexual Orientation:	How does person want to be identified? ☐ Heterosexual ☐ Homosexual ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Transgender ☐ Queer ☐ Questioning ☐ Other _____ Would you like to address your sexuality during treatment? ☐ Yes ☐ No (If yes, explain)

Person Pregnant *(priority population)* at time of this Initial Assessment? ☐ Yes ☐ No ☐ Not applicable (males)

If yes, how many weeks (gestation): _____
If yes, is person receiving prenatal care? ☐ Yes ☐ No (If yes, obtain consent and/or ask for physician information)

Surgeries (type of surgery and dates):

Appetite Issues:

Allergies (food, plant, medication, etc.):

Sleep Issues:

Current or Chronic Diseases	☐ high blood pressure ☐ diabetes ☐ thyroid ☐ cancer ☐ heart disease ☐ epilepsy ☐ HIV ☐ Tuberculosis ☐ Hepatitis ☐ other _____

	Are you being treated for conditions selected above? □ Yes □ No **NOTE**: The DMH's HIV, TB, Hepatitis, and STD Assessment is a separate assessment, required for ALL persons seeking substance use services.
Family History	□ high blood pressure □ diabetes □ thyroid □ cancer □ heart disease □ other _____

Additional Medical History or Health and Safety Issues: (i.e., Traumatic Brain Injury, Epilepsy Disorder, Complications due to Coronavirus, Mobility Limitations, etc.)

Health-Related Needs:

List Current Medications: **NOTE**: Medication information can be gathered separately on the Medication/Emergency Contact form.

DIMENSION 3: EMOTIONAL, BEHAVIORAL, OR COGNITIVE CONDITIONS AND COMPLICATIONS. (Mental Health)
Do you feel you have any current Mental Health Needs that you would like to address? □ Yes □ No If yes, please describe.
Thoughts of Suicide: □ Yes (If yes, explain) □ No (Are you thinking of killing or harming yourself?) □ Yes (If yes, explain) □ No
Attempts of Suicide: □ Yes (If yes, explain) □ No
Thoughts of Homicide: □ Yes (If yes, explain) □ No *(Indicate the need for "duty to warn")* Are you thinking of killing or harming someone? □ Yes (If yes, explain) □ No
Acts of Self-Harm: □ Yes (If yes, explain) □ No
Do you have any problems with remembering, concentration or following simple instructions? □ Yes (If yes, explain) □ No
In the last year have you experienced hallucinations or difficulty telling what is real from what is not real? (auditory, visual, olfactory, tactile) □ Yes (If yes, explain) □ No
Do you currently or have a history of mood changes? □ Yes (If yes, explain) □ No
Do you currently or have a history of depression? □ Yes (If yes, explain) □ No
Do you currently or have a history of anxiety? □ Yes (If yes, explain) □ No
Do you take medication for any of the above? □ Yes (If yes, what medications) □ No (NOTE: Medication information can be gathered separately on the Medication/Emergency Contact form.)
Have you ever been diagnosed with anything not listed above? (i.e., eating disorder, significant weight gain or loss in the past 6 months) □ Yes (If yes, what is your diagnosis, and have you been treated?) □ No
The collection of a Brief Trauma History is required at Intake (Next three-3 questions below). If person answer "yes" to any of the questions below the full DMH Trauma History Questionnaire or an alternate (DMH approved) Trauma Assessment is required within 30 days of Admission.
Do you have trauma concerns that you wish to address during this experience? □ Yes □ No
Have you ever experienced any of the following? □ Yes □ No (select one)

□ Physical Abuse □ Emotional Abuse □ Sexual Abuse □ Neglect □ Domestic Violence □ Military Service □ Natural Disaster □ Other

Have you ever received treatment for Trauma or Post Traumatic Stress Disorder? □ Yes □ No If yes,

When: _____   Where: _____

Level of Care (i.e., Intensive Outpatient, Outpatient, Residential, Hospital Inpatient): _____

Have psychological, educational, or functional assessments been completed in the last twelve months?

□ Yes (If yes, complete release of information to obtain a copy of the applicable assessment.)

If yes, indicate type of assessment_____   □ No

If yes, what was the recommendations of the assessment

Previous or Current Diagnoses (Inquire about origin of said diagnosis):

Family History of Psychiatric or Substance Use Disorder(s) □ Yes □ No

If yes, please describe.

Prior Outpatient Behavioral Health Treatment

□ None Reported

Treatment Agency	Services Received	Dates of Service	Has Consent to Release Information Been Requested?
			□ Yes □ No
			□ Yes □ No

Prior Psychiatric Hospitalizations/Residential Treatment

□ None Reported

Treatments	Reason (suicidal, depressed, etc.)	Dates of Service	Has Consent to Release Information Been Requested?
			□ Yes □ No
			□ Yes □ No

INITIAL OBSERVATIONS
The Clinician's overall impression of Person.

Orientation	□ Person □ Place □ Time □ Situation □ Other (may select more than one)
	Comments:
	Dress: □ Appropriate □ Meticulous □ Eccentric □ Seductive □ Disheveled

General Appearance	Grooming: □ Appropriate □ Meticulous □ Unclean □ Disheveled □ Bizarre
	Facial Expressions: □ Appropriate □ Flat □ Sad □ Angry □ Fearful
	Comments:
Mood/Affect	*Mood: sustained emotions state, emotional tone, what the person subjectively feels i.e. what the person says* □ Appropriate □ Depressed □ Euphoric □ Anxious □ Irritable □ Other
	Affect: outward expression of a person's current feeling state, now they appear to you i.e. facial expressions, body language, laughter, use of humor, tearfulness □ Appropriate □ Hostile □ Manic □ Blunted □ Labile □ Broad □ Flat (incongruent)
	Comments:
Speech	□ Normal □ Pressured □ Stammering □ Mute □ Loud □ Rambling □ Slurred □ Slow □ Rapid □ Echolalia (compulsive repletion of word)
Delusions	□ N/A □ Description:
Hallucinations	□ N/A □ Description:
Memory	*Could explain recent and past events in their history; recalls three words immediately after rehearsal then five minutes later; recalls your name after 30 minutes* Immediate: □ Intact □ Mildly impaired □ Moderately impaired □ Severely impaired Recent: □ Intact □ Mildly impaired □ Moderately impaired □ Severely impaired Remote: □ Intact □ Mildly impaired □ Moderately impaired □ Severely impaired Comments:
Self-Concept	□ Self-assured □ Realistic □ Low self-esteem □ Inflated self-esteem
Impression	Intelligence: □ Below Average □ Average □ Above Average Judgement/Insight: □ Below Average □ Average □ Above Average
Other	Comments overall:

DIMENSION 4: READINESS TO CHANGE (*formerly referenced as Stages of Change*) (Note: An person maybe ready to change one issue, but no interest or readiness to change another issue. The rating below can be specific to one issue, several issues, or overall issues. Providers are permitted to use an alternate (DMH approved) Readiness to Change assessment tool for this Dimension.	
Readiness to Address: (Mental Health or In General)	Do you think you have a problem/issue with alcohol or drugs and/or an emotional or mental health disorder? □ yes □ no If yes, explain:
	Is there anything you need to change or would like to change? (i.e., medication compliance, criminal activity, fight, cursing, impatience, procrastination, relationships, social engagement, road rage)? □ yes □ no If yes, explain:
	How important is it to you to make this change, on a scale of 0 to 10 with 10 being extremely important?

	How confident are you that you can make this change, on a scale of 0 to 10 with 10 being extremely confident?
Readiness to Address: (Substance Use)	Have you tried to hide your use? □ yes □ no If yes, which substance:
	Has anyone ever complained about your use? *(6)* □ yes □ no If yes, explain:
	Has your use caused you to feel depressed, nervous, and suspicious, have decreased sexual desire, diminished your interest in normal activities or caused other psychological problems? *(9)* □ yes □ no If yes, explain:
	Has your use affected your health in any way by causing numbness, blackouts, shakes, tingling, contracting TB, STD's or other health related problems? *(8) (11)* □ yes □ no If yes, explain:
	Have you continued to use despite negative consequences at work, school, or home? *(5)* □ yes □ no If yes, explain:
	Have you had cravings or a strong desire to use alcohol or drugs? *(4)* □ yes □ no If yes, explain:
	Have you had problems with the law because of your use? *(6)* □ yes □ no If yes, explain:
	Has your use affected socially (i.e. fights, problem relationships, etc.? *(6)* □ yes □ no If yes, explain:
	Do you need more of the substance to get high? *(10)* □ yes □ no If yes, explain:
	Do you spend a great deal of time in activities to obtain the substance and/or feel its affects? *(3)* □ yes □ no If yes, explain:
	Has your use caused you to give up or not participate in school, occupational, or recreational/social activities you once enjoyed? *(7)* □ yes □ no If yes, explain:
	Have you continued to use knowing it caused or contributed to physical and/or psychological problems? *(9)* □ yes □ no If yes, explain:
	Have you used large amounts than you intended or for longer than you intended? *(1)* □ yes □ no If yes, explain:
	Have you continued to use despite placing yourself and others in dangerous or unsafe situations? *(8)* □ yes □ no If yes, explain:
	Have you attempted to cut down or control your use of alcohol/drugs without success? *(2)* □ yes □ no If yes, explain:

DIMENSION 5: RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL
(Note: Varies elements in this section may not be applicable to younger children. Indicate "not applicable-younger child" in those instances. Some elements may not be applicable to MH ONLY persons. Indicate "not applicable-MH".

Longest Length of Stability (maintaining one's Mental Health Disorder or Substance Use Disorder): Have you ever stopped taking your medication against doctor's orders? □ yes □ no   If maintained for any period of time, how long were you able to maintain?

What was your longest period of abstinence? If any, from using substance(s)?

How was abstinence maintained? If maintained for any period of time, from using substance(s)?

What would you consider your relapse triggers?

Describe your support network. (i.e., sponsor, peer support, community support services, etc.) If supports were identified, when was their last contact?

Have you ever participated in self-help meetings? □ yes □ no   If yes, what type?

Person's Recovery (Self-Help) Group Attendance Frequency: □ No attendance □ Less than once WK 1-3X past 30 days □ About once a week 4-7X past 30 days □ 2-3X per week/8-15X past 30 days □ At least 4X week/16-30X past 30 days □ Some Attendance-number of times/frequencies is unknown

On a scale of 1-5, how important is receiving Substance Use Treatment or receiving Mental Health Services to you now? (5 being most important)

When you were once in the Maintenance Stage of Change, what was your longest period of maintaining
(socially acceptable behaviors, healthy functioning, etc.)?

DIMENSION 6: RECOVERY/LIVING ENVIRONMENT
(Note: Varies elements in this section may not be applicable to younger children. Indicate "not applicable-younger child" in those instances.

Immediate Household/Family Configuration

What is your current living arrangement (strengths and concerns)? Who lives with you? What are your views on your current arrangement (satisfied/dissatisfied)?

How long has this been your living arrangement?

Is your living environment drug free? □ Yes □ No

Is your living environment alcohol free? □ Yes □ No

Is your living environment supportive of maintaining a positive Mental Health wellbeing? □ Yes □ No

If not, explain: (If answered "no", do the person perceive it to be a problem for their recovery efforts?

Does anyone in your household have a mental health or substance use disorder/diagnosis?

If so, who? Is their disorder/diagnosis being managed?

Needs Related to Living Situation *(money management, benefits, living arrangements, clothing, personal care, childcare, rent, other)*

Marital Status

Are you currently married? □ Never married □ Currently (now) married □ Widowed □ Divorced □ Separated

□ Not/Applicable-Younger Child

Currently involved in a Significant Relationship (not listed above)? □ Yes □ No

History of Marriages/Divorces/Troubled Relationships with Significant Others (be specific, ask the person's perceived reason for divorce(s)/separation(s)):

Children

Does the person meet the DMH Parenting Classification?
(Mother or Father of dependent(s) under the age of five (5); and dependent(s) will be accompanying the parent in the Residential Treatment Facility during their treatment experience?)
□ Yes *(if yes, list the age(s) of dependent(s)* □ No

Total # biological children:
Secondary household for minors:
Other children in the household:
(Are you comfortable with the relationships with them, any affects, dynamics, stressors)

(NOTE: If the person is a child/adolescent inquire about siblings, sibling relationships, household dynamics, etc.)

Ages and gender of children:
Who has custody of these children?
What is your relationship with your children/parent/guardian based on your perception? What would you like for your relationship to be like with your children/parent/guardian?
Additional Comments:

Family of Origin

Information on Family of Origin – include information on who raised the person, relationship with parent, siblings, grandparents, history of substance abuse/use in the family, etc. be specific and include ALL pertinent information:

Other family support:
Overall quality of and interaction with family based on your perception:
Family and Social Support available:

Social/Cultural History

Identification of Support Systems: (i.e., family relationships, interpersonal relationships, and community support systems)

Meaningful Activities, Cultural / Ethnic / Spiritual interests, Supports: (Address hobbies, leisure activities, etc.)

EDUCATION
(Children & Youth up to age 21)

□ Not Applicable-Adult Person

Name of school:

Education Grade Level:
□ None, never attended grade school □ Kindergarten □ 1st Grade □ 2nd Grade □ 3rd Grade □ 4th Grade □ 5th Grade □ 6th Grade □ 7th Grade □ 8th Grade □ 9th Grade □ 10th Grade □ 11th Grade □ 12th Grade

Does child/youth receive Special Education Services?
□ Yes *(If yes, complete release of information to obtain a copy of the Evaluation and the current Personized Education Plan (IEP))* □ No

Educational Issues/Needs (grades, attendance, suspensions, expulsions)

Additional Information (Children & Youth up to age 21)

EDUCATION
(Youth & Adults)

□ Not Applicable-Underage Person

Highest level of education completed:
□ None, never attended school □ 10th Grade □ 11th Grade □ 12th, High School Graduate or GED □ 1-year of College □ 2-years of College or Associates Degree □ 3-years of College □ Bachelor's degree □ Some Post Graduate Study □ Master's degree □ Graduate or Professional School (Doctoral Study, Med School, Law School, etc.) □ Technical Trade School

Are you currently enrolled in school? □ Yes □ No *(If yes, explain)*
Have you or do you currently receive Special Education Services? □ Yes □ No *(If yes, explain)*
Does the person desire to pursuit further education? □ Yes □ No *(If yes, explain)*

DEVELOPMENTAL HISTORY
(Only for Children & Youth up to age 21 and everyone with ID/DD)

□ Not Applicable
During pregnancy, did mother use alcohol or other drugs? □ Yes □ No
Describe any problems with the pregnancy or birth:
Were there any developmental issues? □ Yes □ No *(If yes, explain)*
Describe any childhood accidents or injuries:

EMPLOYMENT

□ Not Applicable-Underage Person
Employment status upon entry into this program: If currently employed, what is your occupation? □ Retired □ Disabled □ Not working by choice □ Unemployment □ Employed in Leve Status □ Work part time □ Work full time
If no, do you want to be employed or do you have employment goals that would like to work on during this experience?
If yes, which of the following occupational codes best describes your current employment situation: □ Healthcare Worker □ First Responder □ Frontline Worker □ Sales □ Farm Owners/Laborers □ Service/Household □ Executive/Managerial □ Professional □ Educator/Teacher □ Counselor/Therapist □ Office Support □ Other (Please provide description.): _____
Employment Barriers/ Related Needs? *(occupational functioning, interpersonal relationships, transportation, etc.)*

Current Legal Status

Has the person been involved with the legal system within the past twelve months? □ Yes □ No	
Arrests: □ Yes □ No	If yes, indicate type and number of arrest(s):
	Number of arrests in the past 30 days:
Pending Charges: □ Yes □ No	If yes, indicate type and number of pending charges:
Substance Use Related Legal Issues:	

Is this person currently on parole? □ Yes □ No
Is this person currently on probation? □ Yes □ No
Is this person currently involved with drug court? □ Yes □ No
If yes, describe (*i.e. indicate which drug court or to whom reports should be submitted*): _____

Legal History

Legal History: □ None
Has person ever been in juvenile detention, incarcerated, or in prison? □ Yes □ No
If yes, when and for what?

Arrest History

□ None □ Public Drunkenness □ DUI □ Drug Violation □ Other-A&D Offense □ Other-not A&D Related   □ Child Abuse □ Elder Abuse □ Domestic Violence □ DUIs □ Fraudulent use of a credit card □ Minor in possession □ Public Intoxication □ Rape □ Receiving stolen property □ Robbery □ Shoplifting □ Sexual Offender Crimes □ Theft of Property □ Unknown
Any History of violating probation? □ Yes □ No   If yes, how did you violate?
Is this admission the result of a Criminal Justice referral? If yes, identify referral source below: □ State/fed. Court □ Formal adjudication □ Probation/Parole □ Other legal entity □ Diversionary Program □ Prison □ DUI □ Other □ Unknown □ Not applicable
DUI Offender? □First time □2nd Offense □3+Offenses □Not applicable
DUI Offender for substance(s) other than alcohol? □Yes □No, if "yes", notate type of substance.
Is the person's driver's license currently suspended? □Yes □No
If yes, was the person enrolled in or referred to a certified DUI Treatment Program?   □Yes □No
Has the DUI assessment process been explained to the person? □Yes   □No
Is the person interested in participating in DUI services? □Yes □No □ Unknown
Name of person to whom reports should be submitted: Type of reports: _____

TREATMENT FORMULATION & SUMMARY (RISK RATING)

Risk Rating: In the 0-4 rating system, the higher number indicates a greater level of intensity.
0= Indication full functioning – no severity and no risk in this dimension
1= Indicates mildly difficult issue or minor signs and symptoms. Issues will be able to be resolved in a short period of time.
2= Indicates moderate difficulty in functioning. Although there is a moderate impairment and persistent chronic issues, person has relevant skills, or support systems may be present.
Note: A Risk Rating of 2 or higher in Dimension 3 requires a Risk Rating score in MH Dimensions 4,5, & 6
3= Indicates a serious issue or difficulty coping. An person presenting at this level of risk maybe considered nearing "imminent danger."
4= Indicates issues of utmost severity. An person presenting at this level present with critical impairments in coping and functioning, with signs and symptoms, indicating an "imminent danger" concern, which will require immediate services.

DIMENSION 1. ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL

☐ Currently intoxicated
☐ Moderate to severe signs and symptoms of intoxication
☐ Moderate to severe signs and symptoms of withdrawal
☐ History of withdrawal problems
☐ Frequent and recent use
☐ Increased or heavy quantities of use
☐ Unreliable or no one available in living environment to assistance with withdrawal management

Comments:

SA: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4

DIMENSION 2. BIOMEDICAL CONDITIONS AND COMPLICATIONS

☐ Acute medical condition
☐ Positive pregnancy status (in need of prenatal care)
☐ Chronic medical condition
☐ Medical/nursing observation and management needed
☐ Medication Management problems
☐ Impediments to treatment and recovery

Comments:

RISK RATING: ☐N/A-Don't have a Substance Abuse Disorder ☐0 ☐1 ☐2 ☐3 ☐4

DIMENSION 3. EMOTIONAL, BEHAVIORAL, OR COGNITIVE CONDITIONS AND COMPLICATIONS

☐ Violence potential
☐ Danger to self or others
☐ Cognitive/Intellectual functioning problems
☐ Other major Mental Health Disorder problems
☐ Co-Occurring Disorders (MH & SUD)
☐ Personality Disorders

Risk Domains: Assess the person's five (5) Risk Domains. Circle all that apply: 1) Danger/Lethality 2) Interference with Addiction and/or Recovery Efforts 3) Social Functioning 4) Ability for Self-Care 5) Course of Illness

Comments: (Include detail information on the five Risk Domains determined to be a barrier/hinderance for person.)

SA: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4   **MH**: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4

DIMENSION 4. READINESS TO CHANGE

☐ Lack of understanding or awareness of problem
☐ No real interest in changing
☐ Not open to family involvement in treatment
☐ Unwillingness to cut ties with negative influences
☐ Commitment concerns
☐ Limited or no personal recovery goals
☐ Little to no involvement in self-help/support groups
☐ Poor indication of one's ability to follow through on plan/need for change

Comments:

SA: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4 ☐A ☐B   **MH**: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4 ☐A ☐B

DIMENSION 5. RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL

☐ Little involvement/engagement in recovery
☐ Inability to recognize relapse triggers
☐ Challenges with resisting cravings/impulses for longer periods of time
☐ Little to no adherence to medical guidance or medication requirements
☐ SUD: 2 or more SUD diagnosis, recent use, multiple substance user, or legal issues caused by SUD
☐ MH: Moderate to unstable MH problems

Comments:

SA: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4 ☐A ☐B   **MH**: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4 ☐A ☐B

DIMENSION 6. RECOVERY/LIVING ENVIRONMENT

Psychological Environment Issues: *(the more boxes checked, the higher the risk rating score)*
☐ Problems with primary support group
☐ Education problems
☐ Housing problems
☐ Legal problems
☐ Other psychological and environmental problems
☐ Problems related to social environment
☐ Occupational problems
☐ Economic problems
☐ Problems with access to health care or no health care
☐ Demographical risk factors (i.e., under 25 yrs. old, never married, unemployed, no high school diploma/GED

Functional Limitations and Barriers: *(check major life areas affected as indicated on the DLA-20/Approved Functional Assessment)*
☐ 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.)

Comments: Provide a detailed summary of all Dimensions (Include Person's presenting problem, referral source, overall Needs, Strengths, Barriers and Personal Preferences)

SA: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4 ☐A ☐B   **MH**: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4 ☐A ☐B

Initial Diagnostic Impression	
Mental Health Disorders:	**Codes & Description:**
Substance Use Disorders:	**Codes & Description:**
Other (Medical Issues):	

Disposition (Assessed Level of Care): ____
Select the Level of Care placement number that offer the most appropriate level of care/service that can provide the service intensity needed to address the person's current functioning/severity; and/or the service needed. Reference Guidance document for further explanation.

Admitted to (received):	Referral to (indicated):

Discrepancy in Level of Care indicated vs admission? Provide an explanation for any discrepancies between the level of care indicated and received. Possible Reasons: ☐service not available ☐provider judgement ☐person preference ☐person is on waiting list for appropriate level of care ☐service available but no payment source ☐geographic accessibility ☐family responsibility ☐language barrier ☐not listed (specify reason if examples are not fitting).

Anticipated Outcome (If service cannot be provided): Select one - ☐Risk admission into an acute care setting; ☐Risk discharge to street; ☐Risk continued stay in acute care facility; ☐Risk incarceration ☐Person may drop out/leave AMA until next crisis; ☐Other (Specify):

SIGNATURES / CREDENTIALS

X _____ Date: Person Signature *"I acknowledge I have participated in this assessment and the questions were presented in a language I could understand".*	X _____ Date: Clinician Signature
X _____ Date: Parent/Legal Representative Signature *"I acknowledge I have participated in this assessment and the questions were presented in a language I could understand".*	X _____ Date: Signature

Level of Care Placement Assessment
Non-Comprehensive

Name: _____

ID Number: _____

Initial Assessment Date: _____

Admission Date: _____

Time In: _____ Time Out: _____ Total Time: _____

Informant: ☐ Person Receiving Services ☐ Other: Relationship to Person_____

PLACEMENT ASSESSMENT

DIMENSION 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL

Does the person appear to be intoxicated or experiencing withdrawal at the time of assessment? ☐Yes ☐No
If yes, assess the person's intoxication, withdrawal potential, and living environment risk factors below:

Intoxication	Current Intoxication: ☐None ☐Mildly ☐Very ☐Extremely
	Physical Signs and Symptoms of Intoxication: *(indication of vital signs, gait, speech, coordination)* ☐Normal ☐Mild ☐Moderate ☐Severe ☐Life Threatening
	Mental Signs and Symptoms of Intoxication: ☐Oriented, alert, normal mental functioning ☐Mild disturbance of mood, cognition, function ☐Moderate disturbance of mood, cognition, function ☐Severe disturbance of mood, cognition, function ☐Life Threatening, disoriented, clouded consciousness, or psychotic
Withdrawal Potential	Physical Signs and Symptoms of Withdrawal: *(vital signs, tremor, sweats, Central Nervous System or Gastrointestinal Intestinal problems)* ☐Normal ☐Mild ☐Moderate ☐Severe ☐Life Threatening
	Mental Signs and Symptoms of Withdrawal: ☐Oriented, alert, normal mental functioning ☐Mild anxiety, agitation, depression, dysfunction ☐Moderate anxiety, agitation, depression, dysfunction ☐Severe anxiety, agitation, depression, dysfunction ☐Life Threatening, suicidal, psychotic, disoriented, hallucinating
	History of Withdrawal Problems: ☐No prior history of withdrawal problems ☐History of minor problems ☐History of moderate problems ☐History of severe problems ☐History of Life-Threatening withdrawal problems
Modifications Needed	Ability to cope/tolerate current intoxication or withdrawal symptoms: ☐Fully ☐Mild difficulty ☐Moderate difficulty ☐Severe difficulty ☐Unable to tolerate or cope
	Current living environment supportive of person and his/her Withdrawal Management needs: ☐Full assistance ☐Some/partial assistance ☐Unreliable ☐No one to assist ☐Toxic

Have you ever been treated for an Alcohol or Drug use/problem? ☐Yes ☐No

If answered yes to the Substance Use question above, gather additional information and summarize (the onset, possible causes, duration, intensity & fluctuations of severity):

Prior Treatment for Substance Use Disorder?

00 = None   01 = 1 Previous   02 = 2 Previous   03 = Unknown

If 1 or 2 (Previous) is indicated above, provide more details.
When: _____   Where: _____

Level of Care (i.e., Detox Only, Intensive Outpatient, Outpatient, Residential, Hospital Inpatient): _____

Type of Discharge (*Did they complete treatment?*) _____

Optional for MH reporting

Is the person receiving **Medication-Assisted Opioid Therapy**: ☐Yes ☐No ☐Not Applicable

*Is the person interested in receiving MAT services? ☐Yes ☐No

Is the person receiving **Methadone**: ☐Yes ☐No ☐Not Applicable ☐Not Collected (for MH-only persons)

Current Substance Problem Code (Detailed Drug Code)
Indicate one (1) detailed drug code in Primary, Secondary, and/or Tertiary Substance Use Code (as applicable) below:
*Reference the DMH website for complete code list: http://www.dmh.ms.gov/wp-content/uploads/2020/04/MS-DMH-DW-Data-Set-Code-Values_03182021.pdf

		Substance Use I Code _____
Primary	*Route of Administration:*	☐ Oral ☐ Smoking ☐ Inhalation ☐ Injection *(priority population)* ☐ Suppositories ☐ Other ☐ Unknown ☐ NA
	Frequency of Recent Use	(At the time you were using the substance, what was your frequency? ☐ No use past month ☐ 1-3x past month ☐ 1-2x week past month ☐ 3-6s week past month ☐ 1x daily past month ☐ 2-3x daily past month ☐ 4+x daily past month ☐ Unknown ☐ NA
	Age at First Use:	Age at first use of Problem Substance I:
		Substance Use II Code _____
Secondary	*Route of Administration:*	☐ Oral ☐ Smoking ☐ Inhalation ☐ Injection *(priority population)* ☐ Suppositories ☐ Other ☐ Unknown ☐ NA
	Frequency of Recent Use	(At the time you were using the substance, what was your frequency? ☐ No use past month ☐ 1-3x past month ☐ 1-2x week past month ☐ 3-6s week past month ☐ 1x daily past month ☐ 2-3x daily past month ☐ 4+x daily past month ☐ Unknown ☐ NA
	Age at First Use	Age at first use of Problem Substance II:
		Substance Use III Code _____
Tertiary	*Route of Administration:*	☐ Oral ☐ Smoking ☐ Inhalation ☐ Injection *(priority population)* ☐ Suppositories ☐ Other ☐ Unknown ☐ NA
	Frequency of Recent Use	(At the time you were using the substance, what was your frequency? ☐ No use past month ☐ 1-3x past month ☐ 1-2x week past month ☐ 3-6s week past month ☐ 1x daily past month ☐ 2-3x daily past month ☐ 4+x daily past month ☐ Unknown ☐ NA

	Age at First Use	Age at first use of Problem Substance III:
Other Drug Use		**List Other Drug Use Code** ____
	Route of Administration:	☐ Oral ☐ Smoking ☐ Inhalation ☐ Injection *(priority population)* ☐ Suppositories ☐ Other ☐ Unknown ☐ NA
	Frequency of Recent Use	(At the time you were using the substance, what was your frequency? ☐ No use past month ☐ 1-3x past month ☐ 1-2x week past month ☐ 3-6s week past month ☐ 1x daily past month ☐ 2-3x daily past month ☐ 4+x daily past month ☐ Unknown ☐ NA
	Age at First Use	Age at first use of Problem Substance:

How much money would you say you've spent on substances during the past 30 days?

Family History of Alcohol and/or Other Drugs:

Person Nicotine Use:

☐ Smoke ☐ Oral (*tobacco*) ☐ Vape ☐ Nicotine Gum
Age of first use:

Frequency of Use:

☐ Current every day ☐ Current someday ☐ Former smoker ☐ Never smoked ☐ Smoker, status unknown

DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS

Person Sexual Orientation:	How does person want to be identified? ☐ Heterosexual ☐ Homosexual ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Transgender ☐ Queer ☐ Questioning ☐ Other _____ Would you like to address your sexuality during treatment? ☐ Yes ☐ No (If yes, explain)

Person Pregnant *(priority population)* at time of this Initial Assessment? ☐ Yes ☐ No ☐ Not applicable (males)

If yes, how many weeks (gestation): _____
If yes, is person receiving prenatal care? ☐ Yes ☐ No (If yes, obtain consent and/or ask for physician information)

Surgeries (type of surgery and dates):

DIMENSION 3: EMOTIONAL, BEHAVIORAL, OR COGNITIVE CONDITIONS AND COMPLICATIONS. (Mental Health)

Do you feel you have any current Mental Health Needs that you would like to address? ☐ Yes ☐ No If yes, please describe.

Do you have any problems with remembering, concentration or following simple instructions? ☐ Yes (If yes, explain) ☐ No

In the last year have you experienced hallucinations or difficulty telling what is real from what is not real? (auditory, visual, olfactory, tactile) ☐ Yes (If yes, explain) ☐ No

Do you currently or have a history of mood changes? ☐ Yes (If yes, explain) ☐ No

Do you currently or have a history of depression? ☐ Yes (If yes, explain) ☐ No

Do you currently or have a history of anxiety? □ Yes (If yes, explain) □ No	

Do you take medication for any of the above? □ Yes (If yes, what medications) □ No (NOTE: Medication information can be gathered separately on the Medication/Emergency Contact form.)

Have you ever been diagnosed with anything not listed above? (i.e., eating disorder, significant weight gain or loss in the past 6 months) □ Yes (If yes, what is your diagnosis, and have you been treated?) □ No

The collection of a Brief Trauma History is required at Intake (Next three-3 questions below). If person answer "yes" to any of the questions below the full DMH Trauma History Questionnaire or an alternate (DMH approved) Trauma Assessment is required within 30 days of Admission.

Do you have trauma concerns that you wish to address during this experience? □ Yes □ No

Have you ever experienced any of the following? □ Yes □ No (select one) □ Physical Abuse □ Emotional Abuse □ Sexual Abuse □ Neglect □ Domestic Violence □ Military Service □ Natural Disaster □ Other

Have you ever received treatment for Trauma or Post Traumatic Stress Disorder? □ Yes □ No If yes, When: _____   Where: _____ Level of Care (i.e., Intensive Outpatient, Outpatient, Residential, Hospital Inpatient): _____

DIMENSION 4: READINESS TO CHANGE (*formerly referenced as Stages of Change*)
(Note: An person maybe ready to change one issue, but no interest or readiness to change another issue. The rating below can be specific to one substance, multiple substances, or an overall issue. Providers are permitted to use an alternate (DMH approved) Readiness to Change assessment tool for this Dimension.

Readiness to Address: (Mental Health or General)	Do you think you have a problem/issue with alcohol or drugs and/or an emotional or mental health disorder? □ yes □ no If yes, explain:
	Is there anything you need to change or would like to change? (i.e., medication compliance, criminal activity, fight, cursing, impatience, procrastination, relationships, social engagement, road rage)? □ yes □ no If yes, explain:
	How important is it to you to make this change, on a scale of 0 to 10 with 10 being extremely important?
	How confident are you that you can make this change, on a scale of 0 to 10 with 10 being extremely confident?
Readiness to Address: (Substance Use)	Have you tried to hide your use? □ yes □ no If yes, which substance:
	Has anyone ever complained about your use? (6) □ yes □ no If yes, explain:
	Has your use caused you to feel depressed, nervous, and suspicious, have decreased sexual desire, diminished your interest in normal activities or caused other psychological problems? (9) □ yes □ no If yes, explain:
	Has your use affected your health in any way by causing numbness, blackouts, shakes, tingling, contracting TB, STD's or other health related problems? (8) (11) □ yes □ no If yes, explain:
	Have you continued to use despite negative consequences at work, school, or home? (5) □ yes □ no If yes, explain:
	Have you had cravings or a strong desire to use alcohol or drugs? (4) □ yes □ no If yes, explain:
	Have you had problems with the law because of your use? (6) □ yes □ no If yes, explain:
	Has your use affected socially (i.e. fights, problem relationships, etc.? (6) □ yes □ no If yes, explain:

	Do you need more of the substance to get high? *(10)* □ yes □ no If yes, explain:
	Do you spend a great deal of time in activities to obtain the substance and/or feel its affects? *(3)* □ yes □ no If yes, explain:
	Has your use caused you to give up or not participate in school, occupational, or recreational/social activities you once enjoyed? *(7)* □ yes □ no If yes, explain:
	Have you continued to use knowing it caused or contributed to physical and/or psychological problems? *(9)* □ yes □ no If yes, explain:
	Have you used large amounts than you intended or for longer than you intended? *(1)* □ yes □ no If yes, explain:
	Have you continued to use despite placing yourself and others in dangerous or unsafe situations? *(8)* □ yes □ no If yes, explain:
	Have you attempted to cut down or control your use of alcohol/drugs without success? *(2)* □ yes □ no If yes, explain:

DIMENSION 5: RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL
(Note: Varies elements in this section may not be applicable to younger children. Indicate "not applicable-younger child" in those instances. Some elements may not be applicable to MH ONLY persons. Indicate "not applicable-MH".

Longest Length of Stability (maintaining one's Mental Health Disorder or Substance Use Disorder): Have you ever stopped taking your medication against doctor's orders? □ yes □ no   If maintained for any period of time, how long were you able to maintain?

What was your longest period of abstinence? If any, from using substance(s)?

How was abstinence maintained? If maintained for any period of time, from using substance(s)?

What would you consider your relapse triggers?

Describe your support network. (i.e., sponsor, peer support, community support services, etc.) If supports were identified, when was their last contact?

Have you ever participated in self-help meetings? □ yes □ no   If yes, what type?

Person's Recovery (Self-Help) Group Attendance Frequency: □ No attendance □ Less than once WK 1-3X past 30 days □ About once a week 4-7X past 30 days □ 2-3X per week/8-15X past 30 days □ At least 4X week/16-30X past 30 days □ Some Attendance-number of times/frequencies is unknown

On a scale of 1-5, how important is receiving Substance Use Treatment or receiving Mental Health Services to you now? (5 being most important)

When you were once in the Maintenance Stage of Change, what was your longest period of maintaining (socially acceptable behaviors, healthy functioning, etc.)?

DIMENSION 6: RECOVERY/LIVING ENVIRONMENT
(Note: Varies elements in this section may not be applicable to younger children. Indicate "not applicable-younger child" in those instances.

Immediate Household/Family Configuration

Is your living environment drug free? □ Yes □ No

Is your living environment alcohol free? □ Yes □ No

Is your living environment supportive of maintaining a positive Mental Health wellbeing? □ Yes □ No

If not, explain: (If answered "no", do the person perceive it to be a problem for their recovery efforts?

Does anyone in your household have a mental health or substance use disorder/diagnosis?

If so, who? Is their disorder/diagnosis being managed?

Legal History

Legal History: □ None □ Yes

Has person ever been in juvenile detention, incarcerated, or in prison? □ Yes □ No

If yes, when and for what?

Arrest History

□ None □ Public Drunkenness □ DUI □ Drug Violation □ Other-A&D Offense □ Other-not A&D Related   □ Child Abuse □ Elder Abuse □ Domestic Violence □ DUIs □ Fraudulent use of a credit card □ Minor in possession □ Public Intoxication □ Rape □ Receiving stolen property □ Robbery □ Shoplifting □ Sexual Offender Crimes □ Theft of Property □ Unknown

Any History of violating probation? □ Yes □ No   If yes, how did you violate?

Is this assessment the result of a Criminal Justice referral?

If yes, identify referral source below:

□ State/fed. Court □ Formal adjudication □ Probation/Parole □ Other legal entity □ Diversionary Program □ Prison □ DUI □ Other □ Unknown □ Not applicable

DUI Offender? □First time □2nd Offense □3+Offenses □Not applicable

DUI Offender for substance(s) other than alcohol? □Yes □No, if "yes", notate type of substance.

Is the person's driver's license currently suspended? □Yes □No

If yes, was the person enrolled in or referred to a certified DUI Treatment Program?   □Yes □No

Has the DUI assessment process been explained to the person? □Yes   □No

Is the person interested in participating in DUI services? □Yes □No □ Unknown

Name of person to whom reports should be submitted:

Type of reports: _____

TREATMENT FORMULATION & SUMMARY (RISK RATING)

Risk Rating: In the 0-4 rating system, the higher number indicates a greater level of intensity.
0= Indication full functioning – no severity and no risk in this dimension
1= Indicates mildly difficult issue or minor signs and symptoms. Issues will be able to be resolved in a short period of time.
2= Indicates moderate difficulty in functioning. Although there is a moderate impairment and persistent chronic issues, person has relevant skills, or support systems may be present.
Note: A Risk Rating of 2 or higher in Dimension 3 requires a Risk Rating score in MH Dimensions 4,5, & 6
3= Indicates a serious issue or difficulty coping. An person presenting at this level of risk maybe considered nearing "imminent danger."
4= Indicates issues of utmost severity. An person presenting at this level present with critical impairments in coping and functioning, with signs and symptoms, indicating an "imminent danger" concern, which will require immediate services.
Note: A Risk Rating of 4 in Substance Use Dimensions 4, 5, & 6 requires a Sub-Risk Rating Score of A or B.
Sub-Risk Rating A: indicates there is no immediate action required. No engagement or motivational enhancement strategies or services are needed to be mentioned in the Treatment Plan

DIMENSION 1. ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL

☐ Currently intoxicated
☐ Moderate to severe signs and symptoms of intoxication
☐ Moderate to severe signs and symptoms of withdrawal
☐ History of withdrawal problems
☐ Frequent and recent use
☐ Increased or heavy quantities of use
☐ Unreliable or no one available in living environment to assistance with withdrawal management

Comments:

SA: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4

DIMENSION 2. BIOMEDICAL CONDITIONS AND COMPLICATIONS

☐ Acute medical condition
☐ Positive pregnancy status (in need of prenatal care)
☐ Chronic medical condition
☐ Medical/nursing observation and management needed
☐ Medication Management problems
☐ Impediments to treatment and recovery

Comments:

SA: RISK RATING: ☐N/A-Don't have a Substance Abuse Disorder ☐0 ☐1 ☐2 ☐3 ☐4
MH: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4

DIMENSION 3. EMOTIONAL, BEHAVIORAL, OR COGNITIVE CONDITIONS AND COMPLICATIONS

☐ Violence potential
☐ Danger to self or others
☐ Cognitive/Intellectual functioning problems
☐ Other major Mental Health Disorder problems
☐ Co-Occurring Disorders (MH & SUD)
☐ Personality Disorders

Risk Domains: Assess the person's five (5) Risk Domains. Circle all that apply: 1) Danger/Lethality 2) Interference with Addiction and/or Recovery Efforts 3) Social Functioning 4) Ability for Self-Care 5) Course of Illness

Comments: (Include detail information on the five Risk Domains determined to be a barrier/hinderance for person.
Include clinician's overall impression of the person: orientation, speech, memory, self-concept, impression, and other.)

SA: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4   **MH**: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4

DIMENSION 4. READINESS TO CHANGE

☐ Lack of understanding or awareness of problem
☐ No real interest in changing
☐ Not open to family involvement in treatment
☐ Unwillingness to cut ties with negative influences
☐ Commitment concerns
☐ Limited or no personal recovery goals
☐ Little to no involvement in self-help/support groups
☐ Poor indication of one's ability to follow through on plan/need for change

Comments:

SA: RISK RATING: □0 □1 □2 □3 □4　□A □B　**MH**: RISK RATING: □0 □1 □2 □3 □4　□A □B

DIMENSION 5.　RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL

　　　　□ Little involvement/engagement in recovery
　　　　□ Inability to recognize relapse triggers
　　　　□ Challenges with resisting cravings/impulses for longer periods of time
　　　　□ Little to no adherence to medical guidance or medication requirements
　　　　□ SUD: 2 or more SUD diagnosis, recent use, multiple substance user, or legal issues caused by SUD

　□ MH: Moderate to unstable MH problems

Comments:

SA: RISK RATING: □0 □1 □2 □3 □4　□A □B　**MH**: RISK RATING: □0 □1 □2 □3 □4　□A □B

DIMENSION 6.　RECOVERY/LIVING ENVIRONMENT

Psychological Environment Issues: *(the more boxes checked, the higher the risk rating score)*
　　　　□ Problems with primary support group
　　　　□ Education problems
　　　　□ Housing problems
　　　　□ Legal problems
　　　　□ Other psychological and environmental problems
　　　　□ Problems related to social environment
　　　　□ Occupational problems
　　　　□ Economic problems
　　　　□ Problems with access to health care or no health care
　　　　□ Demographical risk factors (i.e. under 25 yrs. old, never married, unemployed, no high school diploma/GED

Functional Limitations and Barriers: *(check major life areas affected as indicated on the DLA-20/Approved Functional Assessment)*
　　　　□ 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.)

Comments: Provide a detailed summary of all Dimensions (Include Person's presenting problem, referral source, overall Needs, Strengths, Barriers and Personal Preferences)

SA: RISK RATING: □0 □1 □2 □3 □4　□A □B　**MH**: RISK RATING: □0 □1 □2 □3 □4　□A □B

Initial Diagnostic Impression	
Mental Health Disorders:	**Codes & Description:**
Substance Use Disorders:	**Codes & Description:**
Other (Medical Issues):	

Disposition (Assessed Level of Care): _____

Select the Level of Care placement number that offer the most appropriate level of care/service that can provide the service intensity needed to address the person's current functioning/severity; and/or the service needed. Reference Guidance document for further explanation.

Admitted to (received):	Referral to (indicated):

Discrepancy in Level of Care indicated vs admission? Provide an explanation for any discrepancies between the level of care indicated and received. Possible Reasons: ☐service not available ☐provider judgement ☐person preference ☐person is on waiting list for appropriate level of care ☐service available but no payment source ☐geographic accessibility ☐family responsibility ☐language barrier ☐not listed (specify reason if examples are not fitting).

Anticipated Outcome (If service cannot be provided): Select one - ☐Risk admission into an acute care setting; ☐Risk discharge to street; ☐Risk continued stay in acute care facility; ☐Risk incarceration ☐Person may drop out/leave AMA until next crisis; ☐Other (Specify):

SIGNATURES / CREDENTIALS

X _____ Date:
    Person Signature
"I acknowledge I have participated in this assessment and the questions were presented in a language I could understand".
	X _____ Date:
	    Clinician Signature

X _____ Date:
    Parent/Legal Representative Signature
"I acknowledge I have participated in this assessment and the questions were presented in a language I could understand".
	X _____ Date:
	    Signature

Placement Profile

The Placement Profile for Subsequent Assessments is a guide for what should be captured in the Re-Assessment Progress Note or Re-Assessment Tool developed by the agency. Benchmarks for reassessments depend on the Level of Care the client is placed. Individuals placed in a residential setting (Level 3.1 or higher) must be re-assessed at minimum every fourteen (14) days to ensure level of care appropriateness. Individuals placed in an Intensive Outpatient setting (Level 2.1) must be re-assessed at minimum every thirty (30) days to ensure level of care appropriateness. Individuals placed in an Outpatient setting (Level 1) must be re-assessed at minimum every ninety (90) days to ensure level of care appropriateness.

Indicate the Risk Rating Level, area(s) requiring immediate attention, and/or area(s) of concern to be addressed for each dimension. Indicate if there was a change in the individual's treatment plan, medication, or diagnosis. If there haven't been any changes since the client's prior assessment no explanation needed. Indicate "No change" in those instances.

	2nd ASMT	3rd ASMT	4th ASMT	5th ASMT	6th ASMT	7th ASMT
1. **Intoxication/Withdrawal** **SA**: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4 ☐No Change						
2. **Biomedical Conditions/Complications** **SA**: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4 ☐No Change						
3. **Emotional/Behavioral/Cognitive** *Address changes in MH Risk Domains 1-5:* **SA**: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4 ☐No Change **MH**: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4 ☐No Change						
4. **Readiness to Change** **SA**: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4 ☐No Change **MH**: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4 ☐No Change						
5. **Relapse/Cont. Use/Problem Potential** **SA**: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4 ☐No Change **MH**: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4 ☐No Change						
6. **Recovery Environment** **SA**: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4 ☐No Change **MH**: RISK RATING: ☐0 ☐1 ☐2 ☐3 ☐4 ☐No Change						
Notate ANY **Diagnostic Changes** since initial or prior assessment:						
Treatment Formulation Summary: Risk Rating *(provide a summary for any increases/decreases in risk rating scores)*						
Date of Re-Assessment:						
Level of Care Indicated (referred to):						
Level of Care Received (admitted to):						
Explanation for any discrepancies between the level of care indicated and received (If applicable):						
Anticipated Outcome (If service cannot be provided): Select one - ☐Risk admission into an acute care setting; ☐Risk discharge to street; ☐Risk continued stay in acute care facility; ☐Risk incarceration ☐Client may drop out/leave AMA until next crisis; ☐Other (Specify):						

Level of Care Placement *Addendum*	Name: _____
	ID Number: _____
	Initial Assessment Date: _____
	Admission Date: _____
	Time In: Time Out: Total Time:

Informant: ☐ Person Receiving Services   ☐ Other: Relationship to Person_____

Does the person seeking services meet the DMH Codependent Status? (seeking services based on the mental health or substance use, behavioral problems, of another person, and it is affecting them negatively?) ☐Yes   ☐No   If Yes, Explain:

PLACEMENT ADDENDUM

DIMENSION 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL

Prior Treatment for Substance Use Disorder?

00 = None   01 = 1 Previous   02 = 2 Previous   03 = Unknown

If 1 or 2 (Previous) is indicated above, provide more details.
When: _____   Where: _____

Level of Care (i.e., Detox Only, Intensive Outpatient, Outpatient, Residential, Hospital Inpatient): _____

Type of Discharge (*Did they complete treatment?*) _____

Is the person receiving **Medication-Assisted Opioid Therapy**: ☐Yes ☐No ☐Not Applicable

*Is the person interested in receiving MAT services? ☐Yes ☐No

Is the person receiving **Methadone**: ☐Yes ☐No ☐Not Applicable ☐Not Collected (for MH-only persons)

Current Substance Problem Code (Detailed Drug Code)
Indicate one (1) detailed drug code in Primary, Secondary, and/or Tertiary Substance Use Code (as applicable) below:
*Reference the DMH website for complete code list: http://www.dmh.ms.gov/wp-content/uploads/2020/04/MS-DMH-DW-Data-Set-Code-Values_03182021.pdf

		Substance Use I Code _____
Primary	*Route of Administration:*	☐ Oral ☐ Smoking ☐ Inhalation ☐ Injection *(priority population)* ☐ Suppositories ☐ Other ☐ Unknown ☐ NA
	Frequency of Recent Use	(At the time you were using the substance, what was your frequency? ☐ No use past month ☐ 1-3x past month ☐ 1-2x week past month ☐ 3-6s week past month ☐ 1x daily past month ☐ 2-3x daily past month ☐ 4+x daily past month ☐ Unknown ☐ NA
	Age at First Use:	Age at first use of Problem Substance I:
		Substance Use II Code _____
Secondary	*Route of Administration:*	☐ Oral ☐ Smoking ☐ Inhalation ☐ Injection *(priority population)* ☐ Suppositories ☐ Other ☐ Unknown ☐ NA

	Frequency of Recent Use	(At the time you were using the substance, what was your frequency? ☐ No use past month ☐ 1-3x past month ☐ 1-2x week past month ☐ 3-6s week past month ☐ 1x daily past month ☐ 2-3x daily past month ☐ 4+x daily past month ☐ Unknown ☐ NA
	Age at First Use	Age at first use of Problem Substance II:
Tertiary	**Substance Use III Code _____**	
	Route of Administration:	☐ Oral ☐ Smoking ☐ Inhalation ☐ Injection *(priority population)* ☐ Suppositories ☐ Other ☐ Unknown ☐ NA
	Frequency of Recent Use	(At the time you were using the substance, what was your frequency? ☐ No use past month ☐ 1-3x past month ☐ 1-2x week past month ☐ 3-6s week past month ☐ 1x daily past month ☐ 2-3x daily past month ☐ 4+x daily past month ☐ Unknown ☐ NA
	Age at First Use	Age at first use of Problem Substance III:
Other Drug Use	**List Other Drug Use Code _____**	
	Route of Administration:	☐ Oral ☐ Smoking ☐ Inhalation ☐ Injection *(priority population)* ☐ Suppositories ☐ Other ☐ Unknown ☐ NA
	Frequency of Recent Use	(At the time you were using the substance, what was your frequency? ☐ No use past month ☐ 1-3x past month ☐ 1-2x week past month ☐ 3-6s week past month ☐ 1x daily past month ☐ 2-3x daily past month ☐ 4+x daily past month ☐ Unknown ☐ NA
	Age at First Use	Age at first use of Problem Substance:

How much money would you say you've spent on substances during the past 30 days?

Family History of Alcohol and/or Other Drugs:

Person Nicotine Use:

☐ Smoke ☐ Oral (*tobacco*) ☐ Vape ☐ Nicotine Gum
Age of first use:

Frequency of Use:

☐ Current every day ☐ Current someday ☐ Former smoker ☐ Never smoked ☐ Smoker, status unknown

DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS

Person Sexual Orientation:	How does person want to be identified? ☐ Heterosexual ☐ Homosexual ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Transgender ☐ Queer ☐ Questioning ☐ Other _____ Would you like to address your sexuality during treatment? ☐ Yes ☐ No (If yes, explain)

Person Pregnant *(priority population)* at time of this Initial Assessment? ☐ Yes ☐ No ☐ Not applicable (males)

If yes, how many weeks (gestation): _____
If yes, is person receiving prenatal care? ☐ Yes ☐ No (If yes, obtain consent and/or ask for physician information)

DIMENSION 3: EMOTIONAL, BEHAVIORAL, OR COGNITIVE CONDITIONS AND COMPLICATIONS. (Mental Health)

The collection of a Brief Trauma History is required at Intake (Next three-3 questions below). If person answer "yes" to any of the questions below the full DMH Trauma History Questionnaire or an alternate (DMH approved) Trauma Assessment is required within 30 days of Admission.

Do you have trauma concerns that you wish to address during this experience? □ Yes □ No

Have you ever experienced any of the following? □ Yes □ No (select one)
□ Physical Abuse □ Emotional Abuse □ Sexual Abuse □ Neglect □ Domestic Violence □ Military Service □ Natural Disaster □ Other

Have you ever received treatment for Trauma or Post Traumatic Stress Disorder? □ Yes □ No   If yes,

When: _____   Where: _____
Level of Care (i.e., Intensive Outpatient, Outpatient, Residential, Hospital Inpatient): _____

DIMENSION 6: RECOVERY/LIVING ENVIRONMENT
(Note: Varies elements in this section may not be applicable to younger children. Indicate "not applicable-younger child" in those instances.

Does the person meet the DMH "Parenting" Classification? □ Yes *(if yes, list the age(s) of dependent(s)* □ No
(Parenting - Mother or Father of dependent(s) under the age of five; and their dependent(s) will be accompanying them in the agency's Residential Treatment program the current treatment experience.)

EDUCATION

Select the person's current or highest level of education completed:
□ None, never attended grade school □ Kindergarten □ 1st Grade □ 2nd Grade □ 3rd Grade □ 4th Grade □ 5th Grade □ 6th Grade □ 7th Grade □ 8th Grade □ 9th Grade □ 10th Grade □ 11th Grade □ 12th Grade □ High School Graduate or GED □ 1-year of College □ 2-years of College or Associates Degree □ 3-years of College □ Bachelor's degree □ Some Post Graduate Study □ Master's degree □ Graduate or Professional School (Doctoral Study, Med School, Law School, etc.) □ Technical Trade School

Legal History

Legal History: □ None

Has the person ever been in a juvenile detention, jail, or prison? □ Yes □ No If yes, when?

Arrest History

□ None □ Public Drunkenness □ DUI □ Drug Violation □ Other-A&D Offense □ Other-not A&D Related □ Child Abuse □ Elder Abuse □ Domestic Violence □ DUIs □ Fraudulent use of a credit card □ Minor in possession □ Public Intoxication □ Rape □ Receiving stolen property □ Robbery □ Shoplifting □ Sexual Offender Crimes □ Theft of Property □ Unknown

Any History of violating probation? □ Yes □ No   If yes, how did you violate?

Is this assessment the result of a Criminal Justice referral?

If yes, identify referral source below:

□ State/fed. Court □ Formal adjudication □ Probation/Parole □ Other legal entity □ Diversionary Program □ Prison □ DUI □ Other □ Unknown □ Not applicable

DUI Offender? □First time □2nd Offense □3+Offenses □Not applicable

DUI Offender for substance(s) other than alcohol? □Yes □No, if "yes", notate type of substance.

Is the person's driver's license currently suspended? ☐Yes ☐No
If yes, was the person enrolled in or referred to a certified DUI Treatment Program?   ☐Yes ☐No
Has the DUI assessment process been explained to the person? ☐Yes   ☐No
Is the person interested in participating in DUI services? ☐Yes ☐No ☐ Unknown
Name of person to whom reports should be submitted: Type of reports: _____

NARRATIVE SUMMARY
Summary: Person's Needs Strengths Barriers Personal Preferences

Disposition (Assessed Level of Care): ____ *Select the Level of Care placement number that offer the most appropriate level of care/service that can provide the service intensity needed to address the person's current functioning/severity; and/or the service needed. Reference Guidance document for further explanation.*	
Admitted to (received):	**Referral to (indicated):**

Discrepancy in Level of Care indicated vs admission? Provide an explanation for any discrepancies between the level of care indicated and received. Possible Reasons: ☐service not available ☐provider judgement ☐person preference ☐person is on waiting list for appropriate level of care ☐service available but no payment source ☐geographic accessibility ☐family responsibility ☐language barrier ☐not listed (specify reason if examples are not fitting).
Anticipated Outcome (If service cannot be provided): Select one - ☐Risk admission into an acute care setting; ☐Risk discharge to street; ☐Risk continued stay in acute care facility; ☐Risk incarceration ☐Person may drop out/leave AMA until next crisis; ☐Other (Specify):

SIGNATURES / CREDENTIALS
X _____   Date: Clinician Signature

Substance Abuse Problem Type and Detail-June 2021

Class of Substance (Not to be reported in WITS)	Problem Type (report in WITS/Data Warehouse) Primary, Secondary & Tertiary	Problem Detail/Specific Substance (report in WITS/Data Warehouse) Primary, Secondary & Tertiary
None	None - 01	None - 01
Alcohol	Alcohol - 02	Alcohol - 02
Stimulant	Cocaine/Crack - 03	Crack - 03 Other Cocaine - 0302
Cannabis	Marijuana/Hashish - 04	Marijuana/Hashish, THC, and any other Cannabis Sativa preparations - 04
Opioid	Heroin - 05	Heroin/Morphine - 05
Opiate	Non-Prescription Methadone - 06	Non-Prescription Methadone - 06
Other/Opiates and Synthetics	Other/Opiates and Synthetics	Codeine - 0701 Propoxyphene (Darvon) - 0702 Oxycodone (Oxycontin) - 0703 Merperidine (Demerol) - 0704 Hydromorphone (Dilaudid) - 0705 Butorphanol (Stadol), Morphine, (MS Contin), Opium, Other Narcotic Analgesics, Opiates, or Synthetics - 0706 Pentazocine (Talwin) - 0707 Hydrocodone (Vicodin) - 0708 Tramadol (Ultram) - 0709 Buprenorphine (Subutex, Suboxone) - 0710
PCP-Phencyclidine	PCP-Phencyclidine - 08	PCP-Phencyclidine - 08
Hallucinogens	Hallucinogens -09	LSD - 0901 DMT, Mescaline, Peyote, Psilocybin, STP, and other Hallucinogens - 0902
Methamphetamine	Methamphetamine/Speed - 10	Methamphetamine/Speed - 10
Other Amphetamines	Amphetamines - 11	Amphetamines - 11
		Methylenedioxymethamphetamine (MDMA, Esctasy) - 1102 "Bath Salts," Phenmetrazine, and other Amines and Related Drugs - 1109
Other Stimulants	Other Stimulants - 12	Other Stimulants - 12 Methlylphenidate (Ritalin) - 1202
Sedative, Hypnotic, Anxiolytic	Benzodiazepines - 13	Benzodiazepines - 13 Alprazolam (Xanax) - 1301 Chlordiaepoxide (Librium) - 1302 Clorazepate (Tranxene) - 1303 Diazepam (Valium) - 1304 Flurazepam (Dalmane) - 1305

		Halazepam, Oxazepam (Serax), Prazepam, Temazepam (Restoril), and other Benzodiazepines -1308
		Lorazepam (Ativan) - 1306
		Triazolam (Halcion) - 1307
		Halazepam, Oxazepam (Serax), Prazepam, Temazepam (Restoril), and other Benzodiazepines -1308
		Flunitrazepam (Rohypnol) - 1309
		Clonazepam (Klonopin, Rivotril) - 1310
Sedative, Hypnotic, Anxiolytic	Other Tranquilizers - 14	Other Tranquilizers - 14
		Meprobamate (Miltown) - 1401
		Other Non-Benzodiazepines Tranquilizers - 1403
Sedative, Hypnotic, Anxiolytic	Barbiturates - 15	Phenobarbital - 1501
		Secobarbital/Amobarbital (Tuinal) - 1502
		Secobarbital (Seconal) - 1503
		Amobarbital, Pentobarbital (Nembutal), and other Barbiturate Sedatives - 1509
Sedative, Hypnotic, Anxiolytic	Other Non-Barbiturate Sedatives or Hypnotics - 16	Ethchlorvynol (Placidyl) - 1601
		Glutethimide (Doriden) - 1602
		Methaqualone (Quaalude) - 1603
		Chloral Hydrate and other Non-Barbiturate Sedatives/Hypnotics - 1604
Inhalants	Inhalants - 17	Aerosols - 1701
		Nitrites - 1702
		Gasoline, Glue, and other inappropriately inhaled products -1703
		Solvents (paint thinner and other solvents) - 1704
		Anesthetics (chloroform, ether, nitrous oxide) - 1705
Other/Unknown	Over-the-Counter Medications - 18	Diphenhydramine - 1801
		Other Antihistamines, Aspirin, Dextromethorphan (DXM), other Cough Syrups, Ephedrine, Sleep Aids, any other legally obtained non-prescription medication - 1809
Other/Unknown	Other or Other Drugs - 20	Diphenylhydantoin/Phenytoin (Dilantin) - 2001
		Spice, Carisoprodol (Soma), and other drugs - 2002
		GHB/GBL (Gamma-Hydroxybutyrate, Gamma-Butyrolactone) - 2003
		Ketamine (Special K) - 2004
Unknown	Unknown - 97	Unknown - 9997
Not Collected	Not Collected (State does not collect this field) - 98	Not Collected (State does not collect this field) - 9998

Section K
Administrative Information

Disaster Preparedness and Response Guidance Disaster, Fire, and COOP Drills for all Programs

DMH Plan of Compliance Template

Staff Verification of Training on Suspected Abuse or Neglect Reporting Requirements

Incident Reporting Directions and Guidance

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.

Rule 13.9.B   **Agency providers must develop and maintain an Emergency/Disaster Response Plan for each facility/service location that is specific to each certified service location, approved by the governing body, for responding to natural disasters and 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 facility/service location. 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 person 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 persons 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 employees 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 people receiving services, staff, governing authorities, and accrediting and/or licensing entities**

    Outline how you will notify persons 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 people involved (employees and people 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 persons 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 person.

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.

16. **Procedures for post event conditions (i.e., loss of power, telephone service, ability to communicate).**

What are the procedures taken after an event has occurred? Outline conditions that would require an assessment prior to resuming certified services/moving back into the facility. Some events require the development of an after-action report such an evacuation of your facility due to a gas leak (must comply with EMA directives regarding evacuation for gas leaks) or foreseen unsafe conditions such as the aftermath of a hurricane, etc. What are the precautionary measures taken to ensure a safe return to each certified service location? A power failure, sewage and/or water failure are additional examples where you must address the process/procedures to ensure safe return to your facility. What are the alternative means of communication if telephone services are not yet operable, or power has not yet been restored? You should address or outline the post event procedural process for each location here.

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.C   **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 persons would need even during an emergency/disaster. Some examples could be medications, person 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 persons 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.D   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.

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 agency providers must document implementation of the written plans for emergency/disaster response that are specific to that location/site and continuity of operations. This documentation of implementation must include, but is not limited to the following: (Exception: Supported Living and Shared Supported Living that are not owned or controlled by a certified agency provider, and Host Homes.)

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

For each facility and service location, 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 at the main office for review.

PLEASE SEE RECORD GUIDE GUIDANCE ON **Disaster, Fire, and COOP Drills for all Programs** 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 persons 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 people 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 persons 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 person 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 persons 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

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 each facility and service location.
  - 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.

<u>Fire and Disaster Drill Report Form</u>

Program Name_____

Date of Drill_____

Time of Drill (am/pm)_____

Type of Drill :

☐ **Fire** (quarterly for each facility and service location, 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.

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.

Timeline
The plan must be completed within the timeframe stated in the DMH Written Report of Findings.

Include the implementation date and estimated date of completion for each corrective action.

Deficiencies related to health and safety issues of the DMH Operational Standards must be corrected within 30 days of the date of the accepted plan of compliance submission.

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:	

Staff Verification of Training on Suspected Abuse or Neglect Reporting Requirements

Purpose
All provider staff must be informed of and trained on the procedures for reporting suspicions of abuse or neglect in accordance with state reporting laws to include but not limited to the Vulnerable Persons Act and Child Abuse or Neglect Reporting requirements.

Time Line
All provider staff must be informed of and trained on the procedures for reporting suspicions of abuse or neglect of persons receiving services in accordance with state reporting laws.

People acknowledge receipt of the information and training during General Orientation before service delivery. A copy of the verification must be maintained in the staff personnel record.

Verification form is updated if training is repeated or new training is provided.

Staff Verification of Training on Suspected Abuse or Neglect Reporting Requirements

I acknowledge that I have been informed of and trained on the procedures for reporting suspicions of abuse or neglect in accordance with state reporting laws to include but not limited to the Vulnerable Persons Act and Child Abuse or Neglect Reporting requirements.

I understand that I have a personal responsibility to report suspicions of abuse or neglect in accordance with state reporting laws.

Staff Signature/ Position or Credentials	Witness/ Position or Credentials	Date

Incident Reporting Directions and Guidance

General Information/Purpose

Incidents, as outlined in the current *DMH Operational Standards* document and as defined in the provider's current policies and procedures documents pertaining to incident reporting, <u>must</u> be reported to DMH.

Incidents must be reported to DMH within required timelines, as outlined in the current *DMH Operational Standards* document.

<u>Electronic Reporting System:</u>

- Providers must report incidents in the electronic reporting system designated by DMH, according to the process outlined by DMH.

Extent/Nature of Information Reported

The incident report must address initial information known about the incident which includes, but is not limited to:

1. Name of Agency Provider;
2. Date;
3. Time;
4. Physical location;
5. Who was involved;
6. What led to the incident;
7. A description of the incident;
8. Consequences of incident;
9. Witnesses; and,
10. Notifications.

Once the report has been submitted, DMH may request additional information based on the circumstances.

Reporting to DMH does not replace other legally mandated reporting.

Timelines

Using the DMH-designated electronic reporting system, incidents must be reported to DMH within required timelines, as outlined in the current *DMH Operational Standards* document.

Incidents which must be reported to DMH within eight (8) hours of discovery or notification of the incident include:

1. Death of a person on agency provider property, participating in an agency provider-sponsored event, being served through a certified community living service, Crisis Residential Unit, Primary Residential Treatment, and Transitional Residential Treatment;
2. Death of a person receiving IDD Services;
3. Unexplained absences from any of the previously mentioned services or Alzheimer's Day Services locations; and,

4. Suspicions of abuse, neglect or exploitation of a person receiving services while on agency provider property, at an agency provider-sponsored event, or being transported by a DMH-certified agency provider.

Verbal notification of the above-listed incidents must be made to DMH within eight (8) hours to be followed by the submitted Incident Report within twenty-four (24) hours, as outlined in current *DMH Operational Standards* document. Reporting to DMH does not replace other legally mandated reporting.

For IDD Home and Community-Based Services, incidents must be reported to Support Coordination or Targeted Case Management.

The following are examples (not an exhaustive list) of types of incidents which must be reported to DMH and other appropriate authorities within twenty-four (24) hours, as specified below:

1. Suicide attempts on agency provider property, at an agency provider-sponsored event, or by a person being served through a community living service;
2. Unexplained or unanticipated absence of a person receiving services of any length of time from any DMH-certified service location of any type;
3. Incidents involving injury of a person receiving services while on agency provider property, at an agency provider-sponsored event, or being transported by a DMH-certified agency provider;
4. Emergency hospitalization or emergency treatment of a person receiving services;
5. Accidents which require hospitalization that may be related to abuse, neglect or exploitation, or in which the cause is unknown or unusual;
6. Disasters, such as fires, floods, tornadoes, hurricanes, blizzards, etc.;
7. Any type of mandatory evacuation by local authorities that affects the service location/facility; and,
8. Use of seclusion or restraint that was not part of a person's treatment Behavior Management Plan or that was planned but not implemented properly, or resulted in discomfort or injury for the person.

A provider's written analysis of incidents, as stipulated in the current *DMH Operational Standards* document, must be made available to DMH for review upon request.