Alameda County Behavioral Health
Mental Health Division

CSI ASSESSMENT RECORD DATA
FOR NEW CLIENTS ONLY
Interim Data Collection Form
INSTRUCTIONS

Confidential Patient Information
See Welfare & Institutions Code: 5328

CONTACT INFORMATION

*Today's Date: _____
*Submitter First Name: _____
*Submitter Last Name: _____
*Submitter Phone/Ext: _____
*Submitter Email: _____
*Submitter Clinic Name: _____
*Second Contact Phone Number: _____

PLEASE Print Legibly

CSI Timeliness Reporting Data to be collected for:

New Clients: A brand new Medi-Cal outpatient client to the MHP who has received no services in this county
New returning Client: A Medi-Cal client who has not received outpatient services in over 12 months.

*Client Number: _____ *Client DOB: _____

*Client Last Name: _____

*Client First Name: _____ *RU#: _____ (if applicable)

Timeliness Information:

*New Client / New Returning Client: _____ (Y/N) *Service Request by Client/Guardian: _____ (Y/N)

*Urgent: _____ (Y/N) **(if urgent is "YES" time is required)**

*Type of Service: _____

*Date of First Contact to Request Services: _____ (MM/DD/YYYY) **Time: _____ **(HH:MM)** *Referral Source: _____

*An Assessment Record should be completed for beneficiaries **new or new returning to your MHP treatment system**. It is not necessary to create an Assessment Record for beneficiaries who are already receiving services from your MHP, or have received services in the last 12 months from your MHP.

Assessment Appointment:

*1st OFFER DATE/Attempted OFFER DATE: _____ (MM/DD/YYYY) **Time: _____ **(HH:MM)**

Appt Kept: ___ (Y/N) Missed/Not Accepted Appt Reason: _____ (XXX) Appt Reschedule: _____ (Y/N)

2nd OFFER DATE/Attempted OFFER DATE: _____ (MM/DD/YYYY)

Appt Kept: ___ (Y/N) Missed/Not Accepted Appt Reason: _____ (XXX) Appt Reschedule: _____ (Y/N)

3rd OFFER DATE/Attempted OFFER DATE: _____ (MM/DD/YYYY)

Appt Kept: ___ (Y/N) Missed/Not Accepted Appt Reason: _____ (XXX) Appt Reschedule: _____ (Y/N)

Assessment Appointment ACCEPTED DATE: _____ (MM/DD/YYYY)

* **Meets Medical Necessity:** _____ (Y/N) (conditional)

* ASSESSMENT START DATE: _____(MM/DD/YYYY) (conditional)

* ASSESSMENT END DATE: _____(MM/DD/YYYY) (conditional)

ASSESSMENT- Any intervention in which the purpose is to gather information necessary to complete a client's Medi-cal compliant assessment document. This includes assessing the client for medical necessity for specialty mental health services.

ASSESSMENT START DATE- Date of the first assessment appointment. This indicates that the beneficiary completed the first assessment appointment. *this can be in person or on the phone.

A County Client Number should be assigned and reported from this point through subsequent steps of the assessment process.

- If a beneficiary does not attend the scheduled assessment appointment, the assessment record should be closed with a closure reason of "02 = Beneficiary accepted offered assessment date but did not attend initial assessment appointment.

ASSESSMENT END DATE- The date the Medi-Cal compliant assessment document is completed and signed.
Must include at least one in person visit to complete the mental status exam and diagnosis section of the assessment

TREATMENT APPOINTMENT:

*1ST OFFER DATE: _____ (MM**/DD/YYYY)** Appt Kept: ___ (Y/N) Missed Appt Reason: _____ (XXX) Appt Reschedule: _____(Y/N)

2nd OFFER DATE: _____ (MM**/DD/YYYY)** Appt Kept: ___ (Y/N) Missed Appt Reason: _____ (XXX) Appt Reschedule: _____ (Y/N)

3rd OFFER DATE: _____ (MM**/DD/YYYY)** Appt Kept: ___ (Y/N) Missed Appt Reason: _____ (XXX) Appt Reschedule: _____ (Y/N)

***Treatment Appointment ACCEPTED DATE:** _____ (MM/DD/YYY)

***Treatment START DATE:** _____ (MM/DD/YYYY) (conditional)

TREATMENT-For most providers treatment is a planned service after the treatment plan has been completed. Treatment can also include crisis intervention, crisis stabilization, targeted case management, intensive care coordination, and medication support services. Treatment can be the same day as the assessment start date, can be over the phone. Treatment services do not include assessment or treatment planning interventions

The first treatment appointment offered to a beneficiary is captured in the TREATMENT APPOINTMENT FIRST OFFER DATE field. The TREATMENT APPOINTMENT FIRST OFFER DATE is recorded whether a beneficiary accepts any treatment appointment offer or not.

* **CLOSE OUT DATE**: _____ (MM/DD/YYYY) (conditional) ****Time:** _____ **(HH:MM)**

* **CLOSURE REASON:** _____ (XXX) (conditional)

* **REFERRED TO:** _____ (XXX) (conditional)

Close Out Date- The close out date is when the assessment has been completed and the client has started treatment as defined above. Or when the beneficiary does not complete the assessment process and the case is closed.

Closure Reason-Reason/s the assessment or treatment process was discontinued.
*If assessment end date and treatment start date are entered you will not need to complete this section.

Referred To- List of options to which the beneficiary was referred if found to not meet medical necessity criteria.

*If the process terminates anywhere among the process steps of the APPOINTMENT FIRST OFFER DATE, the TREATMENT APPOINTMENT SECOND OFFER DATE, or the TREATMENT APPOINTMENT THIRD OFFERED DATE and the client accepts none of the offered dates, the Assessment Record should be closed out with a closure reason of "04 = Beneficiary completed assessment process but declined offered treatment dates.

*The CLOSED OUT DATE may be the same date as the beneficiary was last seen, but more likely will be later when the assessment process is administratively terminated.

- For submissions, the Assessment Record should be bundled with the monthly submission of all CSI records.

***(Mandatory)**
****(Mandatory for Urgent)**

Type of Service:

01 = Psychiatry
02 = Outpatient Services
03 = Outpatient Services – Prior Authorization

Referral Source:

01 = Self	13 = Faith-Based Organization
02 = Family Member	14 = Other County / Community Agency
03 = Significant Other	15 = Homeless Services
04 = Friend / Neighbor	16 = Street Outreach
05 = School	17 = Juvenile Hall / Camp / Ranch / Division of Juvenile Justice
06 = Fee-For-Service Provider	18 = Probation / Parole
07 = Medi-Cal Managed Care Plan	19 = Jail / Prison
08 = Federally Qualified Health Center	20 = State Hospital
09 = Emergency Room	21 = Crisis Services
10 = Mental Health Facility / Community Agency	22 = Mobile Evaluation
11 = Social Services Agency	23 = Other Referred
12 = Substance Abuse Treatment Facility / Agency	

Missed/Not Accepted Appointment Reason:

01 = In Jail / Prison	06 = Did not want to go
02 = Transportation (missed bus)	07 = Changed mind about treatment
03 = Transportation (lack of funds)	08 = No babysitter / caregiver
04 = Illness / Family Illness	09 = No ride
05 = Hospitalized	10 = Request Language Interpreter
	11 = Other

Closure Reason:

01 = Beneficiary did not accept any offered assessment dates.
02 = Beneficiary accepted offered assessment date but did not attend initial assessment appointment.
03 = Beneficiary attended initial assessment appointment but did not complete assessment process.
04 = Beneficiary completed assessment process but declined offered treatment dates.
05 = Beneficiary accepted offered treatment date but did not attend initial treatment appointment.
06 = Beneficiary did not meet medical necessity criteria.

Referred To:

01 = Managed Care Plan
02 = Fee-For-Service Provider
03 = Other
04 = No Referral