Alameda County Behavioral Health
Mental Health Division

TIMELINESS REPORTING
FOR NEW CLIENTS ONLY
Interim Data Collection Form

Confidential Patient Information
See Welfare & Institutions Code: 5328

CONTACT INFORMATION – Internal Use - Optional

Today's Date: _____
Submitter First Name: _____
Submitter Last Name: _____
Submitter Phone/Ext: _____
Submitter Email: _____
Clinician's Name: _____
Clinician's ID/Staff #: _____

PLEASE Print Legibly
CSI Timeliness Reporting Data to be collected for:

New Clients: **New to MHP**
New returning Client: **Client has not received service in over one year**

*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/Legal 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: _____

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)

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

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

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)

***CLOSE OUT DATE**: _____ (MM/DD/YYY) (conditional)

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

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

***(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	08 = No babysitter / caregiver
02 = Transportation (missed bus)	09 = No ride
03 = Transportation (lack of funds)	10 = Request Language Interpreter
04 = Illness / Family Illness	11 = Other
05 = Hospitalized	12 = No working phone
06 = Did not want to go	13 = No return call
07 = Changed mind about treatment	14 = Unable to reach client
	15 = No response/No show

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