ALAMEDA COUNTY
Behavioral Health Care Services

November 2017

MENTAL HEALTH PLAN FEE-FOR-SERVICE PROVIDER HANDBOOK

APPENDICES

ACCESS
Network Office
Provider Relations
Quality Assurance
Utilization Management

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APPENDICES

Disclaimer: The documents included in this Appendix are for reference purposes only. For the most current version of these documents, use the web link provided or contact the appropriate BHCS unit (see Section II, *Introduction and Overview, How to Contact BHCS*, of the MHP FFS Provider Handbook).

To use this Appendix, select the document name or web link, where applicable. The Section and Page numbers refer to the MHP FFS Provider Handbook at http://www.acbhcs.org/providers/network/forms/handbook.pdf.

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APPENDIX B

MEDICAL NECESSITY FOR SPECIALTY MENTAL HEALTH SERVICES THAT ARE THE RESPONSIBILITY OF THE MENTAL HEALTH PLAN

STATE DEPARTMENT OF MENTAL HEALTH MEDI-CAL MANAGED CARE

Medical Necessity for Specialty Mental Health Services
that are the Responsibility of the Mental Health Plan

Must have all, A, B, and C:

A. Diagnoses

Must have one of the following DSM IV diagnoses, which will be the focus of the intervention being provided:

Included Diagnoses:

- Pervasive Developmental Disorders, except Autistic Disorder which excluded.
- Attention Deficit and Disruptive Behavior Disorders
- Feeding & Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia & Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders

Excluded Diagnoses:

- Mental Retardation
- Learning Disorders
- Motor Skills Disorder
- Communication Disorders
- Autistic Disorder (Other Pervasive Developmental Disorders are included.)
- Tic Disorders
- Delirium, Dementia and Amnestic and other Cognitive Disorders
- Mental Disorders due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorder
- Other conditions, including V-codes, that may be a focus of Clinical Attention (Except medication induced movement disorders which are included.)

A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present.

B. Impairment Criteria

Must have one of the following as a result of the mental disorder(s) identified in the diagnostic (A") criteria:

Must have one, 1, 2, or 3:

1. A significant impairment in an important area of life functioning, or
2. A probability of significant deterioration in an important area of life functioning or
3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder which can be corrected or ameliorated (current DHCS EPSDT regulations also apply).

C. Intervention Related Criteria

Must have all, 1, 2, and 3 below:

1. The focus of proposed intervention is to address the condition identified in impairment criteria "B" above, and
2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children it is probable the child will progress developmentally as individually appropriate (or if covered by EPSDT can be corrected or ameliorated), and
3. The condition would be responsive to physical healthcare based treatment.

EPSDT beneficiaries with an included diagnosis and a substance related disorder may receive specialty mental health services directed at the substance use component. The intervention must be consistent with, and necessary to the attainment of, the specialty MH treatment goals.

APPENDIX C

MENTAL HEALTH SCREENING FORMS AND REFERRAL INSTRUCTIONS

Adult Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary

MEMBER INFO

Beneficiary Name: _____ Date of Birth: ___/___/___ ☐ M ☐ F

Medi-Cal # (CIN): _____ Current Eligibility: ☐ Yes ☐ No Language/cultural needs: _____

Address: _____ City: _____ Zip: _____ Phone: (___) _____

Caregiver/Guardian: _____ Phone: (___) _____

Behavioral Health Diagnosis 1) _____ 2) _____ 3) _____

Is provisional diagnosis/diagnosis an included diagnosis for MHP services ☐ Yes ☐ No ☐ Unsure

Documents Included: ☐ **Required Release of Info completed** ☐ MD notes ☐ H&P ☐ Assessment ☐ Other: _____

Primary Care Provider _____ Phone: (___) _____

List A (check all that currently apply)	List B (Check all that currently apply)	List C
☐ Persistent mental health symptoms & impairments after psychiatric consult and 2 or more medication trials in past 6 months ☐ Co-morbid mental health and serious health conditions (specify below) ☐ Behavior problems (aggressive/assaultive/self-destructive/extreme isolation) (specify below) ☐ 3+ ED visits or 911 calls in past year ☐ Significant current life stressors [e.g. homelessness, domestic violence, recent loss] (specify below) ☐ Hx of trauma/PTSD that is impacting current functioning** ☐ Non-minor dependent ☐ May not progress developmentally as individually appropriate without mental health intervention (ages 18 to 21 only)	☐ 2+ in-patient psychiatric hospitalizations within past 18 months ☐ Functionally significant paranoia, delusions, hallucinations** ☐ Current & on-going suicidal/significant self-injurious/homicidal preoccupation or behavior in past year (specify below) ☐ Transitional Age Youth with acute psychotic episode ☐ Eating disorder with related medical complications ☐ Personality disorder with significant functional impairment** ☐ Significant functional impairment (not listed above) due to a mental health condition**	☐ Drug or alcohol addiction and failed SBI (screening & brief intervention at primary care)

	Referral Algorithm	
1	Remains in **PCP care** with Beacon consult or therapy only	☐ 1-2 in List A and none in List B
2	Refer to **Beacon Health Strategies** (eFax (866) 422-3413)	☐ 3 in list A (2 if ages 18-21) and none in list B OR ☐ Diagnosis excluded from county MHP
3	Refer to **County Mental Health Plan** for assessment (Fax – 510-346-1083)	☐ 4 or more in list A (3 or more if ages 18-21) OR ☐ 1 or more in list B
4	Refer to County Alcohol & Drug Program (1-800-491-9099)	☐ 1 from list C

Referring Provider Name: _____ Phone: (___) _____

Referring/Treating Provider Type ☐ PCP ☐ MFT/LCSW ☐ ARNP ☐ Psychiatrist ☐ Other _____

Requested service ☐ Outpatient therapy ☐ Medication management ☐ Assessment for Specialty Mental Health Services

Pertinent Current/Past Information **(**Please specify current functional impairments in a core area of life due to the condition(s) checked) :**

Current symptoms and functional impairments: _____

_____

Brief Patient history: _____

_____

Name and Title*(Print:)_____ Signature: _____ Date:____

*Licensed LPHA, MD, DO, NP, CNS, PA

For Receiving Clinician Use ONLY

Assigned Case Manager/MD/Therapist Name: _____ Phone: (___) _____

Date communicated assessment outcome with referral source: _____

FINAL Alameda County Behavioral Health Care Services March 2015

Child 6 – 17 Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary

MEMBER INFO

Patient Name: _____ Date of Birth: ___/___/___ ☐ M ☐ F

Medi-Cal # (CIN): _____ Current Eligibility: _____ Language/cultural requirements: _____

Address: _____ City: _____ Zip: _____ Phone: (___) _____

Caregiver/Guardian: _____ Phone: (___) _____

Behavioral Health Diagnosis 1) _____ 2) _____ 3) _____

Is provisional diagnosis/diagnosis an included diagnosis for MHP services ☐ Yes ☐ No ☐ Unsure

Documents Included: ☐ **Required consent completed** ☐ MD notes ☐ H&P ☐ Assessment ☐ Other: _____

Primary Care Provider _____ Phone: (___) _____

List A (check all that apply)	List B (Check all that apply)	List C
☐ Impulsivity/hyperactivity ☐ Trauma/recent loss ☐ Withdrawn/Isolative ☐ Mild-moderate depression/anxiety ☐ Behavior problems (aggressive/self-destructive/assaultive/bullying/oppositional) ☐ Significant family stressors * ☐ CPS report in the last 6 months ☐ Excessive truancy or failing school ☐ Difficulty developing and sustaining peer relationships ☐ Eating disorder without medical complications ☐ Court dependent or ward of court ☐ May not progress developmentally as individually appropriate without mental health intervention	☐ 1 or more psychiatric hospitalization(s) in past year ☐ Suicidal/homicidal preoccupations or behaviors in past year ☐ Self-injurious behaviors ☐ Paranoia, delusions, hallucinations ☐ Currently in out-of-home foster care placement ☐ Juvenile probation supervision with current placement order ☐ Functionally significant depression/anxiety ☐ Eating disorder with medical complications ☐ At risk of losing home or school placement due to mental health issues	☐ Substance abuse

*** Significant family stressors:** Caretaker(s) with serious physical, mental health, substance use disorders or developmental disabilities, domestic violence, unstable housing or homelessness.

	Referral Algorithm	
1	Remains in **PCP care** with Beacon consult or therapy only	☐ 1 in List A and none in List B
2	Refer to **Beacon Health Strategies** (eFax (866) 422-3413)	☐ 2 in list A and none in List B OR ☐ Diagnosis excluded from county MHP
3	Refer to **County Mental Health Plan** for assessment	☐ 3 or more in List A OR ☐ 1 or more in List B
4	Refer to **County program** or community resources	☐ 1 in list C

Referring Provider Name: _____ Phone: (___) _____

Referring/Treating Provider Type ☐ PCP ☐ MFT/LCSW ☐ ARNP ☐ Psychiatrist ☐ Other _____

Requested service ☐ Outpatient therapy ☐ Medication management ☐ Assessment for Specialty Mental Health Services

Pertinent Current/Past Information:

Current symptoms and impairments: _____

_____

Brief Patient history: _____

_____

Name and Title(Print:)_____ Signature: _____ Date:___

For Receiving Clinician Use ONLY

Assigned Case Manager/MD/Therapist Name: _____ Phone: (___) _____

Date communicated assessment outcome with referral source: _____

ALAMEDA COUNTY

September 2014

Child 0 - 5 Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary

MEMBER INFO

Patient Name: _____ Date of Birth: ___/___/___ ☐ M ☐ F

Medi-Cal # (CIN): _____ Current Eligibility: _____ Language/cultural requirements: _____

Address: _____ City: _____ Zip: _____ Phone: (___) _____

Caregiver/Guardian: _____ Phone: (___) _____

Behavioral Health Diagnosis 1) _____ 2) _____ 3) _____

Is provisional diagnosis/diagnosis an included diagnosis for MHP services ☐ Yes ☐ No ☐ Unsure

Documents Included: ☐ **Required consent completed** ☐ MD notes ☐ H&P ☐ Assessment ☐ Other: _____

Primary Care Provider _____ Phone: (___) _____

List A (check all that apply)	List B (Check all that apply)
☐ Impulsivity/hyperactivity	☐ Significant Parent/Child attachment concerns
☐ Withdrawn/isolative	☐ Child age 0-3 with at least 2 items from List A
☐ Mild-moderate depression/anxiety	☐ Aggression and/or frequent tantrums
☐ Excessive crying; difficult to soothe	☐ Neglect/Abuse
☐ Significant family stressors *	☐ Self-Harm: frequent head banging/risky behavior
☐ CPS report in the last 6 months	☐ Trauma
☐ Limited receptive and expressive communication skills	☐ Currently in out-of-home foster care placement
☐ Sleep Concerns: difficulty falling asleep, night waking, nightmares	☐ At risk of losing home, child care or preschool placement due to mental health issue
☐ Peer relationship issues - little enjoyment or interest in peers; self-isolating; frequent conflict with peers	☐ Separation from/loss of primary caregiver
☐ Feeding/elimination difficulties	
☐ Learning Difficulties	
☐ Sexualized Behaviors	
☐ Serious medical issues/other disabilities	
☐ May not progress developmentally as individually appropriate without mental health intervention	

*** Significant family stressors:** Caretaker(s) with serious physical, mental health, substance use disorders or developmental disabilities, domestic violence, unstable housing or homelessness.

	Referral Algorithm	
1	Remains in **PCP care** with Beacon consult or therapy only	☐ 1 in List A and none in List B
2	Refer to **Beacon Health Strategies** (eFax (866) 422-3413)	☐ 2 in list A and none in List B OR ☐ Diagnosis excluded from county MHP
3	Refer to **County Mental Health Plan** for assessment	☐ 3 or more in List A OR ☐ 1 or more in List B

Referring Provider Name: _____ Phone: (___) _____

Referring/Treating Provider Type ☐ PCP ☐ MFT/LCSW ☐ ARNP ☐ Psychiatrist ☐ Other _____

Requested service ☐ Outpatient therapy ☐ Medication management ☐ Assessment for Specialty Mental Health Services

Pertinent Current/Past Information:

Current symptoms and impairments: _____

_____

Brief Patient history: _____

_____

Name and Title(Print:)_____ Signature: _____ Date:___

For Receiving Clinician Use ONLY

Assigned Case Manager/MD/Therapist Name: _____ Phone: (___) _____

Date communicated assessment outcome with referral source: _____

ALAMEDA COUNTY

September 2014

Mental Health Screening Tool and Referral Instructions for Alameda County Behavioral Health Care Services Providers

KEY CONTACT INFORMATION

Mental Health Plan (MHP) / Specialty Mental Health Services (SMHS) :

Alameda County ACCESS	Phone: 1-800-491-9099	Fax: 510-346-1083

Managed Care Plans (MCP):

Alameda Alliance/Beacon	Phone: 1-855-856-0577	Fax: 866-422-3413
Kaiser Permanente	Phone: 510-752-1075	
Anthem Blue Cross	Phone: 1-888-831-2246	

DIRECTIONS FOR USING THE SCREENING TOOL FORM

1) Providers must complete the screening tool to determine if a consumer meets Specialty Mental Health Services criteria with moderate-severe impairment or should be referred to their managed care plan due to mild-moderate impairment.

2) Administer the screening tool. Please complete as much information on the screening tool as you can.
   Clarifying information:
   - MEMBER INFO section/Documents Included – Consent form only required if sending clinical information to MCP/Primary Care Provider (PCP)
   - Referring Provider Name section – Only required if sending to MCP
   - Name, Title, Signature and Date – Clinician who completed screening form
   - Select screening tool criteria descriptions are listed on the back of this page

   **Please note – If screening tool is completed for client currently in service who continues to meet medical necessity for specialty mental health services, clinician only has to complete the name, date of birth and diagnosis under "Member Info" and file in client's chart.*

3) Use the algorithm to determine if consumer should receive services through specialty mental health services or managed care plan.

4) If algorithm indicates mild-to-moderate condition, refer the consumer to his/her managed care plan or PCP for services (see contact information above). The name of the managed care plan should be listed on the back of consumer's Medi-Cal card.

5) If algorithm indicates significant impairment or moderate-severe condition, which meets medical necessity for SMHS :
   - **Please retain a copy of the <u>completed</u> screening tool form in the client's chart. This will be particularly important if the chart is audited in the future.**
   - If you work for a CBO/Master Contract Provider and bill through INSYT you can provide direct services.
   - If you are/work for a Network Provider and bill through BHCS Provider Relations/Claims department, and the client is an adult 18-64, you can provide direct services.
   - If you are/work for a Network Provider and bill through BHCS Provider Relations/Claims department, and the client is a youth under 18 or an adult over 64, it is necessary to obtain prior authorization through ACCESS. Please have the completed screening form with you when you call ACCESS seeking authorization or

attach a copy of the screening form if you are submitting a Request for Prior Consultation. This is the only situation in which you need to send the completed screening form to ACCESS.

- Network providers seeking re-authorization from BHCS Authorization Services must send a completed, signed copy of the screening form with their RES/RCR.

ADULT SCREENING TOOL CRITERIA DESCRIPTIONS:

Persistent symptoms after 2 medication trials	Two failed attempts at symptom management with medication trials
Multiple co-morbid health and mental health conditions	Example: Diabetes, high blood pressure and bipolar disorder
+ ED visits or 911 calls in past year	Pattern of frequent visits to the emergency room or 911 calls due to mental health condition
Non-minor dependent	Age 18-21 who is a dependent of the court through the juvenile court system (WIC 300)
Transitional age youth with first psychotic episode	Age 16-25 with the first onset of psychotic symptoms
Significant Functional Impairment	Patient is has significant impairment in a core area of life functioning due to the mental health condition. If using the World Health Organization Disability Assessment Schedule, a score of 4-5 denotes a "severe" or "extreme" functional impairment
Eating disorder with medical complications	The eating disorder is so severe that it has led to medical complications.
Failed SBI	The PCP has tried brief interventions for SUD and failed, thus requiring referral for more

CHILD SCREENING TOOL CRITERIA DESCRIPTIONS:

Impulsivity/hyperactivity	May include but not limited to being fidgety, disruptive, impulsive in behaviors, difficult completing tasks or restlessness
Trauma/recent loss	Any incidents including but not limited to death, witness or victim of violence, recent illnesses or family changes that are impacting a child's ability to cope
Self-injurious behavior	Self-injury including cutting, burning and other self-harming behaviors
Eating disorder with medical complications	The eating disorder is so severe that it has led to medical complications.

Substance abuse	Pattern of substance use leading to problems or distress
Oppositional	Pattern of defiance, disobedience or argumentative behavior with adults

Screening Tool Training FAQ's - 9/25/14 & 10/3/14

Provider Questions

Compliance

1. Do we keep the screening tool in the client's record?
   Yes, QA will look for it in an audit.

2. When do we complete the screening tool?
   Before services begin, whether that occurs during Intake in person or over phone – and re-screen at every Treatment Plan Update.

3. Do we have to do the re-screening with the client/family?
   No, the clinician can do it on his/her own.

4. If we can only check two items in List A but we suspect there are more issues, can we do Assessment?
   No, providers need to obtain sufficient information during the screening to determine if meet criteria and shouldn't begin services unless screened to meet criteria.

5. When do we have to start screenings?
   Now.

6. Do current clients need to be screened?
   Yes.

7. Can we complete the screening per the information given by the caller, even if it's not the client (e.g., family member, CWW, etc.)?
   Yes, you can take information from anyone who knows the client.

8. What if we don't use the WHODAS scoring (on Adult screening tool)?
   That is okay; the WHODAS is usually only used by primary care.

9. What if the client has a Provisional Diagnosis?
   Check "Unsure."

10. Can we bill for the screening?
    No.

11. Does this mean we don't have to do the CFE or other assessment tools?
    All prior paperwork requirements are still in effect. The goal is to incorporate the Mild-Moderate Screening Tool into the CANS & ANSA.

12. Why can't we use existing documents?
    The screening is used to refer consumers between providers & insurance systems, so consistency in paperwork is necessary. Other providers should not have to look through a chart to find referral information; also the tool's algorithm is required.

13. Is it okay for providers to create an electronic version of the screening?
    Yes, as long as the content remains the same. It is also available in PDF form.

14. Who can sign the form?
    Since the screening tool includes a diagnosis, an LPHA must sign or co-sign, per BHCS Documentation Standards. Signature(s) that are acceptable on the screening tool are:

    -Licensed LPHA (PhD-Licensed, PsyD-Licensed, LCSW, LMFT, LPCC, LPCC-F)
    -Un-licensed LPHA must have a co-signature of a Licensed LPHA (Phd-Waivered, PsyD-Waivered, MFT-Intern, ASW, PCC-Intern)
    -Medical Providers (MD, DO, NP, CNS, PA)

    Graduate student interns or trainees or other staff are not allowed to fill out or sign the screening tool.

15. May we tell callers to contact ACCESS "for a referral to us" & have ACCESS do the screening?
    Network Managed Care providers (fee-for-service contracts) may refer callers to ACCESS for screening, however, they will need to do their own screening prior to submission of RES as Authorization Services requires a copy. Community Based Organizations (CBO's or master contracts) do their own screening.

<u>Who Must Complete the Screening Tool?</u>

1. How do we sign the screening tool if we are both the "screener" & "receiver" of the case?
   Complete the form as the "screener." The 'Referring Provider Name' section is only required if sending the screening tool to a Managed Care Plan.

2. Do SUD programs need to do screening?
   No, only providers that bill for mental health services.

3. Do Adult Level 1 programs do screening?
   Not at intake but at each Treatment Plan review.

4. Do Children's Level 1 programs do screening?
   Not at intake, if referred by ACCESS, but at each Treatment Plan review. If not referred by ACCESS, the screening should be done prior to intake.

5. Do Level 2 programs do the screening?
   Not at intake but at each Treatment Plan review.

6. Does the Guidance Clinic need to do screening for their mental health services billed to Medi-Cal?
   Not at this time for youth in Juvenile Probation supervision with current placement order.

7. Do EPSDT Probation (outpatient) providers do the screening?
   Yes.

8. Does a CalWorks provider need to do screening?
   No, CalWorks clients do not need to meet medical necessity.

9. Do Wellness Centers need to do screening?
   Only if billing Medi-Cal for Specialty Mental Health Services.

Questions about Certain Situations

1. If a client improves & is stable but gains may be temporary, do we need to transfer the case to the MCP or can we continue services to ensure stability?
   For clients ages 0-21, document clearly that EPSDT impairment criteria are met. For adults, document clearly that at least one medical necessity impairment criterion is met. In addition, develop a transition plan that takes into account the need to ensure the gains are solidified before transferring the client.

2. How long can a transition plan be in effect?
   As long as the chart documents the need/reason for a longer transition; the plan needs to be reviewed often to ensure the need/reason is still valid.

3. For a Level 1 adult client who has been stable for several years with medication & some case management, must we refer out to a MCP?
   If they continue to have four items checked in List A or one item in List B, they can be transitioned to a lower level of Specialty Mental Health Services (level 3) as a step-down to the higher level of care. If the client doesn't meet criteria for Specialty MHS, a transition plan must be developed to step-down to the MCP.

4. How should providers of Level 1 services and programs like CHOICES, where the goal is to increase independence, decide when a client is Mild-Moderate?
   Use the screening tool.

5. If a client is stable regarding their primary diagnosis but are diagnosed with a substance use disorder (List C is checked), can they stay with provider?
   No- list C is specific to substance use disorders.

6. Can Language/Culture be added to the list?
   No, and cases may not be retained for that reason. If the consumer does not meet specialty mental health criteria the MCP's are expected to provide such services.

7. Can a case be retained if a client is screened to be Mild-Moderate but the MCP doesn't provide the most appropriate treatment model (e.g., needs home visits, needs Parent-Infant work)?
   No.

8. If a client has private insurance but is screened as Moderate-Severe, can we serve them?
   No, their private insurance is responsible for providing their mental health services.

9. Providers cannot always discern from the insurance look-up screen whether the insurance plan is private or Medi-Cal.
   If unsure about a specific case, call BHCS Provider Relations at 1-888-346-0605 to verify insurance eligibility.

10. What if the managed care plan screens a client as Mild-Moderate?
    They are required to provide services.

11. For children who receive Level 1 services, can their sibling with Mild-Moderate needs continue to be referred by ACCESS to the Level 1 program so that the family has just one provider?
    No, if Mild-Moderate, the sibling must be served by their MCP. However, ACCESS can continue to make a Level 1 referral if the sibling is screened as Moderate-Severe but not severe enough to require Level 1 services.

12. What if a provider is contracted with both BHCS & Beacon and a consumer needs to shift to Beacon to see the same provider?
    Call Beacon – they may want the provider to complete & submit a current Screening Tool, or they may just begin service authorization to the provider.

APPENDIX C-1

MHP FFS CREDENTIALING APPLICATION

MENTAL HEALTH PLAN (MHP) FEE-FOR-SERVICE (FFS) PROVIDER APPLICATION INSTRUCTIONS

1. *Please complete **all applicable sections** of the application.*
   a. *Urgent Interim Agreements (UIA) and Initial Credentialing applicants: Complete all sections, except Section X.*
   b. *Re-Credentialing applicants: Complete all sections, except Sections V & VI.*

2. *You must have a National Provider Identification (NPI) to contract with Alameda County BHCS. To apply or learn more and why you are required to have one, please visit: https://nppes.cms.hhs.gov.*

3. *You must complete the W-9 Form Taxpayer Identification Number (TIN). The purpose of this form is to obtain or verify the accuracy of information regarding Alameda County's payees. All payees must have an accurate W-9 on file in the Auditor-Controller's office in order to be paid. If you fail to furnish your correct TIN, you could be subject to a penalty. Please visit https://www.irs.gov/forms-pubs to obtain the current W-9.*

   A W-9 is not required for existing contracted providers if there are no changes in the information.

4. *Attach a copy of your current state license with a clearly visible expiration date. **You are required to submit proof of renewal prior to license expiration as part of the contract agreement with Alameda County BHCS.***

5. *For physicians only, attach a copy of your current DEA certificate with a clearly visible expiration date.*

6. *Attach a copy of your **Certificate(s) of Insurance** for professional, commercial general[1], automobile, and workers' compensation liability insurance coverage as required in Exhibit C County of Alameda Minimum Insurance Requirements. **You are required to submit proof of renewal annually prior to expiration as part of the contract agreement with Alameda County BHCS.***

7. *UIA and Initial Credentialing applicants: Sign and date the Request for Insurance Change or Waiver form for Workers' Compensation and Automobile Liability (if applicable).*

8. *Attach an up-to-date work history with start and end dates (a résumé is acceptable). This is not required for existing contracted providers if there are no changes in the initial credentialing or the last re-credentialing application information.*

9. *Provide an **original signature** on the **Certification** page. **An original signature is required to complete this application. BHCS will not accept stamped signatures.***

10. *Return to the address below:*

Alameda County BHCS
Network Office c/o MHP Fee-For-Service Providers
1900 Embarcadero Cove, Suite 205
Oakland, CA 94606
Or
Procurement@acgov.org
Or
Fax: 510-567-8290

[1] *Including an Additional Insured Endorsement Page: Commercial general liability shall be endorsed to name as additional insured: "County of Alameda, its Board of Supervisors, the individual members thereof, and all County officers, agents, employees, volunteers, and representatives."*

SECTION I: PROVIDER INFORMATION											
Last Name				First Name				Middle Initial			
I am applying as a(n)	☐	Individual Provider	☐	ERMHS Assessor[2]	☐	Caregiver Competency Evaluator (Children and Family Services)	☐	Murphy Conservatorship Assessor (Criminal Justice)[2]			
	☐	Member of Group		Name of Group							
Date of Birth				City of Birth				Gender			
State of Birth				Country of Birth				Social Security Number			
NPI Number				Taxonomy				Tax ID # *(as reported on 1099 form)*			

Self-Identified Race/Ethnicity

Please select the categories that most closely matches how you identify.

☐	African American	☐	Middle Eastern
☐	American Indian	☐	Pacific Islander
☐	Asian	☐	South Asian
☐	Caucasian	☐	Southeast Asian
☐	Latino	☐	Other

Please select the categories that most closely matches how you identify. This is an optional section.

☐	Lesbian	☐	Queer
☐	Gay	☐	Intersex
☐	Bisexual	☐	Two-Spirited
☐	Transgender	☐	Straight
☐	Questioning	☐	Other

Languages other than English in which you conduct treatment

☐	American Sign Language	☐	French	☐	Pashto	☐	Tibetan
☐	Arabic	☐	Hmong	☐	Portuguese	☐	Turkish
☐	Burmese	☐	Japanese	☐	Russian	☐	Vietnamese
☐	Cambodian	☐	Korean	☐	Samoan	☐	Other
☐	Cantonese	☐	Laotian	☐	Spanish	☐	Other
☐	Chinese Dialect	☐	Mandarin	☐	Tagalog	☐	Other
☐	Farsi	☐	Mien	☐	Thai	☐	Other

Please describe your multi-cultural experience:

[2] *ERMHS and Murphy Conservatorship Assessors can skip Section II and proceed to Section III.*

SECTION I: PROVIDER INFORMATION										
Primary Office Location										
Street Address			City			State		Zip		
Phone Number			FAX Number			Email				
Primary Mailing Information										
Street Address			City			State		Zip		
Phone Number			FAX Number			Email				
Primary Billing Information										
Street Address			City			State		Zip		
Phone Number			FAX Number			Email				
Tax I.D. Information										
Street Address			City			State		Zip		
Phone Number			FAX Number			Email				
ADA access? ☐ No ☐ Yes	Evening availability? ☐ No ☐ Yes List Hours					Weekend availability? ☐ No ☐ Yes List Hours				
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday			
Please check the locations where you provide services	☐Private office ☐Skilled nursing facility ☐Board and Care					☐Inpatient hospital ☐Outpatient clinic ☐Hospital emergency room				
Secondary Office Location Information ☐ N/A										
Street Address			City			State		Zip		
Phone Number			FAX Number			Email				
Secondary Mailing Information										
Street Address			City			State		Zip		
Phone Number			FAX Number			Email				
Secondary Billing Information										
Street Address			City			State		Zip		
Phone Number			FAX Number			Email				

SECTION I: PROVIDER INFORMATION							
ADA access? ☐ No ☐ Yes	Evening availability? ☐ No ☐ Yes List Hours					Weekend availability? ☐ No ☐ Yes List Hours	
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Please check the locations where you provide services	☐Private office ☐Skilled nursing facility ☐Board and Care					☐Inpatient hospital ☐Outpatient clinic ☐Hospital emergency room	

SECTION II: REFERRALS			
BHCS' ACCESS serves as a referral source for the MHP Provider Network. Referrals are normally made to best meet client needs and preferences. Please indicate your interest/availability for referrals for the following:			
Medi-Cal	☐ No ☐ Yes	HealthPAC *(an Alameda County BHCS client benefit with a 12 month limit per client)*	☐ No ☐ Yes
Social Services Children and Family Services (CFS)	☐ No ☐ Yes	Children who are Dependents or Wards of the Court	☐ No ☐ Yes
AB 109 Probation	☐ No ☐ Yes	Total Number of BHCS slots	
Medication services[3]	☐ No ☐ Yes	Please list the categories of medications you can prescribe	

SECTION III: LICENSURE/PRACTICE INFORMATION					
Primary State of licensure		License Number		License Type	
License issued by		Effective Date		Expiration Date	
Secondary State of licensure		License Number		License Type	
License issued by		Effective Date		Expiration Date	

[3] MD/DOs only

SECTION III: LICENSURE/PRACTICE INFORMATION					
Board Certified[3]	☐ No ☐ Yes	Date		Name of Board	
Certified by		Adult Psychiatric	☐ No ☐ Yes	Certification Expiration Date	
Certified by		Child Psychiatric	☐ No ☐ Yes	Certification Expiration Date[5]	
DEA Number[4]		DEA Issue Date		DEA Expiration Date	

SECTION IV: PRIVILEGES/AFFILIATIONS (MDs Only)							
Name of Hospital/Clinic				Date of Affiliation			
Type of Affiliation				Type of Service			
Street Address		City		State		Zip	
Contact Person's Name				Contact Person's Title			
Contact Person's Phone Number		Contact Person's FAX #		Contact Person's Email			

SECTION V: POST GRADUATE TRAINING AND EXPERIENCE *(UIA and Initial Credentialing Only)*			
Internship/Residencies/ Fellowship Institution Name		Supervisor Name	
Mailing Address		City/State/Zip	
Specialty		Start Date	End Date
Internship/Residencies/ Fellowship Institution Name		Supervisor Name	
Mailing Address		City/State/Zip	
Specialty		Start Date	End Date
Internship/Residencies/ Fellowship Institution Name		Supervisor Name	
Mailing Address		City/State/Zip	
Specialty		Start Date	End Date

[4] For physicians/psychiatrists only

SECTION V: POST GRADUATE TRAINING AND EXPERIENCE *(UIA and Initial Credentialing Only)*					

SECTION VI: EDUCATION *(UIA and Initial Credentialing Only)*					
Name of Medical/Graduate School				Degree Received	
Mailing Address				City/State/Zip	
Specialty		Start Date		Graduation Date	
Name of Bachelor's Degree School				Degree received	
Mailing Address				City/State/Zip	
Specialty		Start Date		Graduation Date	

SECTION VII: MEDICARE/MEDICAID INFORMATION		
Are you a Medicare enrolled provider?	No ☐ Yes ☐	If yes, what is your Medicare Provider Number?
Are you a Medi-Cal provider in any other county?	No ☐ Yes ☐	If yes, please indicate your host county:
Are you a Value Options provider?	No ☐ Yes ☐	

SECTION VIII: LIABILITY INFORMATION

See Exhibit C for County of Alameda Minimum Insurance Requirements

Insurance	Commercial General	Medical Professional	Auto	Worker's Compensation
Policy Number:				
Insurance Carrier:				
Expiration Date:				
Per Occurrence:	$	$	$	$
Aggregate:		$		

SECTION IX: LICENSE INFORMATION				
1. Has your clinical license ever been revoked, suspended or limited?	No ☐ Yes ☐	If yes, please explain		
2. Within the past five years, have you ever been subject to disciplinary review action by any of the following?				
a. State Licensing Board	No ☐ Yes ☐	Board Name		If yes, please explain
b. County, State or Professional Society	No ☐ Yes ☐	Name		If yes, please explain
c. Hospital, Medical or Clinical Staff	No ☐ Yes ☐	Hospital Name		If yes, please explain

SECTION IX: LICENSE INFORMATION					
3. Within the past five years, have you ever been denied hospital privileges?	No ☐ Yes ☐	Hospital Name		If yes, please explain	
4. Has your narcotics license ever been revoked, suspended or limited?	No ☐ Yes ☐	If yes, please explain			
5. Within the past five years, have you ever been denied professional liability insurance; has your insurance been cancelled; renewal refused or have premiums been surcharged due to claims?	No ☐ Yes ☐	If yes, please explain			
6. Within the past five years, have you been a party to a malpractice suit which went to final disposition and resulted in payment to the plaintiff?	No ☐ Yes ☐	Number of Suits	Total Payments	Describe Nature of Suits	
7. Presently, do you have any malpractice suits pending against you?	No ☐ Yes ☐	If yes, please explain			
8. Within the past five years, have you ever resigned from the staff of any hospital or professional organization because of problems regarding privileges or credentials?	No ☐ Yes ☐	If yes, please explain			
9. Within the past five years, have you ever been convicted or pleaded guilty to a felony?	No ☐ Yes ☐	If yes, please explain			
10. Do you currently use illegal drugs?	No ☐ Yes ☐	If yes, please explain including the last time you used it			
11. Have you ever been arrested for driving under the influence of alcohol?	No ☐ Yes ☐	If yes, please explain			

SECTION X: BHCS TRAINING (*Re-Credentialing Only*)			
Did you attend BHCS QA sponsored trainings?	No ☐ Yes ☐	Name of Training	Date of Training

SECTION XI: CLINICAL/REFERRAL PROFILE

BHCS' ACCESS unit serves as the primary referral source to the MHP Provider Network. In reference to Section II Referrals, please check all areas of expertise for which you would be interested in accepting new client referrals from the ACCESS Program. Please check all areas of expertise/specialty you have. You must provide detailed information to substantiate experience.

Area of Expertise

Diagnosable Mental Disorders

☐	Adjustment Disorders	☐	Conduct Disorders	☐	Oppositional Defiant Disorder
☐	Anxiety Disorders	☐	Depressive Disorders	☐	Personality Disorder
☐	Asperger's Disorders	☐	Dissociative Disorders/MPD	☐	Phobias
☐	Attachment Disorders	☐	Eating Disorders (ED)	☐	Psychotic Disorders
☐	Attention Deficit Disorder	☐	Gender Identity	☐	Schizophrenic Disorders
☐	Attention Deficit Disorder	☐	Obsessive Compulsive Disorder		
☐	Bipolar Disorder	☐	Obsessive Compulsive Disorder		

Demographic Factors

☐	Children (0-5)	☐	Adults (18-64)
☐	Children (6-12)	☐	Older Adults (60+)
☐	Adolescents (13-17)	☐	Court Dependents
☐	Transitional Age Youth (18-25)	☐	LGBTQI

Psychosocial Problems

☐	Adoption	☐	HIV/AIDS	☐	Sexual Abuse Survivor
☐	Assaultive Behavior/Anger Management	☐	Medical Conditions	☐	Sexual Perpetrators: (Adults)
☐	Co-Occurring Disorder (SA and MH)	☐	Neurological Conditions	☐	Sexual Perpetrators: (Juveniles)
☐	Developmentally Disabled *with* MH problems	☐	Occupational Stress	☐	Substance Abuse
☐	Domestic Violence	☐	Physical Abuse Survivor	☐	Suicide History
☐	Family Relationship/Parenting	☐	Pregnancy Issues	☐	Trauma/PTSD

Clinical Specialties From Above List: Please provide detailed information re: experience, education, certification and training to substantiate each area of specialty. Use additional pages as necessary.

NOTE: If you have experience providing eating disorder (ED) treatment but are not currently certified, you must complete the supplemental questionnaire for ED.

1.

2.

3.

4.

5.

SECTION XI: CLINICAL/REFERRAL PROFILE			
BHCS' ACCESS unit serves as the primary referral source to the MHP Provider Network. In reference to Section II Referrals, please check all areas of expertise for which you would be interested in accepting new client referrals from the ACCESS Program. Please check all areas of expertise/specialty you have. You must provide detailed information to substantiate experience.			
Services			
☐	Case Management	☐	Couples Counseling
☐	Groups	☐	Medication Support
☐	Home Visits	☐	Individual Therapy
☐	Psychological Testing	☐	Inpatient Experience
☐	Family Counseling		
Modality			
Select all that you are trained AND qualified to provide therapy. Please attach applicable education, experience and certifications.			
☐	Eye Movement Desensitization and Reprocessing	☐	Hypnotherapy
☐	Dialectical Behavioral Therapy	☐	Motivational Interviewing
☐	Cognitive Behavioral Therapy	☐	Other

SECTION XII: COMPOSITION OF OWNERSHIP			
Race/ethnicity must be reported for Alameda County's payment practices with the Auditor's Office. Please select the most applicable category below:			
☐	African American or Black (> 50%)	☐	Multi-ethnic minority ownership (> 50%)
☐	American Indian or Alaskan Native (> 50%)	☐	Multi-ethnic ownership (50% Minority – 50% Non-Minority)
☐	Asian (> 50%)	☐	Native Hawaiian or other Pacific Islander (> 50%)
☐	Caucasian/White (> 50%)	☐	Other (> 50%)

CERTIFICATION

I, the undersigned, hereby attest that the information given in or attached to this application is accurate, complete, and fairly represents the current level of my training, experience, capability, and competence to practice at the level requested. I specifically authorize Alameda County BHCS and its authorized representatives to consult with any third party which may have information bearing on the subject matter Addressed by this Application.

I also specifically authorize any third parties to release information to Alameda County BHCS and/or its authorized representatives upon request. I hereby release Alameda County BHCS and/or its authorized representatives, and any third parties, from any liability for any reports, records, recommendations, or other documents or disclosures involving me that are made, requested, or received by you and/or your authorized representatives to, from, or by any third parties, including otherwise privileged or confidential information, made or given in good faith and relating to the subject matter Addressed by this Application.

I warrant that I have the authority to sign this Application, on my own behalf, and on behalf of any entity or organization for which I am signing in a representative capacity. I understand that if this Application is accepted by the Alameda County Mental Health Plan, I will be bound by the terms of the Mental Health Plan, of which this Application is a part.

I also understand that as a condition of enrollment, I am required to consent to criminal background checks including fingerprinting when required to do so under State law or by the level of screening based on risk of fraud, waste or abuse as determined by my provider category.

I understand that the information contained in this Application, and the verification of this information, may be shared with the mental health plans, such as, but not limited to Marin, Napa, Santa Clara, San Francisco, and/or Sonoma Counties.

I can perform the duties of this provider position.

I have provided the following information and/or documentation:

- A current and up-to-Date NPI Number or have applied for a NPI Number
- A completed the W-9 form (*For Re-Credentialing applicants, complete only if tax information has changed*)
- A photocopy of my state license(s)
- For physicians only: a copy of my DEA certificate
- For physicians only: a completed Accreditation and Verification form
- A copy of my professional malpractice and general liability insurance verification (*with minimum coverage in accordance with Exhibit C County of Alameda Minimum Insurance Requirements*)
  You are required to submit proof of renewal annually as part of the contract agreement with Alameda County BHCS.
- A recent resume (*Required for new Credentialing applicants. Provide during re-credentialing only if new education, training, certification since last credentialing date.*)
- All certificates that substantiate my Clinical Profile and Modalities
- All pages of this application are completed and this Certification page is signed
  Provider signature is required to complete this application. Stamped signatures will not be accepted.

Printed Name	**Title**
Signature	**Date *(must be within 60 days of submission)***

Any information entered into this application which subsequently is found to be false could result in Alameda County BHCS' refusal to enter into a contract with the undersigned, or termination of any contract with the undersigned.

APPENDIX D

ACCESS REFERRAL LETTER

CONFIDENTIAL

Alameda County
Behavioral Health Care Services
Mental Health Plan

Access Program

(Level: 3)
2000 Embarcadero Cove, Ste. 205, Oakland, CA 94606

TO:
FAX #:

Referral # 164550 referral form3 10/14/98
1 (800) 491-9099 Fax: (510) 346-1083

Referral Letter

Date: 9/22/2017 Reviewed by: Staff Staff #: 9999
Provider Name:
Provider Address:
Provider Phone #: Provider Ext:
Client Name: Test Case, Joe PSP Number: 75071453
Client Address: 123 B street Hayward, CA. 94541-
Client's Date of Birth: 6/1/1987 Social Security #: 000-00-0000
Client Phone #: 510-999-9999 Work Phone #: Other Phone #:
Insurance Medi-Cal Insurance No: 000000000

We are referring the above-named client to you for:

☑ Assessment and possible treatment
☐ Other (describe)
☐ Psycho-diagnostic evaluation
☐ Court Ordered Services
☐ Medication Evaluation

Based on the following symptoms:

Caller requesting therapy to help deal with symptoms of depression and anxiety, including panic attacks, isolation, and difficulty getting to work most days. This consumer is also being referred for medication evaluation and management.

Under the following condition:

☑ This is a Medi-Cal client who must continue to meet medical necessity criteria to be eligible for ongoing treatment. This Client has active Medi-Cal in the current month. It is your responsibility to verify Medi-Cal status and Share of Cost for subsequent months. You may do so by using the AEVS system. Authorization expires 6 months from the date of this referral letter.

PLEASE CONTACT CLIENT TO SCHEDULE AN APPOINTMENT WITHIN 10 BUSINESS DAYS OF DATE ON THIS REFERRAL LETTER.

If you have any questions regarding the above referral, or if you cannot offer an appointment within 10 business days of date on this letter, please contact the ACCESS reviewer at 1-800-491-9099. For therapy referrals only, the following services have been approved/pre-authorized: 2 sessions for assessment/treatment planning, 20 therapy sessions, 2 hours of brokerage/linkage and 2 hours of collateral. Attestation must be submitted to Utilization Management (formerly Authorization Services) prior to 3rd session and within 60 days of initial visit.
Fax to 510-567-8148.

APPENDIX E

REQUEST FOR PRIOR CONSULTATION

Alameda County Behavioral Health Care Services

REQUEST FOR PRIOR CONSULTATION

USE TO OBTAIN AUTHORIZATION/APPROVAL BEFORE CLIENT HAS BEEN SEEN. SUBMIT THIS INFORMATION DIRECTLY TO ACCESS PROGRAM ALONG WITH BENEFICIARY REGISTRATION FOR PRIOR CONSULTATION FORM AND SCREENING FORM FOR APPROPRIATE AGE..

BENEFICIARY NAME: _____

BIRTH DATE: _____

SSN: _____

MEDI-CAL NUMBER: _____

Referral Source/Agencies Involved in Referral

_____

Presenting Problem

_____

_____

_____

_____

_____

Functional Impairments

_____

_____

_____

_____

_____

_____

_____

CLINICIAN NAME: _____

PHONE: _____ EXT. _____ FAX: _____

IF ORGANIZATION, GIVE NAME: _____

SIGNATURE: _____ LICENSE: _____ DATE: _____

G: ACCESSFORMS/FORMS/PRIORCONSULT 6/2016

REV: 6/16

APPENDIX F

BENEFICIARY REGISTRATION FOR PRIOR CONSULTATION

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES

Beneficiary Registration For Prior Consultation

ACCESS PROGRAM
1900 EMBARCADERO COVE, SUITE 208
OAKLAND, CA 94606
PHONE 1-800-491-9099
FAX: (510) 346-1083

The following information must be filled out by the provider.
Forward this completed form, along with the Request For Prior Consultation, to the ACCESS Program at the above address.
For Boxes 1- 10, use CSI codes (See the INSYST Table of Codes for CSI codes).

CLIENT LAST NAME	FIRST NAME	MI	GEN Jr., Sr.
1. ALIAS LAST NAME	FIRST NAME	MI	GEN Jr., Sr.
BIRTH LAST NAME	FIRST NAME	MOTHER FIRST NAME	
2. ADDRESS	CITY ZIP CODE	PH # _____ ALT PH #	

SSN:_____-_____-_____	3: EDUCATION: __ __	4: PHYSICAL DISABILITY: __ __
D.O.B: _____-_____-_____	5: PRIMARY LANGUAGE: __	5: PREFERRED LANGUAGE: __
SEX: M / F	6: ETHNICITY/RACE:__ __ __ __ __	7: HISPANIC ORIGIN: __
8: MARITAL STATUS: __	10: BIRTH PLACE: _____	
9: CARE GIVER UNDER 18: __ __ OVER 18:__ __	__ __ COUNTY __ __ STATE __ __ COUNTRY	

IF CHILD LIVES WITH: PARENT o RELATIVE o PLACEMENT o
CONTACT PERSON: _____ GUARDIAN/CONSERVATOR o PARENT o
PHONE #: _____

PROVIDER NAME/ADDRESS:	PHONE # FAX #

INSIDE DOUBLE BORDERS FOR MENTAL HEALTH PLAN ADMINISTRATION USE ONLY:

TODAY'S DATE: REVIEWER: STAFF #:

MEDS ADDRESS: _____ CIN #_____

MEDI-CAL #: _____ EFF. DATE: _____ BIC ISSUE: _____

MEDICARE #: _____ PART A: _____ PART B: _____

OTHER INS:

COMMENTS:

VERIFIED / COMPLETED BY: _____

INSYST #: _____

DATA ENTRY BY: _____ DATE / / CLINICAL ENTRY BY: _____ DATE / /

REVISED 02/21/07

APPENDIX G

PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST

ACBHCS PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST (PTAR)

Please fax this completed form along with the medical records documenting the clinical indications or medical necessity to ACCESS at 510-346-1083. Authorization for psychological testing will not be considered until all sections of this form are completed. Psychological testing should not be initiated until an authorization has been received. Please note that extended testing for ADHD is not authorized prior to a thorough evaluation with rating scales and a clear explanation as to why the initial evaluation was insufficient to answer ADHD referral question(s).

Client Name: DOB:

Client SS#: InSyst Client ID:

Client's Primary Language: Client's 2ND Language:

Caretaker's Primary Language: Caretaker's 2nd Language:

Client Address: Phone No(s):

Child Welfare Worker's Name: Contact No:

Psychological Testing Referral by: Phone No.:

Primary Therapist/Physician: Agency/Phone No:

Prior Psychological Testing? Y/N
Date tested: By Whom:
Testing Report Attached Y/N. If not, why not able to obtain?

Mental Health Assessment Attached? Y/N
If not, why not able to obtain?

What are the specific referral questions that cannot be determined by diagnostic interviews, mental health assessment, review of psychological/psychiatric records, or a second opinion?

What are the current symptoms and/or functional impairments related to testing question(s)?

How will the results of testing affect the Treatment Plan?

History of client.
[Summary of psychosocial and medical information (with examination dates) and past treatment; include any past psychological testing, date and results, medical, psychiatric and neurological exams. List current medical & psychotropic medications/dosage/start date.]

Are there other psychological or medical explanations for current behavior/symptoms (i.e. closed head injury, medications, poisoning, thyroid dysfunction, etc.)? Y/N. Explain:

Is client actively abusing any substances? History? Y/N. Explain:

If this request is URGENT please check here: [ ] Reason for Urgent Request:

Authorization Request (Check all that apply):
_____ 16 hrs. Psychological/Developmental Testing
_____ 5 hrs. Neuropsychological Testing
_____ 1.5 hrs. Additional Report for:
_____ 1.5 hrs. Additional Report for:
_____ 3 hrs. Additional for Travel time if Client is Homebound or unable to travel to the testing site.
_____ 3 hrs. Additional for Monolingual, Limited English Speaking or Limited English Proficiency Client.

Select One:

_____Assign to psychologist selected by Access
_____Name of psychologist suggested for testing:
Contact Phone:
Fax:
Date available to begin testing:
Is psychologist fluent in client/family's primary language?

Provider Signature (with credential): Date:

Clinical Supervising Psychologist Signature (if required): Date:

The Access Unit reserves the right to assign specific psychologists.
Fax this request to 510-346-1083. Please use HIPAA compliant faxing procedures.
<u>This client should be tested only after written authorization from Access</u>

5/29/15

APPENDIX G-1

PROVIDER MANUAL ACBHCS PSYCHOLOGICAL TESTING

PROVIDER MANUAL
ACBHCS PSYCHOLOGICAL TESTING

INDEX

1. Psychological Testing Guidelines
2. Criteria for Approval of Psychological Testing
3. Guidelines for Review of Psychological Testing
4. Obtaining Authorization for Psychological Testing
5. Psychological Testing Report
6. Quality Assurance Process for Psychological Testing Reports

1.) PSYCHOLOGICAL TESTING GUIDELINES

- All psychological testing administered by providers requires the completion of a *Psychological Testing Authorization Request* (PTAR) form (Attachment I) and prior authorization by ACCESS.

2.) CRITERIA FOR APPROVAL OF PSYCHOLOGICAL TESTING

- The following criteria must be met for approval of psychological testing:
    - There is a need to clarify the client's diagnosis in order to further treatment, and one or more of the following is true:
        - Multiple treatment interventions have failed;
        - Non-verbal client must be assessed in the absence of historical data;
        - There is an unaccountable decline in the client's functioning;
        - The client presents with an unusual or high-risk behavior;
        - The client presents with a risk of non-emergency harm to self or others that is denied by the client; or
        - Other special circumstances.
- Note: ACCESS does not authorize psychological testing for:
    - General assessments unrelated to mental health treatment;
    - Learning disabilities;
    - Mental retardation;
    - Pre-adoption studies;
    - General intelligence testing;
    - General Diagnosing of Attention-Deficit/Hyperactivity Disorder (ADHD) (Please note that extended testing for ADHD is not authorized prior to a thorough evaluation with rating scales and a clear explanation as to why the initial evaluation was insufficient to answer ADHD referral question(s).);
    - Court ordered testing (with the exception of CFS referrals);
    - Ruling out dementias or other neurologically-based disorders prior to an evaluation by an appropriate medical specialist; and
    - Determining if medication is warranted.

3.) GUIDELINES FOR REVIEW OF PSYCHOLOGICAL TESTING

- The ACCESS Clinical Review Specialists (CRS) utilize the following guidelines in approving requests for psychological testing:
    - The PTAR form must include information that provides a compelling rationale for Psychological testing;

- The client must meet medical necessity criteria for Specialty Mental Health Services in order to be considered for psychological testing;
- Psychological testing must be an adjunct to ongoing mental health treatment (of at least three months duration);
- The consumer has not been tested within the last two years;
- Children six years and younger have not been tested within the last year;
- Neuropsychological testing requires a prior psychological testing and a prior neurological evaluation;
- Psychological testing is not to be performed during a crisis;
- Psychological testing shall not be performed solely to make decisions as to whether the client is to be on medication;
- Referral questions are specific, relevant and individualized to the client and the treatment plan; and
- The request for psychological testing must clearly demonstrate that testing is necessary at this time.

4.) OBTAINING AUTHORIZATION FOR PSYCHOLOGICAL TESTING

- Authorization Process:
  - Prior authorization by ACBHCS ACCESS for Psychological Testing is required,
  - Consistent use of Psychological Testing Codes which includes:
    Psychological Testing code 415-96101, Neuropsychological Testing code 417-96118 and Developmental Testing code 535-96111 performed by licensed or waivered Psychologists (by contract--ACBHCS may allow practicum students for specific programs).
  - 16 hours of Testing would be the standard authorization for 90 days.
  - If both Psychological Testing and Developmental Testing codes are utilized, it would remain a maximum of 16 hours in total.
  - If Neuropsychological Testing is authorized, an additional 5 hours of neuropsychological testing code 417-96118 would be added to the initial 16 hours of psychological testing, resulting in 21 hours of authorized testing.
    - Note Neuropsychological Testing is a sub-specialty that requires specialized training and experience to perform. It is only allowed if the client has already had psychological testing, a medical neurological work-up and appropriate questions remain.
  - Psychological and Neuropsychological Testing codes are <u>inclusive</u>:
    - Of Mental Health Assessment (323-90791 & 324—96151). Note, if only Psych Testing codes are being claimed without provision of any other MH services, the MH Assessment at 30 days is not required;
    - Of Plan Development (581). Note, if only Psych Testing codes are being claimed without provision of any other MH services, the Client Plan at 60 days is not required; and
    - Of Test Administration (including client interviewing, review of client records, & collaterals), Test Scoring, Interpretation, Report Writing, and Feedback.
  - If the client is monolingual, Limited English Speaking, or has Limited English Proficiency an additional 3 hours of Testing may be authorized. Priority for testing monolingual and Limited English Speaking clients will be given to bilingual psychologists who speak the same language as the client/family.

- If the client is home bound, or unable to travel to the testing site, an additional 3 hours of Testing may be authorized to include travel time if testing would otherwise not be possible. **This only applies to programs that are authorized to bill for their travel time and priority will be given to Psychologists that are nearby the client if they may travel to that particular site.**
- If one or two reports are written in addition to the Psychological Evaluation Report (for the guardian/parent and/or client), an additional 1.5 hours of Testing per Report may be authorized for each.
- In the highly unusual circumstance that the Psychologist is unable to complete the Psychological Testing with the client, they may call the Access Line for a clinical consult on how to proceed.
- Intervention services (Individual, Family, and/or Group Psychotherapy) are authorized and coded independently of Testing.

- The provider must submit a completed PTAR form by fax or mail to: ACBHCS ACCESS (Fax (510) 346-1083; 1900 Embarcadero, Suite, 208, Oakland, CA 94606).
- ACCESS will approve, defer, or deny PTARs. Only the ACCESS Clinical Review Specialists (CRS') are authorized to select and assign testing to a provider. However, the referring party may suggest a provider. Please indicate if the suggested provider is fluent in the client/family's primary language.
- The ACCESS CRS' will consult with the referring party or the provider within five working days of the request, as needed. Requests are deferred/pending for reasons such as further information is needed.
- When testing is approved by ACCESS, a *Psychological Testing Authorization Request – Response* (PTAR-R) form (Attachment II) is sent to the referring provider and an ACCESS Referral Letter and/or a PTAR-R form is sent to the psychologist/program selected to administer the testing. The selected provider is expected to contact ACCESS within 3 days of receiving the ACCESS Referral Letter/PTAR-R form to confirm whether they are able to accept the assignment. If so, ACCESS will fax the provider all of the referring materials; if not, ACCESS will assign the testing to another provider. The PTAR-R also gives the provider the number of hours authorized for testing and the time frame for testing to be completed (usually 90 days).
- When psychological testing services are denied or modified, the provider and the client will be sent a *Notice of Action* form (NOA-B and NOA-Back) within three days of the decision.

5.) PSYCHOLOGICAL TESTING REPORT

- Note: Psychological testing reports submitted without prior authorization, or completed in an untimely manner will not be approved for payment.
- All testing must be:
  - Per American Psychological Association (APA) guidelines;
  - Clinically adequate; and
  - Placed in the Medi-Cal client's clinical record.

6.) QUALITY ASSURANCE GUIDELINES FOR PSYCHOLOGICAL TESTING REPORTS

- ACBHCS expects that providers will comply with the Ethical Principles and Code of Conduct (June 2010) of the *American Psychological Association* (APA).
- ACBHCS also expects that providers who conduct psychological testing and prepare psychological test reports for minors who are dependents (WIC300) of the Juvenile Court, will be familiar with the *Guidelines For Psychological Evaluations In Child Protection Matters*

(1998) approved by the Council of Representatives of the APA [American Psychological Association Committee on Professional Practice and Standards (1998). *Guidelines for Psychological Evaluations in Child Protection Matters* Washington, DC: APA].

- ACCESS expects that providers will answer referral questions that are within the scope of practice for a licensed psychologist.
- Furthermore, ACCESS expects providers not to answer referral questions that are outside the particular field or fields of competence as established by his or her education, training and experience.
- Acceptable psychological test reports are those that:
    - Use the most recent edition of a specific test;
    - Use the version of the test in the client's language (if available);
    - Answer or address the reason(s) for referral;
    - Clearly describe whether the client's test-taking behavior did, or did not, allow the psychologist to arrive at a valid assessment of the client's functioning;
    - Offer a coherent psychological explanation for the behavior(s) of the client and how best to treat the behavior(s);
    - Employ a norm-referenced measure of adaptive behavior to assess the role of a developmental delay in the client's Axis I diagnosis;
    - Use age-related norms to describe test behavior when such norms are available;
    - Include a norm-referenced measure of cognitive functioning, and if not provide an explanation as to why the use of such a measure would not be in the best interests of the client;
    - Offer diagnoses consistent with ACBHCS designated version of the DSM Codes criteria, and, offer diagnoses that meet the definition of mental disorders found in the DSM manual. This is especially relevant to the severe and incapacitating developmental or behavioral deficits typically associated with the criteria that define the diagnosis of "Other Specified Early Childhood Psychoses" in the manual;
    - Consider diagnoses other than Oppositional Defiant Disorder for minors under the age of three years, and when writing reports that offer a diagnosis of Oppositional Defiant Disorder to minors between the ages of three and five years use carefully documented, behaviorally based, norm-referenced criteria;
    - Consider diagnoses other than Attention-Deficit /Hyperactivity Disorder for children under the age of three years, and when writing reports that offer a diagnosis of Attention-Deficit/Hyperactivity Disorder to minors between the ages of three and five years use carefully documented, behaviorally-based, norm-referenced criteria;
    - Offer new understandings about the functioning of the client beyond what could be achieved without the use of psychological tests;
    - Offer a diagnosis of Mental Retardation using norm-referenced instruments that address ACBHCS designated version of the DSM Code criteria. (Significant sub-average intellectual functioning, i.e., an IQ of 70 or below on an individually administered IQ test, and concurrent deficits or impairments in present adaptive functioning in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety); and
    - Report test results consistent with the administration of a full test battery, whether a development inventory, a measure of cognitive functioning, or other psychological measure.

ACBHCS PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST RESPONSE (PTAR-RESPONSE)

Date:

Psych Testing Referring Party:

Client Name:

InSyst Client ID:

Client Address:

Assigned Psychologist's Name:
Phone: Fax:
Email:

Provider will:

- Test this client only after receiving written authorization;
- Consult with all professionals involved in the client's care (i.e.: therapist, psychiatrist, Regional Center Case Manager, etc.) prior to testing, and to provide documentation of the consultation in the psychological report;
- Conduct a comprehensive psychological evaluation that includes: history, test behavior, mental status examination, along with individually administered measures of intelligence, achievement, neuropsychological screening, diagnosis, and personality;
- Provide a report to the referring source (or appropriate party) that integrates current test results and prior test results, as well as directly answering the referral questions which are specific and unique to this client.

Note: Treating provider must add psychological testing to the client's treatment plan.

ACBHCS USE ONLY BELOW THIS LINE

Psychological Testing Authorization
Testing Request Approved for _____ hours of psychological testing between / / and / /
Request Pending
Testing request pending (testing authorization withheld until the following conditions are met):
_____ Receipt of CFS Form ***directly*** from CSW with SCSW signature.
_____ Receipt of permission to test from conservator.
_____ Client must be examined by a medical _____ specialist prior to psychological testing. Please inform this office when the exam has occurred (provide written report with outcome).
_____ Other
Request Denied
____ Does not meet Medical Necessity Criteria
_____Not eligible for Specialty Mental Health Services
_____ Other

Reviewer: Phone: Date:

5/29/15

APPENDIX H

CLIENT PLAN

CLIENT PLAN

Page **1** of **2**

Name:
InSyst #:
RU#:

☐ **(If NOT check box)** **Client is an ACBHCS long-term beneficiary (3 mos tx--current or expected).**

PLAN TYPES ***(check one):*** □ **Initial** □ **Update** ***(includes Annual)***

LIFE GOALS: *CLIENT'S DESIRED RESULTS FROM MH INTERVENTIONS (Client quote if possible)*

CLIENT/FAMILY STRENGTHS *TOWARD OVERCOMING BARRIERS AND ACHIEVING DESIRED MH RELATED RESULTS*

IMPAIRMENTS OF FUNCTIONING IN DAILY LIVING

Area of Difficulty: *Community Life, Family Life, Safety School/Education, Vocational, Independent Living (ADL's), Health, Housing, Legal, SUD, Food/Clothing/Shelter, etc.*	**Level of Difficulty:** *Moderate, Or Severe*	**Describe Specific Functional Impairments related to MH Diagnosis's Signs & Symptoms.** *[For Case Mgt, must indicate need for C/M service, i.e. ct. is homeless. Also, must indicate (1) which severe Symptoms/Impairments resulting from MH Diagnosis that prevents client from accessing/maintaining needed services, or (2) for child that the lack of such services (caretaker not providing) exacerbates child's MH symptoms/impairments.]*

Long Term MH GOALS (Optional)
*(Links life goals & MH objectives)**:***

DISCHARGE PLAN
(readiness/timeframe/expected referrals/etc.):

Short–Term Mental Health Objectives: *Specific, quantifiable or observable outcomes of target symptoms, behaviors, or impairments in functioning. (Note: these are ALWAYS MENTAL HEALTH Objectives—even when providing Case Management Services.)*	**Target Date:** *(12 months unless specified as fewer)*	**At Reassessment:** *When appropriate indicate level of improvement; date and initial.*
OBJ#		
		□ Not Improved □ Somewhat Improved □ Very much Improved □ Met Date: Initials:

CLIENT PLAN

Page **2** of **2**

Name:
InSyst #:
RU#:

Short–Term Mental Health Objectives: *Specific, quantifiable or observable outcomes of target symptoms, behaviors, or impairments in functioning. (Note: these are ALWAYS MENTAL HEALTH Objectives—even when providing Case Management Services.)*	**Target Date:** *(12 months unless specified)*	**At Reassessment:** *When appropriate indicate level of improvement; date and initial.*
OBJ#		□ Not Improved □ Somewhat Improved □ Very much Improved □ Met Date: Initials:

LIST EACH SERVICE MODALITY AND IT'S DETAILED INTERVENTIONS:

BELOW LIST MODALITIES* *(for each include frequency & duration & interventions)*	**Detailed Intervention(s):** *(For Case Management indicate as relevant: "linkage to, and monitoring of, community support services for _____ (i.e. homelessness, joblessness, medical illness, or substance abuse) will result in client achieving their Mental Health Objectives of # and # listed above")*	**Optional:** *Check any Individuals involved—not limited to.*
		□ Case Manager □ Clinician □ MD/NP/PA □ Peer □ Family Partner □ Other:_____
		□ Case Manager □ Clinician □ MD/NP/PA □ Peer □ Family Partner □ Other:_____
		□ Case Manager □ Clinician □ MD/NP/PA □ Peer □ Family Partner □ Other:_____

Client/Guardian/Conservator:

By signing, I agree that I have: 1) participated in the development of the Treatment Plan, and 2) have been offered a copy of the plan.

		DATE
CLIENT (IF NO SIGNATURE, PLEASE SEE PROGRESS NOTE DATED:_____ FOR EXPLANATION & WHEN NEXT ATTEMPT WILL BE).		
GUARDIAN/PARENT (IF NEEDED & NO SIGNATURE, PLEASE SEE PROGRESS NOTE DATED:_____ FOR EXPLANATION & WHEN NEXT ATTEMPT WILL BE.)		
PROVIDER COMPLETING PLAN	INDICATE M/C CREDENTIAL	
LICENSED LPHA SUPERVISOR (IF NEEDED)	INDICATE LICENSED M/C CREDENTIAL	
PSYCHIATRIST/OTHER PRESCRIBER (REQUIRED WHEN PRESCRIBING)	INDICATE LICENSED M/C CREDENTIAL: MD, DO, NP, CNS, PA	

Planned Service Modalities which must be indicated in Plan if claimed include, but are not limited to: *Case Management, Collateral, Individual Psychotherapy, Family Psychotherapy, Group Psychotherapy, Individual Rehab., Group Rehab., Medication Services (E/M, Med. Trng. & Support, & RN Med. Svcs.), Crisis Residential, Adult Residential, Day Tx Intensive, Day Rehab., TBS, Psychological Testing, Katie A.: ICC & IHBS.* ***Non-Planned Service Modalities which need not be indicated in Plan include:*** *Psychiatric Diag. Eval., Behavioral Eval. (CFE, CANS, ANSA-T), Plan Development, Crisis Intervention, and Interactive Complexity.*

APPENDIX I

INITIAL MENTAL HEALTH ASSESSMENT – SHORT

Initial MH Assessment – Short Form

For Provider Use
☐ Informing Materials signed (annually)
☐ Release of Information Forms signed (annually)

Name: _____

Insyst# _____

RU# _____

PROVIDER	ADDRESS	PHONE	FAX

CLIENT LAST NAME	CLIENT FIRST NAME	MIDDLE NAME	SUFFIX (Sr.,Jr.)

PREFERRED LAST NAME	PREFERRED FIRST NAME	D.O.B. *Circle Preferred Pronoun: He/Him, She/Her, They/Them, Other:_____*

EPISODE OPENING DATE

Sex Assigned at Birth: ☐Male ☐Female ☐Intersex ☐Other:

Gender Identity: ☐Male ☐Female ☐Intersex ☐ Gender Queer ☐Unknown ☐Male to Female ☐Female to Male

☐Decline to State ☐Gender non-conforming ☐Other

SEXUAL ORIENTATION: ☐Unknown ☐Heterosexual/Straight ☐Lesbian ☐Gay ☐Bisexual ☐ Queer ☐Gender Queer ☐Questioning ☐Declined to State ☐Other:

Emergency Contact	Relationship	Contact address (Street, City, State, Zip)	Contact Phone number

☐Release for Emergency Contact obtained for this time period:

Assessment Sources of Information(Check All that Apply):	☐**Client**	☐**Family Guardian**	☐**School**	☐**Other:**

REFERRAL SOURCE/ RESON FOR REFERRAL/ CLIENT COMPLAINT

Describe precipitating event(s) for Referral; Current Symptoms and Behaviors (intensity, duration, onset, frequency): Impairments in Life Functioning caused by the MH symptoms/Behaviors (from perspective of client and/or others):

☐Narrative continued in Addendum

MENTAL HEALTH HISTORY

Inpatient & Outpatient Treatment, Trauma & Risk Factors (If any mandatory reports filed—discuss):

☐Narrative continued in Addendum

Name: _____

Insyst# _____

RU# _____

Mental Health Assessment Continued

PSYCHOSOCIAL HISTORY & FUNCTIONING

Include: Family History; *Family History (of mental illness, substance abuse, trauma, and neglect/abuse);* Complete Developmental History (children <18yrs.); Cultural factors; and History of Educational, Vocational, Social & Criminal Justice; Client/Family Strengths:

☐Narrative continued in Addendum

MEDICAL HISTORY

	Name:	**Phone#:**	**Last Date of Service**
a. Primary Physician:			
b. Other medical provider(s):			
c. Date records requested: From whom, if applicable:			

Relevant Medical History (complete checklist and comment on those checked below): ***Check only those that are relevant***

General Information:	Weight Changes:		Baseline Weight (if able to obtain):		BP:
Cardiovascular/Respiratory:	☐Chest Pain	☐Hypertension	☐Hypotension	☐Palpitation	☐Smoking
Genital/Urinary/Bladder:	☐Incontinence	☐Nocturnal	☐Urinary Tract Infection	☐Retention	☐Urgency
Gastrointestinal/Bowel:	☐Heartburn	☐Diarrhea	☐Constipation	☐Nausea	☐Vomiting
	☐Ulcers	☐Laxative Use	☐Incontinence		
Nervous System:	☐Headaches	☐Dizziness	☐Seizures	☐Memory	☐Concentration
Musculoskeletal:	☐Back Pain	☐Stiffness	☐Arthritis	☐Mobility/Ambulation	
Gynecology:	☐Pregnant	☐Pelvic Inflam. Disease	☐Menopause	☐TBI/ LOC	
Skin:	☐Scar	☐Lesion	☐Lice	☐Dermatitis	☐Cancer
Endocrine:	☐Diabetes	☐Thyroid	☐Other:		
Respiratory:	☐Bronchitis	☐Asthma	☐COPD	☐Other	

☐*Others:*

Other: ☐Significant Accident/Injuries/Surgeries: _____

☐Hospitalizations: _____

☐Physical Disabilities: _____

☐Chronic Illness: _____

☐HIV disease: _____

☐Liver disease:

Alternative healing practice/date (e.g., acupuncture, hypnosis, herbs, supplements, etc.)

Date	**Provider/Type**	**Reason for Treatment**	**Outcome (was it helpful and why)**

Name: _____

Insyst# _____

RU# _____

Mental Health Assessment Continued

Current/ previous medications (include all prescribed- psychotropics & non-psychotropics, over the counter, and holistic/ alternative remedies):							
	Rx Name	**Effectiveness/Side Effects**	**Dosage**	**Date Started**	**Prescriber**	**Current**	**Past**
Psychotropic							
Non-Psychotropic							

Allergies/Adverse Reactions/ Sensitivities	Check if Yes and List ☐Food ☐ Drugs(Rx/OTC/ILLICT) ☐Unknown Allergies ☐Other:

Date of last physical exam:		**Date of last dental exam:**	
Referral made to primary care or specialty	**☐NO**	**☐YES**	**If yes, list:**

Additional Medical Information:

☐Narrative continued in Addendum

SUBSTANCE USE									
SUBSTANCE EXPOSURE, **Check if ever used:**	**Prenatal Exposure Unknown**	**AGE AT FIRST USE**	**CURRENT SUBSTANCE USE**						
			None/ Denies	Current Use	Current Abuse	Current Dependence	In Recovery	Client-perceived Problem?	
ALCOHOL	☐		☐	☐	☐	☐	☐	Y☐	N☐
AMPHETAMINES (SPEED/UPPERS, CRANK, ETC)	☐		☐	☐	☐	☐	☐	Y☐	N☐
COCAINE/CRANK	☐		☐	☐	☐	☐	☐	Y☐	N☐
OPIATES (HEROIN, OPIUM, METHADONE)	☐		☐	☐	☐	☐	☐	Y☐	N☐
HALLUCIENOGENS (LSD, MUSHROOMS, PEYOTE, ECTASY)	☐		☐	☐	☐	☐	☐	Y☐	N☐
SLEEPING PILLS, PAIN KILLERS, VALIUM, OR SIMILAR	☐		☐	☐	☐	☐	☐	Y☐	N☐
PSP (PHENCYCLIDINE) OR DESIGNER DRUGS (GHB)	☐		☐	☐	☐	☐	☐	Y☐	N☐
INHALANTS (PAINT, GAS, GLUE, AREOSOLS)	☐		☐	☐	☐	☐	☐	Y☐	N☐
MARIJUANA/ HASHISH	☐		☐	☐	☐	☐	☐	Y☐	N☐
TABACCO/ NICOTINE	☐		☐	☐	☐	☐	☐	Y☐	N☐
CAFFEINE (ENGERY DRINKS, SODAS, COFFEE, ETC.)	☐		☐	☐	☐	☐	☐	Y☐	N☐
OVER THE COUNDER:	☐		☐	☐	☐	☐	☐	Y☐	N☐
OTHER SUBSTANCE:	☐		☐	☐	☐	☐	☐	Y☐	N☐
COMPLIMENETARY ALTERNATIVE MEDICATION	☐		☐	☐	☐	☐	☐	Y☐	N☐
Is beneficiary receiving alcohol and drug services?	☐Yes, from this provider		☐Yes, from a different provider			☐No			
If yes, type of alcohol and drug services:	☐Residential		☐Outpatient			☐Community/ Support Group			

Name: _____

Insyst# _____

RU# _____

Mental Health Assessment Continued

SUSBSTANCE RISKS, USE, & ATTITUDES/EXPOSURE

	NO	YES	UNABLE TO ASSESS
Were any risk factors identified based on clinical judgment?	☐	☐	☐
Does the client currently appear to be under the influence of alcohol or drugs?	☐	☐	☐
Has the client ever received professional help for his/her use of alcohol or drugs?	☐	☐	☐
Comments on alcohol/drug use: ☐Narrative continued in Addendum			
How is the mental health impacted by substance use (clinician's perspective)? *Must be completed if any services will be directed towards substance Use/Abuse, such as Case Management.*	☐Narrative continued in Addendum		

SUBSTANCE ABUSE/SEVERITY ASSESSMENT:

A. Beneficiary self-assessment (*check one)*:

- ☐ No alcohol or drug use
- ☐ Alcohol or drug use with no related problems
- ☐ Alcohol or drug use with related problems

B. Provider assessment (*check one*):

- ☐ Use (minimal or no alcohol or drug relation problems)
- ☐ Substance abuse (frequent and/or periodic use associated with alcohol or drug problems)
- ☐ Substance dependence in recovery (prior significant, but now minimal or no substance related problems)
- ☐ Substance dependence not in recovery (uncontrolled use with significant alcohol or drug related problems)

SUD REFERRALS (From the ACBHCS SUD Treatment Referral Guide, www.acbhcs.org/providers/SUD/resources.htm, indicate the specific referrals provided to client.)

Check below, for any referral made based on abuse assessment. List specific referral below.

☐Referral to SUDS (Substance Use Disorder Services) ACCESS line #1-800-491-9099 for:

- ☐ Self-help groups- groups for consumer's interested in support of sobriety include AA, NA, and Dual Recovery Anonymous. Referral should ideally be to a group known to support clients in psychiatric recovery. • Alcoholic Anonymous 510-839-8900
  •Moderation Management:paulstayley@comcast.net or www.moderation.org
- ☐ Outpatient counseling- for consumer's assessed at abuse level, and who have an environment supportive of recovery.
- ☐ Residential treatment- for chemically dependent consumer's with a low level of function, requiring an intense level of support to initiate sobriety.
- ☐ Detoxification- for chemically dependent consumers who are at risk of at least moderate withdrawal symptoms, and who require high level of structure to initiate sobriety.
- ☐ Other (specify):

Name: _____

Insyst# _____

RU# _____

Mental Health Assessment Continued

MENTAL STATUS: ***(Check and describe if abnormal or impaired)***				
Appearance/Grooming:	☐Unremarkable	Remarkable for:		
Behavior/Relatedness:	☐Unremarkable	☐Motor Agitated	☐Inattentive	☐Avoidant
	☐Impulsive	☐Motor Retarded	☐Hostile	☐Suspicious/Guarded
	☐Other:			
Speech:	☐Unremarkable	Remarkable for:		
Mood/Affect:	☐Unremarkable	☐Depressed	☐Elated/Expansive	☐Anxious
	☐Labile	☐Irritable/Angry	☐Other:	
Thought Processes:	☐Unremarkable	☐Concrete	☐Distorted	☐Disorganized
	☐Odd/Idiosyncratic	☐Blocking	☐Paucity of Content	☐Circumstantial
	☐Tangential	☐Obsessive	☐Flight of Ideas	☐Racing Thoughts
	☐Loosening of Assoc	☐Other:		
Thought Content:	☐Unremarkable	☐Hallucinations	☐Delusions	☐Ideas of Reference
	☐Other			
Perceptual Content:	☐Unremarkable	☐Hallucinations	☐Homicidal Ideation	☐Paranoid Reference
	☐Flashbacks	☐Depersonalization	☐Derealization	☐Dissociation
	☐Other:			
Fund of Knowledge:	☐Unremarkable	Remarkable for:		
Orientation:	☐Unremarkable	Remarkable for:		
Memory:	☐Unremarkable	Impaired:		
Intellect:	☐Unremarkable	Remarkable for:		
Insight/Judgment:	☐Unremarkable	Remarkable for:		

Describe abnormal/impaired findings:

☐Narrative continued in Addendum

FUNCTIONAL IMPAIRMENTS:

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Family Relations	☐	☐	☐	☐	Circle appropriate: Substance Use/Abuse	☐	☐	☐	☐
School Performance/Employment	☐	☐	☐	☐	Activities of Daily Living	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Episodes of decompensation & increase of symptoms, each of extended duration	☐	☐	☐	☐
					Other (Describe):	☐	☐	☐	☐
Food/Shelter	☐	☐	☐	☐					
Social/Peer Relations	☐	☐	☐	☐					
Physical Health	☐	☐	☐	☐					

Comments (if any):

☐Narrative continued in Addendum

TARGETED SYMPTOMS:

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Cognition/Memory/Thought	☐	☐	☐	☐	Perceptual Disturbance	☐	☐	☐	☐
Attention/Impulsivity	☐	☐	☐	☐	Oppositional/Conduct	☐	☐	☐	☐
Socialization/Communication	☐	☐	☐	☐	Destructive/Assaultive	☐	☐	☐	☐
Depressive Symptoms	☐	☐	☐	☐	Agitation/Lability	☐	☐	☐	☐
Anxiety/phobia/Panic Attack	☐	☐	☐	☐	Somatic Disturbance	☐	☐	☐	☐
Affect Regulation	☐	☐	☐	☐	Other:	☐	☐	☐	☐

Comments (if any):

☐Narrative continued in Addendum

MEDICAL NECESSITY

Name: _____

Insyst# _____

RU# _____

Mental Health Assessment Continued

Impairment Criteria, must have one of the following :		AND:	Intervention Criteria, proposed INTERVENTION will:
☐ A.	Significant impairment in an important area of life function.	**AND**	A. Significantly diminish impairment
☐ B.	Probability of significant deterioration in an important area of functioning.	**AND**	B. Prevent significant deterioration in an important area of life functioning.
☐ C.	(Under 21) Without treatment will not progress developmentally as individually appropriate.	**AND**	C. (Under 21) Probably allow the child to progress developmentally as individually appropriate.
☐ D.	None of the above.	**AND**	D. None of the above

ICD-10 DX's — NOT BY HISTORY, MUST BE CURRENT DIAGNOSTIC FORMULATION

Dimensions:	**ICD-10 Code:**	**DSM –5* Description WITH all specifiers:** **for Codes F84.5, F84.9, F84.2, F84.3 & F84: list DSM-IV-TR Descriptor (Dx Name)*	**Primary & Secondary Dx's**
MH Diagnoses:			**PRIMARY DX**
			Secondary Dx
			Secondary Dx
			Secondary Dx
Substance Use Diagnoses:			Secondary Dx
			Secondary Dx
			Secondary Dx
Psychosocial Conditions Diagnoses:			
General Medical Conditions:			

Optional Disability Measures (WHODAS, etc.):	Diagnosis est.by (with license):	On date:

ADDENDUM

Name: _____

Insyst# _____

RU# _____

Mental Health Assessment Continued

Alameda County Behavioral Health Care Services Mental Health Assessment
Infant/Toddler (0-5 yrs.) ADDENDUN TO INTAKE DATE:

Provider: _____
Beneficiary: _____

MENTAL STATUS – *check all that are appropriate:*

Appearance	**Reactions**	**State-Regulation**	**Unusual Behavior**	**Activity Level**
☐ Well-groomed	☐ Explores	☐ Asleep	☐ Mouthing after 1yr	☐ Squirming
☐ Disheveled	☐ Freezes	☐ Quiet Alert	☐ Head Banging	☐ Sitting Quietly
☐ Small for sage	☐ Cries	☐ Active Alert	☐ Smelling objects	☐ Constantly moving
☐ Large for age	☐ Hides face	☐ Distress	☐ Spinning/twirling	☐ Climbing
☐ Inappropriate dress	☐ Acts Excited	☐ Smooth Transition	☐ Hand flapping	☐ Visual Fixing
☐ Dysmorphic features	☐ Acts Apathetic	☐ Abrupt Transitions	☐ Finger flickering	☐ Tracking
☐ Abnormal head size	☐ Anxious	☐ Able to sooth self	☐ Rocking	☐ Attention to faces
☐ Cutaneous lesions	☐ Difficulty with transitions	☐ Seeks simulation excessively	☐ Tow walking	☐ Attention to own hands
☐ Looks young for age	☐ Adapts to situation	☐ Hyper-responsive	☐ Staring at lights	☐ Frozen
☐ Looks mature for age	☐ Avoidance	☐ Hypo-responsive	☐ Preservative speech	☐ Average of attention to task
☐ Other:	☐ Withdrawal	☐ Other:	☐ Bizarre behaviors	☐ Other:
	☐ Aggression		☐ Hair Pulling	
	☐ Easily frustrated		☐ Breath Holding	
	☐ Other:		☐ Ruminating	

Gross Motor	**Fine Motor**	**Speech/ Language**	**Mood**	**Affect**
☐ Pushes up	☐ Grasps/releases	☐ Responds to sounds	☐ Depressed	☐ Flat
☐ Controls heads	☐ Transfer hands	☐ Follow commands	☐ Anxious	☐ Blunted
☐ Rolls over	☐ Pincer grasps	☐ Points “where is?”	☐ Euphoric	☐ Restricted
☐ Sits alone	☐ Banging	☐ Vocalizes sounds	☐ Irritable	☐ Broad
☐ Stands	☐ Throwing	☐ Single Words #	☐ Angry	☐ Labile
☐ Walks	☐ Stacking	☐ Short phrases	☐ Bored	☐ Congruent
☐ Runs	☐ Scribing	☐ Full sentences	☐ Shy	☐ Other:
☐ Jumps	☐ Cutting	☐ Caregiver understands	☐ Responsive to caregiver	
☐ Climbs	☐ Handles Toys	☐ Echolalia	☐ Other:	
☐ Other:	☐ Other:	☐ Overgeneralizations		

Cognition	**Thought**	**Play**
☐ WNL	☐ Specific Fears	☐ Sensorimotor Play
☐ Developmental Delay	☐ Feared object	☐ (0-6 mo.) mouthing, dropping, banging, throwing
☐ Precocious	☐ Worry about being lost	☐ (6-12 mo.) exploring, moving, poking, pulling
☐ Other:	☐ Fear of separation	☐ Functional play (12-18 mo.) shows understanding of use/function
	☐ Dreams/Nightmares	☐ Early symbolic splay (18+ mo.) presents with increasing complexity
	☐ Dissociative state	☐ Complex symbolic play (30+ mo.) plans/acts out dramatic play
	☐ Sudden withdrawal	☐ Uses imaginary objects
	☐ Eyes glazed	☐ Imitation, turn taking, problem solving
	☐ Failure to track	☐ Emotional themes
	☐ Hallucinations	☐ Other:
	☐ Other:	

Name: _____

Insyst# _____

RU# _____

Mental Health Assessment Continued

History of Caregiving	Duration and separations?
☐ Day Care	
☐ Relative Care	
☐ Hospital	
☐ Foster Care	
Number of placements	

ATTACHMENT OBSERVED: Check all that are appropriate:	
Pre-attachment (4-6 weeks)	☐ Orients to people, social smile ☐ Signal for help
Attachment in the Making (1-8 months)	☐ 4-6 weeks recognizes sound and feel ☐ 4 months- visual discrimination ☐ 5-6 months- reaches, actively prefers through actions
Clear cut attachment (7-12 months)	☐ Object Constancy ☐ Protests Separations, responds to internal needs ☐ Normal Stranger Anxiety ☐ Normal Separation Anxiety
Goal Directed Partnership (12-36 months)	☐ Attachment sequences with modulation of affect ☐ Two-way communication of feelings ☐ Intentional communication of needs & goals ☐ Demonstrates problem solving skills integrated with affect ☐ Able to remain organized in challenging situations

Clinician: _____	_____	_____	_____
Print	Signature, Discipline	License/Registration#	Date
Licensed Supervisor:	Signature, Discipline		
Print		License#	Date

v. 4.11.17

APPENDIX J

INITIAL MENTAL HEALTH ASSESSMENT – LONG

Mental Health Assessment – Long Form

Name: _____

For Provider Use	
☐ Initial	☐ Update
☐ Informing Materials signed (annually)	
☐ Release of Information Forms signed	

Insyst# _____

RU# _____

PROVIDER	ADDRESS	PHONE	FAX
CLIENT LAST NAME	CLIENT FIRST NAME	MIDDLE NAME	SUFFIX(Sr.,Jr.)
PREFERRED LAST NAME	PREFERRED FIRST NAME		D.O.B. MM/DD/YY --- MM/DD/YY
EPISODE OPENING DATE	INDICATE 12 MO. AUTHORIZATION CYCLE		*Circle Preferred Pronoun: He/Him, She/Her, They/Them, Other:_____*

Sex Assigned at Birth: ☐Male ☐Female ☐Intersex ☐Other:

Gender Identity: ☐Male ☐Female ☐Intersex ☐ Gender Queer ☐Gender Non-Conforming ☐Male to Female ☐Female to Male

☐Other:

Emergency Contact	Relationship	Contact address (Street, City, State, Zip)	Contact Phone number

☐Release for Emergency Contact obtained for this time period:

Assessment Sources of Information(Check All that Apply): ☐**Client** ☐**Family Guardian** ☐**School** ☐**Other:**

REFERRAL SOURCE/ RESON FOR REFERRAL/ CLIENT COMPLAINT

Describe precipitating event(s) for Referral:

☐Narrative continued in Addendum

Current Symptoms and Behaviors (intensity, duration, onset, frequency):

☐Narrative continued in Addendum

Impairments in Life Functioning caused by the MH symptoms/Behaviors (from perspective of client and/or others):

☐Narrative continued in Addendum

MENTAL HEALTH HISTORY

Psychiatric Hospitalizations: ☐ Yes ☐ No ☐ Unable to Assess

If Yes, describe dates, locations, reasons, response to, and satisfaction with treatment:

☐Narrative continued in Addendum

Outpatient Treatment: ☐ Yes ☐ No ☐ Unable to Assess

If Yes, describe dates, locations, reasons, response to, and satisfaction of treatment:

☐Narrative continued in Addendum

Mental Health Assessment Continued

MENTAL HEALTH HISTORY CONTINUED

Prior Mental Health Records Requested: ☐ **Yes** ☐ **No (See InSyst Face Sheet for current and history of past services)**
Prior Mental Health Records Requested from:

☐ Narrative continued in Addendum

History of Trauma or Exposure to Trauma: ☐ **Yes** ☐ **No** ☐ **Unable to Assess**
Has client ever: (1) been physically hurt or threatened by another, (2) been raped or had sex against their will, (3) lived through a disaster, (4) been a combat veteran or experienced an act of terrorism, (5) been in severe accident, or been close to death from any cause, (6) witnessed death or violence or the threat of violence to someone else, or (7) been the victim of crime? **Describe:**

☐ Narrative continued in Addendum

Risk factors:
Aggressive/violent behavior/danger to self/others, and include level of impairments (i.e., school suspension, law enforcement/incarceration, crisis services, and hospitalization)
☐ *Please check if occurred within the last 30 days. Date of onset*_____
Client:

Family:

☐ Narrative continued in Addendum

☐ **Safety plan completed or MH objective in Tx Plan**

Additional Risk Assessment (Elaboration of ALL risk factors, note: frustration tolerance, hostility, paranoia, command hallucination, violent thinking, exploitative, and gambling risk behaviors. Also include factors that might lessen risk, such as client's commitment to self-control and involvement in treatment)

☐ Narrative continued in Addendum

Reports Filed as a result of this Assessment: ☐ **N/A** ☐ **CPS** ☐ **APS** ☐ **Other:**_____

Mental Health Assessment Continued

PSYCHOSOCIAL HISTORY

FAMILY HISTORY

☐Narrative continued in Addendum

FAMILY HISTORY OF MENTAL ILLNESS, SUBSTANCE ABUSE/NEGLECT (physical, sexual, emotional, etc.), AND/OR SUICIDE (suicide attempt/ unexplained death):

☐Narrative continued in Addendum

Cultural factors which may influence presenting problems as viewed by client/family/caregiver and clinician (may include ethnicity, race religion, spiritual practice, sexual orientation, gender identity, caregiver socioeconomic status, living environment, etc.):

☐Narrative continued in Addendum

How is beneficiary's/family's diversity a strength for the beneficiary?

☐Narrative continued in Addendum

What special treatment issues result from beneficiary's/ family's diversity?

☐Narrative continued in Addendum

SEXUAL ORIENTATION: ☐Unknown ☐Heterosexual/Straight ☐Lesbian ☐Gay ☐ Bisexual ☐ Queer ☐Gender Queer ☐Questioning ☐Declined to State ☐Other:

ADULTS, 18+ yrs. only (CHILDREN & YOUTH, *SEE PAGE 8*)

Childhood (where, who reared/lived in house where grew up, important/traumatic events, school experience and performance, history of physical/sexual abuse, placement history, etc.).

☐Narrative continued in Addendum

Adolescence (school and activities, friendships/relationships, sexual experiences, traumas, leaving home, placement history, etc.)

☐Narrative continued in Addendum

Adulthood (military service, marriage/divorce, children, geographical changes, traumas, current relationship with family/significant other, etc.)

☐Narrative continued in Addendum

Aging issues (retirement, grandchildren, support systems, sleep changes, losses, etc.)

☐Narrative continued in Addendum

Education and Vocational History (first job, longest job, current structured activities, type of work, etc.)

☐Narrative continued in Addendum

Mental Health Assessment Continued

PSYCHOSOCIAL HISTORY CONTINUED

CRIMINAL HISTORY

Criminal Justice History/Violent Incidents of Individual and/or Family	Within last 90 days		Past	
	Y	N	Y	N
Assault on persons				
Threat to persons				
Property Damage				
Weapons Involved				
Legal History				

	Within last 90 days		Past	
	Y	N	Y	N
Probation				
Parole				
Adjudicated				
Diversion				
Other:				

Describe criminal justice involvement/incidents (include level of community threat/safety, dates, types of crimes, outcomes, etc.)

☐ Narrative continued in Addendum

Describe any relevant family involvement with criminal justice (include level of community threat/safety, dates, types of crimes, outcomes, etc.)

☐ Narrative continued in Addendum

MEDICAL HISTORY

	Name:	Phone#:	Last Date of Service
d. Primary Physician:			
e. Other medical provider(s):			
f. Date records requested: From whom, if applicable:			

Relevant Medical History (complete checklist and comment on those checked below): ***Check only those that are relevant***

General Information:	Weight Changes:		Baseline Weight (if able to obtain):		BP:
Cardiovascular/Respiratory:	☐ Chest Pain	☐ Hypertension	☐ Hypotension	☐ Palpitation	☐ Smoking
Genital/Urinary/Bladder:	☐ Incontinence	☐ Nocturia	☐ Urinary Tract Infection	☐ Retention	☐ Urgency
Gastrointestinal/Bowel:	☐ Heartburn	☐ Diarrhea	☐ Constipation	☐ Nausea	☐ Vomiting
	☐ Ulcers	☐ Laxative Use	☐ Incontinence		
Nervous System:	☐ Headaches	☐ Dizziness	☐ Seizures	☐ Memory	☐ Concentration
Musculoskeletal:	☐ Back Pain	☐ Stiffness	☐ Arthritis	☐ Mobility/Ambulation	
Gynecology:	☐ Pregnant	☐ Pelvic Inflam. Disease	☐ Menopause	☐ TBI/ LOC	
Skin:	☐ Scar	☐ Lesion	☐ Lice	☐ Dermatitis	☐ Cancer
Endocrine:	☐ Diabetes	☐ Thyroid	☐ Other:		
Respiratory:	☐ Bronchitis	☐ Asthma	☐ COPD	☐ Other	

☐ *Others:*

Other:
- ☐ Significant Accident/Injuries/Surgeries: _____
- ☐ Hospitalizations: _____
- ☐ Physical Disabilities: _____
- ☐ Chronic Illness: _____
- ☐ HIV disease: _____
- ☐ Liver disease:

Comments:

☐ Narrative continued in Addendum

Mental Health Assessment Continued

MEDICAL HISTORY CONTINUED

Alternative healing practice/date (e.g., acupuncture, hypnosis, herbs, supplements, etc.)

Date	Provider/Type	Reason for Treatment	Outcome (was it helpful and why)

Current/ previous medications (include all prescribed- psychotropics & non-psychotropics, over the counter, and holistic/ alternative remedies):

	Rx Name	Effectiveness/Side Effects	Dosage	Date Started	Prescriber	Current	Past
Psychotropic							
Non-Psychotropic							

Allergies/Adverse Reactions/ Sensitivities Check if Yes and List ☐Food ☐ Drugs(Rx/OTC/ILLICT) ☐Unknown Allergies ☐Other:

Date of last physical exam: **Date of last dental exam:**

Referral made to primary care or specialty ☐**NO** ☐**YES** **If yes, list:**

Additional Medical Information:

☐Narrative continued in Addendum

Name: _____

Insyst# _____

RU# _____

Mental Health Assessment Continued

This Section for YOUTH ONLY < 18 YRS OLD	☐ See MENTAL HEALTH ASSESSMENT ADDENDUM FOR INFANT/TODDLERS, AGES 0-5		
LIVES WITH:	First Name of others in home (children & adults)	Age	Relationship
☐Immediate Family			
☐Extended Family			
☐Foster Family			
☐Other			

DESCRIBE FAMILY OF ORIGIN:

☐Narrative continued in Addendum

EDUCATION	Current School:	Spec Ed ☐ YES ☐ NO
Grade:	Contact/Teacher/ Ph#:	
Active IEP/Special Assessment/Services:		☐ LD ☐ DD/ID ☐ SED
Last School Attended:		
Vocational Activities:		

Developmental History (for each section also include any significant culturally related rites of passage, rituals, ceremonies, etc.)

Prenatal/birth/childhood information (include pregnancy, developmental milestones, environmental stressors, and other significant events) 0-6yrs:

☐Narrative continued in Addendum

Latency (peer/sibling relations, extracurricular activities, delinquency, environmental stressors of other significant events) 7-11yrs.:

☐ N/A

☐Narrative continued in Addendum

Adolescence (include onset of puberty, extracurricular activities, teen parenthood, delinquency, gang involvement, environmental stressors of other significant events) 12-17 yrs.:

☐ N/A

☐Narrative continued in Addendum

Name: _____

Insyst# _____

RU# _____

Mental Health Assessment Continued

SUBSTANCE USE

SUBSTANCE USE SCREENING

0-10 yo:

☐ Child is under 11 years and SUD screening not indicated per clinical judgment. ☐ See Substance Risk, Use, & Attitude Exposure, next page.

11-17yo:

☐ Client is unwilling to discuss at this time; will address as appropriate.

During the Past 12 months, did you:	NO	YES
1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high? (anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	☐	☐
For Clinic use only: Did patient answer "yes" to any question?	☐	☐

NO ↓ **Ask CAR question #1 below, then stop**

YES ↓ **Ask all 6 CRAFFT questions below**

	NO	YES
1. Have you ever ridden in a **C**AR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to **R**ELAX, feel better about yourself, or fit it?	☐	☐
3. Do you every use alcohol or drugs while you are by yourself or **A**LONE?	☐	☐
4. Do you every **F**ORGET things you did while using alcohol or drugs?	☐	☐
5. Do your **F**AMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into **T**ROUBLE while you were using alcohol or drugs?	☐	☐

2 or more "yes" indicate need for further assessment.

18+yo	NO	YES
A. Have you felt you should cut down or stop drinking or using substance?	☐	☐
B. Has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using substance?	☐	☐
C. Have you felt guilty or bad about how much you drink or use of substance?	☐	☐
D. Have you been waking up wanting to drink or use substance?	☐	☐

Any "yes" answer may indicate a problem and need for further assessment.

SUBSTANCE EXPOSURE

Check if ever used:	**Prenatal Exposure Unknown**	**AGE AT FIRST USE**	**CURRENT SUBSTANCE USE** None/ Denies	Current Use	Current Abuse	Current Dependence	In Recovery	Client-perceived Problem?	
ALCOHOL	☐		☐	☐	☐	☐	☐	Y☐	N☐
AMPHETAMINES (SPEED/UPPERS, CRANK, ETC)	☐		☐	☐	☐	☐	☐	Y☐	N☐
COCAINE/CRANK	☐		☐	☐	☐	☐	☐	Y☐	N☐
OPIATES (HEROIN, OPIUM, METHADONE)	☐		☐	☐	☐	☐	☐	Y☐	N☐
HALLUCIENOGENS (LSD, MUSHROOMS, PEYOTE, ECTASY)	☐		☐	☐	☐	☐	☐	Y☐	N☐
SLEEPING PILLS, PAIN KILLERS, VALIUM, OR SIMILAR	☐		☐	☐	☐	☐	☐	Y☐	N☐
PSP (PHENCYCLIDINE) OR DESIGNER DRUGS (GHB)	☐		☐	☐	☐	☐	☐	Y☐	N☐
INHALANTS (PAINT, GAS, GLUE, AREOSOLS)	☐		☐	☐	☐	☐	☐	Y☐	N☐
MARIJUANA/ HASHISH	☐		☐	☐	☐	☐	☐	Y☐	N☐
TABACCO/ NICOTINE	☐		☐	☐	☐	☐	☐	Y☐	N☐
CAFFEINE (ENGERY DRINKS, SODAS, COFFEE, ETC.)	☐		☐	☐	☐	☐	☐	Y☐	N☐
OVER THE COUNDER:	☐		☐	☐	☐	☐	☐	Y☐	N☐
OTHER SUBSTANCE:	☐		☐	☐	☐	☐	☐	Y☐	N☐
COMPLIMENETARY ALTERNATIVE MEDICATION	☐		☐	☐	☐	☐	☐	Y☐	N☐
Is beneficiary receiving alcohol and drug services?	☐ Yes, from this provider		☐ Yes, from a different provider				☐ No		
If yes, type of alcohol and drug services:	☐ Residential		☐ Outpatient				☐ Community/ Support Group		

Name: _____

Insyst# _____

RU# _____

Mental Health Assessment Continued

SUBSTANCE USE CONTINUED

SUSBSTANCE RISKS, USE, & ATTITUDES/EXPOSURE			
	NO	**YES**	**UNABLE TO ASSESS**
Were any risk factors identified based on clinical judgment?	☐	☐	☐
Does the client currently appear to be under the influence of alcohol or drugs?	☐	☐	☐
Has the client ever received professional help for his/her use of alcohol or drugs?	☐	☐	☐
Comments on alcohol/drug use:			
☐Narrative continued in Addendum			
How is the mental health impacted by substance use (clinician's perspective)? *Must be completed if any services will be directed towards substance Use/Abuse, such as Case Management.*	☐Narrative continued in Addendum		

SUBSTANCE ABUSE/SEVERITY ASSESSMENT:

C. Beneficiary self-assessment (*check one)*:

- ☐ No alcohol or drug use
- ☐ Alcohol or drug use with no related problems
- ☐ Alcohol or drug use with related problems

D. Provider assessment (*check one*):

- ☐ Use (minimal or no alcohol or drug relation problems)
- ☐ Substance abuse (frequent and/or periodic use associated with alcohol or drug problems)
- ☐ Substance dependence in recovery (prior significant, but now minimal or no substance related problems)
- ☐ Substance dependence not in recovery (uncontrolled use with significant alcohol or drug related problems)

SUD REFERRALS

Check below, for any referral made based on abuse assessment. List specific referral below.

☐Referral to SUDS (Substance Use Disorder Services) ACCESS line #1-800-491-9099 for:

- ☐ Self-help groups- groups for consumer's interested in support of sobriety include AA, NA, and Dual Recovery Anonymous. Referral should ideally be to a group known to support clients in psychiatric recovery. • Alcoholic Anonymous 510-839-8900
  •Moderation Management:paulstayley@comcast.net or www.moderation.org
- ☐ Outpatient counseling- for consumer's assessed at abuse level, and who have an environment supportive of recovery.
- ☐ Residential treatment- for chemically dependent consumer's with a low level of function, requiring an intense level of support to initiate sobriety.
- ☐ Detoxification- for chemically dependent consumers who are at risk of at least moderate withdrawal symptoms, and who require high level of structure to initiate sobriety.
- ☐ Other (specify):

From the ACBHCS SUD Treatment Referral Guide, www.acbhcs.org/providers/SUD/resources.htm, indicate the specific referrals provided to client. Make a copy for the client to take with them to follow-up with referral..

AGENCY	ADDRESS	TELEPHONE NUMBER

Name: _____

Insyst# _____

RU# _____

Mental Health Assessment Continued

MEDICAL NECESSITY

MENTAL STATUS: *(Check and describe if abnormal or impaired)*				
Appearance/Grooming:	☐Unremarkable	Remarkable for:		
Behavior/Relatedness:	☐Unremarkable	☐Motor Agitated	☐Inattentive	☐Avoidant
	☐Impulsive	☐Motor Retarded	☐Hostile	☐Suspicious/Guarded
	☐Other:			
Speech:	☐Unremarkable	Remarkable for:		
Mood/Affect:	☐Unremarkable	☐Depressed	☐Elated/Expansive	☐Anxious
	☐Labile	☐Irritable/Angry	☐Other:	
Thought Processes:	☐Unremarkable	☐Concrete	☐Distorted	☐Disorganized
	☐Odd/Idiosyncratic	☐Blocking	☐Paucity of Content	☐Circumstantial
	☐Tangential	☐Obsessive	☐Flight of Ideas	☐Racing Thoughts
	☐Loosening of Assoc	☐Other:		
Thought Content:	☐Unremarkable	☐Hallucinations	☐Delusions	☐Ideas of Reference
	☐Other			
Perceptual Content:	☐Unremarkable	☐Hallucinations	☐Homicidal Ideation	☐Paranoid Reference
	☐Flashbacks	☐Depersonalization	☐Derealization	☐Dissociation
	☐Other:			
Fund of Knowledge:	☐Unremarkable	Remarkable for:		
Orientation:	☐Unremarkable	Remarkable for:		
Memory:	☐Unremarkable	Impaired:		
Intellect:	☐Unremarkable	Remarkable for:		
Insight/Judgment:	☐Unremarkable	Remarkable for:		

Describe abnormal/impaired findings:

Additional Observations/Comments (if any): ☐Narrative continued in Addendum

FUNCTIONAL IMPAIRMENTS:

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Family Relations	☐	☐	☐	☐	Circle appropriate: Substance Use/Abuse	☐	☐	☐	☐
School Performance/Employment	☐	☐	☐	☐	Activities of Daily Living	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Episodes of decompensation & increase of symptoms, each of extended duration	☐	☐	☐	☐
					Other (Describe):	☐	☐	☐	☐
Food/Shelter	☐	☐	☐	☐					
Social/Peer Relations	☐	☐	☐	☐					
Physical Health	☐	☐	☐	☐					

Comments (if any): ☐Narrative continued in Addendum

TARGETED SYMPTOMS:

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Cognition/Memory/Thought	☐	☐	☐	☐	Perceptual Disturbance	☐	☐	☐	☐
Attention/Impulsivity	☐	☐	☐	☐	Oppositional/Conduct	☐	☐	☐	☐
Socialization/Communication	☐	☐	☐	☐	Destructive/Assaultive	☐	☐	☐	☐
Depressive Symptoms	☐	☐	☐	☐	Agitation/Lability	☐	☐	☐	☐
Anxiety/phobia/Panic Attack	☐	☐	☐	☐	Somatic Disturbance	☐	☐	☐	☐
Affect Regulation	☐	☐	☐	☐	Other:	☐	☐	☐	☐

Comments (if any): ☐Narrative continued in Addendum

Impairment Criteria (must have one of the following :)	**AND:**	**Intervention Criteria (proposed INTERVENTION will….))**
☐ E. Significant impairment in an important area of life function.	**AND**	E. Significantly diminish impairment
☐ F. Probability of significant deterioration in an important area of functioning.	**AND**	F. Prevent significant deterioration in an important area of life functioning.
☐ G. (Under 21) Without treatment will not progress developmentally as individually appropriate.	**AND**	G. (Under 21) Probably allow the child to progress developmentally as individually appropriate.
☐ H. None of the above.	**AND**	H. None of the above

Name: _____

Mental Health Assessment Continued

Insyst# _____

RU# _____

MEDICAL NECESSITY CONTINUED

Diagnostic Summary: (Be sure to include assessment for risk of suicidal/homicidal behaviors, significant strengths/weaknesses, observations/descriptions, symptoms/impairments in life functioning, i.e. Work, School, Home, Community, Living Arrangements, etc. and justification for diagnosis)

☐ Narrative continued in Addendum

ICD-10 DIAGNOSIS — NOT BY HISTORY, MUST BE CURRENT DIAGNOSTIC FORMULATION			
Dimensions:	**ICD-10 Code:**	**DSM –5* Description WITH all specifiers:** **for Codes F84.5, F84.9, F84.2, F84.3 & F84: list DSM-IV-TR Descriptor (Dx Name)*	**Primary & Secondary Dx's**
MH Diagnoses:			**PRIMARY DX**
			Secondary Dx
			Secondary Dx
			Secondary Dx
Substance Use Diagnoses:			Secondary Dx
			Secondary Dx
			Secondary Dx
Psychosocial Conditions Diagnoses:			
General Medical Conditions:			

Optional Disability Measures (WHODAS, etc.)	Diagnosis est. by (with license):	On date:

Disposition / Recommendations/ Plan

☐ Narrative continued in Addendum

Signatures (OR SEE PROVIDER _____ PROGRESS NOTE DATED:_____):

Assessor's Signature & M/C Credential	**Date**	**Co-Signature & M/C Credential**	**Date**
Printed Name	**Date**	**Printed Name**	**Date**

Mental Health Assessment Continued

MEDICAL NECESSITY CONTINUED
ADDENDUM

APPENDIX K

MANAGED CARE NETWORK PROVIDER ATTESTATION

ALAMEDA COUNTY MENTAL HEALTH PLAN
SPECIALTY MENTAL HEALTH SERVICES
MANAGED CARE NETWORK PROVIDER ATTESTATION
EFFECTIVE July 1, 2016

Fax to Utilization Management (UM) Program: (510) 567-8148. Questions, call UM: (510) 567-8141

CLIENT NAME:	DOB:	CIN OR SSN:
_____	_____	_____

Submit prior to 3rd session and within 60 days of initial visit. *Providers cannot provide treatment services before the client plan is completed.* Provider must initial each statement.

PROVIDER INITIALS	PROVIDER CERTIFICATION
_____	I hereby certify that medical necessity has been met for Specialty Mental Health Services (SMHS) as specified by Medi-Cal (see Medical Necessity for SMHS on Providers Web Site – ACCESS Forms) and the Alameda County Mental Health Plan (MHP) moderate-to-severe criteria per the ACBHCS screening tool.
	Date of 1st offered appointment: Click here to enter a date. Date of 1st face to face service: Click here to enter a date.
_____	I certify that I have completed a full Assessment (Dated: Click here to enter a date._____) and Client Plan (Dated: Click here to enter a date._____), which meet the published QA standards, prior to delivering my first treatment service. These services are only Medi-Cal reimbursable when there is a completed client plan.
_____	I certify that my Client Plan documents the need for the specific services provided and lists service modalities (e.g. psychotherapy, brokerage, collateral) as well as detailed interventions for each.
_____	I agree to submit my Assessment and Client Plan for Utilization Review within a specified timeframe when requested by the Utilization Management Program.
_____	I acknowledge that I am subject to review or audit of my records and agree to keep up to date records.
_____	I certify that every claimed service has an individual progress note.
_____	I certify that services were medically indicated and necessary to the health of the client and were personally rendered by me or for an organization only, an employee under my direct supervision.
_____	I certify that all information provided is true, accurate, and complete. I understand that payment claims will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

PROVIDER/CLINICIAN INFORMATION

_____

Clinician's printed name **Signature with discipline (e.g. PhD, LCSW, MFT, MD)** **Date**

FOR LEVEL III ORGANIZATION USE ONLY

_____

Organization Name

If Clinician is not licensed, Licensed Supervisor's Information is required on the line below:

_____

Lic. Supervisor's printed name **Signature with discipline (e.g. PhD, LCSW, MFT, MD)** **Date**

APPENDIX L

UTILIZATION MANAGEMENT LETTER OF APPROVAL OR DENIAL

Alameda County
Behaviorial Health Care Services
Mental Health Plan

[redacted]
2000 Embarcadero Cove Suite 400
Oakland, CA 94606
510-567-8141 Fax 510-567-8148

Monday, September 18, 2017

[redacted]

The treatment plan for the client named below has been reviewed. Services that have been rendered are approved. Your claims will be reviewed and services will be authorized according to this plan. Any change in the treatment plan will require review. Please call Authorization Services or send a Request for Concurrent Review Form if the plan changes.

Insurance: Medi-Cal- Policy # [redacted]

Treatment Plan

Start Date: 09/01/2017

Plan Update requested 2 weeks before 02/28/2018

Client Name	Home Phone	Work Phone	Date of Birth	SSN #	REF #
[redacted]	[redacted]		[redacted]	[redacted]	[redacted]
Service			Auth. Number		CPT Code
MH - Outpatient/Specialty - 6AAAM OP Service Ext Pkg			201700500198		6AAAM
Estimated Frequency of Service/Length of Sessions				Provider Rate	Total Co-pay
1 Session Per Day Lasting 1 hr Everyday					

Notwithstanding this authorization, failure to comply with the terms and conditions of your contract with our organization or its policies and procedures will result in claims denial. Many circumstances, including existence of other insurance, income, and residency can influence eligibility. You should verify eligibility every month.

This authorization is contingent upon your good standing with the Mental Health Plan.

Should you have any questions please feel free to contact us.

Sincerely,

UM Clinical Review Specialist

Your authorization includes 26 services (1 client plan session, 20 therapy sessions, 3 hours of brokerage, and 2 hours of collateral) within the next six months. Please note that the 1 client plan session must be rendered prior to any of the other authorized services.

APPENDIX M

REQUEST FOR CONTINUED SERVICES

REQUEST FOR CONTINUED SERVICE (RCS)

SUBMIT 2 WEEKS PRIOR TO CURRENT AUTHORIZATION EXPIRATION DATE TO:

Utilization Management Program (UM)

Alameda County Behavioral Health Care Services

Client Name: _____
Client DOB: _____
Client CIN or SSN: _____
Provider Name: _____
Agency, if applicable: _____
Provider Phone:

General Instructions:

- This form is available online at http://www.acbhcs.org/providers/Forms/Forms.htm under "Utilization Management" section.
- Please press "Tab" on your keyboard each time after typing in (1) Client Name, (2) Client CIN or SSN, and (3) Provider Name, in the box above. The same information will appear on other pages.
- If client has a Client Identification Number (CIN), the CIN must be used, per State regulations. (CIN is on the Medi-Cal card and AEVS)
- Indicate "N/A" or "none" if the question is not relevant to client.
- Incomplete or illegible forms will be returned to sender.
- Please note: Only one age-appropriate screening form is required. Your signature is required on page 6.
- Submit extra pages, if needed, and check the following box to alert UM staff: ☐

RELATED TO YOUR REIMBURSEMENT

- **Date of first face-to-face contact with client:** _____
- **If you have multiple sites, at which site does this client receive services?** _____

CLIENT ASSESSMENT INFORMATION:

1. **Please describe your client's current presenting problems. Include specific risks, symptoms, and diagnosis (es), and the specific, current impairment(s) in daily functioning that result. What are the specific maladaptive behaviors in important areas of daily functioning that result from your client's mental illness? (**e.g. suicidal ideation, poor sleep, poor eating, low energy and social isolation due to a major depressive episode puts the client at risk for self-harm and loss of housing, and prevents ability to work and hinders ability to find community support) _____

2. **If not already noted above, please indicate current medical necessity for continuing Specialty Mental Health treatment?**

   _____

Client Name: **Error! Reference source not found.** Client CIN or SSN: **Error! Reference source not found.**
Provider Name: **Error! Reference source not found.**

3. **Criteria Screening:** (Please choose age appropriate screening form):

List A (Check all that currently apply)	List B (Check all that currently apply)	List C
☐ Persistent mental health symptoms & impairments after psychiatric consult and 2 or more medication trials in past 6 months ☐ Co-morbid mental health and serious health conditions- Specify: _____ ☐ Behavior problems (aggressive/assaultive/self-destructive/extreme isolation)- Specify:_____ ☐ 3+ ED visits or 911 calls in past year ☐ Significant current life stressors [e.g. homelessness, domestic violence, recent loss]- Specify: _____ ☐ Hx of trauma/PTSD that is impacting current functioning ☐ Non-minor dependent ☐ May not progress developmentally as individually appropriate without mental health intervention (ages 18 to 21only)	☐ 2+ in-patient psychiatric hospitalizations within past 18 months ☐ Functionally significant paranoia, delusions, hallucinations ☐ Current & on-going suicidal/significant self-injurious/homicidal preoccupation or behavior in past year- Specify: _____ ☐ Transitional Age Youth with acute psychotic episode ☐ Eating disorder with related medical complications ☐ Personality disorder with significant functional impairment ☐ Significant functional impairment (not listed above) due to a mental health condition	☐ Drug or alcohol addiction and failed SBI (screening & brief intervention at primary care)

Adult 18+

Meets Criteria For:	
Primary Care Provider (PCP) care	☐1-2 in List A and none in List B
Managed Care Plan (MCP) [Alameda Alliance, Anthem Blue Cross or Kaiser]	☐3 in list A (2 if ages 18-21) and none in list B OR ☐Diagnosis excluded from county MHP
Specialty Mental Health Plan	☐ 4 or more in list A (3 or more if ages 18-21) OR ☐1 or more in list B
Refer to County Alcohol & Drug Program (1-800-491-9099)	☐1 from list C

PLEASE LIST COVERED DIAGNOSES, INCLUDING ICD-10 CODES,

AND, FOR ANY OF THE CHECKED ITEMS IN LISTS A & B ABOVE, YOU MUST PROVIDE CLARIFYING DETAILS IF NOT ALREADY SPECIFIED ELSEWHERE IN THIS DOCUMENT: _____

Client Name: **Error! Reference source not found.** Client CIN or SSN: **Error! Reference source not found.**
Provider Name: **Error! Reference source not found.**

Child 6-17

List A (Check all that currently apply)	List B (Check all that currently apply)	List C
☐ Impulsivity/hyperactivity ☐ Trauma/recent loss ☐ Withdrawn/Isolative ☐ Mild-moderate depression/anxiety ☐ Behavior problems (aggressive/self-destructive/assaultive/bullying/oppositional) ☐ Significant family stressors * ☐ CPS report in the last 6 months ☐ Excessive truancy or failing school ☐ Difficulty developing and sustaining peer relationships ☐ Eating disorder without medical complications ☐ Court dependent or ward of court ☐ May not progress developmentally as individually appropriate without mental health intervention	☐ 1 or more psychiatric hospitalization(s) in past year ☐ Suicidal/homicidal preoccupations or behaviors in past year ☐ Self-injurious behaviors ☐ Paranoia, delusions, hallucinations ☐ Currently in out-of-home foster care placement ☐ Juvenile probation supervision with current placement order ☐ Functionally significant depression/anxiety** ☐ Eating disorder with medical complications ☐ At risk of losing home or school placement due to mental health issues	☐ Substance abuse

* Significant family stressors: Caretaker(s) with serious physical, mental health, substance use disorders, or developmental disabilities, domestic violence, unstable housing or homelessness.

Referral Algorithm		
1.	Remains in **PCP care** with Beacon consult or therapy only	☐1- in List A and none in List B
2.	**Managed Care Plan (MCP)** [Alameda Alliance, Anthem Blue Cross or Kaiser]	☐2 in list A and none in list B OR ☐Diagnosis excluded from county MHP
3.	Refer to **County Mental Health Plan** for assessment	☐ 3 or more in list A OR ☐1 or more in list B
4.	Refer to **County program** or community resources	☐1 in list C

PLEASE LIST COVERED DIAGNOSES, INCLUDING ICD-10 CODES,

AND, FOR ANY OF THE CHECKED ITEMS IN LISTS A & B ABOVE, YOU MUST PROVIDE CLARIFYING DETAILS IF NOT ALREADY SPECIFIED ELSEWHERE IN THIS DOCUMENT: _____

Client Name: **Error! Reference source not found.** Client CIN or SSN: **Error! Reference source not found.**
Provider Name: **Error! Reference source not found.**

Child 0-5

List A (Check all that apply)	List B (Check all that apply)
☐ Impulsivity/hyperactivity ☐ Withdrawn/Isolative ☐ Mild-moderate depression/anxiety ☐ Excessive crying; difficult to soothe ☐ Significant family stressors * ☐ CPS report in the last 6 months ☐ Limited receptive and expressive communication skills ☐ Sleep Concerns: difficulty falling asleep, night waking, nightmares ☐ Peer relationship issues - little enjoyment or interest in peers; self-isolating; frequent conflict with peers ☐ Feeding/elimination difficulties ☐ Learning Difficulties ☐ Sexualized Behaviors ☐ Serious medical issues/other disabilities ☐ May not progress developmentally as individually appropriate without mental health intervention	☐ Significant Parent/Child attachment concerns Child age 0-3 with at least 2 items from List A ☐ Aggression and/or frequent tantrums ☐ Neglect/Abuse ☐ Self-Harm: frequent head banging/risky behavior Trauma ☐ Currently in out-of-home foster care placement ☐ At risk of losing home, child care or preschool placement due to mental health issue ☐ Separation from/loss of primary caregiver

* Significant family stressors: Caretaker(s) with serious physical, mental health, substance use disorders, or developmental disabilities, domestic violence, unstable housing or homelessness.

Referral Algorithm		
1.	Remains in **PCP care** with Beacon consult or therapy only	☐1- in List A and none in List B
2.	**Managed Care Plan (MCP)** [Alameda Alliance, Anthem Blue Cross or Kaiser])	☐2 in list A and none in list B OR ☐Diagnosis excluded from county MHP
3.	Refer to **County Mental Health Plan** for assessment	☐ 3 or more in list A OR ☐1 or more in list B

PLEASE LIST COVERED DIAGNOSES, INCLUDING ICD-10 CODES

AND, FOR ANY OF THE CHECKED ITEMS IN LISTS A & B ABOVE, YOU MUST PROVIDE CLARIFYING DETAILS IF NOT ALREADY SPECIFIED ELSEWHERE IN THIS DOCUMENT: _____

Client Name: **Error! Reference source not found.** Client CIN or SSN: **Error! Reference source not found.**
Provider Name: **Error! Reference source not found.**

4. **For recent psychiatric hospitalizations or crisis visits, please Indicate reason, dates, and duration:** _____

5. **List the current treatment goals (Achievable within 6 months):**
_____

6. **What previous treatment goals have been met?** _____

7. **Current Substance Abuse Issues:** _____

8. **Is psychotropic medication being prescribed?** ☐**Yes** ☐**No**

If yes, please list current medications including dosage and frequency (e.g. Seroquel 300mg once daily at bedtime): _____

- **Is a medication evaluation indicated?** ☐**Yes** ☐**No**

9. **Has the client been seen by a Primary Care Clinic/Physician since treatment began?** ☐**Yes** ☐**No**

If so, for what health problems?_____

Name of Physician/Clinic: _____

Have you consulted with the Primary Care Clinic/Physician? ☐**Yes** ☐**No**

PSYCHIATRIST TO COMPLETE

10. Active medical conditions: _____

11. Medication allergies/sensitivities

History of Serious Side Effects? ☐Yes ☐No Current Assessment of Serious Side Effects? ☐Yes ☐No

12. Past psychiatric medications (maximum dose, duration, when first prescribed, effectiveness, reason if discontinued):
_____

13. Current psychiatric medications (Dose, frequency, duration, target symptoms and response, side effects, and compliance):
(Note: Informed Consent must be in chart for all prescribed medication and when prescription is significantly changed.)

14. Non-psychiatric medications (dose, duration, target medical condition): _____

15. Comments:_____

16. **Does the client have any special needs that must be addressed? (cultural, communication, physical limitations)**
_____

Client Name: **Error! Reference source not found.** Client CIN or SSN: **Error! Reference source not found.**
Provider Name: **Error! Reference source not found.**

17. **What are the current barriers to discharge from Specialty Mental Health Services to a lower level of care** (i.e. Managed Care Plan: Alameda Alliance/Beacon, Anthem Blue Cross or Kaiser; PCP) _____

18. **Discharge Plan** (termination/transition plan): _____

19. **Additional information, optional:** _____

20. **Service Request for Authorization**:

IF THE FULL PACKAGE OF SERVICES IS REQUIRED for treatment completion, please check here: ☐

OR

IF LESS THAN THE FULL PACKAGE OF SERVICES IS REQUIRED, please check here: ☐ **and specify required services below:**

CPT Service Code (per your rate sheet)	Service Description (per your rate sheet)	Number of Service Required	Frequency of Service	ICD-10 Diagnostic Code(s) Addressed
Example: 90834	Individual Therapy	4	1x/month	F33.2

(PLEASE NOTE: An annual assessment & a client plan every 6 months are required before service delivery.)

21. **If this is an open Social Services, Children and Family Services (CFS) case, check here** ☐
If CFS case has been closed, indicate the closure date: _____.
If applicable, indicate current Child Welfare Worker (CWW) contact information:

_____ _____
Name Phone#

22. **IF CLOSING CASE: Reason for closing:** _____

Date of last session: _____ **Referrals made:**_____

Provider/Clinician information is required on the line below:

_____

Clinician's printed name **Signature with discipline (e.g., MFT, LCSW, MD)** **Date**

If Clinician is not licensed, Licensed Supervisor's information is required on the line below:

APPENDIX N

CMS 1500 – INSTRUCTIONS AND EXAMPLE

CMS-1500 FORM – COMPLETION INSTRUCTIONS

(Complete required boxes by the number as indicated below)

1. Indicate the type of insurance you are billing on this claim by placing an "X" in the appropriate box.

1a. Provide the patient's Medi-Cal ID Number (social security number, CIN number, pseudo social security #)

2. Patient's Name (last, first, and middle initial).
3. Patient's date of birth and sex.
5. Patient's Address (number, street, city, state, zip code and phone number).
6. Patient's Relationship (self)
10. Is Patient's condition related to: (check yes or no for boxes a-c).
12. Patient's Authorizing Signature or "Signature on File" if the provider retains an original copy, both front and back, on site. (The patient's or authorized person's signature indicates there is an authorization on file for release of any medical or other information necessary to process and/or adjudicate the claim).
13. Insured's Authorizing Signature or "Signature on File" if the provider retains an original copy, both front and back, on site. (The insured's or authorized person's signature indicates there is a signature on file authorizing payment of medical benefits).
17. Name of Referring Physician or other source, ie: ACCESS, CalWorks, Children and Family Services, Healthy Families (SED). Please include referring physician's NPI number in 17b if available.
21. Enter numeric diagnosis coded in A-L as appropriate. Indicate in 24E, the diagnosis A-L per Service Charge Information.
24. Service Charge Information:
    a. From Date
    b. Place of Service: 11=Office; 12=Patient's Home; 21=Inpatient Hospital; 22=Outpatient Hospital; 31=Skilled Nursing Facility.
    d. Procedure Code (BHP contracted procedure codes only).
    e. Related diagnosis code (indicated A-L) from field 21.
    f. Customary Charge.
    g. Units of Service.
    i. Non-NPI identifying Qualifier =OB=State License Number, ZZ = Provider Taxonomy Code, IC = Medicare Provider Number, ID = Medicaid Provider Number.
    j. Enter Provider NPI number, license number should be placed in the shaded area.

25. Federal Tax ID Number, SSN or EIN (check appropriate box)
26. Patient's ID Number (if applicable for your practice)
27. Accept Assignment (Must be Y)
28. Total Charges (sum of 24f lines 1 to)
29. Amount Paid, (if primary insurance plan has made a payment or if provider collected any portion of the share of cost from the beneficiary)
31. Signature of Provider **or** Biller Representative and date (this is a mandatory requirement)
32. Name & address of the facility where services were performed (if services were provided at a location different from the Facility identified in box 33). Place NPI number in box 32a.
33. Providers name, address & phone number where payment should be mailed. Box 33a is to be used only if services are being rendered by a Group or Organization. Indicate the Group or Organization's provider NPI number.

(The CMS-1500 Form Must Be Legible)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) X | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 999-99-9999

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): BROWN, JAMES

3. PATIENT'S BIRTH DATE MM DD YY: 04 04 1979 | SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 2020 TOWN ST

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street): SAME

CITY: OAKLAND | STATE: CA

8. RESERVED FOR NUCC USE

CITY: SAME | STATE

ZIP CODE: 94551 | TELEPHONE (Include Area Code): (510) 777-9311

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | X NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES | X NO | PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO — If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE | DATE: 07/01/17

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY | QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. F33.2 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
06 29 17		11		90834		A	73.00	1		NPI	1054456465
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER: 946000501 | SSN | EIN X

26. PATIENT'S ACCOUNT NO.: 75121667/889342

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES | NO

28. TOTAL CHARGE: $ 73.00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Donald Duck

DONALD DUCK 07/01/17

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # (510) 999-9999

DONALD DUCK
P.O. BOX 3450
SAN LORENZO, CA 94566-0424

a. 1054456465 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

APPENDIX O

SHARE OF COST/SPEND DOWN CLEARANCE REQUEST FORM INSTRUCTIONS

Alameda County
Behavioral Health Care Services

Mental Health Plan Provider
Share of Cost/Spend Down Clearance Request Form

Provider Information

Provider Name: _____ Date Submitted: _____

Prepared by: _____
(Print Name)

Phone No: _____ FAX No: _____

Client/Share of Cost Update Information

Client Name _____ Client Date of Birth: _____

CIN or SSN _____ Medi-Cal Card Issue Date: _____

				BHCS USE ONLY			
Line #	Date of Service	Procedure Code (enter CPT code)	Dollar Amount (Enter amount recv'd from client or obligated towards SOC)	InSyst Client Number	InSyst Procedure Code	InSyst Reporting Unit Number	$ Amount Applied towards SOC
1							
2							
3							
4							
5							
			TOTAL:				

State DHCS Eligibility Response:

Subscriber Name: _____ Eligibility Response Message: _____

County Code: _____

Primary Aid Code: _____ Other Health Coverage: _____

BHCS USE ONLY			
Date Rec'd:		SOC Entry Date:	
Date Completed:		Entered By:	

ACBHCS Mental Health Plan Provider (MHP)
Share of Cost/Spend Down Clearance Request Form Instructions

PROCEDURE TITLE: MHP Share of Cost/Spend Down Clearance Form Instructions
DATE CREATED: August 1, 2017
DISTRIBUTION: MHP Providers

PURPOSE: Providers should complete the SOC/Spend down Clearance Request Form for the purpose of certifying client's Medi-Cal Share-of-Cost (SOC) amounts

PROCEDURE:

Provider Information:

- **Provider Name:** enter the individual provider, group or organization name
- **Date Submitted:** enter the date the form is completed
- **Prepared by:** enter the name of the person completing the form
- **Phone No.:** enter the contact phone number of the person completing the form
- **FAX No.:** enter the contact FAX number of the person completing the form

Client / Share of Cost Update Information:

- **Client Name:** enter the full name of the client (first, middle initial and last)
- **Client Date of Birth:** enter the client's date of birth (mm/dd/yyyy).
- **CIN or SSN:** enter the client ID number (first 9 characters on the client's Medi-Cal card) or the client's Social Security Number
- **Medi-Cal Card Issue Date:** enter the issue date on the client's Medi-Cal card or leave blank, if unknown
- **Date of Service:** enter the date the service was rendered to the client. Dates must coincide with dates of service claimed on the CMS1500 claim form being submitted to the ACBHCS Claims Processing Dept.
- **Procedure Code:** enter the CPT code for the service as indicated on the CMS1500 claim form being submitted to the ACBHCS Claims Processing Dept.
- **Dollar Amount:** enter the dollar amount received from the client or obligated towards the client's SOC amount
- **BHCS USE Only –** this section to be completed by BHCS staff

State DHCS Eligibility Response

- **Subscriber Name:** enter the full name of the client (first, middle initial and last) as indicated via the State's AEVS automated or internet response information
- **Eligibility response message:** enter the AEVS automated response information or attach a copy of the internet response.
- **County Code:** enter the County code for the client's Medi-Cal eligibility per the AEVS automated or internet response
- **Primary Aid Code:** enter the client's Primary aid code per the AEVS automated or internet response

Page 1 of 2

- **Other Health Coverage:** enter the Other Health Coverage code information per the AEVS automated or internet response.

  Note: If the client is Medi-Cal w/Other Health Coverage, please attach a copy of the payment information or EOB (explanation of benefits) with the submission of the CMS1500 claim to the ACBHCS Claims Processing Dept.

- **BHCS USE Only –** this section to be completed by BHCS staff

Please send completed form to the ACBHCS Claims Processing Center P.O. Box 738, San Leandro, Ca 94577, along with the submission of the CMS1500 claim form for the corresponding date(s) of service.

Page 2 of 2

v.4.11.17

APPENDIX P

LATE CLAIM SUBMISSION EXCEPTION REQUEST

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
Mental Health Plan

Late Claim Submission Exception Request Form
See Reverse for instructions and additional information.

Late Reason Codes Check applicable code(s).

☐ **10 Medicare Delays (Organizational Providers Only)**
Attach a copy of the Medicare Explanation of Benefits or Remittance Advice showing payment or denial. Claims to Medicare must be made within 60 days of date of service. Substantiation of claim date must accompany claims to the MHP. Include justification if claims could not be submitted within 60 days.

☐ **20 Other Health Coverage Delays**
Attach a copy of the Other Health Coverage Explanation of Benefits or Remittance Advice showing payment or denial. Claims to Other Health Coverage must be made within 60 days of date of service. Substantiation of claim date must accompany claims to the MHP. Include justification if claims could not be submitted within 60 days.

☐ **30 Authorization delays in TAR approval for inpatient hospital services**
In the Remarks area, enter the approval date of the TAR.

☐ **40 Proof of benefit eligibility unknown or unavailable**
In the Remarks area, enter the month, day, and year when eligibility could be confirmed. Explain the reason for the delay in eligibility determination.

☐ **50 Processing Delays solely the responsibility of the MHP Claims Processing, Authorization or ACCESS units**
In the Remarks area, state where the delay occurred, the dates of your original submissions, re-submissions of required forms, dates of other communications with the MHP, date(s) of responses from the MHP. Attach any substantiating documentation.

☐ **60 Delays in processing of Provider Applications, Credentialing, or Certification solely the responsibility of the MHP**
In the Remarks area, state the enrollment process where the delay occurred, the date of your original application, credentialing or certification date, dates of other communications with the MHP that support your request for payment approval.

☐ **70 Retroactive SSI/SSP Eligibility Approval/Court Order/State or Administrative Hearing/County Error**
Attach original LOA form (MC-180) with original signature of county official & date received.

☐ **80 Substantial Damage By Fire, Flood Or Disaster to Provider Records/Theft, Sabotage Or Other Willful Acts By an Employee**
Attach a letter on provider letterhead describing the circumstances & date of occurrence and if applicable the date reported to a law enforcement agency.

Remarks/Other Supporting Information _____

_____

_____

_____

CPC – 8/99 ATTACH TO CLAIMS RESUBMISSION

ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
Mental Health Plan

Late Claim Submission Exception Request Form

Instructions and Additional Information:

This form must be completed and attached to claim forms submitted after the claiming deadline, i.e., 60 days from the month of service. For example, if services are provided to a client on October 15, the claim must be received prior to December 31st to meet the 60 day billing limit.

If, due to circumstances beyond the Provider's control, the claim cannot be submitted within the billing limit, this form must be submitted along with the claim form. Or, the Late Reason Code may be indicated on the claim form, HCFA 1500 use Box 10d, UB92 use Box 64. Required substantiating documentation and/or explanations **must** accompany the claim forms.

With the exception of claims with Late Reason Code 70, claims with service dates over 6 months from the month of service will not be paid regardless of the original submission date. If you believe that you have a valid reason for submission of a claim over 6 months old, you must submit a Claims Appeal to the Claims Processing Center.

Claims over one year old, must include a copy of the recipient's proof of eligibility.

Please contact the Claims Processing Center at **(800) 878-1313** with any questions on claim submission procedures or policies.

APPENDIX Q

REMITTANCE ADVICE

Diana Craven
1111 Cove Street

Oakland, CA 94666-

Remittance Advice

Check Number: 011111
Check Date: 07/26/2017

Claim#	Member Name	Reference #	Member #	Birth Date	Sex	Authorization #	Service Category	Dates of Service	Amount
201700000000	Walt, Daisey	2016000000000	Walt, D	07/27/1992	F	201712345678	Primary Service	07/01/2017-07/01/2017	73.00
									$ 73.00
									$ 73.00

Alameda County BHCS Mental Health Plan
P.O. BOX 738
San Leandro, CA 94577-0738

APPENDIX R

CLAIMS RETURN LETTER

ALAMEDA COUNTY
Behavioral Health Care Services

ALCOHOL, DRUG & MENTAL HEALTH SERVICES
DON KINGDON, PH.D, INTERIM DIRECTOR

Claims Processing Center
P.O. Box 738
San Leandro, CA 94577-0738
1-800-878-1313
FAX (510) 383-1585

July 20, 2017

Diana Craven
1111 Cove Street
Oakland, CA 94666

Dear Ms. Diana Craven

Subject: Returned Claims for: **Daisey Walt** Batch # **000011**

Your claim(s) is/are being returned for the following reason(s):

*The Provider's signature is missing from the claim form.

In order for us to process this claim after corrections have been made you must re-submit this claim to the Claims Processing Center by **9/5/2017**.

If you have any questions concerning this returned claim or if you would like to file an appeal, please contact the Claims Processing Center at (800) 878-1313 ext. #1.

Returned by **Joe Test**, Claims Processor

Authorization does not guarantee payment if other program requirements are not met.

APPENDIX S

CLAIMS DENIAL LETTER

ALAMEDA COUNTY
Behavioral Health Care Services

ALCOHOL, DRUG & MENTAL HEALTH SERVICES
DON KINGDON, PH.D, INTERIM DIRECTOR

Claims Processing Center
P.O. Box 738
San Leandro, CA 94577-0738
1-800-878-1313
FAX (510) 383-1585

July 20, 2017

Diana Craven
1111 Cove Street
Oakland, CA 94666

Dear Ms. Diana Craven

Subject: Provider Claim Denial(s) for: **Daisey Walt** Batch # **000011**

☒ **Medi-Cal**

☐ **Other Health Plans**

Your Claim(s) is/are being denied for the following reason(s):

*The client has a share of cost which has not been met, please bill the client for these services.

If you have any questions concerning this denial or if you would like to file an appeal please contact the Claims Processing Center at (800) 878-1313 ext. #1.

Denied by **Joe Test**, Claims Processor

Warning: This message is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable laws. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately. Thank you.

APPENDIX T

CLAIMS APPEAL

Alameda County Mental Health Plan
Claims Appeal

☐ 1st Level Appeal

☐ 2nd Level Appeal

Provider Name: _____

Address: _____

_____

Phone Number: _____ FAX:_____

I am submitting an appeal of my claim/s as listed below. Enclosed are all the pertinent documentation supporting this appeal, including copies of the claim/s, MHP denial, Medicare EOB/RA, insurance denial letter and any previous correspondence with the MHP.

Beneficiary Name: _____ Beneficiary ID Number: _____

Date of Service: _____ Original Claim Submission Date: _____

Procedure Code:_____ Denial Reason/Code: _____

Justification for the appeal: _____

(Attach additional pages as needed)

This is to certify that the information contained above is true, accurate and complete.

_____ _____

Signature of Provider or person authorized by provider Date of Appeal

Forward Claims Appeal (1st and 2nd level) within 30 days of the action precipitating the appeal to:
Provider Relations
P.O. Box 738
San Leandro, CA 94577-0738

For Behavioral Health Plan use only

Received Date _____ Appeal Document Number _____

G/Claims Processing Center/Claims Appeals/Claim Appeal Form June 2017

APPENDIX U

CLAIMS INQUIRY

Alameda County Behavioral Health Plan
Claims Processing Center
P. O. Box 738
San Leandro, CA 94577-0738
(800) 878-1313

CLAIMS INQUIRY FORM

Submitted By

Provider Name _____ Provider Phone Number _____

Provider Address _____

Claim Information

Client Name _____ Client Social Security #_____

Date of Service _____ Procedure Code _____

Date Original Claim Submitted _____ Remarks: _____

_____

(Corrections or information necessary to resubmit a returned claim, or trace an unpaid claim)

CIF Response

Received Date: _____

Paid Date: _____ Check #_____

Denied date: _____ Denial Reason: _____

_____

Returned date: _____ Returned Due to: _____

_____

Comments: _____

_____

Response submitted by_____

Provider: Complete 'Submitted By' and 'Claim Information' sections and submit this form along with the completed original CMS1500 form to the: **Claims Processing Center, P. O. Box 738, San Leandro, CA 94577-0738**. For more information concerning this form call 1 (800) 878-1313.

APPENDIX U-1

MEDI-CAL REVIEW REQUEST

Alameda County
Behavioral Health Care Services

Mental Health Plan Provider
Medi-Cal Review Request

Provider is requesting a Medi-Cal chart review, to establish medical necessity for a client with Medicare (Part A) only, for the purposes of Medi-Cal reimbursement for Professional fees.

PROVIDER INFORMATION

Agency/Provider Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Contact Person: _____ _____ **Phone No.** _____
First Name *Last Name*

CLIENT INFORMATION

Client Name: _____ _____ _____
First Name *Middle* *Last Name*

Date of Birth _____ **CIN:** _____ **SSN:** _____

Admission Date: _____ **Discharge Date:** _____

- Please submit the Medi-Cal Review Request form, along with the beneficiary's chart and a copy of the completed CMS-1500 Claim form to the BHCS Utilization Management (UM) Department at 2000 Embarcadero Cove Suite 400, Oakland, CA 94606.
- Please submit the original CMS-1500 Claim form along with a copy of the Medi-Cal Review Request form to the BHCS Claims Processing Center (CPC) at P.O. Box 738 San Leandro, Ca 94577.

BHCS UTILIZATION MANAGEMENT RESPONSE SECTION

Approved _____ to _____ CPT Code _____, _____, _____

Denied _____ to _____ CPT Code _____,_____, _____

Remarks: (e.g. service does not meet medical necessity, etc.) _____

_____

_____

Reviewer Name: _____

Processed Date: _____

APPENDIX V

INFORMING MATERIALS – YOUR RIGHTS & RESPONSIBILITIES AND ACKNOWLEDGEMENT OF RECEIPT

Informing Materials -- Your Rights & Responsibilities

Welcome to the Alameda County Mental Health Plan

Welcome! As a member (beneficiary) of the Alameda County Mental Health Plan (MHP) who is requesting mental health services with this provider, we ask that you review this packet of informing materials which explains your rights and responsibilities.

PROVIDER NAME:

The person who welcomes you to services will go over these materials with you. You will be given this packet to take home to review whenever you want, and **you will be asked to sign the last page of this packet to indicate what was discussed and that you received the materials.** The provider will keep the original signature page. Providers of services are also required to notify you about the availability of certain materials in this packet every year and the last page of this packet has a place for you to indicate when those notifications happen.

The next pages contain a lot of information, so take your time and feel free to ask any questions! Knowing and understanding your rights and responsibilities helps you get the care you deserve.

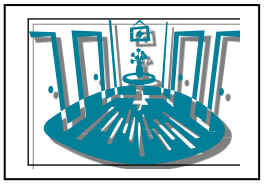
Consent for Services

As a member of this Mental Health Plan (MHP), your signature on the last page of this packet gives your consent for voluntary mental health treatment services with this provider. If you are the legal representative of a beneficiary of this MHP, your signature provides that consent.

Your consent for services also means that this provider has a duty to inform you about their recommendations of care, so that your decision to participate is made with knowledge and is meaningful. In addition to having the right to stop services at any time, you also have the right to refuse to use any recommendations, psychological interventions or treatment procedures.

This provider may have an additional consent form for you to sign that describes in more detail the kinds of services you might receive. These may include, but are not limited to: assessments; evaluations; crisis intervention; psychotherapy; case management; rehabilitation services; medication services; referrals to other behavioral health professionals; and consultations with other professionals on your behalf.

Freedom of Choice



It is our responsibility, as your mental health care program, to tell you that anyone receiving our services (including minors and the legal representative of minors) should know the following:

A. Acceptance and participation in the mental health system is voluntary; it is not a requirement for access to other community services.

B. You have the right to access other behavioral health services funded by Medi-Cal or Short-Doyle/Medi-Cal and have the right to request* a change of provider and/or staff.

C. The mental health program has contracts with a wide range of providers in our community, including faith-based providers. There are laws governing faith-based providers receiving Federal funding, including that they must serve all eligible members (regardless of religious beliefs) and that Federal funds must not be used to support religious activities (such as worship, religious teaching or attempts to convert a member to a religion). If you are referred to a faith-based provider and object to receiving services from that provider because of its religious character, you have the right to see a different provider, upon request*.

*The MHP works with members and their families to grant every reasonable request, but we cannot guarantee that all requests to change providers will happen. Requests will be granted, however, to change a provider because of an objection to its religious character.

Guide to Medi-Cal Mental Health Services, Member Handbook, & Provider List

Providers: The Member Handbook is available from the Quality Assurance Office in all threshold languages; the Guide and Provider List (updated quarterly) are available under the QA tab at www.acbhcs.org/providers.

The three (3) documents described below are available from this provider for your review or to have a copy of at any time, at your request.

The Behavioral Health Plan's Guide to Medi-Cal Mental Health Services will be offered to you when you begin services. It contains information on how a beneficiary is eligible for mental health services, what services are available and how to access them, who our service providers are, more information about your rights and our Grievance and State Fair Hearing process. It also includes important phone numbers regarding the Mental Health Plan.

The Mental Health Plan's Member Handbook for Alameda County Medi-Cal Recipients Needing Behavioral Health Services is a small brochure that summarizes the information in the Guide described above. It also describes what your rights & responsibilities are, as a member of this health plan.

The Provider List is a list of contracted providers of mental health services in our community. The County ACCESS program makes referrals for all outpatient non-emergency services. You may contact ACCESS at 1-800-491-9099 for further information regarding the Provider List, including whether a provider has current openings.

Confidentiality & Privacy

The confidentiality and privacy of what you discuss at this service site is an important personal right of yours. This packet contains your copy of the "Notice of Privacy Practices" document which explains how your records and personal information are kept confidential.

In certain situations involving your safety or the safety of others, providers are required by law to discuss your case with people outside the Mental Health Care Services system.

Those situations include:

1. If you threaten to harm another person(s), that person(s) and/or the police must be informed.
2. When necessary, if you pose a serious threat to your own health and safety.
3. All instances of suspected child abuse must be reported.
4. All instances of suspected abuse of an elder/dependant adult must be reported.
5. If a court orders us to release your records, we must do so.

If you have any questions about these limits of confidentiality, please speak with the person explaining these materials to you. More information about the above and other limits of confidentiality are in the "Notice of Privacy Practices" section of this packet.

Advance Directive Information: "Your Right to Make Decisions about Medical Treatment"

(Only applies if you are age 18 or older)

Providers: "Your Right to Make Decisions About Medical Treatment," is available in English at www.acbhcs.org/providers, in the QA tab. The same information, in the five threshold languages, is also online in booklet format.

If you are age 18 or older, the Mental Health Plan is required by federal & state law to inform you of your right to make health care decisions and how you can plan now for your medical care, in case you are unable to speak for yourself in the future. Making that plan now can help make sure that your personal wishes and preferences are communicated to the people who need to know. That process is called creating an Advance Directive.

At your request, you will be given an information sheet or booklet about Advance Directives called, "Your Right to Make Decisions About Medical Treatment." It describes the importance of creating an Advance Directive, what kinds of things you might consider if you decide to create one, and it describes the relevant state laws. You are not required to create an Advance Directive but we do encourage you to explore and address issues related to creating one. Alameda County BHCS providers and staff are able to support you in this process, but are not able to create an Advance Directive for you. We hope the information will help you understand how to increase your control over your medical treatment.

The care provided to you by any Alameda County BHCS provider will not be based on whether you have created an Advance Directive. If you have any complaints about Advance Directive requirements, please contact the California Department of Health Services Licensing and Certification by calling 1-800-236-9747 or by mail at P.O. Box 997413, Sacramento, CA 95899-7413.

Beneficiary Problem Resolution Information
Deciding Where to Take Your Grievance

PATIENTS' RIGHTS

- If you feel that one (or more) of your rights as a mental health patient is being denied:

Examples:

- If you were put in restraints and you do not think the facility had good cause to do this.
- If you were hospitalized against your will and you do not understand why or what your options were.

Where to Register Your <u>Patient's Rights</u> Grievance

- Call the Patients' Rights Advocate at **(800) 734-2504**. This is a 24-hour number with an answering machine after hours. Collect calls are accepted.

UNSATISFACTORY SERVICE

Examples:

- If you are not getting the kind of service you want.
- If you are getting poor quality service.
- If you are being treated unfairly.
- If you feel you need a service team assignment, but you are assigned a medication support service.
- If appointments are never scheduled at the time which is good for you.

Where to Register Your <u>Unsatisfactory Service</u> Grievance

- Speak directly with your service provider and/or call the Consumer Assistance Office at **(800) 779-0787**. Your complaint can be informal or you can make a formal, written grievance.

DENIAL OF SERVICE

If you receive a "Notice of Action" (**NOA**) letter, informing you of denial of a service:

Examples:

- If a service you are currently receiving is terminated or reduced.
- If you go to a hospital and ask to be admitted for inpatient services, but you are denied admission.
- If your doctor requests that you continue to be hospitalized, but the county Medi-Cal authorization denies the request.
- If you go to ACBHCS's ACCESS Service and ask to be admitted, but you are denied admission.

Where to Appeal Your <u>Denial of Services: NOA</u>

- First, call the Authorization Department and tell them you want to appeal the NOA Letter y**o**u received. **(510) 567-8141**
- You can request a State Fair Hearing. This must be done within 10 days if you are to continue receiving a service pending the hearing.
- To request a hearing, complete the Request for a State Hearing form or call the Public Inquiry and Response Unit at **(800) 743-8525**.

For more information about these options, you have the right to request and obtain the "Guide to Medi-Cal Mental Health Services" that is described on Page 2 of this packet.

<u>Maintaining a Welcoming & Safe Place</u>

It is very important to us that every member feels welcomed for care exactly as they are. Our most important job is to help you feel that you are in the right place, and that we want to get to know you & help you to have a happy and productive life. Please let us know if there is anything that we are doing that you find is not welcoming, or that makes you feel unsafe or disrespected.

It is also very important that our service settings are safe and welcoming places. We want you to let us know if anything happens at our service settings that make you feel unsafe so we can try to address it.

One way we help create safety is by having rules that ask everyone (providers & members) to have safe and respectful behaviors. These rules are:

**Behave in safe ways towards yourself & others.* **Be free of weapons of any kind.*
**Speak with courtesy towards others.* **Respect people's privacy.*
**Respect the property of others & of this service site.*

In order to have a welcoming place for all, anyone who is intentionally unsafe may be asked to leave, services may be stopped temporarily or completely, and legal action could be taken, if necessary. So if you think you might have trouble following these rules, please let your provider know. We will work hard to help you to feel welcome in a way that feels safe to you and those around you.

We appreciate everyone working with us to follow these rules.

NOTICE OF PRIVACY PRACTICES

per the
Health Insurance Portability & Accountability Act (HIPAA) and
Health Information Technology for Economic & Clinical Health (HITECH) Act

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact your health care provider or Alameda County Behavioral Health Care Services' Consumer Assistance Office at (800)779-0787.

You have been admitted to receive mental health and related services from

PROVIDER NAME:

a provider in the Alameda County Behavioral Health Care Services (ACBHCS) Program. The Alameda County BHCS Program consists of a comprehensive range of services provided at various sites throughout Alameda County. This provider and/or service site is a component of ACBHCS and is identified on the signature page (last page of this document).

Purpose of this Notice

This notice describes the privacy practices of ACBHCS, its departments and programs and the individuals who are involved in providing you with health care services. These individuals are health care professionals and other individuals authorized by the County of Alameda to have access to your health information as a part of providing you services or compliance with state and federal laws.

Health care professionals and other individuals include:

- Physical health care professionals (such as medical doctors, nurses, technicians, medical students);
- Behavioral health care professionals (such as psychiatrists, psychologists, licensed clinical social workers, marriage and family therapists, psychiatric technicians, and registered nurses, interns);
- Other individuals who are involved in taking care of you at this agency or who work with this agency to provide care for its beneficiaries, including ACBHCS employees, staff, and other personnel who perform services or functions that make your health care possible.

These people may share health information about you with each other and with other health care providers for purposes of treatment, payment, or health care operations, and with other persons for other reasons as described in this notice.

Our Responsibility

Your health information is confidential and is protected by certain laws. It is our responsibility to protect this information as required by these laws and to provide you with this notice of our legal duties and privacy practices. It is also our responsibility to abide by the terms of this notice as currently in effect.

This notice will:

- Identify the types of uses and disclosures of your information that can occur without your advance written approval.
- Identify the situations where you will be given an opportunity to agree or disagree with the use or disclosure of your information.
- Advise you that other disclosures of your information will occur only if you have provided us with a written authorization.
- Advise you of your rights regarding your personal health information.

How We May Use and Disclose Health Information about You

The types of uses and disclosures of health information can be divided into categories. Described below are these categories with explanations and some examples. Not every type of use and disclosure can be listed, but all uses and disclosures will fall within one of the categories.

- **Treatment.** We may use or share your health information to provide you with medical treatment or other health services. The term "medical treatment" includes physical health care treatment and also "behavioral health care services" (mental health services and alcohol or other drug treatment services) that you might receive. For example, a licensed clinician may arrange for a psychiatrist to see you about possible medication and might discuss with the psychiatrist his or her insight about your treatment. Or, a member of our staff may prepare an order for laboratory work to be done or to obtain a referral to an outside physician for a physical exam. If you obtain health care from another provider, we may also disclose your health information to your new provider for treatment purposes.
- **Payment.** We may use or share your health information to enable us to bill you or an insurance company or third party for payment for the treatment and services that we had provided to you. For example, we may need to give your health plan information about treatment or counseling you received here so that they will pay us or reimburse you for the services. We may also tell them about treatment or services we plan to provide in order to obtain prior approval or to determine whether your plan will cover the treatment. If you obtain health care from another provider, we may also disclose your health information to your new provider for payment purposes.
- **Health Care Operations.** We may use and disclose health information about you for our own operations. Alameda County includes several departments that provide operations support to the Alameda County Behavioral Health Care Services, such as the Auditor-Controller, County Administrator, County Counsel, and others. We may share limited portions of your health information with Alameda County departments but only to the extent necessary for the performance of important functions in support of our health care operations. These uses and disclosures are necessary to the successful operation of the Alameda County Behavioral Health Care Services and to make sure that all of our beneficiaries receive quality care. For example, we may use your health information:
    - To review our treatment and services and to evaluate the performance of the staff in caring for you.
    - To help decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective.
    - For the review or learning activities of doctors, nurses, clinicians, technicians, other health care staff, students, interns and other agency staff.
    - To help us with our fiscal management and compliance with laws.

  If you obtain health care from another provider, we may also disclose your health information to your new provider for certain of its health care operations. In addition, we may remove information that identifies you from this set of health information so that others may use it to study health care and health care delivery without learning the identity of specific patients.

    - We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the ACCESS.

    - Sign-in Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

  Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief

organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

Disclosures For Which We are Not Required to Give You an Opportunity to Agree or Object.

In addition to the above situations, the law permits us to share your health information without first obtaining your permission. These situations are described next.

- **As Required by Law.** We will disclose health information about you when required to do so by federal, state, or local law. For example, information may need to be disclosed to the Department of Health and Human Services to make sure that your rights have not been violated.
- **Suspicion of Abuse or Neglect**. We will disclose your health information to appropriate agencies if relevant to a suspicion of child abuse or neglect, or elder or dependent adult abuse and neglect, or if you are not a minor, if you are a victim of abuse, neglect or domestic violence and either you agree to the disclosure or we are authorized by law to disclose this and it is believed that disclosure is necessary to prevent serious harm to you or others.
- **Public Health Risks.** We may disclose health information about you for public health activities. These activities generally include the following:
  - To prevent or control disease, injury or disability;
  - To report births and deaths;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- **Health Oversight Activities.** We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Judicial and Administrative Proceedings**. We may, and are sometimes required by law, to disclose your personal health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative
- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official:
  - In response to a court order or similar directive.
  - To identify or locate a suspect, witness, missing person, etc.
  - To provide information to law enforcement about a crime victim.
  - To report criminal activity or threats concerning our facilities or staff.
- **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients at our facilities in order to assist funeral directors as necessary to carry out their duties.
- **Organ or Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ donations or transplants.
- **Research.** We may use or disclose your information for research purposes under certain limited circumstances.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety, or to the health and safety of the public or another person. Any disclosure however, would only be to someone who we believe would be able to prevent the threat or harm from happening.
- **For Special Government Functions.** We may use or disclose your health information to assist the government in its performance of functions that relate to you. Your health information may be

disclosed (i) to military command authorities if you are a member of the armed forces, to assist in carrying out military mission; (ii) to authorized federal officials for the conduct of national security activities; (iii) to authorized federal officials for the provision of protective services to the President or other persons or for investigations as permitted by law; (iv) to a correctional institution, if you are in prison, for health care, health and safety purposes; (v) to workers' compensation programs as permitted by law; (vi) to government law enforcement agencies for the protection of federal and state elective constitutional officers and their families; (vii) to the California Department of Justice for movement and identification purposes about certain criminal patients, or regarding persons who may not purchase, possess or control a firearm or deadly weapon; (viii) to the Senate or Assembly Rules Committee for purpose of legislative investigation; (ix) to the statewide protection and advocacy organization and County Patients' Rights Office for purposes of certain investigations as required by law.

- **Other Special Categories of Information.** Special legal requirements may apply to the use or disclosure of certain categories of information — e.g., tests for the human immunodeficiency virus (HIV) or treatment and services for alcohol and drug abuse. In addition, somewhat different rules may apply to the use and disclosure of medical information related to any general medical (non-mental health) care you receive.
- **Psychotherapy Notes.** Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

  We may use or disclose your psychotherapy notes, as required by law, or:
  - For use by the originator of the notes
  - In supervised mental health training programs for students, trainees, or practitioners
  - By this provider to defend a legal action or other proceeding brought by the individual
  - To prevent or lessen a serious & imminent threat to the health or safety of a person or the public
  - For the health oversight of the originator of the psychotherapy notes
  - For use or disclosure to coroner or medical examiner to report a patient's death
  - For use or disclosure necessary to prevent or lessen a serious & imminent threat to the health or safety of a person or the public
  - For use or disclosure to you or the Secretary of DHHS in the course of an investigation or as required by law.
  - To the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

- **Change of Ownership.** In the event that this practice/program is sold or merged with another organization, your personal health information/record will become the property of the new owner, although you will maintain the right to request that copies of your personal health information be transferred to another practice/program

Disclosure Only After You Have Been Given Opportunity To Agree or To Object.

There are situations where we will not share your health information unless we have discussed it with you (if possible) and you have not objected to this sharing. These situations are:

- **Patient Directory.** Where we keep a directory of our patients' names, health status, location of treatment, etc. for purposes of disclosure to members of the clergy or to persons who ask about you by name, we will consult you about whether your information can be shared with these persons.
- **Persons Involved in Your Care or Payment for Your Care.** We may disclose to a family member, a close personal friend, or another person that you have named as being involved with your health care (or the payment for your health care) your health information that is related to the person's involvement. For example, if you ask a family member or friend to pick up a medication for you at the pharmacy, we may tell that person what the medication is and when it will be ready for pick-up. Also,

we may notify a family member (or other person responsible for your care) about your location and medical condition provided that you do not object.

- **Disclosures in Communications with You.** We may have contacts with you during which we will share your health information. For example, we may use and disclose health information to contact you as a reminder that you have an appointment for treatment here, or to tell you about or recommend possible treatment options or alternatives that might be of interest to you. We may use and disclose health information about you to tell you about health-related benefits or services that might be of interest to you. We might contact you about our fundraising activities.
- **Other Uses of Health Information.** Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Your Rights Regarding Health Information About You

You have the following rights regarding health information we maintain about you:

- **Breach Notification**. In the case of a breach of unsecured protected personal health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: email notification will only be used if we are certain it will not contain PHI and it will not disclose inappropriate information. For example if our email address is "digestivediseaseassociates.com" an email sent with this address could, if intercepted, identify the patient and their condition.]
-
- **Right to Inspect and Copy.** You have the right to inspect and copy this health information. Usually this includes medical and billing records, but may not include some mental health information. Certain restrictions apply:
  - You must submit your request in writing. We can provide you a form for this and instructions about how to submit it.
  - If you request a photocopy, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.
  - We may deny your request in certain circumstances. If you are denied access to health information, you may request that the denial be reviewed as provided by law.
  - If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

- **Right to Amend.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. We are not required to make the amendment if we determine that the existing information is accurate and complete. We are not required to remove information from your records. If there is an error, it will be corrected by adding clarifying or supplementing information. You have the right to request an amendment for as long as the information is kept by or for the facility. Certain restrictions apply:
  - You must submit your request for the amendment in writing. We can provide you a form for this and instructions about how to submit it.
  - You must provide a reason that supports your request.
  - We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
    - was not created by us, unless the creator of the information is no longer available to make the amendment;
    - is not part of the health information kept by or for our facility;

- is not part of the information which you would be permitted to inspect or copy.

Even if we deny your request for an amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your health record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

- **Right to Request Special Privacy Protections.** You have the right to request restrictions on certain uses and disclosures of your personal health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your health plan concerning mental health care items or services for which you paid for in full, out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

- **Right to Request Confidential Communications.** You have the right to request that you receive your personal health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
- **Right to a Paper Copy of the Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice from your provider or from the Alameda County Behavioral Health Care Services' office. That office is generally open from Monday to Friday from 9:00 a.m. to 4:00 p.m. (except holidays).
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you in the six (6) years prior to the date you request the accounting. The accounting will not include:
  - Disclosures needed for treatment, payment or health care operations.
  - Disclosures that we made to you.
  - Disclosures that were merely incidental to an otherwise permitted or required disclosure.
  - Disclosures that were made with your written authorization.
  - Certain other disclosures that we made as allowed or required by law.

  To request this list or accounting of disclosures, you must submit your request in writing. We can provide you a form for this and instructions about how to submit it. Your request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

  In addition, we are required to notify you as required by law if your health information is unlawfully accessed or disclosed.

Changes to this Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facilities and on our provider website. The notice will contain on the first page, in the bottom right-hand corner, the effective date. In addition, each time you register at a new service site, they will provide you with a copy of the current notice in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the facility or with the Secretary of the Department of Health and Human Services. To file a complaint with the facility, contact the Alameda County Consumer & Family Assistance Line (CFA Line) at 1-800-779-0787, which is the group

responsible for handling complaints. That group can provide you with more information about this notice and our confidentiality practices. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

Your dated signature on the last page of this packet acknowledges that you were provided with this Notice of Privacy Practices.

Alameda County Department of Behavioral Health Care Services Mental Health Division	Beneficiary's Name: Birth Date: Admit Date: ID/Chart #: RU#, if applies: Provider Name:

Informing Materials -- Your Rights & Responsibilities
Acknowledgement of Receipt

Consent for Services
As described on page one of this packet, your signature below gives your consent to voluntary mental health care services from this provider. If you are a beneficiary's legal representative, your signature gives that consent.

Informing Materials
Your signature also means that the materials marked below were discussed with you in a language or way that you could understand, and that you were given the packet for your records. You may request an explanation and/or copies of the materials again, at any time.

Initial Notification: Please mark the boxes below to show which materials were discussed with you at admission or any other time.

- ☐ Consent for Services
- ☐ Freedom of Choice
- ☐ "Guide to Medi-Cal Mental Health Services" (copy available upon request)
- ☐ Provider List for Alameda County Behavioral Health Plan (copy available upon request)
- ☐ Confidentiality & Privacy
- ☐ Advance Directive Information (for age 18+ & when client turns 18)
  Have you ever created an Advance Directive? ☐*Yes* ☐*No*
  If yes, may we have a copy for our records? ☐*Yes* ☐*No* *If no, may we support you to create one?* ☐*Yes* ☐*No*
- ☐ Beneficiary Problem Resolution Information
- ☐ Maintaining a Welcoming & Safe Place (not a State-required informing material)
- ☐ Notice of Privacy Practices (HIPAA document)

Beneficiary Signature: (or legal representative, if applicable)	Date:
Clinician/Staff Witness Initials:	Date:

Annual Notification: Your provider must remind you each year that the materials listed above are available for your review. Please put your initials and the date in a box below to show when that happens.

Initials & date:	Initials & date:	Initials & date:	Initials & date:

Use one box every year (see above) for the ***beneficiary's*** initials & date (or their legal representative).

Provider Directions:

- *Initial Notification: Discuss each relevant item in the packet with the beneficiary (or legal representative) in their preferred language or method of communication. Complete the identifying information box at the top right of this page. Mark the relevant checkboxes to indicate the items discussed/provided. Ask the beneficiary to sign & date in the appropriate box. Provide staff initials & date in the appropriate box. Give the remaining informing materials packet to the beneficiary for their records. File this signature page in the chart.*
- *Annual Notifications: Remind beneficiaries of the availability of all materials for their review, and review any materials, if requested. Obtain the appropriate dated initials in the boxes provided.*

(The packet in all threshold languages & a detailed instruction sheet are available at www.acbhcs.org/providers, in the QA tab.)

APPENDIX W

PROGRESS NOTES

Name: _____

Insyst# _____

RU# _____

PROGRESS NOTES

Be sure to include the following components in your progress note (PIRP):

1. Client's presenting ***problem/*** focus of session / progress made or not made/ current clinical status (i.e., mood/affect, physical presentation, any significant behavior/risk factors, level of orientation, socio-economic changes, etc.). Indicate Medi-Cal included Primary Diagnosis – DSM IV/ ICD-10.
2. Specific ***intervention***s consistent with client's current Mental Health Objectives—indicate # of MH Objective.
3. Client's ***response*** to intervention and progress towards MH Objectives.
4. ***Plan*** for subsequent services (i.e., client homework, plan changes, referrals, discharge planning, etc.).
5. Face-to-Face (FTF)= an ***interaction*** in-person with the client and/or other person(s).
6. Begin Progress Note Narrative with language service is provided, indicate if interpreter/relationship to client.
7. Legible provider signature (co-sig) with Medi-Cal credential (LCSW, MFT-I, Grad Student, MHRS, Adjunct Staff, etc.)

MH OBJ. #	DATE MM/DD/YYYY	HRS:MM FTF/TT	LOC	SVC Code CPT/BIS HCPCS/BIS	NOTES *(Begin with language service provided in, if interpreter—indicate such and relationship to client).*

Location Codes: 1= Office, 2= Field, 3=Phone, 4= Home, 5= School, 6= Stateline Clinic, 9= Inpatient/SNF

Name: _____

Insyst# _____

RU# _____

PROGRESS NOTES

MH OBJ. #	DATE MM/DD/YYYY	HRS:MM FTF/TT	LOC	SVC Code CPT/BIS HCPCS/BIS	NOTES *(Begin with language service provided in, if interpreter—indicate such and relationship to client).*

Location Codes: 1= Office, 2= Field, 3=Phone, 4= Home, 5= School, 6= Stateline Clinic, 9= Inpatient/SNF