Behavioral Health Department
Alameda County Health

# Timely Access Data Tool / Timeliness Data Reporting

## New/New Returning Clients & New Psychiatry Service Requests

## Data Collection Form

Confidential Patient Information - See Welfare & Institutions Code: 5328

**PLEASE PRINT LEGIBLY**

*NOTE: Timely Access Data submission is required for new clients, clients that have not received a Mental Health service in the past 12 months, and for established Mental Health clients seeking psychiatry services for the first time. Timely Access standards refer to the number of business days, or hours (for urgent service requests) in which a Behavioral Health Plan provider must make an appointment available to a beneficiary from the date the beneficiary, or a provider acting on behalf of the beneficiary, requests a medically necessary service.*

*You need either the Client ID or the Medi-Cal CIN# in order to complete this form. If you do not have either a Client ID or Medi-Cal CIN#, then you cannot complete this form.*

Date of First Contact to Request Services: _____ (MM/DD/YYYY)

## CONTACT INFORMATION

Today's Date: _____ (MM/DD/YYYY)

Type of Request: **CSI Timeliness**

Contact Person's First Name: _____

Contact Person's Last Name: _____

Contact Person's Phone #: _____

Contact Person's Email: _____

Select Provider Name (dba): _____

Enter Name of Clinic / Program: _____

Second Contact Phone Number: _____

Clinician's First Name: _____

Clinician's First Name: _____

## CLIENT INFORMATION

Is this form a Correction / Update to a previous submission? ◯ Yes ◯ No

New/New Returning Client: ◯ Yes ◯ No

Client ID: _____

Client First Name: _____

Client Last Name: _____

Client Date of Birth: _____ (MM/DD/YYYY)

Medi-Cal CIN#: _____

Program Name (MHS Only): _____

## TIMELINESS INFORMATION

Type of Service/Modality: ◯ Outpatient Non-Psychiatry SMHS ◯ Outpatient Psychiatry SMHS

**Referral Source (see last page):

Were the Request Services Urgent? ◯ Not Urgent ◯ Medical Condition (Urgent) ◯ Imminent Risk (Urgent)
Medication Required (Urgent) ◯ Mental Health Event (Urgent) (if urgent is "YES" time is required)

Is this request for services that require Prior Authorization?

- ◯ No Prior Authorization Needed
- ◯ Day Rehabilitation (DR) (prior authorization needed)
- ◯ Day Treatment Intensive (DTI) (prior authorization needed)
- ◯ Intensive Home-Based Services (IHSS) (prior authorization needed)
- ◯ Outpatient Electroconvulsive Therapy (ECT) (prior authorization needed)
- ◯ Short-Term Residential Treatment Program (STRTP) (prior authorization needed)
- ◯ Therapeutic Behavioral Services (TBS) (prior authorization needed)
- ◯ Therapeutic Foster Care (TFC) (prior authorization needed)

Date of First Contact to Request Services: _____ (MM/DD/YYYY)

Time of First Contact: _____ (HH:MM) (if Urgent)

Was the Beneficiary referred to Out-Of-Network Provider: ◯ Yes ◯ No

Reason for Out of Network Referral (If Yes): _____

_____

## FIRST SERVICE APPOINTMENT INFORMATION

**(The evaluation by the clinician to determine medical necessity)**

Date of First Service Appt Offer: _____ (MM/DD/YYYY)

**Time of First Service: _____ (HH:MM) (if urgent)

Did the Beneficiary Attend the First Service Appt: ◯ Yes ◯ No

Date of First Service Appt Rendered: _____ (MM/DD/YYYY)

Wait List - Was the beneficiary offered a Follow-up appointment: ◯ Yes ◯ No

Was the beneficiary delayed access to services: ◯ Yes ◯ No

Wait List Reason (If Yes):

- ◯ 01 = Beneficiary choice: Treatment modality unavailable
- ◯ 02 = Beneficiary choice: Preferred MHP provider unavailable
- ◯ 03 = Beneficiary choice: Preferred service medium unavailable
- ◯ 04 = No available provider
- ◯ 05 = Other (Please Specify)

Description of Facts (If Other): _____

_____

## FOLLOW-UP APPOINTMENT INFORMATION

Date of First Follow-up Appt Offer: _____ (MM/DD/YYYY)

Date of First Follow-up Appt Rendered: _____ (MM/DD/YYYY)

Was the Follow-up Appt Wait Time Extended: ◯ Yes ◯ No

## CLOSURE INFORMATION

Closure Date: _____ (MM/DD/YYYY)

Closure Reason:

- ◯ 01 = member did not accept any offered appointment dates.
- ◯ 02 = member accepted offered appointment date but did not attend initial appointment.
- ◯ 03 = member attended initial appointment but did not complete assessment process.
- ◯ 04 = member attended first service appointment but declined treatment.
- ◯ 05 = Beneficiary did not meet medical necessity criteria.
- ◯ 06 = Out of county/presumptive transfer.
- ◯ 07 = Unable to contact (e.g. deceased or client unresponsive).
- ◯ 08 = Other (Please Specify)

Description of Facts (If Other): _____

_____

Reset Form

## **Referral Source

| | |
|---|---|
| Self | Faith-Based Organization |
| Family Member | Other County / Community Agency |
| Significant Other | Homeless Services |
| Friend / Neighbor | Street Outreach |
| School | Juvenile Hall / Camp / Ranch / Division of Juvenile Justice |
| Fee-For-Service Provider | Probation / Parole |
| Medi-Cal Managed Care Plan | Jail / Prison |
| Federally Qualified Health Center | State Hospital |
| Emergency Room | Crisis Services |
| Mental Health Facility / Community Agency | Mobile Evaluation |
| Social Services Agency | Other Referred |
| Substance Abuse Treatment Facility / Agency | |