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

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 / Ext: _____

Contact Person's Email: _____

Select Provider Name (dba) acronyms not used:
_____

Enter Name of Clinic / Program: _____

Second Contact Phone Number: _____

Clinician's First Name: _____

Clinician's Last Name: _____

CLIENT INFORMATION

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

New/New Returning Client or New Psychiatry Service Request: ◯ Yes ◯ No

Client ID: _____

Client First Name: ----------

Client Last Name: _____

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

Medi-Cal CIN#: _____

Program Name (MHS Only): ZTEST-Test

TIMELINESS INFORMATION

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

Referral Source: Other Referred

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)

◯ 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 to Out-Of-Network Provider: ◯ Yes ◯ No

Description of Facts (If Yes):

FIRST SERVICE APPOINTMENT INFORATION

The evaluation by the clinician to determine medical necessity

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

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

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

First Service Appt Rendered Date: _____ (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): ◯ Beneficiary choice – Treatment modality unavailable

◯ Beneficiary choice – Preferred MHP provider unavailable

◯ Beneficiary choice – Preferred service medium unavailable

◯ No available provider

◯ 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

Closed Out Date: _____ (MM/DD/YYYY)

Closure Reason:

◯ member did not accept any offered appointment dates

◯ member accepted offered appointment date but did not attend initial appointment

◯ member attended initial appointment but did not complete assessment process

◯ member attended first service appointment but declined treatment

◯ Beneficiary did not meet medical necessity criteria

◯ Out of county/presumptive transfer

◯ Unable to contact (e.g. deceased or client unresponsive)

◯ Other

Description of Facts (if Other):

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	

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