

DEMOGRAPHIC INFORMATION

| | | | | | | |
|--|------|------------|--------------------------------------|---|-----------------|------|
| Assessment Date | | | | Medicaid Number: | | |
| Recipient Name: (first, middle, last) | | | | | | MCO: |
| Age: | DOB: | Ethnicity: | Gender: | Gender Expression: | Marital Status: | SSN: |
| Legal Status (if applicable; please include court order): <input type="checkbox"/> None <input type="checkbox"/> Judicial Civil <input type="checkbox"/> Judicial Civil 648B <input type="checkbox"/> NGBRI <input type="checkbox"/> Parole <input type="checkbox"/> Probation <input type="checkbox"/> Charges Pending <input type="checkbox"/> AOT <input type="checkbox"/> Judicial <input type="checkbox"/> Court Ordered outpatient Treatment <input type="checkbox"/> Legal Detainer <input type="checkbox"/> Other: (list) _____ | | | | Power of Attorney (POA): <input type="checkbox"/> Medical <input type="checkbox"/> Financial <input type="checkbox"/> Both Phone Number of POA: _____ Curator: Name: _____ Phone Number: _____ | | |
| If available, please attach a copy of legal documentation including Legal status, Power of Attorney, or Interdiction | | | | | | |
| Past Judicial Status: <input type="checkbox"/> None <input type="checkbox"/> DWI <input type="checkbox"/> Prior Arrests <input type="checkbox"/> History of Sexual Offense <input type="checkbox"/> History of Elderly Abuse <input type="checkbox"/> Prior Incarcerations _____ <input type="checkbox"/> History of Aggressive Behavior: (describe) _____ | | | | | | |
| LOCUS: (date and score) | | | PRIMARY DIAGNOSIS (from Psych Eval): | | | |
| Facility/Agency/Individual Requesting Placement (please include contact person, phone#, and fax to send determination): | | | | | | |
| Current Location of the Individual: | | | | | | |
| Type of Referral: <input type="checkbox"/> Pre-admission; <input type="checkbox"/> Resident Review; <input type="checkbox"/> Extension Request | | | | | | |

DOCUMENTS REVIEWED/INDIVIDUAL INTERVIEWS

Federal regulations require that the following items are reviewed as part of this evaluation and must be submitted to the Level II Authority with the PASRR Level II Independent Behavioral Health Comprehensive Evaluation. **The Evaluation will not be considered as complete until this information is provided to OBH.** (attach all records reviewed):

Medical H&P Functional Assessment Psychiatric Evaluation or Psychiatric Consult Psychosocial Evaluation Comprehensive Medications
 Psychological Testing Results Progress Notes(most recent) Additional Labs or Consults: _____
 Other: _____

The following individuals were interviewed:

Individual Family/significant other (specify name) _____
 Legal representative/Guardian/Conservator (specify name) _____
 NF/Hospital Staff (specify name/discipline) _____ / _____
 Other agency for interdisciplinary coordination (specify/organization) _____
 Other: _____

Was the Individual able to participate in the interview? Yes No If no, please explain why: _____

BEHAVIORAL HEALTH HISTORY

| | |
|--|--|
| I. | CHIEF COMPLAINT ACCORDING TO THE RECIPIENT (the person's viewpoint of their needs.) |
| | |
| II. | FAMILY OR SIGNIFICANT OTHER'S DESCRIPTION OF THE PROBLEM |
| | |
| Person Providing Information: _____ Relationship to Applicant: _____ | |

III. PRESENTING PROBLEM/HISTORY OF PRESENT ILLNESS: (Including recipient's reason for seeking services, precipitating factors, symptoms, behavioral and functioning impacts, onset/course of issues, *current behavioral health providers*, services sought and recipient expectation, include information on medicaid and medicare-funded services, as well as services provided through alternate funding.)

| | |
|--|--|
| <p>IV. CURRENT BEHAVIORAL HEALTH PROVIDER/PRESCRIBER: <input type="checkbox"/> check if N/A</p> <p>AGENCY NAME: _____</p> <p>PHONE NUMBER: _____</p> <p>DATE SERVICES BEGAN: _____</p> <p>LAST APPOINTMENT: _____</p> <p>NAME OF MENTAL HEALTH PROFESSIONAL: _____</p> <p>Are services funded through Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Describe current behavioral health services beyond medication management including the level of engagement recipient had with services:</p> | <p>SERVICES RENDERED BY PROVIDER: Check if medication management only: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> |
|--|--|

| | |
|--|--|
| <p>V. PAST PSYCHIATRIC HISTORY (First onset of illness, past diagnostic and treatment history, medications, hospitalizations-date, length, reasons, & facility):</p> | |
| <p>Within the last two (2) years, experienced Prior Outpatient Mental Health Treatment: (excluding medication management only) <input type="checkbox"/> No; <input type="checkbox"/> Yes; Please check all that apply:</p> <p><input type="checkbox"/> LGE <input type="checkbox"/> IOP <input type="checkbox"/> Individual Counseling with LMHP <input type="checkbox"/> PSR (Psychosocial Rehabilitation)</p> <p><input type="checkbox"/> Crisis Intervention <input type="checkbox"/> Community Psychiatric Support and Treatment (CPST)</p> <p><input type="checkbox"/> Assertive Community Treatment (ACT) <input type="checkbox"/> Partial Hospitalization/Day Treatment</p> <p><input type="checkbox"/> Other (Describe)</p> <p>Location(s) / Date(s): *include additional pages as necessary*</p> <p>Location: _____ / Date(s) _____</p> <p>Location: _____ / Date(s) _____</p> | <p>Within in the last two (2) years experienced Psychiatric Hospitalizations:</p> <p><input type="checkbox"/> No; <input type="checkbox"/> Yes; If yes, was the hospitalization due to a Neurocognitive diagnosis? <input type="checkbox"/> No; <input type="checkbox"/> Yes</p> <p>Location(s) / Date(s): *include additional pages as necessary*</p> <p>Location: _____ / Date(s) _____</p> <p>Location: _____ / Date(s) _____</p> <p>Location: _____ / Date(s) _____</p> |

ADDITIONAL COMMENTS REGARDING BEHAVIORAL HEALTH TREATMENT: (reason for hospitalization/treatment, types of treatment provided, psychiatric complications to treatment, order of protective custody/legal commitment, etc.)

Within the last three (3) to six (6) months, has the individual had an episode of significant decline to their psychiatric status resulting in one of the following: legal/judicial involvement loss of housing crisis intervention bizarre behavior (ex: hallucinations, delusions, excessive spending, aggressive behavior) other (please describe):

VI. SUBSTANCE USE/DEPENDENCE (Past use of primary, secondary & tertiary current substance, incl. type, frequency, method & age of first use.)

Check any/all that apply in past 12 months:

- Alcohol Use; Illegal Drug Use; Injected Drug Use ; Tobacco Product Use; Prescription Drugs Abuse; Non-Prescription (OTC) abuse;
- Alcohol and/or Drug Overdose; Alcohol and/or Drug Withdrawal; Problems caused by gambling; Trouble stopping any substance; Denies
- Other/Describe:

Substance Use Treatment History: None; Outpatient; Intensive Outpatient; Residential/Inpatient; Detox;
 Other/Describe:

| SUBSTANCE TYPE Include all use in last 30 days. | AGE OF 1ST USE | YEARS IN LIFETIME | DAYS IN PAST 30 | DAYS SINCE LAST USE | AMOUNT | ROUTE OF ADMINISTRATION |
|--|-------------------|----------------------|--------------------|------------------------|--------|---|
| | | | | | | <input type="checkbox"/> Oral; <input type="checkbox"/> Nasal; <input type="checkbox"/> Smoking; <input type="checkbox"/> Non-IV Injxn; <input type="checkbox"/> IV |
| | | | | | | <input type="checkbox"/> Oral; <input type="checkbox"/> Nasal; <input type="checkbox"/> Smoking; <input type="checkbox"/> Non-IV Injxn; <input type="checkbox"/> IV |
| | | | | | | <input type="checkbox"/> Oral; <input type="checkbox"/> Nasal; <input type="checkbox"/> Smoking; <input type="checkbox"/> Non-IV Injxn; <input type="checkbox"/> IV |
| | | | | | | <input type="checkbox"/> Oral; <input type="checkbox"/> Nasal; <input type="checkbox"/> Smoking; <input type="checkbox"/> Non-IV Injxn; <input type="checkbox"/> IV |

PHYSICAL/MEDICAL HISTORY

VII. CURRENT MEDICAL CONDITIONS (Check all that apply; supporting documentation must be attached)

Meets Medical Eligibility for NF placement as determined by the Level I Authority Yes No

| | | | | |
|--|---|--|---|---|
| <input type="checkbox"/> Pregnant | Due date: | Prenatal care: | | |
| <input type="checkbox"/> None Reported | <input type="checkbox"/> Congestive Heart Failure Date of onset: | <input type="checkbox"/> Asthma Date of onset: | <input type="checkbox"/> Seizure Date of onset: | <input type="checkbox"/> Sexually Transmitted Dz Date of onset: |
| <input type="checkbox"/> High Blood Pressure Date of onset: | <input type="checkbox"/> Stroke Date of onset: | <input type="checkbox"/> Emphysema Date of onset: | <input type="checkbox"/> Cirrhosis Date of onset: | <input type="checkbox"/> Chronic Pain Date of onset: |
| <input type="checkbox"/> Heart Disease (specify): Date of onset: | <input type="checkbox"/> Diabetes <input type="checkbox"/> Insulin Date of onset: | <input type="checkbox"/> Epilepsy Date of onset: | <input type="checkbox"/> Digestive Problems Date of onset: | <input type="checkbox"/> Thyroid Disease Date of onset: |
| <input type="checkbox"/> Cancer (specify type): Date of onset: Life expectancy of less than 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Dementia <input type="checkbox"/> Early Stage <input type="checkbox"/> Late Stage Date of onset: Must provide proof of dx and complete dementia addendum | <input type="checkbox"/> Underweight <input type="checkbox"/> Overweight Date of onset: | <input type="checkbox"/> COPD <input type="checkbox"/> Oxygen <input type="checkbox"/> No oxygen Date of onset: | Chronic Kidney Disease <input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Stage 4 Date of onset: |

Other/Describe:

List source of medical conditions noted above:

| SOCIAL HISTORY | |
|--|---------------------------------|
| XIII. FAMILY HISTORY (relationship status with relatives, family involvement in treatment, and living status of significant relatives): | |
| Current Adverse Circumstances: <input type="checkbox"/> N/A; <input type="checkbox"/> Poverty; <input type="checkbox"/> Criminal Behavioral; <input type="checkbox"/> Mental Illness; <input type="checkbox"/> Substance Use; <input type="checkbox"/> Abuse; <input type="checkbox"/> Neglect; <input type="checkbox"/> Domestic Violence; <input type="checkbox"/> Violence; <input type="checkbox"/> Trauma/Describe: _____ <input type="checkbox"/> Other/Describe: _____ | |
| Current Family Stress: <input type="checkbox"/> Low Stress; <input type="checkbox"/> Mildly Stressful; <input type="checkbox"/> Moderately Stressful; <input type="checkbox"/> Highly Stressful; <input type="checkbox"/> Extremely Stressful <input type="checkbox"/> Other/Describe: _____ | |
| Current Family Supports: <input type="checkbox"/> Highly Supportive; <input type="checkbox"/> Supportive; <input type="checkbox"/> Limited Support; <input type="checkbox"/> Minimal Support; <input type="checkbox"/> No Support <input type="checkbox"/> Other/Describe: _____ | |
| Additional Comments: | |
| XIV. TRAUMA HISTORY | |
| History of Trauma: <input type="checkbox"/> None; <input type="checkbox"/> By History <input type="checkbox"/> Experienced; <input type="checkbox"/> Witnessed; TYPE: <input type="checkbox"/> Abuse; <input type="checkbox"/> Neglect; <input type="checkbox"/> Violence; <input type="checkbox"/> Sexual Assault; <input type="checkbox"/> Related to Military experience <input type="checkbox"/> Other/Describe: _____ | |
| XV. LIVING SITUATION (Current status and functioning) | |
| a. Primary Residence: <input type="checkbox"/> Own Home; <input type="checkbox"/> Apartment; <input type="checkbox"/> Relative's Home; <input type="checkbox"/> Group Home; <input type="checkbox"/> Homeless; <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Other/Describe: _____ | |
| How long at current residence? | |
| Individuals Living in the Home: | |
| Source of meals/food: | Means of transportation: |
| Have you ever been homeless? (if yes give dates and describe living situation) <input type="checkbox"/> Yes <input type="checkbox"/> No Additional Comments: (Include psychological and social adjustments made to disabilities and/or disorders as it relates to housing needs.) | |
| b. Preferences: include things the individual or their family member feels will enhance his/her living situation | |

c. Abilities/Interests/Strengths –Include strengths, skills, aptitudes that might assist in maintaining or improving living situation; also list assets, service options and resources the person has to meet needs, including available housing options

d. Does the individual want nursing home placement? Yes; No If yes how long? 1-3 months 3-9 Months 9-12 Months Permanently (Describe reason for wanting nursing home placement)

e. Where would you like to live?

f. Prior Community Services Utilized such as: Home Health; Sitters; Waiver Services; Adult Day Care;
 PSH Voucher: Name of PSH Provider: _____
 Voucher (Type) _____
 Services through the Office of Citizens with Developmental Disabilities

g. Prior Nursing Home Placement: Date(s) and Names of Facility(ies) *include additional pages as necessary* None

Name of Facility: _____ / Date(s) _____ / Reason for Leaving: _____

Name of Facility: _____ / Date(s) _____ / Reason for Leaving: _____

h. Needs – From evaluator’s perspective, identify the needs that will allow the individual to remain in the community (Ex. Transportation, personal care attendant day program, outpatient therapy, council on aging, home health, medication management, ACT, CPST, substance abuse treatment housing subsidy, money in savings, care-giver resource assessment, etc.)

XVI. LEARNING/WORKING AND FUNCTIONAL STATUS

a. Employment/Education/Rehabilitation Status:

| | |
|--|---|
| Current source of income: | Estimated Monthly Income Amount: |
| Military income: <input type="checkbox"/> No; <input type="checkbox"/> Yes; | Military Status: |
| Difficulties with Reading/Writing: <input type="checkbox"/> No; <input type="checkbox"/> Yes; | Estimated Literacy Level: |
| Employed within the last year?: <input type="checkbox"/> No; <input type="checkbox"/> Yes | Type of Work Performed? |

Assistive Devices utilized/required: No; Yes: Hearing Aid Wheelchair Walker Cane
 Other (describe)

Additional Comments: (Include psychological and social adjustments made to disabilities and/or disorders.)

b. Current Status & Functioning (Assess ability to fulfill responsibilities; interact with others, capacity self-care, etc.)

| ADLs/IADLs | Explanation for how Determined | Impairment Expected to improve? | No Impairment | Supervision | Limited Assistance | Extensive Assistance | Total Assistance |
|----------------------------------|--------------------------------|---------------------------------|---------------|-------------|--------------------|----------------------|------------------|
| Mobility | | | | | | | |
| Bathing | | | | | | | |
| Dressing | | | | | | | |
| Self-Feeding | | | | | | | |
| Personal hygiene & grooming | | | | | | | |
| Toilet hygiene | | | | | | | |
| Housework | | | | | | | |
| Meal Preparation | | | | | | | |
| Medication Management | | | | | | | |
| Managing Finances | | | | | | | |
| Shopping (groceries or clothing) | | | | | | | |
| Communication | | | | | | | |
| Transportation | | | | | | | |

Comments – indicate if the impairment is due to the current illness, including individual’s reliance on support systems to perform activities in the community

Functional Abilities - Include recipient reported strengths, skills, aptitudes that may help maintain or improve the current level of functioning

| CURRENT STATUS | |
|---|---|
| XVII. | MENTAL STATUS EXAMINATION <i>(Circle or Check all that apply)</i> |
| a. GENERAL APPEARANCE | <input type="checkbox"/> Healthy; <input type="checkbox"/> As stated Age; <input type="checkbox"/> Older Than Stated Age; <input type="checkbox"/> Young-looking; <input type="checkbox"/> Tattoos; <input type="checkbox"/> Disheveled; <input type="checkbox"/> Unkempt; <input type="checkbox"/> Malodorous; <input type="checkbox"/> Thin; <input type="checkbox"/> Overweight; <input type="checkbox"/> Obese; <input type="checkbox"/> Other/Describe: |
| b. BEHAVIOR & PSYCHOMOTOR ACTIVITY | <input type="checkbox"/> Normal; <input type="checkbox"/> Overactive; <input type="checkbox"/> Hypoactive; <input type="checkbox"/> Catatonia; <input type="checkbox"/> Tremor; <input type="checkbox"/> Tics; <input type="checkbox"/> Combative; <input type="checkbox"/> Other/Describe: |
| c. ATTITUDE | <input type="checkbox"/> Optimal; <input type="checkbox"/> Constructive; <input type="checkbox"/> Motivated; <input type="checkbox"/> Obstructive; <input type="checkbox"/> Adversarial; <input type="checkbox"/> Inaccessible; <input type="checkbox"/> Cooperative; <input type="checkbox"/> Seductive; <input type="checkbox"/> Defensive; <input type="checkbox"/> Hostile; <input type="checkbox"/> Guarded; <input type="checkbox"/> Apathetic; <input type="checkbox"/> Evasive; <input type="checkbox"/> Other/Explain: |
| d. SPEECH | <input type="checkbox"/> Normal; <input type="checkbox"/> Spontaneous; <input type="checkbox"/> Slow; <input type="checkbox"/> Impoverished; <input type="checkbox"/> Hesitant; <input type="checkbox"/> Monotonous; <input type="checkbox"/> Soft/Whispered; <input type="checkbox"/> Mumbled; <input type="checkbox"/> Rapid; <input type="checkbox"/> Pressured; <input type="checkbox"/> Verbose; <input type="checkbox"/> Loud; <input type="checkbox"/> Slurred; <input type="checkbox"/> Impediment; <input type="checkbox"/> Other/Describe: |
| e. MOOD | <input type="checkbox"/> Dysphoric; <input type="checkbox"/> Euthymic; <input type="checkbox"/> Expansive; <input type="checkbox"/> Irritable; <input type="checkbox"/> Labile; <input type="checkbox"/> Elevated; <input type="checkbox"/> Euphoric; <input type="checkbox"/> Ecstatic; <input type="checkbox"/> Depressed; <input type="checkbox"/> Grief/mourning; <input type="checkbox"/> Alexithymic; <input type="checkbox"/> Elated; <input type="checkbox"/> Hypomanic; <input type="checkbox"/> Manic; <input type="checkbox"/> Anxious; <input type="checkbox"/> Tense; <input type="checkbox"/> Other/Describe: |
| d. AFFECT | <input type="checkbox"/> Appropriate; <input type="checkbox"/> Inappropriate; <input type="checkbox"/> Blunted; <input type="checkbox"/> Restricted; <input type="checkbox"/> Flat; <input type="checkbox"/> Labile; <input type="checkbox"/> Tearful; <input type="checkbox"/> Intense; <input type="checkbox"/> Other/Describe: |
| g. PERCEPTUAL DISTURBANCES | <input type="checkbox"/> None; <input type="checkbox"/> Hallucinations: <input type="checkbox"/> Auditory; <input type="checkbox"/> Visual; <input type="checkbox"/> Olfactory; <input type="checkbox"/> Tactile; <input type="checkbox"/> Other/Describe: |
| h. THOUGHT PROCESS | <input type="checkbox"/> Logical/Coherent; <input type="checkbox"/> Incomprehensible; <input type="checkbox"/> Incoherent; <input type="checkbox"/> Flight of Ideas; <input type="checkbox"/> Loose Associations; <input type="checkbox"/> Tangential; <input type="checkbox"/> Circumstantial; <input type="checkbox"/> Rambling; <input type="checkbox"/> Evasive; <input type="checkbox"/> Racing Thoughts; <input type="checkbox"/> Perseveration; <input type="checkbox"/> Thought Blocking; <input type="checkbox"/> Concrete; <input type="checkbox"/> Other/Describe: |
| i. THOUGHT CONTENT | <input type="checkbox"/> Preoccupations; <input type="checkbox"/> Obsessions; <input type="checkbox"/> Compulsions; <input type="checkbox"/> Phobias; <input type="checkbox"/> Delusions; <input type="checkbox"/> Thought Broadcasting; <input type="checkbox"/> Thought Insertion; <input type="checkbox"/> Thought Withdrawal; <input type="checkbox"/> Ideas of Reference; <input type="checkbox"/> Ideas of Influence <input type="checkbox"/> Other/Describe: Comments – If checked, please describe: |
| j. SUICIDAL/HOMICIDAL IDEATION | <input type="checkbox"/> Suicidal Thoughts; <input type="checkbox"/> Suicidal Attempts; <input type="checkbox"/> Suicidal Intent; <input type="checkbox"/> Suicidal Plans; <input type="checkbox"/> History of Self-Injurious Behavior; <input type="checkbox"/> Homicidal Thoughts; <input type="checkbox"/> Homicidal Attempts; <input type="checkbox"/> Homicidal Intent; <input type="checkbox"/> Homicidal Plans; <input type="checkbox"/> Other/Describe: Comments – If checked, please describe: |
| k. SENSORIUM/COGNITION | <input type="checkbox"/> Alert; <input type="checkbox"/> Lethargic; <input type="checkbox"/> Somnolent; <input type="checkbox"/> Stuporous; <input type="checkbox"/> Normal Concentration; <input type="checkbox"/> Impaired Concentration; <input type="checkbox"/> Other/Describe: Oriented to: <input type="checkbox"/> Person; <input type="checkbox"/> Place; <input type="checkbox"/> Time; <input type="checkbox"/> Situation; |
| l. MEMORY | Remote Memory: <input type="checkbox"/> Normal; <input type="checkbox"/> Impaired; Recent Memory: <input type="checkbox"/> Normal; <input type="checkbox"/> Impaired; Immediate Recall: <input type="checkbox"/> Normal; <input type="checkbox"/> Impaired <input type="checkbox"/> Other/Describe: |
| m. INTELLECTUAL FUNCTIONING | (Estimate) <input type="checkbox"/> Above Avg.; <input type="checkbox"/> Normal/Avg.; <input type="checkbox"/> Borderline; Intellectual Disability: <input type="checkbox"/> Mild; <input type="checkbox"/> Moderate; <input type="checkbox"/> Severe <input type="checkbox"/> Other/Describe: |
| n. JUDGEMENT | <input type="checkbox"/> Critical Judgment Intact; <input type="checkbox"/> Impaired Judgment; <input type="checkbox"/> Other/Describe: |
| o. INSIGHT | <input type="checkbox"/> True Emotional Insight; <input type="checkbox"/> Intellectual Insight; <input type="checkbox"/> Some Awareness of Illness/symptoms; <input type="checkbox"/> Impaired Insight; <input type="checkbox"/> Denial; <input type="checkbox"/> Other/Describe: |
| p. IMPULSE CONTROL | <input type="checkbox"/> Recent Impulsive Behavior; <input type="checkbox"/> Impaired Impulse Control; <input type="checkbox"/> Compulsions; <input type="checkbox"/> Other/Describe: |

XVIII. Mood and Behavioral Assessment: within the last 3 to 6 Months, has the individual had an episode of significant decline to their psychiatric status resulting in one of the following:

| Mood | Within past 30 Days | Within past 31-90 Days | Indicate if present within the last 7 days |
|--------------------------|--|--|--|
| Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Loneliness | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Feelings of Hopelessness | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Suicidal Thoughts | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Suicidal Threats | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lability/Mood Swings | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sadness | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mania | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Homicidal Ideation | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Suicidal Ideation | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

A) Has an effective strategy been identified to have helped the individual manage these symptoms in the past? (Please describe your answer)
 Yes No (describe)_____

B) Are there other strategies not currently in place that may assist the individual with managing these symptoms? Yes No (if yes, please describe)_____

Are there early warning signs that the individual or his/her family/significant other is able to identify prior to the person decompensating?
 Yes No(if yes describe)_____

Comments - Provide a summary of mental status, including details about externalizing and internalizing behaviors, intellectual functioning, cognitive functioning, and reality testing.

XIX. RISK ASSESSMENT: Assess the potential risk of harm to self or others, including patterns of risk behavior and/or risk due to personality factors, substance use, criminogenic factors, exposure to elements, exploitation, abuse, neglect, suicidal or homicidal history, self-injury, psychosis, impulsiveness, etc.

a. **Risk of Harm to Self - unintentional or intentional:** Prior Suicide Attempt; Stated Plan/Intent; Access to means (weapons, pills, etc.);
 Recent Loss; Presence of Behavioral Cues (isolation, giving away possessions, rapid mood swings, etc.); Family History of Suicide;
 Terminal Illness; Substance Abuse; Marked lack of support; Psychosis; Suicide of friend/acquaintance;
 Other/Describe:

b. **Risk of Harm to Others - unintentional or intentional:** Prior acts of violence; If yes, when was the most recent violent act? _____
 Destruction of property; Arrests for violence; Access to means (weapons); Substance use; Physically abused as child; Was physically abusive as a child; Harms animals; Fire setting; Angry mood/agitation; Prior hospitalizations for danger to others; Psychosis/command hallucinations; If yes, is there a history of acting on any commands to harm others? Yes No;
 Other/Describe:

c. **Risk of Harm to Self or Others Rating:** (From LOCUS Risk of Harm Evaluation Parameters.) Minimal; Low; Moderate; Serious;
 Extreme; as evidenced by:

d. **Recipient Safety & Other Risk Factors:** Feels unsafe in current living environment; Feels currently being harmed/hurt/abused/threatened by someone; Engages in dangerous sexual behavior; Past involvement with Child or Adult Protective Services; Relapse/decompensation triggers; Other/Describe:

e. Describe recipient's **preferences and desires** for addressing risk factors, including any Mental Health Advance Directives or plan of response to periods of decompensation/relapse (Ex. Resources recipient feels comfortable reaching out to for assistance in a crisis.):

| | | |
|--|--------------------------------|----------------------------|
| XX. CULTURAL AND LANGUAGE PREFERENCES (Language, Customs/Values/Preferences) | | |
| a. Spiritual Beliefs/Preferences: | | |
| b. Cultural Beliefs/Preferences: | | |
| c. Language Preferences: | | |
| XXI. PRINCIPAL DIAGNOSES (PROVIDE PRINCIPLE BEHAVIORAL, MEDICAL DIAGNOSES, AND DEVELOPMENTAL DISABILITY) | | |
| <i>DIAGNOSIS</i> | <i>SEVERITY, IF APPLICABLE</i> | <i>SOURCE OF DIAGNOSIS</i> |
| | | |
| | | |
| | | |
| | | |
| XXII. IDENTIFIED NEEDS | | |
| Recipient would benefit from the following services (as indicated by recipient, family, staff, etc): | | |
| Living Situation: <input type="checkbox"/> Home <input type="checkbox"/> Independent Living <input type="checkbox"/> Supportive Housing <input type="checkbox"/> Other (describe): | | |
| Additional Services: | | |
| Medical: <input type="checkbox"/> Home Health <input type="checkbox"/> Evaluation for a diagnosis of dementia <input type="checkbox"/> Audiological evaluation <input type="checkbox"/> Dental evaluation <input type="checkbox"/> Vision evaluation Personal Care Attendant Assistance in obtaining medical appliances/devices (describe): | | |
| Mental Health: <input type="checkbox"/> Short term counseling <input type="checkbox"/> Medication education <input type="checkbox"/> Crisis intervention plan/safety plan <input type="checkbox"/> LGE <input type="checkbox"/> Medication Monitoring <input type="checkbox"/> Group Counseling <input type="checkbox"/> Family Counseling | | |
| Supportive/Recreational: <input type="checkbox"/> Transportation <input type="checkbox"/> Training in ADLs <input type="checkbox"/> Training in independent living skills <input type="checkbox"/> Meals on Wheels <input type="checkbox"/> Interpretive services <input type="checkbox"/> Services for the visually/hearing impaired <input type="checkbox"/> Reading/writing Training <input type="checkbox"/> Structured leisure activities (day program, council on Aging) <input type="checkbox"/> Employment <input type="checkbox"/> Skill Training other: | | |
| Substance Use: <input type="checkbox"/> AA/NA <input type="checkbox"/> MAT <input type="checkbox"/> Res Tx <input type="checkbox"/> AA <input type="checkbox"/> NA <input type="checkbox"/> Other(describe) | | |
| Income: <input type="checkbox"/> Benefits Planning <input type="checkbox"/> Other (describe) | | |
| Legal: <input type="checkbox"/> Guardian <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Living Will <input type="checkbox"/> Will <input type="checkbox"/> A guardian/conservator for decisions regarding health and safety | | |
| Other: <input type="checkbox"/> Other (describe) <input type="checkbox"/> Referrals to other agencies or community programs (please specify): | | |
| Recipient would benefit from the following services (as indicated by treating medical clinicians/records): | | |
| <input type="checkbox"/> Rehabilitation services ordered by a medical doctor and provided by a licensed physical, occupational, respiratory, or speech therapist <input type="checkbox"/> Rehabilitation services provided by a technician or aide <input type="checkbox"/> Rehabilitation services following major surgery during a post-operative period <input type="checkbox"/> Treatment for severe and debilitating medical conditions, which require daily care from medical staff and cannot be cared for in the home even with the assistance of home health nursing. <input type="checkbox"/> Oxygen therapy when monitoring the need or regulating flow rate either temporarily or intermittently (do not include those using continuous oxygen who are in stable condition) <input type="checkbox"/> Treatment for chronic skin conditions requiring daily dressing changes with aseptic techniques and use of prescription drugs or when have a co-occurring medical condition (such as diabetes) which can complicate healing (do not include those conditions which can be treated by topical ointments) <input type="checkbox"/> Medication administration requiring close observation and assessment (e.g. IV, NG, gastrostomy, etc) <input type="checkbox"/> Medication monitoring through assistance with medication compliance or routine medication administration <input type="checkbox"/> Clinically required observation, assessment, and documentation of significant nutritional deficit such as parenteral feedings, gastrostomy or NG tubes which are included in a specific treatment plan <input type="checkbox"/> Special diet or assistance with food preparation <input type="checkbox"/> Treatment for dementia, delirium, or another cognitive disorder related to a medical condition <input type="checkbox"/> Nursing treatment for the purpose of maintaining or restoring maximum functioning for individuals with restorative potential <input type="checkbox"/> Care and/or maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, and other indwelling tubes for a recipient who is unable to self-care <input type="checkbox"/> Support/training in the self-maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, and other indwelling tubes for a recipient | | |

Comments - indicate any additional needs of the recipient that speak to the need for community-based or NF placement.

| | | | |
|---|------------------|-----------------------|-------------|
| EVALUATOR SIGNATURE | | | |
| PRINTED NAME OF ASSESSOR | SIGNATURE | LICENSE NUMBER | DATE |
| <i>*BY SIGNING THIS DOCUMENT, I CERTIFY THAT I AM INDEPENDENT OF THE OFFICE OF BEHAVIORAL HEALTH MAKING THE DETERMINATIONS AND THAT I HAVE NO DIRECT OR INDIRECT AFFILIATION OR RELATIONSHIP WITH THE NURSING FACILITY.</i> | | | |

DEMENTIA ADDENDUM – *Only complete if Dementia suspected or if an indication of Dementia in Section VII of the Evaluation*

A. Interview individuals with direct contact/knowledge of the individual’s decline in everyday functioning such as their ability to fulfill responsibilities; interact with others, and their capacity for self-care. This should NOT include anecdotal or third party information. Within the table below, for each behavior, indicate how the person functioned during the listed time-period using the following criteria:

- **No impairment = able to complete independently**
- **Some impairment = needs assistance to complete some aspects of the task, but primarily completes tasks independently,**
- **Major impairment = needs a lot of assistance to complete tasks,**
- **Total impairment = unable to complete any aspect of task on own,**
- **Not applicable = have never completed task even at the best level of functioning**

| Behavior | 5 + years | 3-4 years | 1-2 years | 6-12 Months |
|--|------------------|------------------|------------------|--------------------|
| Mobility | | | | |
| Bathing | | | | |
| Dressing | | | | |
| Self-Feeding | | | | |
| Personal hygiene & grooming | | | | |
| Toilet hygiene | | | | |
| Housework | | | | |
| Meal Preparation | | | | |
| Medication Management | | | | |
| Managing Finances | | | | |
| Shopping (groceries or clothing) | | | | |
| Communication | | | | |
| Driving | | | | |
| Memory (Forgetting simple words/everyday items/activities) | | | | |
| Wandering | | | | |
| Behavior (aggressive or bizarre behavior which is unusual to the person) | | | | |

B. Describe in detail how the person’s current level of function is different from their best-sustained level of functioning:

C. Describe in Detail the timeline of the person’s decline in functioning to current level of functioning (tell the story of what happened first to last in the person’s ability to function)

Testing that may be required: MRI/CAT SCAN, extensive detailed psychiatric evaluation, neurological exam. If an additional psychiatric evaluation is requested, special emphasis to all aspects of memory and executive functioning should be included. Single word descriptors and checklist evaluations cannot be accepted for diagnostic purposes.

TO BE COMPLETED BY MCO ONLY

- MCO HAS REVIEWED THE EVALUATION AND IT IS COMPLETE (incomplete evaluations will be returned to the MCO as not accepted)
- BASED ON THE REVIEW, NURSING FACILITY APPEARS APPROPRIATE (final determination will be made by OBH PASRR)
- BASED ON THE REVIEW, NURSING FACILITY DOES NOT APPEAR APPROPRIATE; THE PERSON CAN BE SERVED IN:
 - A MORE RESTRICTIVE SETTING (INPATIENT PSYCHIATRIC HOSPITAL)
 - A LESS RESTRICTIVE SETTING

DOES THE MCO SHOW A HISTORY OF BEHAVIORAL HEALTH CLAIMS IN THE PAST 2 YEARS? YES NO (CHECK ALL THAT APPLY)
 INPATIENT INTENSIVE OUTPATIENT (ACT/MHR) LMHP MEDICATION MANAGEMENT

RECOMMENDED SERVICES (PROVIDED THROUGH MCO'S PROVIDER NETWORK)

| | | | | | |
|---------------|--|--|--|--|-------------------------------------|
| MH SERVICES: | <input type="checkbox"/> ACT | <input type="checkbox"/> CPST | <input type="checkbox"/> PSR - Individual | <input type="checkbox"/> PSR -Group | <input type="checkbox"/> PSH |
| | <input type="checkbox"/> Med Mgt | <input type="checkbox"/> Outpt Therapy (Ind) | <input type="checkbox"/> Outpt Therapy (Fam) | <input type="checkbox"/> Outpt Therapy (Group) | <input type="checkbox"/> PRESCRIBER |
| SUD SERVICES: | <input type="checkbox"/> Residential Tx | <input type="checkbox"/> Halfway House | <input type="checkbox"/> IOP | <input type="checkbox"/> Ambulatory Detox | |
| | <input type="checkbox"/> Outpt Therapy (Ind) | <input type="checkbox"/> Outpt Therapy (Fam) | <input type="checkbox"/> Outpt Therapy (Group) | | |

OTHER (with explanation)

CASE MANAGEMENT

PLAN FOR PROVISION OF CASE MANAGEMENT:

ADDITIONAL SERVICE RECOMMENDATIONS TO MAINTAIN PERSON IN THE LEAST RESTRICTIVE SETTING:

| | | | |
|----------------------------------|------------------|-----------------------|-------------|
| PRINTED NAME OF MCO STAFF | SIGNATURE | POSITION TITLE | DATE |
|----------------------------------|------------------|-----------------------|-------------|