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Questionnaire: SMI Termination Request

AGENCY REQUEST TO TERMINATE OR INTERRUPT SERVICES FORM

Services to Be Terminated / Interrupted

1. *Please indicate if this is a request to terminate or interrupt services.*
(Please select one.)
   - ○ Terminate
   - ○ Interrupt

If you answered "Interrupt" on question 1

1.3.1. *Please explain*

2. *Check all that apply*
(Please select between 1 and 13 items.)
   - ☐ ACT
   - ☐ Behavioral Health Homes
   - ☐ Community Integration
   - ☐ Crisis Residential
   - ☐ Daily Living Support Services
   - ☐ Day Supports Services
   - ☐ Intensive Case Management
   - ☐ Intensive Community Integration
   - ☐ Medication Management
   - ☐ Residential/PNMI
   - ☐ Skills Development Services
   - ☐ Supported Housing
   - ☐ Vocational Services
   - ☐ Other
   - ☐ Supported Housing/Residential/PNMI

If you answered "Other" on question 2

2.15.1. *Other:*

If you answered "Supported Housing/Residential/PNMI" on question 2

Instructions: *Client may not be discharged to a shelter, emergency department, or homelessness. The PNMI Provider is required to set up all outpatient services. ** Any admission or a resident to an acute hospital does not constitute a transfer or discharge under OBH contracts or MaineCare rules.

2.16.1. *What are the alternative housing arrangements?*

Please List Name of Worker and Service(s) to be Terminated/Interrupted

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#1

1. *Worker's Name*

2. *Service*

3. *Phone number*

4. *Worker"s email address*

5. *Supervisor's Name and Title*

6. *Supervisor"s phone number*

#2

1. *Worker's Name*

2. *Service*

3. *Phone number*

4. *Worker"s email address*

5. *Supervisor's Name and Title*

6. *Supervisor"s phone number*

#3

1. *Worker's Name*

2. *Service*

3. *Phone number*

4. *Worker"s email address*

5. *Supervisor's Name and Title*

6. *Supervisor"s phone number*

Request to Terminate/Interrupt Services info

1. *Please State Reason(s) for Request to Terminate/Interrupt Services (please explain)*
(Please select between 1 and 9 items.)

☐ Goals have been met	☐ Consumer requesting termination
☐ Consumer relocated	☐ Consumer transferred to another agency
☐ Consumer not engaging in services	☐ Incarcerated for indefinite period
☐ Consumer poses a threat to worker/agency	☐ Consumer in residential facility/needs met
☐ Consumer is deceased	☐ Other

If you answered "Goals have been met" on question 1

1.2.1. *Please enter the goal(s) which have been met and the dates in which they were met.*

If you answered "Consumer requesting termination" on question 1

Instructions: If the information provided is uncomplete, your request will be rejected.

1.3.1. *Please provide information explaining why the client requested to be discharged.*

If you answered "Consumer relocated" on question 1

Instructions: If the information provided is uncomplete, your request will be rejected.

1.4.1. *Please identify whether or not the client requested to transfer their service(s) to another agency.*
(Please select one.)

- ○ Yes
- ○ No

1.4.2. *Identify if the client wishes to discontinue services.*
(Please select one.)

- ○ Yes
- ○ No

1.4.3. *Identify the date, if known, that the client relocated*

If you answered "Consumer transferred to another agency" on question 1

1.5.1. *Please identify the agency the client transferred to.*

1.5.2. *Please identify the date of the transfer.*

1.5.3. *If the transfer is not immediate, identify the plan to support the client in the interim. If a new agency has opened the client, provide the details of the transfer. If the client is on the new agency"s Hold for Service list AND you have identified a plan to support the client in the interim, indicate the details. If you plan to continue to provide services until the new agency opens, indicate the plan and transfer date.*

If you answered "Consumer not engaging in services" on question 1

Instructions: *For Section 17 and 92 a client not engaging means there has been at least three

(3) missed appointments within sixty (60) days. The agency needs to make multiple attempts (at least three (3)) to outreach the client including phone calls, letters, visits to the client's residence, and telehealth contacts. The Provider must submit progress notes and letters showing attempts to engage the client. Letters attempting to engage a client shall not say the client will be discharged from service until the Provider has received approval from Kepro to discharge the client. *For Medication Management Services - Medication Management Providers shall make multiple attempts (at least three (3)) to engage the client including phone calls, letters, and telehealth contacts. The provider must submit progress notes and letters showing attempts to engage the client. Letters attempting to engage the client shall not say the client will be discharged from the service until the Provider has received approval from Kepro to discharge the client. **If the required information is incomplete or not submitted, this request will be rejected.

1.6.1. *Please outline attempts made to re-engage the client and the dates of the attempts.*

If you answered "Incarcerated for indefinite period" on question 1

Instructions: *Do not submit requests for clients who are incarcerated for less than thirty (30) days. *Incomplete information will result in your request being rejected.

1.7.1. *Please indicate the length of time the client will be in the correction facility, name/location of the correctional facility, and any other additional pertinent information.*

If you answered "Consumer poses a threat to worker/agency" on question 1

Instructions: Please upload your agency's incident report and police report (if applicable) which documents the threats/aggression toward worker/member/agency. If the agency is no longer able to work with the client due to threat or aggression, the provider shall upload supporting documentation including the critical incident report(s), police report(s), progress notes, attempts to rectify the client's behavior/boundary setting and any interventions that provider has utilized with the client in attempt to ensure staff safety, etc. *Incomplete information/documentation will result in your request being rejected.

1.8.1. *Have you uploaded the documents?*
(Please select one.)

- ○ Yes
- ○ No

If you answered "Consumer in residential facility/needs met" on question 1

1.9.1. *Please explain*

If you answered "Consumer is deceased" on question 1

Instructions: *If the client's death was unattended a Critical Incident Report is required. **Incomplete information or if a Critical Incident Report is required but not submitted your request will be rejected.

1.10.1. *Please provide the date of death*

1.10.2. *Please provide how and where the client passed away.*

If you answered "Other" on question 1

1.11.1. *If the interruption or termination of services include a circumstance not captured by the above options, please provide details regarding the nature of the request.*

Instructions: The Provider shall inform the client of the request to terminate and inform the client that DHHS or Kepro may be calling them regarding the request. The only exception to the Provider ensuring the client is aware of the termination request is if the Provider is unable to reach the client after multiple attempts. This shall be documented in your request.

2. *Is the Consumer aware of the request to Terminate/Interrupt Services?*
(Please select one.)

- ○ Yes
- ○ No

If you answered "No" on question 2

Instructions: The Provider shall inform the client of the request to terminate and inform the client that DHHS or Kepro may be calling them regarding the request. The only exception to the Provider ensuring the client is aware of the termination request is if the Provider is unable to reach the client after multiple attempts. This shall be documented in your request.

2.2.1. *Please explain why the client is not aware of the termination request.*

3. *Is the Consumer in Agreement?*
(Please select one.)
   - ○ Yes
   - ○ No

If you answered "No" on question 3

3.2.1. *If the client is not in agreement with the Provider"s request to discharge, the Provider shall explain why the client is not in agreement and why the Provider is requesting a discharge despite the client"s disagreement with the request.*

4. *Agency consumer was referred to for services*

5. *If the client was referred to another agency for the same or different service(s), please provide that information regarding the service the client was referred to, the agency and the start date.*

6. *Please identify any other agencies or services the client was referred to.*

Instructions: *Incomplete information provided shall result in your request being rejected.

7. *Please identify Providers who were notified of the Provider"s intent to submit the termination request.*

8. *Person Completing Form*

9. *Title of Person Completing Form*

Discharge Information

1. *What is the projected discharge/transition date?*

2. *Indicate the discharge disposition*
(Please select one.)
   - ○ Member deceased
   - ○ Program"s determination to discontinue services
   - ○ Transfer
   - ○ Treatment is complete and treatment goals are attained
   - ○ Treatment is not complete and discharge is unplanned
   - ○ Treatment is not complete but is a planned discharge

3. *Indicate the member"s employment status at time of discharge.*
(Please select one.)
   - ○ Clubhouse Transitional Employment
   - ○ Competitively employed full-time (32 or more hours per week)
   - ○ Competitively employed part-time (Less than 32 or more hours per week)
   - ○ Not employed - looking for work
   - ○ Not employed - not looking for work
   - ○ Self-employed
   - ○ Volunteer
   - ○ Working with supports full-time (32 or more hours per week)

4. *Indicate the member"s living arrangement at time of discharge.*
(Please select one.)
   - ○ Assisted Living Facility
   - ○ Community Residential Facility
   - ○ Dorothea Dix
   - ○ Foster Care
   - ○ Homeless Shelter or on the Streets
   - ○ Hospitalized for Medical Reasons
   - ○ Incarcerated in a State Prison or County Jail
   - ○ Nursing Home
   - ○ Other Psychiatric
   - ○ Own Apartment or Home
   - ○ Residential Crisis Unit
   - ○ Residential Treatment Facility (Group Home Arrangement)
   - ○ Riverview Psychiatric Center
   - ○ Supported Apartment

- ○ Temporarily Staying with Others

5. *Does this member have a guardian?*
(Please select one.)
   - ○ Yes
   - ○ No

If you answered "Yes" on question 5

5.1.1. *Please indicate the guardian"s name, phone number, and email address.*

6. *What is the preferred way to contact the member ? (ex. phone, email)*

7. *Indicate the member"s phone number at time of discharge*

8. *Indicate the member"s email address at time of discharge*
