Questionnaire: Section 17

Section 17

1. *Is this your first CSR?*
(Please select one.)
   - ○ Yes
   - ○ No

   If you answered "Yes" on question 1

   1.1.1. *Date of referral:*

   1.1.2. *Date Case Worker assigned:*

   1.1.3. *Date seen face to face:*

2. *Has the member received treatment in a state psychiatric hospital (Riverview, and/or Dorothea Dix Psychiatric Center) within the past 24 months, for a non-excluded DSM 5 diagnosis?*
(Please select one.)
   - ○ Yes
   - ○ No

   If you answered "Yes" on question 2

   2.1.1. *Provide the dates:*

3. *Has the member been discharged from a mental health residential facility, within the past 24 months, OR currently resides in a mental health residential facility, for a non-excluded DSM 5 diagnosis?*
(Please select one.)
   - ○ Yes
   - ○ No

   If you answered "Yes" on question 3

3.1.1. *Provide the dates:*

4. *Has the member had two or more episodes of inpatient treatment for mental illness, greater than 72 hours per episode, within the past 24 months, for a non-excluded DSM 5 diagnosis?*
(Please select one.)
   - ○ Yes
   - ○ No

If you answered "Yes" on question 4

4.1.1. *Provide the admission and discharge dates:*

5. *Has the member been admitted by a civil court for emergency involuntary psychiatric treatment as an adult (Blue Paper)?*
(Please select one.)
   - ○ Yes
   - ○ No

If you answered "Yes" on question 5

5.1.1. *Provide the dates:*

6. *Is there an uploaded clinical letter from a clinician dated within the past year stating member is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis, that would result in or have significant risk factors of homlessness, criminal justice invlovelment or require a mental health inpatient treatment greater than 72 hours, or residential treatment unless community support program services are provided?*
(Please select one.)
   - ○ Yes
   - ○ No

If you answered "Yes" on question 6

6.1.1. *Date of clinical letter:*

6.1.2. *Name and credentials of clinician who wrote clinical letter:*

Instructions: REQUIRED - LOCUS composite score must be a numerical value between 0-35. Only numbers should be entered in this box.

7. *LOCUS Composite Score:*
   Min/Max - 0/35; No decimal places allowed

Instructions: REQUIRED – Date LOCUS Completed must be a date in the following format MM/DD/YYYY. Please do not enter a date in any other format.

8. *Date LOCUS Completed:*

9. *LOCUS Level of Care:*
   Min/Max - 0/10; No decimal places allowed

10. *Name and credentials of who completed the LOCUS assessment:*

11. *LOCUS Rater ID#:*

12. *Does the member receive Vocational Rehabilitation Services?*
    (Please select one.)
    - ○ Yes
    - ○ No

13. *Does the member currently have a rent subsidy or live in subsidized housing?*
    (Please select one.)
    - ○ Yes
    - ○ No

If you answered "Yes" on question 13

13.1.1. *Please indicate what type of rent subsidy or subsidized housing:*
(Please select one.)

- ○ Bridging Rental Assistance Program (B.R.A.P.)
- ○ Building is subsidized
- ○ Section 8
- ○ Shelter Plus Care
- ○ Veteran"s Housing
- ○ Other

If you answered "Other" on question 13.1.1

13.1.1.6.1. *Explain other:*

14. *Select the Section 17 service type:*
(Please select one.)
- ○ Assertive Community Treatment (ACT)
- ○ Community Integration (CI)
- ○ Community Rehabilitation Services (CRS)
- ○ Daily Living Support Services (DLSS)
- ○ Skills Development

If you answered "Assertive Community Treatment (ACT)" on question 14

14.1.1. *Provide rationale why member requires a multidisciplinary team available seven days per week, twenty four hours per day:*

14.1.2. *Has member been receiving a minimum of three contacts from ACT team per week?*
(Please select one.)
- ○ Yes
- ○ No

If you answered "No" on question 14.1.2

14.1.2.2.1. *Provide rational of why a minimum of three contacts have not occurred per week:*

14.1.3. *How are services allowing member to retain community tenure and would require hospitalization or crisis services without the service?*

If you answered "Community Integration (CI)" on question 14

14.2.1. *Has the CI worker facilitated formal and informal opportunities for career exploration during the last review period?*
(Please select one.)

- ○ Yes
- ○ No

If you answered "Yes" on question 14.2.1

14.2.1.1.1. *Please Explain:*

14.2.2. *Has the CI worker coordinated referrals, and advocated for access by the member to the service(s) and natural support(s) identified in his or her Individual Support Plan during the last review period?*
(Please select one.)

- ○ Yes
- ○ No

If you answered "Yes" on question 14.2.2

14.2.2.1.1. *Please Explain:*

14.2.3. *Has the CI worker participated in ensuring the delivery of crisis intervention and resolution services during the last review period?*
(Please select one.)

- ○ Yes
- ○ No

If you answered "Yes" on question 14.2.3

14.2.3.1.1. *Please Explain:*

14.2.4. *Has the CI worker assisted in the exploration of less restrictive alternatives to hospitalization during the last review period?*
(Please select one.)

- ○ Yes

○ No

If you answered "Yes" on question 14.2.4

14.2.4.1.1. *Please Explain:*

14.2.5. *Has the CI worker made face-to-face contact with other professionals, caregivers, or individuals included in the treatment plan in order to achieve continuity of care, coordination of services, and the most appropriate services for the member per their ISP in the last review period?*
(Please select one.)

○ Yes
○ No

If you answered "Yes" on question 14.2.5

14.2.5.1.1. *Please Explain:*

14.2.6. *Has the CI worker contacted the member"s guardian, family, significant other, and providers of services or natural supports to ensure the continuity of care and coordination of services between inpatient and community settings during the last review period?*
(Please select one.)

○ Yes
○ No

14.2.7. *Has the CI worker provided information and consultation with the member receiving Community Support Services, to the member, his or her family, or his or her immediate support system, in order to assist the member to manage the symptoms or impairments of his or her illness with a focus on independence within the last review period?*
(Please select one.)

○ Yes
○ No

If you answered "Yes" on question 14.2.7

14.2.7.1.1. *Please Explain:*

14.2.8. *Has the CI worker assisted the member in restoring and improving communication skills needed to request assistance or clarification from supervisors and co-workers during the last review period?*
(Please select one.)

- ○ Yes
- ○ No

If you answered "Yes" on question 14.2.8

14.2.8.1.1. *Please Explain:*

14.2.9. *Has the CI worker assisted the member to enhance skills and employment strategies to overcome or address psychiatric symptoms that interfere with seeking, obtaining, and maintaining a job during the last review period?*
(Please select one.)

- ○ Yes
- ○ No

If you answered "Yes" on question 14.2.9

14.2.9.1.1. *Please Explain:*

If you answered "Community Rehabilitation Services (CRS)" on question 14

14.3.1. *Provide rationale why member requires staff availability seven days per week, twenty four hours per day:*

14.3.2. *Has the member been receiving a minimum of one contact per day?*
(Please select one.)

- ○ Yes
- ○ No

If you answered "No" on question 14.3.2

14.3.2.2.1. *Provide rational of why a daily minimum contact has not occurred:*

If you answered "Daily Living Support Services (DLSS)" on question 14

14.4.1. *If provider is a Certified Residential Medication Aide (CRMA), are they administering and supervising medications?*
(Please select one.)

- ○ Yes
- ○ No

14.4.2. *If member is accessing a higher level of care, please describe coordination with service provider and non duplication of interventions?*

If you answered "Skills Development" on question 14

14.5.1. *If provider is a Certified Residential Medication Aide (CRMA), are they administering and supervising medications?*
(Please select one.)

- ○ Yes
- ○ No
