|  |  |  |
| --- | --- | --- |
| Client Name: | Last: | First: |
| ID#: |  | |
| DOB: |  | |



**MH Psychiatric SMHS Timeliness Record**

*This is only required for Medi-Cal beneficiaries who are making an initial request for psychiatric specialty mental health services.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Initial Request and Appointment** | | | | | |
| **Referral Source:** *(Select only one)* | | | | | |
| |  |  | | --- | --- | | 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 |  | | | | | | |
| **Date & Time of First Contact to Request Services:** | | Date:       Time:        AM  PM (time required if urgent) | | | |
| **Urgent:**  Yes | | **Prior Authorization Required:**  Yes  No | | | |
| **First Service Appointment Offered Date:** | | Date:       Time:        AM  PM (time required if urgent) | | | |
| If more than **15 business days** (not urgent) or **48 hours (urgent)** after request date/time, document reason for delay: | | | | | |
| Treatment Modality unavailable  Preferred MHP provider unavailable  Preferred service medium unavailable  No available provider | Other: | | | | |
| **First Service Appointment Rendered Date:** | |  | | | |
| **Closure:** ***(O****nly required if a person does not complete the enrollment process successfully)* | | | | | |
| **Closure Date:** | |  | | | |
| **Closure Reason:** *(Select if, one of the following are meet)* | | | | | |
| |  | | --- | | Client did not accept any offered appointment dates | | Client accepted offered appointment but did not attend initial appointment | | Client attended initial assessment but did not complete assessment process | | Client attended the first appointment but declined treatment | | Client did not meet medical necessity criteria. | | Out of county/presumptive transfer | | Unable to contact (e.g., deceased or client unresponsive) | | Other: | | | | | | |
|  |  | |  | | |
|  | Date | |  | Signature, Title |  |