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



**MH Non-Psychiatric SMHS Timeliness Record**

*This is only required for Medi-Cal beneficiaries who are making an initial request for non-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 | | | |
| **Urgent:**  Yes | | | | **Prior Authorization Required:**  Yes  No | | | |
| **First Service Appointment Offered Date** | | | | Date:  Time:       AM  PM (time required if Urgent) | | | |
| If more than **10 business days** (not urgent) or **48 hours (urgent)** after request date/time, document reason why: | | | | | | | |
| Treatment Modality unavailable  Preferred MHP provider unavailable  Preferred service medium unavailable | | | No available provider  Other: | | | | |
| **First Service Appointment Rendered Date** | | | | Date:  Time:       AM  PM (time required if Urgent) | | | |
| **Follow-Up** | | | | | | | |
| **Follow Up Appointment NOT Offered:** | | | | Not Offered | | | |
| **First Follow Up Appointment Offered Date:** | | | |  | | | |
| **First Follow Up Appointment Rendered Date:** | | | |  | | | |
| **Closure** | | | | | | | |
| **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 assessment appointment | | Client attended initial appointment but did not complete assessment process | | Client attended first service 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: | | | | | | | | |
|  | | |  | |  | | |
|  | Program Name |  | Date | |  | Signature, Title |  |