|  |  |  |
| --- | --- | --- |
| 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.*

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| **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)* |
|

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| --- |
| [ ]  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:       |

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|  |  |  |
|  | Program Name |  | Date |  | Signature, Title |  |