CSI Assessment Data is required for all new clients and clients not seen in the past 12 months. This data is used to capture the timeliness of service provision from time of request for service to assessment and subsequent receipt of services. Dates must correspond to the appropriate date of contact, offered appointment, or provided service as they relate to the client's CSI reportable services.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Program Name | | |  | | | | | | | | | | Initial Staff: | | | |
| Request Date | | | | | | | Client/Person Served Name | | | | | |  | | | |
| Client ID/PATID | | | |  | | | | | Date of Birth |  | | | | SSN: |  | |
| **Referral Source (Select One)** | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | |  | | | | | |
| **Contact Attempt(s):** | | | | | | | | | | | | | | | | |
| **Date** | **Notes:** | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | |
| Unable to Contact would have offered date:      \_\_\_\_\_\_  If refused before offered assessment, Go to Closure Reason “Other” | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | |
| Unable to Contact would have offered date:      \_\_\_\_\_\_  If refused before offered assessment, Go to Closure Reason “Other” | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | |
| Unable to Contact would have offered date:      \_\_\_\_\_\_, Go to Closure Reason “Unable to Contact.”  If refused before offered assessment, Go to Closure Reason “Other” | | | | | | | | | | | | | | | |
| **Status of Contact Attempt(s)** | | | | | | | | | | | | | | | | |
| **Assessment Offered Date(s)** | | | | | | | | | | | | | | | | |
| First: | |  | | | | | |  | | | | | | | | |
| Second: | |  | | | | | |  | | | | | | | | |
| Third: | |  | | | | | |  | | | | | | | | |
| Accepted: | |  | | | | | |  | | | | | | | | |
| Assessment Start Date | | | | | |  | | | | | | Assessment End Date | | | |  |
| Status of Assessment | | | | | |  | | | | | | | | | | |
| **Treatment (Tx) Offered Date(s): *Do not enter below if closed at assessment*** | | | | | | | | | | | | | | | | |
| First: | |  | | | | | |  | | | | | | | | |
| Second: | |  | | | | | |  | | | | | | | | |
| Third: | |  | | | | | |  | | | | | | | | |
| Accepted: | |  | | | | | |  | | | | | | | | |
| Treatment Start Date | | | | | |  | | | | | | | | | | |
| Status of Treatment | | | | | |  | | | | | | | | | | |
| **Closure Reason (Select one if Client/PS did not complete the assessment and/or treatment process)** | | | | | | | | | | | | | | | | |
| Closed Out Date | | | | |  | | | | | | | | | | | |
| Referred To: (Required when Closed “Client didn’t meet medical necessity”) | | | | | | | | | | | | | | | | |
| Comment(s): | | | | | | | | | | | | | | | | |
| Completed by: | | | | | | | | | | | | | | | | |