|  |  |  |  |
| --- | --- | --- | --- |
| Please Print | | | |
| Client Name: | Last: | | First: | |
| Medi-Cal ID#: |  | | | |
| DOB: |  | | | |
| Program: |  | | |
| Staff Member/Title: | |  | | |
| Staff Phone or E-Mail: | |  | | |



**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 | Emergency Room | Probation/parole | | Family Member | Mental Health Facility / Community Agency | Jail/Prison | | Significant Other | Social Services Agency | State Hospital | | Friend/Neighbor | Substance Abuse Treatment Facility / Agency | Crisis Services | | School | Faith-based Organization | Mobile Evaluation | | Fee-For-Service Provider | Other County / Community Agency | Other referred: | | Medi-Cal Managed Care Plan | Homeless Services | | Federally Qualified Health Center | Street Outreach | | Juvenile Hall/Camp/ Ranch/Division of Juvenile Justice | | | | | | | | | |
| Icon  Description automatically generated**Urgent:**  Yes – If yes, the time offered is required on the following fields **Date First Contact to Request Services,** **First Service Appointment Offered Date,** and **First Service Appointment Rendered Date**. | | | | | | | |
| **Date First Contact to Request Services:**       Time:       AM  PM | | | | | | | |
| **Prior Authorization Required:**  Yes  No | | | | | | | |
| **First Service Appointment Offered Date:**       Time:       AM  PM | | | | | | | |
| Icon  Description automatically generated | | This **must** be the **first offered** and **NOT** the **first accepted** | | | | | |
| **A red sign with white text  Description automatically generated with medium confidence** | | If client **does not accept any offered appointment**, go to closure and select the 1st reason. | | | | | |
| If **First Service Appointment Offered** is more than **10 business days** (not urgent) or **48 hours (urgent)** after request date/time, **NOABD-Timely-Access-Notice** (County Website - Contract Provider Forms)will need to be sent to client.  ***Select one*** of the following reasons why timeliness was not met: | | | | | | | |
| Treatment Modality unavailable  Preferred MHP provider unavailable  Preferred service medium unavailable  No available provider | | | | Other: | | | |
| **First Service Appointment Rendered Date:**       Time:       AM  PM | | | | | | | |
| **A red sign with white text  Description automatically generated with medium confidence** | | If client **No Shows** or has **late Cancelation** go to closure and select the 2nd reason | | | | | |
| **Referred to an out-of-network provider** | | | | | | | |
| Yes  No  **Details:** | | | | | | | |
| **Follow-Up** | | | | | | | |
| **A red sign with white text  Description automatically generated with medium confidenceFollow Up Appointment NOT Offered:**  Not Offered, **Go to Closure** and select one of the closure reasons numbered 4-8 | | | | | | | |
| **First Follow Up Appointment Offered Date**: | | | | | | | |
| Icon  Description automatically generated | | This **must** be the **first follow up offered** and **NOT** the **first follow up accepted** | | | | | |
| If **follow up offered** is more than ***10 business days*** from the first rendered date, provide justification: | | | | | | | |
| **First Follow Up Appointment Rendered Date:** | | | | | | | |
| **A red sign with white text  Description automatically generated with medium confidence** | | If client **No Shows** or has **late Cancelation** go to closure, Select the 3rd Reason | | | | | |
| **Closure, is not required if client received both services as offered/accepted.** | | | | | | | |
| **Closure Date:** | | | | | | | |
| **Closure Reason:** *(Select if, one of the following are meet)* | | | | | | | |
| |  |  |  | | --- | --- | --- | | 1 | Client did not accept any offered appointment dates | | | 2 | Client accepted offered appointment but did not attend initial assessment appointment | | | 3 | Client attended initial appointment but did not complete assessment process | | | 4 | Client attended first service appointment but declined treatment | | | 5 | Client did not meet medical necessity criteria. | | | 6 | Out of county/presumptive transfer | | | 7 | Unable to contact (e.g., deceased or client unresponsive) | | | 8 | Other: | Declined **without** 1st offered  Client only wants medication services  Other Reason Details: | | | | | | | | |
|  | | | |  |  | | |
|  |  | |  | Date |  | Signature |  |