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| --- |
| 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.*

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| **Initial Request and Appointment** |
| **Referral Source:** *(Select only one)* |
|

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| --- | --- | --- |
| [ ]  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)* |
|

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| 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 servicesOther Reason Details:       |

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|  |  |  |
|  |  |  | Date |  | Signature |  |