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|  | **Fresno County** | **Beneficiary Information** |
|  | **Department of Behavioral Health (DBH)** | **PATID:** (If available) |  |
|  | **Mental Health Access Form** | **DOB:** |  |
|  | ***Used for a specialty mental health service request*** | **Last Name:** |       |
|  | Mail paper form to Fresno County DBH Managed Care DivisionPO BOX 45003 Fresno, CA 93718-9886You may also submit electronically at <https://www.co.fresno.ca.us/?navid=3948> Contact Managed Care at 559-600-4645 for any questions. |  | **First Name:** |       |
|  |  |  | **MI:** |   |
|  |  |  |  |  |
|  |  |
| Is this request: |  |
| Request Date:  |      . | Program Initiating Service Request: |       |
| Staff Initiating service request:  |       | Phone: |     **-**     **-**      | ext:       |
| Request Type:  |   |      .  |

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| **Section 1: Referral Source – Select one referral source** |
|  |  |      . |

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| **Section 1a: Status of Service Request** |
| **Refused Service:** | Stop sign***If Yes, STOP/Submit form*** |

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| **Section 1b: Disposition – Check all that apply** |
| [ ]  | Referred to MHP Provider, Referred to:  |       |  |
| ***Stop signIf only the below disposition(s) is selected***  |
| [ ]  | Referred to Crisis Service ***STOP/Submit form*** | [ ]  | Not a Mental Health Request  |
| [ ]  | Referred to Community Resources  | [ ]  | Fee-For-Service Provider  |
| [ ]  | Referred to PCP/Health Care Plan  |
| [ ]  | Other, Enter Other Disposition: |       |
| [ ]  | Referred to ODS-DMC Provider, SUD Program Referred to: |       |
| Warning **Limited space go to Section 5 additional comments if necessary.** |
| **Section 2: Contact Attempts to Schedule Assessment – no more than one attempt recorded for each date** |
| Do Not Use this Section, if the assesssment was scheduled at time of request. **Go to Section 3** |
| 1st Attempt | 2nd Attempt | 3rd Attempt |
| **Date**:  |      . | **Time**:  | ***\*= Go to*** | **Date**:  |      . | **Time**: | ***\*= Go to*** | **Date**:  |      . | **Time**: | ***\*= Go to*** |
| **Staff Name:**  |       | **Staff Name:** |       | **Staff Name:** |       |
| **Status** [ ]  Scheduled Assessment, **\****Section 3*[ ]  Refused Services, **\****Section 1a*[ ]  Unable to Contact, **\****2nd Attempt* | **Status** [ ]  Scheduled Assessment, **\****Section 3*[ ]  Refused Services, **\****Section 1a*[ ]  Unable to Contact, **\****3rd Attempt* | **Status** [ ]  Scheduled Assessment, **\****Section 3*Stop sign[ ]  Refused Services, **\****Section 1a****If unable to contact STOP/Submit form***[ ]   |
| Warning **Comments:**  | Warning **Comments:** | Warning **Comments:** |
| **PATID:** |  | **DOB:** |  | **Last:** |  | **First:** |  | **MI:** |  |
|  |
| **Section 3: Assessment** |
| Assessment Appointment  | Date Offered | Accepted |
| 1st Offered |       |   |
| 2nd Offered |       |   |
| 3rd Offered |       |   |
| Warning Scheduling Comments: |       |
| Assessment Appointment Accepted Date:  |      . | NOABD Timely Access Sent  |  |
| [ ]  | Beneficiary did not accept any offered assessment dates, ***STOP/Submit form*** |  |
|  | **Enter Closure Date:** |      . | Stop sign |
|  |  |  |  |
| **Section 3a: Status of Assesment Appointment** |
| [ ]  | Beneficiary, ***attended*** assessment appointment, **Go to Section 4**: Initial Treatment Appointment. |
| [ ]  | Stop signBeneficiary, *Select One Status Below* **– Enter Closure Date:**      . ***STOP/Submit form*** |
|  | [ ]  | Beneficiary accepted offered assessment, but did not attend. |
|  | [ ]  | Beneficiary attended initial assessment appointment, but did not complete assessment process. |
|  | [ ]  | Beneficiary did not meet medical necessity criteria. |
| **Section 4: Initial Treatment Appointment (Post Assessment)** |
| Treatment Appointment | Date Offered | Accepted |
| 1st Offered |       |   |
| 2nd Offered |       |   |
| 3rd Offered |       |   |
| Warning Treatment (Tx) Scheduling Comments: |      . |
| Treatment Appointment Accepted Date: |      . |
| **Section 4a: Status of Initial Treatment Appointment** |
| [ ]   | Stop signBeneficiary, ***attended*** Initial Treatment Appointment, ***No Closure Reason Required*** |
| [ ]  | Stop signBeneficiary, *Select One Status Below* **– Enter Closure Date**:      ***STOP/Submit form*** |
|  | [ ]  | Beneficiary completed assessment process, but declined offered treatment dates.***STOP/Submit form*** |
|  | [ ]  | Beneficiary accepted offered treatment date, but did not attend initial treatment appointment. |
|  |
| **Section 5: Additional Comments** |
| Please provide any additional comments/information about the reason for closure or delay in meeting the timely access standard. (e.g., client’s phone was out-of-service, interpreter unavailable, etc.)  |
|       . |

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| **Fresno County Use Only** |
| Entered into Avatar |   | [ ]  Current Access form is valid [ ]  Beneficiary is/has been in services with in last 12 months and request is not Urgent.[ ]  Other, enter details in comments section below |
| Comments: |       |
|  |       |  |       |  |  |
|  | Date |  | Print Staff Name |  | Staff Signature |