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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 Division  PO BOX 45003 Fresno, CA 93718-9886  You 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 |