Appendix A
Systems of Care

REFFERAL TO PRIMARY CARE

San Diego County Behavioral Health Services (SDCBHS)

SECTION A. REASON FOR REFERRAL	
☐ A) For physical healthcare - SDCBHS will continue to provide specialty mental health services.	☐ B) For total healthcare - SDCBHS no longer providing routine treatment. Available for psychiatric consult.

SECTION B. CLIENT INFORMATION and MENTAL HEALTH INFORMATION		
Last Name :	First Name:	Middle Initial:
AKA:		
Street Address:	Date of Birth :	☐ Male ☒ Female
City, State and ZIP:	Last Psychiatric Hospitalization: Date: None: ☐	
Telephone # :		
Current Mental Health Diagnosis:	Current Mental Health Symptoms:	
Current Mental Health and Non-Psychiatric Medications and Doses:		
Known Physical Health Problems:		

PLACE A COPY OF THIS FORM IN THE CLIENT'S MEDICAL RECORD

REFFERAL TO PRIMARY CARE

San Diego County Behavioral Health Services (SDCBHS

SECTION C. BEHAVIORAL HEALTH PROVIDER INFORMATION	
Name, Organization OR Medical Group:	
Street Address:	City, State, Zip:
Telephone #:	Fax #:

SECTION D. BEHAVIORAL HEALTH CONTACTS FOR FURTHER INFORMATION	
Psychiatrist:	Phone #:
Nurse:	Phone #:
Case Manager or Clinician:	Phone #:

SECTION E. PRIMARY CARE PROVIDER INFORMATION	
Name, Organization OR Medical Group:	
Street Address:	City, State, Zip:
Telephone # :	Fax #:

SECTION F. ACCEPTED FOR TREATMENT OR REFERRED BACK TO SDCBHS
☐ **Patient accepted for physical heath treatment**
☐ **Patient accepted for psychotropic medication treatment**
☐ **Patient not accepted for psychotropic medication treatment and referred back due to:**

PLACE A COPY OF THIS FORM IN THE CLIENT'S MEDICAL RECORD

COUNTY OF SAN DIEGO

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below.

			DATE:
PATIENT/RESIDENT/CLIENT			
LAST NAME:		FIRST NAME:	MIDDLE INITIAL:
ADDRESS		CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	SSN (OPTIONAL):	DATE OF BIRTH:	
AKA'S:			
THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO MAKE THE DISCLOSURE.			
LAST NAME OR ENTITY:		FIRST NAME:	MIDDLE INITIAL:
ADDRESS		CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:		DATE:	
THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION.			
LAST NAME OR ENTITY:		FIRST NAME:	MIDDLE INITIAL:
ADDRESS		CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:		DATE:	

TREATMENT DATES:	PURPOSE OF REQUEST: ☐ AT THE REQUEST OF THE INDIVIDUAL.

THE FOLLOWING INFORMATION IS TO BE DISCLOSED: (PLEASE CHECK)

- ☐ History and Physical Examination
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Medication Records
- ☐ Interpretation of images: x-rays, sonograms, etc.
- ☐ Laboratory results
- ☐ Dental records
- ☐ Psychiatric records including Consultations
- ☐ HIV/AIDS blood test results; any/all references to those results
- ☐ Physician Orders
- ☐ Pharmacy records
- ☐ Immunization Records
- ☐ Nursing Notes
- ☐ Billing records
- ☐ Drug/Alcohol Rehabilitation Records
- ☐ Complete Record
- ☐ Other *(Provide description)* _____

_____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____

If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information

from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section164.524.

I have the right to receive a copy of this authorization. I would like a copy of this authorization. ☐ Yes ☐ No

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE	
SIGNATURE:	DATE:
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP OF INDIVIDUAL:	

FOR OFFICE USE

VALIDATE IDENTIFICATION ☐	
SIGNATURE OF STAFF PERSON:	DATE:

County of San Diego

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Client: _____

Record Number: _____

Program: _____

Appendix B
Compliance and Confidentiality

Documentation Standards for Client Records

The documentation standards are described below under key topics related to client care. All standards shall be addressed in the client record; however, there is no requirement that the record have a specific document or section addressing these topics.

A. Assessments

1. The following areas shall be included as appropriate as part of a comprehensive client record.

- Relevant physical health conditions reported by the client shall be prominently identified and updated as appropriate.
- Presenting problems and relevant conditions affecting the client's physical health and mental health status shall be documented, for example: living situation, daily activities, and social support.
- Documentation shall describe client strengths in achieving client plan goals.
- Special status situations that present a risk to client or others shall be prominently documented and updated as appropriate.
- Documentation shall include medications that have been prescribed by mental health plan physicians, dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications.
- Client self report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities shall be clearly documented.
- A mental health history shall be documented, including: previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant results of relevant lab tests and consultation reports.
- For children and adolescents, pre-natal and perinatal events and complete developmental history shall be documented.
- Documentation shall include past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed and over-the-counter drugs.
- A relevant mental status examination shall be documented.
- A five axis diagnosis from the most current DSM, or a diagnosis from the most current ICD, shall be documented, consistent with the presenting problems, history, mental status evaluation and/or other assessment data.

2. Timeliness/Frequency Standard for Assessment

- The MHP shall establish standards for timeliness and frequency for the above-mentioned elements.

B. Client Plans

1. Client Plans shall:

- have specific observable and/or specific quantifiable goals

- identify the proposed type(s) of intervention
- have a proposed duration of intervention(s)
- be signed (or electronic equivalent) by:
  - the person providing the service(s), or
  - a person representing a team or program providing services, or
  - a person representing the MHP providing services
  - when the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the above staff are not of the approved category,
    - a physician
    - a licensed/"waivered" psychologist
    - a licensed/registered/waivered social worker
    - a licensed/registered/waivered marriage and family therapist or
    - a registered nurse

- In addition,
  - client plans shall be consistent with the diagnoses, and the focus of intervention shall be consistent with the client plan goals, and there shall be documentation of the client's participation in and agreement with the plan. Examples of documentation include, but are not limited to, reference to the client's participation and agreement in the body of the plan, client signature on the plan, or a description of the client's participation and agreement in progress notes.
  - client signature on the plan shall be used as the means by which the MHP documents the participation of the client
    - when the client is a long term client as defined by the MHP, and
    - the client is receiving more than one type of service from the MHP
  - when the client's signature is required on the client plan and the client refuses or is unavailable for signature, the client plan shall include a written explanation of the refusal or unavailability
  - the MHP shall give a copy of the client plan to the client on request

2. Timeliness/Frequency of Client Plan:
   - Shall be updated at least annually.
   - The MHP shall establish standards for timeliness and frequency for the individual elements of the client plan described in item 1

C. Progress Notes

1. Items that shall be contained in the client record related to the client's progress in treatment include:

   - The client record shall provide timely documentation of relevant aspects of client care
   - Mental health staff/practitioners shall use client records to document client encounters, including relevant clinical decisions and interventions

- All entries in the client record shall include the signature of the person providing the service (or electronic equivalent); the person's professional degree, licensure or job title; and the relevant identification number, if applicable
- All entries shall include the date services were provided
- The record shall be legible
- The client record shall document referrals to community resources and other agencies, when appropriate
- The client record shall document follow-up care, or as appropriate, a discharge summary

2. Timeliness/Frequency of Progress Notes:

Progress notes shall be documented at the frequency by type of service indicated below:

a. Every Service Contact

- Mental Health Services
- Medical Support Services
- Crisis Intervention

b. Daily

- Crisis Residential
- Crisis Stabilization (1x/23hr)
- Day Treatment Intensive

c. Weekly

- Day Treatment Intensive: a clinical summary reviewed and signed by a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service
- Day Rehabilitation
- Adult Residential

d. Other

- Psychiatrist health facility services: notes on each shift
- Targeted Case Management: every service contact, daily, or weekly summary
- As determined by the MHP for other services

Appendix C
Accessing Services

County of San Diego - Health and Human Services Agency

Mental Health Services

WEEKLY WAIT TIMES REPORT

1. GENERAL INFORMATION:

Contractor Name		Program Type	**ADULT**
Program Name		Provider Type	**COUNTY**
Contract Number		Report Period	
Sub Unit Number		Date Submitted	
Submitted By		Contact Phone	

2. REQUEST FOR SERVICES LOG WITH WAIT TIMES

Client Initial Contact with Program								Mental Health Assessment			Psychiatric Assessment			FQHC/Comm. Clinic
Date of Inquiry	Client Anasazi Number	Questions Problems Issues	Manner of Contact	Res-ponse Code	Benefit Code	Referral Code	Dis-position Code	First Available Appt	Wait Time (Days)	Appt Date Chosen	First Available Appt	Wait Time (Days)	Appt Date Chosen	Name of FQHC/Comm. Clinic

County of San Diego - Health and Human Services Agency

Mental Health Services

WEEKLY WAIT TIMES REPORT

1. GENERAL INFORMATION:

Contractor Name		Program Type	**ADULT**
Program Name		Provider Type	**COUNTY**
Contract Number		Report Period	
Sub Unit Number		Date Submitted	
Submitted By		Contact Phone	

2. REQUEST FOR SERVICES LOG WITH WAIT TIMES

Client Initial Contact with Program								Mental Health Assessment			Psychiatric Assessment			FQHC/Comm. Clinic
Date of Inquiry	Client Anasazi Number	Questions Problems Issues	Manner of Contact	Res-ponse Code	Benefit Code	Referral Code	Dis-position Code	First Available Appt	Wait Time (Days)	Appt Date Chosen	First Available Appt	Wait Time (Days)	Appt Date Chosen	Name of FQHC/Comm. Clinic

CYFS

PROVIDER:
Month/Year:

Request for Services Log

Title 9, Section 1810.405

Contractual Requirements
May use for wait time calculations

Inquiry date	Name	Indicate Y or N			Referring Party / District	Response Code	Dispo. Code	Appointment Date (reason for no appt. or unusual delays)
		M/C	MHSA	Healthy Families				

Response Codes
E = Emergent - access within I hour
C= Crisis - within 24 hours
U = Urgent - access within 72 hours
H = Patient D/C'd from psychiatric hospital (1 week except when urgent & 72 hr rapid assessment needed)
R = Routine - within 5 days
I = Request for Information/referral

Disposition Codes
1) Made appt.
2) Provided client with health insurance referral information
3) Provided client with Healthy Families, Healthy San Diego or LIHP referral information
4) Referred out for Emergent Services
5) Referred out for Urgent services
6) Referred out for Routine services
7) Referred out for non-Mental Health services
8) No appt or referral made
9) Other

For assistance contact: QI Unit at (619) 584-5026

Adult/Older Adult Mental Health Outpatient Clinics
Urgent Walk-in Services Schedule and Contact Information

The hours posted below are for urgent walk-in services only at regional clinics which provide psychiatric outpatient services, including medication. The programs serve Medi-Cal beneficiaries and uninsured adults 18 and over. Insured persons are referred to their own providers.
Whenever possible, please call in advance to arrange appointment.

This schedule, arranged by Region, provides the Clinics' addresses, contact phone numbers and urgent Walk-in days/hours.

REGION	CLINIC	DAY AVAILABLE FOR WALK-IN	TIME AVAILABLE FOR WALK-IN	ADDRESS	PHONE NUMBER	COMMENT/NOTES	PROGRAM MANAGER	COUNTY MHS PROGRAM COORDINATOR
North Central	CRF/Areta Crowell Center			1963 4th Avenue San Diego, CA 92101	(619) 233-3432			Virginia West, LCSW 619-563-2744 Virginia.West@sdcounty.ca.gov
	CRF/Douglas Young BPSR Center	Mon, Tue, Wed & Fri	9:00AM - 11:00AM	10717 Camino Ruiz Suite 207 San Diego, CA 92126	(858) 695-2211	Up to 2 admissions per shift.	Jennifer Whelan	
		Thur	12:00PM - 2:00PM					
	North Central MHC	Mon - Fri	9:00AM - 4:00PM	1250 Morena Boulevard San Diego, CA 92110	(619) 692-8750	Some direct assessments with MD available each week. To have rapid service capability we will not schedule those more than 1 week out.	Carter Gardner	
	CRF/Jane Westin WRC	Mon - Fri	10:00AM - 4:00PM	1568 6th Avenue San Diego, CA 92101	(619) 235-2600	Walk-ins triaged by clinician and then taken in for assessment or referred out if indicated. After BHA and/or med eval, client is referred out to a BPSR clinic for	Colette Lord	
Central	FHCSD/Logan Heights Family Counseling Center			2204 National Ave. San Diego Ca 92113	(619) 515-2355			
	NHA/Project Enable	Mon - Fri	10:00AM - 2:00PM	286 Euclid Avenue Suite 102 San Diego, CA 92114	(619) 266-2111	Triaged and scheduled for intake accordingly. Triage Coordinator: Christina Forzani, PsyD	Evelina Jaime	
	Survivors of Torture International Mental Health Services to Victims of Trauma and Torture			Confidential Address	(619) 278-2401			

REGION	CLINIC	DAY AVAILABLE FOR WALK-IN	TIME AVAILABLE FOR WALK-IN	ADDRESS	PHONE NUMBER	COMMENT/NOTES	PROGRAM MANAGER	COUNTY MHS PROGRAM COORDINATOR
	UCSD Outpatient (Gifford)	Mon - Fri	11:00AM - 3:00PM	140 Arbor Drive San Diego, CA 92103	(619) 543-6250	Consumers must be prepared to be at the clinic for a few hours.	Giovanna Zerbi	
	UCSD Outpatient Services for Clients with Co-occuring Disorders			140 Arbor Drive San Diego, CA 92103	(619) 543-6350			
	Union of Pan Asian Communities Biospsychosocial and Rehabilitation (BSPR) Center Mid-City Clinic			5348 University Ave, Suite 101 San Diego CA 92105	(619) 229-2999			
	Union of Pan Asian Communities Biospsychosocial and Rehabilitation (BSPR) Center Serra Mesa			8745 Aero Drive #330 San Diego, CA 92123	(858) 268-4933			
	Deaf Community Services (DCS) of San Diego, Inc. - Outpatient Services for Deaf and Hard of Hearing			3930 Fourth Ave. Suite 300 San Diego CA 92103	(619) 398-2441 {TTY +1 619-398-2440			
	National Center for Deaf Advocacy- San Diego Deaf Mental Health Services			10765 Woodside Ave. Suite B Santee, CA 92071	(619) 456-9609 Ans.Svc. (858) 410-1067			
East	BPSR Heartland Center	Mon, Wed & Fri	(M) 9-11(W&F) 9am-12pm	1060 Estes Street El Cajon, CA 92020	(619) 440-5133	Triage Coordinator: Danielle Barcello	Yi-Chuan (Cathy) Cheng	Tabatha Lang, MFT 619-563-2741 Tabatha.Lang@sdcounty.ca.gov
		Tue & Thur	9:00AM - 4:00PM					
	Chaldean Middle-Eastern Social Services-Behavioral health			436 S. Magnolia Ave, Ste. 201 El Cajon, CA 92020	(619) 631-7400			
	East County MHC	Mon - Thur	9:00AM - 4:00PM	1000 Broadway Suite 210 El Cajon, CA 92021	(619) 401-5500	For questions/information, contact Frontline Clinician during walk-in times. Hours listed are for walk-in triage. MD available for meds as deemed necessary.	Luz Fernandez	
		Fri	9:00AM - 3:00PM					

REGION	CLINIC	DAY AVAILABLE FOR WALK-IN	TIME AVAILABLE FOR WALK-IN	ADDRESS	PHONE NUMBER	COMMENT/NOTES	PROGRAM MANAGER	COUNTY MHS PROGRAM COORDINATOR
South	Maria Sardiñas WRC	Tue & Thur	9:00AM - 3:00PM	1465 30th Street, Ste K San Diego, CA 92154	(619) 428-1000	Triage Coordinator: Sandra Carranza	Juan Camarena	Tabatha Lang, MFT 619-563-2741 Tabatha.Lang@sd county.ca.gov
	South Bay Guidance BPSR	Mon, Wed & Fri	9:00AM - 1:00PM	835 3rd Avenue Suite C Chula Vista, CA91911	(619) 427-4661	Triage Coordinator: Sandra Camargo	Michael Juan	
North Coastal	BPSR – Vista	Mon - Fri	8:30 AM - 4:00PM	550 W. Vista Way Suite 407 Vista, CA 92083	(760) 758-1092	The walk in hours for BPSR Vista Clinic have not changed. They are open, as we have few walk-ins so we triage on the	Kathy Robbins	Anna Palid, LCSW 619-584-5009 Anna.Palid@sdcounty.ca.gov
	Exodus Recovery, Inc. Walk In Assess. Center	Mon - Fri	11:00AM - 6:30PM	524 W. Vista Way Vista, CA 92083	(760) 758-1150	Hours listed are walk-in assessment. Telepsychiatry also available daily noon to 7pm. Average number of clients seen	Cynthia Halpin Brown	
	North Coastal MH Clinic	Mon - Fri	8:30AM - 4:00PM	1701 Mission Avenue Suite A Oceanside, CA 92054	(760) 967-4475	Hours listed are for immediate traige at walk-in. Assessment scheduled as needed.	Payal Beam	
North Inland	BPSR Kinesis North	Mon - Fri	8:00AM - 4:00PM	474 W. Vermont Avenue Suite 101 Escondido, CA 92025	(760) 480-2255	We have 4 hours at Kinesis Escondido location and 2 hours at each satellite clinics. We are establishing days which as of yet have not been set in stone. Hours listed are for walk-in triage. Dr. available for med refill as deemed necessary.	Scott Elizonado	
	Exodus Recovery, Include Walk In Assess. Center	Mon - Fri	11:00AM - 6:30PM	660 East Grand Avenue Escondido, CA 92025	(760) 796-7760	Hours listed are for walk-in assess-ment. Telepsychiatry also available daily noon to 7pm. Average number of clients seen	Cynthia Halpin Brown	
	Mental Health Systems, Inc. Fallbrook Satelite Clinic			1328 South Mission Rd. Fallbrook, CA 92028	(760) 451-4720			
	North Inland MH Clinic	Mon - Fri	8:30AM - 4:00PM	125 W. Mission Avenue Suite 103 Escondido, CA 92025	(760) 747-3424	Walk -in triage. Assessment scheduled as needed.	Linda Richardson	
	Mental Health Systems,Inc. Ramona Satelitte Clinic			1521 Main St. Ramona, CA 92065	(760) 736-2429			

County of San Diego
Health and Human Services Agency/ Child Welfare Services/ Probation

Service Authorization Form
Interpreter Services for Clients

Instructions:

1. ***This Service Authorization Form is not to be used for Low-Income Health Program (LIHP) services.***
2. To request interpreter services, please complete Client Information, Service Information Section A, and Requester Information and fax to selected interpreter service provider.
3. Complete Service Information Section B after services have been provided/canceled and fax to interpreter service provider. For ongoing requests, an authorized County of San Diego representative should verify and submit the form for processing on a weekly basis.
4. Retain original form at program site as a record of services provided.

Please Select the Provider with an "X":

Service Provider:	Phone:	Fax:	Type of Interpretation:
☐ Interpreters Unlimited	(800) 726-9891	(800) 726-9822	Oral/ Spoken Language Interpretation
☐ Deaf Community Services of San Diego	(619) 398-2488	(619) 398-2490	American Sign Language (Primary)

Client Information:

The County of San Diego HHSA has authorized the following interpretation services for:

Participant Name:

Age of children under 18: Choose

Language Requested:

☐ Conference Call

Nature of Appointment:

Service Information						
Section A		Section B				
Date	Requested Time *(In Hours)*	Actual Time*			Interpreter's Name *(If Services were canceled, type "Canceled")*	Verified By *Initial & Date*
		Start	End	Hrs		
		7:00 AM	8:00 AM			
		7:00 AM	8:00 AM			
		7:00 PM	8:00 AM			
		7:00 AM	8:00 AM			
		7:00 AM	8:00 AM			

Requestor Information			
Name		**Manager/Designee Approved by**	
Phone		**Signature**	
Fax		**Date**	
Email		**Service Site**	
Agency Name		**Site Contact**	
Program Name		**Site Phone**	
Program Address		**Site Email**	
County Agency to be Invoiced HHSA			

Assigned interpreter shall inform the requestor of the phone number to call in advance of the conference call.

* *Minimum Hours Billed: 0.5 hours at 50% the hourly rate.*

NOTE: it is a HIPAA violation to email any document containing protected health information (PHI). 07/2012

County of San Diego
Health and Human Services Agency (HHSA)

SERVICE AUTHORIZATION FORM INSTRUCTIONS

The purpose of Service Authorization Form is to request authorized scheduled interpreting services with contracted service providers and to verify that authorized scheduled interpreting services were provided **OR** cancelled and when they were cancelled.

The Service Authorization Form must be completed for each individual requiring interpreter services and authorizes services for one or more date(s) at the specified times and at a single location.

The form accompanying these Instructions dated 01/06/10 replaces all Service Authorization Forms previously in use to request interpreter services for clients/family members.

The Service Authorization Form may not be emailed with client information on it. A copy of the form may be provided to the interpreter if requested.

Note that oral interpreter services must be cancelled 24 hours in advance and American Sign Language (ASL) interpreter services must be cancelled 48 hours in advance. Please notify the client/family member of this requirement and ask them to contact your program in a timely manner if they need to cancel an appointment utilizing interpreter services. Services not cancelled timely will be charged to the County.

Instructions for Completing Section A:

- Select the Service Provider to be contacted by placing an "X" next to the Service Provider's name.
- Circle either "client" or a "family member" to indicate who is receiving the interpreter services.
- Provide the name of the person/participant(s) needing interpreter services and the date(s) the services are required. If the person is under 18 years of age provide the age only, not the date of birth.
- Complete this section by providing the nature of appointment, language requested, requested start time, and end time. Next fill out all of the requestor information including agency name, program name and address, service site of where interpreting shall take place if different than the program address, and obtain approval by a manager or designee. Multiple appointments can be requested as long as they are at the same service site.
- Provide the name of the County department to be invoiced.
- Mental Health programs are required to indicate if the request is from a Children's program or an Adult program.
- **FAX the Service Authorization Form with Section A completed to the service provider selected to officially request interpreter services. *** The selected service provider will call or email you to verify availability of interpreter staff.

Instructions for Completing Section B:

- If services were provided, state the date, actual start time, actual end time and the name of the interpreter. If services were cancelled, state the date and time the service request was cancelled.
- Provide initials of staff and date that were witness to services to verify information in Section B is accurate.
- **FAX the Service Authorization Form with Section B completed to the selected provider after the services have either been completed or cancelled. ***

It is an expectation that all programs will make every effort to develop bilingual/bicultural staff to reflect the population they serve. In this way, services will be delivered in a culturally competent manner, in the client's preferred language; and interpreter services will be utilized more efficiently by everyone.

**Please note that some service providers may provide web based requesting services now or in the future. If the SAF is incorporated into their on-line services then the faxing of the form will not be necessary. Please verify this process with your service provider should there be any questions.*

County of San Diego
Low Income Health Program (LIHP)

SERVICE AUTHORIZATION FORM INSTRUCTIONS
For In-person Interpreter Services

LIHP Enrollee Interpreter Services Form – On-Site Interpreter Services Instructions

Instructions:

The purpose of the Service Authorization Form (SAF) is to confirm with the requesting clinic that in-person or in-person American Sign Language (ASL) interpreting service has been arranged at the clinic's request for a LIHP enrollee. The LIHP provider clinic will utilize this form for verification that authorized, scheduled, interpreting services were provided **OR** canceled, and when they were canceled. This form will also be used for ensuring appropriate payment for interpreter services for the LIHP.

Clinics **MUST complete Section B** of the SAF once interpreting service is provided or canceled, and fax the form back to the LIHP at 855-394-7927.

Instructions for the Clinics for Completing Section B:

- If services were provided: provide the service date, actual start time, actual end time, and the name of the interpreter.
- If services were canceled: provide the date and time that the service request was canceled.
- Provide your initials and date to indicate that you verify the information in Section B is accurate.
- FAX the SAF with Section B completed to the Administrative Service Organization (ASO) for the LIHP at 855-394-7927.

NOTE: It is an expectation that all programs will make every effort to develop bilingual/bicultural staff to reflect the population they serve. In this way, services will be delivered in a culturally competent manner, in the client's preferred language, and interpreter services will be utilized more efficiently by everyone.

IMPORTANT: Providers are requested to CANCEL any scheduled interpreter services that are not needed by contacting the ASO at 858-658-8650 immediately after it is determined that the services will not be needed. Services must be canceled at least 48 hours in advance, or it will still be billed to the LIHP; however, notification of all canceled services must be made.

County of San Diego
Low Income Health Program (LIHP)

SERVICE AUTHORIZATION FORM

LIHP Enrollee Interpreter Service Form – On-Site Interpreter Services

Instructions:

1. ASO: To request interpreter services, please complete Client Information, Service Information Section A, Requester Information, and then sign. Fax completed form to the selected interpreter service provider **AND** the requesting clinic.

2. CLINICS: Complete Service Information **Section B** after services have been provided or canceled, and fax the form back to the LIHP ASO, 855-394-7927. This form MUST be faxed back for the purpose of payment.

Please "X" the Provider Selected:

	Service Provider:	Phone:	Fax#:	Type of Interpreting:
☐	Interpreters Unlimited	800-726-9891	800-726-9822	Oral/Spoken, In-person
☐	Deaf Community Serv. of SD, Inc.	619-398-2488	619-398-2490	American Sign Language

Client Information:
The County of San Diego, LIHP has authorized the following interpreting service for:

Client Name:_____ Date of Birth:_____

LIHP Enrollee #:_____ Eligibility Dates: _____

Language Requested:_____ Nature of Appointment:_____

Special Instructions:

_____

Service Information:

Section A:			Section B:			
Date:	Requested:		Actual:		Interpreter's Name: (If Services were canceled, please write "Canceled")	Verified By: (Initial Date)
	Start Time	End Time	Start Time	End Time		

Requester Information:
Requester:

- Name:_____
- Phone:_____
- Fax:_____
- Agency Name:_____

_____

Manager/Designee Approved By:

_____
(Print Name)

_____
(Signature) (Date)

Service Address:_____

_____

Site Contact:
Name:_____
Phone Number (if different):_____

LIHP
Rev. 7-12

TRANSITION AGE YOUTH REFERRAL FORM

To be completed and submitted with referral packet

The following youth has been served by _____program and will be transitioning to Adult Mental Health Services by_____ (Date).

I have referred this client to Adult Mental Health Services and have been unable to obtain services due to the following:_____
_____

Name of Youth:_____
Birthdate: _____Date of this referral:_____
Currently Residing :_____
Address:_____Phone Number:_____
Services currently receiving: _____
_____
Insurance Status:_____
Name of provider referring this youth: _____
Address: _____ Phone Number:_____

Mental health needs/services required by this client:
_____
_____
_____

Program client referred to:_____
When: _____Staff member contacted: _____
Results:
_____
_____
Program client referred to:
_____
When: _____Staff member contacted: _____
Results:
_____
_____
Program client referred to:
_____
When: _____Staff member contacted:
_____
Results: _____
_____
_____

Other Issues/Concerns: _____

TRANSITION AGE YOUTH REFERRAL PLAN

Name: _____ Client #: _____

Date of Birth: _____ Plan Date: _____

Current Services: _____

Needed Services: _____

Actions Planned: _____

Signature of Youth (to indicate agreement): _____

Person Who Will Follow Up: _____

Comments: _____

_____

_____

Multidisciplinary Team Members' Signatures:

_____

_____

_____

_____

_____

_____

PUBLIC CONSERVATOR REESTABLISHMENT RECOMMENDATION

Return by 15th of the Month

Client: _____ MH: _____

Case Manager: _____

Facility: _____ Phone #: _____ Date of Placement: _____

Address: _____

Current Placement: ☐ B/C ☐ Open ☐ Locked ☐ Ind. Living ☐ State Hospital

Treating Psychiatrist: _____ Phone #: _____

O.P./Day Program at: _____ Phone #: _____

Primary Doctor: _____ Phone #: _____

COMPLETE JUSTIFICATION FOR "REESTABLISHMENT"

☐ Conservatee is in a locked or out-of-county placement (proceed to update collaterals, medication sensitivity, and dangerous propensities)

☐ Conservatee is non-compliant with psychiatric treatment and gravely disabled

Additional information:

OR **"TERMINATION OF CONSERVATORSHIP"**

☐ Recommend to allow conservatorship to terminate. Please explain:

IMMEDIATE FAMILY/SIGNIFICANT OTHERS INFORMATION CHANGES IN PAST YEAR:

☐ **NO KNOWN CHANGES IN PAST YEAR**

_____

Name Address Phone

_____

Name Address Phone

_____ _____ _____

Print Case Manager's Name Telephone# Date

Medication Sensitivity Past Year: _____

_____

Dangerous Propensities Past Year: _____

_____

Call: 619-767-5019 if you are not the case manager. **Delay in returning the form by due date above may result in TERMINATION of conservatorship.** **FAX TO: 619-767-5057/5058**

Appendix D
Providing Specialty Mental Health Services

SAN DIEGO COUNTY MENTAL HEALTH PLAN
72 – HOUR POST DISCHARGE LOG FOR SPECIALTY MENTAL HEALTH SERVICES

CARE COORDINATOR: _____ **MONTH/YEAR:** _____

Client Name	Anasazi #	Admission Facility & Date of Admission	Date Program Learned of Admission	Date of Discharge	Date of Follow-up Appt.	Client Showed (yes or no)

Rev. 10/31/11

Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health (Title IX 1830.205)

(a) The following medical necessity criteria determines Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under this subchapter, except as specifically provided.

(b) The beneficiary must meet criteria outlined in (1), (2), and (3) below to be eligible for services:

(1) Be diagnosed by the MHP with one of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders, except Autistic Disorders

(B) Disruptive Behavior and Attention Deficit Disorders

(C) Feeding and Eating Disorders of Infancy and Early Childhood

(D) Elimination Disorders

(E) Other Disorders of Infancy, Childhood, or Adolescence

(F) Schizophrenia and Other Psychotic Disorders

(G) Mood Disorders

(H) Anxiety Disorders

(I) Somatoform Disorders

(J) Factitious Disorders

(K) Dissociative Disorders

(L) Paraphilias

(M) Gender Identity Disorder

(N) Eating Disorder

(O) Impulse Control Disorders not Elsewhere Classified

(P) Adjustment Disorders

(Q) Personality Disorders, excluding Antisocial Personality Disorder

(R) Medication-induced Movement Disorders related to other included diagnoses

(2) Must have at least one of the following impairments as a result of the mental disorder(s) listed in subdivision (1) above:

(A) A significant impairment in an important area of life functioning.

(B) A probability of significant deterioration in an important area of life functioning.

(C) Except as provided in Section 1830.210, a probability a child will not progress developmentally as individually appropriate. For the purpose of this section, a child is a person under the age of 21 years.

(3) Must meet each of the intervention criteria listed below:

(A) The focus of the proposed intervention is to address the condition identified in (2) above.

(B) The expectation is that the proposed intervention will:

1. Significantly diminish the impairment, or

2. Prevent significant deterioration in an important area of life function, or

3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.

(C) The condition would not be responsive to physical health care based treatment.

(c) When the requirements of this section are met, beneficiaries shall receive specialty mental health services for a diagnosis included in subsection (b)(1) even if a diagnosis that is not included in subsection (b)(1) is also present.

California State Penal Institutions

Avenal State Prison

California Correctional Center

California Correctional Institution

California Institution for Men

California Institution for Women

California Medical Facility

California Men's Colony

California Rehabilitation Center

California State Prison, Corcoran

California State Prison, Los Angeles County

California State Prison, Sacramento

California State Prison, Solano

Calipatria State Prison

Centinela State Prison

California Substance Abuse Treatment Facility

Central California Women's Facility

Chuckawalla Valley State Prison

Correctional Training Facility

Deuel Vocational Institution

Folsom State Prison

High Desert State Prison

Ironwood State Prison

Mule Creek State Prison

North Kern State Prison

Northern California Women's Facility

Pelican Bay State Prison

Pleasant Valley State Prison

Richard J. Donovan Correctional Facility at Rock Mountain

Salinas Valley State Prison

San Quentin State Prison

Sierra Conservation Center

Valley State Prison for Women

Wasco State Prison

Mental Health Services Administration
Request for Verification of Veterans Eligibility To Counseling and Guidance Services
Confidential Fax Form

Directions: **Section 1: To be completed by client.**
Section 2: To be completed by clinician and faxed to San Diego County Veterans Service Office
Section 3: To be completed by San Diego County Veterans Service Office and faxed to clinician

Section 1: **Client Claiming Veterans Eligibility Complete This Section Only**

I hereby authorize the release of the information below to the County Veterans Service Office and the Veterans Administration for the purposes of identifying or obtaining benefits as a veteran or eligible dependent of a veteran. I also authorize the County Veterans Service Office and the Veterans Administration to release their findings (to be noted on this fax/form).

Signature: _____ Date: _____

Section 2: Mental Health Provider Complete This Side	**Section 3:** San Diego County Veterans Service Office Complete This Side
To: Veterans Service Office **Fax: (858) 505-6961**	To: _____ Fax: _____
From: _____ County or Contract staff (please print) _____ Program name _____ Address _____ city/state/zip Phone: _____ Comments _____ _____	From: _____ CVSO Representative (please print) _____ Address _____ City/State/Zip Phone: _____ Client Current Status _____ _____ *(Check appropriate boxes below)*
The client listed below claims to have veteran's status. Please verify eligibility to counseling and guidance services.	☐ Client does not have eligibility to veteran's counseling and guidance services. Please assess for mental health services.
Name of Veteran: _____ DOB: _____ SSN: _____ Date of Entry: _____ Date of Discharge: _____ Branch of Service: _____ Military Serial Number: _____ VA Claim Number:	☐ Client has been determined to be eligible to veteran's counseling and guidance services. Please refer client to the Veterans Service Center below: ☐ 5560 Overland Ave., Ste. 310 San Diego CA 92123 (858) 694-3222 ☐ 1300 Rancho del Oro Road Oceanside CA 92056 (760) 643-2000

START PROGRAM TCC & URC RECORD

Facility Name: _____ TCC/URC Date: _____
Client Name: _____ Admit Date: _____

Client attended this meeting? YES ☐ NO ☐ If no, explain:_____
Input from client (regarding treatment requests, suggestions or preference):_____
_____
_____

Progress and status of presenting symptoms (per client report & staff observations):_____
_____
_____

Response to Medications (per client report & staff observation):_____
_____

Input from Other Mental Health Providers (if applicable):_____
_____

Treatment Recommendations (effective interventions, treatment approach, focus of treatment, housing, follow-up treatment, medications...):_____
_____
_____
_____
_____

Change in Diagnostic Impression: ☐ No Change from Dx at Admission ☐ Change Noted Below
Axis I_____
Axis I_____
Axis II_____
Justification:_____
_____

D/C Plans: **D/C Date:** _____ Is client at risk for readmission? No ☐ Yes ☐
Housing: _____ Finances: _____
Med Monitoring: _____ Tx: _____
Other: _____

Signatures of staff attendees:_____
_____

DATE OF NEXT REVIEW: ☐

REVIEW DATE: _____

Note Progress (sxs, med. changes, response to meds., extension needed...)_____
_____
_____

Signatures of staff attendees: _____
_____

County of San Diego
Health and Human Services Agency
Mental Health Services

START TCC & URC RECORD (06/2005)

Client:_____

Medical Record No:_____

Program:_____

Policy #_____
Effective date:_____

URC Minutes

Program Name:_____ Date:_____ Meeting Time:_____

Chairperson Name, Signature and Credentials:_____

Signatures of Committee Members (include credentials):_____
_____
_____

Client Name	Admit Date	Dates Authorized Through	Tentative D/C Date	Comments

NOTE: Requests for extensions and result will be noted in the "Comments" column

START Policy 606 Attachment A

This section to be used by Provider (Physician, Nurse, Therapist, Case Manager)

Provider
Name:_____

Date:_____

Although _____ (client name) has a MORs Rating of ___6, ___ 7 or ___ 8 on-going at the County or Contracted Outpatient Program are justified based on:

☐Client has been in Long Term Care, had a psychiatric hospitalization, or was in a crisis residential facility in the last year
☐ Client has been a danger to self or others in the last six months
☐Clients impairment is so substantial and persistent that current living situation is in jeopardy or client is currently homeless
☐Clients' behavior interferes with client's ability to get care elsewhere
☐Complex psychiatric medication regimen is very complex

Comments and Treatment Plan:
_____
_____
_____
_____

This section to be used by Program Manager or designee

☐Treatment justification for on-going services is supported.
☐Treatment justification for on-going services not supported. See reverse for utilization management recommendation

Comments:
_____
_____
_____

Signature:_____ Date:_____

Printed Name:_____

Based on Utilization Management Review the following services are recommended:

_____ Recommended for referral to Primary Care:

☐Stable functioning
☐Low risk of harm
☐High community support or independent
☐High illness management skills
☐Medications within scope of primary care
☐No hospitalizations or Start admissions within last year

Comments and Transition Plan:

_____
_____
_____
_____
_____
_____

_____ Recommended for referral to FFS or FQHC Psychiatry services:

☐Moderate functioning
☐Low risk of harm
☐Moderate community support or independent
☐Moderate illness management skills
☐Complex medications not within scope of primary care
☐No hospitalizations or Start admissions within last six months

Comments and Transition Plan:

_____
_____
_____
_____
_____
_____
_____

Outpatient Utilization Review Minutes

Program Name:_____ **Date:**_____

Committee Members, Credentials: **Signatures:**

_____ _____

_____ _____

_____ _____

_____ _____

Chairperson, Credentials: **Signature:**

_____ _____

Client Name	Anasazi #	Disposition		
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied

Outpatient Utilization Review Minutes
(continued)
Page ___ of ___

Program Name:_____ **Date:**_____

Client Name	Anasazi #	Disposition		
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied
		☐ Request Approved	☐ Request Reduced	☐ Request Denied

Current Level of Case Management Services:

_____ Preventive (Maintenance)
_____ Comprehensive (Traditional)
_____ Intensive
_____ Older Adult

Location of Service	
Duration of Service	
Service Code	

_____ Assessment Reviewed _____ No changes _____Changes noted/initialed

_____ Medical History Reviewed _____ No changes _____Changes noted/initialed

_____ CFE Completed or Reviewed _____ No changes _____Changes noted/initialed

_____Client meets Medical Necessity for Mental Health Plan Specialty Mental Health Services by:

Current Diagnosis: Axis I _____ # _____. ____

Axis II _____ # _____. ____

AND:

_____ Client has a significant impairment in life functioning. **OR:**

_____ Client has a probability of significant deterioration in an important area of functioning

Describe:

AND all three of the following are true:

_____ The focus of the mental health intervention will address the condition described above

_____ It is expected that the client will benefit from interventions listed on the revised or new Client Plan, which has been signed (_____client refused to sign)

_____ The client's impairment would not be responsive to physical healthcare based treatment

AND:

_____ The client meets Service Level of Care Criteria for Case Management Services (Over)

_____ _____ _____
Clinician Name Signature Date

The case manager's signature verifies that client meets both Medical Necessity and Service Level of Care Criteria

County of San Diego
Health and Human Services Agency
Mental Health Services
Case Management Services

SIX MONTH REVIEW AND PROGRESS NOTE

HHSA:MHS-

Client:

Medical Record #:

Annual Review Date:

SERVICE LEVEL OF CARE CRITERIA (Must Meet Either A or B)

A. FOR CONTINUING COMPREHENSIVE (TRADITIONAL) CASE MANAGEMENT SERVICES

Treatment history meets ONE of the following criteria

_____ 10 days or 2 admissions for psychiatric inpatient treatment in the past twelve months

_____ 28 days or 4 admissions to a crisis house in the past twelve months.

_____ Discharge from an IMD in the past twelve months

_____ LPS Conservatorship is in effect - Client is gravely disabled as a result of a mental disorder.

OR: TWO of the following are true regarding client's functioning

_____ Client is a young adult (18 – 21) transitioning from the Children's System of Care.

_____ Client is 55 or older and mental illness is exacerbated due to issues of aging or loss of support.

_____ Client has at least (3) missed mental health appointments, or documentation that medication has not been taken on at least five occasions during the past twelve months, or has had two or more face -to-face encounters with crisis intervention/emergency services personnel; within the past twelve months

_____ Besides mental health needs, client requires assistance with two or more human service agencies or public systems such as Drug and Alcohol, Vocational Rehabilitation, Criminal Justice, Physical Health Care, and Public Benefits. List the agencies:

_____ _____

_____ Due to high risk behaviors, client has had one period of homelessness or one or more disruptions to placement or place of treatment in the past two years. List the disruptions

_____ _____

B. FOR CONTINUING CASE MANAGEMENT AT A PREVENTIVE (MAINTENANCE) LEVEL

BOTH of the following are true

1._____ Client requires ongoing support and assistance from case management to attend psychiatric treatment appointments or obtain and take medications.

2._____ Despite ongoing attempts by case manager to allow client to manage own funds and complete necessary paperwork to keep benefits in place, over the past twelve months, client has not been able to do so without assistance and there are no other persons available to provide the assistance.

Additional comments:

County of San Diego
Health and Human Services Agency
Mental Health Services
Case Management Services

SIX MONTH REVIEW PROGRESS NOTE

HHSA:MHS-

Client:

Medical Record #:

Annual Review Date:

Page 2 of 2

Case Management URC Record

Program Name: _____ URC Date: _____

Client Name: _____ Admission Date: _____

Client S#: _____

Primary Diagnostic Impression and Justification on Date of UR:

Axis I or Axis II:

Chart documents Medical Necessity:

_____ Yes _____ No

Comments:

Chart documents Service Necessity:

_____ Yes _____ No

Comments:

Recommended Level of Case Management Services:

Discharge Plan/Other Service Recommendations:

_____ _____

Name of person reviewing chart Signature

URC Minutes for Case Management

Program Name: **Date of URC:**

Committee Members

Print Name	Signature	Degree/License
Chair:		

List of Charts Reviewed

Client Name	Admit Date	Date Authorized Through	Continue at Same LOS	Transfer to Preventive LOS	Transfer to Comprehensive LOS	Discharge from Program	Comments
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	

Utilization Review Committee

Program: _____Quarter/Date: _____

Participants: _____
_____
_____
_____
_____
_____

Client Name: _____

Client ID # : _____

Provider/s name/s: _____
_____
_____

MORs History:

Date: _____ MORs: _____
Date: _____ MORs: _____
Date: _____ MORs: _____
Date: _____ MORs: _____
Date: _____ MORs: _____
Date: _____ MORs: _____

Root Cause Analysis:

Client Issues: _____
_____
_____
_____
_____

Environmental issues: _____
_____
_____
_____
_____

Clinical issues: _____
_____
_____
_____
_____

Other: _____
_____
_____
_____
_____

Disposition:

Client to continue services: _____
_____
_____

Client to be referred for services: _____
_____
_____

Client to be discharged: _____
_____
_____

Changes in Treatment Plan/Interventions: _____
_____
_____

Client Referred to: _____
_____
_____

Signature of Program Manager or Designee:
_____

UTILIZATION MANAGEMENT REQUEST AND AUTHORIZATION
Outpatient Treatment

Client: Client #: Program:

Date of Program Admission:

Current Service: ☐MHS ☐MHS-R ☐CM ☐Meds

Current Planned Session Frequency:

session/s per month

Comments:

DSM IV – TR Axis I –

Primary: Code:

Secondary: Code:

Other: Code:

Axis II – Code:

Axis III – Code:

Axis IV - ☐ Primary Support Group ☐ Social Environment ☐Educational ☐Occupational ☐Housing ☐Economic ☐Access to Health Care ☐Interaction with the Legal System ☐Other Psychosocial & Environmental

Axis V - (*GAF*) Current: Highest in last 12 months:

Does youth and/or family request continuation of service? Y ☐ N ☐ (*Comments*):

Psychiatric Hospitalizations: Y ☐ N ☐ (*If yes please specify how long ago)*:

Concurrent Interventions: (*Please Check off all that apply*): ☐TBS ☐Day Treatment Intensive ☐WRAP ☐Day Treatment Rehabilitation ☐Chemical Dependency ☐Rehabilitation ☐Other Outpatient (*Please Specify*):

☐past month ☐past 3 months ☐past 6 months ☐past year ☐more than one year

CURRENT CLIENT FUNCTIONING (CFARS Rating):

1	2	3	4	5	6	7	8	9
No Problem	**Less than Slight**	**Slight Problem**	**Slight to Moderate**	**Moderate Problem**	**Moderate to Severe**	**Severe Problem**	**Severe to Extreme**	**Extreme Problem**

Depression ____			**Anxiety** ____		
☐Depressed Mood	☐Happy	☐Sleep Problems	☐Anxious/Tense	☐Calm	☐Guilt
☐Sad	☐Hopeless	☐Lacks Energy / Interest	☐Phobic	☐Worried/ Fearful	☐Anti-Anxiety Meds
☐Irritable	☐Withdrawn	☐Anti-Depression Meds	☐Obsessive/Compulsive	☐Panic	

Hyper activity ____			**Thought Process** ____		
☐Manic	☐Inattentive	☐Agitated	☐Illogical	☐Delusional	☐Hallucinations
☐Sleep Deficit	☐Overactive / Hyperactive	☐Mood Swings	☐Paranoid	☐Ruminative	☐Command Hallucination
☐Pressured Speech	☐Relaxed	☐Impulsivity	☐Derailed Thinking	☐Loose Associations	☐Intact
☐ADHD Meds	☐Anti-Manic Meds		☐Oriented	☐Disoriented	☐Anti-Psych Meds

Cognitive Performance ____		**Medical / Physical** ____		
☐Poor Memory	☐Low Self-Awareness	☐Acute Illness	☐Hypochondria	☐Good Health
☐Poor Attention/Concentration	☐Developmental Disability	☐CNS Disorder	☐Chronic Illness	☐Need Med./Dental Care
☐Insightful	☐Concrete Thinking	☐Pregnant	☐Poor Nutrition	☐Enuretic/ Encopretic
☐Impaired Judgment	☐Slow Processing	☐Eating Disorder	☐Seizures	☐Stress-Related Illness

Traumatic Stress ____		**Substance Use** ____		
☐Acute	☐Dreams/Nightmares	☐Alcohol	☐Drug(s)	☐Dependence
☐Chronic	☐Detached	☐Abuse	☐Over Counter Drugs	☐Cravings/Urges
☐Avoidance	☐Repression/Amnesia	☐DUI	☐Abstinent	☐I.V. Drugs
☐Upsetting Memories	☐Hyper Vigilance	☐Recovery	☐Interfere w/Functioning	☐Med. Control

Interpersonal Relationships ____		**Behavior in "Home" Setting** ____	
☐Problems w/Friends	☐Diff. Estab./ Maintain	☐Disregards Rules	☐Defies Authority
☐Poor Social Skills	☐Age-Appropriate Group	☐Conflict w/Sibling or Peer	☐Conflict w/Parent or Caregiver
☐Adequate Social Skills	☐Supportive Relationships	☐Conflict w/Relative	☐Respectful
☐Overly Shy		☐Responsible	

ADL Functioning ____			**Socio-Legal** ____		
☐Handicapped	☐Not Age Appropriate In:		☐Disregards Rules	☐Offense/Property	☐Offense/Person
☐Permanent Disability	☐Communication	☐Self Care	☐Fire Setting	☐Comm. Control/Reentry	☐Pending Charges
☐No Known Limitations	☐Hygiene	☐Recreation	☐Dishonest	☐Use/Con Other(s)	☐Incompetent to Proceed
	☐Mobility		☐Detention/ Commitment		☐Street Gang Member

Select: ☐ **Work** ☐**School** ____			**Danger to Self** ____		
☐Absenteeism	☐Poor Performance	☐Regular	☐Suicidal Ideation	☐Current Plan	☐Recent Attempt
☐Dropped Out	☐Learning disabilities	☐Seeking	☐Past Attempt	☐Self-Injury	☐Self-Mutilation
☐Employed	☐Doesn't Read/Write	☐Tardiness	☐"Risk-Taking" Behavior	☐Serious Self-Neglect	☐Inability to Care for Self
☐Defies Authority	☐Not Employed	☐Suspended			
☐Disruptive	☐Terminated/ Expelled	☐Skips Class			

Danger to Others ____		**Security/ Management Needs** ____	
☐Violent Temper	☐Threatens Others	☐Home w/o Supervision	☐Suicide Watch
☐Causes Serious Injury	☐Homicidal Ideation	☐Behavioral Contract	☐Locked Unit
☐Use of Weapons	☐Homicidal Threats	☐Protection from Others	☐Seclusion
☐Assaultive	☐Homicide Attempt	☐Home w/Supervision	☐Run/Escape Risk
☐Cruelty to Animals	☐Accused of Sexual Assault	☐Restraint	☐Involuntary Exam/ Commitment
☐Does not appear dangerous to Others	☐Physically Aggressive	☐Time-Out	☐PRN Medications
		☐Monitored House Arrest	☐One-to-One Supervision

RATIONALE FOR ADDITIONAL SERVICES:

☐ **Program is on a COR approved UM Cycle exception. Exception is for session cycle OR months cycle (written exception on file).**

☐ **New Client Plan completed and available for committee's review (client/family input and signatures may be pending UM approval)**

ELIGIBILITY CRITERIA – INITIAL UM CYCLE / POST INITIAL 13 SESSIONS

☐ **Client continues to meet Medical Necessity and demonstrates benefit from services**

☐ **Consistent participation in services**

☐ CFARS – Impairment Rating guideline of 5

☐ **Client meets the criteria for SED based upon the following:**

As a result of a mental disorder the child has **substantial** and **persistent** impairment in at least two of the following areas (check):

- ☐ Self-care and self regulation
- ☐ Family relationships
- ☐ Ability to function in the community
- ☐ School functioning

AND One of the following occurs:

- ☐ Child at risk for removal from home due to a mental disorder
- ☐ Child has been removed from home due to a mental disorder
- ☐ Mental disorder/impairment is severe and has been present for six months, or is highly likely to continue for more than one year without treatment.

OR The child displays:

- ☐ acute psychotic features,
- ☐ imminent risk for suicide
- ☐ imminent risk of violence to others due to a mental disorder

ELIGIBILITY CRITERIA – SUBSEQUENT UM CYCLE / POST 26 SESSIONS (*Requires COR approval*)

☐ **Client has met the above criteria as indicated AND**

Meets a minimum of one continuing current Risk Factor related to child's primary diagnosis:

- ☐ Child has been a danger to self or other in the last two weeks
- ☐ Child experienced severe physical or sexual abuse or has been exposed to extreme violent behaviors in the home in the last two weeks
- ☐ Child's behaviors are so substantial and persistent that current living situation is in jeopardy
- ☐ Child exhibited bizarre behaviors in the last two weeks
- ☐ Child has experienced trauma within the last two weeks

Proposed Treatment Modalities:	**Planned Frequency:**	**Expected Outcome and Prognosis:**	**REQUESTED NUMBER OF TREATMENT SESSIONS**
☐ MHS – Family	session(s) per month	☐ Return to full functioning	
☐ MHS – Group	session(s) per month	☐ Expect improvement, anticipate less than full functioning	
☐ MHS – Individual	session(s) per month	☐ Relieve acute symptoms, return to baseline functioning	**REQUESTED NUMBER OF MONTHS (for programs under written COR approval)**
☐ MHS – Collateral	session(s) per month	☐ Maintain current status/prevent deterioration	
☐ Case Management/Brokerage	session(s) per month		
☐ MHS – Rehab	session(s) per month		
☐ Medication Support	session(s) per month		
Katie A. Subclass Only			
☐ MHS – Intens. Home Based Svcs	session(s) per month		
☐ CM - Intens. Care Coordination	session(s) per month		

Requesting Staff's Name, Credential &Signature: _____ **Date:**

Program Level Review – Initial UM Cycle

# of Sessions/Time Approved: ☐ Request Approved ☐ Request Reduced ☐ Request Denied

UM Clinician's Name: Signature/Credentials: _____ Date:

Committee Members Names and Credentials:

Comments:

COR Level Review – Subsequent UM Cycle (past 26 services):

# of Sessions/Time Approved: ☐ Request Approved ☐ Request Reduced ☐ Request Denied

DATE: COR Name and Credentials: (attach written COR approval) (NOA-B may be required for MC Clients)

☐ Retroactive Authorization (attach written COR approval): DATE Approved:

Approved Time Frame: COR Name and Credentials:

CYF OUTPATIENT LEVEL OF CARE
BRIEF TREATMENT MODEL
EFFECTIVE 1-1-10
Updated: 2/1/12; 8/1/12; 1/7/13

On 1-1-10 the children Outpatient Organizational Providers system transitioned from time to session based services. This transition established session limited brief treatment that is intended to be efficient and effective across target populations. Clients receive brief treatment services that focus on one or two most important issues identified by the client/family and treatment episode concludes when those are stabilized. Intent is to provide appropriate services in a timely fashion and allow access back into the system when needed (episodic care as indicated).

Effective 1-1-13, all referrals shall be **screened** by a clinician for appropriate level of care. Brief screening will be conducted without an episode opening and done on the phone unless the caregiver/youth is a walk in. Screening will facilitate timely and appropriate services which are family centered and support maximizing capacity at the Organizational Provider level. Direct referrals from the Access and Crisis Line (ACL) do not require program screening as screening was completed by the ACL, and therefore an assessment appointment shall be offered. To determine level of care, clinician brief screening (non billable activity) will consider:

- Risk of Harm
- Functional Status
- Co Morbidity
- Environmental Stress and Support
- Resiliency and Treatment History
- Caregiver Acceptance and Engagement

Based on brief screening, the appropriate level of care will be determined and communicated to the caregiver/youth. In addition to use of natural community resources, the **Outpatient Level of Care** consists of:

Clinical Presentation	**Appropriate Provider**	**Session Level**	**Notes**
Mild / Non Complex calling for medical intervention or medication	Primary Care Physician (PCP) Medical Home Health Plans	TBD by medical team	
Mild / Non Complex need	Fee For Service (FFS) Network via Access and Crisis Line (ACL)	Roughly 6 to 12 sessions	Organizational Provider calls the ACL to inform of screening/recommendation
Moderate / Complex needs Medical Necessity met	Organizational Provider	Up to 13 sessions	
Severely Emotionally Disturbed (SED) Pervasive impairment	Organizational Provider	Up to 26 sessions	Require program level UM
Current Risk Factors	Organizational Provider Ancillary Services	27 Sessions and beyond	Require COTR UM approval
Children/Youth who present with safety risk factors may require a 911 contact and/or an evaluation at the Emergency Screening Unit (ESU) to determine need for crisis stabilization or inpatient psychiatric care.			

Physical Health Coordination

- Effective 1-1-13 Coordination of Physical and Behavioral Health form shall be completed for all CYF-BHS clients at intake and as clinical services progress; encouraging communication between caregiver/youth, clinician and PCP/Medical Home. When needed BHS provider shall connect client to Medical Home. Medical provider shall be informed by program when client is discharged from services.
- Program shall refer clients who are stable on medication to the PCP. If the PCP is not yet comfortable taking over the medication services, program will continue to provide PCP with updates and regularly assess the ability to transfer medication monitoring to PCP; documenting all efforts.
- PCP will be offered regular updates on medication only clients with the objective of transferring those clients who are stable on medication to their Medical Home. Regular updates to PCP will facilitate improved client care through care coordination and assist in building relationships with PCP to work towards collaborative treatment.

Initial Eligibility – at Organizational Provider Level

Clients that meet the criteria for Title 9 medical necessity shall be eligible for 13 sessions (within a 12 month period).

- 1 Assessment Session
- 12 Treatment Sessions
- Emphasis on group and family treatment
- Adhere to Children, Youth and Families Services (CYF) SED Priority Population – others seen when space permits and priorities as follows:

  Emergency – assessed within 1 hour or referred to ESU/911
  Urgent – seen within 72 hours of contact
  Routine – seem within 5 calendar days of initial client contact/referral
- Clients receiving group and/or family sessions only are eligible for an additional five (5) group or family sessions for a total of 18 sessions.
- Applies to MediCal, MHSA (indigent), and Healthy Families SED clients which are transitioning to MediCal under Targeted Low Income Children's Program (TLICP).
- Included services (count toward 13 sessions): assessment, individual, family and/or group treatment. Individual rehabilitative services are included when provided by a clinician.
- Excluded services (not counted toward 13 sessions): medication management, case management brokerage (CMBR), crisis intervention (CI), plan development, evaluation of records, report preparation, Therapeutic Behavioral Services (TBS), psychological testing (for those programs approved to do testing), and collateral (contact with significant others such as teachers, probation officers, child welfare services workers, and parent/guardians). Paraprofessional rehabilitative services (Rehab-individual, Rehab-group, and Rehab-family) are excluded.
- No-show appointments count toward the 13 sessions. Cancelled appointments do not.
- The majority of clients will only be eligible for the initial 13 treatment sessions.
- At the conclusion of the initial 13 authorized treatment sessions, the client assignment shall be closed unless the client meets SED criteria and reauthorization is obtained (program level UM authorization).
- Medication-only cases may continue as needed and under existing procedure and are excluded from UM but continue to be subject Medication Monitoring process.
- Client's returning to treatment from medication only services may technically still have authorized services from last UM cycle; however a change in service needs would indicate a need for an updated UM review as well as a new Client Plan. If the client had received less than 26 sessions since episode opening, an internal (program level) UM should occur to authorize up to 26 sessions from episode opening. If the client has received 26 or more session, UM request shall be submitted to the COTR.
- Evidence Based Programs may be pre-authorized for the program to provide services for the time limited term of the model with written COTR documentation.

Updated 12-12-12 A.D.15; 1-7-13

Eligibility and Utilization Management: In order to continue services beyond 13 treatment sessions, clients shall meet specific criteria and be reviewed through a Utilization Management process, conducted internally at each program by a licensed clinician.

A. Utilization Management

- Services may continue for 1 to 13 additional treatment sessions when clinically indicated as determined by UM review.
- The UM process is completed before the end of 13 sessions to determine continued eligibility and services,
- CFARS-Impairment Rating guideline of 5.
- The subsequent 13 treatment sessions must meet all three of the following criteria:
  1) Continued Medical Necessity with demonstrated benefit from services
  2) Meet SED criteria – pervasive impairment
  3) Consistent participation in services

B. The UM criteria are specifically defined as follows:

- Continue to meet Medical Necessity and demonstrate benefit from services (showing progress).
- Meet SED criteria:
  1) As a result of a mental disorder the child has substantial and persistent impairment in at least two of the following areas:
     a. Self-care and self regulation
     b. Family relationships
     c. Ability to function in the community
     d. School functioning

     AND one of the following occurs:

     e. Child is at risk for removal from home due to a mental disorder.
     f. Child has been removed from home due to a mental disorder.
     g. Mental disorder/impairment is severe and has been present for six months, or is highly likely to continue for more than one year without treatment.

     OR

  2) The child displays: acute psychotic features, is an imminent risk for suicide or imminent risk of violence due to a mental disorder.

- Consistent participation in services as prescribed by treating clinician.
- Current Client Functioning Impairment (CFARS) Guideline: Rating of 5 (Moderate to Severe in all domains addressed through the Client Plan as it relates to the client's primary diagnosis.

Post 26 Sessions

- Must obtain prior written COTR approval.
- Approximately 10% of those clients who successfully went through the initial UM will require more than 26 treatment sessions.

To continue beyond 26 treatment sessions clients shall be reviewed through a UM process and meet the following five criteria in order to obtain COTR approval:

- Continued Medical Necessity and demonstrated benefit from services
- Meet SED criteria – pervasive impairment
- CFARS-Impairment Rating guideline of 5
- Consistent participation in services
- Meet a minimum of one continuing current Risk Factor related to child's primary diagnosis:
    1) Child has been a danger to self or other(s) in the last two weeks.
    2) Child experienced severe physical or sexual abuse or has been exposed to extreme violent behaviors in the home in the last two weeks.
    3) Child's behaviors are so substantial and persistent that the current living situation is in jeopardy.
    4) Child exhibited bizarre behaviors in the last two weeks.
    5) Child has experienced trauma within the last two weeks. "A trauma is an exceptional experience in which powerful and dangerous events overwhelm the person's capacity to cope."

Utilization Management:

- Clinicians will clearly explain the process and limitations of services to client/families upon intake.
- Community services shall be routinely explored as natural support systems for clients and families, with an emphasis on establishing and strengthening those connections so a supported and sustainable transition out of services can occur.
- UM will be completed at the program level; approval will be by a licensed clinician only. (Post 26 sessions requires written authorization from COTR).
- Programs with Family Partners will include the Family Partner as part of the UM review process.
- UM forms will be utilized and will be accompanied by a new Client Plan. Client Plans will be completed within thirty (30) days of admission and prior to UM request.
- CFARS will be completed at admission and discharge and prior to each UM submission (13 sessions, 26 sessions).
- CAMS outcome measures will be administered at intake, aligned with UM cycle and prior to discharge if the previous CAMS is done over 2 months before discharge.
- Providers are required to implement a system to track UM for each client; this may be done at the Anasazi Clinician Home Page.
- Program Managers will report on the Quarterly Status Report (QSR) the number of screenings and disposition, the number of clients seen at 13, 26, and beyond 26 sessions as it compares to the total number of clients being served. This allows for program self assessment of adherence to brief treatment model.
- Retroactive authorization cannot be obtained at the program level through the UM process (COTR shall be informed when no UM is in place to determine retroactive authorization).
- Written exception to the UM process by evidence based program may be obtained from COTR.
- Documentation from COTR approving post 26 sessions shall be in medical record and a notation of COTR approval shall be documented on the UM form.
- Client's who seek re-entry post a recently closed assignment (approximately 6 months) shall be evaluated for a new or exacerbated stressor. If client presents a different clinic, previous provider shall be consulted.

Updated 12-12-12 A.D.15; 1-7-13

INCLUDED AND EXCLUDED SERVICE CODES

Service Codes designated "included" are those that are included when counting the number of sessions provided for the 13 treatment session limit.

ID	DESCRIPTION	
5	SCREENING	excluded
9	ASSESSMENT PSYCHOSOC INTERACT	included
10	ASSESSMENT - PSYCHOSOCIAL	included
11	MEDICATION EVALUATION	excluded
12	PSYCHOLOGICAL TESTING	excluded
13	PLAN DEVELOPMENT	excluded
14	EVAL OF RECORDS FOR ASSESSMENT	excluded
15	EXTERNAL REPORT PREPARATION	excluded
20	MEDICATION SUPPORT OTHER	excluded
21	MEDICATION EDUCATION GROUP	excluded
~~22~~	~~MEDS - PHARMOCOLOGICAL MGMT~~	~~excluded~~
23	MED CHECK MD BRIEF	excluded
24	MEDS EM MINIMAL PROBLEM	excluded
25	MEDS EM MINOR PROBLEM	excluded
26	MEDS EM EXPANDED LOW	excluded
27	MEDS EM DETAILED MODERATE	excluded
28	MEDS EM COMPREHENSIVE HIGH	excluded
30	PSYCHOTHERAPY-INDIVIDUAL	included
31	PSYCHOTHERAPY - GROUP	included
32	PSYCHOTHERAPY - FAMILY	included
33	COLLATERAL	excluded
34	REHAB – INDIVIDUAL*	excluded/included
35	REHAB – GROUP*	excluded/included
36	REHAB – FAMILY*	excluded/included
37	REHAB EVALUATION	excluded
38	PSYCHOTHERAPY INTERACTIVE - IND	included
39	PSYCHOTHERAPY INTERACTIVE - GRP	included
40	COLLATERAL PARENT GROUP	excluded
46	THERAPEUTIC BEH SVCS - PLAN DEV	excluded
47	THERAPEUTIC BEH SVCS - DIRECT	excluded
48	THERAPEUTIC BEH SVCS - ASSESSMENT	excluded
49	THERAPEUTIC BEH SVCS - COL	excluded
50	CASE MANAGEMENT/BROKERAGE	excluded
60	OTHER SUPPORT NON-BILLABLE	excluded
63	SUBSTANCE ABUSE EDUCATION	excluded
65	COMMUNITY SERVICES	excluded
70	CRISIS INTERVENTION	excluded
90	CRISIS STABILIZATION	excluded
95	DAY TREATMENT	excluded

NOTE: rehabilitative services with * are excluded when provided by a paraprofessional and included if provided by a licensed or licensed eligible provider.

Updated 12-12-12 A.D.15; 1-7-13

This form should be used to request initial authorization of payment for Day Program services.	County of San Diego Mental Health Plan **Initial Day Program Request** RECEIVED:	fax/mail to: **OptumHealth Public Sector, 3111 Camino del Rio North, Suite 500 San Diego, CA 92108** **Phone: (800) 798-2254, option #4** **Fax: (866) 220-4495**

CLIENT INFORMATION *******CONFIDENTIAL*******

Client Name: (*First & Last*)	Client Anasazi ID#:	Date of Birth

DAY PROGRAM INFORMATION

Legal Entity & Day Program Name: *Please print clearly*

_____Phone:_____

Day Program Unit#_____Subunit #_____ Assignment Open Date _____/____/_____

Anticipated Date of Discharge _____/____/_____

INITIAL AUTHORIZATION REQUEST: ☐ Intensive Day Treatment ☐ Day Rehab Frequency : _____ days a week

Begin Date for this Request: ____/____/____ (mm/dd/yyyy) End Date for this Request: ____/____/____ (mm/dd/yyyy)

DAY PROGRAM SERVICE NECESSITY CRITERIA **COMPLETE DIAGNOSIS and CHECK ALL CRITERIA THAT APPLY**

DIAGNOSIS ***TIP:*** Use **DSM-IV** Codes; include all Axes. **Client must also meet Title 9 Medical Necessity Criteria**

Axis I - Primary _____ **Axis II** -_____ **Axis III** - _____

Secondary _____

Axis IV _____ **Axis V** (*GAF*) Current _____ **Highest in last 12 months**_____

For adult clients only: Day Program Services Medical Necessity #_____ (Please review Day Program Medical Necessity Grid to determine this number)

SERVICE NECESSITY CRITERIA

1) Client exhibits an impairment in functioning due to the above diagnosis as evidenced by one or more of the following:

A. ☐ Substantial impairment in living arrangement, daily activities, social relationships, and/or age appropriate ADL skills as demonstrated by: (describe) _____

_____

B. ☐ Risk factors such as recurring psychotic symptoms, suicidal or homicidal ideation, without evidence of plan, or other violent ideation or behavior as demonstrated by:(describe) _____

_____

C. ☐ Demonstrative history that without day program services there is a substantial risk of recurrence of A. or B. (describe behavior/history supporting risk.)_____

_____

D. ☐ *(For children/youth)* Probability that child will not progress developmentally as individually appropriate, or will deteriorate developmentally as demonstrated by: _____

_____

2)☐ Client (and family for children) has been in, or is currently in lower level of care and the client has not demonstrated progress or stabilization (describe progress or lack of progress)_____

_____

3)☐ Client requires structured Day Program in order to move successfully from higher level of care to lower level of care or to prevent deterioration in functioning and admission to a higher level of care. (describe how is this determined)_____

_____

4)☐ Present living situation and functioning indicate need for structured day program. Describe living situation & functioning that supports need for Day Program._____

_____

5)☐ *(For children/youth)* Recent troubling life events, such as a change of placement, arrest and incarceration, or child abuse. (Describe behaviors/functioning indicating need for Day Program. A formal assessment must confirm medical necessity within 30 days after admission.)_____

CURRENT FUNCTIONING (CFARS Rating):

1	2	3	4	5	6	7	8	9
No problem	**Less than Slight**	**Slight Problem**	**Slight to Moderate**	**Moderate Problem**	**Moderate to Severe**	**Severe Problem**	**Severe to Extreme**	**Extreme Problem**

Depression ____			**Anxiety** ____		
☐Depressed Mood	☐Happy	☐Sleep Problems	☐Anxious/Tense	☐Calm	☐Guilt
☐Sad	☐Hopeless	☐Lacks Energy / Interest	☐Phobic	☐Worried/ Fearful	☐Anti-Anxiety Meds
☐Irritable	☐Withdrawn	☐Anti-Depression Meds	☐ Obsessive/Compulsive	☐Panic	
Hyper activity ____			**Thought Process** ____		
☐Manic	☐Inattentive	☐Agitated	☐Illogical	☐Delusional	☐Hallucinations
☐Sleep Deficit	☐Overactive / Hyperactive	☐Mood Swings	☐Paranoid	☐Ruminative	☐Command Hallucination
☐Pressured Speech	☐Relaxed	☐Impulsivity	☐Derailed Thinking	☐Loose Associations	☐Intact
☐ADHD Meds	☐Anti-Manic Meds		☐Oriented	☐Disoriented	☐Anti-Psych Meds

Cognitive Performance ____		**Medical / Physical** ____		
☐Poor Memory	☐Low Self-Awareness	☐Acute Illness	☐Hypochondria	☐Good Health
☐Poor Attention/Concentration	☐Developmental Disability	☐CNS Disorder	☐Chronic Illness	☐Need Med./Dental Care
☐Insightful	☐Concrete Thinking	☐Pregnant	☐Poor Nutrition	☐Enuretic/ Encopretic
☐Impaired Judgment	☐Slow Processing	☐Eating Disorder	☐Seizures	☐Stress-Related Illness
Traumatic Stress ____		**Substance Use** ____		
☐Acute	☐Dreams/Nightmares	☐Alcohol	☐Drug(s)	☐Dependence
☐Chronic	☐Detached	☐Abuse	☐Over Counter Drugs	☐Cravings/Urges
☐Avoidance	☐Repression/Amnesia	☐DUI	☐Abstinent	☐I.V . Drugs
☐Upsetting Memories	☐Hyper Vigilance	☐Recovery	☐Interfere w/Functioning	☐Med. Control

Interpersonal Relationships ____		**Behavior in "Home" Setting** ____	
☐Problems w/Friends	☐Diff. Estab./ Maintain	☐Disregards Rules	☐Defies Authority
☐Poor Social Skills	☐Age-Appropriate Group	☐Conflict w/Sibling or Peer	☐Conflict w/Parent or Caregiver
☐Adequate Social Skills	☐Supportive Relationships	☐Conflict w/Relative	☐Respectful
☐Overly Shy		☐Responsible	

ADL Functioning ____			**Socio-Legal** ____		
☐Handicapped	☐Not Age Appropriate In:		☐Disregards Rules	☐Offense/Property	☐Offense/Person
☐Permanent Disability	☐ Communication	☐Self Care	☐Fire Setting	☐Comm. Control/Reentry	☐Pending Charges
☐No Known Limitations	☐Hygiene	☐Recreation	☐Dishonest	☐Use/Con Other(s)	☐Incompetent to Proceed
	☐Mobility		☐Detention/ Commitment		☐Street Gang Member

Select: ☐ **Work** ☐**School** ____			**Danger to Self** ____		
☐Absenteeism	☐Poor Performance	☐Regular	☐Suicidal Ideation	☐Current Plan	☐Recent Attempt
☐Dropped Out	☐Learning disabilities	☐Seeking	☐Past Attempt	☐Self-Injury	☐Self-Mutilation
☐Employed	☐Doesn't Read/Write	☐Tardiness	☐"Risk-Taking" Behavior	☐Serious Self-Neglect	☐Inability to Care for Self
☐Defies Authority	☐Not Employed	☐Suspended			
☐Disruptive	☐Terminated/ Expelled	☐Skips Class			

Danger to Others ____		**Security/ Management Needs** ____	
☐Violent Temper	☐Threatens Others	☐Home w/o Supervision	☐Suicide Watch
☐Causes Serious Injury	☐Homicidal Ideation	☐Behavioral Contract	☐Locked Unit
☐Use of Weapons	☐Homicidal Threats	☐Protection from Others	☐Seclusion
☐Assaultive	☐Homicide Attempt	☐Home w/Supervision	☐Run/Escape Risk
☐Cruelty to Animals	☐Accused of Sexual Assault	☐Restraint	☐Involuntary Exam/ Commitment
☐Does not appear dangerous to Others	☐Physically Aggressive	☐Time-Out	☐PRN Medications
		☐Monitored House Arrest	☐One-to-One Supervision

CLIENT INFORMATION *****CONFIDENTIAL*****

Client Name: (*First & Last*)	Client Anasazi ID #:	Date of Birth

REQUIRED ATTACHMENTS

PLEASE SUBMIT THE FOLLOWING DOCUMENT WITH THIS INITIAL DAY PROGRAM REQUEST:

☐ Specialty Mental Health Services DPR if the client receives ancillary services in addition to Day Program Services.

Day Program Clinician: (print)_____ Date:_____

Countersignature by Licensed Clinician:_____ Date:_____

For OptumHealth Disposition Only: DOCUMENT AUTHORIZATIONS FOR DAY PROGRAM and ANCILLARY SERVICES

OptumHealth Clinician:_____ Day Program Authorization Period: Begin Date:_____ End Date:_____

Approved # Days:_____ Frequency (# times/week) _____ Review Date:_____ Circle approved AS on next page(s) Logged ☐

Reduce DP Request:☐ Deny DP Request:☐ Date NOA Sent: _____ Reduce AS Request:☐ Deny AS Request:☐ Date NOA Sent:_____

Date DP Auths Entered:_____ **Date AS Auths Entered:**_____ **D/E Name:**_____ **Logged** ☐

This form should be used to request authorization of payment for **Specialty Mental Health Services.**	**County of San Diego Mental Health Plan** **Specialty Mental Health Services DPR** RECEIVED:	**Form must be submitted to OptumHealth Public Sector by client's Day Program provider. OptumHealth Public Sector cannot accept this form if submitted by Specialty Mental Health Services Provider**

CLIENT INFORMATION *******CONFIDENTIAL*******

Client Name: (*First & Last*)	Client Anasazi ID #:	Date of Birth

DAY PROGRAM INFORMATION

Legal Entity & Day Program Name: *Please print clearly*

_____Phone: :_____

Day Program Unit#_____Subunit# _____

SPECIALTY MENTAL HEALTH SERVICES PROGRAM INFORMATION

Legal Entity & Specialty Mental Health Program Name: *Please print clearly*

_____Phone: :_____

Specialty Mental Health Program Uni#_____Subunit# _____

REQUEST FOR AUTHORIZATION of Specialty Mental Health Services delivered by Organizational County Contracted providers on the same day as Day Program Services.

*** Treatment must include coordination with the other professionals treating client. Authorization is required only for ancillary services delivered on the same day client receives Day Program Services. Ancillary Services delivered to client in an Intensive Day Program require continued authorization within 3 months. Ancillary Services delivered to client in a Day Rehab program require continued authorization within 6 months. Medication Management, Case Management, TBS, and Crisis Intervention Services do not require authorization. ***

Complete the request by writing below the total # of visits requested per week to include all Individual Mental Health Services, Collateral Mental Health Services, Group Mental Health Services, or Other Mental Health Services covered under Specialty Mental Health Services.

Request: Specialty Mental Health Services _____ sessions per week.

Start date of this authorization: _____/___/_____ (MM/DD/YYYY) End date of this authorization: _____/___/_____ (MM/DD/YYYY)

Ancillary Assignment Open Date:____/____/_____

Community services/self help do not require authorization but must be coordinated comprehensively with all mental health and psychosocial rehab services.

Community services/self help (please list) _____

ADULT/OLDER ADULT Ancillary Service Necessity Criteria: **CHECK ALL THAT APPLY and complete description.**

☐ The client is unable to receive these services while attending the Day Rehabilitation program due to client's specific clinical needs or family/caregiver needs. (Describe needs) _____

_____

☐ Client transition issues make these services necessary for a time limited interval. (Describe why transition services are needed and length of interval) _____

☐ These concurrent services are essential to coordination of care. (Describe why services are essential for coordination) _____

_____

CHILD and YOUTH Ancillary Service Necessity Criteria: **CHECK ALL THAT APPLY and complete description.**

☐ Requested service(s) is not available through the day program. (Describe why service is not available through day program) _____

_____

☐ Continuity or transition issues make these services necessary for a time limited interval. (Describe why transition services are needed and time interval) _____

☐ These concurrent services are essential to coordination of care. (Describe why services are essential for coordination) _____

_____

CURRENT FUNCTIONING (CFARS Rating) :

1	2	3	4	5	6	7	8	9
No problem	**Less than Slight**	**Slight Problem**	**Slight to Moderate**	**Moderate Problem**	**Moderate to Severe**	**Severe Problem**	**Severe to Extreme**	**Extreme Problem**

Depression			**Anxiety**		
☐Depressed Mood	☐Happy	☐Sleep Problems	☐Anxious/Tense	☐Calm	☐Guilt
☐Sad	☐Hopeless	☐Lacks Energy / Interest	☐Phobic	☐Worried/ Fearful	☐Anti-Anxiety Meds
☐Irritable	☐Withdrawn	☐Anti-Depression Meds	☐Obsessive	☐Panic	
Hyper activity			**Thought Process**		
☐Manic	☐Inattentive	☐Agitated	☐Illogical	☐Delusional	☐Hallucinations
☐Sleep Deficit	☐Overactive / Hyperactive	☐Mood Swings	☐Paranoid	☐Ruminative	☐Command Hallucinations
☐Pressured Speech	☐Relaxed	☐Impulsivity	☐Derailed Thinking	☐Loose Associations	☐Intact
☐ADHD Meds	☐Anti-Manic Meds		☐Oriented	☐Disoriented	☐Anti-Psych Meds

Cognitive Performance		**Medical / Physical**		
☐Poor Memory	☐Low Self-Awareness	☐Acute Illness	☐Hypochondria	☐Good Health
☐Poor Attention/Concentration	☐Developmental Disability	☐CNS Disorder	☐Chronic Illness	☐Need Med./Dental Care
☐Insightful	☐Concrete Thinking	☐Pregnant	☐Poor Nutrition	☐Enuretic/ Encopretic
☐Impaired Judgment	☐Slow Processing	☐Eating Disorder	☐Seizures	☐Stress-Related Illness
Traumatic Stress		**Substance Use**		
☐Acute	☐Dreams/Nightmares	☐Alcohol	☐Drug(s)	☐Dependence
☐Chronic	☐Detached	☐Abuse	☐Over the Counter Drugs	☐Cravings/Urges
☐Avoidance	☐Repression/Amnesia	☐DUI	☐Abstinent	☐I.V . Drugs
☐Upsetting Memories	☐Hyper Vigilance	☐Recovery	☐Interfere w/Functioning	☐Med. Control

Interpersonal Relationships		**Behavior in "Home" Setting**	
☐Problems w/Friends	☐Diff. Estab./ Maintain	☐Disregards Rules	☐Defies Authority
☐Poor Social Skills	☐Age-Appropriate Group	☐Conflict w/Sibling or Peer	☐Conflict w/Parent or Caregiver
☐Adequate Social Skills	☐Supportive Relationships	☐Conflict w/Relative	☐Respectful
☐Overly Shy		☐Responsible	

ADL Functioning			**Socio-Legal**		
☐Handicapped	☐Not Age Appropriate In:		☐Disregards Rules	☐Offense/Property	☐Offense/Person
☐Permanent Disability	☐Communication	☐Self Care	☐Fire Setting	☐Comm. Control/Reentry	☐Pending Charges
☐No Known Limitations	☐Hygiene	☐Recreation	☐Dishonest	☐Use/Con Other(s)	☐Incompetent to Proceed
	☐Mobility		☐Detention/ Commitment		☐Street Gang Member
Select: ☐ Work ☐School			**Danger to Self**		
☐Absenteeism	☐Poor Performance	☐Regular	☐Suicidal Ideation	☐Current Plan	☐Recent Attempt
☐Dropped Out	☐Learning disabilities	☐Seeking	☐Past Attempt	☐Self-Injury	☐Self-Mutilation
☐Employed	☐Doesn't Read/Write	☐Tardiness	☐"Risk-Taking" Behavior	☐Serious Self-Neglect	☐Inability to Care for Self
☐Defies Authority	☐Not Employed	☐Suspended			
☐Disruptive	☐Terminated/ Expelled	☐Skips Class			

Danger to Others		**Security/ Management Needs**	
☐Violent Temper	☐Threatens Others	☐Home w/o Supervision	☐Suicide Watch
☐Causes Serious Injury	☐Homicidal Ideation	☐Behavioral Contract	☐Locked Unit
☐Use of Weapons	☐Homicidal Threads	☐Protection from Others	☐Seclusion
☐Assaultive	☐Homicide Attempt	☐Home w/Supervision	☐Run/Escape Risk
☐Cruelty to Animals	☐Accused of Sexual Assault	☐Restraint	☐Involuntary Exam/ Commitment
☐Does not appear dangerous to Others	☐Physically Aggressive	☐Time-Out	☐PRN Medications
		☐Monitored House Arrest	☐One-to-One Supervision

Clinician requesting authorization: (print)_____**Phone:**_____ **Date:**_____

Countersignature by Licensed Clinician:_____ **Phone:**_____ **Date:**_____

Created by UBH 01-1-05 Revised 9.01.10

This form should be used to request *continued authorization* of payment for Day Program services	County of San Diego Mental Health Plan ***CONTINUED*** **Day Program Request** RECEIVED:	Fax/Mail to: **OptumHealth Public Sector,** **3111 Camino del Rio North,** **Suite 500** **San Diego, CA 92108** **Phone: (800) 798-2254, option 4** **Fax: (866) 220-4495**

CLIENT INFORMATION *******CONFIDENTIAL*******

Client Name: (*First & Last*)	Client Anasazi ID #	Date of Birth

DAY PROGRAM INFORMATION

Legal Entity & Day Program Name: *Please print clearly* _____

Phone: _____ Assignment Open Date _____

Day Program Unit# _____ Subunit# _____

Anticipated Discharge Date: _____ Current Session Frequency : _____ days a week
mm/dd/yyyy

CONTINUED AUTHORIZATION REQUEST: ☐ Intensive Day Treatment ☐ Day Rehab Frequency : _____ days a week

Begin Date for this Request: _____ End Date for this Request: _____
mm/ dd/ yyyy mm/ dd/ yyyy

HISTORY

☐ **Significant Life Events Since Last Review** : _____

DAY PROGRAM SERVICE NECESSITY CRITERIA **COMPLETE DIAGNOSIS and CHECK ALL THAT APPLY**

DIAGNOSIS ***TIP:*** Use **DSM-IV** Codes; include all Axes**.** **Client must also meet Title 9 Medical Necessity Criteria**

Axis I - Primary _____ **Axis II** - _____ **Axis III** - _____

Secondary _____

Axis IV _____ **Axis V** (*GAF*) Current _____ **Highest in last 12 months** _____

For adult clients only: Day Program Services Medical Necessity # _____ (Please review Day Program Medical Necessity Grid to determine this number)

SERVICE NECESSITY CRITERIA

1) Client exhibits an impairment in functioning due to the above diagnosis as demonstrated by one or more of the following:

A. ☐ Substantial impairment in living arrangement, daily activities, social relationships, and/or age appropriate ADL skills as demonstrated by: (describe)_____

B. ☐ Risk factors such as recurring psychotic symptoms, suicidal or homicidal ideation without evidence of plan, or other violent ideation or behavior as demonstrated by: (describe) _____

C. ☐ Demonstrative history that without day program services there is a substantial risk of recurrence of A. or B. (describe behavior/history supporting risk.)_____

D. ☐ *(For children/youth* Probability that child will not progress developmentally as individually appropriate or will deteriorate developmentally as demonstrated by:_____

2) ☐ Client (and family for children) has been in, or is currently in lower level of care and the client has not demonstrated progress or stabilization (describe progress or lack of progress)_____

3) ☐ Client requires structured Day Program in order to move successfully from higher level of care to lower level of care or to prevent deterioration in functioning and admission to a higher level of care. (describe how is this determined)_____

4) ☐ Present living situation and functioning indicate need for structured day program. Describe living situation & functioning that supports need for Day Program. _____

5) ☐ Current treatment goals have not been met. There is progress toward treatment goals or a reasonable expectation that progress will be made during the next authorization cycle. _____

CLIENT INFORMATION	*******CONFIDENTIAL*******	
Client Name: (*First & Last*)	Client Anasazi ID #:	Date of Birth:

CLIENT AREAS of STRENGTH	**DESCRIBE STRENGTHS IN DETAIL (For children, include family strengths)**
Job, School, Daily Activities	
Relationships, Family, Social Supports	
Social Activities, Interests	

TREATMENT GOALS: List goals directed at improving functioning. **Progress Rating Scale**: **N – New Goal, 1 – Much worse, 2 – Somewhat worse, 3 – No change, 4 – Slight Improvement, 5 – Great improvement, R – Resolved**

Measurable Behavioral Goal:	**As Demonstrated by:**	**Method(s) for Achieving Goal**	**Progress since last report**

Client received psychiatric evaluation? ☐ Yes ☐ No **NAME OF PSYCHIATRIST**:

CURRENT MEDICATIONS	**Current Dose**	**CURRENT MEDICATIONS**	**Current Dose**

REQUIRED ATTACHMENTS

PLEASE SUBMIT THE FOLLOWING DOCUMENT WITH THIS CONTINUING DAY PROGRAM REQUEST:

☐ Specialty Mental Health Services DPR if the client receives ancillary services in addition to Day Program Services.

Print Form

Service Authorization Request

For out-of-county organizational providers only.

Client's Name:			DOB:	Age:	CIN OR SSN:
(First)	(Middle)	(Last)			

Requesting Agency:	Contact Person:

Contact Phone Number:	Contact Fax Number:

Submitted to (MHP):	Date Submitted:

◯ Initial Authorization for "Client Assessment" only.

◯ Initial Authorization (Required documents: "Client Assessment" and "Client Plan")

◯ Re-Authorization (Submit "Client Assessment Update" and "Client Plan" consistent with authorizing MHP's frequency requirements)

◯ Annual Re-Authorization (Submit "Client Assessment Update" and "Client Plan" consistent with authorizing MHP's frequency requirements)

(Please note: The MHP may request clarifying information / documentation to process your request for any of the above)

Speciality Mental Health Services Requested	Frequency of Service		Total Units Requested	Start Date	End Date	MHP Authorization (initial approved service)
☐ Day Treatment Intensive	_____ Days/week		3 Months			
	◯ Half Day	◯ Full Day				
☐ Day Rehabilitation	_____ Days/week		6 Months			
	◯ Half Day	◯ Full Day				

Explain why is this level of service necessary; if requesting more than 5 days per week, include your explanation for this level of care:

Service Necessity:

Child/youth requires a day rehabilitation, a structured program of rehabilitation and therapy, to:

1. ☐ Improve personal independence and functioning.
2. ☐ Maintain personal independence and functioning.
3. ☐ Restore personal independence and functioning.

Child/youth requires day treatment intensive, a structured, multi-disciplinary program program of therapy, which may be:

1. ☐ An alternative to hospitalization.
2. ☐ To avoid placement in a more restrictive environment
3. ☐ To maintain in a community setting.
4. ☐ Other (list): _____

Attachment-A, Refer to #MHS-01-02-225

Client Name: **Record/Identification Number:**

Specialty Mental Health Service(s) Requested	Frequency of Service(s) (Indicate how many AND select the Frequency)	Total Minutes Requested	Start Date	End Date	MHP Authorization (initial approved service)
☐ Assessment	____ per ◯ Week ◯ Month ◯ Authorization				
☐ Plan Development	____ per ◯ Week ◯ Month ◯ Authorization				
☐ Individual Therapy	____ per ◯ Week ◯ Month ◯ Authorization				
☐ Group Therapy	____ per ◯ Week ◯ Month ◯ Authorization				
☐ Collateral Services	____ per ◯ Week ◯ Month ◯ Authorization				
☐ Family Therapy	____ per ◯ Week ◯ Month ◯ Authorization				
☐ Targeted Case Mgmt	____ per ◯ Week ◯ Month ◯ Authorization				
☐ Medication Support	____ per ◯ Week ◯ Month ◯ Authorization				
☐ Other: _____	____ per ◯ Week ◯ Month ◯ Authorization				

Explain why this service level is necessary. If the above services are in addition to day treatment intensive/day rehabilitation services, explain why additional services are needed:

Client Name: **Record/Identification Number:**

Diagnosis

List Primary Diagnosis first.

Axis I: P: _____

_____

_____

Axis II: P: _____

_____

Axis III: P: _____

_____

Axis IV: P: _____

_____

Axis V: Current GAF: _____ Past Year GAF (if available) _____

Impairment criteria (Must have one of the following impairments as a result of the DSM diagnosis):

1. ☐ A significant impairment in an important area of life functioning.
2. ☐ A probability of significant deterioration in an important area of life functioning.
3. ☐ A probability that the client will not progress developmentally as individually appropriate.
4. ☐ For EPSDT beneficiaries, a condition as a result of a mental disorder that specialty mental health services can correct or ameliorate.

Intervention criteria (Must have 5, 6, and 7 or 7 and 8):

5. ☐ The focus of treatment is to address the condition identified in the impairment criteria.
6. ☐ The proposed intervention will significantly diminish the impairment or prevent significant deterioration in an important area of life functioning or allow the client to progress developmentally as individually appropriate.
7. ☐ The condition would not be responsive to physical health care based treatment.
8. ☐ For EPSDT beneficiaries, a condition as a result of a mental disorder that specialty mental health services can correct or ameliorate.

Authorized by (Printed Name/License): _____ **Date:** _____

Signature: _____ **Authorizer's Phone Number:** _____

Appendix E
Interface With Physical Health Care

Coordination with Primary Care Physicians and Behavioral Health Services

Coordination of care between behavioral health care providers and health care providers is necessary to optimize the overall health of a client. Behavioral Health Services (BHS) values and expects coordination of care with health care providers, linkage of clients to medical homes, acquisition of primary care provider (PCP) information and the entry of all information into the client's behavioral health record. With healthcare reform, BHS providers shall further strengthen integration efforts by improving care coordination with primary care providers. Requesting client/guardian authorization to exchange information with primary care providers is mandatory, and upon authorization, communicating with primary care providers is required. County providers shall utilize the *Coordination and/or Referral of Physical & Behavioral Health Form & Update Form*, while contracted providers may obtain legal counsel to determine the format to exchange the required information. *This requirement is effective immediately and County QI staff and/or COTR will audit to this standard beginning FY 13-14*.

For all clients:

Coordination and/or Referral of Physical & Behavioral Health Form:

- Obtain written consent from the client/guardian on the *Coordination and/or Referral of Physical & Behavioral Health Form*/ contractor identified form at intake, but no later than 30 days of episode opening.
- For clients that do not have a PCP, provider shall connect them to a medical home. Contractor will initiate the process by completing the *Coordination and/or Referral of Physical & Behavioral Health Form* /contractor form and sending it to the PCP within 30 days of episode opening. It is critical to have the specific name of the treating physician.
- Users of the form shall check the appropriate box at the top of the *Coordination and/or Referral of Physical & Behavioral Health Form* /contractor form noting if this is a referral for physical healthcare, a referral for physical healthcare and medication management, a referral for total healthcare, or coordination of care notification only. If it is a referral for physical healthcare, or physical healthcare and medication management, type in your program name in the blank, and select appropriate program type.

Coordination of Physical and Behavioral Health Update Form:

- Update and send the *Coordination of Physical and Behavioral Health Update Form* /contractor form if there are significant changes like an addition, change or discontinuation of a medication.
- Notify the PCP when the client is discharged from services by sending the *Coordination of Physical and Behavioral Health Update Form* /contractor form. The form shall be completed prior to completion of a discharge summary.

Tracking Reminders:

- Users of the form shall have a system in place to track the expiration date of the authorization to release/exchange information.
- Users of the form shall have a system in place to track and adhere to any written revocation for authorization to release/exchange information.
- Users of the form shall have a system in place to track and discontinue release/exchange of information upon termination of treatment relationship. Upon termination of treatment the provider may only communicate the conclusion of treatment, but not the reason for termination.

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Coordination and/or Referral of Physical & Behavioral Health Form

☐ Referral for *physical* healthcare – [Program Name] will continue to provide specialty behavioral health services
☐ Mental Health ☐ Alcohol and Drug

☐ Referral for *physical* healthcare & Medication Management – [Program Name] will continue to provide limited specialty behavioral health services
☐ Mental Health ☐ Alcohol and Drug

☐ Referral for *total* healthcare – [Program Name] is no longer providing specialty behavioral health services. Available for psychiatric consult.

☐ Coordination of care notification only.

Section A: CLIENT INFORMATION

Client Name: Last First Middle Initial	AKA	☐ Male ☐ Female
Street Address	Date of Birth	
City	Telephone #	
Zip	Alternate Telephone #	

Section B: BEHAVIORAL HEALTH PROVIDER INFORMATION

Name of Treatment Provider:	Name of Treating Psychiatrist (If applicable)
Agency/Program	
Street Address	City, State, Zip
Telephone #	Specific provider secure fax # or secure email address:
Date of Initial Assessment:	
Focus of Treatment (*Use Additional Progress Note if Needed*)	
Case Manager/ Mental Health Clinician/ Alcohol and Drug Counselor/ Program Manager:	Behavioral Health Nurse: Phone #:

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Date Last Seen	Mental Health Diagnoses: Alcohol and Drug Related Diagnoses:
Current Mental and Physical Health Symptoms (*Use Additional Progress Note if Needed*)	
Current Mental Health and Non-Psychiatric Medication and Doses (*Use Additional Medication/Progress Note if Needed*)	
Last Psychiatric Hospitalization Date:	None

Section C: PRIMARY CARE PHYSICIAN INFORMATION

Provider's Name	
Organization OR Medical Group	
Street Address	
City, State, Zip	
Telephone #:	Specific provider secure fax # or secure email address:

Section D: FOR PRIMARY CARE PHYSICIAN COMPLETION ACCEPTED FOR TREATMENT OR REFERRED BACK TO SDCBHS PROGRAM (PLEASE COMPLETE THE FOLLOWING INFORMATION AND RETURN TO BEHAVIORAL HEALTH PROVIDER WITHIN TWO WEEKS OF RECEIPT)

☐ Coordination of Care notification received.

If this is a primary care referral, please indicate appropriate response below:

1. ☐ Patient accepted for physical health treatment only
2. ☐ Patient accepted for physical healthcare and psychotropic medication treatment while additional services continue with behavioral health program
3. ☐ Patient accepted for total healthcare including psychotropic medication treatment
4. ☐ Patient not accepted for psychotropic medication treatment and referred back due to:

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Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Photocopy or Fax:
I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section164.524.

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:	DATE:

Client Name (*Please type or print clearly*)
Last: First: Middle:

IF SIGNED BY LEGAL REPRESENTATIVE, PRINT NAME:	RELATIONSHIP OF INDIVIDUAL:

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed, or 60 days after termination of treatment.

☐ Information Contained on this form	☐ Discharge Reports/Summaries
☐ Current Medication & Treatment Plan	☐ Laboratory/Diagnostics Test Results
☐ Substance Dependence Assessments	☐ Medical History
☐ Assessment /Evaluation Report	☐ Other _____

The above signed authorizes the behavioral health practitioner and the physical health practitioner to release the medical records and Information/updates concerning the patient. The purpose of such a release is to allow for coordination of care, which enhances quality and reduces the risk of duplication of tests and medication interactions. Refusal to provide consent could impair effective coordination of care.

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I would like a copy of this authorization ◯Yes ◯No
Clients/Guardians Initials

➔Please place a copy of this Form in your client's chart

TO REACH A PLAN REPRESENTATIVE

Care1st Health Plan	Community Health Group	Health Net	Kaiser Permanente	Molina Healthcare	Access &Crisis Line
(800) 605-2556	(800) 404-3332	(800) 675-6110	(800) 464-4000	(888) 665-4621	(888) 724-7240

COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY

Date Release of Information Signed:

COORDINATION OF PHYSICAL AND BEHAVIORAL HEALTH UPDATE FORM

CLIENT NAME		
Last First Middle		
Date of Birth	☐ Male	☐ Female
BEHAVIORAL HEALTH UPDATE	Date:	
Treating Provider Name	Phone	FAX
Treating Psychiatrist Name (If applicable)	Phone	FAX
☐ Medications prescribed on _____ Date ☐ Medications changed on _____ Date ☐ Medications discontinued on _____ Date	Name/Dosage:_____ Name/Dosage:_____ Name/Dosage:_____	
☐ Medications prescribed on _____ Date ☐ Medications changed on _____ Date ☐ Medications discontinued on _____ Date	Name/Dosage:_____ Name/Dosage:_____ Name/Dosage:_____	
☐ Diagnosis Update :		
☐ Key Information Update:		
☐ Discharge from Treatment Date:		
☐ Follow-up Recommendations:		
PRIMARY CARE PHYSICIAN UPDATE		
Please provide any relevant Update/Change to Patient's Physical Health Status.		

COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY

Live Well, San Diego!

Healthy San Diego Health Plan Contact Information

	Care1st Health Plan	Community Health Group	Health Net	Kaiser Permanente	Molina Healthcare
Member Services	1-800-605-2556	1-800-224-7766	1-800-675-6110	1-800-464-4000	1-888-665-4621
24-Hour Telephone Advice Line	1-800-605-2556	1-800-647-6966	1-800-675-6110	1-800-290-5000	1-800-357-0163
Pharmacy Line *(formulary available online)*	1-800-605-2556 www.care1st.com	1-800-224-7766 www.chgsd.com	1-800-867-6564 www.healthnet.com	1-800-290-5000 www.kp.org	1-888-665-4621 www.molinahealthcare.com
Transportation	1-800-605-2556	1-800-224-7766	1-800-675-6110	1-800-290-5000	1-888-665-4621
Language Assistance Services	1-800-605-2556 TTY:1-800-735-2929	1-800-224-7766	1-800-675-6110 Hearing & Speech Impairment: 1-800-431-0964	1-800-290-5000 TTY: 1-619-528-5138	1-888-665-4621
Access & Crisis Line 7 days a week & 24 hours a day: 1-888-724-7240					

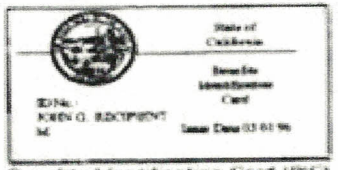
Care1st HEALTH PLAN Community Health Group Health Net COMMUNITY SOLUTIONS KAISER PERMANENTE® MOLINA HEALTHCARE

HEALTHY SAN DIEGO

Plan Partner Identification for Pharmacies†

Step 1 - State

If patient has this (BIC) CARD:



Benefits Identification Card (BIC)

Step 1, please inquire if the patient has one of the other Plan Partner cards.
Step 2, if not, use your Point of Service (POS) Swipe Card Box for Plan Partner, Provider identification, and Member eligibility verification,
or call AEVS at 800-456-2387 or 800-786-4346. Your PIN# _____

Note: To obtain a POS device, please contact your pharmacy affiliation (Chain, PSAO).

Drug Carve-Out List

The drugs listed below should be submitted to Electronic Data System (EDS) Medi-Cal Fee-For-Service (FFS).

HIV/AIDS Drugs:

Abacavir Sulfate	Emtricitabine	Lopinavir/Ritonavir	Stavudine
Amprenavir	Indinavir Sulfate	Nelfinavir Mesylate	Tenofovir Disoproxil Fumarate
Atazanavir	Lamivudine	Nevirapine	Zidovudine/Lamivudine
Delavirdine Mesylate	Lexiva	Ritonavir	Zidovudine/Lamivudine/Abacavir
Efavirenz	Lopinavir	Saquinavir	
		Saquinavir Mesylate	

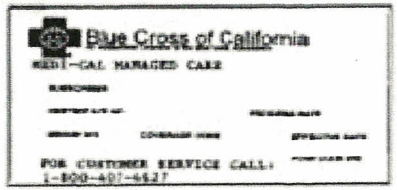
Anti-Psychotic Drugs:

Amantadine HCL	Fluphenazine HCL	Mesoridazine Mesylate	Thioridazine HCL
Aripiprazole	Haloperidol	Molindone HCL	Thiothixene
Benztropine Mesylate	Haloperidol Decanoate	Olanzapine	Thiothixene HCL
*Biperiden HCL	Haloperidol Lactate	Perphenazine	*Tranylcypromine Sulfate
*Biperiden Lactate	*Isocarboxazid	*Phenelzine Sulfate	Trifluoperazine HCL
Chlorpromazine HCL	Lithium Carbonate Caps	*Pimozide	*Trifluopromazine HCL
Chlorprothixene	Lithium Carbonate Tabs/CR	Proclyclidine HCL	Trihexyphenidyl
Clozapine	Lithium Citrate Syrup	*Promazine HCL	Ziprasidone
Fluphenazine Decanoate	*Loxapine HCL	Quetiapine	Ziprasidone Mesylate
Fluphenazine Enanthate	*Loxapine Succinate	Risperidone	

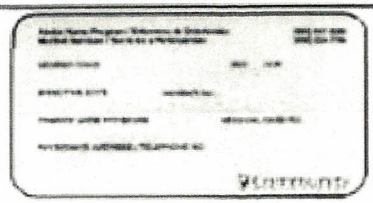
*Indicates medications which require a TAR (treatment authorization request)

† *Document adapted courtesy the L.A. Care Health Plan*

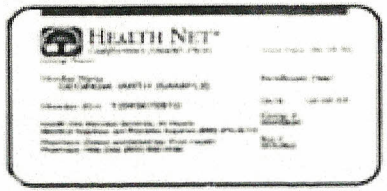
Step 2 - Plan Information



PBM:Wellpoint	800-700-2541
Eligibility:	800-962-7378
Prior Auth. Fax:	888-831-2243
CCU:	800-407-4627
Member ID:	Client Identification # (CIN)



PBM:MedImpact:	800-788-2949
Eligibility:	800-854-0208
Prior Auth. Phone:	800-788-2949
Prior Auth. Fax:	800-578-9732
Member ID:	Social Security #

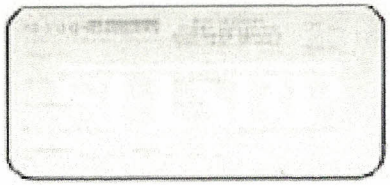


PBM:HNPS
(Health Net Pharmaceutical Services)

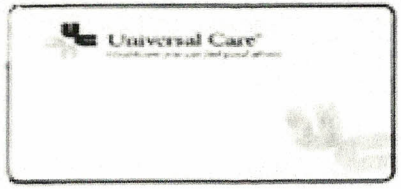
Eligibility:	800-554-1444 #1
Prior Auth. Phone:	800-867-6564
Prior Auth. Fax:	800-977-8226
Member ID:	Social Security #

PBM: Kaiser Pharmacy Services

	800-464-4000
Eligibility:	800-464-4000
Medi-Cal Program:	619-528-5282
Member ID:	Medical Record #



PBM:RxAmerica	800-770-8014
Eligibility:	800-359-2002
Prior Auth. Phone:	619-228-2400
Prior Auth. Fax:	619-228-2448
Member ID:	Social Security #



PBM:MedImpact	800-788-2949
Eligibility:	800-673-4666
Prior Auth. Phone:	800-673-4666
Prior Auth. Fax:	562-981-5808
Member ID:	Social Security#

التنسيق مع أطباء الرعاية الصحية الأولية والخدمات الصحية السلوكية

تنسيق الرعاية بين مزودي الرعاية الصحية السلوكية ومزودي الرعاية الصحية أمر ضروري لتحسين الصحة العامة للعميل. وتقدر الخدمات الصحية السلوكية (BHS) وتتوقع تنسيق الرعاية مع مزودي الرعاية الصحية، حلقة الوصل بين العملاء ودور العلاج، معلومات الحصول على مزود رعاية صحية أولية (PCP)، وإدخال كل المعلومات إلى سجل الصحة السلوكية للعميل. ومع إصلاحات الرعاية الصحية، سيعزز مزودو الخدمات الصحية السلوكية تكامل الجهود من خلال تحسين تنسيق الرعاية مع مزودي الرعاية الصحية الأولية. طلب تصريح العميل/الوصي القانوني لتبادل المعلومات مع مزودي الرعاية الصحية الأولية أمر إلزامي، وحال الحصول على التصريح، يصبح التواصل مع مزودي الرعاية الصحية الأولية أمرًا مطلوبًا. **سيستخدم مزودو المقاطعة *نموذج التنسيق و/أو التحويل الصحي البدني والسلوكي ونموذج التحديث*، في حين يمكن للمزودين المُتعاقد معهم الحصول على مستشار قانوني لتحديد صيغة تبادل المعلومات المطلوبة.**

يسري نفاذ هذا المتطلب فورًا وسيقوم موظفو المقاطعة لتحسين الجودة و/أو COTR بتدقيق هذا المعيار بدءًا من السنة المالية 13-14.

لكافة العملاء:

نموذج التنسيق و/أو التحويل الصحي البدني والسلوكي:

- احصل على موافقة كتابية من العميل/الوصي القانوني على نموذج التنسيق و/أو التحويل الصحي البدني والسلوكي/نموذج تحديد المتعاقد عند قبول العميل، ولكن في فترة لا تتجاوز 30 يومًا من بدء الواقعة.
- للعملاء الذين ليس لديهم مزود رعاية صحية أولية، سيصلهم المزود مع دار علاج. سيبدأ المتعاقد العملية عبر تعبئة *نموذج التنسيق و/أو التحويل الصحي البدني والسلوكي/نموذج المتعاقد* وإرسالها إلى مزود رعاية صحية أولية خلال 30 يومًا من episode opening. ومن الضروري أن يكون هناك اسم محدد للطبيب المعالج.
- سيضع مستخدمو النموذج علامة في المربع الملائم في بداية *نموذج التنسيق و/أو التحويل الصحي البدني والسلوكي/نموذج المتعاقد* والذي يشير إلى ما إذا كان هذا تحويلة لرعاية صحية بدنية، أو تحويلة لرعاية صحية بدنية وإدارة دواء، أو تحويلة لرعاية صحية كاملة، أو إشعار تنسيق للرعاية فقط. وإذا كانت تحويلة للرعاية الصحية البدنية، أو للرعاية الصحية البدنية وإدارة دواء، دوّن اسم برنامجك في الفراغ، وحدد نوع البرنامج الملائم.

نموذج تنسيق تحديث الرعاية الصحية البدنية والسلوكية:

- حدّث وأرسل *نموذج تنسيق تحديث الرعاية الصحية البدنية والسلوكية/*نموذج المتعاقد إذا كانت هناك تغيرات هامة كإضافة، أو تغيير أو توقف عن دواء.
- أبلغ مزود الرعاية الصحية الأولية عند صرف العميل من الخدمات من خلال إرسال *نموذج تنسيق تحديث الرعاية الصحية البدنية والسلوكية/*نموذج المتعاقد. تتم تعبئة النموذج قبل إتمام ملخص الصرف.

تعقب التذكيرات:

- سيكون لمستخدمي النموذج نظام موضوع لتعقب تاريخ انتهاء صلاحية التصريح بالإفصاح عن/تبادل المعلومات.
- سيكون لمستخدمي النموذج نظام موضوع لتعقب والالتزام بأي إلغاء تصريح كتابي للإفصاح عن/تبادل المعلومات.
- سيكون لمستخدمي النموذج نظام موضوع لتعقب وإيقاف نفاذ الإفصاح عن/مشاركة المعلومات حال إلغاء علاقة العلاج. وعند إلغاء العلاج، يمكن للمزود أن يسلّم فقط نتيجة العلاج، ولكن ليس سبب الإلغاء.

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نموذج تنسيق و/أو تحويل الرعاية الصحية البدنية والسلوكية

◯ التحويل لرعاية صحية *بدنية* –[ ] سيستمر بتوفير خدمات صحية سلوكية متخصصة
☐ الصحة النفسية ☐ الكحول والمخدرات

◯ التحويل لرعاية صحية *بدنية* وإدارة دواء –[ ] سيستمر بتوفير خدمات صحية سلوكية محدودة التخصص
☐ الصحة النفسية ☐ الكحول والمخدرات

◯ التحويل لرعاية صحية *كاملة* –[ ] ما عاد يوفر خدمات صحية سلوكية متخصصة. متاح للاستشارة النفسية.

◯ إشعار تنسيق رعاية فقط

القسم أ: معلومات العميل		
اسم العميل: الأسرة الأول الأب	اسم الشهرة	◯ ذكر ◉ أنثى
العنوان	تاريخ الميلاد	
المدينة	رقم الهاتف	
الرمز البريدي	رقم الهاتف البديل	

القسم ب: معلومات مزود الرعاية الصحية السلوكية	
اسم مزود العلاج:	اسم الطبيب المعالج (إن وجد)
الوكالة/البرنامج	
العنوان	المدينة، الولاية، الرمز البريدي
رقم الهاتف	رقم الفاكس الآمن أو البريد الإلكتروني الآمن للمزود المحدد:
تاريخ التقييم المبدئي:	
محور العلاج *(استخدم ملاحظة تقدم الحالة الإضافية إن لزم الأمر)*	
مدير الحالة/ طبيب الصحة النفسية/ مستشار الكحول والمخدرات/ مدير البرنامج:	ممرضة الرعاية الصحية السلوكية: رقم الهاتف:

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تاريخ آخر مقابلة	تشخيصات الصحة النفسية: التشخيصات المتعلقة بالكحول والمخدرات:
الأعراض الصحية الحالية النفسية والبدنية *(استخدم ملاحظة تقدم الحالة الإضافية إن لزم الأمر)*	
أدوية وجرعات الصحة النفسية غير التحليلية الحالية *(استخدم ملاحظة الأدوية/تقدم الحالة الإضافية إن لزم الأمر)*	
آخر إدخال نفسي للمستشفى ◯ التاريخ: ◯ لا يوجد	

القسم ج: معلومات طبيب الرعاية الصحية الأولية

اسم المزود	
المنظمة أو المجموعة الطبية	
العنوان	
المدينة، الولاية، الرمز البريدي	
رقم الهاتف:	رقم الفاكس الآمن أو البريد الإلكتروني الآمن للمزود المحدد:

القسم د: لتعبئته من قبل طبيب الرعاية الصحية الأولية المقبول للعلاج أو المحول منه إلى برنامج خدمات الرعاية الصحية السلوكية لمقاطعة سان دييغو (يرجى تعبئة المعلومات التالية وإعادتها إلى مزود الرعاية الصحية السلوكية خلال أسبوعين من الاستلام)

☐ تم استلام إشعار تنسيق الرعاية.
إذا كان هذا تحويل من الرعاية الأولية، فيرجى الإشارة إلى الإجابة الملائمة أدناه:

1. ◯ تم قبول المريض لعلاج الرعاية الصحية البدنية فقط
2. ◯ تم قبول المريض للرعاية الصحية البدنية والعلاج الدوائي النفسي مع استمرار خدمات إضافية مع برنامج الصحة السلوكية
3. ◯ تم قبول المريض للرعاية الصحية الكاملة ومن ضمنها العلاج النفسي الدوائي
4. ◯ لم يتم قبول المريض للعلاج الدوائي النفسي وتم تحويله بسبب:

معلومات حساسة: إنني أفهم أن المعلومات في سجلي قد تشمل معلومات تتعلق بالأمراض التي تنتقل عن طريق الاتصال الجنسي، متلازمة نقص المناعة المكتسب (الإيدز)، أو الإصابة بفيروس نقص المناعة البشرية (HIV). وأنها قد تشمل أيضًا معلومات حول خدمات الصحة النفسية أو العلاج من إدمان الكحول أو المخدرات.

الحق في الإلغاء: إنني أفهم أن لدي الحق في إلغاء هذا التصريح في أي وقت. وأفهم أنني في حال ألغيت التصريح فيجب أن أقوم بذلك كتابيًا. وأفهم أن الإلغاء لن ينطبق على المعلومات التي تم الإفصاح عنها بالفعل بناءً على هذا التصريح.

التصوير أو الإرسال بالفاكس:
أنا أوافق على أن تعتبر صورة من هذا التصريح يتم تصويرها أو إرسالها عبر الفاكس نافذة المفعول كالنسخة الأصلية.

إعادة الإفصاح: إذا سمحت بالإفصاح عن معلوماتي الصحي لشخص غير مطالب قانونًا بالاحتفاظ بها سرية، فإنني أفهم أنه قد يُعاد الإفصاح عنها وأنها لن تصبح محمية بعد ذلك. يمنع قانون كاليفورنيا بشكل عام مستلمي معلوماتي الصحية من إعادة الإفصاح عن تلك المعلومات إلا بإذن كتابي مني أو حسب ما يتطلبه أو يسمح به القانون تحديدًا.

الحقوق الأخرى: إنني أفهم أن السماح بالإفصاح عن هذه المعلومات الصحية أمر طوعي. وأن بإمكاني رفض توقيع هذا التصريح. وأنني لا أحتاج إلى التوقيع على هذا النموذج لضمان تلقي العلاج. وأنني أفهم أن باستطاعتي معاينة المعلومات التي ستُستخدم أو يتم الإفصاح عنها والحصول على نسخة منها، وذلك طبقًا للبند 45 من قانون اللوائح الفيدرالية، القسم 164.524.

توقيع الفرد أو الممثل القانوني

التاريخ:	التوقيع:

اسم العميل *(يرجى كتابته أو طباعته بوضوح)*
اسم العائلة: **الاسم الأول:** **اسم الأب:**

صلة القرابة للفرد:	إن قام الممثل القانوني بالتوقيع، يرجى طباعة الاسم:

انتهاء الصلاحية: ما لم يتم إلغاؤه بصورة أخرى، فإن هذا التصريح تنتهي صلاحيته في التاريخ أو الحالة أو الوضع التالي:

_____

إذا لم أحدد تاريخ انتهاء صلاحية، أو حالة أو وضعًا، فستنتهي صلاحية هذا التصريح خلال عام واحد (1) من تاريخ توقيعه، أو بعد 60 يومًا من إنهاء العلاج.

☐ تقارير/ملخصات الصرف	☐ المعلومات المضمنة على هذا النموذج
☐ نتائج فحوصات المختبر/التشخيص	☐ الدواء وخطة العلاج الحاليين
☐ التاريخ الطبي	☐ تقييمات الإدمان
☐ غير ذلك _____	☐ تقرير التقييم/التقدير

الموقع عليه أعلاه يسمح لطبيب الرعاية الصحية السلوكية وطبيب الرعاية الصحية البدنية بالإفصاح عن السجلات الطبية والمعلومات/التحديثات الخاصة بالمريض. الهدف من هذا الإفصاح هو السماح بتنسيق الرعاية، وهو ما يزيد من الجودة ويقلل من خطر ازدواجية الفحوص وتداخلات الأدوية. يمكن لرفض منح الموافقة أن يعيق التنسيق الفعال للرعاية.

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أود الحصول على نسخة من هذا التصريح ◯ نعم ◯ لا الحروف الأولى من اسم العملاء/الأوصياء
ك يرجى وضع نسخة من هذا النموذج في ملف العميل
للوصول إلى ممثل خطة

Care1st Health Plan	Community Health Group	Health Net	Kaiser Permanente	Molina Healthcare	Access &Crisis Line
(800) 605-2556	(800) 404-3332	(800) 675-6110	(800) 464-4000	(888) 665-4621	(888) 724-7240

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تاريخ التوقيع على الإفصاح عن المعلومات:

نموذج تحديث تنسيق الرعاية الصحية البدنية والسلوكية

اسم العميل		
اسم العائلة Program Name	**الاسم الأول** Program Name	**اسم الأب** Program Name
تاريخ الميلاد	ذكر	أنثى
تحديث الرعاية الصحية السلوكية	التاريخ:	
اسم المزود العلاجي	هاتف	فاكس
اسم الطبيب النفسي المعالج (إن وجد)	هاتف	فاكس
☐ تم وصف الأدوية في _____ التاريخ	الاسم/الجرعة: _____	
☐ تم تغيير الأدوية في _____ التاريخ	الاسم/الجرعة: _____	
☐ تم إيقاف الأدوية في _____ التاريخ	الاسم/الجرعة: _____	
☐ تم وصف الأدوية في _____ التاريخ	الاسم/الجرعة: _____	
☐ تم تغيير الأدوية في _____ التاريخ	الاسم/الجرعة: _____	
☐ تم إيقاف الأدوية في _____ التاريخ	الاسم/الجرعة: _____	
☐ تحديث التشخيص:		
☐ تحديث المعلومات الرئيسية:		
☐ تاريخ الصرف من العلاج:		
☐ توصيات المتابعة:		
تحديث طبيب الرعاية الصحية الأولية		
يرجى ذكر أي تحديث/تغير ذي صلة بالحالة الصحة البدنية للمريض.		

HSD/PBH_CoC Form: Revised 032007-dbsrn HHSA BHS Revision 5-16-13

LIVE WELL SAN DIEGO

Coordinación con los servicios médicos de atención primaria y de salud del comportamiento

La coordinación de atención entre los profesionales de atención de salud del comportamiento y los profesionales de atención de salud es necesaria para optimizar la salud en general de un cliente. Los Servicios de Salud del Comportamiento (BHS, Behavioral Health Services) valoran y anticipan la coordinación de atención con los profesionales de atención de salud, el nexo de los clientes con sus centros médicos permanentes, la adquisición de información del profesional de atención primaria (PCP, primary care provider) y la captura de toda la información en el expediente de salud del comportamiento del cliente. Con la reforma de atención de salud, los profesionales de BHS deberán adicionalmente fortalecer los esfuerzos de integración al mejorar la coordinación de atención con los profesionales de atención primaria. Es obligatorio solicitar la autorización del cliente o del tutor legal para intercambiar información con los profesionales de atención primaria, y al recibir la autorización, es necesario comunicarse con los profesionales de atención primaria. **Los profesionales del Condado deberán utilizar el *Formulario de coordinación y/o derivaciones de salud física y del comportamiento* y el *Formulario actualizado*, mientras que los profesionales contactados pueden obtener asesoría legal para determinar el formato para intercambiar la información requerida.**
Este requisito tiene una vigencia inmediata y el personal QI y COTR del condado realizará auditorias de acuerdo con esta norma a partir del año fiscal 2013-2014.

Para todos los clientes:

Formulario de coordinación y/o derivación de salud física y del comportamiento:

- Obtener el consentimiento escrito del cliente/tutor en el *Formulario de coordinación y/o derivación de salud física y del comportamiento /* formulario del contratista identificado durante la admisión, en un máximo de 30 días después de la apertura del episodio.

- Para los clientes que no tienen un PCP, el profesional deberá ponerse en contacto con ellos en un centro médico permanente. El contratista iniciará el proceso al llenar el *Formulario de coordinación y/o derivación de salud física y del comportamiento* /el formulario del contratista y enviándolo al PCP dentro de los siguientes 30 días de la apertura del episodio. Es muy importante contar con el nombre específico del médico tratante.

- Los usuario del formulario deberán marcar el casillero correspondiente en la parte superior del *Formulario de coordinación y/o derivación de salud física y del comportamiento* / formulario del contratista, indicando si se trata de una derivación para atención física; una derivación para atención física y administración de medicamento; una derivación para atención de salud total; o solamente una notificación de coordinación de atención. Si se trata de una derivación para atención de salud física o atención de salud física y administración de medicamentos, escriba el nombre de su programa en el espacio en blanco y seleccione el tipo de programa apropiado.

Formulario actualizado de coordinación de salud física y del comportamiento:

- Actualice y envíe el *Formulario actualizado de coordinación de salud física y del comportamiento* / formulario del contratista si existen cambios importantes como una adición, un cambio o una suspensión de medicamento.

- Notifique al PCP cuando el cliente se dé de alta de los servicios al enviar el *Formulario actualizado de coordinación de salud física y del comportamiento*/ formulario del contratista. Debe llenar el formulario antes de terminar con el resumen de alta.

Recordatorios de seguimiento:

- Los usuarios del formulario deberán contar con un sistema establecido para darle seguimiento a la fecha de autorización para liberar/intercambiar información.
- Los usuarios del formulario deberán contar con un sistema establecido para darle seguimiento y adherirse a cualquier revocación de la autorización para liberar/intercambiar información.
- Los usuarios del formulario deberán contar con un sistema establecido para darle seguimiento y descontinuar la liberación/intercambio de información al culminar la relación de tratamiento. Al culminar el tratamiento el profesional solamente podrá comunicar la conclusión del tratamiento sin embargo no podrá dar la razón de la conclusión.

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Formulario de coordinación y/o derivación de salud física y del comportamiento

☐ Derivación para atención de salud *física* – [ ] continuará proporcionando servicios especiales de salud del comportamiento

☐ Salud mental ☐ Alcohol y drogas

☐ Derivación para atención de salud *física* y administración de medicamento – [ ] continuará proporcionando servicios especiales limitados de salud del comportamiento

☐ Salud mental ☐ Alcohol y drogas

☐ Derivación para atención de salud *total* – [Program Name] ya no se proporcionarán servicios especiales de salud del comportamiento. Disponible para consulta psiquiátrica.

☐ Solamente para notificación de coordinación de atención.

Sección A: INFORMACIÓN DEL CLIENTE

Nombre del cliente: Apellido Nombre Inicial segundo nombre	Alias	☐ Hombre ☐ Mujer
Domicilio	Fecha de nacimiento	
Ciudad	No. de teléfono	
Código postal	No. de teléfono alternativo	

Sección B: INFORMACIÓN DEL PROFESIONAL DE SALUD DEL COMPORTAMIENTO

Nombre del profesional de tratamiento:	Nombre del psiquiatra tratante (si corresponde)
Agencia/Programa	
Domicilio	Ciudad, estado, código postal
No. de teléfono	No. de fax seguro del profesional específico o dirección segura de correo electrónico:
Fecha de evaluación inicial:	
Enfoque del tratamiento (*Use una nota adicional de progreso si es necesario*)	
Gerente del caso/ Clínico de salud mental/ Consejero de alcohol y drogas/ Gerente del programa:	Enfermera de salud del comportamiento: Teléfono:

Fecha en que vio por última vez	Diagnóstico de salud mental: Diagnóstico relacionado con alcohol y drogas:
Síntomas actuales de salud mental y física (*Use notas de progreso adicionales si es necesario*)	
Salud mental actual y medicamento y dosis no psiquiátricas *(Use notas de medicamento adicional y progreso si es necesario)*	
Ultima hospitalización psiquiátrica Fecha:	Ninguna

Sección C: INFORMACIÓN DEL MÉDICO DE ATENCIÓN PRIMARIA

Nombre del profesional	
Organización O grupo médico	
Domicilio	
Ciudad, estado, código postal	
No. teléfono:	No. fax seguro del profesional específico o dirección segura de correo electrónico:

Sección D: A RELLENAR POR EL MÉDICO DE ATENCIÓN PRIMARIA ACEPTADO PARA TRATAMIENTO O DERIVADO DE REGRESO AL PROGRAMA SDCBHS (LLENE POR FAVOR LA SIGUIENTE INFORMACIÓN Y REGRÉSELA AL PROFESIONAL DE SALUD DEL COMPORTAMIENTO DENTRO DE DOS SEMANAS AL ACUSE DE RECIBO)

☐ Notificación de coordinación de atención recibida.

Si esta es una derivación de atención primaria, indique por favor la respuesta apropiada a continuación:

1. ☐ Paciente aceptado solo para tratamiento de salud física.
2. ☐ Paciente aceptado para atención física y tratamiento con medicamento psicotrópico mientras que los servicios adicionales continúan con el programa de salud del comportamiento.
3. ☐ Paciente aceptado para atención física total incluyendo tratamiento con medicamento psicotrópico.

4. ☐ Paciente no aceptado para tratamiento con medicamento psicotrópico y derivado de nuevo debido a:

Información confidencial: Comprendo que la información en mi expediente puede incluir información relacionada con enfermedades transmitidas sexualmente, síndrome de inmunodeficiencia adquirida (SIDA) o infección con el virus de inmunodeficiencia humana (VIH). También puede incluir información sobre servicios de salud mental o tratamiento contra el abuso de alcohol y drogas.

Derecho a la revocación: Entiendo que tengo el derecho a revocar esta autorización en cualquier momento. Entiendo que si revoco esta autorización lo debo hacer por escrito. Entiendo que la revocación no se aplicará a la información que ya ha sido divulgada con base a esta autorización.

Copia o fax:
Estoy de acuerdo en que una copia o un fax de esta autorización tendrá el mismo efecto que el documento original.

Divulgación por terceros: Si yo he autorizado la divulgación de mi información de salud a alguien que no está legalmente obligado a mantenerla con carácter confidencial, comprendo que se puede divulgar a terceros y ya no será información protegida. La ley de California prohíbe que los receptores de mi información de salud divulguen a terceros dicha información a excepción de que cuenten con mi autorización escrita o al ser específicamente requerido o permitido por ley.

Otros derechos: Entiendo que la autorización de divulgación de esta información de salud es voluntaria. Yo me puedo negar a firmar esta autorización. Yo no necesito firmar este formulario para asegurar el tratamiento. Entiendo que puedo inspeccionar u obtener una copia de la información que se usará o divulgará, como lo establece la sección 164.524 del código 45 de las Regulaciones Federales.

FIRMA DEL INDIVIDUO O REPRESENTANTE LEGAL

FIRMA:	FECHA:

Nombre del cliente (imprima o escriba claramente)
Apellido: **Nombre:** **Segundo nombre:**

SI LA FIRMA EL REPRESENTANTE LEGAL, ESCRIBA EL NOMBRE:	RELACIÓN CON EL INDIVIDUO:

Vencimiento: A menos que se revoque, esta autorización vencerá en la siguiente fecha, evento o padecimiento:

_____

Si no se especifica una fecha de vencimiento, evento o padecimiento, esta autorización se vencerá en un (1) año calendario a partir de la fecha en que se firmó, o 60 días después de la culminación del tratamiento.

☐ Información incluida en este formulario	☐ Informes/resumes de alta
☐ Medicamento y plan de tratamiento actual	☐ Resultados de pruebas de laboratorio/diagnóstico
☐ Valoraciones de dependencia a sustancias	☐ Historial médico
☐ Informe de valoraciones /evaluación	☐ Otro _____

La persona que firmó arriba autoriza al profesional de salud del comportamiento y al profesional de salud física a que libere los expedientes médicos y la información/actualizaciones relacionadas con el paciente. El propósito de dicha liberación es para permitir la coordinación de atención, lo cual mejora la calidad y reduce el riesgo de duplicación de pruebas e interacciones de medicamento. Negarse a proporcionar el consentimiento podría afectar la coordinación eficaz de atención.

Me gustaría contar con una copia de esta autorización ◯ Sí ◯ No
Iniciales de los clientes/tutores

➔ **Coloque por favor una copia de este formulario en el expediente de su cliente**

PARA CONTACTAR UN REPRESENTATE DEL PLAN

Care1st Health Plan	Community Health Group	Health Net	Kaiser Permanente	Molina Healthcare	Access &Crisis Line
(800) 605-2556	(800) 404-3332	(800) 675-6110	(800) 464-4000	(888) 665-4621	(888) 724-7240

COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY

Fecha en que se firmó la divulgación de información:

FORMULARIO ACTUALIZADO DE COORDINACIÓN DE SALUD FÍSICA Y DEL COMPORTAMIENTO

NOMBRE DEL CLIENTE		
Apellido	Nombre	Segundo nombre
Fecha de nacimiento	◯ Hombre	◯ Mujer
ACTUALIZACIÓN DE SALUD DEL COMPORTAMIENTO	Fecha:	
Nombre del profesional tratante	Teléfono	FAX
Nombre del psiquiatra tratante (si corresponde)	Teléfono	FAX
☐ Medicamentos recetados en _____ Fecha ☐ Medicamentos cambiados en _____ Fecha ☐ Medicamentos descontinuados en _____ Fecha	Nombre/Dosis:_____ Nombre/Dosis:_____ Nombre/Dosis:_____	
☐ Medicamentos recetados en _____ Fecha ☐ Medicamentos cambiados en _____ Fecha ☐ Medicamentos descontinuados en _____ Fecha	Nombre/Dosis:_____ Nombre/Dosis:_____ Nombre/Dosis:_____	
☐ Actualización de diagnóstico :		
☐ Actualización de información clave:		
☐ Fecha de alta del tratamiento:		
☐ Recomendaciones de seguimiento:		

ACTUALIZACIÓN DEL MÉDICO DE ATENCIÓN PRIMARIA

Proporcione por favor cualquier actualización/cambio relevante al estado de salud física del paciente.

Formulario HSD/PBH_CoC: Revisado 032007-dbsrn HHSA BHS Revisión 5-16-13

LIVE WELL SAN DIEGO

Koordinasyon sa pagitan ng Primary Care Physicians at Behavioral Health Services

Ang koordinasyon ng pag-aalaga sa pagitan ng behavioral health care providers at health care providers ay kinakailangan para mapagbuti ang pangkalahatang kalusugan ng kliyente. Mahalaga sa Behavioral Health Services (BHS) at inaasahan nito ang koordinasyon sa pagitan ng health care providers, pati na rin ang pag-uugnay ng mga kliyente sa medical homes, ang pagkuha ng impormasyon tungkol sa primary care provider (PCP) at ang paglagay ng lahat ng impormasyon sa behavioral health record ng kliyente. Sa reporma sa healthcare, ang BHS providers ay lalong magsusumikap tungo sa integrasyon sa pamamagitan ng pagpapabuti ng koordinasyon ng pangangalaga sa pagitan ng mga primary care providers. Ang paghiling ng pahintulot mula sa kliyente/tagapag-alaga para magpalitan ng impormasyon ang mga primary care providers ay ipinag-uutos, at pag nabigay ang pahintulot, ang pakikipag-ugnayan sa mga primary care providers ay kinakailangan. **Dapat gamitin ng County providers ang *Form para sa Koordinasyon at/o Referral ng Pangangalaga sa Kalusugang Pisikal at Pagkilos at Update Form,* habang ang mga kinontratang providers ay maaaring makakuha ng legal na tagapayo o legal counsel para matiyak ang format na gagamitin para magpalitan ng mga kinakailangang impormasyon.**
Ang utos na ito ay magiging epektibo kaagad at ang County QI staff at/o ang COTR ay i-aaudit ang pamantayang ito simula sa taong piskal ng 2013-2014.

Para sa lahat ng mga kliyente:

Form para sa Koordinasyon at/o Referral ng Pangangalaga sa Kalusugang Pisikal at Pagkilos:

- Kumuha ng nakasulat na pahintulot mula sa kliyente/tagapag-alaga sa *Form para sa Koordinasyon at/o Referral ng Pangangalaga sa Kalusugang Pisikal at Pagkilos*/contractor identified form sa intake, pero dapat na hindi lalampas sa 30 araw ng pagbubukas ng episode.

- Para sa mga kliyenteng walang PCP, ikokonekta sila ng provider sa isang medical home. Ang contractor ay sisimulan ang proseso at kukumpletuhin ang *Form para sa Koordinasyon at/o Referral ng Pangangalaga sa Kalusugang Pisikal at Pagkilos* /contractor form, at ipapadala ito sa loob ng 30 araw ng episode ng pagbubukaspagbukas ng episode. Mahalagang magkaroon ng tiyak na pangalan ng tagapaggamot na doktor o treating physician.

- Ang mga gumagamit ng form ay dapat i-check ang naaangkop na kahon sa tuktok ng *Form para sa Koordinasyon at/o Referral ng Pangangalaga sa Kalusugang Pisikal at Pagkilos* /contractor form at dapat ipaalam kung ito ay isang referral para sa pangangalaga sa pisikal na kalusugan, isang referral para sa pangangalaga ng pisikal na kalusugan at pamamahala ng mga gamot, isang referral para sa kabuuang pangangalaga ng kalusugan, o abiso para sa koordinasyon ng pag-aalaga lamang. Kung ito ay isang referral para sa pangangalaga ng pisikal na kalusugan, o para sa pangangalaga ng pisikal na kalusugan at pamamahala ng mga gamot, i-type ang pangalan ng iyong programa sa patlang, at piliin ang naaangkop na uri ng programa.

Update Form para sa Koordinasyon ng Pangangalaga sa Kalusugang Pisikal at Pagkilos:

- I-update ang at ipadala ang *Update Form para sa Koordinasyon ng Pangangalaga sa Kalusugang Pisikal at Pagkilos* /contractor form kung may mga makabuluhang pagbabago tulad ng pagbabago, pagdaragdag, o pagtitigil ng gamot.

- Ipaalam sa PCP kapag tinanggal ang kliyente sa mga serbisyo sa pamamagitan ng pagpapadala ng *Update Form para sa Koordinasyon ng Pangangalaga sa Kalusugang Pisikal at Pagkilos* /contractor form. Ang form ay dapat na makumpleto bago kunpletuhin ang buod ng pagtanggal o discharge summary.

Mga paalala tungkol sa forms:

- Ang mga gagamit ng form ay may sistema para malaman ang expiration date o petsa ng pagtatapos ng pahintulot para magbigay o magpalitan ng impormasyon.
- Ang mga gagamit ng form ay sistema para malaman at sumunod sa anumang nakasulat na pagbawi ng pahintulot para magbigay o pagpalitan magpalitan ng impormasyon.
- Ang mga gagamit ng form ay may sistema malaman at bawiin ang pahintulot para magbigay o magpalitan ng impormasyon kapag nagwakas ang pagpapagamot. Sa pagwawakas ng pagpapagamot, maaari lamang ipag-alam ng provider na nagwakas na ang pagpapagamot, at hindi ang dahilan ng pagwakas.

COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY

Form/at o Referral para sa Koordinasyon ng Pangangalaga sa Kalusugang Pisikal at Pagkilos:

☐ Referral para sa pangangalaga sa kalusugang *pisikal* – *[ ]* ay patuloy na magbibigay ng serbisyong pangkalusugan sa pagkilos ☐ Kalusugang Pangkaisipan ☐ Alcohol at Pinagbabawal na Gamot

☐ Referral para sa pangangalaga sa kalusugang *pisikal* & pamamahala ng mga gamot – *[ ]* ay patuloy na magbibigay ng limitadong serbisyong pangkalusugan sa pagkilos ☐ Kalusugang Pangkaisipan ☐ Pinagbabawal na Gamot

☐ Referral para sa pangangalaga sa *buong* kalusugan *[ ]* ay hindi na magbibigay ng serbisyong pangkalusugan sa pagkilos. Pwedeng gamitin para sa psychiatric na pagkonsulta

☐ Abiso lang para sa koordinasyon ng pag-aalaga.

Seksyon A: IMPORMASYON NG KLIYENTE		
Pangalan ng Kliyente: Apelyido Pangalan Inisyal	AKA	◯ Lalake ◯ Babae
Kalye	Petsa ng kapanganakan	
Lungsod	Telepono #	
Zip	Kahaliling Telepono #	

Seksyon B: IMPORMASYON ng BEHAVIORAL HEALTH PROVIDER	
Pangalan ng Treatment Provider:	Pangalan ng Treating Psychiatrist (kung)
Ahensiya / Programa	
Kalye	Lungsod, Estado, Zip
Telepono #	Secure na fax # o email address ng provider:
Petsa ng unang pagtingin:	
Focus ng pagpapagamot (*Gumamit ng Karagdagang Progress Note kung kailangan*)	
Case Manager / Mental Health Clinician / Alcohol at Drug Counselor / Program Manager:	Behavioral Health Nurse: Telepono #:

HSD / PBH_CoC Form: Binago 032,007-dbsrn HHSA BHS Rebisyon 5-16-13

LIVE WELL SAN DIEGO

Petsa ng Huling Pagtingin	Mga Diagnosis sa Kalusugang Pangkaisipan: Mga Diagnosis ukol sa Alkohol at Pinagbabawal na Gamot::

Kasalukuyang sintomas sa mental at pisikal na kalusugan (*Gumamit ng Karagdagang Progress Note kung kinakailangan*)

Kasalukuyang gamot at dosis na hindi pang-psychiatric, ngunit para sa mental na kalusugan (*Gumamit ng Karagdagang Progress Note kung kinakailangan*)

Huling pagpunta sa ospital dahil sa psychiatric na dahilan

☐ Petsa: ☐ Wala

Seksyon C: IMPORMASYON ng PRIMARY CARE PHYSICIAN

Pangalan ng Provider

Samahan O Medical Group

Kalye

Lungsod, Estado, Zip

Telepono #	Secure na fax # o email address ng provider:

Seksyon D: DAPAT PUNAN NG PRIMARY CARE PHYSICIAN TINANGGAP PARA SA PAGPAPAGAMOT o NAI-REFER ULIT SA PROGRAMANG SDCBHS (ILAGAY ANG MGA SUMUSUNOD NA IMPORMASYON AT IBALIK SA BEHAVIORAL HEALTH PROVIDER SA LOOB NG DALAWANG LINGGO MULA MATANGGAP ITO)

☐ Natanggap ang abiso sa Koordinasyon ng Pangangalaga.
Kung ito ay isang primary care referral, ilagay ang naaangkop na sagot sa ibaba:

1. ☐ Tinanggap ang pasyente para sa pagpapagamot ng pisikal na kalusugan lang
2. ☐ Tinanggap ang pasyente para sa pagpapagamot ng pisikal na kalusugan at psychotropic medication na pagpapagamot habang tuloy ang mga karagdagang serbisyo sa behavioral health program
3. ☐ Tinanggap ang pasyente para sa pangkalahatang pangangalaga sa kalusugan kasama ang psychotropic medication na pagpapagamot
4. ☐ Hindi tinanggap ang pasyente para sa psychotropic medication na pagpapagamot at pinabalik dahil sa:

Sensitibong Impormasyon: Nauunawaan ko na ang impormasyon sa aking record o talaan ay maaaring magsama ng impormasyon na may kaugnayan sa mga sakit na nahahawa sa paraang sekswal o mga sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), o impeksiyong kaugnay ng Human Immunodeficiency Virus (HIV). Maaari rin itong magsama ng impormasyon tungkol sa mga serbisyo sa pagpapagamot para sa alcohol at pinagbabawal na gamot.

Karapatang Bawiin: Nauunawaan kong mayroon akong karapatang bawiin ang pahintulot na ito anumang oras. Nauunawaan ko na kung bawiin ko ang pahintulot na ito, na dapat itong gawin na pasulat. Nauunawaan ko na ang pagbabawi ay hindi nalalapat sa mg aimpormasyon na inilabas na batay sa pahintulot na ito.

Photocopy o Fax:
Sumasang-ayon ako na ang isang photocopy o fax ng mga pahintulot na ito ay kasing-epektibo ng orihinal.

Muling Pagsisiwalat: Kung nagpahintulot ako sa pagsisiwalat ng aking impormasyon sa kalusugan sa isang tao na hindi legal na kinakailangan na panatiliin itong kumpidensyal, nauunawaan kong maaari itong isiwalat ulit at na hindi na ito protektado. Sa pangkalahatan, ang Batas ng California ay ipinagbabawal sa mga tumatanggap ng aking impormasyon sa kalusugan na muling isiwalat ang naturang impormasyon maliban kung may nakasulat na pahintulot mula sa akin o kung partikular na kinakailangan o pinahihintulutan ng batas.

Ibang Karapatan: Nauunawaan ko na ang pahintulot sa pagsisiwalat ng impormasyong ito sa kalusugan ay boluntaryo. Maaari kong tanggihang pirmahan ang pahintulot na ito. Hindi ko kailangang pirmahan ang form na ito para tiyakin ang pagpapagamot. Nauunawaan ko na maaari kong siyasatin o kumuha ng kopya ng impormasyon na gagamitin o isisiwalat, bilang ibinigay sa 45 Code of Federal Regulations section164.524.

PIRMA NG INDIBIDWAL o NG LEGAL REPRESENTATIVE

PIRMA:	PETSA:

Pangalan ng Kliyente (*Paki-type o i-print nang malinaw*)

Apelyido: **Pangalan:** **Gitnang Pangalan:**

KUNG PINIRMAHAN NG LEGAL NA KINATAWAN, ILAGAY ANG PANGALAN:	RELASYON SA INDIBIDWAL:

Pagtatapos: Maliban kung binawi, ang pahintulot na ito ay magtatapos sa mga sumusunod na petsa, kaganapan, o kundisyon: _____ Kung hindi ako maglagay ng petsa ng pagtatapos, kaganapan o kundisyon, ang pahintulot na ito ay mawawalan ng bisa matapos ang isang (1) taon sa kalendaryo mula sa petsang pagpirma nito, o 60 araw pagkatapos ng pagwawakas ng pagpapagamot.

☐ Impormasyon na nasa form na ito	☐ Discharge Reports/Summaries
☐ Kasalukuyang plano sa gamot at pagpapagamot	☐ Test Laboratory / Diagnostic Results
☐ Pagtatasa sa Subtance Dependence	☐ Medical History
☐ Assessment / Evaluation Report	☐ Iba pa _____

Ang nakapirma sa itaas ay nagbibigay ng pahintulot sa behavioral health practitioner at physical health practicioner na isiwalat ang medical records at mga impormasyon/updates tungkol sa pasyente. Ang layunin ng nasabing pagsisiwalat ay para sa koordinasyon ng pag-aalaga, na pinapahusay ang kalidad at binabawasan ang pagdodoble ng mga tests at pagpapagamot. Ang pagtangging magbigay ng pahintulot ay maaaring makapinsala sa epektibong koordinasyon ng pag-aalaga.

Gusto ko ng isang kopya ng awtorisasyon ◯ Oo ◯ Hindi
Inisyal ng kliyente/tagapag-alaga

➔ Ilagay ang kopya ng form na ito sa chart ng iyong kliyente

PARA MAKONTAK ANG PLAN REPRESENTATIVE

Care1st Health Plan	Community Health Group	Health Net	Kaiser Permanente	Molina Healthcare Access & Crisis Line
(800) 605-2556	(800) 404-3332	(800) 675-6110	(800) 464-4000	(888) 665-4621 (888) 724-7240

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Petsa ng pagpirma sa pahintulot na magbigay ng impormasyon Program Name

UPDATE FORM PARA SA KOORDINASYON NG PANGANGALAGA SA KALUSUGANG PISIKAL AT PAGKILOS:

Pangalan ng Kliyente:		
Apelyido Pangalan Inisyal		
Petsa ng kapanganakan	◯ Lalaki	◯ Babae
BEHAVIORAL HEALTH UPDATE	Petsa:	
Pangalan ng Treating Provider	Telepono #:	FAX
Pangalan ng Treating Psychiatrist (Kung naaangkop)	Telepono #:	FAX
☐ Mga gamot na inireseta noong _____ Petsa ☐ Mga gamot na binago noong _____ Petsa ☐ Mga gamot na tinigil noong _____ Petsa	Pangalan / dosis: _____ Pangalan / dosis: _____ Pangalan / dosis: _____	
☐ Mga gamot na inireseta noong _____ Petsa ☐ Mga gamot na binago noong _____ Petsa ☐ Mga gamot na tinigil noong _____ Petsa	Pangalan / dosis: _____ Pangalan / dosis: _____ Pangalan / dosis: _____	
☐ Update ng Diagnosis:		
☐ Update ng Mahahalagang Impormasyon:		
☐ Petsa ng Pagtanggal mula sa Pagpapagamot o Discharge from Treatment:		
☐ Mga rekomendasyon sa follow-up:		
PRIMARY CARE PHYSICIAN UPDATE		
Ibigay ang anumang update /pagbabago sa status ng pisikal na kalusugan ng pasyente.		

HSD / PBH_CoC Form: Binago 032,007-dbsrn HHSA BHS Rebisyon 5-16-13

LIVE WELL SAN DIEGO

Phối Hợp với Các Bác Sĩ Chăm Sóc Chính và Các Dịch Vụ Về Sức Khỏe Hành Vi

Việc phối hợp chăm sóc giữa các nơi chăm sóc sức khỏe hành vi và chăm sóc sức khỏe là điều cần thiết để tối ưu hóa sức khỏe tổng quát của thân chủ. Dịch Vụ Về Sức Khỏe Hành Vi (BHS) quý trọng và mong muốn có sự phối hợp chăm sóc với các nơi chăm sóc sức khỏe, nối kết thân chủ với các nhà y tế, thâu thập các thông tin của nơi chăm sóc chính (PCP) và ghi nhận tất cả mọi thông tin vào hồ sơ sức khỏe hành vi của thân chủ. Với sự cải tổ về chăm sóc sức khỏe, các nơi cung cấp dịch vụ BHS sẽ củng cố thêm những nỗ lực kết hợp bằng cách cải thiện sự phối hợp chăm sóc với các nơi chăm sóc chính. Việc yêu cầu thân chủ/người giám hộ cho phép trao đổi thông tin với các nơi chăm sóc chính là điều bắt buộc phải làm, và khi được phép, thì phải liên lạc với các nơi chăm sóc chính. **Các nơi chăm sóc của Quận sẽ dùng *Mẫu Đơn Phối Hợp và/hoặc Giới Thiệu về Sức Khỏe Thân Thể & Hành Vi & Mẫu Đơn Cập Nhật*, đồng thời các nơi chăm sóc có hợp đồng có thể xin cố vấn pháp lý để xác định hình thức trao đổi những thông tin cần thiết.**
Đòi hỏi này có hiệu lực ngay và ban nhân viên QI của Quận và/hoặc COTR sẽ thanh tra theo tiêu chuẩn này bắt đầu Năm Tài Khóa 13-14.

Đối với tất cả thân chủ:

Mẫu Đơn Phối Hợp và/hoặc Giới Thiệu về Sức Khỏe Thân Thể & Hành Vi:

- Xin đơn thỏa thuận của thân chủ/người giám hộ trên *Mẫu Đơn Phối Hợp và/hoặc Giới Thiệu về Sức Khỏe Thân Thể & Hành Vi/* mẫu đơn có lý lịch của người ký hợp đồng lúc nhập viện, nhưng không được trễ hơn 30 ngày sau mở hồ sơ khám bệnh.

- Đối với những thân chủ không có một PCP, nơi chăm sóc sẽ nối kết họ với một nhà y tế. Người ký hợp đồng sẽ khởi đầu tiến trình bằng cách điền vào *Mẫu Đơn Phối Hợp và/hoặc Giới Thiệu về Sức Khỏe Thân Thể & Hành Vi /* mẫu đơn của người ký hợp đồng và gửi đơn đó cho PCP trong vòng 30 ngày sau khi mở hồ sơ khám bệnh. Điều thiết yếu là phải có tên họ rõ ràng của bác sĩ điều trị.

- Người dùng mẫu đơn phải đánh dấu vào ô thích hợp ở đầu *Mẫu Đơn Phối Hợp và/hoặc Giới Thiệu về Sức Khỏe Thân Thể & Hành Vi /*mẫu đơn của người ký hợp đồng và lưu ý xem đây là thư giới thiệu chăm sóc sức khỏe thân thể, thư giới thiệu chăm sóc sức khỏe thân thể và quản lý thuốc men, thư giới thiệu chăm sóc sức khỏe toàn diện, hay chỉ là thư thông báo về việc phối hợp chăm sóc. Nếu đây là thư giới thiệu chăm sóc sức khỏe thân thể, hoặc chăm sóc sức khỏe thân thể và quản lý thuốc men, hãy đánh máy tên chương trình của quý vị vào chỗ trống, và chọn loại chương trình thích hợp.

Mẫu Đơn Cập Nhật Việc Phối Hợp Chăm Sóc Sức Khỏe Thân Thể và Hành Vi:

- Cập nhật và gửi *Mẫu Đơn Cập Nhật Việc Phối Hợp Chăm Sóc Sức Khỏe Thân Thể và Hành Vi /*mẫu đơn của người ký hợp đồng nếu có những thay đổi đáng kể như thêm, thay đổi hoặc chấm dứt một loại thuốc.

- Thông báo với PCP khi thân chủ chấm dứt các dịch vụ bằng cách gửi *Mẫu Đơn Cập Nhật Việc Phối Hợp Chăm Sóc Sức Khỏe Thân Thể và Hành Vi /*mẫu đơn của người ký hợp đồng. Mẫu đơn này cần phải được điền trước khi hoàn tất bản tóm lược về sự chấm dứt.

Những Nhắc Nhở Để Theo Dõi:

- Người sử dụng mẫu đơn phải áp dụng một hệ thống để theo dõi ngày hết hạn cho phép tiết lộ/trao đổi thông tin.

- Người sử dụng mẫu đơn phải áp dụng một hệ thống để theo dõi và thực thi thư hủy bỏ việc cho phép tiết lộ/trao đổi thông tin.

- Người sử dụng mẫu đơn phải áp dụng một hệ thống để theo dõi và chấm dứt việc tiết lộ/trao đổi thông tin khi chấm dứt mối liên hệ qua cuộc điều trị. Khi chấm dứt điều trị nơi chăm sóc chỉ có thể thông báo về sự chấm dứt của cuộc điều trị, nhưng không được nói về lý do chấm dứt.

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Mẫu Đơn Phối Hợp và/hoặc Giới Thiệu về Chăm Sóc Sức Khỏe Thân Thể & Hành Vi

☐ Giới thiệu để chăm sóc sức khỏe *thân thể* – [ ] sẽ tiếp tục cung cấp các dịch vụ chăm sóc sức khỏe hành vi đặc biệt
☐ Sức Khỏe Tâm Thần ☐ Rượu Bia và Ma Túy

☐ Giới thiệu để chăm sóc sức khỏe *thân thể* & Quản Lý Thuốc Men – [ ] sẽ tiếp tục cung cấp các dịch vụ chăm sóc sức khỏe hành vi đặc biệt có giới hạn
☐ Sức Khỏe Tâm Thần ☐ Rượu Bia và Ma Túy

☐ Giới thiệu để chăm sóc sức khỏe *toàn diện* – [ ] không còn cung cấp các dịch vụ chăm sóc sức khỏe hành vi. Sẵn sàng để tham vấn về tâm thần.

☐ Chỉ để thông báo về việc phối hợp chăm sóc.

Phần A: THÔNG TIN VỀ THÂN CHỦ

Tên Họ của Thân Chủ: Họ Tên Tên Đệm Tắt	Cũng Có Tên Là	☐ Nam ☐ Nữ
Địa Chỉ	Ngày Sinh	
Thành Phố	Điện Thoại #	
Số Zip	Số Điện Thoại Khác #	

Phần B: THÔNG TIN VỀ NƠI CHĂM SÓC SỨC KHỎE HÀNH VI

Tên của Nơi Điều Trị:	Tên của Chuyên Viên Điều Trị Tâm Thần (Nếu thích hợp)
Cơ Quan/Chương Trình	
Địa Chỉ	Thành Phố, Tiểu Bang, Số Zip
Điện Thoại #	Số fax an toàn hoặc địa chỉ email an toàn của nơi chăm sóc cụ thể:
Ngày Thẩm Định Ban Đầu	
Trọng Tâm Điều Trị (*Dùng Phần Chi Chú Thêm Về Tiến Triển nếu Cần*)	
Quản Lý Hồ Sơ/ Chuyên Viên Sức Khỏe Tâm Thần/ Cố Vấn Về Rượu Bia và Ma Túy/ Quản Lý Chương Trình: Điện Thoại #:	Y Tá Về Sức Khỏe Hành Vi: Điện Thoại #:

HSD/PBH_CoC Form: Revised 032007-dbsrn HHSA BHS Revision 5-16-13

LIVE WELL SAN DIEGO

Ngày Khám Bệnh Gần Đây Nhất	Những Chẩn Đoán Về Sức Khỏe Tâm Thần: Những Chẩn Đoán Liên Quan Đến Rượu Bia và Ma Túy:

Những Triệu Chứng Hiện Thời Về Sức Khỏe Tâm Thần và Thân Thể (*Dùng Phần Ghi Chú Thêm Về Mức Tiến Triển nếu Cần*)

Thuốc và Liều Lượng cho Sức Khỏe Tâm Thần và Không Phải Cho Tâm Thần
(*Dùng Phần Ghi Chú Thêm Về Thuốc Men/Mức Tiến Triển nếu Cần*)

Lần Nhập Viện Tâm Thần Gần Đây Nhất
☐ Ngày: ☐ Không Có

Phần C: THÔNG TIN VỀ BÁC SĨ CHĂM SÓC CHÍNH

Tên Của Bác Sĩ Chăm Sóc

Tổ Chức HOẶC Tổ Hợp Y Khoa

Địa Chỉ

Thành Phố, Tiểu Bang, Số Zip

Điện Thoại #:	Số fax an toàn hoặc địa chỉ email an toàn của nơi chăm sóc cụ thể:

Phần D: ĐỂ CHO BÁC SĨ CHĂM SÓC CHÍNH ĐIỀN VÀO ĐƯỢC NHẬN ĐỂ ĐIỀU TRỊ HOẶC GIỚI THIỆU TRỞ LẠI CHƯƠNG TRÌNH SDCBHS (XIN VUI LÒNG ĐIỀN VÀO NHỮNG THÔNG TIN SAU ĐÂY VÀ GỬI LẠI CHO NƠI CHĂM SÓC SỨC KHỎE HÀNH VI TRONG VÒNG HAI TUẦN LỄ SAU KHI NHẬN ĐƯỢC)

☐ Thông báo đã nhận được về Việc Phối Hợp Chăm Sóc.
Nếu đây là thư giới thiệu của bác sĩ chăm sóc chính, xin vui lòng chọn câu trả lời thích hợp dưới đây:

1. ☐ Bệnh nhân đã được nhận vào chỉ để điều trị sức khỏe tâm thần
2. ☐ Bệnh nhân đã được nhận vào để chăm sóc sức khỏe thân thể và điều trị tâm thần bằng thuốc trong lúc vẫn tiếp tục nhận thêm các dịch vụ với chương trình sức khỏe hành vi
3. ☐ Bệnh nhân được nhận vào để chăm sóc sức khỏe toàn diện gồm cả điều trị tâm thần bằng thuốc
4. ☐ Bệnh nhân không được nhận vào để điều trị tâm thần bằng thuốc và được giới thiệu trở lại vì:

Thông Tin Nhạy Cảm: Tôi hiểu rằng những thông tin trong hồ sơ của tôi có thể bao gồm những thông tin liên quan đến bệnh truyền nhiễm qua đường tình dục, hội chứng suy giảm miễn dịch (AIDS), hoặc nhiễm vi-rút gây suy giảm miễn dịch (HIV) . Nó cũng có thể bao gồm những thông tin về các dịch vụ sức khỏe tâm thần hoặc điều trị cho tình trạng lạm dụng rượu bia và ma túy.

Quyền Hủy Bỏ: Tôi hiểu rằng tôi có quyền hủy bỏ việc cho phép này bất cứ lúc nào. Tôi hiểu rằng nếu tôi hủy bỏ việc cho phép này tôi phải viết thư để làm điều đó. Tôi hiểu rằng việc hủy bỏ sẽ không áp dụng cho những thông tin đã được tiết lộ dựa vào việc cho phép này.

Bản Sao hoặc Fax:
Tôi đồng ý rằng một bản sao hoặc fax của đơn cho phép này được xem là có hiệu lực như bản gốc.

Tái Tiết Lộ: Nếu tôi đã cho phép tiết lộ thông tin về sức khỏe của tôi cho một người mà người đó không bị luật pháp bắt buộc phải giữ kín thông tin đó, tôi hiểu rằng nó có thể bị tái tiết lộ và không còn được bảo vệ nữa. Luật California nói chung cấm những người nhận được thông tin về sức khỏe của tôi không được tái tiết lộ thông tin đó trừ khi có thư cho phép của tôi hoặc do luật pháp đòi hỏi hoặc cho phép rõ ràng.

Các Quyền Khác: Tôi hiểu rằng việc cho phép tiết lộ thông tin về sức khỏe này là do tự nguyện. Tôi có thể không ký tên vào đơn cho phép này. Tôi không cần phải ký vào đơn để bảo đảm được điều trị. Tôi hiểu rằng tôi có thể xem xét hoặc xin một bản sao của thông tin sẽ được sử dụng hoặc tiết lộ, như được quy định trong Tiêu Đề 45 trong Bộ Luật Về Các Điều Lệ Của Liên Bang ở đoạn 164.524.

CHỮ KÝ CỦA CÁ NHÂN HOẶC NGƯỜI ĐẠI DIỆN PHÁP LÝ

CHỮ KÝ:	NGÀY:

Tên Họ của Thân Chủ (*Xin vui lòng đánh máy hoặc viết theo kiểu chữ in rõ ràng)*
Họ: **Tên:** **Tên Đệm:**

NẾU LÀ CHỮ KÝ CỦA ĐẠI DIỆN PHÁP LÝ, XIN VIẾT TÊN THEO KIỂU CHỮ IN:	MỐI LIÊN HỆ CỦA NGƯỜI ĐÓ:

Hết Hạn: Trừ khi bị hủy bỏ, đơn cho phép này sẽ hết hạn vào ngày, trường hợp, hoặc tình trạng sau đây**:** _____
Nếu tôi không ghi rõ ngày, trường hợp, hoặc tình trạng hết hạn, đơn cho phép này sẽ hết hạn trong một (1) năm theo niên lịch tính từ ngày được ký tên, hoặc 60 ngày sau khi chấm dứt điều trị.

☐ Thông Tin Được Ghi trên mẫu đơn này	☐ Báo Cáo/Tóm Lược Về Việc Chấm Dứt
☐ Chương Trình Dùng Thuốc & Điều Trị Hiện Thời	☐ Kết Quả Thử Nghiệm Trong Phòng Thí Nghiệm/Chẩn Đoán
☐ Thẩm Định Mức Lệ Thuộc Vào Ma Túy	☐ Tiểu Sử Bệnh Lý
☐ Báo Cáo Về Thẩm Định/Đánh Giá	☐ Tình trạng khác _____

Người ký tên ở trên cho phép bác sĩ chăm sóc sức khỏe hành vi và bác sĩ chăm sóc sức khỏe thân thể tiết lộ những hồ sơ và thông tin/cập nhật về y khoa liên quan đến bệnh nhân. Mục đích của việc tiết lộ này là để giúp phối hợp chăm sóc, nhằm nâng cao phẩm chất và giảm bớt nguy cơ lập lại các thử nghiệm và tác động lẫn nhau giữa các loại thuốc. Không thỏa thuận có thể gây tác hại đến sự phối hợp chăm sóc hữu hiệu.

Tôi muốn có một bản sao của đơn cho phép này ◯ Có ◯ Không
Chữ ký tắt của Thân Chủ/Người Giám Hộ

➔ **Xin vui lòng đặt một Mẫu Đơn này vào hồ sơ của thân chủ của quý vị**

ĐỂ LIÊN LẠC VỚI MỘT ĐẠI DIỆN CỦA CHƯƠNG TRÌNH

Care1st Health Plan	Community Health Group	Health Net	Kaiser Permanente	Molina Healthcare	Access &Crisis Line
(800) 605-2556	(800) 404-3332	(800) 675-6110	(800) 464-4000	(888) 665-4621	(888) 724-7240

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Ngày Ký Tên Cho Phép Tiết Lộ Thông Tin:

MẪU ĐƠN CẬP NHẬT VIỆC PHỐI HỢP CHĂM SÓC SỨC KHỎE THÂN THỂ VÀ HÀNH

TÊN HỌ CỦA THÂN CHỦ		
Họ	Tên	Tên Đệm
Ngày Sinh	◯ Nam	◯ Nữ
CẬP NHẬT VỀ SỨC KHỎE HÀNH VI	Ngày:	
Tên Của Bác Sĩ Điều Trị	Điện Thoại	FAX
Tên Của Bác Sĩ Điều Trị Tâm Thần (Nếu thích hợp)	Điện Thoại	FAX
☐ Thuốc được kê toa vào ngày _____ Ngày ☐ Thuốc được thay đổi vào ngày _____ Ngày ☐ Thuốc được ngưng lại vào ngày _____ Ngày	Tên Thuốc/Liều Lượng:_____ Tên Thuốc/Liều Lượng:_____ Tên Thuốc/Liều Lượng:_____	
☐ Thuốc được kê toa vào ngày _____ Ngày ☐ Thuốc được thay đổi vào ngày _____ Ngày ☐ Thuốc được ngưng lại vào ngày _____ Ngày	Tên Thuốc/Liều Lượng:_____ Tên Thuốc/Liều Lượng:_____ Tên Thuốc/Liều Lượng:_____	
☐ Cập Nhật Chẩn Đoán:		
☐ Cập Nhật Những Thông Tin Chính Yếu:		
☐ Ngày Chấm Dứt Điều Trị:		
☐ Những Đề Nghị Để Tiếp Tục Theo Dõi:		

CẬP NHẬT CỦA BÁC SĨ CHĂM SÓC CHÍNH

Xin vui lòng cung cấp những Cập Nhật/Thay Đổi liên quan đến Tình Trạng Sức Khỏe Thân Thể Của Bệnh Nhân.

HSD/PBH_CoC Form: Revised 032007-dbsrn HHSA BHS Revision 5-16-13

LIVE WELL SAN DIEGO

Appendix F
Beneficiary Rights Issue Resolution

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

I. BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY

In its commitment to honoring mental health consumer rights, the County of San Diego shall maintain a beneficiary and client problem resolution process, in compliance with State and Federal regulations, which provides a quality, impartial, and effective process for resolving consumer problems encountered while accessing or receiving mental health services. All County-operated and contracted providers shall be required by contract to cooperate with the problem resolution process as described herein. The full and timely cooperation of the provider shall be considered essential in honoring the client's right to an efficient problem resolution.

PLEASE NOTE: PROVIDERS SHALL NOT SUBJECT A CLIENT TO ANY DISCRIMINATION OR ANY OTHER PENALTY OF ANY KIND FOR FILING A GRIEVANCE, APPEAL OR EXPEDITED APPEAL.

A. PROCESS

San Diego County Mental Health Services is committed to providing a quality, impartial, and effective process for resolving consumer complaints encountered while accessing or receiving mental health services. The process is designed to:

- Provide easy access
- Support the rights of individuals
- Be action-oriented
- Provide timely resolution
- Provide effective resolution at the lowest level
- Improve the quality of services for all consumers in the population

While the consumer is encouraged to present problems directly to the provider for resolution, when a satisfactory resolution cannot be achieved, one or more of the processes below may be used:

1) Grievance process
2) Appeal process (in response to an "action" as defined as: denying or limiting authorization of a requested service, including the type or level or service; reducing, suspending, or terminating a previously authorized service, denying, in whole or in part, payment for a service; failing to provide services in a timely manner, as determined by the Mental Health Plan (MHP) or; failing to act within the timeframes for disposition of standard grievances, the resolution of standard appeals or the resolution of expedited appeals.)

3) Expedited Appeal process (available in certain limited circumstances)
~~4)~~ State Fair Hearing process--available to Medi-Cal beneficiaries who have filed an appeal through the County Mental Health Program (MHP) process and are dissatisfied with the resolution. The State Fair Hearing is also for clients whose grievance or appeal was not resolved timely in the MHP process (including an extension if permission was given), or no permission for an extension was given. In this instance, clients are not required to wait until the completion of the County MHP process to do so.

The Mental Health Problem Resolution process covers Medi-Cal beneficiaries, Severely Emotionally Disabled (SED) certified children through the Healthy Families program, and persons without Medi-Cal funds receiving County-funded mental health services. It is designed to meet the regulations in CCR Title 9, Division 1, Chapter 11, Subchapter 5, Section 1850.205 and 42 CFR Subpart F, Part 438.400. **The procedures relating to children and youth served under AB 3632/2726 legislation will take precedence over this document.** By law, Welfare and Institution (WI) Code WI 10950, the State Fair Hearing process, is only available to a Medi-Cal beneficiary.

B. OBJECTIVES

1. To provide the consumer with a process for independent resolution of grievances and appeals.

2. To protect the rights of consumers receiving mental health services, including the right to:
   - Be treated with dignity and respect,
   - Be treated with due consideration for his or her privacy,
   - Receive information on available treatment options in a manner appropriate to his or her condition and ability to understand,
   - Participate in decisions regarding his or her mental health care, including the right to refuse treatment,
   - Be free from any form of unnecessary restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation,
   - Request a copy of his or her medical records, and to request that an additional statement amending or correcting the information be included, and
   - Freely exercise these rights without adverse effects in the way providers treat him or her.

3. To protect the rights of consumers during grievance and appeal processes.

4. To assist individuals in accessing medically necessary, high quality, consumer-centered mental health services and education.

5. To respond to consumer concerns in a linguistically appropriate, culturally competent and timely manner.

6. To provide education regarding, and easy access to, the grievance and appeal process through widely available informational brochures, posters, and self-addressed grievance and appeal forms located at all provider sites.

C. BENEFICIARY and CLIENT RIGHTS DURING THE GRIEVANCE AND APPEAL PROCESS

1. Consumer concerns shall be responded to in a linguistically appropriate, culturally competent and timely manner.

2. Clients' rights and confidentiality shall be protected at all stages of the grievance and appeal process by all providers and advocates involved.

3. Consumers shall be informed of their right to contact the Jewish Family Service (JFS) Patient Advocacy Program regarding problems at inpatient and residential mental health facilities or the Consumer Center for Health Education and Advocacy (CCHEA) for problems with outpatient and all other mental health services, at any time for assistance in resolving a grievance or appeal. Medi-Cal beneficiaries shall also be informed of their right to request a State Fair Hearing.

4. Consumers of the MHP and persons seeking services shall be informed of the process for resolution of grievances and appeals. This includes information about the availability of the JFS Patient Advocacy Program and CCHEA, the programs that currently are contracted with the MHP to assist consumers with problem resolution, at the consumer's request. The information shall be available in the threshold languages, and shall be given to the client at the point of intake to Mental Health Plan services, and upon request during the provision of services. Continuing clients must be provided with the information annually. Providers shall document the provision of this information.

5. The client may authorize another person or persons to act on his/her behalf. A client may select a provider as his or her representative in the appeal process. His or her representative, or the legal representative of a deceased client's estate, shall be allowed to be included as parties to an appeal.

6. A support person chosen by the client, such as family member, friend or other advocate may accompany them to any meetings or hearings regarding a grievance or appeal.

7. The client and/or his or her representative may examine the case file, including documents or records considered during the grievance or appeal process.

8. Consumers shall not be subject to any discrimination, penalty, sanction or restriction for filing a grievance or appeal. The consumer shall not be discouraged, hindered or otherwise interfered with in seeking or attempting to file a grievance or appeal.

9. Advocates shall treat clients, their chosen support persons, and all providers with courtesy and respect throughout the grievance resolution process.

   - Providers shall participate fully and in a timely manner in order to honor the client's right to an efficient, effective problem resolution process.

   - Medi-Cal beneficiaries, who have appealed through the MHP Beneficiary Problem Resolution process and are dissatisfied with the resolution, have the right to request an impartial review in the form of a State Fair Hearing within 90 days of the decision whether or not the client received a Notice of Action

(NOA). At a State Fair Hearing, a client has the opportunity to present his or her concerns to an administrative law judge for a ruling. (See Section VIII for more information on the State Fair Hearings.)

- Clients who are Medi-Cal beneficiaries and who have a grievance or appeal which has not been resolved by the MHP within mandated timelines, and no client permission for an extension has been granted, may request a State Fair Hearing. They need not wait until the end of the County process before making the request.
- Quality of care issues identified as a result of the grievance and appeal process shall be reviewed by the MHP and the Quality Review Council for implementation of system changes, as appropriate.

D. CLIENT AND BENEFICIARY NOTIFICATION

1. Consumers shall be informed in a clear and concise way of the process for reporting and resolving grievances and appeals. This includes information on how to contact JFS Patient Advocacy and CCHEA. The information shall be available in the threshold languages and shall be given to the client at the point of intake to a program and, as appropriate, during the provision of services. Continuing clients must be provided with the information annually, and providers will document these efforts.
2. Notices in threshold languages describing mental health rights, as well as the grievance and appeal procedures, shall be posted in prominent locations in public and staff areas, including waiting areas of the provider location. Brochures with this information will also be available in these areas in the County's threshold languages.
3. Grievance/Appeal forms and self-addressed envelopes must be available for consumers at all provider sites in a visible location, without the consumer having to make a written or verbal request to anyone. This includes common areas of both locked and unlocked behavioral health units.
4. CCHEA and Patient Advocacy Program shall have interpreter services and toll-free numbers with adequate TDD/TTY, available at a minimum during normal business hours.
5. Under certain circumstances, when the MHP denies any authorization for payment request from a provider to continue specialty mental health services to a Medi-Cal beneficiary, the MHP must provide the Medi-Cal beneficiary with a Notice of Action (NOA), which informs the beneficiary of his or her right to request a State Fair Hearing, and the right to contact a representative from JFS or CCHEA.

II. INFORMAL PROBLEM RESOLUTION –available to all mental health clients

Consumers are encouraged to seek problem resolution at the provider level by speaking or writing informally to the therapist, case manager, facility staff, or other person

involved in their care. Often this is the quickest way to both make the provider aware of the client's issue, as well as come to a satisfactory resolution. **However, no consumer shall be required to take the matter directly to the provider unless he or she chooses.**

In addition to, or instead of, bringing the issue directly to the individual provider, consumers may work directly with the supervisor or Program Director, who shall make efforts to resolve it. In attempting to reach resolution, and consistent with confidentiality requirements, the appropriate supervisor or Program Director shall utilize whatever information, resources and/or contacts the consumer agrees to.

III. GRIEVANCE PROCESS—available to all mental health clients

Any consumer of mental health services may express dissatisfaction with mental health services or their administration by filing a grievance through JFS Patient Advocacy (for inpatient and residential services) or the Consumer Center for Health Education and Advocacy (for outpatient and all other mental health services).

IV. GRIEVANCE PROCEDURES:

At any time the consumer chooses, the consumer may contact CCHEA or JFS Patient Advocacy, as appropriate. CCHEA or JFS Patient Advocacy shall work to resolve the issue according to the following steps:

1. Client contacts JFS Patient Advocacy Program for issues relating to inpatient and other 24-hour-care programs, or CCHEA for issues relating to outpatient, day treatment and all other services, either orally or in writing, to file a grievance. A grievance is defined as an expression of dissatisfaction about anything other than an "action" (see Section IV for complete definition.).
   NOTE: If the client's concern is in regard to an "action" as defined, the issue is considered an "appeal" (see Section X for Definition) not a grievance. See "Appeal Process" in Section V below for procedure.

2. CCHEA or Patient Advocacy Program logs the grievance within one working day of receipt. The log shall include:

   - the client name or other identifier,
   - date the grievance was received,
   - the date it was logged, the nature of the grievance,
   - the provider name,
   - whether the issue concerns a child.

   The log is to be maintained in a confidential location at CCHEA or JFS Patient Advocacy. The log content pertaining to the client shall be summarized in writing, if the client requests it.

3. CCHEA or Patient Advocacy Program provides the client a written acknowledgement of receipt of the grievance within three working days.

4. CCHEA or Patient Advocacy Program shall contact the provider involved in the grievance as soon as possible and within three working days of receipt of the client's written permission to represent the client.

5. CCHEA or Patient Advocacy Program investigates the grievance.
   - CCHEA or JFS shall ensure that the person who makes the final determination of the grievance resolution has had no prior or current involvement in the grievance determination.
   - In cases where the CCHEA or JFS staff member has another existing relationship with the client or provider, that contractor's Program Director shall reassign the case or consult with the MHP QI Unit about conflict of interest of issues.
   - The client's confidentiality shall be safeguarded per all applicable laws.
6. If the grievance is about a clinical issue, the decision maker must be a mental health professional with the appropriate clinical expertise in treating the client's condition.
7. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential to honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's grievance, CCHEA or Patient Advocacy staff will often find it necessary to discuss the issue with the providers involved, either in person or by phone at various points in the process. The expectation is that CCHEA or JFS and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

   If a case should arise in which CCHEA or JFS and the provider are unable to reach a mutually agreeable resolution to the grievance within the required timeframe as stated below, CCHEA or JFS shall make a finding based on the facts as they are known. The grievance disposition letter shall include this finding. The letter may include a request that the provider write a Plan of Correction to be submitted by the provider directly to the MHP Director or designee. CCHEA or JFS may also choose to include what they believe to be equitable, enforceable suggestions or recommendations to the provider for resolution of the matter. Notification of the resolution shall go out to all parties as described below.
8. CCHEA or Patient Advocacy Program shall notify the client in writing regarding the disposition of the grievance within the timeframe for resolution stated below. The notice shall include:
   - the date
   - the resolution

   A copy of the grievance resolution letter will be sent to the provider and the QI Unit at the time the letter is sent to the client.
9. Timelines for grievance dispositions cannot exceed 60 calendar days from the date of receipt of the grievance. However, in some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days for good cause, such as a satisfactory resolution is pending but not complete. Timeliness of grievance resolution is an important issue for consumers. If an extension is required, CCHEA or JFS will contact the client to discuss an extension, clearly

document in the file the extenuating circumstances that indicate the need for the extension, and the date the client was contacted and agreed to an extension. If the timeframe extension was not requested by the client, CCHEA or JFS staff must give the client written notice of the reason for the delay. If CCHEA or JFS staff is unable to meet the timeframe described herein, the staff person shall issue a Notice of Action D (NOA-D) to the beneficiary informing them of their rights. A copy of the NOA-D shall be sent to the QI Unit. Clients whose grievances are not completed according to mandated timelines, and have not given permission for an extension, may request a State Fair Hearing. They need not wait until the end of the County process to make this request.

10. CCHEA or JFS Patient Advocacy Program shall record in the log, the final disposition of the grievance, and date the decision was sent to the client, or reason there has not been a final disposition of the grievance.

11. Providers who do not successfully resolve the grievance with the advocacy organization during the grievance process shall receive two letters from CCHEA or JFS. One is a copy of the disposition sent to the client, that includes a request for Plan of Correction, and the other is a letter requesting that the provider write a Plan of Correction and submit it within 10 working days directly to:

    Grievance Plan of Correction
    Quality Improvement Unit
    P.O. Box 85524, Mail Stop P531G
    Camino Del Rio South
    San Diego, CA 92186-5524

    The Plan of Correction letter to the provider (not the grievance disposition letter) may include CCHEA's or JFS's suggestions of what the Plan of Correction could include. Responsibility for reviewing the Plan of Correction and monitoring its implementation rests with the MHP. The monitoring of any provider's Plan of Correction and handling of any provider's request for administrative review shall be performed by the MHP directly with the provider.

    In the event that a provider disagrees with the findings of the grievance investigation as decided by the advocacy organization, and does not agree to write a Plan of Correction, the provider may choose instead to write a request for administrative review by the MHP. This request shall be submitted directly by the provider to the MHP Director or designee within 10 working days of receipt of the grievance disposition. The provider must include rationale and evidence to support the provider's position that the disposition of the grievance is faulty and/or that no Plan of Correction is indicated.

    Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing a grievance.

GRIEVANCE PROCESS

STEP	ACTION	TIMELINE
1	Grievance Filed by client	Filing Date

2	Grievance Logged	1 Working Day from Grievance Filing
3	Written Acknowledgement to client	3 Working Days from Grievance Filing
4	Provider Contact	Within 3 Working Days from Client's Written Permission to Represent
5	Clinical Consultant review, if applicable	Within 60 day total timeframe
6	Grievance Disposition	60 Days from Filing Date
7	Disposition Extension (if needed)	14 Calendar Days from the 60th day
8	Provider Plan of Correction (if needed)	10 Working Days from Disposition Date
9	Request for Administrative Review	10 Working Days from receipt of the Grievance Disposition

V. APPEAL PROCESS—available to Medi-Cal Beneficiaries only

The appeal procedure begins when a Medi-Cal beneficiary contacts JFS Patient Advocacy Program (for issues relating to inpatient and other 24 hour care program) or CCHEA (for issues relating to outpatient, day treatment and all other services) to file an appeal to review an "action."

An "action" is defined by 42 Code of Federal Regulations as occurring when the MHP does at least one of the following:

- Denies or limits authorization of a requested service, including the type or level of service;
- Reduces, suspends, or terminates a previously authorized service;
- Denies, in whole or in part, payment for a service;
- Delays completion of the MHP appeals process within the mandated timeframe, without client permission for an extension.

In San Diego County this is relevant only for inpatient, day treatment, and outpatient services provided by fee-for-service providers, as these are currently the only services for which an authorization is required. Clients wishing to have a review of a clinical decision made by an individual provider, not the MHP or its administrative services organization, may use the grievance process.

The MHP is required to provide *Aid Paid Pending* for beneficiaries who want continued services, and have made a timely request for an appeal:

- within 10 days of the date the NOA was mailed, or
- within 10 days of the date the NOA was personally given to the beneficiary, or
- before the effective date of the service change, <u>whichever is later</u>.

The MHP must ensure that benefits are continued while the appeal is pending, if the beneficiary so requests. The beneficiary must have:

- an existing service authorization which has not lapsed and the service is being terminated, reduced, or denied for renewal by the MHP, or
- been receiving specialty mental health services under an 'exempt pattern of care' (see Section X. Definitions).

The benefits will stay the same until the period covered by the existing authorization expires, the date an appeal is resolved or a hearing decision is rendered, or the date on which the appeal or state fair hearing is otherwise withdrawn or closed, whichever is earliest.

VI. APPEAL PROCEDURES

1. The client may file the appeal orally or in writing. If the appeal is oral, the client is required to follow up with a signed, written appeal. The client shall be provided with assistance in completing the written appeal, if requested. The date of the oral appeal begins the appeal resolution timeframe, regardless of when the follow-up, written appeal was signed. The client may present evidence in person or in writing.

2. CCHEA or JFS Patient Advocacy Program, as appropriate, determines whether the appeal meets the criteria for expedited appeal and, if so, follows the expedited appeal process as stated in section VI below.

3. CCHEA or Patient Advocacy Program logs the appeal within one working day of receipt. The log shall include the:

   - client name or other identifier,
   - date the appeal was received,
   - date the appeal was logged,
   - nature of the appeal,
   - the provider involved,
   - and whether the issue concerns a child.

   The log is to be maintained in a confidential location at CCHEA or JFS Patient Advocacy. If the client requests to see the log, CCHEA or JFS will summarize in writing the content pertaining to the client.

4. CCHEA or JFS shall acknowledge, in writing, receipt of the appeal within three working days.

5. CCHEA or JFS shall contact the provider as soon as possible and within three working days of receipt of the client's written authorization to represent the client.

6. CCHEA or JFS Patient Advocacy Program shall notify the QI Unit within three working days of any appeal filed.

7. CCHEA or JFS evaluates the appeal and:

   - Ensures that the person who determines the final resolution of the appeal has

had no decision-making involvement in any prior level of review.

- Safeguards the client's confidentiality per all applicable laws.

In cases where the CCHEA or JFS staff member has another existing relationship with the client or provider, that contractor's Program Director shall reassign the case or consult with the MHP QI Unit about conflict of interest of issues.

8. If the appeal is about a clinical issue, the decision-maker must also be a mental health professional with the appropriate clinical expertise in treating the client's condition.

9. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential in honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's appeal, CCHEA or JFS staff will often find it necessary to discuss the issue with the providers involved and the Administrative Service Organization (ASO), either in person or by phone at various points in the process. The expectation is that CCHEA or JFS, the ASO, and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

   If CCHEA or JFS denies the appeal, or if the appeal is granted but is not an appeal of one of the actions listed in Item #10 below, proceed to item #12.

10. If CCHEA or JFS believes that there is sufficient merit to grant an appeal regarding an action that:

    - denied or limited authorization of a requested service, including the type or level of service,
    - reduced, suspended or terminated a previously authorized service, or
    - denied, in whole or in part, payment for a service, CCHEA or JFS shall do the following within 30 calendar days of the date the appeal was filed:

      a) notify the MHP Director or designee in writing of details of the appeal and the specific, supported rationale for why it should be granted, and
      b) provide copies to the MHP Director or designee of all relevant medical records, the clinical consultant's evaluation, case notes, and other materials including an accurate representation of the provider's position regarding the appeal.

      In some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days for good cause, such as a satisfactory resolution is pending but not complete.

11. The MHP Director or designee shall return a decision on the appeal to the advocacy organization within 10 calendar days of receipt of the above.

12. CCHEA or JFS shall notify the beneficiary in writing regarding the disposition of the appeal within the timeframe for resolution stated below. The notice shall include:

- the date,
- the resolution,
- and if the decision is not wholly in favor of the client AND the client is a Medi-Cal beneficiary, information regarding:
  - the right to request a State Fair Hearing within 90 days of notice of the decision,
  - how to request a State Fair Hearing, and
  - the beneficiary's right to request services while the hearing is pending and how to make that request for continued services.
  - A copy of the appeal resolution letter will be sent to the provider and the Quality Improvement (QI) Unit at the time the letter is sent to the client.

13. Appeals must be resolved within 45 calendar days (59 calendar days if extension granted) from the date of receipt of the appeal. Timeliness of appeal resolution is an important issue for consumers. If an extension is required, CCHEA or Patient Advocacy Program will contact the client to discuss an extension, document clearly in the file the extenuating circumstances for the extension, and the date the client was contacted and agreed to an extension.

14. If the timeframe extension was not requested by the client, CCHEA or Patient Advocacy staff must give the client written notice of the reason for the delay. The notice shall include the client's right to file a grievance if the client disagrees with the decision to extend the timeframe.

15. If CCHEA or Patient Advocacy staff is unable to meet the timeframe described herein, they are required to issue an NOA-D to Medi-Cal beneficiaries only. A copy shall be sent to the QI Unit. CCHEA or JFS Patient Advocacy Program shall record in the log the final disposition of the appeal, and the date the decision was sent to the client, or the reason for no final disposition of the appeal.

16. If the decision of the appeal process reverses a decision to deny services, those services shall be promptly provided.

Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing an appeal.

APPEALS PROCESS

STEP	ACTION	TIMELINE
1	Appeal Filed by client	File Date
2	Appeal Logged	1 Working Day from Appeal
3	Expedited Appeal Criteria?	Go to Section VII
4	Written Acknowledgement of appeal to client	3 Working Days from Receipt of Appeal
5	Provider Contact	3 Working Days from Client's Written Permission to Represent
6	Clinical consultant review, if applicable	As soon as possible
7	Notify QI Unit	3 Working Days of Appeal Filing
8	Advocacy Organization recommends denying appeal	See #10 for timelines

9	Advocacy Organization recommends granting the appeal, and notifies MHP Director in writing with supporting documentation	Within 30 calendar days from date appeal was filed
10	MHP Director makes decision on the appeal	Within 10 calendar days from receipt of appeal.
11	**Appeal Resolution**	**45 Calendar Days from Receipt of Appeal**
12	Appeal Extension (if needed)	14 Calendar Days from Extension Filing Date

VIII. EXPEDITED APPEAL PROCESS—available to Medi-Cal beneficiaries only

When a client files an oral or written appeal to review an action (as previously defined) and use of the standard appeal resolution process could, in the opinion of the client, the MHP, or CCHEA or JFS Patient Advocacy program staff, jeopardize the client's life, health or ability to attain, maintain, or regain maximum function, the expedited appeal process will be implemented instead.

IX. EXPEDITED APPEAL PROCEDURES

1. The client may file the expedited appeal orally or in writing.
2. The CCHEA or Patient Advocacy Program logs the expedited appeal within one working day of receipt. The log shall include the:
   - client name or other identifier,
   - date appeal was received,
   - date the appeal was logged,
   - nature of the appeal,
   - provider involved,
   - and whether the issue concerns a child.
4. The log is to be maintained in a confidential location at CCHEA or JFS Patient Advocacy. If the client requests to see the log, the advocacy agency will summarize in writing the content pertaining to the client.
5. CCHEA or Patient Advocacy Program provides the client a written acknowledgement of receipt of the expedited appeal within two working days.
6. CCHEA or Patient Advocacy Program shall notify the QI Unit immediately of any expedited appeal filed. CCHEA or Patient Advocacy Program shall contact the provider as soon as possible but not to exceed two working days.
7. The client or his or her representative may present evidence in person or in writing.
8. CCHEA or Patient Advocacy Program evaluates the expedited appeal.
   - They shall ensure that the person who determines the final resolution of the appeal has had no decision-making involvement in any prior level of review.
   - The client's confidentiality shall be safeguarded per all applicable laws.

9. If the expedited appeal is about a clinical issue, the decision-maker must also be a mental health professional with the appropriate clinical expertise in treating the client's condition.

10. If, CCHEA or Patient Advocacy Program, finds that the appeal does not meet the criteria for the expedited appeal process that has been requested, CCHEA or Patient Advocacy program staff shall:
    - Obtain agreement of the MHP to deny the use of the expedited appeal process and to treat the appeal as a standard appeal instead.
    - Transfer the appeal to the timeframe for standard appeal resolution (above), and
    - Make reasonable efforts to give the client prompt oral notice of the denial of the expedited process, and follow up within two calendar days with a written notice. A copy of the letter shall be sent to QI.

11. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential to honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's expedited appeal, CCHEA or JFS staff will often find it necessary to discuss the issue with the providers involved, and the Administrative Service Organization (ASO), either in person or by phone at various points in the process. The expectation is that CCHEA or JFS, the ASO, and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

    If CCHEA or JFS denies the expedited appeal, or if the expedited appeal is granted but is not an appeal of one of the actions listed in item #12 below, *proceed to item #14*.

12. If the advocacy organization believes that there is sufficient merit to grant an expedited appeal regarding an action that:
    - denied or limited authorization of a requested service, including the type or level of service,
    - reduced, suspended or terminated a previously authorized service, or
    - denied, in whole or in part, payment for a service, the advocacy organization shall do the following within two working days of the date the appeal was filed:
        - notify the MHP Director or designee in writing of details of the expedited appeal and the specific, supported rationale for why it should be granted, and
        - provide copies to the MHP Director or designee of all relevant medical records, the clinical consultant's evaluation, case notes, and other materials including an accurate representation of the provider's position regarding the expedited appeal.

13. The MHP Director or designee shall return a decision on the expedited appeal to the advocacy organization within one working day of receipt of the above.

14. CCHEA or Patient Advocacy Program shall make a reasonable effort to notify the client orally of the expedited appeal resolution decision as soon as possible. In

addition, they shall notify the client in writing within the timeframe for resolution stated below, regarding the results of the expedited appeal. The notice shall include:

- the date,
- the resolution,
- and only if the decision is not wholly in favor of the client AND the client is a Medi-Cal beneficiary
- information regarding the right to request an expedited State Fair Hearing
- information on how to request continued services (aid paid pending) while the hearing is pending.

A copy of the appeal resolution letter will be sent to the provider and the QI Unit at the same time the letter is sent to the client.

15. Expedited appeals must be resolved and the client must be notified in writing within three working days from the date of receipt of the expedited appeal. However, in some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days if the client requests an extension. In rare circumstances, the timeframe may be extended up to the 14 calendar days if CCHEA or JFS staff determines that there is a need for more information AND that the delay is in the client's best interest.

16. If the timeframe extension was not requested by the client, CCHEA or JFS Patient Advocacy staff must give the client written notice of the reason for the delay.

17. If CCHEA or JFS staff is unable to meet the timeframe described herein, they shall issue an NOA-D to the beneficiary. A copy shall be sent to the QI Unit.

18. CCHEA or JFS Patient Advocacy Program shall record in the log the final disposition of the expedited appeal, and the date the decision was sent to the client, or reason there has not been a final disposition of the expedited appeal.

19. If the decision of the appeal process reverses a decision to deny services, those services shall be promptly provided.

Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing an appeal.

EXPEDITED APPEAL PROCESS

STEP	ACTION	TIMELINE
1	Expedited Appeal Filed by client	File Date
2	Expedited Appeal Criteria? If not, obtain MHP agreement and treat as regular appeal.	If no, notify client in 2 calendar days in writing
3	Expedited Appeal Logged	1 Working Day from Appeal receipt
4	Written Acknowledgement of appeal to client	2 Working Days from Receipt of Appeal
5	Provider Contact	2 Working Days from Client's Written Permission to Represent
6	Notify QI Unit	Immediately
7	Advocacy Organization recommends denying appeal	See #10 above for timelines

8	Advocacy Organization recommends granting the appeal, and notifies MHP Director in writing with supporting documentation.	Within 2 working days from date appeal was filed
9	MHP Director makes decision on the appeal	Within 1 working day from receipt of notification from the Advocacy Organization
10	Appeal Resolution	3 Working Days from Receipt of Appeal
11	Disposition Extension (if needed)	14 Calendar Days from 3rd working day.

X. STATE FAIR HEARING—available to Medi-Cal beneficiaries only, who are not receiving services through the Department of Education

A. A State Fair Hearing is a legal process that includes an impartial hearing and ruling by an administrative law judge. A Medi-Cal beneficiary is required to exhaust the MHP's problem resolution process above prior to requesting a State Fair Hearing. Only a Medi-Cal beneficiary may request a state hearing:

- within 90 days after the completion of the MHP beneficiary problem resolution process, whether or not the client received a Notice of Action (NOA), or
- when the grievance or appeal has not been resolved within mandated timelines, and who gave no permission for an extension. The beneficiary does not need to wait for the end of the MHP Problem Resolution process.

A Medi-Cal beneficiary may request a State Fair Hearing by writing to or calling the State Fair Hearings Division of the California Department of Social Services at 1(800) 952-5253, or by contacting CCHEA or JFS Patient Advocacy Program for assistance.

Children and youth receiving mental health services under AB 3632/2726 legislation through the Department of Education should use that Department's Grievance and Appeals process.

B. When the MHP QI Unit has been notified by the State Fair Hearings Division that an appeal or state fair hearing has been scheduled, the QI Unit shall:

1. Contact the client or his or her advocate, investigate the problem, and try to resolve the issue before the matter goes to State Fair Hearing. In cases where a successful resolution of the matter is not reached, the client proceeds to a hearing.
2. Attend the hearing to represent the MHP position.
3. Require that County-operated and/or contracted providers involved in the matter assist in the preparation of a position paper for the hearing, and/or may be requested to attend the hearing as a witness in the case.
4. The MHP is required to provide *Aid Paid Pending* for beneficiaries who want continued services while awaiting a Hearing, have met the Aid Paid Pending criteria per CCR, Title 22, Section 51014.2 summarized below, and have made a timely request for a fair hearing:

- o within 10 days of the date the NOA was mailed, or
- o within 10 days of the date the NOA was personally given to the beneficiary, or
- o before the effective date of the service change, whichever is later.

5. The beneficiary must have:
   - o an existing service authorization which has not lapsed and the service is being terminated, reduced, or denied for renewal by the MHP, or
   - o been receiving specialty mental health services under an 'exempt pattern of care' (see Section XII. Definitions).
6. The benefits will stay the same until the period covered by the existing authorization expires, the date an appeal is resolved or a hearing decision is rendered, or the date on which the appeal or state fair hearing is otherwise withdrawn or closed, whichever is earliest.
7. After a judge has heard a case, he or she forwards the decision to the MHP QI Unit. In the event that the case is not resolved in the MHP's favor, the QI Unit staff shall communicate the decision and any actions to be implemented, to the MHP Program Monitors to oversee implementation of the resolution by the County-operated and/or contracted providers.

Please note: A beneficiary may file an appeal or state fair hearing whether or not a Notice of Action (NOA) has been issued.

XI. MONITORING GRIEVANCES AND APPEALS

The MHP QI Unit shall be responsible for monitoring grievances and appeals, identifying issues and making recommendations for needed system improvement.

A. Procedures

1. The MHP QI Unit shall review the files of CCHEA and JFS Patient Advocacy program periodically and as frequently as needed in order to monitor timely adherence to the policy and procedures outlined herein, and ensure that consumer rights under this process are protected to the fullest extent.
2. On a monthly basis, by the 20th of the following month, JFS Patient Advocacy Program and CCHEA shall submit their logs of all grievances and appeals for the previous calendar month, to the MHP QI Unit. The logs shall specify whether each item is a grievance, appeal, or expedited appeal. They shall include the:
   - client name or other identifier
   - date the grievance or appeal was filed,
   - date logged
   - nature of the grievance or appeal
   - provider involved,

- and whether the issue concerns a child.

3. For those grievances and appeals that have been resolved, the log shall note the final disposition of the grievance or appeal, and the date the decision was sent to the client.

4. The MHP QI Unit will keep centralized records of monitoring grievances and appeals, including the nature of the grievance/appeal, as well as track outcomes of appeals that were referred to other entities including State Fair Hearings. Trends will be identified and referred to the Quality Review Council, MHP Director, and/or Mental Health Board for recommendations or action as needed. The MHP QI Unit shall submit a grievance and appeal log to the State Department of Mental Health annually.

B. Handling Complaint Clusters

1. CCCHEA and JFS Patient Advocacy shall report to the QI Unit complaint clusters about any one provider or therapist occurring in a period of several weeks or months, immediately upon discovery. Background information and copies of client documentation shall be provided to the QI Unit also.

2. The QI Unit will investigate all such complaint clusters.

3. Findings will be reported to the MHP Director.

XII. DEFINITIONS

ASO: Administrative Service Organization contracted by HHSA to provide Managed Care Administrative functions.

Action: As defined by 42 Code of Federal Regulations (CFR) an action occurs when the Mental Health Plan (MHP) does at least one of the following:

- Denies or limits authorization of a requested service, including the type or level of service;
- Reduces, suspends, or terminates a previously authorized service;
- Denies, in whole or in part, payment for a service;
- Fails to provide services in a timely manner, as determined by the MHP or;
- Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

Appeal:	A request for review of an action (as action is defined above).
Beneficiary:	A client who is Medi-Cal eligible and currently requesting or receiving specialty mental health services paid for under the County's Medi-Cal Managed Care Plan.
Client:	Any individual currently receiving mental health services from the County MHS system, regardless of funding source.
Consumer Center for Health Education and Advocacy (CCHEA):	CCHEA is an MHP contractor currently designated by the Local Mental Health Director to fulfill two roles: to operate the County's Grievance and Appeal process for client problems with outpatient and all other non-residential mental health services; and to provide patient advocacy services which include information and education on client rights and individual assistance for mental health clients with problems accessing/maintaining services in the community.
Consumer:	Any individual who is currently requesting or receiving specialty mental health services, regardless of the individual's funding source and/or has received such services in the past and/or the persons authorized to act on his/her behalf. (This includes family members and any other person(s) designated by the client as his/her support system.)
Grievance:	An expression of dissatisfaction about any matter other than an action (as action is defined).
Grievance and Appeal Process:	A process for the purpose of attempting to resolve consumer problems regarding specialty mental health services.
Mental Health Plan (MHP):	County of San Diego, Health & Human Services Agency, Mental Health Services.

Notice of Action (NOA):

A notice sent to Medi-Cal beneficiaries to inform them of a decision regarding denial, reduction, or termination of requested services and their rights for appeal if they disagree with the decision.

NOA-A: (Assessment) Denial of service sent from providers to Medi-Cal beneficiaries when the face-to-face assessment indicates they do not meet medical necessity criteria and no specialty mental health services will be provided.

NOA-B: (Denial of Services) Denial or modification of provider's request for Medi-cal services requiring pre-authorization. The denial is sent from the point of authorization to both provider and beneficiary, when the beneficiary did not receive the service.

NOA-C: (Post-Service Denials) Denial or modification of provider's request for specialty mental health services sent from the point of authorization to both the provider and the beneficiary, when the beneficiary has already received the service.

NOA-D: (Delayed Grievance/Appeal Decisions) Notice sent by advocacy contractor to the beneficiary when the resolution of the grievance, appeal or expedited appeal was not provided within the required timeframe.

NOA-E: (Lack of Timely Services) Notice sent by provider to beneficiary when the provider does not provide services in a timely manner according to the MHP standards for timely services.

Patients' Rights Advocate:

The persons designated under Welfare and Institutions Code, Section 5500 et seq. to protect the rights of all recipients of specialty mental health services. The Patients' Rights Advocate "shall have no direct or indirect clinical or administrative responsibility for any recipient of Medi-Cal Managed Care Services, and shall have no other responsibilities that would otherwise compromise his or her ability to advocate on behalf of specialty mental health beneficiaries."

JFS Patient Advocacy Program staff currently serve as the Patients' Rights Advocate for acute inpatient and other 24-hour residential services, and CCHEA staff serve as the Patients' Rights Advocate for outpatient, day treatment, and all other services.

Quality Improvement (QI) Program:

The Quality Improvement Program is a unit within HHSA Mental Health Services whose duties include monitoring and oversight of the Grievance and Appeal Process.

State Fair Hearing:	A formal hearing before an administrative law judge, requested by a Medi-Cal beneficiary and conducted by the State Department of Social Services as described in Welfare and Institutions Code, Section 10950, and Federal Regulations Subpart E, Section 431.200 et seq.
Jewish Family Service (JFS) Patient Advocacy Program:	The Jewish Family Service Patient Advocacy Program is an agency currently designated by the Local Mental Health Director to fulfill two roles: to operate the County's Grievance and Appeal process for client problems in acute care hospitals and residential services; and to provide patient advocacy services which include information and education on patient rights and individual client assistance in resolving problems with possible violations of patient's rights.

County of San Diego
Medi-Cal Specialty Mental Health Program
NOTICE OF ACTION
(Assessment)

Date: _____

To: _____, Medi-Cal Number: _____

The mental health plan for San Diego County has decided, after reviewing the results of an assessment of your mental health condition, that your mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services through the plan.

In the mental health plan's opinion, your mental health condition did not meet the medical necessity criteria, which are covered in the state regulations at Title 9, California Code of Regulations (CCR), Section 1830.205, for the reason checked below:

☐ Your mental health diagnosis as identified by the assessment is not covered by the mental health plan (Title 9, CCR, Section 1830.205(b)(1)).

☐ Your mental health condition does not cause problems for you in your daily life that are serious enough to make you eligible for specialty mental health services from the mental health plan (Title 9, CCR, Section 1830.205(b)(2)).

☐ The specialty mental health services available from the mental health plan are not likely to help you maintain or improve your mental health condition (Title 9, CCR, Section 1830.205(b)(3)(A) and (B)).

☐ Your mental health condition would be responsive to treatment by a physical health care provider (Title 9, CCR, 1830.205(b)(3)(C)).

If you agree with the plan's decision, and would like information about how to find a provider outside the plan to treat you, you may call and talk to a representative of the Access and Crisis Line at (800) 479-3339.

If you don't agree with the plan's decision, you may do one or more of the following:

You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan through the Access and Crisis Line at (800) 479-3339 or write to: Optum Access and Crisis Line, P.O. Box 601370, San Diego, CA 92160-1370.

You may file an appeal with your mental health plan. For inpatient/residential services, you may call and talk to or write a representative of JFS Patient Advocacy Program at (800) 479-2233, 2710 Adams Avenue, San Diego, CA 92116. For outpatient and all other mental health services, you may call and talk to or write a representative of the Consumer Center for Health Education and Advocacy at (877) 734-3258, 1764 San Diego Avenue, Suite 200, San Diego, CA 92110. Or you can follow the directions in the information pamphlet the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions.

If you have questions about this notice, for inpatient/residential services, you may call and talk to or write a representative of JFS Patient Advocacy Program at (800) 479-2233, 2710 Adams Avenue, San Diego, CA 92116. For outpatient and all other mental health services, you may call and talk to or write a representative of the Consumer Center for Health Education and Advocacy at (877) 734-3258, 1764 San Diego Avenue, Suite 200, San Diego, CA 92110.

If you are dissatisfied with the outcome of your appeal, you may request a State Fair Hearing. The other side of this form will explain how to request a hearing.

County of San Diego
Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION

Date: _____

To: _____ Medi-Cal Number _____

The mental health plan for San Diego County has ☐ denied ☐ changed your provider's request for payment of the following service(s):

_____

The request was made by: (provider name) _____

The original request from your provider was dated _____

The mental health plan took this action based on information from your provider for the reason checked below:

☐ Your mental health condition does not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (Title 9, California Code of Regulations (CCR), Section 1820.205).

☐ Your mental health condition does not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services for the following reason (Title 9, CCR, Section 1830.205): _____
_____
_____

☐ The service requested is not covered by the mental health plan (Title 9, CCR, Section 1810.345).

☐ The mental health plan requested additional information from your provider that the plan needs to approve payment of the proposed service. To date, the information has not been received.

☐ The mental health plan will pay for the following service(s) instead of the service requested by your provider, based on the available information on your mental health condition and service needs: _____
_____

☐ Other:_____
_____

<u>If you don't agree with the plan's decision, you may</u>:

1. You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at (800) 479-3339 or write to: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370; or follow the directions in the information brochure the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions. You can request that your services stay the same until an appeal decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period _____. The effective date for the change in these services is _____.

2. If you are dissatisfied with the outcome of your appeal, you may request a state hearing which may allow services to continue while you wait for the hearing. The other side of this notice explains how to request a hearing. You can request that your services stay the same until a hearing decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period _____. The effective date for the change in these services is _____. The services may continue while you wait for a resolution of your hearing.

3. You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan at (800) 479-3339 or write to: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370.

NOA-B (DMH revised 6/1/05. SD update 7/12/11.)

YOUR HEARING RIGHTS

You only have 90 days to ask for a hearing. The 90 days start either:

1. The day after we personally gave you this the mental health plan's appeal decision notice, OR
2. The day after the postmark date of this mental health plan's appeal decision notice.

Expedited State Hearings

It usually takes about 90 days from the date of your request to make a hearing decision. If you think this timing will cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions, you may request an expedited state hearing. **To request an expedited hearing, please check the first box in the right hand column of this page under HEARING REQUEST and include the reason why you are requesting an expedited hearing.** If your expedited hearing request is approved, a hearing decision will be issued within three working days of the date your request is received by the State Hearings Division.

To Keep Your Same Services While You Wait for a Hearing

- You must ask for a hearing within 10 days from the date the mental health plan's appeal decision notice was mailed or personally given to you or before the effective date of the change in services, whichever is later.
- Your Medi-Cal mental health services will stay the same until a final hearing decision is made which is adverse to you, you withdraw your request for a hearing, or the time period or service limits for your current services expire, whichever happens first.

State Regulations Available

State regulations, including those covering state hearings, are available at your local county welfare office.

To Get Help

You may get free legal help at your local legal aid office or other groups. For problems with inpatient and residential mental health services, call JFS Patient Advocacy Program at 800-479-2233. For problems with outpatient and all other mental health services, call toll free the Consumer Center for Health Education and Advocacy at 877-734-3258. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:

Call toll free: 1-800-952-5253
If you are deaf and use TDD, call: 1-800-952-8349

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, an attorney or anyone else you choose. You must arrange for this representative yourself.

Information Practices Act Notice (California Civil Code Section 1798, et seq.) The information you are asked to write in on this form is needed to process your hearing request. Processing may be delayed if the information is not complete. A case file will be set up by the State Hearings Division of the Department of Social Services. You have the right to examine the materials that make up the record for decision and may locate this record by contacting the Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with the mental health plan, the State Departments of Health Services and Mental Health and with the U.S. Department of Health and Human Services (Authority: Welfare and Institutions Code, Section 14100.2)

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then send this page to:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call 1-800-952-8349.

HEARING REQUEST

I want a hearing because of a Medi-Cal related action by the Mental Health Plan of San Diego County.

☐ Check here if you want an expedited state hearing and include the reason below.

Here's why: _____

_____

_____

_____

_____

_____

_____

☐ Check here and add a page if you need more space.

My Name: (print) _____

My Social Security Number: _____

My Address: (print) _____

_____

My Phone Number: (_____)_____

My Signature: _____

Date: _____

I need an interpreter at no cost to me. My language or dialect is: _____

I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name: _____

Address: _____

_____

Phone Number: (_____)_____

Condado de San Diego
Programa de Especialidades de Salud Mental de Medi-Cal
AVISO DE ACCIÓN
(Evaluación) Fecha: ____

Para: _____ Número de Medi-Cal _____

El plan de salud mental del Condado de San Diego ha decidido, después de revisar los resultados de la evaluación de su condición mental, que su condición mental no cumple con el criterio de necesidad médica para ser elegible para recibir servicios de salud mental especializados a través del plan.

En opinión del plan de salud, su condición de salud mental no cumple con el criterio de necesidad médica que se encuentra cubierto en los reglamentos estatales, Título 9, Sección 1830.205 del Código de Regulaciones de California (CCR), por la razón que se marca a continuación:

☐ Su diagnóstico de salud mental, según se identifica por medio de la evaluación, no está cubierto por el plan de salud mental (Título 9, Sección 1830.205 (b)(1) CCR).

☐ Su condición de salud mental no le ocasiona problemas suficientemente serios en su vida diaria como para que usted sea elegible para recibir servicios de salud mental especializados de su plan de salud mental (Título 9, Sección 1830.205 (b)(2) CCR).

☐ No es probable que los servicios especializados de salud mental con los que cuenta su plan de salud le ayuden a mantener o mejorar su condición de salud mental (Título 9, Sección 1830.205 (b)(3)(A) y (B)) CCR).

☐ Su condición de salud mental respondería al tratamiento proporcionado por un proveedor de salud física (Título 9, Sección 1830.205 (b)(3)(C) CCR).

Si usted está de acuerdo con la decisión tomada por el plan y le gustaría obtener información sobre como encontrar un proveedor para su tratamiento alterno a este plan, llame y hable con un representante de la Línea de acceso y ayuda para casos de crisis (San Diego Access and Crisis Line) al 1-800-479-3339.

Si usted no está de acuerdo con la decisión tomada por el plan:

Puede pedirle al plan que le tramite una segunda opinión acerca de su condición de salud mental. Para hacer esto, puede llamar y hablar con un representante de la Línea de acceso y ayuda para casos de crisis (San Diego Access and Crisis Line) al 1-800-479-3339 o escriba a: Optum al P.O. Box 601370, San Diego, CA 92160-1370.

Puede presentar una apelación a su plan de salud mental. Para servicios para pacientes internos/residenciales, puede llamar o escribir a un representante del Programa de Intercesión a Favor del Paciente al (800) 479-2233, 2710 Adams Avenue, San Diego, CA 92116. Para pacientes ambulatorios y para todos los demás servicios de salud mental puede llamar o escribir a un representante del Centro del Consumidor para Intercesión y Educación sobre la Salud al (877) 734-3258, 1764 San Diego Avenue, Suite 200, San Diego, CA 92110, o seguir las instrucciones en el folleto de información que le entregó el plan de salud mental. Usted debe presentar la apelación dentro de los 90 días posteriores a la fecha de este aviso. En la mayoría de los casos el plan de salud mental debe tomar una decisión sobre su apelación dentro de los 45 días posteriores a su solicitud. Si usted piensa que un retraso podría ocasionar serios problemas a su salud mental, como problemas relacionados con su capacidad de adquirir, mantener o recuperar funciones vitales importantes, entonces puede solicitar una apelación expedita, en la que la decisión debe tomarse en un período de tres días hábiles.

Si tiene preguntas acerca de este aviso, para servicios para pacientes internos/residenciales, puede llamar o escribir a un representante del Programa de Intercesión a Favor del Paciente al (800) 479-2233, 2710 Adams Avenue, San Diego, CA 92116. Para pacientes ambulatorios y para todos los demás servicios de salud mental puede llamar o escribir a un representante del Centro del Consumidor para Intercesión y Educación sobre la Salud al (877) 734-3258, 1764 San Diego Avenue, Suite 200, San Diego, CA 92110.

Si no esta satisfecho con el resultado de su apelación, usted puede solicitar una Audiencia Imparcial del Estado. Al reverso de este formulario se explica cómo solicitar una audiencia.

Quận Hạt San Diego
Chương Trình Dịch Vụ Sức Khỏe Tâm Thần của Chuyên Ngành Medi-Cal
BẢNG THÔNG BÁO
(Sự Giám Định)

Ngày tháng _____

Kính gửi _____, Thẻ Medi-cal số _____

Sau khi giám định tình trạng sức khỏe tâm thần của quí vị, Chương trình sức khỏe tâm thần Quận hạt San Diego nhận thấy tình trạng của quí vị không hội đủ tiêu chuẩn cần thiết để có quyền hưởng dịch vụ tâm thần qua chương trình của chúng tôi..

Thep ý kiến của của chương trình sức khỏe tâm thần, tình trạng sức khỏe tâm thần của quí vị không hội đủ tiêu chuẩn y tế cần thiết để được trả tiền theo LuậtTitle 9 của tiểu bang, California Code of Regulations (CCR), Phần 1830.205, vì những lý do sau đây::

☐ Sau khi giám định, tình trạng sức khỏe tâm thần của quí vị đuợc xác nhận là không đủ tiêu chuẩn hưởng chương trình sức khỏe tâm thần (Luật Title 9, California Code of Regulations, Phần 1830.205(b)(1)).

☐ Tình trạng sức khỏe tâm thần của quí vị không gây cản trở nghiêm trọng trong đời sống hàng ngày để quí vị có thể hội đủ điều kiện nhận dịch vụ sức khỏe tâm thần đặc biệt của chúng tôi (Luật Title 9, California Code of Regulations, Phần 1830.205(b)(2)).

☐ Các dịch vụ sức khỏe tâm thần gần như không hiệu quả gì cho quí vị trong việc duy trì và cải tiến tình trạng sức khỏe tâm thần của quí vị (Luật Title 9, California Code of Regulations, Phần 1830.205(b)(3)(A) và (B)).

☐ Tình trạng sức khỏe tâm thần của quí vị có thể có hiệu quả nếu đi khám bác sĩ chăm sóc sức khỏe tổng quát (Luật Title 9, California Code of Regulations, Phần 1830.205(b)(3)(C)).

Nếu quí vị đồng ý với sự quyết định này, và muốn biết thêm chi tiết về việc tìm bác sĩ bên ngòai chương trình, quí vị có thể gọi điện thọai và thảo luận với người đại diện chương trình sức khỏe tâm thần của quí vị ở số (800) 479-3339 hay viết thư cho: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370.

Nếu quí vị không đồng ý với quyết định của chương trình, quí vị có thể làm một hay những điều sau đây:

Quí vị có quyền yêu cầu chương trình sắp xếp để xin ý kiến thứ hai về tình trạng sức khỏe tâm thần của quí vị. Để làm việc này, quí vị có thể gọi và thảo luận với người đại diện chăm sóc sức khỏe tâm thần của quí vị ở số (800) 479-3339 hay viết thư cho: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370.

Quí vị có thể mở hồ sơ khiếu nại với chương trình sức khỏe tâm thần. Với bệnh nhân đang nằm bệnh viện/hay dịch vụ tại gia, quí vị có thể gọi điện thọai và thảo luận hay viết thư cho người đại diện của chương trình Bênh Vực Quyền Lợi JFS ở số (800) 479-2233, 2710 Adams, San Diego, CA 92116. Với bệnh nhân ngọai viện và tất cả những dịch vụ sức khỏe tâm thần, quí vị có thể gọi thảoluận hay viết thư cho người đại diện của Trung Tâm Tiêu Thụ về Giáo Dục Sức Khỏe và Bệnh Vực Quyền Lợi (Consumer Center for Health Education and Advocacy) ở số (877) 734-3258, 1764 San Diego Ave, Ste 200, San Diego, CA 92110. Hay quí vị có thể làm theo sự hướng dẫn viết trong quyển chỉ dẫn sức khỏe tâm thần mà quí vị đã nhận. Quí vị phải mở hồ sơ khiếu nại trong vòng 90 ngày tính từ ngày nhận được thông báo này. Hầu hết các trường hợp, chương trình sức khỏe phải giải quyết trong vòng 45 ngày từ khi quí vị yêu cầu. Quí vị có thể yêu cầu một phiên xử để giải quyết sớm hơn bình thường, có nghĩa là vấn đề sẽ được giải quyết trong vòng 3 ngày làm việc nếu quí vị tin là sự trễ nãi sẽ khiến tình trạng bệnh tâm thần của mình trở nên trầm trọng, bao gồm việc ảnh hưởng không tốt đến khả năng duy trì hay hồi phục chức năng quan trọng của đời sống.

Nếu quí vị có câu hỏi liên quan đến thông báo này, với bệnh nhân nằm viện/ dịch vụ tại gia, quí vị có thể gọi thảo luận hay viết thư cho người đại diện của Chương Trình Bênh vực Bệnh nhân của JFS ở số (800) 479-2233, 2710 Adams, San Diego, CA 92116. Với bệnh nhân ngọai viện và tất cả những dịch vụ sức khỏe tâm thần khác, xin quí vị gọi thảo luận hay viết cho người đại diện của Trung Tâm Tiêu Thụ về Giáo dục Sức Khỏe và Bênh vực Quyền lợi (Consumer Center for Health Education and Advocacy0) ở số (877) 734-3258, 1764 San Diego Ave, Ste 200, San Diego, CA 92110.

If you are dissatisfied with the outcome of your appeal, you may request a State Fair Hearing. The other side of this form will explain how to request a hearing.

A.F.06

QUYỀN ĐIỀU TRẦN

Quí vị chỉ có 90 ngày để yêu cầu buổi điều trần. 90 ngày bắt đầu:

1. Tính từ ngày chúng tôi đích thân đưa quí vị bản thông báo khiếu nại sức khỏe tâm thần này, HAY
2. Tính từ ngày dấu bưu điện in trên bản thông báo khiếu nại sức khỏe tâm thần này.

Buổi Điều trần Nhanh Chóng cấp Tiểu bang

Thường mất 90 ngày kể từ ngày quí vị yêu cầu. Nếu quí vị nghĩ thời gian này có thể gây nguy hại trầm trọng cho sức khỏe tâm thần của mình gồm việc duy trì và phục hồi các chức năng quan trọng của đời sống, quí vị có thể xin được xử nhanh hơn thường lệ**. Để có một buổi điều trần nhanh, xin vui lòng đánh dấu ô đầu tiên bên phải của trang này dưới chữ YÊU CẦU ĐIỀU TRẦN và ghi cả nguyên nhân yêu cầu được xử nhanh.** Nếu lời yêu cầu của quí vị được chấp nhận, người ta sẽ thông báo cho quí vị biết trong vòng ba ngày làm việc tính từ ngày Ủy Ban Điều Trần Tiểu bang nhận khiếu nại của quí vị.

Để được nhận cùng dịch vụ trong khi quí vị chờ đợi buổi Điều trần

- Quí vị phải yêu cầu có buổi điều trần trong vòng 10 ngày tính từ ngày bản thông báo khiếu nại sức khỏe tâm thần gửi đến hay được giao tận tay cho quí vị trước ngày thay đổi dịch vụ, tính theo việc nào xảy ra trễ hơn.
- Các dịch vụ sức khỏe tâm thần Medi-Cal sẽ vẫn giữ nguyên cho đến khi có quyết định cuối cùng của buổi điều trần và nếu kết quả bất lợi cho quí vị, và quí vi thu hồi lời yêu cầu, hay cho đến khi thời hạn nhận dịch vụ bị hết hạn, tính theo việc nào đến trước.

Các Luật Điều Hành Cấp Tiểu Bang

Luật điều hành tiểu bang, bao gồm tin tức điều trần đều có sẵn trong văn phòng trợ cấp xã hội của quận hạt địa phương.

Để được giúp đỡ

Quí vị có thể nhận đuợc sự giúp đỡ pháp lý từ văn phòng trợ giúp pháp lý địa phương hay từ các nhóm khác. Về các vấn đề khó khăn với bệnh nhân nội trú hay các dịch vụ sức khỏe tâm thần tại gia, hãy gọi Chương trình Bênh vực Bệnh nhân JFS ở số 800-479-2233. Về các vấn đề khó khăn với bệnh nhân ngoại viện và các dịch vụ sức khỏe tâm thần khác, hãy gọi số miễn phí đến Trung tâm Tiêu thụ Giáo dục Sức khỏe và Bênh vực quyền lợi (Consumer Center for Health Education and Advocacy) ở số 877-734-3258. Quí vị có thể yêu cầu tin tức về quyền xin điều trần hay giúp đỡ pháp lý từ Public Inquiry and Response Unit:

Gọi số miễn phí : 1-800-952-5253
Nếu khiếm thính, gọi TDD, call: 1-800-952-8349

Người đại diện hợp pháp

Quí vị có thể tự điều trần trước phiên xử. Quí vị cũng có thể chọn một người bạn, một luật sư hay bất cứ ai đại diện cho mình. Quí vị phải tự mình sắp xếp việc này

Thông báo của Practices Act Notice (California Civil Code Section 1798, et seq.) Chi tiết mà quí vị được yêu cầu viết trong mẫu này rất cần thiết để xúc tiến buổi điều trần của quí vị. Việc xúc tiến có thể trễ nãi nếu chi tiết không đầy đủ. Hồ sơ sẽ được thiết lập bởi Bộ Xã Hội Tiểu bang, Bộ phận Điều trần. Quí vị có quyền tham khảo hồ sơ và biết nó ở đâu bằng cách liên lạc với Public Inquiry and Response Unit (điện thoại đã ghi bên trên). Bất cứ chi tiết nào mà quí vị cung cấp, chúng tôi sẽ chia sẽ với chương trình sức khỏe tâm thần, với Bộ Dịch vụ Y tế và Sức Khỏe Tâm thần Tiểu bang và với Bộ Y tế và Nhân sinh của Liên bang (Authority: Welfare and Institutions Code, Section 14100.2)

CÁCH YÊU CẦU BUỔI ĐIỀU TRẦN CẤP TIỂU BANG

Cách hay nhất để yêu cầu được buổi điều trần là điền vào mẫu này. Làm bản sao phần trước và sau của mẫu này để lưu giữ vào hồ sơ của quí vị. Sau đó gửi trang này về:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Một cách khác để xin buổi điều trần là gọi điện thoại số 1-800-952-5253. Nếu quí vị bị khiếm thính thì dùng TDD, gọi số 1-800-952-8349.

YÊU CẦU ĐIỀU TRẦN

Tôi muốn có một buổi điều trần liên hệ đến Medi-Cal và Chương Trình Sức Khỏe Tâm Thần của Quận hạt San Diego.

☐ Đánh dấu trong ô này nếu quí vị muốn có một buổi điều trần nhanh chóng và viết nguyên nhân tại sao :.

Nguyên nhân: _____

_____

_____

_____

_____

☐ Đánh dấu vào ô này nếu muốn viết thêm một trang nữa.

Tên họ (chữ in) _____

Số An sinh xã hội: _____

Địa chỉ (chữ in) _____

_____

Điện thọai: (_____) _____

Chữ ký: _____

Ngày tháng: _____

Tôi cần một thông dịch viên miễn phí. Ngôn ngữ gốc của tôi là _____

Tôi muốn người có tên dưới đây đại diện tôi trong buổi điều trần. Tôi cho phép người này xem hồ sơ của tôi và đến dự buổi điều trần dùm tôi.

Tên họ: _____

Địa chỉ: _____

_____

Điện thọai: (_____) _____

Condado de San Diego
Programa de Servicios Especializados de Salud Mental de Medi-Cal
AVISO DE ACCIÓN

Fecha: _____

Para: _____ Número de Medi-Cal: _____

El plan de salud mental del Condado de San Diego ha ☐ negado ☐ cambiado la solicitud de su proveedor por el pago del siguiente(s) servicio(s):

_____

La solicitud fue hecha por: (nombre del proveedor) _____

La solicitud original de su proveedor tenía fecha del _____.

El plan de salud mental tomó esta acción basándose en la información de su proveedor por la razón que se marca a continuación:

☐ Su condición de salud mental no cumple con el criterio de necesidad médica para recibir servicios como paciente internado en un hospital psiquiátrico ni para servicios profesionales relacionados (Título 9, Sección 1830.205 del Código de Regulaciones de California (CCR))

☐ Su condición de salud mental no cumple con el criterio de necesidad médica para recibir servicios de salud mental especializados que no sean servicios de hospital psiquiátrico como paciente internado, por la siguiente razón (Título 9, Sección 1830.205, CCR): _____

_____

☐ El servicio que se solicita no está cubierto por el plan de salud mental (Título 9, Sección 1830.205, CCR).

☐ El plan de salud mental solicitó información adicional de su proveedor, la cual necesita para aprobar el pago del servicio propuesto. Hasta la fecha no se ha recibido dicha información.

☐ El plan de salud mental pagará por el/los siguientes servicios, en lugar de por los servicios solicitados por su proveedor, basándose en la información disponible sobre sus necesidades de servicio y su condición de salud mental:

_____

_____

☐ Otra _____

_____

<u>Si no está de acuerdo con la decisión tomada por el plan, usted puede:</u>

1. Presentar una apelación a su plan de salud mental. Para hacer esto, puede llamar y hablar con un representante de su plan de salud mental al (800) 479-3339 o escribir a: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370 o seguir las instrucciones en el folleto de información que le entregó el plan de salud mental. Usted debe presentar la apelación dentro de los 90 días posteriores a la fecha de este aviso. En la mayoría de los casos el plan de salud mental debe tomar una decisión sobre su apelación dentro de los 45 días posteriores a su solicitud. Si piensa que un retraso podría ocasionar serios problemas a su salud mental, como problemas relacionados con su capacidad para adquirir, mantener o recuperar funciones vitales importantes entonces usted puede solicitar una apelación expedita, en la que la decisión debe tomarse en un período de tres días hábiles. Usted puede solicitar que sus servicios continúen igual hasta que se tome la decisión a su apelación. Para mantener sus servicios usted debe presentar la apelación dentro de los 10 primeros días a partir de la fecha de este aviso o antes de la fecha en que el cambio de servicios sea efectivo, lo que suceda después. Los servicios solicitados fueron previamente aprobados por el plan, por el período de _____.
   La fecha efectiva para el cambio de estos servicios es: _____

2. Solicitar una audiencia del estado si no está satisfecho(a) con el resultado a su apelación, lo que permitiría que usted siguiera recibiendo servicios mientras espera por dicha audiencia. Al reverso de este formulario se explica cómo solicitar la audiencia. Usted puede solicitar que sus servicios continúen igual hasta que se tome la decisión a su apelación. Para conservar sus servicios debe presentar la apelación dentro de los 10 primeros días a partir de la fecha de este aviso o antes de la fecha en que los cambios de servicios sean efectivos, lo que suceda después. Los servicios solicitados fueron previamente aprobados por el plan, por el período de _____ _____. La fecha efectiva para el cambio de estos servicios es: _____Los servicios pueden continuar mientras espera la resolución de su audiencia.

3. Puede pedirle al plan que haga arreglos para tener una segunda opinión sobre su condición de salud mental. Para hacer esto, puede llamar y hablar con un representante de su plan de salud mental al (800) 479-3339 o escribir a: Utilization Management, Optum, P. O. Box 601370, San Diego, CA 92160-1370.

Quận Hạt San Diego
Chương Trình Sứ Khỏe Tâm Thần Chuyên Ngành Medi-Cal
THÔNG BÁO

Ngày tháng: _____

Kính gửi_____ Thẻ Medi-Cal số _____

Chương Trình Sức Khỏe Tâm Thần của Quận hạt San Diego đã ☐ từ chối ☐ đổi lời yêu cầu của cơ quan chăm sóc sức khỏe của quí vị về việc trả tiền các dịch vụ sau đây:

_____

Lời yêu cầu do (tên của của cơ quan chăm sóc sức khỏe) _____

Yêu cầu đầu tiên của cơ quan ghi ngày _____

Chương trình sức khỏe tâm thần quyết định như thế này vì căn cứ vào chi tiết mà cơ quan chăm sóc sức khỏe của quí vị ghi nhận như sau:

☐ Tình trạng sức khỏe tâm thần của quí vị không hội đủ tiêu chuẩn cần thiết để hưởng dịch vụ tâm thần cung cấp trong bệnh viện hay các dịch vụ chuyên ngành (Luật Title 9, California Code of Regulations (CCR), Phần 1820.205).

☐ Tình trạng sức khỏe tâm thần của quí vị không hội đủ tiêu chuẩn cần thiết để nhận dịch vụ tâm thần chuyên ngành khác hơn là những dịch vụ tâm thần do bệnh viện cung cấp vì những lý do sau đây: (LuậtTitle 9, CCR, Phần 1830.205): _____

_____

_____

☐ Dịch vụ yêu cầu không được chương trình sức khỏe tâm thần trang trãi (Luật Title 9, CCR, Phần 1810.345).

☐ Chương trình sức khỏe tâm thần yêu cầu cơ quan chăm sóc sức khỏe của quí vị cung cấp thêm chi tiết để chương trình xét và chấp nhận trả tiền các dịch vụ đề nghị. Đến giờ phút này mà chúng tôi vẫn chưa nhận được..

☐ Chương trình sức khỏe tâm thần sẽ trả tiền cho những dịch vụ kể dưới đây thay vì dịch vụ do cơ quan chăm sóc sức khỏe của quí vị yêu cầu, căn cứ vào những chi tiết về tình trạng sức khỏe tâm thần và dịch vụ cần thiết của quí vị: _____

_____

☐ Những điều khác_____

_____

<u>Nếu quí không đồng ý với quyết định của chương trình, quí vi có thể</u>:

1. Mở hồ sơ khiếu nại với chương trình sức khỏe tâm thần của mình Để làm việc này, quí vị có thể gọi điện thọai và thảo luận với người đại diện chương trình ở số (800) 479-3339 hay viết thư cho: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370; hay làm theo lời chỉ dẫn trong quyển sách hướng dẫn mà quí vị đã nhận được. Quí vị phải mở hồ sơ khiếu nại trong vòng 90 ngày từ ngày nhận thông báo này. Hầu hết các trường hợp, chương trình sức khỏe tâm thần phải giải quyết khiếu nại của quí vị trong vòng 45 ngày từ lúc quí vị yêu cầu. Quí vị có thể yêu cầu giải quyết nhanh trong vòng ba ngày làm việc, nếu quí vị tin rằng sự giải quyết trễ nãi có thể gây hậu quả nghiêm trọng cho sức khỏe tâm thần, kể cả vấn đề duy trì, hồi phục các chức năng quan trọng của đời sống. Quí vị có thể yêu cầu được nhận dịch vụ cho đến khi có được quyết định của sự khiếu nại. Để giữ được những dịch vụ, quí vị phải mở hồ sơ khiếu nại trong vòng 10 ngày tính từ lúc nhận thông báo này hay trước ngày thay đổi những dịch vụ, tính theo việc nào xảy ra trễ hơn. Những dịch vụ được chương trình chấp nhận trước kia trong khỏang thời gian _____. Sự thay đổi những dịch vụ bắt đầu có hiệu lực từ ngày _____.

2. Nếu quí vị không bằng lòng kết quả của việc khiếu nại, quí vị có thể yêu cầu có một buổi điều trần cấp tiểu bang và quí vị vẫn tiếp tục nhận các dịch vụ trong khi chờ được điều trần. Trang sau của thông báo này có giải thích làm cách nào để xin buổi điều trần. Quí vị có thể yêu cầu giữ những dịch vụ như cũ cho đến khi có kết quả. Để giữ được dịch vụ, quí vị phải mở hồ sơ khiếu nại trong vòng 10 ngày tính từ lúc nhận thông báo này hay trước ngày thay đổi những dịch vụ, tính theo việc nào xảy ra trễ hơn. Những dịch vụ được chương trình chấp nhận trước kia trong khỏang thời gian _____. Sự thay đổi những dịch vụ bắt đầu có hiệu lực từ ngày _____. Các dịch vụ có thể vẫn tiếp tục trong khi quí vị chờ đợi kết quả của buổi điều trần.

3. Quí vị có thể yêu cầu chương trình sắp xếp để có một ý kiến thứ hai về tình trạng sức khỏe tâm thần của quí vị. Để làm việc này, quí vị có thể gọi và thảo luận với một người đại diện của chương trình sức khỏe tâm thần của quí vị ở (800) 479-3339 hay viết thư về: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370.

Distrito ng San Diego
Programa ng Pinagdalubhasaang Medi-Cal ng mga Serbisyo ng Kalusugang Kaisipan
PAUNANG -SABI NG PAG-GAWA

Petsa: _____

Para kay: _____ Numero ng Medi-Cal _____

Ang panukala ng kalusugang kaisipan para sa Distrito ng San Diego ay ☐ pinagkait ☐ binago sa kahilingan ng iyong tagapagkaloob para sa pagbabayad ng sumusunod na (nga) serbisyo:

_____

Ang kahilingan ay ginawa ni: (pangalan ng taga-pagkaloob) _____
Ang orihinal na kahilingan ng iyong tagapagkaloob ay nakatala sa araw ng _____
Ang panukala ng kalusugang kaisipan ay nakuha ang pag-gawa batay sa inpormasyon ng iyong taga-pagkaloob sa dahilan ay tiyakin sa ibaba :

☐ Ang kalagayan ng iyong kalusugang kaisipan ay hindi nakasapat sa pamantayan na kinakailangan ng Medikal para sa mga serbisyo ng ospital na tumatanggap ng tirahan at pagkain kasama ang pag-gamot sa mga may sakit sa utak o kaugnay ng propesyonal na mga serbisyo (Title 9, California Code of Regulations (CCR), Section 1820.205).
☐ Ang kalagayan ng iyong kalusugang kaisipan ay hindi nakasapat ng pamantayan na kinakailangan ng Medikal para sa pinagdalubhasaang serbisyo ng kalusugang kaisipan bukod sa mga serbisyo ng ospital na tumatanggap ng tirahan at pagkain kasama ang pag-gamot sa mga may sakit sa utak para sa mga sumusunod na dahilan (Title 9, CCR, Section 1830.205): _____
_____
☐ Ang serbisyo na hinihiling ay hindi napabilang batay sa panukala ng kalusugang kaisipan (Title 9, CCR, Section 1810.345).
☐ Ang panukala ng kalusugang kaisipan ay humihiling ng karagdagang inpormasyon na galing sa iyong taga-pagkaloob na ang panukala ay nangangailangan ng pahintulot para sa pagbabayad sa iminungkahing serbisyo. Sa araw na ito, ang inpormasyon ay hindi pa natatanggap.
☐ Ang panukala ng kalusugang kaisipan ay siyang magbabayad sa mga sumusunod ng (mga) serbisyo sa halip na hinihiling na serbisyo ng iyong taga-pagkaloob, batay sa nagagamit na inpormasyon ng iyong kalagayan ng kalusugang kaisipan at ang serbisyo na kinakailangan: _____
☐ Iba pa:_____

<u>Kung ikaw ay hindi sang-ayon nitong panukalang pasiya, ikaw ay maaring</u>:

1. Ikaw ay maaring magsampa ng panawagan kasama ng iyong panukala ng kalusugang kaisipan. Ang paggawa nito, ikaw ay maaring tumawag at kausapin ang representante ng iyong panukala ng kalusugang kaisipan sa (800) 479-3339 o sumulat sa: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370; o sundin ang mga direksyon nasa inpormasyon ng polyeto na ibinigay sa iyo ng panukala ng kalusugang kaisipan . Ikaw ay dapat mag-sampa ng panawagan sa loob ng 90 na araw mula sa petsa nitong paunang-sabi. Karamihan sa mga kalagayan ang panukala ng kalusugang kaisipan ay dapat gumawa ng pasiya ng iyong panawagan sa loob ng 45 na araw ng iyong paghiling. Ikaw ay maaring humiling ng mapabilis na panawagan, na kailangang mapasiyahan sa loob ng 3 gumaganang mga araw, kung ikaw ay naniniwala na pagnaatraso ito ay magiging dahilan ng malubhang mga problema ng iyong kalusugang kaisipan kasama na ang mga problema ng iyong kakayanang makamit, mapanatili, o mabawi ang mahalagang takbo ng buhay. Ikaw ay maaring humiling na ang iyong mga serbisyo ay manatiling walang pagkaiba hanggang ang pasiya ng panawagan ay magawa. Upang manatili ang iyong mga serbisyo kailangan mong magsampa ng panawagan sa loob ng 10 na araw mula sa petsa nitong paunang-sabi o bago ang petsa na mgkabisa ng pagpalit ng serbisyo, alinman ang huli. Ang serbisyo na hinihiling ay dating pinagsang-ayonan ng panukala para sa panahon _____. Ang petsa na magkabisa para sa pagpalit nitong serbisyo ay _____.
2. Kung ikaw ay hindi nasisiyahan sa resulta ng iyong panawagan, ikaw ay maaring humiling ng pormal na paghukom na maaring pahintulutang ipagpatuloy ang mga serbisyo habang ikaw ay naghihintay ng paghukom. Sa kabila nitong paunang-sabi ay nagpaliwanag kung paano humiling ng paghukom. Ikaw ay maaring humiling na ang iyong mga serbisyo ay manatiling walang pagkaiba hanggang ang paghukom ay magawa. Upang manatili ang iyong serbisyo kailangan mong magsampa ng panawagan sa loob ng 10 na araw mula sa petsa nitong paunang-sabi o bago ang petsa na magkabisa ng pagpalit sa serbisyo, alinman ang huli. Ang serbisyo na hinihiling ay dating pinagsang-ayonan ng panukala para sa panahon _____. Ang petsa na magkabisa para sa pagpalit nitong serbisyo ay _____. Ang mga serbisyo ay amaring magpatuloy habang ikaw ay naghihintay sa katatagan ng pasiya ng iyong hukom.
3. Ikaw ay maaring humiling sa panukala na mag-areglo ng pangalawang pagpalagay tungkol sa kalagayan ng iyong kalusugang kaisipan. Ang paggawa nito, ikaw ay maaring tumawag at kausapin ang representante ng iyong panukala ng kalusugang kaisipan sa (800) 479-3339 o sumulat sa: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370.

مقاطعة سان دييغو
برنامج خدمات الصحة النفسية المتخصصة بالتأمين الصحي الحكومي (Medi-Cal)
بيان إجرائي

التأريخ: _____

إلى: _____ رقم التأمين الصحي الحكومي: _____

إن برنامج الصحة النفسية لمقاطعة سان دييغو قد قرر ☐ رفض طلبك ☐ تغيير طلب موفر الخدمات الخاص بك لدفع تكاليف الخدمات التالية:

_____

تم تقديم الطلب من قبل: (إسم موفر الخدمات) _____

تأريخ الطلب الأصلي المقدم من قبل موفر الخدمات الخاص بك: _____

إتخذ برنامج خدمات الصحة النفسية هذا القرار إعتماداً على البيانات الواردة من موفر الخدمات الخاص بك و ذلك للأسباب المبينة أدناه:

☐ إن حالة صحتك النفسية لا تحقق المعايير الطبية الضرورية للحصول على خدمات مستشفى الصحة النفسية السريرية أو الخدمات المتخصصة المتعلقة بالصحة النفسية (المادة 9، CCR، الفقرة 1820.205).

☐ إن حالة صحتك النفسية لا تحقق المعايير الطبية الضرورية للحصول على خدمات الصحة النفسية المتخصصة بإستثناء خدمات مستشفى الصحة النفسية السريرية و ذلك بسبب (المادة 9، CCR، الفقرة 1830.205): _____

_____

_____

☐ الخدمات المطلوبة غير مشمولة في برنامج الصحة النفسية (المادة 9، CCR، الفقرة 1810.345).

☐ لقد طلب برنامج الصحة النفسية المزيد من المعلومات من موفر الخدمات الخاص بك، يحتاج البرنامج لتلك المعلومات للموافقة على دفع تكاليف الخدمات المطلوبة. لغاية الآن لم يتم إستلام المعلومات المطلوبة.

☐ سيقوم برنامج الصحة النفسية بدفع تكاليف الخدمات التالية بدلاً عن الخدمات التي تم طلبها من قبل موفر الخدمات الخاص بك، إعتماداً على المعلومات المتوفرة عن حالة صحتك النفسية و إحتياجك للخدمات. _____

_____

☐ أخرى: _____

_____

إن لم توافق على قرار البرنامج فيمكنك:

1. يمكنك أن تقدم طلب إستئناف لبرنامج الصحة النفسية الخاص بك. لقيام بذلك، يمكنك الإتصال و التكلم مع ممثل عن برنامج الصحة النفسية على الهاتف المرقم 3339-479 (800) أو بمراسلة العنوان التالي: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370، أو بإتباع الإجراءات الواردة في كتيب المعلومات الذي قام برنامج الصحة النفسية بإعطائك إياه. يجب أن تقوم بتقديم طلب الإستئناف خلال 90 يوماً من تأريخ هذا البيان. في أغلب الحالات، يجب أن يقوم برنامج الصحة النفسية بإتخاذ قرار بخصوص طلب الإستئناف الذي تقدمت به خلال 45 يوماً من تأريخ تقديمك للطلب. يمكنك أن تطلب الحصول على إستئناف مستعجل، و الذي يجب أن يتم إتخاذ قرار بخصوصه خلال 3 أيام عمل، إن كنت تعتقد بأن التأخير قد يؤدي إلى مشاكل جدية على صحتك النفسية، مثل المشاكل المتعلقة بقدرتك على إكتساب أو الحفاظ أو إستعادة بعض وظائف الحياة المهمة. يمكنك أن تطلب الإبقاء على الخدمات التي تحصل عليها حتى يتم إتخاذ قرار بخصوص طلب الإستئناف الذي تقدمت به. للإبقاء على الخدمات التي تحصل عليها، يجب أن تقوم بتقديم طلب الإستئناف خلال 10 أيام من تأريخ هذا البيان أو قبل تأريخ نفاذ التغيير في الخدمات، أيهما أبعد. لقد وافق البرنامج من قبل على الخدمات المطلوبة للفترة _____. تأريخ نفاذ التغيير في هذه الخدمات هو _____.

2. إن لم تكن راضياً عن نتيجة الإستئناف، يمكنك أن تطلب الحصول على جلسة إستماع عادلة، ذلك قد يسمح بإستمرارك بالحصول على الخدمات إثناء فترة إنتظارك للجلسة. ستبين الصفحة الثانية من هذا البيان كيف يمكنك طلب الحصول على جلسة الإستماع. يمكنك أن تطلب الإبقاء على الخدمات التي تحصل عليها حتى يتم إتخاذ قرار جلسة الإستماع. للإبقاء على الخدمات التي تحصل عليها، يجب أن تقوم بتقديم طلب الإستئناف خلال 10 أيام من تأريخ هذا البيان أو قبل تأريخ نفاذ التغيير في الخدمات، أيهما أبعد. لقد وافق البرنامج من قبل على الخدمات المطلوبة للفترة _____. تأريخ نفاذ التغيير في هذه الخدمات هو _____. قد تستمر بالحصول على الخدمات أثناء إنتظارك لقرار جلسة الإستماع.

3. يمكنك أن تطلب من البرنامج الترتيب للحصول على رأي أخر بخصوص حالة صحتك النفسية. للقيام بذلك، يمكنك الإتصال و التكلم مع ممثل عن برنامج الصحة النفسية على الهاتف المرقم 3339-479 (800) أو بمراسلة العنوان التالي: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370.

مقاطعة سان دييغو
برنامج خدمات الصحة النفسية المتخصصة بالتأمين الصحي الحكومي (Medi-Cal)
بيان إجرائي
(تقييم)

التأريخ: _____

إلى: _____، رقم التأمين الصحي الحكومي: _____

قرر برنامج الصحة النفسية في مقاطعة سان دييغو، بعد مراجعة نتائج تقييم حالة صحتك النفسية، بأن حالة صحتك النفسية لا تحقق المعايير الضرورية لتكون مؤهلاً للحصول على خدمات الصحة النفسية المتخصصة ضمن البرنامج.

من وجهة نظر برنامج الصحة النفسية، فإن حالة صحتك النفسية لم تحقق المعايير الطبية الضرورية الواردة في أنظمة الولاية ضمن المادة 9، من قانون الأنظمة في ولاية كاليفورنيا ((California Code of Regulations (CCR))، الفقرة 1830.205، و ذلك للسبب المؤشر إزاءه أدناه:

☐ إن حالة صحتك النفسية كما تم تشخيصها في عملية التقييم غير مشمولة في خدمات برنامج الصحة النفسية (المادة 9، CCR، الفقرة 1830.205 (ب) (1)).

☐ إن حالة صحتك النفسية لا تسبب لك مشاكل جدية في حياتك اليومية بشكل يجعلك مؤهل للحصول على خدمات الصحة النفسية المتخصصة المقدمة من قبل برنامج خدمات الصحة النفسية (المادة 9، CCR، الفقرة 1830.205 (ب) (2)).

☐ لا يُعتقد بأن خدمات الصحة النفسية المتخصصة المتوفرة لدى برنامج الصحة النفسية ستساعدك على الحفاظ أو تحسين حالة صحتك النفسية (المادة 9، CCR، الفقرة 1830.205 (ب) (3) (أ) و (ب)).

☐ إن حالة صحتك النفسية ستستجيب للعلاج المقدم من قبل موفر خدمات صحية بدنية (المادة 9، CCR، الفقرة 1830.205 (ب) (3) (ج)).

إن وافقت على قرار البرنامج، و كنت ترغب بالحصول على المعلومات المتعلقة بإيجاد موفر خدمات خارج البرنامج للمساعدة على علاج حالتك، يمكنك الإتصال و التكلم مع ممثل عن برنامج الصحة النفسية على الهاتف المرقم 3339-479 (800) أو بمراسلة العنوان التالي: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370.

إن لم توافق على قرار البرنامج، فيمكنك القيام بأي من الإجراءات التالية:

يمكنك أن تطلب من البرنامج الترتيب للحصول على رأي أخر بخصوص حالة صحتك النفسية. للقيام بذلك، يمكنك الإتصال و التكلم مع ممثل عن برنامج الصحة النفسية على الهاتف المرقم 3339-479 (800) أو بمراسلة العنوان التالي: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370.

يمكنك أن تقدم طلب إستئناف لبرنامج الصحة النفسية الخاص بك. للخدمات السريرية/أو لخدمات الإقامة، يمكنك الإتصال و التكلم مع ممثل برنامج الدفاع عن حقوق المرضى (JFS) على الهاتف المرقم 2233-479 (800) أو مراسلته على العنوان التالي 2710 Adams Avenue, San Diego, CA 92116. أما بالنسبة لخدمات العيادة الخارجية و باقي خدمات الصحة النفسية، يمكنك الإتصال و التكلم مع ممثل مركز التوعية و التثقيف الصحي للمستهلك على الهاتف المرقم 3258-734 (877) أو مراسلته على العنوان التالي 1764 San Diego Avenue, Suite 200, San Diego, CA 92110. أو يمكنك إتباع التوجيهات الواردة في كتيب المعلومات الذي أعطاك إياه برنامج الصحة النفسية. يجب أن تقوم بتقديم طلب الإستئناف خلال 90 يوماً من تأريخ هذا البيان. في أغلب الحالات، يجب أن يقوم برنامج الصحة النفسية بإتخاذ قرار بخصوص طلب الإستئناف الذي تقدمت به خلال 45 يوماً من تأريخ تقديمك للطلب. يمكنك أن تطلب الحصول على إستئناف مستعجل، و الذي يجب أن يتم إتخاذ قرار بخصوصه خلال 3 أيام عمل، ذلك إن كنت تعتقد بأن التأخير قد يؤدي إلى حصول مشاكل جدية تؤثر على صحتك النفسية، مثل المشاكل المتعلقة بقدرتك على إكتساب أو الحفاظ أو إستعادة بعض وظائف الحياة المهمة.

إن كان لديك إستفسارات بخصوص هذا البيان، للخدمات السريرية/أو لخدمات الإقامة، يمكنك الإتصال و التكلم مع ممثل برنامج الدفاع عن حقوق المرضى (JFS) على الهاتف المرقم 2233-479 (800) أو مراسلته على العنوان التالي 2710 Adams Avenue, San Diego, CA 92116. بالنسبة لخدمات العيادة الخارجية و باقي خدمات الصحة النفسية، يمكنك الإتصال و التكلم مع ممثل مركز التوعية و التثقيف الصحي للمستهلك على الهاتف المرقم 3258-734 (877) أو مراسلته على العنوان التالي 1764 San Diego Avenue, Suite 200, San Diego, CA 92110. أو يمكنك إتباع التوجيهات الواردة في كتيب المعلومات الذي أعطاك إياه برنامج الصحة النفسية.

إن لم تكن راضياً عن نتيجة الإستئناف، فيمكنك أن تطلب الحصول على جلسة إستماع عادلة على مستوى الولاية. ستبين الصفحة الثانية من هذا البيان كيف يمكنك طلب الحصول على جلسة الإستماع.

حقوقك المتعلقة بالحصول على جلسة إستماع

لديك 90 يوماً لطلب الحصول على جلسة إستماع. تبدأ فترة الـ 90 يوماً إعتباراً من:

1. اليوم الذي قمنا فيه بتسليمك شخصياً هذا ال بيان المتعلق بقرار الإستئناف الصادر عن برنامج الصحة النفسية ، أو
2. اليوم الذي يلي اليوم الذي ختم به هذا البيان بختم مكتب البري د.

طلب الحصول على جلسة إستماع عاجلة على مستوى الولاية

عادة ما يستغرق إتخاذ القرار 90 يوماً من تأريخ تقديمك لطلب الحصول على قرار جلسة الإستماع. يمكنك طلب الحصول على جلسة إستماع عاجلة إن كنت تعتقد أن هذه الفترة ستسبب مشاكل أ خطرة على صحتك النفسية، بضمن ذلك ، المشاكل التي قد تؤثر على إستعادة أو المحافظة على قدرتك على ممارسة نشاطات الحياة الضرورية. **لطلب الحصول على جلسة إستماع عاجلة، يرجى أن تأشر في المربع الأول في العمود الأيسر لهذه الصفحة المعنون طلب الحصول على جلسة إستماع و أن تبين الأسباب التي دعتك إلى طلب الحصول على جلسة إستماع عاجلة.** إن تمت الموافقة على طلبك الخاص بجلسة الإستماع العاجلة، فسيتم إتخاذ قرار خلال ثلاثة أيام عمل من تأريخ إستلام طلبك من قبل قسم جلسات الإستماع في الولاية.

من أجل إستمرارك بالحصول على ذات الخدمات أثناء إنتظارك لجلسة الإستماع

- يجب أن تطلب الحصول على جلسة إستماع خلال 10 أيام من تأريخ إرسال بيان قرار الإستئناف الصادر عن برنامج الصحة النفسية أو من تأريخ تسليمه إليك شخصياً؛ أو قبل تأريخ نفاذ التغييرات الطارئة على الخدمات ، أيهم أبعد.
- ستستمر خدمات الصحة النفسية التي تحصل عليها من قبل برنامج التأمين الصحي الحكومي (Medi-Cal) كما هي حتى يتم إتخاذ قرار نهائي ل جلسة الإستماع لا يصب في مصلحتك، أو تقوم بسحب طلبك بالحصول على جلسة إستماع، أو عندما تنتهي فترة أو حدود الخدمات، أيهم أقرب.

توفر نصوص أنظمة الولاية

أنظمة الولاية، بضمنها تلك الأنظمة المتعلقة بجلسات الإستماع متوفرة في مكتب دائرة الضمان الإجتماعي في مقاطعتك.

للحصول على المساعدة

يمكنك الحصول على المساعدة القانونية مجاناً من مكتب المشورة القانونية المحلي أو من قبل المجموعات الأخرى. للمشاكل المتعلق بخدمات الصحة النفسية السريرية أو المقيمة، إتصل ببرنامج الدفاع عن حقوق المريض (JFS) على الهاتف المرقم 800-479-2233. للمشاكل المتعلقة بالعيادة الخارجية و لكافة خدمات الصحة النفسية الأخرى، يرجى الإتصال مجاناً بمركز التثقيف و التوعية الصحية للمستهلك على الهاتف المرقم 877-734-3258. يمكنك أن تحصل على المعلومات المتعلقة بحقوقك الخاصة بجلسة الإستماع و المشورة القانونية المجانية من قبل وحدة الإستفسارات و الإجابات العامة.

يرجى الإتصال على الهاتف المجاني 1-800-952-5253

إن كنت أصماً و تستعمل نظم الإتصال الخاصة بالصم 1-800-952-8349

الممثل المخول

يمكنك أن تمثل نفسك في جلسة الإستماع. كما و يمكن أن تُمثل من قبل صديق، أو محامي أو أي شخص أخر تختاره. يجب أن تقوم بإختيار هذا الممثل بنفسك.

بيان قانون إستخدام المعلومات (القانون المدني لولاية كاليفورنيا المادة 1798)

إن المعلومات المطلوبة منك في هذه الإستمارة هي معلومات ضرورية لإجراءات طلب الإستئناف الخاص بك. يمكن أن تتأخر تلك الإجراءات إن لم تكن هذه المعلومات كاملة و دقيقة. سيتم إستحداث ملف خاص بالقضية من قبل قسم جلسات الإستماع في الولاية التابع لوزارة الشؤون الإجتماعية. لديك الحق بمراجعة المواد التي تشكل الوثائق المؤثرة على القرار و يمكنك الحصول على هذه الوثائق عن طريق الإتصال بوحدة الإستفسارات و الإجابة (على رقم الهاتف المذكور أعلاه). قد يتم تداول أي معلومات تقدمها مع برنامج الصحة النفسية ، و وزار تي الصحة و الصحة النفسية في الولاية ، و وزارة الصحة والخدمات الإنسانية الفدرالية (المصدر: قانون سلطات و مؤسسات الضمان الإجتماعي، الفقرة 14100.2).

كيف يمكنك طلب الحصول على جلسة إستماع على مستوى الولاية

أفضل طريقة لطلب جلسة إستماع هي ب تعبئة حقول هذه الصفحة. قم بإستنساخ كلاً من وجهي هذه الورقة للإحتفاظ به في ملفاتك الخاصة. بعد ذلك، ق م بإرسال هذه الورقة الى العنوان التالي:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

كما و يمكنك طلب الحصول على جلسة إستماع عن طريق الهاتف ب الإتصال بالهاتف 1-800-952-5253 . إن كنت أصماً و من الذين يستخدمون نظم الإتصال الخاصة بالصم، يمكنك الإتصال بالهاتف المرقم 1-800-952-8349.

طلب الحصول على جلسة إستماع

أرغب بطلب جلسة إستماع بسبب الإجراءات المتعلقة ببرنامج التأمين الصحي الحكومي (Medi-Cal) المتخ ذة من قبل برنامج الصحة النفسية التابع لمقاطعة سان دييغو.

☐ قم بتأشير هذا المربع إن كنت ترغب بالحصول على جلسة إستماع عاجلة و قم ب توضيح الأسباب أدناه.

الأسباب: _____

_____

_____

_____

_____

_____

☐ قم بتأشير هذا المربع و أضف صفحة أخرى إن إحتجت إلى مجال أكبر لشرح الأسباب.

إسمي: (أكتب بوضوح) _____

رقم الضمان الإجتماعي الخاص بيّ: _____

عنواني: (أكتب بوضوح) _____

_____

رقم هاتفي: (_____) _____

توقيعي: _____

التأريخ: _____

إنني أحتاج لمترجم مجاني. لغتي أو لهجتي هي: _____

إنني أرغب أن يمثلني الشخص المذكور أدناه خلال جلسة الإستماع. إنني أمنح هذا الشخص حق مطالعة سجلاتي الخاصة و حق حضور جلسة الإستماع بدلاً عني.

الإسم: _____

العنوان: _____

_____

رقم الهاتف: _____

Distrito ng San Diego
Programa ng Pinagdalubhasaang Medi-Cal ng Kalusugang Kaisipan
PAUNANG-SABI NG PAG-GAWA
(Pagpahalaga)

Petsa: _____

Para kay: _____, Numero ng Medi-Cal: _____
Ang panukala ng kalusugang kaisipan para sa Distrito ng San Diego ay nagpasiya, pagkatapos suriin muli ang mga resulta ng pagpahalaga sa kalagayan ng iyong kalusugang kaisipan, na ang kalagayan ng iyong kalusugang kaisipan ay hindi nakasapat sa pamantayan na kinakailangan ng medikal na maging karpat-dapat mahirang para sa pinagdalubhasaang mga serbisyo ng kalusugang kaisipan sa pamagitan ng panukala.

Sa palagay ng panukala ng kalusugang kaisipan, ang kalagayan ng iyong kalusugang kaisipan ay hindi nakasapat ng pamantayan na kinakailangan ng medikal, na siyang napabilang sa pormal na mga pamahala sa Titulo 9, California Code of Regulations (CCR), Section 1830.205, sa dahilan ay tiyakin sa ibaba:

☐ Ang pag-susuri ng iyong kalusugang kaisipan na kinikilala sa pagpahalaga ay hindi napabilang sa panukala ng kalusugang kaisipan (Title 9, CCR, Section 1830.205(b)(1)).
☐ Ang kalagayan ng iyong kalusugang kaisipan ay hindi dahilan ng mga problema para sa iyong araw-araw na pamumuhay na maging sapat na mahalaga para ikaw ay karpat-dapat mahirang para sa pinagdalubhasaang mga serbisyo ng kalusugang kaisipan na mula sa panukala ng kalusugang kaisipan (Title 9, CCR, Section 1830.205(b)(2)).
☐ Ang mga serbisyo ng pinagdalubhasaang kalusugang kaisipan na magagamit mula sa panukala ng kalusugang kaisipan ay hindi ka maaring matutulungan upang manatili o pagbutihin ang kalagayan ng iyong kalusgang kaisipan (Title 9, CCR, Section 1830.205(b)(3)(A) and (B)).
☐ Ang kalagayan ng iyong kalusugang kaisipan ay maaring sumang-ayon sa pag-gamot ng tagapag-alaga ng kalusugang pangkatawan (Title 9, CCR, 1830.205(b)(3)(C)).

Kung ikaw ay sang-ayon sa panukalang pasiya, at gustong magkaroon ng inpormasyon tungkol kung paano makahanap ng tagapag-alaga sa labas ng iyong panukala na mag-gagamot sa iyo, ikaw ay maaring tumawag o kausapin ang representante ng iyong panukala ng kalusugang kaisipan sa (800) 479-3339 o sumulat sa: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370.

Kung ikaw ay hindi sang-ayon sa panukalang pasiya, ikaw ay maaring gumawa ng isa o mahigit pa sa mga sumusunod:
Ikaw ay maaring humiling sa panukala ng pangalawang opinyon tungkol sa iyong kalagayan ng kalusugang kaisipan. Sa pag-gawa nito, ikaw ay maaring tumawag o kausapin ang representante ng iyong panukala ng kalusugang kaisipan sa (800) 479-3339 o sumulat sa: Utilization Management, Optum, P.O. Box 601370, San Diego, CA 92160-1370.

Ikaw ay maaring magsampa ng panawagan sa iyong kalusugang kaisipan. Para sa mga serbisyo ng mga pasyenteng nasa ospital na tumatanggap ng tirahan at pagkain kasama na ang pag-gamot/naninirahan, ikaw ay maaring tumawag at makiusap o sumulat sa representante ng JFS Programa ng Tagapagtanggol ng Pasyente sa (800) 479-2233, 2710 Adams Avenue, San Diego, CA 92116. Para sa mga pasyenteng hindi na ospital at lahat ng iba pang mga serbisyo ng kaulsugang kaisipan, ikaw ay maaring tumawag at makiusap o sumulat sa representante ng Lugar para sa partikular na Gawain ng Mamimili para sa Edukasyon ng Kalusugan at Tagapagtanggol sa (877)734-3258, 1764 San Diego Avenue, Ste 200, San Diego, CA 92110. O maaring sundin ang mga direksyon nasa inpormasyon ng polyeto na ibinigay sa iyo ng kalusugang kaisipan. Ikaw ay dapat magsampa ng panawagan sa loob ng 90 na araw mula sa petsa nitong paunang-sabi. Karamihan sa mga kalagayan ang panukala ng kalusugang kaisipan ay dapat gumawa ng pasiya ng inyong panawagan sa loob ng 45 na araw ng iyong paghiling. Ikaw maaring humiling ng mapabilis na panawagan, na kailangang mapasiyahan sa loob ng 3 gumaganang mga araw, kung iyong pinapaniwala na pag-naatraso ay magiging dahilan ng malubhang mga problema ng iyong kalusugang kaisipan kasama ang mga problema ng iyong kakayanang makamit, mapanatili, o mabawi ang mga mahalagang takbo ng buhay.

Kung ikaw ay may katanongan tungkol nitong paunag-sabi, para sa mga serbisyo ng mga pasyenteng nasa ospital na tumatanggap ng tirahan at pagkain kasama na ang pag-gamot/naninirahan, ikaw ay maaring tumawag at makiusap o sumulat sa representante ng JFS Programa ng tagapagtanggol ng Pasyente sa (800) 479-2233, 2710 Adams Avenue, San Diego, CA 92116. Para sa mga pasyenteng hindi na ospital at lahat ng iba pang mga serbisyo ng kalusugang kaisipan, ikaw ay maaring tumawag at makiusap o sumulat sa representante ng Lugar para sa partikular na Gawain ng Mamimili para sa Edukasyon ng Kalusugan at Tagapagtanggol sa (877) 734-3258, 1764 San Diego Avenue, Ste 200, San Diego, CA 92110.

Kung ikaw ay hindi nasisiyahan sa resulta ng iyong panawagan, ikaw ay maaring humiling ng makatarungan na paghukom sa Estados. Sa kabila nitong porma ay nagpapaliwanag kung paano humiling ng paghukom.

ANG IYONG KARAPATAN SA PAGHUKOM

Ikaw ay maroong 90 na ar aw lamang para humiling ng paghuko m. Ang 90 na araw ay magsimula alinmang:

1. Ang araw pagkatapos naming pinansariling ibinigay sa iyo itong paunang sabing pasiya ng panukala ng kalusugang kaisipang panawagan, O
2. Ang araw pagkatapos sa p etsa ng tatak-koreo nitong paunang sabing pasiya ng panukala ng kalusugang kaisipang panawagan.

Minamadalimg Pormal Na Paghukom

Ito'y karaniwang umabot ng 90 na araw , mula sa petsa n g iyong kahilingan para magawa ang pasiya ng paghukom. Kung iyong iniisip na itong tiyempo ay maging dahilan ng malubhang mga problema ng iyong kalusugang kaisipan, k asama ang mga problema ng iy ong kakayanang makamit, mapanatili o mabawi a ng mga mahalagang takbo ng buhay, ikaw ay maaaring humiling ng pormal na minamadaling paghukom. **Upang humiling ng minamadalimg paghukom, kung maaari ay tiyakin and unang kahon na nasa hanay ng kanang kamay nitong pahina sa ibaba ng KAHILINGAN NG PAGHUKOM at isama ang dahilan kung bakit ikaw ay humihiling ng minamadaling paghukom.** Kung ang minamadaling paghukom na iyong hinihiling ay pinahintulutan, ang pasiya ng p aghukom ay mabibigay sa loob ng tatlong gumaganang mga araw sa p etsa ng pagkatanggap ng iyong hinihiling ng Pangkat na Pormal ng Paghukom.

Upang Maitago ang Iyong mga Serbisyo na Walang Pagbabago Habang Ikaw ay Naghihintay ng Paghukom

- Ikaw ay dapat humiling ng paghukom sa loob ng 10 na araw mula sa petsa ng pagpadala ng paunang sabi ng p asiya ng panukala ng kalusugang kaisipang panawagan o pribadong ibinigay sa iyo o bago sa petsang magkabisa sa pagpalit ng mga serbisyo, alinmang huli.
- Ang serbisyo ng iyong Medi-Cal ng k alusugang kaisipan ay manatiling walang pagbabago hanggang ang huling pasiya ng hukoman ay magagawa alinmang salungat sa iyo, iurong mo ang iyong kahilingan para sa pagh ukom, o sa oras ng pan ahon o ang takda ng serb isyo para sa iy ong kasalukuyang mga serbisyo ay n a walang bisa, alin mang unang naganap.

Pormal na mga Pamahalang Magagamit

Pormal na mga pamahala, kasama ang mga nakabilang na pormal na mga paghukom, ay magagamit sa iy ong lokal na opisina ng distrito ng kabutihan .

Upang Makakuha ng Tulong

Ikaw ay maaaring makakuha ng libring tulong sa iy ong lokal na opisina ng tulong ayon sa batas o ib ang mga pangkat. Para sa mga pro blema ng mga serbisyo ng kalusugang k aisipan ng mga p asyenteng nasa ospital na tumatanggap ng tirahan at p agkain kasama na ang paggamot at s a naninirahan, tumawag sa JFS Programa ng Tagapagtanggol ng Pasyente sa 800-479-2233. Para sa mga probl ema ng mga pasyenteng hindi na ospital at sa lahat ng ib a pang mga serbis yo ng kalusugang kaisipan, tumawag ng lib ring bayad sa Lugar para sa p articular na Gawain ng Mamimili para sa Edukasyon ng Kalusugan at Pasyente sa 877- 734-3258. Ikaw ay maaring magtanong tungkol sa karapatan ng paghukom o libring tulong ayon sa b atas na g alling sa Pampublikong Pagtatanong at Pangkat ng Tumutugon:

Tumawag ng libring bayad: 1-800-952-5253

Kung ikaw ay bingi at gumagamit ng TDD, tu mawag sa: 1-800-952-8349

Ang Maaaring maging Representante

Maaaring ikaw ang representante para sa iyong sarili sa pormal na paghukom. Maaari d ing ikaw ay representantehan ng iyong kaibigan, maging ang abogado o kung sin o man ang pipiliin mo. Ikaw mis mo ang mag-areglo nitong magiging representante.

Inpormasyon ng Paunang sabi na Isinagawa ng Batas (California Civil Code Section 1798, et seq.) Ang inpormasyong tinatanong sa iy o na isusulat sa pormang ito ay kininakailangan upang mag awan ng hakbang ang iyong hinihiling sa hukom an. Maaring maatraso ang paggawa ng h akbang kung ang iyong inpormasyon ay hindi kompleto. Ang kaso na s inampa ay gagawin ng Pangk at ng Pormal na mga Paghukom sa Departamento ng mga Serbisyong Panlipunan. Ikaw ay may karapatang magsiyasat ng mga materyales na ginawa sa p agtala para sa pasiya at maaring mahanap itong pagtala ng makipag- alam sa Pampublikong Pagtatanong at Pangkat ng Tumutugon (ang numero ng telepono ay makikita sa itaas). Ano mang inpormasyon na iyong ibinigay ito ay maaring ibahagi sa panukala ng k alusugang kaisipan, sa Pormal na Departamento ng mga Serbisyo ng Ka lusugang Kaisipan at kas ama ang Estados Unidos Departamento ng Kalusugan at Makatang mga Serbisyo. (Kapangyarihan: Kodigo ng Kabutihan at Pagtatatag, Seksiyon 14100.2)

PAANO HUMILING NG PORMAL NA PAGHUKOM

Ang pinakamabuting paraan sa paghiling ng hukoman ay ang pagpuno nitong pahina. Gumawa ng kopya sa harapan at likuran para sa iyong mga tala. Pagkatapos ipadala itong pahina sa:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Ibang paraan sa pagh iling ng hukoman ay ang pagtawag sa 1-800-952-5253. Kung ikaw ay bingi at gumagamit ng TDD, tumawag sa 1-800-952-8349.

KAHILINGAN NG PAGHUKOM

Gusto ko ng paghukom dahil s a kaugnayan ng paggawa ng Medi-Cal batay sa Kalusugang Kaisipan sa Distrito ng San Diego.

☐ Tiyakin dito kung gusto mo nang minamadaling pormal na paghukom at isama ang dahilan sa ibaba.

Ito ang dahilan: _____

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☐ Tiyakin dito at magdagdag ng pahina kung kinakailangan mong magdagdag ng lugar.

Ang aking pangalan: (isulat ng palimbag) _____

Numero ng aking Sosyal Sekyuriti: _____

Ang aking tirahan: (isulat na palimbag) _____

_____

Numero ng aking telepono: (____) _____

Ang aking pirma: _____

Petsa: _____

Kailangan ko n g tagapagliwanag na walang b ayad sa ak in. Ang aking lingguwahe o wikain ay: _____

Gusto ko ang taong nakap angalan sa ibab a na magrepresentante sa akin nitong paghukom. Ibibigay ko ang aking pahintulot nitong tao na makikita ang aking mga tala at darating sa hukoman para sa akin.

Pangalan: _____

Tirahan: _____

_____

Numero ng telepono: (_____) _____

ANG IYONG KARAPATAN SA PAGHUKOM

Ikaw ay maroong 90 na ar aw lamang para humiling ng paghuko m. Ang 90 na araw ay magsimula alinmang:

1. Ang araw pagkatapos naming pinansariling ibinigay sa iyo itong paunang sabing pasiya ng panukala ng kalusugang kaisipang panawagan, O
2. Ang araw pagkatapos sa p etsa ng tatak-koreo nitong paunang sabing pasiya ng panukala ng kalusugang kaisipang panawagan.

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Upang Maitago ang Iyong mga Serbisyo na Walang Pagbabago Habang Ikaw ay Naghihintay ng Paghukom

- Ikaw ay dapat humiling ng paghukom sa loob ng 10 na araw mula sa petsa ng pagpadala ng paunang sabi ng p asiya ng panukala ng kalusugang kaisipang panawagan o pribadong ibinigay sa iyo o bago sa petsang magkabisa sa pagpalit ng mga serbisyo, alinmang huli.
- Ang serbisyo ng iyong Medi-Cal ng k alusugang kaisipan ay manatiling walang pagbabago hanggang ang huling pasiya ng hukoman ay magagawa alinmang salungat sa iyo, iurong mo ang iyong kahilingan para sa pagh ukom, o sa oras ng pan ahon o ang takda ng serb isyo para sa iy ong kasalukuyang mga serbisyo ay n a walang bisa, alin mang unang naganap.

Pormal na mga Pamahalang Magagamit

Pormal na mga pamahala, kasama ang mga nakabilang na pormal na mga paghukom, ay magagamit sa iy ong lokal na opisina ng distrito ng kabutihan .

Upang Makakuha ng Tulong

Ikaw ay maaaring makakuha ng libring tulong sa iy ong lokal na opisina ng tulong ayon sa batas o ib ang mga pangkat. Para sa mga pro blema ng mga serbisyo ng kalusugang kaisipan ng mga p asyenteng nasa ospital na tumatanggap ng tirahan at p agkain kasama na ang paggamot at s a naninirahan, tumawag sa JFS Programa ng Tagapagtanggol ng Pasyente sa 800-479-2233. Para sa mga probl ema ng mga pasyenteng hindi na ospital at sa lahat ng ib a pang mga serbis yo ng kalusugang kaisipan, tumawag ng lib ring bayad sa Lugar para sa p articular na Gawain ng Mamimili para sa Edukasyon ng Kalusugan at Pasyente sa 877- 734-3258. Ikaw ay maaring magtanong tungkol sa karapatan ng paghukom o libring tulong ayon sa b atas na galling sa Pampublikong Pagtatanong at Pangkat ng Tumutugon:

Tumawag ng libring bayad: 1-800-952-5253

Kung ikaw ay bingi at gumagamit ng TDD, tu mawag sa: 1-800-952-8349

Ang Maaaring maging Representante

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Inpormasyon ng Paunang sabi na Isinagawa ng Batas (California Civil Code Section 1798, et seq.) Ang inpormasyong tinatanong sa iy o na isusulat sa pormang ito ay kininakailangan upang mag awan ng hakbang ang iyong hinihiling sa hukom an. Maaring maatraso ang paggawa ng h akbang kung ang iyong inpormasyon ay hindi kompleto. Ang kaso na s inampa ay gagawin ng Pangk at ng Pormal na mga Paghukom sa Departamento ng mga Serbisyong Panlipunan. Ikaw ay may karapatang magsiyasat ng mga materyales na ginawa sa p agtala para sa pasiya at maaring mahanap itong pagtala ng makipag- alam sa Pampublikong Pagtatanong at Pangkat ng Tumutugon (ang numero ng telepono ay makikita sa itaas). Ano mang inpormasyon na iyong ibinigay ito ay maaring ibahagi sa panukala ng k alusugang kaisipan, sa Pormal na Departamento ng mga Serbisyo ng Ka lusugang Kaisipan at kas ama ang Estados Unidos Departamento ng Kalusugan at Makatang mga Serbisyo. (Kapangyarihan: Kodigo ng Kabutihan at Pagtatatag, Seksiyon 14100.2)

PAANO HUMILING NG PORMAL NA PAGHUKOM

Ang pinakamabuting paraan sa paghiling ng hukoman ay ang pagpuno nitong pahina. Gumawa ng kopya sa harapan at likuran para sa iyong mga tala. Pagkatapos ipadala itong pahina sa:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Ibang paraan sa pagh iling ng hukoman ay ang pagtawag sa 1-800-952-5253. Kung ikaw ay bingi at gumagamit ng TDD, tumawag sa 1-800-952-8349.

KAHILINGAN NG PAGHUKOM

Gusto ko ng paghukom dahil s a kaugnayan ng paggawa ng Medi-Cal batay sa Kalusugang Kaisipan sa Distrito ng San Diego.

☐ Tiyakin dito kung gusto mo nang minamadaling pormal na paghukom at isama ang dahilan sa ibaba.

Ito ang dahilan: _____

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☐ Tiyakin dito at magdagdag ng pahina kung kinakailangan mong magdagdag ng lugar.

Ang aking pangalan: (isulat ng palimbag) _____

Numero ng aking Sosyal Sekyuriti: _____

Ang aking tirahan: (isulat na palimbag) _____

_____

Numero ng aking telepono: (____) _____

Ang aking pirma: _____

Petsa: _____

Kailangan ko n g tagapagliwanag na walang b ayad sa ak in. Ang aking lingguwahe o wikain ay: _____

Gusto ko ang taong nakap angalan sa ibaba na magrepresentante sa akin nitong paghukom. Ibibigay ko ang aking pahintulot nitong tao namakikita ang aking mga tala at darating sa hukoman para sa akin.

Pangalan: _____

Tirahan: _____

_____

Numero ng telepono: (_____) _____

SUS DERECHOS A TENER UNA AUDIENCIA

Sólo tiene 90 días para solicitar una audiencia. Los 90 días comienzan, ya sea:

1. El día después de que personalmente le entregamos este aviso de la decisión a la apelación de salud mental, **O**
2. El día después de la fecha en el matasellos de este aviso de la decisión a la apelación de salud mental**.**

Audiencias Expeditas del Estado

Generalmente tarda 90 días a partir de la fecha de su solicitud para tomar una decisión sobre la audiencia. Si piensa que esperar por ese período de tiempo podría ocasionar serios problemas a su salud mental, como problemas relacionados con su capacidad para adquirir, mantener o recuperar funciones vitales importantes, usted puede solicitar una audiencia expedita del estado. **Para solicitar una audiencia expedita, por favor marque la primera casilla en la columna del lado derecho de esta página, bajo el título SOLICITUD DE AUDIENCIA, e incluya la razón por la qué está solicitando una audiencia expedita**. Si su solicitud para una audiencia expedita es aprobada, la decisión para la audiencia será emitida dentro de los tres días hábiles siguientes a la fecha en que la División de Audiencias del Estado (*State Hearings Division*) haya recibido su solicitud.

Para conservar los mismos servicios que está recibiendo mientras espera por la audiencia

- Usted debe solicitar la audiencia dentro de los 10 primeros días a partir de la fecha en que se le envió por correo la decisión del plan de salud mental o de la fecha en que se le entregó personalmente; o antes de la fecha efectiva del cambio de servicios, lo que ocurra después.
- Sus servicios de salud mental de Medi-Cal seguirán siendo los mismos hasta que en la audiencia se tome una decisión en contra suya, usted retire su solicitud para una audiencia, o el período de tiempo o los límites de servicio para sus servicios actuales expire, lo que suceda primero.

Reglamentos estatales disponibles

Los reglamentos estatales, incluyendo aquellos que cubren audiencias estatales, están a su disposición en la oficina local de prestaciones de bienestar social (*welfare*) del condado.

Para obtener ayuda

Usted puede obtener ayuda legal gratuita en su oficina local de asistencia legal o a través de otros grupos. Para problemas relacionados con servicios de salud mental residenciales o de pacientes hospitalizados, llame a l programa de call JFS Patient Advocacy Program at 800-479-2233. Para problemas con pacientes ambulatorios y para todos los otros servicios de salud mental llame al número de teléfono gratuito del Consumer Center for Health Education and Advocacy at 877-734-3258. Puede preguntar acerca de sus derechos de audiencia o sobre la asistencia legal gratuita del *Public Inquiry and Response Unit* (Unidad de Preguntas y Respuestas al Público):

Llame gratuitamente al:	1-800-952-5253
Si usted es sordo y usa la línea TDD, llame al:	1-800-952-8349

Representante autorizado

Usted puede representarse a sí mismo en la audiencia del estado. También puede ser representado por un amigo, un abogado o por cualquier persona que usted elija. Usted debe hacer los arreglos para que lo representen.

Aviso de la ley sobre prácticas de información (Sección 1798, et. seq. del Código Civil de California). La información que se le pide que proporcione en este formulario es necesaria para procesar su solicitud de audiencia. El proceso puede retrasarse si la información no está completa. La División de Audiencias del Estado del Departamento de Servicios Sociales abrirá un expediente de su caso. Usted tiene derecho a examinar los materiales que componen el expediente para la decisión y puede localizar dicho expediente contactando a la Unidad de Preguntas y Respuestas al Público (a los números de teléfono anteriores). Cualquier información que usted proporcione podría ser compartida con el plan de salud mental, los Departamentos Estatales de Servicios de Salud y de Servicios de Salud Mental y con el Departamento de Servicios Humanos y de Salud de los Estados Unidos. (Autoridad: Sección 14100.2 del Código de Instituciones y Prestaciones de Bienestar Social.)

CÓMO SOLICITAR UNA AUDIENCIA DEL ESTADO

La mejor forma de solicitar una audiencia del estado es completando esta página. Saque una copia del frente y del reverso para conservar como constancia. Después envíe esta página a:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Otra forma de solicitar una audiencia es llamando al 1-800-952-5253
Si usted es sordo y usa TDD, llame al 1-800-952-8349

SOLICITUD DE AUDIENCIA

Deseo una audiencia debido a la acción tomada por el Plan de Salud Mental del Condado de San Diego en relación con Medi-Cal.

☐ Marque aquí si desea una audiencia expedita del estado y explique la razón de su solicitud a continuación.

La razón por la que deseo una audiencia expedita es: _____

_____

_____

_____

_____

_____

☐ Si necesita más espacio marque aquí y añada una página.

Mi nombre: (letra de imprenta) _____

Mi número de Seguro Social: _____

Mi domicilio: (letra de imprenta) _____

_____

Mi número de teléfono: (_____) _____

Mi firma: _____

Fecha: _____

Necesito de los servicios de un intérprete sin costo para mí. Mi idioma o dialecto es: _____

Deseo que la persona nombrada a continuación me represente en esta audiencia. Autorizo a dicha persona a que vea mi expediente y a que acuda a la audiencia por mí.

Nombre _____

Domicilio _____

_____

Número de teléfono: _____

QUYỀN ĐIỀU TRẦN

Quí vị chỉ có 90 ngày để yêu cầu buổi điều trần. 90 ngày bắt đầu:

1. Tính từ ngày chúng tôi đích thân đưa quí vị bản thông báo khiếu nại sức khỏe tâm thần này, HAY
2. Tính từ ngày dấu bưu điện in trên bản thông báo khiếu nại sức khỏe tâm thần này.

Buổi Điều trần Nhanh Chóng cấp Tiểu bang

Thường mất 90 ngày kể từ ngày quí vị yêu cầu. Nếu quí vị nghĩ thời gian này có thể gây nguy hại trầm trọng cho sức khỏe tâm thần của mình gồm việc duy trì và phục hồi các chức năng quan trọng của đời sống, quí vị có thể xin được xử nhanh hơn thường lệ**. Để có một buổi điều trần nhanh, xin vui lòng đánh dấu ô đầu tiên bên phải của trang này dưới chữ YÊU CẦU ĐIỀU TRẦN và ghi cả nguyên nhân yêu cầu được xử nhanh.** Nếu lời yêu cầu của quí vị được chấp nhận, người ta sẽ thông báo cho quí vị biết trong vòng ba ngày làm việc tính từ ngày Ủy Ban Điều Trần Tiểu bang nhận khiếu nại của quí vị.

Để được nhận cùng dịch vụ trong khi quí vị chờ đợi buổi Điều trần

- Quí vị phải yêu cầu có buổi điều trần trong vòng 10 ngày tính từ ngày bản thông báo khiếu nại sức khỏe tâm thần gửi đến hay được giao tận tay cho quí vị trước ngày thay đổi dịch vụ, tính theo việc nào xảy ra trễ hơn.
- Các dịch vụ sức khỏe tâm thần Medi-Cal sẽ vẫn giữ nguyên cho đến khi có quyết định cuối cùng của buổi điều trần và nếu kết quả bất lợi cho quí vị, và quí vi thu hồi lời yêu cầu, hay cho đến khi thời hạn nhận dịch vụ bị hết hạn, tính theo việc nào đến trước.

Các Luật Điều Hành Cấp Tiểu Bang

Luật điều hành tiểu bang, bao gồm tin tức điều trần đều có sẵn trong văn phòng trợ cấp xã hội của quận hạt địa phương.

Để được giúp đỡ

Quí vị có thể nhận đuợc sự giúp đỡ pháp lý từ văn phòng trợ giúp pháp lý địa phương hay từ các nhóm khác. Về các vấn đề khó khăn với bệnh nhân nội trú hay các dịch vụ sức khỏe tâm thần tại gia, hãy gọi Chương trình Bênh vực Bệnh nhân JFS ở số 800-479-2233. Về các vấn đề khó khăn với bệnh nhân ngoại viện và các dịch vụ sức khỏe tâm thần khác, hãy gọi số miễn phí đến Trung tâm Tiêu thụ Giáo dục Sức khỏe và Bênh vực quyền lợi (Consumer Center for Health Education and Advocacy) ở số 877-734-3258. Quí vị có thể yêu cầu tin tức về quyền xin điều trần hay giúp đỡ pháp lý từ Public Inquiry and Response Unit:

Gọi số miễn phí : 1-800-952-5253
Nếu khiếm thính, gọi TDD, call: 1-800-952-8349

Người đại diện hợp pháp

Quí vị có thể tự điều trần trước phiên xử. Quí vị cũng có thể chọn một người bạn, một luật sư hay bất cứ ai đại diện cho mình. Quí vị phải tự mình sắp xếp việc này

Thông báo của Practices Act Notice (California Civil Code Section 1798, et seq.) Chi tiết mà quí vị được yêu cầu viết trong mẫu này rất cần thiết để xúc tiến buổi điều trần của quí vị. Việc xúc tiến có thể trễ nãi nếu chi tiết không đầy đủ. Hồ sơ sẽ được thiết lập bởi Bộ Xã Hội Tiểu bang, Bộ phận Điều trần. Quí vị có quyền tham khảo hồ sơ và biết nó ở đâu bằng cách liên lạc với Public Inquiry and Response Unit (điện thoại đã ghi bên trên). Bất cứ chi tiết nào mà quí vị cung cấp, chúng tôi sẽ chia sẽ với chương trình sức khỏe tâm thần, với Bộ Dịch vụ Y tế và Sức Khỏe Tâm thần Tiểu bang và với Bộ Y tế và Nhân sinh của Liên bang (Authority: Welfare and Institutions Code, Section 14100.2)

CÁCH YÊU CẦU BUỔI ĐIỀU TRẦN CẤP TIỂU BANG

Cách hay nhất để yêu cầu được buổi điều trần là điền vào mẫu này. Làm bản sao phần trước và sau của mẫu này để lưu giữ vào hồ sơ của quí vị. Sau đó gửi trang này về:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Một cách khác để xin buổi điều trần là gọi điện thoại số 1-800-952-5253. Nếu quí vị bị khiếm thính thì dùng TDD, gọi số 1-800-952-8349.

YÊU CẦU ĐIỀU TRẦN

Tôi muốn có một buổi điều trần liên hệ đến Medi-Cal và Chương Trình Sức Khỏe Tâm Thần của Quận hạt San Diego.

☐ Đánh dấu trong ô này nếu quí vị muốn có một buổi điều trần nhanh chóng và viết nguyên nhân tại sao :.

Nguyên nhân: _____

_____

_____

_____

_____

☐ Đánh dấu vào ô này nếu muốn viết thêm một trang nữa.

Tên họ (chữ in) _____

Số An sinh xã hội: _____

Địa chỉ (chữ in) _____

_____

Điện thọai: (_____) _____

Chữ ký: _____

Ngày tháng: _____

Tôi cần một thông dịch viên miễn phí. Ngôn ngữ gốc của tôi là _____

Tôi muốn người có tên dưới đây đại diện tôi trong buổi điều trần. Tôi cho phép người này xem hồ sơ của tôi và đến dự buổi điều trần dùm tôi.

Tên họ: _____

Địa chỉ: _____

_____

Điện thọai: (_____) _____

State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

January 26, 2012

Medi-Cal Eligibility Division Information Letter No.: I 12-02

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS

SUBJECT: THE SECRETARY OF STATE'S CHANGES TO THE CALIFORNIA NATIONAL VOTER REGISTRATION ACT (NVRA) MANUAL (2011 REVISION)
References: Medi-Cal All County Welfare Director's Letter (ACWDL) No. 94-85, 95-36, 95-78, 96-01, California Department of Social Services (CDSS) All County Information Notice (ACIN) No. I-01-12, and Public Law 103-31 Section 7, May 20, 1993

The purpose of this letter is to notify County Welfare Departments (CWDs) of the Secretary of State's (SOS) most recent changes to the California NVRA Manual, specifically Chapter 4, for public assistance and other voter registration agencies. The public assistance programs include: CalFresh, California Work Opportunity and Responsibility to Kids (CalWORKs), Medi-Cal, Women, Infants and Children (WIC) nutrition program, and In-Home Supportive Services (IHSS). In addition to the changes made to the California NVRA manual, the SOS has also made changes to the California Voter Registration Card (VRC), the NVRA Voter Preference Form, formerly entitled Voter Registration Interest/Declination Form, and has eliminated the "flagging" policy used by CWDs when reviewing questionable voter registration forms.

Under federal law, the NVRA requires states to provide voter registration opportunities at all offices that provide public assistance and all offices that provide state-funded programs primarily engaged in providing services to person(s) with disabilities. All applicants and continuing clients must be given a VRC and a NVRA Voter Preference Form, regardless of whether they indicate they want to register to vote or not. This policy replaces the policy in ACIN I-09-09 to "offer" voter registration materials. If CWDs fail to comply with the NVRA, the county and state can be subject to a civil action by the United States Department of Justice or a private party.

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- Provide the same degree of assistance to all applicants, including persons with disabilities, when completing VRCs either in their home or in person as offered when completing the agency's own application forms;
- Inform clients that receipt of benefits is not linked in any way to the client's decision to register or not register to vote;
- Ensure that CWD employees do not seek to influence the client's decision to register or not register to vote, or the client's political party preference;
- If a client declines to indicate whether they wish to register or that he/she will complete the VRC at a later time, the Voter Preference Form should still be completed;
- CWDs must retain the Voter Preference Form for 24 months. Counties may determine the manner for filing and retaining the forms (e.g., with the client's case file or filed separately). An electronic record of the form or the individual's response (Yes/No/Already registered) may be kept in lieu of retaining paper forms; and
- Provide staff training annually on the NVRA requirements and how to assist clients with voter registration.

Note: Please understand that the aforementioned responsibilities of CWDs must be provided whether the client transaction occurs in-person, through internet, over the telephone, e-mail, or through the mail.

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The NVRA requires CWDs to give applicants applying for benefits, renewal, or a change of address a Voter Preference Form and a VRC so that the applicant may register to vote. The NVRA also requires all states to accept the National Mail Voter Registration Form, but allows each state to develop its own voter registration form, as long as it is equivalent to the federal form. Public assistance agencies should make every effort to distribute the California VRC, rather than the National Mail Voter Registration Form, in order to ensure county election officials can properly track and report the number of registrations coming from public assistance agencies. Below are procedures for obtaining California VRCs.

Procedures for CWDs when ordering VRCs

In California, the SOS supplies VRCs to county elections officials. The SOS prints county-specific VRCs including a postage-paid envelope and the county elections office address in the county where the agency office is located. In turn, county elections officials distribute supplies of VRCs to public assistance agencies within the county. County election officials record the serial number ranges of VRCs distributed to public assistance agencies in order to track the number of completed VRCs returned and attribute new registrations to the public assistance agencies providing voter registration services under the NVRA. Therefore, in order to ensure proper tracking and reporting of NVRA voter registrations, CWDs must obtain supplies of VRCs exclusively from their county elections office. When ordering VRCs, it is important that CWD staff identify themselves as a NVRA public assistance agency.

NVRA Voter Preference Form

The NVRA Voter Preference Form has been redesigned and simplified: 1) to allow clients and agency staff to complete the form more quickly; and 2) to allow agencies to use an electronic form and encourage online voter registration whenever possible. Below are examples of ways to assist clients with the Voter Preference Form, either in person or remotely. If the CWD chooses to create its own form, the form must include the NVRA statutory language as specified by Section 7 of the NVRA.

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CWDs must retain the completed Voter Preference Form for two years. However, federal and state laws do not state the manner in which the forms are to be filed within the agency. The SOS office recommends CWDs store the Voter Preference Form in a central, chronological file (e.g. case file), so that CWD staff can easily determine how many Voter Preference Forms are received in a given month, which can help demonstrate NVRA compliance. Voter Preference Forms and responses may be stored electronically.

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CDSS will continue to monitor counties to ensure NVRA compliance with the above instructions during county Management Evaluations (ME). An example of such monitoring will include a check of the informational packets provided to applicants/clients to ensure they include the VRCs and NVRA Voter Preference Forms.

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Quarterly NVRA meetings will be arranged for CWDs who are identified as potentially out of compliance under the NVRA. The identified county/counties director(s), SOS, CDSS, and County Welfare Director's Association (CWDA) representatives will be invited to these quarterly meetings to identify and resolve any issues regarding NVRA compliance. CWDs that are identified as fully complying with the NVRA requirements will also be invited to attend to share best practices in regard to NVRA compliance.

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CWDs should appoint one staff person at each agency office to be in charge of NVRA compliance, which includes arranging staff training, ordering supplies of VRCs from the county elections office, and ensuring VRCs are submitted in a timely manner to the county elections office.

Annual Training

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If you have any questions regarding this letter, please contact Shanee Clark, Program Consultant for CDSS at (916) 653-7973 and for DHCS contact Debora Wong-Kochi of the Medi-Cal Eligibility Division at (916) 552-8429.

Sincerely,

Original signed by Robert Sugawara
for

Rene Mollow, MSN,RN, Chief
Medi-Cal Eligibility Division
Department of Health Care Services

Original signed by Brian Tam
for

Linda Patterson, Chief
CalFresh Branch
Department of Social Services

Useful NVRA Resource Links

Secretary of State's NVRA Webpage:
http://www.sos.ca.gov/elections/nvra/

Secretary of State NVRA Coordinator:
Phone: (916) 657-2166
Fax: (916) 653-3214
E-mail: nvra@sos.ca.gov

Secretary of State California NVRA Manual (2011):
http://www.sos.ca.gov/elections/nvra/nvra-manual.htm

Secretary of State California NVRA Manual (2011) Chapter Four:
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United States Department of Justice Civil Rights Division Voting Section Website:
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STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • *www.cdss.ca.gov*

CDSS
WILL LIGHTBOURNE
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order
[ ] Clarification Requested by One or More Counties
[X] Initiated by CDSS

January 5, 2012

ALL COUNTY INFORMATION NOTICE NO. I-01-12

TO: ALL COUNTY WELFARE DIRECTORS
ALL CONSORTIA PROJECT MANAGERS
ALL CALFRESH PROGRAM COORDINATORS
ALL CALWORKS PROGRAM COORDINATORS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS

SUBJECT: THE SECRETARY OF STATE'S CHANGES TO THE CALIFORNIA NATIONAL VOTER REGISTRATION ACT (NVRA) MANUAL (2011 REVISION)

REFERENCES: All County Information Notice (ACIN) No. I-46-94, I-56-95, I-17-96, I-09-09, All County Letter (ACL) No. 95-26, 96-21, 96-01, Medi-Cal All County Welfare Director's Letter (ACWDL) No. 94-85, 95-36, 95-78, 96-01, and Public Law 103-31 Section 7, May 20, 1993

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Sincerely,

Original Document Signed By:

Linda Patterson, Chief
CalFresh Branch

Original Document Signed By:

Rene Mollow, MSN,RN, Chief
Medi-Cal Eligibility Division

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County Elections Office Roster:
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Chapter 4

NVRA Implementation at Public Assistance and Other Voter Registration Agencies

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I. Implementation of Section 7 of the National Voter Registration Act of 1993 (NVRA)

A. Designated Voter Registration Agencies

The NVRA requires states to offer voter registration services at all public assistance and disability service offices. Specifically, Section 7 of the NVRA required states to designate as voter registration agencies all offices that provide public assistance or state-funded programs primarily engaged in providing services to persons with disabilities. These offices are collectively referred to as public assistance agencies.

The NVRA also required states to designate Armed Forces recruitment offices and other offices in the state as voter registration agencies. In California, the following offices are designated as voter registration agencies under the NVRA:

Department of Motor Vehicles (DMV) Field Offices

Public Assistance Agencies (including County Human Service Agencies):

County offices which accept applications and administer benefits for CalFresh, formerly known as Food Stamps, and the California Work Opportunity and Responsibility to Kids (CalWORKs) program which replaced the Aid to Families with Dependent Children (AFDC) program.

County offices which accept applications and administer benefits for the Medi-Cal program.

County offices and community based non-profit organizations under contract with the Department of Public Health, formerly the Department of Health Services, which accept applications and administer benefits for the Women, Infants and Children (WIC) nutrition program.

County offices which accept applications and administer benefits for the In-Home Supportive Services Program (IHSS).

State-Funded Agencies Primarily Serving Persons with Disabilities

Offices of the State Department of Rehabilitation which provide vocational rehabilitation services.

Independent Living Centers

Department of Developmental Services Regional Centers

Offices of contractors with the Department of Social Services, Office of Deaf Access which provide services to the deaf.

State and County Mental Health Providers

Armed Forces Recruitment Offices

Other Agencies Designated by the State Under NVRA

Franchise Tax Board district offices which provide public access for income tax and Homeowner and Renter Assistance forms, instructions and assistance.

State Board of Equalization district offices which provide services to the public.

B. Responsibilities of Voter Registration Agency Offices

At a minimum, the NVRA requires voter registration agencies to provide voter registration services each time a person:

- Applies for services or benefits;
- Requests renewal or recertification; or
- Requests a change of address.

The NVRA requires voter registration agencies to provide the following voter registration services to each applicant:

- Distribute a voter registration card (VRC);
- Distribute an NVRA voter preference form (preference form);
- Assist with filling out the VRC;
- Accept and transmit completed VRCs to elections officials; and
- Accept and retain completed preference forms on file for two years.

These voter registration services must be provided whether the transaction is conducted in person or remotely, for example via phone, email or Internet (online).

Technology Upgrades and Remote Transactions: Integrating Voter Registration

When upgrading NVRA agency technology related to the application, renewal or recertification, or change of address process, public assistance agencies should ensure that such upgrades include the voter registration process.

Below are examples of how NVRA compliance can be accomplished when conducting NVRA-covered transactions in various settings: in person, by mail, over the phone, or via email or the Internet. Agencies have flexibility in determining the best methods to use to ensure NVRA compliance in each setting. Therefore, in the following descriptions, the term “must” indicates a specific practice is mandated under the NVRA, while the term

"should" indicates a recommended practice that can help ensure compliance but which is not expressly mandated under the NVRA.

The United States Department of Justice (USDOJ) has published guidance on complying with the NVRA that contains a number of the practices described below. For more information, please visit the USDOJ Civil Rights Division Voting Section website directly at: http://www.justice.gov/crt/about/vot/nvra/nvra_faq.php.

In-Person/Mail Transactions: Voter registration agencies must include a VRC and preference form in the agency's standard packet of application materials handed or mailed to applicants who request services or benefits, renewal, recertification, or a change of name or address.

Phone Transactions: Agency staff must ask applicants who apply for services or benefits, renewal, recertification, or a change of name or address by phone:

"If you are not registered to vote where you live now, would you like to register today?"

Agency staff must note the applicant's response on the preference form and if the applicant says "yes" the agency must provide an opportunity to register to vote either by sending a VRC to the applicant by mail or by sending a link to the online, fillable National Mail Voter Registration Form (National Form) (www.sos.ca.gov/nvrc/fedform/) on the Secretary of State's website. Agencies which choose to provide a link to the online voter registration form rather than mail a VRC should coordinate with the Secretary of State and their county elections office to establish electronic tracking of the number of applicants who use the online form to register to vote.

Email and Internet Transactions: Voter registration agencies must provide a preference form and a VRC to each applicant. This may be accomplished by either mailing the forms after the online application is complete or by providing an electronic preference form that the applicant can fill out and submit electronically and by sending the applicant a link to the online, fillable National Mail Voter Registration Form (National Form) (www.sos.ca.gov/nvrc/fedform/). Agencies which choose to provide a link to this form rather than mail a VRC should coordinate with the Secretary of State and their county elections office to establish electronic tracking of the number of applicants who use this form to register to vote. In addition, voter registration agencies should include a link on the agency's main webpage to the National Mail Voter Registration Form posted on the Secretary of State's website at https://www.sos.ca.gov/nvrc/fedform/.

Voter Registration at Public Counters: Voter registration agencies should offer applicants an opportunity to register to vote in public areas and waiting rooms by keeping a supply of VRCs on public counters and displaying voter information. For tracking purposes, VRC supplies must be obtained from the county elections office where the agency is located. To obtain voter *educational* materials, such as posters, DVDs, and brochures, please call the Secretary of State's NVRA Coordinator at (916) 657-2166 or email nvra@sos.ca.gov.

Applicant Assistance

The NVRA requires voter registration agencies to assist applicants with filling out the VRC. Section 7 specifically requires that agencies must provide each person the same degree of assistance in completing the voter registration application as is provided by the office in completing its own agency forms, unless the person declines assistance. For example, if it is standard practice for caseworkers to review agency forms for completeness, caseworkers must also check the VRC for completeness.

When an agency provides services to a person with a disability at the person's home, the agency must also provide voter registration services at the person's home.

For remote transactions via phone, email and the Internet, agencies should provide the Secretary of State's Voter Hotline: (800) 345-8683 for applicants to use if they need help registering or have questions about their voting rights.

For in-person transactions, voter registration agencies must make review of the VRC and preference form part of the agency's regular process for helping applicants apply for benefits enrollment, renewal, recertification, and change of address. Agency staff must advise each applicant that assistance with filling out the VRC will be provided if the applicant wishes, but that the applicant has the right to complete the VRC without assistance.

Completing the NVRA Voter Preference Form

For in-person transactions, the voter registration agency should ask the applicant to complete the preference form. If the applicant chooses not to register at the agency but still takes a blank VRC home, the agency staff should ask the applicant to complete the preference form and check the "No" box, since the applicant is choosing not to register at that time.

For remote transactions, such as mail, phone, email, and the Internet, if an applicant fails to complete and return the preference form, agency staff

should attempt to follow up once with the applicant to find out whether the applicant would like to register to vote or needs assistance.

Agencies are not required to complete preference forms on behalf of applicants who choose not to return the preference form in a transaction. In such instances, after following up with the person, agencies should include a blank preference form with the applicant's name in their records.

Retaining the NVRA Voter Preference Form

Agencies must retain completed preference forms for two years, while completed VRCs must be forwarded to the county elections office. Preference forms should be stored in a central, chronological file, so that the agency can easily determine how many preference forms are received in a given month, which can help demonstrate NVRA compliance.

Restrictions on Influencing Applicants

The NVRA places restrictions on how agency staff may interact with applicants when providing the opportunity to register to vote. Voter registration agency staff must not:

- Seek to influence an applicant's political party preference or party registration;
- Display any political preference or party allegiance;
- Make any statement to an applicant or take any action the purpose or effect of which is to discourage the applicant from registering to vote; or,
- Make any statement to an applicant or take any action the purpose or effect of which is to lead the applicant to believe that a decision to register or not to register has any bearing on the availability of services or benefits.

Written Procedures and Training Protocols

In order to ensure uniform compliance with the NVRA, public assistance agencies and other agencies designated as voter registration agencies under the NVRA should consider developing scripts for agency staff to use when providing voter registration services under the NVRA.

Annual Training

Agencies must ensure staff are trained on NVRA requirements and on how to assist applicants with voter registration. Refer to the Secretary of State's NVRA training webpage for materials and an easy-to-use training presentation, which can be downloaded from the Secretary of State's

NVRA Training webpage: www.sos.ca.gov/elections/nvra/pdf/ca-nvra-voter-registration-training-for-public-assistance-agencies.pdf. The Secretary of State encourages county elections offices to provide annual training sessions for public assistance agency staff on how to assist applicants with filling out the VRC.

NVRA Coordinator:

Voter registration agencies should appoint one staff person at each agency office to be in charge of NVRA compliance, including arranging staff training, ordering supplies of VRCs from the county elections office, and ensuring VRCs are submitted in a timely manner to the county elections office.

Monitoring NVRA Compliance:

In some counties, voter registration agencies monitor NVRA compliance by tracking on a monthly basis the following:

- Total number of completed VRCs accepted and transmitted to county elections officials.
- Total number of preference forms collected and responses (yes/no/already registered).

To ensure complete tracking and reporting of voter registrations, public assistance agencies should consider tracking and reporting to their county elections office the number of VRCs and preference forms received and preference form responses.

For example, if a person submits a voter registration on a paper copy of the National Form, the agency must accept the form and forward it to the county elections office. Agencies that track and report NVRA registrations will be able to capture this registration as an agency registration, while public assistance agencies that rely on their county elections office to track the serial numbers on state VRCs will not be credited with the registration.

As public assistance agencies continue to upgrade the technology they use for enrollment, renewal and change of address transactions, they should coordinate with their county elections office to explore automating the tracking and reporting of NVRA data. For example, public assistance agencies in a given county may find that tracking and reporting voter registrations and voter preference forms can be done effectively and efficiently on a quarterly basis. If so, the county elections office may note in its monthly NVRA report to the Secretary of State that its public assistance agency NVRA data will be included on a quarterly basis. This

alternative to month-by-month reporting is permissible as long as the NVRA data (registrations and voter preferences) is accurately tracked by the public assistance agency and reported to the county elections office.

The Secretary of State has developed an easy-to-use reporting form for public assistance agencies, which may be downloaded at: www.sos.ca.gov/elections/nvra/pdf/nvra-reporting-form-to-county-from-agency.pdf (see illustration on page 28).

Public Assistance Agency
National Voter Registration Act (NVRA)
Monthly Reporting Form

National Voter Registration Act (NVRA)
Reporting Form Template*

Agency _____

Address _____

Contact Name and Phone _____

Month/Year (xx/xxxx)	Total VRCs** Sent to County Elections Office	Total Voter Preference Forms*** Received	Response Totals from Voter Preference Forms Received
			Already Registered:
			Yes:
			No:

**The Secretary of State recommends that agencies track and report NVRA data to the county elections office as a supplement to the voter registration card (VRC) serial number tracking system currently in place.*
***Order all supplies of VRCs from the county elections office. Forward completed VRCs to the county elections office as soon as possible, but no later than 10 days after receipt.*
**** The NVRA voter preference form (formerly called a "declination" form) and a VRC should be provided to each person who contacts your agency to apply for new benefits or services, renewal or recertification, or a change of address. Agencies must retain voter preference forms on file for two years. Do not forward voter preference forms to your county elections office.*

II. Registering Voters

A. Part 1: The NVRA Voter Preference Form (Preference Form)

The NVRA requires voter registration agencies to give applicants for services or assistance a form asking the applicant if he or she wishes to register to vote. The form, called the "NVRA voter preference form" or "preference form," must contain certain statutory language, as specified by Section 7 of the NVRA.

The Secretary of State has developed a uniform preference form for California voter registration agencies to use (see illustration on page 31). The Secretary of State's office has translated the uniform preference form into Spanish, Chinese, Vietnamese, Japanese, Korean and Tagalog.

All versions of the preference form may be downloaded and printed from the Secretary of State's NVRA website at: http://www.sos.ca.gov/elections/nvra/declination-forms.htm.

If an agency chooses to create its own form, the form must include the following NVRA statutory language:

- The question: "If you are not registered to vote where you live now, would you like to apply to register to vote here today?";
- If the agency provides public assistance, the statement: "Applying to register or declining to register to vote will not affect the amount of assistance you will be provided by this agency.";
- Boxes for the applicant to check to indicate whether the applicant would like to register to vote or declines to register to vote (failure to check either box is interpreted as declining to register), together with the statement (in close proximity to the boxes and in prominent type), "IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.";
- The statement: "If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek help is yours. You may fill out the application form in private."; and
- The statement, "If you believe that someone has interfered with your right to register or decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with _____." The blank should be filled with the name, and official address,

telephone number, and e-mail address of the appropriate official to whom such a complaint should be addressed.

As noted above, the preference form and VRC must be provided along with agency forms routinely distributed to each applicant during the intake procedure for new applicants, and along with agency forms provided for applicants seeking renewal, recertification or a change of address.

NVRA Voter Preference Form (Preference Form)

Would You Like to Register to Vote?

You may register to vote in California if:

1. You are a United States citizen.
2. You are a resident of California.
3. You are at least 18 years of age (or will be by the date of the next election).
4. You are not in prison or on parole for a felony conviction.
5. You have not been judged by a court to be mentally incompetent.

Important Notices

1. Applying to register or declining to register to vote will **not** affect the amount of assistance that you will be provided by this agency.
2. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.
3. If you decline to register to vote here today, that information is confidential and may not be used for any purpose other than voter registration. If you register to vote here today, the agency or office at which you are registering is confidential.
4. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party preference or other political preference, you may file a complaint with the Secretary of State by calling toll-free (800) 345-VOTE (8683) or you may write to: Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814. For more information on elections and voting, please visit the Secretary of State's website at www.sos.ca.gov.
5. If you move to a new address, or if you change your name or want to change your political party preference, you must fill out a new voter registration card.
6. We will retain this Voter Preference Form with this agency. If you choose to register today, we will send your completed voter registration card to the county elections office.

If you are not registered to vote where you live now, would you like to apply to register to vote here today?
(Check One)

☐ Already registered. I am registered to vote at my current residence address.

☐ Yes. I would like to register to vote. (Please fill out the attached voter registration card.)

☐ No. I do not want to register to vote.

NOTE: IF YOU DO NOT CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applicant Name _____ Date

04/11 NVRA Voter Preference Form

B. Part 2: The Voter Registration Card (VRC)

The NVRA requires voter registration agencies to give applicants for services or assistance a California Voter Registration Card (VRC) so that the applicant may register to vote.

In California, the Secretary of State supplies VRCs to county elections officials. In turn, county elections officials distribute supplies of VRCs to public assistance agencies within the county. In doing so, county elections officials record the serial number ranges of VRCs distributed to public assistance agencies in order to be able to track the number of completed VRCs returned and attribute new registration data to the public assistance agencies providing voter registration services under the NVRA. Therefore, in order to ensure proper tracking and reporting of NVRA voter registrations, public assistance agencies must either obtain supplies of VRCs exclusively from their county elections office or coordinate with the Secretary of State's office to obtain bulk supplies of VRCs and ensure the Secretary of State's office reports the serial number ranges on the VRCs supplied to the appropriate county elections office.

The NVRA requires all states to accept the National Mail Voter Registration Form but allows each state to develop its own voter registration form, as long as it is equivalent to the federal form. Public assistance agencies should make every effort to distribute the California VRC rather than the National Mail Voter Registration Form in order to ensure county elections officials can properly track and report the number of registrations coming from public assistance agencies.

In 2008, the Secretary of State re-designed the California VRC using the services of a language readability expert to make the form easier to read and complete (see illustration on page 33).

California Voter Registration Card (VRC)

CALIFORNIA VOTER REGISTRATION FORM
SOS

Fill out this form if you are a new voter, have moved or changed your name, or want to change your political party preference.
You must be a U.S. citizen and at least 18 years old by the next election to use this form. Use blue or black ink. Print clearly.

Your legal name: First name — Middle name

①

Last name — *Optional* ③ ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

②

Home address – *not a P.O. Box or business address – (Number, Street, Ave., Drive, etc. Include N, S, E, W)* — Apt or unit #

④

City — State — Zip — California county

⑤ C A

If you do not have a street address, describe where you live *(Cross streets, Route, N, S, E, W)*

⑥

Mailing address – *if different from above, or P.O. Box*

⑦

City — State — Zip — Foreign country

⑧

Date of birth — U.S. state or foreign country of birth

⑨ M M D D 1 9 Y Y ⑩

CA driver's license or CA ID card # — If you do not have a CA driver's license or ID card, list the last 4 numbers of your Social Security Number, if you have one. — SSN *(Last 4 numbers)* — Phone numbers are posted at polling places on election day.

⑪

Email *(optional)* — Phone number *(optional)*

⑫ ⑬

⑭ Do you want to choose a political party preference?

☐ **No Party Preference.** No, I do not want to choose a political party preference. *(If you check this box, you may not be able to vote for some parties' candidates at a primary election for U.S. President or party committee.)*

Yes, my political party preference is *(check one)*:
☐ American Independent Party ☐ Democratic Party ☐ Green Party
☐ Libertarian Party ☐ Peace and Freedom Party ☐ Republican Party
☐ Other *(specify)*: _____.

⑮ **To receive a vote-by-mail ballot in all elections,** initial here: _____.

⑯ If you were registered to vote before, fill out below:

First name — Middle initial — Last name

Previous address where you were registered — City

State — Zip — Previous county — Previous political party preference *(if any)*

⑰ Are you a U.S. citizen? . . . . . ☐ Yes ☐ No
Will you be 18 or older by the next election? . . ☐ Yes ☐ No

A "No" answer to either question means you CANNOT register to vote.

⑱ **Read and sign below.**
I am a U.S. citizen and will be at least 18 years old on election day. I am not in prison or on parole for a felony. I understand that it is a crime to intentionally provide incorrect information on this form. I declare under penalty of perjury under the laws of the State of California that the information on this form is true and correct.

Voter Signature — Month Day Year

59 BS — 140001

Important! To vote in the next election, you **must** mail or deliver this card at least **15 days** before the next election. New voters who register by mail may have to show their ID at the polling place the first time they vote.

Tear here and fold. Moisten edge to seal. Do not staple or tape.
The bottom part is your receipt.
Keep it until you receive a Voter Notification Card in the mail.

As a registered voter, you may vote for any candidate for state or congressional office, regardless of the party preference or lack of party preference chosen by you or the candidate.

Optional

A. ☐ Check here if you can be a poll worker.
(If bilingual, indicate language: _____*)*
☐ Check here if you can provide a polling place on election day.

B. Your ethnicity/race: _____

C. Check your language preference: ☐ English ☐ Spanish Español
☐ Chinese 中文 ☐ Vietnamese Việt ngữ ☐ Korean 한국어 ☐ Tagalog Tagalog ☐ Japanese 日本語

Did someone help you fill out or deliver this form?
If yes, the person who helped you must fill out and sign both parts of this green box.

Signature — ___/___/___ Month Day Year
Name, address, and tel.: _____
Org. name and tel. *(if any)*: _____

(This part is the voter's receipt.)

Signature — ___/___/___ Month Day Year
Name, address, and tel.: _____
Org. name and tel. *(if any)*: _____

C. Obtaining Supplies of Voter Registration Cards

The Secretary of State prints county-specific postage-paid Voter Registration Cards (VRCs), which include the address of the county elections office, for each of California's 58 counties. Public assistance service and other voter registration agencies must obtain supplies of VRCs from the county elections office in the county where the agency office is located. This will ensure proper tracking and reporting of completed registrations and help attribute new registrations to the correct voter registration agency.

As noted above, while the National Mail Voter Registration Form is valid and accepted in California, voter registration agencies should avoid distributing copies of the national form and instead obtain and distribute supplies of the state VRC from their county elections office (or from the Secretary of State in coordination with their county elections office). The national form contains no serial number and gives county elections officials no method of tracking whether a new registration came from a voter registration agency.

Using the California VRC helps ensure: 1) completed VRCs will be returned to the county elections office where the voter lives, because the VRC is self-addressed and postage paid; and 2) the county elections office can properly track and report the number of voter registrations coming from local voter registration agency offices.

The Secretary of State, the federal Election Assistance Commission, and the United States Department of Justice review reports of the number of voter registrations coming from voter registration agencies in order to determine whether agencies are providing the opportunity to register to vote in compliance with the NVRA. To ensure public assistance agencies are recognized for their compliance with the NVRA, all supplies of VRCs must be obtained from the county elections office in which the agency is located.

D. Confidentiality

The NVRA requires a voter's decision to register or decline to register to vote to be kept confidential. The NVRA also requires the location (e.g., public assistance agency) where an applicant registers to be kept confidential. One of the primary goals of the NVRA's confidentiality provisions is to protect the privacy of applicants who receive public assistance or disability services.

In California, voter registration agencies and elections offices must keep information regarding an applicant's choice to register or decline to

register as well as the identity of the agency through which a particular voter registered confidential.

In order to protect privacy and accurately report on voter registration at public assistance agencies, county elections officials should distribute VRCs by noting the serial number ranges of the VRCs supplied to public assistance agencies and by tracking those VRC numbers as completed when they are submitted to elections offices by applicants.

E. Providing Materials and Assistance in Other Languages

The NVRA requires that agencies provide the same level of service to persons wishing to register to vote as they provide to applicants completing applications for the services provided by that agency. This includes providing voter registration materials in languages other than English at agency offices where services or assistance is provided in other languages.

In conformance with the Federal Voting Rights Act, the Secretary of State provides voter registration forms in the following languages (in combination with English): Spanish, Chinese, Vietnamese, Japanese, Korean and Tagalog/Filipino. NVRA voter registration agencies that need the preference forms and VRCs in languages other than English or Spanish should contact their local elections officials or the Secretary of State.

The NVRA voter preference form is available in all of the above languages and may be downloaded from the Secretary of State's website at: www.sos.ca.gov/elections/nvra/declination-forms.htm.

III. Transmittal Deadlines and Late Registrations

A. Transmittal of Voter Registration Cards (VRCs) to County Elections Office

The NVRA requires that voter registration agency offices transmit completed voter registration cards to the county elections office within 10 days. If a voter registration agency receives a completed VRC within five days of the voter registration deadline (the 15th day prior to an election), the agency must transmit the VRC to the county elections office within five days.

In order to meet these transmittal deadlines, each NVRA voter registration agency office must establish procedures for ensuring timely transmittal of accepted forms to the appropriate local elections official. These

procedures should be developed in consultation with the local elections official to whom the forms will be transmitted.

Daily transmittal of completed VRCs

Since the California VRC is a self-addressed and postage-paid form, voter registration agencies should make it part of their daily routine to drop completed VRCs in the mail. If the voter registration agency is located in the same facility as the county elections office, the agency may hand deliver or use inter-office mail on a daily basis to transmit completed VRCs to the county elections office.

B. Late Voter Registrations

The voter registration deadline in California is the 15th day prior to each election. Under the NVRA, if a person completes and submits a VRC to an NVRA voter registration agency on or before the voter registration deadline, the registration meets the voter registration deadline as long as the voter registration agency forwards the registration to the county elections office by the end of the official canvass.

Elections officials should make every effort to facilitate the transmittal of completed registration forms from agency offices in order to minimize the number of registrations that arrive at the elections office after the deadline to register. Elections officials should notify NVRA agency offices of upcoming election dates and voter registration deadlines and should remind NVRA agencies of the need to transmit VRCs on a daily basis beginning 10 days before each Election Day. This will help minimize the number of provisional ballots used in a given election.

IV. Resources

Secretary of State's NVRA Webpage:
http://www.sos.ca.gov/elections/nvra/

Secretary of State NVRA Coordinator:
Phone: (916) 657-2166
Fax: (916) 653-3214
Email: nvra@sos.ca.gov

NVRA Voter Preference Forms:
http://www.sos.ca.gov/elections/nvra/declination-forms.htm

NVRA Monthly Reporting Form for NVRA Voter Registration Agencies:
http://www.sos.ca.gov/elections/nvra/pdf/nvra-reporting-form-to-county-from-agency.pdf

Secretary of State's NVRA Training Webpage for Public Assistance Agencies:
http://www.sos.ca.gov/elections/nvra/training-for-agencies-that-provide-public-assistance.htm

United States Department of Justice Civil Rights Division Voting Section Website:
http://www.justice.gov/crt/about/vot/nvra/activ_nvra.php

Voter Information: www.sos.ca.gov

Secretary of State Voter Hotlines:

- (800) 345-VOTE (8683) - English
- (800) 232-VOTA (8682) - Spanish
- (800) 339-2857 - Chinese
- (800) 339-2865 - Japanese
- (866) 575-1558 - Korean
- (800) 339-2957 - Tagalog
- (800) 339-8163 - Vietnamese
- (800) 833-VOTE (8683) - TDD

Secretary of State's brochure, "A Guide to Voting in California":
http://www.sos.ca.gov/elections/Outreach/a-guide-to-voting.pdf

County Elections Offices Roster:
http://www.sos.ca.gov/elections/elections_d.htm

مقاطعة سان دييغو
برنامج خدمات الصحة النفسية المتخصصة بالتأمين الصحي الحكومي (Medi-Cal)
بيان إجرائي
(رفض الدفع بعد الحصول على الخدمات)

التأريخ:_____

إلى: _____**رقم التأمين الصحي الحكومي:** _____

إن برنامج الصحة النفسية لمقاطعة _____ قرر ☐ رفض طلبك ☐ تغيير طلب موفر الخدمات الخاص بك لدفع تكاليف الخدمات التالية:

_____

تم تقديم الطلب من قبل: (إسم موفر الخدمات) _____

تأريخ الطلب الأصلي المقدم من قبل موفر الخدمات الخاص بك _____ و قد أشار موفر الخدمات الخاص بك إلى

إنك قد حصلت على الخدمات المذكورة أعلاه في التواريخ التالية: _____.

هذا البيان ليس بقائمة حساب. لن يتوجب عليك الدفع لهذه الخدمات أو الخدمات المذكورة في هذه الإستمارة.

إتخذ برنامج خدمات الصحة النفسية هذا القرار إعتماداً على البيانات الواردة من موفر الخدمات الخاص بك و ذلك للأسباب المبينة أدناه:

☐ إن حالة صحتك النفسية كما تم وصفها لنا من قبل موفر الخدمات الخاص بك لا تحقق المعايير الطبية الضرورية للحصول على خدمات مستشفى الصحة النفسية السريرية أو الخدمات المتخصصة المتعلقة بالصحة النفسية (المادة 9، CCR، الفقرة 1820.205).

☐ إن حالة صحتك النفسية كما تم وصفها لنا من قبل موفر الخدمات الخاص بك لا تحقق المعايير الطبية الضرورية للحصول على خدمات الصحة النفسية المتخصصة بإستثناء خدمات مستشفى الصحة النفسية السريرية و ذلك بسبب (المادة 9، CCR، الفقرة 1830.205): _____

_____

☐ الخدمات التي تم تقديمها غير مشمولة ببرنامج الصحة النفسية (المادة 9، CCR، الفقرة 1810.345).

☐ لقد طلب برنامج الصحة النفسية المزيد من المعلومات من موفر الخدمات الخاص بك، يحتاج البرنامج لتلك المعلومات للموافقة على دفع تكاليف الخدمات التي تم تقديمها لك. لغاية الآن لم يتم إستلام المعلومات المطلوبة.

☐ أخرى: _____

_____

إذا كنت لا توافق على قرار برنامجك:

يجوز لك تقديم طلب استئناف بشأن برنامج صحتك النفسية. ومن أجل تقديم طلب الاستئناف لخدمات الصحة النفسية كمريض دائم أو مقيم، اتصل بمركز خدمات الصحة النفسية التابع لبرنامج إدارة التوظيف والأسرة الخاص بانضمام المريض على رقم 2233-479 (800) والواقع عنوانهم في 8788 Balboa Avenue، San Diego، CA 92123. ومن أجل تقديم طلب استئناف بشأن خدمات الصحة النفسية كمريض خارجي، اتصل بمركز خدمة المرضى للتربية الصحية والانضمام على رقم 3258-734 (877) والواقع عنوانهم في 1764 San Diego Avenue، Suite 200، San Diego، CA 92110. أو قُمّ باتباع التعليمات الواردة في نشرة المعلومات التي قدمها لك برنامج الصحة النفسية. ويتعين عليك أن تُقدم طلب الاستئناف في غضون 90 يومًا من تاريخ هذا الإشعار.

.

إن لم تكن راضياً عن نتيجة الإستئناف، فيمكنك أن تطلب الحصول على جلسة إستماع عادلة على مستوى الولاية. ستبين الصفحة الثانية من هذا البيان كيف يمكنك طلب الحصول على جلسة الإستماع. ستقرر جلسة الإستماع على مستوى الولاية إن كان يجب على البرنامج دفع تكليف الخدمات التي حصلت عليها إلى موفر الخدمات الخاص بك. أياً كان قرار الإستئناف أو جلسة الإستماع، سوف لن تلزم بدفع تكاليف تلك الخدمات.

County of San Diego
Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION
(Post-Service Denial of Payment)

Date:_____

To: _____, Medi-Cal Number _____

The mental health plan for _____ County has denied/changed your provider's request for payment of the following service(s):

_____

The request was made by: (provider name) _____

The original request from your provider was dated _____ and your provider says that you received the service on the following date or dates: _____.

THIS IS NOT A BILL. YOU WILL NOT HAVE TO PAY FOR THE SERVICE OR SERVICES DESCRIBED ON THIS FORM.

The mental health plan took this action based on information from your provider for the reason checked below:

☐ Your mental health condition as described to us by your provider did not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (Title 9, California Code of Regulations (CCR), Section 1820.205).

☐ Your mental health condition as described to us by your provider did not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services for the following reason (Title 9, CCR, Section 1830.205): _____
_____

☐ The service provided is not covered by the mental health plan (Title 9, CCR, Section 1810.345).

☐ The mental health plan requested additional information from your provider that the plan needs to approve payment of the service you received. To date, the information has not been received.

☐ Other _____
_____

<u>If you don't agree with the plan's decision</u>:
You may file an appeal with your mental health plan. To file an appeal about inpatient or residential mental health services contact JFS Patient Advocacy Program at (800) 479-2233, 8788 Balboa Avenue, San Diego, CA 92123. To file an appeal about mental health services received on an outpatient basis contact Consumer Center for Health Education and Advocacy (CCHEA) at (877) 734-3258, 1764 San Diego Avenue, Suite 200, San Diego, CA 92110. Or follow the directions in the information brochure the mental health plan has given you. You must file an appeal within 90 days of the date of this notice.

If you are unhappy with the outcome of your appeal, you may request a State Fair Hearing. The other side of this notice explains how to request a hearing. The state hearing will decide if the plan should pay your provider for the service that you already received. Whatever the appeal or state hearing decision, you will not have to pay for the service.

Condado de San Diego
Programa de Servicios Especializados de Salud Mental de Medi-Cal
AVISO DE ACCIÓN
(Denegación de pago después de recibido el servicio

Fecha:_____

Para: _____, Número de Medi-Cal_____

El plan de salud mental del Condado de _____ ha denegado/cambiado la solicitud de su proveedor para el pago del o de los siguientes servicios: _____
_____

La solicitud fue hecha por: (nombre del proveedor) _____

La solicitud original de su proveedor tiene la siguiente fecha _____ y su proveedor indica que usted recibió el servicio en la siguiente fecha(s): _____

ÉSTE NO ES UN RECIBO, USTED NO TIENE QUE PAGAR POR EL O LOS SERVICIOS DESCRITOS EN ESTE FORMULARIO.

El plan de salud mental tomó esta acción en base a la información proporcionada por su proveedor por la razón que se marca a continuación:

☐ Su condición de salud mental, según nos fue descrita por su proveedor, no cumple con el criterio de necesidad médica necesario para recibir servicios como paciente internado en un hospital psiquiátrico ni para recibir servicios profesionales relacionados [Título 9, Sección 1820.205 del Código de Regulaciones de California (CCR)].

☐ Su condición de salud mental, según nos fue descrita por su proveedor, no cumple con el criterio de necesidad médica necesario para recibir servicios especializados de salud mental que no sean servicios de hospital psiquiátrico como paciente internado, por la siguiente razón (Título 9, Sección 1830.205, CCR):_____
_____

☐ El servicio prestado no está cubierto por el plan de salud mental (Título 9, Sección 1810.345, CCR).

☐ El plan de salud mental solicitó información adicional de su proveedor, la cual es necesaria para que el plan apruebe el pago del servicio que usted ya recibió. Hasta este momento la información no ha sido recibida.

☐ Otra _____
_____

Si no está de acuerdo con la decisión tomada por el plan, usted puede:
Presentar una apelación con su plan de salud mental. Para presentar una apelación relacionada con servicios de hospital o centros residenciales de salud mental, comuníquese con Jewish Family Service Patient Advocacy Program (Programa de Protección del Paciente JFS) al (800) 479-2233, 8788 Balboa Avenue, San Diego, CA 92123. Para presentar una apelación relacionada con servicios de salud mental ambulatorios, comuníquese con el Centro del Consumidor para Educación de Salud y Defensoría (CCHEA por sus siglas en inglés) al (877) 734-3258, 1764 San Diego Avenue, Suite 200, San Diego, CA 92110, o siga las instrucciones del folleto de información que le entregó el plan de salud mental. Usted debe presentar su apelación dentro de 90 días de la fecha de esta notificación.

Si no está satisfecho(a) con el resultado a su apelación usted puede solicitar una audiencia del estado. Al reverso de este formulario se explica cómo solicitar la audiencia. En la audiencia del estado se decidirá si el plan debe pagar a su proveedor por el servicio que usted ya recibió. Cualquiera que sea la decisión de la apelación o de la audiencia del estado usted no tendrá que pagar por el servicio.

Distrito ng San Diego
Programa ng Pinagdalubhasaang mga Serbisyo ng Kalusugang Kaisipan
PAUNANG-SABI NG PAG-GAWA
(Pagkatapos ng Serbisyo sa Pagtanggi ng Pagbabayad)

Petsa:_____

Para kay: _____, Numero ng Medi-Cal _____

Ang panukala ng kalusugang kaisipan para sa _____ Distrito ay pinagkait na binago sa kahilingan ng iyong taga-pagkaloob para sa pagbabayad ng sumusunod ng (mga) serbisyo:

_____

Ang kahilingan ay ginawa ni: (pangalan ng taga-pagkaloob) _____

Ang orihinal na kahilingan ng iyong taga-pagkaloob ay naka tala sa araw ng _____ at ang iyong tag-pagkaloob nagsasabi na ikaw ay nakatanggap ng serbisyo sa mga sumusunod na araw o mga araw: _____

ITO AY HINDI KUWENTA NG UTANG. HINDI MO KAILANGANG MAGBAYAD PARA SA SERBISYO O MGA SERBISYO NA ILARAWAN SA POMULARYONG ITO.

Ang panukala ng kalusugang kaisipan ay nakukuha ang pag-gawa batay sa inpormasyon ng iyong taga-pagkaloob sa dahilan ay tiyakin as ibaba:

☐ Ang kalagayan ng iyong kalusugang kaisipan na inilarawan sa amin ng iyong taga-pagkaloob ay hindi nakasapat sa pamantayan na kinakailangan ng medikal para sa mga serbisyo ng ospital na tumatanggap ng tirahan at pagkain kasama na ang pag-gamot sa mga may sakit sa utak o kaugnay ng propesyonal na mga serbisyo (Title 9, California Code of Regulations (CCR), Section 1820.205).

☐ Ang kalagayan ng iyong kalusugang kaisipan na inilarawan sa amin ng iyong taga-pagkaloob ay hindi nakasapat ng pamantayan na kinakailangan ng medikal para sa pinagdalubhasaang mga serbisyo ng kalusugang kaisipan bukod sa mga serbisyo ng ospital na tumatanggap ng tirahan at pagkain kasama ang paggamot sa mga may sakit sa utak para sa mga sumusunod na dahilan (Title 9, CCR, Section 1830.205): _____

_____

☐ Ang serbisyo na pinagkaloob ay hindi napabilang batay sa panukala ng kalusugang kaisipan (Title 9, CCR, Section 1810.345).

☐ Ang panukala ng kalusugang kaisipan ay humihiling ng karagdagang inpormasyon na galing sa iyong taga-pagkaloob na ang panukala ay nangangaulangan ng pauintulot para sa pagbayad sa serbisyo na iyong natatanggap. Sa araw na ito, ang inpormasyon ay hindi pa natatanggap.

☐ Iba pa _____

_____

<u>Kung ikaw ay hindi sumasang-ayon sa desisyon ng plano</u>:
Maaari kang mag sampa ng apila sa iyong pangkaisipang kalusugan plano. Upang magsampa ng apila tungkol sa mga serbisyo ng inpatient o residential na pangkaisipang kalusugan maaring tawagan ang JFS Patient Advocacy Program sa (800) 479-2233, 8788 Balboa Avenue, San Diego, CA 92123. Upang magsampa ng apila tungkol sa mga serbisyong kaisipan pangkalusugan na natanggap bilang isang outpatient maaring tawagan ang Consumer Center for Health Education and Advocacy (CCHEA) sa (877) 734-3258, 1764 San Diego Avenue, Suite 200, San Diego, CA 92110. O sundin ang mga direksyon sa polyeto ng impormasyon na ibinigay ng iyong pangkaisipiang kalusugang plano. Ikaw ay dapat mag-sampa ng apila sa loob ng 90 araw mula sa petsa nitong paunang-sabi.

Kung ikaw ay hindi nasisiyahan sa resulta ng iyong panawagan, ikaw ay maaring humiling ng pormal na paghukom. Sa kabila nitong paunang-sabi ay nagpapaliwang kung paano humiling ng pormal na paghukom. Ang pormal na paghukom ay siyang pasiya kung ang panukala ay dapat magbayad sa iyong tag-pagkaloob para sa serbisyo na iyong natanggap. Kung ano man ang pasiya ng panawagan o pormal na paghukom, hindi mo kailangang magbayad para sa serbisyo.

Quận Hạt San Diego
Chương Trình Dịch Vụ Sức Khỏe Tâm Thần Chuyên Ngành Medi-Cal
THÔNG BÁO
(Từ Chối Trả Tiền Dịch Vụ Đã Cung Cấp)

Ngày tháng:_____

Kính gửi: _____, Thẻ Medi-Cal số _____

Chương trình sức khỏe tâm thần của Quân hạt _____ từ chối không trả tiền những dịch vụ mà cơ quan chăm sóc sức khỏe của quí đã yêu cầu:

_____

Tên cơ quan chăm sóc sức khỏe _____

Ngày tháng mà cơ quan chăm sóc sức khỏe bắt đầu yêu cầu _____ và cơ quan chăm sóc sức khỏe cho biết quí vị đã nhận những dịch vụ vào các ngày sau đây: _____.

GIẤY NÀY KHÔNG PHẢI LÀ HÓA ĐƠN. QUÍ VỊ KHÔNG PHẢI TRẢ TIỀN DỊCH VỤ MÀ CHÚNG TÔI KỂ RA TRONG MẪU NÀY

Chương trình sức khỏe tâm thần có quyết định như trên là vì căn cứ vào chi tiết mà cơ quan chăm sóc sức khỏe của quí vị cho biết như sau:

☐ Cơ quan chăm sóc sức khỏe của quí vị cho chúng tôi biết là tình trạng sức khỏe tâm thần của quí vị không hội đủ tiêu chuẩn cần thiết để nội trú bệnh viện nhận dịch vụ tâm thần hay các dịch vụ chuyên môn liên quan đến sức khỏe tâm thần (Luật Title 9, California Code of Regulations (CCR), Phần 1820.205).

☐ Cơ quan chăm sóc sức khỏe của quí vị cho chúng tôi biết là tình trạng sức khỏe tâm thần của quí vị không hội đủ tiêu chuẩn cần thiết để nhận các dịch vụ tâm thần đặc biệt ngòai các dịch vụ tâm thần nội trú bệnh viện vì lý do sau đây: (luật Title 9, CCR, Phần 1830.205): _____

_____

☐ Chương trình sức khỏe tâm thần không trang trãi dịch vụ đã cung cấp (Luật Title 9, CCR, Phần 1810.345).

☐ Chương trình sức khỏe tâm thần yêu cầu cơ quan chăm sóc sức khỏe của quí vị cung cấp thêm chi tiết để chấp thuận trả tiền những dịch vụ quí vị đã nhận. Đến hôm nay mà chúng tôi vẫn chưa nhận gì cả.

☐ Những điều khác_____

_____

<u>Nếu quý vị không đồng ý với quyết định của chương trình</u>:
Quý vị có thể mở hồ sơ khiếu nại với chương trình sức khỏe tâm thần của mình. Để mở hồ sơ khiếu nại về các dịch vụ sức khỏe tâm thần cho bệnh nhân nội viện hoặc tư gia, hãy liên lạc với Chương Trình Bênh Vực Bệnh Nhân JFS ở số (800) 479-2233, 8788 Balboa Avenue, San Diego, CA 92123. Để mở hồ sơ khiếu nại về các dịch vụ sức khỏe tâm thần được bệnh nhân nội viện tiếp nhận, hãy liên lạc với Trung Tâm Giáo Dục Y Tế và Bênh Vực Người Tiêu Thụ (CCHEA) ở số (877) 734-3258, 1764 San Diego Avenue, Suite 200, San Diego, CA 92110. Hoặc làm theo những chỉ dẫn trong quyển sách hướng dẫn do chương trình sức khỏe tâm thần trao cho quý vị. Quý vị phải mở hồ sơ khiếu nại trong vòng 90 ngày kể từ ngày nhận thông báo này.

Nếu quí vị không vừa lòng với kết quả của sự khiếu nại, quí vị có thể yêu cầu một buổi điều trần cấp tiểu bang. Trang sau của thông báo này sẽ giải thích cách xin buổi điều trần. Buổi điều trần tiểu bang sẽ quyết định xem chương trình sức khỏe tâm thần có phải trả tiền các dịch vụ mà quí vị đã nhận từ cơ quan chăm sóc sức khỏe của quí vị hay không. Dù kết quả sự khiếu nại hay điều trần như thế nào thì quí vị vẫn không phải trả tiền dịch vụ mà quí vị đã nhận.

Appendix G
Quality Improvement Program

CALIFORNIA DEPARTMENT OF
Mental Health

REASONS FOR RECOUPMENT FOR FY 2011-2012

NON-HOSPITAL SERVICES

MEDICAL NECESSITY:

1. Documentation in the chart does not establish that the beneficiary has a diagnosis contained in California Code of Regulations, (CCR), title 9, chapter 11, section 1830.205(b)(1)(A-R).

   CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R); CCR, title 9, chapter 11, section 1810.345(a); CCR, title 9, chapter 11, section 1840.112(b)(1) and (4)

2. Documentation in the chart does not establish that, as a result of a mental disorder listed in CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R), the beneficiary has, at least, one of the following impairments:

   - A significant impairment in an important area of life functioning
   - A probability of significant deterioration in an important area of life functioning
   - A probability the child will not progress developmentally as individually appropriate
   - For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate

   CCR, title 9, chapter 11, section 1830.205(b)(2)(A – C); CCR, title 9, chapter 11, section 1830.210(a)(3)

3. Documentation in the chart does not establish that the focus of the proposed intervention is to address the condition identified in CCR, title 9, chapter 11, section 1830.205(b)(2)(A),(B),(C)-(see below):

   - A significant impairment in an important area of life functioning
   - A probability of significant deterioration in an important area of life functioning
   - A probability the child will not progress developmentally as individually appropriate
   - For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate

   NOTE: EPSDT services may be directed toward the substance abuse disorders of EPSDT eligible children who meet the criteria for specialty mental health services under this agreement, if such treatment is consistent with the goals of the mental health treatment and services are not otherwise available.

   CCR, title 9, chapter 11, section 1830.205(b)(3)(A); CCR, title 9, chapter 11, section 1840.112(b)(4)

REASONS FOR RECOUPMENT FOR FY 2011-2012

4. Documentation in the chart does not establish the expectation that the proposed intervention will do, at least, one of the following:
   - Significantly diminish the impairment
   - Prevent significant deterioration in an important area of life functioning
   - Allow the child to progress developmentally as individually appropriate
   - For full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition

   CCR, title 9, chapter 11, section 1830.205(b)(3)(B); CCR, title 9, chapter 11, section 1810.345(c)

CLIENT PLAN:

5. Initial client plan was not completed within time period specified in the MHP's documentation guidelines, or lacking MHP guidelines, within 60 days of intake unless there is documentation supporting the need for more time.

   CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract, Exhibit A, Attachment 1, Appendix C

6. Client plan was not completed, at least, on an annual basis as specified in the MHP's documentation guidelines.

   CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract, Exhibit A, Attachment 1, Appendix C

7. No documentation of client or legal guardian participation in the plan or written explanation of the client's refusal or unavailability to sign as required in the MHP Contract with the DMH.

   CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract, Exhibit A, Attachment 1, Appendix C

8. For beneficiaries receiving Therapeutic Behavioral Services (TBS), no documentation of a plan for TBS.

   CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract, Exhibit A, Attachment 1, Appendix C; DMH Letter No. 99-03, Pages 6-7

PROGRESS NOTES:

9. No progress note was found for service claimed.

   CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(3); CCR, title 22, chapter 3, section 51458.1(a)(3); MHP Contract, Exhibit A, Attachment 1, Appendix C

10. The time claimed was greater than the time documented.

    CCR, title 9, chapter 11, section 1810.440(c); CCR, title 22, chapter 3, section 51458.1(a)(3) and (4); CCR, title 22, chapter 3, section 51470(a); MHP Contract, Exhibit A, Attachment 1, Appendix C

REASONS FOR RECOUPMENT FOR FY 2011-2012

11. The progress note indicates that the service was provided while the beneficiary resided in a setting where the beneficiary was ineligible for Federal Financial Participation. (e.g. Institute for Mental Disease, jail, and other similar settings, or in a setting subject to lockouts per CCR, title 9, chapter 11.)

    CCR, title 9, chapter 11, section 1840.312(g-h); CCR, title 9, chapter 11, sections 1840.360-1840.374; Code of Federal Regulations (CFR), title 42, sections 435.1008 – 435.1009; CFR, title 42, section 440.168; CCR, title 22, section 50273(a)(1-9); CCR, title 22, section 51458.1(a)(8); United States Code (USC), title 42, chapter 7, section 1396d

12. The progress note clearly indicates that the service was provided to a beneficiary in juvenile hall and when ineligible for Medi-Cal. (Dependent minor is Medi-Cal eligible. Delinquent minor is only Medi-Cal eligible after adjudication for release into community).

    CFR, title 42, sections 435.1008 – 435.1009; CCR, title 22, section 50273(a)(1-9)

13. The progress note indicates that the service provided was solely for one of the following:

    a) Academic educational service
    b) Vocational service that has work or work training as its actual purpose
    c) Recreation
    d) Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors

    CCR, title 9, chapter 11, section 1840.312(a-d); CCR, title 9, chapter 11, section 1810.247; CCR, title 22, chapter 3, section 51458.1(a)(5) and (7)

14. The claim for a group activity was not properly apportioned to all clients present.

    CCR, title 9, chapter 11, section 1840.314(c); CCR, title 9, chapter 11, section 1840.316(b)(2)

15. The progress note does not contain the signature (or electronic equivalent) of the person providing the service.

    MHP Contract, Exhibit A, Attachment 1, Appendix C

16. The progress note indicates the service provided was solely transportation.

    CCR, title 9, chapter 11, section 1810.355(a)(2), CCR, title 9, chapter 11, section 1840.312(f); CCR, title 9, chapter 11, section 1810.247; CCR, title 9, chapter 11, section 1840.110(a)

17. The progress note indicates the service provided was solely clerical.

    CCR, title 9, chapter 11, section 1840.312(f); CCR, title 9, chapter 11, section 1810.247; CCR, title 9, chapter 11, section 1840.110(a); CCR, title 9, chapter 11, section 1830.205(b)(3)

18. The progress note indicates the service provided was solely payee related.

    CCR, title 9, chapter 11, sections 1840.312(f); CCR, title 9, chapter 11, section 1810.247; CCR, title 9, chapter 11, section 1840.110(a); CCR, title 9, chapter 11, section 1830.205(b)(3)

REASONS FOR RECOUPMENT FOR FY 2011-2012

19. No service provided: Missed appointment per DMH Letter No. 02-07

CCR, title 9, chapter 11, section 1840.112(b)(3); CCR, title 22, chapter 3, section 51470(a); DMH Letter No. 02-07

20. For beneficiaries receiving TBS, the TBS progress notes overall clearly indicate that TBS was provided solely for one of the following reasons:

    a) For the convenience of the family, caregivers, physician, or teacher
    b) To provide supervision or to ensure compliance with terms and conditions of probation
    c) To ensure the child's/youth's physical safety or the safety of others, e.g., suicide watch
    d) To address conditions that are not a part of the child's/youth's mental health condition

DMH Letter No. 99-03, Page 4

21. For beneficiaries receiving TBS, the progress note clearly indicates that TBS was provided to a beneficiary in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility.

DMH Letter No. 99-03, Page 5

HOSPITAL SERVICES

MEDICAL NECESSITY:

22. Documentation in the chart does not establish that the beneficiary has a diagnosis contained in Section 1820.205(a)(1)(A-R).

CCR, title 9, chapter 11, section 1820.205(a)(1)(A-R)

23. Documentation in the chart does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), the beneficiary requires psychiatric inpatient hospital services for, at least, one of the following reasons:

    - Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction
    - Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing food, clothing or shelter
    - Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health
    - Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function
    - Need for psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the beneficiary is in a psychiatric inpatient hospital
    - Presence of either a serious adverse reaction to medications or the need for procedures/therapies that require continued psychiatric inpatient hospitalization

CCR, title 9, chapter 11, sections 1820.205(a)(2)(B) and 1820.205(b)

REASONS FOR RECOUPMENT FOR FY 2011-2012

ADMINISTRATIVE DAY:

24. Documentation in the chart does not establish that the beneficiary previously met medical necessity for acute psychiatric inpatient hospital service during the current hospital stay.

    CCR, title 9, chapter 11, sections 1820.220(j)(5) and 1820.225(d)(2)

25. Documentation in the chart does not establish that the hospital made the minimum number of contacts with the non-acute residential treatment facilities as evidenced by a lack of the following:
    a) The status of the placement option(s)
    b) The dates of the contacts, and
    c) The signature of the person making each contact.

    CCR, title 9, chapter 11, sections 1820.220(j)(5) and 1820.225(d)(2)

CLIENT PLAN:

26. The beneficiary record does not contain a client plan.

    CFR, title 42, section 456.180; CCR, title 9, chapter 11, section 1820.210

27. The client plan was not signed by a physician.

    CFR, title 42, section 456.180; CCR, title 9, chapter 11, section 1820.210

OTHER

28. A claim for a day when the beneficiary was not admitted to the hospital.

    CCR, title 9, chapter 11, section 1840.320(b)(1)

APPEAL PROCESS
Medi-Cal/ QI Billing Summary Report
San Diego County Mental Health Services

BHS Quality Improvement has developed the following 2-level process for a provider who wishes to appeal a disallowed service(s) decision.

1. QI Specialist will mail the provider a formal written report outlining the results of their medical record review within 30 days of review completion.

2. Provider has 14 days from the **date** of the cover letter attached to the written report to request a first level appeal.

3. First level appeal must be in writing, specify which disallowed service(s) is being appealed, reason why, and include any supporting documentation from the medical record. Appeal should be marked "confidential" and mailed to QI Program Manager.

4. First level appeal decision will be made within 7 working days from receipt of appeal letter. Provider will be informed of this decision in writing.

5. Should provider disagree with first level decision, provider has 7 working days from receipt of written decision to request a second level appeal. Second level appeal must be in writing, specify which disallowed service(s) is being appealed from first level decision, and reason why. Appeal should be marked "confidential" and mailed to QI Director.

6. Second level appeal decision will be made within 7 working days from receipt of appeal letter. Provider will be informed of this decision in writing.

Mailing address for Quality Improvement:
County of San Diego
Behavioral Health Services
P.O. Box 85524 Mailstop P-531G
San Diego, CA 92186-5524

Any questions regarding this procedure may be directed to QI Program Manager at 619.563.2747

QUALITY IMPROVEMENT – HHSA-MHS
ADULT/OLDER ADULT OUTPATIENT
MEDICATION MONITORING SCREENING TOOL

Program:	**Client:**		**Gender: M ☐ or F ☐**	
Psychiatrist:	**Client#:**		**Date of last MD visit:**	
Review Date:	**DOB:**	**Age:**	**Wt (lb):**	**Ht (in):**
Reviewer:	**Allergies: ☐ NKDA ☐Other:_____**			
	☐ **Diagnosis**			

	CRITERIA	COMPLIANCE			COMMENTS
		YES	NO	N/A	
1.	Medication rationale and dosage is consistent with the community standards.	☐	☐	☐	
2.	a. Were labs indicated? b. Were lab results obtained? c. Were labs reviewed by Medical Staff? d. Were lab results present in chart? e. Were attempts made to obtain appropriate labs? f. If treatment continues without labs, is there appropriate rationale to continue or discontinue meds	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	
3.	Physical health conditions and treatment considered when prescribing psychiatric medication.	☐	☐	☐	
4.	No more than 1 medication of each chemical class concurrently without a clearly documented rationale.	☐	☐	☐	
5.	Adverse drug reactions and/or side effects treated and managed effectively.	☐	☐	☐	
6.	Informed consent is evidenced by a signed consent form	☐	☐	☐	
7.	Documentation is in accordance with prescribed medication.	☐	☐	☐	
	Documentation includes client's:				
8a.	Response to medication therapy.	☐	☐	☐	
8b.	Presence/absence of side effects.	☐	☐	☐	
8c.	Extent of client's adherence with the prescribed medication regimen and relevant interventions.	☐	☐	☐	
8d.	Client's degree of knowledge regarding management of his/her medication(s).	☐	☐	☐	
	BENZODIAZEPINE CRITERIA				
9.	Dose is within community standards of FDA guidelines: a.) **Diazepam** max dose **40mg/day** b.) **Clonazepam** max dose **6mg/day** c.) **Lorazepam** max dose **6mg/day**	☐	☐	☐	
10.	Documentation shows absence of BZD abuse.	☐	☐	☐	
11.	For long-term use of BZD medication, rationale is documented based on previous failures on other treatment medications or modalities.	☐	☐	☐	
12.	No more than one anxiolytic is prescribed without a clearly documented rationale.	☐	☐	☐	
13.	If treatment is for short-term use as a sleep aid, documentation shows evidence that patient has failed previous non-BZD medications.	☐	☐	☐	
14.	If patient is requesting medication between doctor visits or escalating doses without physician approval, interventions to address these behaviors are documented.	☐	☐	☐	

Please complete a McFloop Form if there are any variances.

QUALITY IMPROVEMENT – HHSA-MHS
CHILD & ADOLESCENT OUTPATIENT
MEDICATION MONITORING SCREENING TOOL

Program:	**Client:**		**Gender: Circle M or F**	
Psychiatrist:	**Case#:**		**Date of last MD visit:**	
Review Date:	**DOB:**	**Age:**	**Wt (lb):**	**Ht (in):**
Reviewer:	**Allergies:** ☐**NKDA** ☐**Other:**_____			
	☐ **Diagnosis**			

	CRITERIA	COMPLIANCE			COMMENTS
		YES	NO	N/A	
1	Medication rationale and dosage is consistent with the community standards.	☐	☐	☐	
2	a. Were labs indicated? b. Were lab results obtained? c. Were labs reviewed by Medical Staff? d. Were lab results present in the chart? e. Were attempts made to obtain appropriate labs? f. If treatment continues without labs, is there appropriate rationale to continue or discontinue meds?	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	
3	Physical health conditions and treatment are considered when prescribing psychiatric medication.	☐	☐	☐	
4	Is the patient on more than one medication of any of the following chemical classes concurrently?				
	a. 1. **Stimulants:** Yes ☐ No ☐ N/A ☐ 2. If "yes", is rationale documented? Yes ☐ No ☐	☐	☐	☐	
	b. 1. **Mood Stabilizers:** Yes ☐ No ☐ N/A ☐ 2. If "yes", is rationale documented? Yes ☐ No ☐	☐	☐	☐	
	c. 1. **Antidepressants:** Yes ☐ No ☐ N/A ☐ 2. If "yes", is rationale documented? Yes ☐ No ☐	☐	☐	☐	
	d. 1. **Antipsychotics:** Yes ☐ No ☐ N/A ☐ 2. If "yes", is rationale documented? Yes ☐ No ☐	☐	☐	☐	
	e. 1. **Anticholinergic agents:** Yes ☐ No ☐ N/A ☐ 2. If "yes", is rationale documented? Yes ☐ No ☐	☐	☐	☐	
5	Adverse drug reactions and/or side effects treated and managed effectively.	☐	☐	☐	
6	Informed consent is evidenced by a signed consent form.	☐	☐	☐	
7	Documentation is in accordance with prescribed medication.	☐	☐	☐	
	Documentation includes client's:				
8a	Response to medication therapy.	☐	☐	☐	
8b	Presence/absence of side effects.	☐	☐	☐	
8c	Extent of client's adherence with the prescribed medication regimen and relevant interventions.	☐	☐	☐	
8d	Client's degree of knowledge regarding management of his/her medication(s).	☐	☐	☐	

Please complete a McFloop Form if there are any variances.

Medication Monitoring Committee Minutes

Program Name:			**Meeting Date:**
☐ Quarter 1 Jul 1 – Sep 30, 20_____	☐ Quarter 2 Oct 1 – Dec 31, 20_____	☐ Quarter 3 Jan 1 – Mar 31, 20_____	☐ Quarter 4 Apr 1 – Jun 30, 20_____
Screened by: ☐ County Pharmacy ☐ MM Committee			

Committee Members	**Print Name**	**Discipline**	**Sign Name**
Chairperson	_____	_____	_____
Members	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Description of Activities

_____ Total Number of records screened this quarter

_____ Total Number of variances identified

_____ Total Number of McFloops required _____# Approved/Completed _____# Outstanding

(please note that one McFloop form can be completed for one or more variances on a MM Screening Tool)

Please note
The Medication monitoring Submission Form is due 15 days after the end of each quarter (e.g. for first quarter; July, Aug, Sept; report due by Oct. 15) and can be emailed.

Any McFloops that are disapproved must be faxed in.

Do not submit this form or the medication monitoring tools

Please email your Medication Monitoring Submission form to:

QIMatters.hhsa@sdcounty.ca.gov

Or fax to: (619) 236-1953

Q.I. Confidential Information

Medication Monitoring Feedback Loop Form

(McFloop)

TO: _____
Treating Physician

FROM: **Medication Monitoring Committee**

RE: **Program Name** _____

Patient Name _____

Case # _____

Summary of Recommendations/Requests for Action:

_____

Reviewer Signature & Discipline **Date**

Response/ Action taken by Treating Physician to Committee
(Written documentation/proof must be provided within 2 weeks)

_____

Physician Signature & Discipline **Date**

Verification of Physician Response

( ) Approved

( ) Disapproved (Forwarded to Medical Director)

_____

Reviewer Signature & Discipline **Date**

County of San Diego - Health and Human Services Agency

Mental Health Services

QUARTERLY STATUS REPORT-NARRATIVE

due the 20th calendar day of the month via email: MHS-COTR.HHSA@sdcounty.ca.gov

For instructions please click on the RED Markers located at top of the column

1. GENERAL INFORMATION:

Contractor Name	**County of San Diego**	Program Type	**ADULT**
Program Name	**Program Name**	Provider Type	**COUNTY**
Contract Number	**NA**	Report Period	**Quarter 1 (7/1/2011-9/30/2011)**
Unit/SubUnit Number	**Unit/Sub Unit**	Date Submitted	**Date**
Submitted By	**Program Manager**	Contact Phone	

2. PROGRAM DESCRIPTION:

3. ACTIVITIES & EVENTS

4. COMMUNITY OUTREACH /COLLABORATION WITH OTHER AGENCIES/EDUCATION REGARDING SERVICES:

Target Population:		**Venue:**		**# Hours:**	0.0	**# Contacts:**	
Target Population:		**Venue:**		**# Hours:**	0.0	**# Contacts:**	
Target Population:		**Venue:**		**# Hours:**	0.0	**# Contacts:**	
Target Population:		**Venue:**		**# Hours:**	0.0	**# Contacts:**	

OTHER INFORMATION

A.G.7

County of San Diego - Health and Human Services Agency

Mental Health Services

Quarterly STATUS REPORT-NARRATIVE 2

Due the 20th calendar day of the month via email: MHS-COTR.HHSA@sdcounty.ca.gov

for instructions place cursor over the RED Markers located at the top of the column

1. GENERAL INFORMATION:

Contractor Name	**County of San Diego**	Program Type	**ADULT**
Program Name	**Program Name**	Provider Type	**COUNTY**
Contract Number	**NA**	Report Period	**Quarter 1 (7/1/2011-9/30/2011)**
Unit	**Unit/Sub Unit**	Date Submitted	**Date**
Submitted By	**Program Manager**	Contact Phone	

5. PROGRAMMATIC ISSUES AND ACTIONS INITIATED TO SOLVE OR MITIGATE THEM:

6. EMERGING ISSUES OR POTENTIAL PROBLEMS:

7. QUALITY IMPROVEMENT ACTIVITIES:

OTHER INFORMATION

County of San Diego - Health and Human Services Agency

QUARTERLY STATUS REPORT-DATA

1. GENERAL INFORMATION:

Contractor Name	**County of San Diego**	Program Type	**ADULT**
Program Name	**Program Name**	Provider Type	**COUNTY**
Contract Number	**NA**	Report Period	**Quarter 1 (7/1/2011-9/30/2011)**
Unit	**Unit/Sub Unit**	Date Submitted	**Date**
Submitted By	**Program Manager**	Contact Phone	

2. SERVICE AND BILLING UNITS:

SERVICE FUNCTIONS	Service Units				Billing Units			
	Annual Budgeted	Report Quarter Actual	YTD Actual	% obj complete	Annual Budgeted	Report Quarter Actual	YTD Actual	% obj complete
MHS	0	0	0		0	0	0	
MED SUPPORT	0	0	0		0	0	0	
CRISIS INTERVENTION	0	0	0		0	0	0	
CM BROKERAGE	0	0	0		0	0	0	
MAA	0	0	0		0	0	0	
LIHP	0	0	0		0	0	0	
Non LIHP	0	0	0		0	0	0	
SUB TOTAL BILLABLE	0	0	0		0	0	0	
Non-BILLABLE SERVICES		0	0			0	0	
Non-MAA		0	0			0	0	
TOTAL of budgeted units	0	0	0		0	0	0	
Percent of Year Elapsed								**25%**

COMMENTS	

3. STATISTICAL INFORMATION:

Total number count as of last calendar day of report month from ADC Quarter Report	Report Quarter	Year to Date
Admissions (ADC = Opened)	0	0
Discharges (ADC = Closed)	0	0
Active cases (ADC = End Load)	0	0
Unduplicated clients - (ADC = Unique Clients Served)	0	0
Unduplicated Clients LIHP (ADC Unique Clients Served)	0	0
Unduplicated LIHP Receiving Non LIHP Services (Tracked by Program)	0	0
Incident Report	0	0
Budgeted FTE Direct Service Staff (excluding consultants)	0.00	
Actual FTE Direct Service Staff	0.00	
Average Caseload per Actual Direct Service Staff FTE - #active cases/#direct service		

County of San Diego - Health and Human Services Agency

QUARTERLY STATUS REPORT-STAFFING AND PERSONNEL

1. GENERAL INFORMATION:

Contractor Name	**County of San Diego**	Program Type	**ADULT**
Program Name	**Program Name**	Provider Type	**COUNTY**
Contract Number	**NA**	Report Period	**Quarter 1 (7/1/2011-9/30/2011)**
Unit/Sub Unit Number	**Unit/Sub Unit**	Date Submitted	**Date**
Submitted By	**Program Manager**	Contact Phone	

2. STAFFING UPDATES

☐ **NONE (No Staffing Updates were generated this reporting period.)**

3. PERSONNEL LISTING

Position	Name	Credential	Pos Type Code	Budgted Direct FTE	Actual Direct FTE	Budgted Admin FTE	Actual Admin FTE	Ethnic Code	Language Proficiency Codes (Enter **ONLY 1 code per column.** IF more than 3 languages, enter additional codes in last column)				Read & Write Proficiency (Enter **ONLY 1 code per column.** IF more than 3 languages, enter additional codes in last column)				Specialty Code (Enter **ONLY 1 code per column.** IF more than 8 specialty codes, enter additional codes in last column)								Hire Date	Term Date	Dist. Trng Comp	Date Training Attended	Cult Comp Trng Comp	Date Training Attended
Staff																																
				0.00000	0.00000	0.00000	0.00000																									
Volunteers/Interns																																
				0.00000	0.00000	0.00000	0.00000																									
										0																						
				0.00000	0.00000	0.00000	0.00000																									
				0.00000	0.00000	0.00000	0.00000																									
TERMINATED STAFF																																
																												N		N		
																												N		N		
																												N		N		
																												N		N		
																												N		N		
																												N		N		
																												N		N		

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County of San Diego

Instructions to Monthly Status Report Staffing and Personnel Revised

The following instructions refer to section 3, "Personnel Listing," of the S&P-revised tab on the Monthly Status Report

Position

Enter the full title of the employee's position. For example:

•Director	•Analyst
•Clerk	•Student
•Secretary	•Intern
•Volunteer	

Name

Enter employee's First and Last Name

Credential

Enter employee's credential/degree. If the employee is not credentialed, leave blank.

•M.D	•LCSW	•CSW	•Ph.D	•DAC
•D.O.	•LMFT	•R.N.	•Ed.D	•BCD
•MFT	•MFCC	•M.H.N	•LPC	
•LMSW	•ACSW	•Psy.D	•LMHC	

Position Type

Use one of the following categories when completing the Monthly Staffing and Personnel Report:

- •A: Administration/Management- Managers & Analysts
- •D: Direct Services- Psychiatrists, Psychologists, Clinicians, Social Workers, or Interns
- •S: Support Services- Clerican and Case Aides
- •V: Volunteers and/or Student Workers

Budgeted Direct FTE

Take Budgeted Direct FTE listing from contract documents, Schedules I & II. For interns, volunteers, or student workers, indicate paid/nonpaid status and hours worked (0.01 to 1.00)

Budgeted Admin FTE

Take Budgeted Admin FTE listing from contract documents, Schedules I & II. For interns, volunteers, or student workers, indicate paid/nonpaid status and hours worked (0.01 to 1.00)

Actual Direct FTE

Enter the actual Full Time Equivalent Direct Services employment for the employee during the report period. (0.01 to 1.00)

Actual Admin FTE

Enter Indirect Services employment for the employee during the report period. (0.01 to 1.00)

Ethnicity Code

Enter the employee's Ethnicity code, choose from the following:

•A: White	•R: Hmong
•B: African American	•S: Cuban
•C: American Indian	•T: Dominican
•D: Mexican American	•U: Salvadoran
•E: Other Latin America	•V: Sudanese
•F: Puerto Rican	•W: Ethiopian
•G: Chinese	•X: Somali
•H: Vietnamese	•Y: Iranian
•I: Laotian	•Z: Iraqi
•J: Cambodian	•1: Ameriasian
•K: Japanese	•2: Samoan
•L: Filipino	•3: Asian Indian
•M: Other Asian	•4: Hawaiian Native
•N: Other	•5: Guamanian
•O: Unknown	•6: Other Middle Eastern
•P: Pacific Islander	•7: Unknown/Not Reported
•Q: Korean	

Read & Write Proficiency

Enter one (1) language code per column the individual reads or writes in, other than English. **IF** more than 4 languages, enter additional codes in LAST column.

•A: English	•S: Armenian
•B: Spanish	•T: Ilocano
•C: Tagalog	•U: Mien
•D: Japanese	•V: Turkish
•E: Arabic	•W: Hebrew
•F: Vietnamese	•X: French
•G: Laotian	•Y: Polish
•H: Cambodian	•Z: Russian
•I: Sign Language	•1: Portuguese
•J: Other	•2: Italian
•K: Korean	•3: Samoan
•L: Mandarin Chinese	•4: Thai
•M: Cantonese Chinese	•5: German
•N: Other Chinese	•6: None (no reading/ writing proficiency
•O: Hmong	•7: Ethiopian
•P: Farsi	•8: Unknown/ Not reported
•Q: Other Filipino Dialec	
•R: Other Sign Language	

Specialty Code

Enter the appropriate code (1 per column) for each staff whose education, experience, and training may qualify them to provide culturally competent services working with the specialty populations listed below.

IF more than 9 codes, enter additional codes in LAST column.

NOTE: The Specialty code was added in the right hand column on the modified Cultural Competency form.

•A: Homeless	•I: Middle Eastern
•B: Adult Sexual Orientation (Gay/ Lesbian/Bisexual/ Transgender	•J: American Indian
•C: Older Adult	•K: Transition Age Youth
•D: African American	•L: Children Under the Age of Six
•E: Northeast African Refugee	•M: Youth Gay/ Lesbian/ Transgender
•F: Eastern European	•N: Juvenile Court Dependents
•G: Hispanic/Latino	•O: Juvenile Court Wards
•H: Southeast Asian	•P: Self-report of personal lived experience w/ mental illness

Hire Date

Enter the actual Hire Date for each respective staff member hired by the program. Date format: mm/dd/yy

Term Date

Enter the actual Termination Date for the employee. If the employee is still employed by the program, leave blank.

Cultural Competency Training Completed

Enter "Y" if the employee has completed 4 hours of Cultural Competency Training. Enter "N" if the employee has attended partial or no training. NOTE: Employees must attend Cultural Competency Training annually.

Disaster Training Completed

Enter "Y" if the employee has completed Disaster Training. Enter "N" if the employee has attended partial or no training. NOTE: Employees must attend Cultural Competency Training annually.

Cultural Competency/Disaster Training Attended

Enter the Training Course Designation, which corresponds to the course(s) attended by the employee.

NOTE: The Training Course Designation can be acquired from the Training Report, leftmost column.

Language Proficiency

Enter one (1) language code per column the individual speaks fluently from the following. **IF** there are more than 4 languages enter additional codes in LAST column.

•A: English	•J: Other	•S: Armenian	•2: Italian
•B: Spanish	•K: Korean	•T: Ilocano	•3: Samoan
•C: Tagalog	•L: Mandarin Chinese	•U: Mien	•4: Thai
•D: Japanese	•M: Cantonese Chinese	•V: Turkish	•5: German
•E: Arabic	•N: Other Chinese	•W: Hebrew	•6: None (no reading/writing proficiency
•F: Vietnamese	•O: Hmong	•X: French	•7: Ethiopian
•G: Laotian	•P: Farsi	•Y: Polish	•8: Unknown/ Not reported
•H: Cambodian	•Q: Other Filipino Dialect	•Z: Russian	
•I: Sign Language	•R: Other Sign Language	•1: Portuguese	

Terminated Staff

When a staff person is terminated from the program, please transfer their information to the "Terminated Staff" section at the bottom of the page leaving the position information open until filled.

County of San Diego - Health and Human Services Agency

Mental Health Services

QUARTERLY STATUS REPORT-SUGGESTIONS and TRANSFERS

Due the 20th calendar day of the month via email: MHS-COTR.HHSA@sdcounty.ca.gov

for instructions place cursor over the RED Markers located at the top of each column

1. GENERAL INFORMATION:

Contractor Name	**County of San Diego**	Program Type	**ADULT**
Program Name	**Program Name**	Provider Type	**COUNTY**
Contract Number	**NA**	Report Period	**Quarter 1 (7/1/2011-9/30/2011)**
Unit	**Unit/Sub Unit**	Date Submitted	**Date**
Submitted By	**Program Manager**	Contact Phone	

2. Suggestion and Transfer Data

☑ **NONE (No Suggestion or Transfer Requests were received this reporting period.)**

Date Received or Initiated **mm/dd/yy**	Indicate if this is Client **(S)** Suggestion or **(T)** Transfer Request	Client Suggestion Code **1-15**	Transfer Request Code **1-11**	Indicate if Client Transfer Request is **(O)** Out of Program or **(N)** To New Provider within the Program	Description of Client Suggestion or Transfer Request	Date of Resolution **mm/dd/yy**	Describe Resolution or Action Taken

County of San Diego - Health and Human Services Agency

Mental Health Services

QUARTERLY STATUS REPORT-NOTICE OF ACTION

Due the 20th calendar day of the month via email: MHS-COTR.HHSA@sdcounty.ca.gov

for instructions place cursor over the RED Markers located at the top of each column

1. GENERAL INFORMATION:

Contractor Name	**County of San Diego**	Program Type	**ADULT**
Program Name	**Program Name**	Provider Type	**COUNTY**
Contract Number	**NA**	Report Period	**Quarter 1 (7/1/2011-9/30/2011)**
Unit	**Unit/Sub Unit**	Date Submitted	**Date**
Submitted By	**Program Manager**	Contact Phone	

2. Notice of Action - Assessment (NOA-A)

☑ **NONE (No Notice of Action-A was issued this report month.)**

Date	ID Number	Client Response

3. Notice of Action - Denial of Service (NOA-B)

☑ **NONE (No Notice of Action-B was issued this report month.)**

Date	ID Number	Client Response

PATH GRANT DATA - Quarterly Demographic ROLLUP

B. PERSONS SERVED

		YTD	Q1	Q2	Q3	Q4
B1	Persons who are homeless and have serious mental illnesses served by PATH funds and other sources.	0				
B2a	Persons served by PATH funds via OUTREACH	0	0	0	0	0
B2b	Number of OUTREACH contacts who became enrolled in PATH during the year.	0				
B2c	Number of OUTREACH contacts who did not become enrolled in PATH (B2a - B2b)	0	0	0	0	0
B2d	Number Not Enrolled due to Ineligibility (Subset of B2c)	0				
	Number Eligible But Not Enrolled	0	0	0	0	0
B3	TOTAL Persons Served (Enrolled) by PATH (Via outreach, referrals, walk-ins, etc)	0				
B4	Total Number of Persons Receiving and PATH Supported Service (this includes those not enrolled)	0	0	0	0	0

C. SERVICES PROVIDED

		YTD	Q1	Q2	Q3	Q4
	Number of Unduplicated Clients Who Received any of the Following Services in the Report Month	0	0	0	0	0
Ca	Outreach (Ca)	0				
Cb	Screening & Dx (Cb)	0				
Cc	Habiliatation/Rehab (Cc)	0				
Cd	Mental Health Services (Cd)	0				
Ce	Substance Abuse Tx (Ce)	0				
Cg	Case Management (Cg)	0				
Ch	Suppt/Suprv in Residential Setting (Ch)	0				
Ci	Referral: 1° Health, Educ, Job Training, Housing (Ci)	0				
Cj4	Housing: Tech asst in Applying (Cj4).	0				

Table C Outcomes

	OUTCOME MEASURES	YTD	Q1	Q2	Q3	Q4
	ASSISTED REFERRAL	0	0	0	0	0
Ck1	Housing (transitional, supportive, permanent)	0				
Ck2	Income Benefits (SSI, SSDI, GR, etc)	0				
Ck3	Earned Income (Employment)	0				
Ck4	Medical Insurance (MediCal, Medicare, etc.)	0				
Ck5	Primary Medical Care (Physical Health Care)	0				
OUTCOMES	ATTAINED	0	0	0	0	0
	Housing (transitional, supportive, permanent)	0				
	Income Benefits (SSI, SSDI, GR, etc)	0				
	Earned Income (Employment)	0				
	Medical Insurance (MediCal, Medicare, etc.)	0				
	Primary Medical Care (Physical Health Care)	0				

D. DEMOGRAPHICS

	Age	YTD	Q1	Q2	Q3	Q4
D1		0	0	0	0	0
	18-34	0				
	35-49	0				
	50-64	0				
	65-74	0				
	75+	0				
	Unknown	0				

	Gender	YTD	Q1	Q2	Q3	Q4
		0	0	0	0	0

PATH GRANT DATA - Quarterly Demographic ROLLUP

D2	M	0				
	F	0				
	Unknown	0				
D3	Race/Ethnicity	YTD	Q1	Q2	Q3	Q4
		0	0	0	0	0
	American Indian/Alaskan	0				
	Asian	0				
	Black	0				
	Hispanic	0				
	Hawaiian/Pacific Islander	0				
	White	0				
	Other	0				
	Unknown	0				
D4	Principal Mental Illness Diagnosis	YTD	Q1	Q2	Q3	Q4
		0	0	0	0	0
	Schizophrenia & Schizophreniform	0				
	Schizoaff., Psychosis NOS & Delusional D/O	0				
	Affective Disorders: PTSD, Mood, Anxiety, Bi-Polar	0				
	Personality Disorders	0				
	Other Mental Illness: somatoform, disassociative, etc.	0				
	Unknown or undiagnosed Mental Illness	0				
D5	Co-occurring Substance Abuse Disorders	YTD	Q1	Q2	Q3	Q4
		0	0	0	0	0
	Co-Occurring Substance Abuse Disorders	0				
	No Co-Occurring Substance Abuse Disorders	0				
	Unknown if Substance Abuse Disorders	0				
D6	Veteran Status	YTD	Q1	Q2	Q3	Q4
		0	0	0	0	0
	Vet	0				
	Non-Vet	0				
	Unknown	0				
D7	Housing Status at Intake	YTD	Q1	Q2	Q3	Q4
		0	0	0	0	0
	Outdoors	0				
	Shelter or other temporary housing	0				
	Long term shelter	0				
	Own or someone else's apt, room or house	0				
	Hotel, SRO, boarding house	0				
	Halfway house, residential tx, sober living	0				
	Institution	0				
	Jail or other correctional facility	0				
	Other	0				
	Unknown	0				
D8	Time Homeless (days) (on the street or short term shelter only)	YTD	Q1	Q2	Q3	Q4
		0	0	0	0	0
	2	0				
	<30	0				
	31-90	0				
	91-365	0				
	365+	0				
	Unknown	0				
	Further Information					

Definitions

Alcohol or Drug Treatment Services	Preventive, diagnostic, and other outpatient treatment services as well as support for people who have a psychological and/or physical dependence on one or more addictive substances, and a co-occurring mental illness.
Assisted Referral	A referral that results in the completion and filing of a consumer's application for a service. An assisted referral would include the following activities being conducted by the program on behalf of or in conjunction with the consumer (if some, but not all, of these activities were conducted it does not count as a complete assisted referral): * Assisting the consumer in obtaining the application, AND * Assisting the consumer in obtaining the appropriate supporting documentation, AND * Assisting the consumer with completion of the application, AND * Assisting the consumer in filing the application with the appropriate agency or organization (business if employment) * OR Referral to a program that specializes in assisting consumers with an application process and who can provide certification that the application has been successfully filed by the consumer.
Attainment	The PATH Provider confirms that the client attained the indicated service through client self-report or confirmation by other providers. A client is counted as attaining a service when they begin receiving the service. The client is not counted as attaining a service when the application process for a service is complete. PATH Providers are not required to obtain written documentation from another provider to confirm attainment.
Case Management Services	Services that develop case plans for delivering community services to PATH eligible recipients. The case plans should be developed in partnership with people who receive PATH services to coordinate evaluation, treatment, housing and/or care of individuals, tailored to individual needs and preferences. Case managers assist the individual in accessing needed services, coordinate the delivery of services in accordance with the case plan, and follow-up and monitor progress. Activities may include financial planning, access to entitlement assistance, representative payee services, etc.
Community Mental Health Services	Community-based supports designed to stabilize and provide ongoing supports and services for individuals with mental illnesses/co-occurring disorders or dual diagnoses. This general category does not include case management, alcohol or drug treatment and/or habilitation and rehabilitation, since they are defined separately in this document.
Co-Occurring Substance Use Disorders	Individuals experiencing substance use disorders only are not eligible for PATH services. However, PATH Providers are expected to serve individuals with co-occurring substance use disorders and provide documentation of this in the PATH Annual Report. The designation of a co-occurring disorder would occur when the worker, and in some cases the consumer, believes that the consumer is in a period of active use that affects his/her functioning or recovery from substance use and continues to require support. This definition does not require the consumer to be in treatment. Providers are encouraged to engage in a dialogue with the consumer to gain consensus on this determination.
Earned income	See employment
Eligibility	Once an individual is determined to meet the homeless or at risk of homelessness criteria and the mental health or co-occurring criteria, they are determined to be PATH eligible.
Enrollment	PATH Enrollment implies that there is the intent to provide services for an individual other than those provided in the outreach setting. The term enrolled means that there is a mutual intent for the services to begin. PATH Enrollment is when: 1) The individual has been determined to be PATH Eligible, 2) The individual and the PATH Provider have reached a point of engagement where there is a mutual agreement that "services" will be provided, and 3) The PATH Provider has started an individual file or record for the individual that includes at a minimum: a. Basic demographic information needed for reporting, b. Documentation by the Provider of the determination of PATH Eligibility, 2010 PATH Annual Reporting Guide 23 c. Documentation by the Provider of the mutual agreement for the provision of services, and

	d. Documentation of services provided. Although the goal of the PATH program is to assist individuals in accessing mental health services and housing, services that begin the PATH enrolled relationship can be any service, assistance, or provision of resources that the individual is willing to accept or any mutual work that the individual identifies as important. PATH does not require that a service plan be developed unless case management services are part of the services provided to the individual. PATH Providers are expected to document all services and the outcomes in an individual file.
Employment	Employment is any instance where services are performed that is subject to the will and control of an employer and for which wages are received by the worker. This definition of employment is not limited to full, part or seasonal employment, a minimum number of hours worked per week, or the availability of benefits.
Employment Services	Services designed to assist consumers with obtaining employment. Services may include, but are not limited to, application completion, resume development, interview training, and providing access to job listings.
Habilitation and Rehabilitation Services	Community-based treatment and education services designed to promote maximum functioning, a sense of well-being, and a personally satisfying level of independence for individuals who are homeless and have mental illnesses/co-occurring disorder.
Homeless Individual	According to the Public Health Services Act the definition of a homeless individual is an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing.
Housing Services	Specialized services designed to increase access to and maintenance of stable housing for individuals enrolled in PATH who have significant or unusual barriers to housing. For each enter the number of individuals enrolled in PATH who benefited from or received the service. These services are distinct from and not part of PATH funded case management, supportive and supervisory services in residential settings, or housing assistance referral activities.
Imminent Risk	Definitions of imminent risk for homelessness commonly include one or more of the following criteria: doubled-up living arrangement where the individual's name is not on the lease, living in a condemned building without a place to move, arrears in rent/utility payments, having received an eviction notice without a place to move, living in temporary or transitional housing that carries time limits, being discharged from a health care or criminal justice institution without a place to live. In addition to the criteria above, persons who live in substandard conditions are, by definition at risk of homelessness, due to local code enforcement, police action, voluntary action by the person, or inducements by service providers to go to alternatives like short-term shelters whose residents are considered to be homeless. There is not a recommended time-frame for imminence as individual state eviction laws vary in time and process.
Income Benefits	Income supports that are not earned income (wages), non-cash benefits (food stamps/Supplemental Nutrition Assistance Program (SNAP), etc), or temporary financial assistance (security deposits, rental assistance, utility or energy assistance). Income supports are financial supports that can be used at the consumer's discretion and are not limited to specific uses. Examples include Social Security Income (SSI), Social Security Disability Income (SSDI), Temporary Assistance for Needy Families (TANF), and pensions.
Literal Homelessness	Per the PATH legislation, "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing.
Mainstream Services	Programs and resources that are available to consumers with an understanding that they will be able to remain available to the consumer after their transition out of homelessness. The PATH program encourages a focus on sustainable mental health services and housing. Other mainstream services of importance are services that provide health care, employment/vocational training, community connection, support, and resources for daily needs.
Medical Insurance Program	A program designed to provide medical insurance and/or medical co-pay assistance.

Outreach Services	The process of bringing individuals who do not access traditional services into treatment. Effective outreach utilizes strategies aimed at engaging persons into the needed array of services, including identification of individuals in need, screening, development of rapport, offering support while assisting with immediate and basic needs, and referral to appropriate resources. Outreach results in increased access to and utilization of community services by people who are experiencing homelessness and mental illness. * Active outreach is defined as face-to-face interaction with literally homeless people in streets, shelters, under bridges, and in other non-traditional settings. In active outreach, workers seek out homeless individuals. * Outreach may include methods such as distribution of flyers and other written information, public service announcements, and other indirect methods. * Outreach may also include "inreach," defined as when outreach staff are placed in a service site frequented by homeless people, such as a shelter or community resource center, and direct, face to face interactions occur at that site. In this form of outreach, homeless individuals seek out outreach workers.
Primary Medical Care	Medical care that is overseen by a licensed medical primary care provider.
Referrals for Primary Health Services, Job Training, Educational Services and Relevant Housing	Services intended to link persons to primary health care, job training, income supports, education, housing, and other needed services not directly provided by the PATH program or individual PATH Providers.
Serious Mental Illness:	PATH Providers may determine individuals as meeting the Serious Mental Illness criteria if there is an informed presumption that the individual: * is experiencing or displaying symptoms of mental illness and is experiencing difficulty in functioning as a result of these symptoms that indicates severity, and * has shared or has a known history of engagement with mental health services OR has symptoms and functioning that indicates there is a history of or expected tenure of significant mental health concerns, and * is of appropriate age to be diagnosed with a Serious Mental Illness, where transition-age youth may be eligible. This determination should reflect and be consistent with the State's definition of Serious Mental Illness.
Screening and Diagnostic	A continuum of assessment services that ranges from brief eligibility screening to comprehensive clinical assessment.
Technical assistance in Applying for Housing Assistance	Targeted training, guidance, information sharing, and assistance to, or on behalf of, individuals enrolled in PATH who encounter complex access issues related to housing.
Transition to Mainstream Services	Individuals enrolled in PATH make a formal change to housing and services funded through programs such as Section 8, Medicaid, public health, Mental Health/Substance Abuse, Block Grant, etc.
Youth	Transition age youth who are homeless or at-risk of homelessness, have a serious mental illness, and who are otherwise considered adults (e.g. emancipated youth, may be PATH Enrolled. Youth who are still eligible for other protective or human services may be served by PATH in the outreach setting, and when appropriate enrolled, for the sole purpose of engaging the human services agencies, mental health services, or the education system to serve them. The goal of PATH enrollment is to advocate for the youth in accessing the services available to them and prevent them from falling through the cracks. Serving youth who are minors solely in PATH without the purpose of rapidly, safely, and effectively connecting them to the mainstream child services system is not recommended for PATH programs.

PATH Eqv	PATH Services for Tracking	Anasazi ID	Anasazi Service Codes Available
Ca	**Outreach/Inreach**	65	Community Services (non-MAA)
Cb	**Screen/Dx**	5	Screening Non-MAA
		9	Assessment Psychosoc Interact
		10	Assessment - Psychosocial
		12	Psychological Testing
		16	Psychological Test-Technician
Cc	**Hab and Rehab**	13	Plan Development
		30	Psychotherapy-Individual
		31	Psychotherapy - Group
		32	Psychotherapy - Family
		33	Collateral
		34	Rehab - Individual
		35	Rehab - Group
		36	Rehab - Family
		37	Rehab Evaluation
		38	Pyschotherapy Interactive-Ind
		39	Pyschotherapy Interactive-Grp
Cd	**Comm. MH Services**	11	Medication Evaluation
		14	Eval of Records for Assessment
		20	Medication Support Other
		21	Medication Education Group
		23	Med Check MD Brief
		70	Crisis Intervention
Ce	**AOD/COD Services**	22	Meds - Pharmacological Mgmt
Cg	**Case Management**	50	Case Management / Brokerage
		55	Case Mgmt Institutional Svc
		60	Other Support non-billable
		63	Substance Abuse Education
Ci	**Referral to: Primary Care, Job Training,**	52	PATH Referral-Special Service
Cj4	**Technical Assistance in Applying for Housing Assistance**	51	PATH Section 8 Assistance

Frequency of MORS Ratings:

							Monthly Average
Extreme risk							
High risk/not engaged							
High risk/engaged							
Poorly coping/not engaged							
Poorly coping/engaged							
Coping/rehabilitating							
Early Recovery							
Advanced Recovery							

County of San Diego - Health and Human Services Agency

QUARTERLY STATUS REPORT-NOTICE OF ACTION A and B

1. General Information

Contractor Name		Program Type	**CHILD**
Program Name		Provider Type	**CONTRACTOR**
Contract Number		Report Period	**JULY 1-SEPTEMBER 30, 2011**
Unit		Date Submitted	
SubUnit(s)	**0**		
Submitted By		Contact Phone	

2. Notice of Action - Assessment (NOA-A)

☑ **NONE (No Notice of Action-A was issued this reporting period.)**

Date	ID Number	Client Response

3. Notice of Action - Denial of Service (NOA-B)

☑ **NONE (No Notice of Action-B was issued this report month.)**

Date	ID Number	Client Response

County of San Diego - Health and Human Services Agency

Mental Health Services - QUARTERLY STATUS REPORT

due the 15th calendar day of the month following each quarter via email:
MHS-COTR.HHSA@sdcounty.ca.gov; Tess.Widmayer@sdcounty.ca.gov; Angela.Hawley@sdcounty.ca.gov
QSR Naming Convention: Contractor name.Program name.Contract #.CQSR.Q# - year
Please write the QSR file name in the subject line of the email. If a revised MSR is sent, add "Revised.mm-dd-yy" after the QSR file name.
for instructions place cursor over the RED Markers located at the upper right corner of each heading.

VLOOKUP DATE TABLE:
Report Period for cell I7

JULY 1-SEPTEMBER 30, 2011

OCTOBER 1-DECEMBER 31, 2011

JANUARY 1-MARCH 31, 2012

APRIL 1-JUNE 30, 2012

1. GENERAL INFORMATION:

Contractor Name		Program Type	**CHILD**
Program Name		Provider Type	**CONTRACTOR**
Contract Number		Report Period	**JULY 1-SEPTEMBER 30, 2011**
Unit		Date Submitted	
SubUnit(s)			
Submitted By		Contact Phone	

2. PROGRAM DESCRIPTION:

3. ACTIVITIES AND EVENTS:

4. COMMUNITY OUTREACH /COLLABORATION WITH OTHER AGENCIES/EDUCATION REGARDING SERVICES:

Target Population		**Venue**		**# of Hrs**		**# of Audience**	
Target Population		**Venue**		**# of Hrs**		**# of Audience**	
Target Population		**Venue**		**# of Hrs**		**# of Audience**	
Target Population		**Venue**		**# of Hrs**		**# of Audience**	

5. EMERGING ISSUES OR POTENTIAL PROBLEMS AND ACTIONS INITIATED TO SOLVE/ MITIGATE THEM

6. QUALITY IMPROVEMENT ACTIVITIES:

7. UTILIZATION MANAGEMENT ACTIVITIES (Year-to-Date) based on Unique Clients Services YTD

Over 13 (18) sessions (1st UM)		0.0%	Date of COTR Approval
Over 26 (36) sessions (2nd UM)		0.0%	
Over 39 sessions (3rd UM)		0.0%	
UM's Denied			

Comments:

County of San Diego - Health and Human Services Agency

QUARTERLY STATUS REPORT-OUTCOMES

1. General Information

Contractor Name		Program Type	**CHILD**
Program Name		Provider Type	**CONTRACTOR**
Contract Number		Report Period	**JULY 1-SEPTEMBER 30, 2011**
Unit		Date Submitted	
SubUnit(s)	**0**		
Submitted By		Contact Phone	

7. OUTCOMES DATA:

Number	Objectives	YTD Results		
		%	X of	Y
1	For 80% of discharged clients whose episode lasted 2 months or longer, the **P-CAMS** total score shall show **improvement** between Intake and Discharge CAMS.			
2	For 80% of discharged clients whose episode lasted 2 months or longer, the **Y-CAMS** total score shall show **improvement** between Intake and Discharge CAMS.			
3	For 80% of discharged clients whose episode lasted 3 weeks or longer, the **CFARS score** shall be at least one level lower **(improvement)** at Discharge than at Intake in at least one index area.			
4	For 80% of those clients whose episodes lasted 3 weeks or longer, the discharge summary shall reflect no increased impairment resulting from **substance use**, as measured by the domain rating for substance use.			
5	90% of clients will avoid **psychiatric hospitalization** or re-hospitalization during the outpatient episode.			
6	At Discharge, 80% of clients whose episode lasted 2 months or longer, will have **parent CAMS data available** for both Intake and Discharge CAMS.			
7	At Discharge, 80% of clients whose episode lasted 2 months or longer, will have **child CAMS data available** for both Intake and Discharge CAMS.			
8	At Discharge, 100% of clients with an intake after September 1, 2007 and whose episode lasted 3 weeks or longer will have **CFARS data available** for both Intake and Discharge.			

If there is a discrepancy between the numbers in the "Y" column and the number of Closed Cases (Discharges), please describe findings and mitigation.

Contacted CASRC to resolve discrepancies on	Date:	

8. SCHOOL SITE LOCATIONS

********** ENTIRE PROGRAM **********

Number	School Site (Year-to-Date)	School District	Hours/Week (as of the end of the report period)	# of Clients (as of the end of the report period)	# of groups held this QTR
0	**TOTAL SCHOOL SITE DATA**				

County of San Diego - Health and Human Services Agency

QUARTERLY STATUS REPORT-DATA

1. GENERAL INFORMATION:

Contractor Name		Program Type	**CHILD**
Program Name		Provider Type	**CONTRACTOR**
Contract Number		Report Period	**JULY 1-SEPTEMBER 30, 2011**
Unit		Date Submitted	
SubUnit(s)			
Submitted By		Contact Phone	

2. SERVICE AND BILLING UNITS: Budgeted at %

SERVICE FUNCTIONS					Billing Units			
					Annual Budgeted	Report Period Actual	YTD Actual	% Elapsed
MHS								
MHS-R								
MHS-TBS								
MED SUPPORT								
CRISIS INTERVENTION								
C.M. BROKERAGE								
DAY TREATMENT INTENSIVE								
DAY REHABILITATION								
OTHER(SPECIFY)								
TOTAL					**0**	**0**	**0**	
Percent of Year Elapsed								**25%**
Mitigation Plan if program is behind producing <u>billing minutes</u>.								
Mitigation Plan if program is below <u>productivity standard</u>.								
Actual program productivity	**(YTD actual units)/ (total direct fte x 108,000 x % of year passed)**							**#DIV/0!**
Estimated clinician productivity	**(YTD actual MHS + CI units)/ (total clinician fte x 108,000 x % of year passed)**							**#DIV/0!**
Estimated paraprofessional productivity	**(YTD actual CM + MHS-R units)/ (total paraprofessional fte x 108,000 x % of year passed)**							**#DIV/0!**

3. STATISTICAL INFORMATION:

Report Item *(total number count as of last calendar day of report month)*	Target # Report Period	Year to Date
Cases Opened (Admissions)		
Cases Closed (Discharges)		
Ending Caseload (Active cases)		
Unique Client Services (Unduplicated clients)		**100**
Unusual Occurrence/Incident Report		
Actual FTE Direct Service Staff	**0.00**	
Average Caseload per Actual Direct Service Staff FTE - *#active cases/#direct service*	**#DIV/0!**	

4. FAMILIES PARTICIPATING IN PERSON AT LEAST ONCE PER MONTH (at the end of the report period)

Total Number of Available Families	Total Number of Participating Families	Percent of Participation

Comments:

Vlookup table:

PERIOD	PERCENT
JULY 1-SEPTEMBER 30, 2(	25%
OCTOBER 1-DECEMBER 3	50%
JANUARY 1-MARCH 31, 2(	75%
APRIL 1-JUNE 30, 2012	100%

25% **% of year passed**

County of San Diego - Health and Human Services Agency

QUARTERLY STATUS REPORT-STAFFING AND PERSONNEL

1. GENERAL INFORMATION:

Contractor Name		Program Type	**CHILD**
Program Name		Provider Type	**CONTRACTOR**
Contract Number		Report Period	**JULY 1-SEPTEMBER 30,**
Unit		Date Submitted	
SubUnit(s)	**0**		
Submitted By		Contact Phone	

2. STAFFING UPDATES

☑ **NONE (No Staffing Updates were generated this reporting period.)**

For each vacant position, note length of vacancy. If position is under-filled, please explain why.

3. PERSONNEL LISTING (as of the end of the reporting period)

Position	Name	Credential	Pos Type Code	Budgtd Direct FTE	Actual Direct FTE	Budgtd Admin FTE	Actual Admin FTE	Hire Date	Term Date	Ethnic Code	Language Proficiency Codes (Enter **ONLY 1 code per column.** IF more than 4 languages, enter additional codes in last column)			Read & Write Proficiency (Enter **ONLY 1 code per column.** IF more than 4 languages, enter additional codes in last column)			Specialty Code (Enter **ONLY 1 code per column.** IF more than 9 specialty codes, enter additional codes in last column)						Cult Comp Trng Comp	Disaster Training Attend

County of San Diego - Health and Human Services Agency

QUARTERLY STATUS REPORT-SUGGESTION & TRANSFER

1. General Information

Contractor Name		Program Type	**CHILD**
Program Name		Provider Type	**CONTRACTOR**
Contract Number		Report Period	**JULY 1-SEPTEMBER 30, 2011**
Unit		Date Submitted	
SubUnit(s)	**0**		
Submitted By		Contact Phone	

2. Suggestion and Transfer Data (Year-to-Date)

☑ **NONE (No Suggestion or Transfer Requests were received.)**

Date Received or Initiated **mm/dd/yy**	Indicate if this is Client **(S)** Suggestion or **(T)** Transfer Request	Client Suggestion Code **1-15**	Transfer Request Code **1-11**	Indicate if Client Transfer Request is **(O)** Out of Program or **(N)** To New Provider within the Program	Description of Client Suggestion or Transfer Request	Date of Resolution **mm/dd/yy**	Describe Resolution or Action Taken

CONFIDENTIAL

SERIOUS INCIDENT REPORT (SIR)

County of San Diego Behavioral Health Services (BHS)
FAX: 619-236-1953 Serious Incident Report Line 619-563-2781
Fax LEVEL ONE SIR within 24 hours. Fax Level Two SIR within 72 hours.

For a **LEVEL ONE** incident, call the BHS Serious Incident Report Line **immediately**.

NOTE: Reporting of a serious incident is based on criteria and determined severity of the serious incident.

A **LEVEL ONE** Serious Incident is the most severe type of incident. A level one incident must include at least one of the following:

- The event has been reported in the media or has the potential for significant **adverse media involvement**, i.e. TV, newspaper, internet.
- The event has resulted in a death or serious physical injury on the program's premises.
- The event is associated with a significant adverse deviation from the usual process for providing behavioral health care.

A level one serious incident must be reported to Quality Management (QM) immediately upon knowledge of the incident. Call 619-563-2781.

A **LEVEL ONE** Serious Incident that occurs on the weekend or holiday shall be reported in accordance with the procedure documented in the Organizational Provider Operations Handbook (OPOH).

All other serious incidents are reported as Level Two incidents.

Client Name:	Case Number:	Type: ☐Level Two ☐**LEVEL ONE**
DOB: Date of Last Service:	DSM Diagnosis (TREATING DIAGNOSIS/DESCRIPTION): Axis I (Primary) : Axis I (Secondary) : Axis II:	
Primary Drug of Choice: Secondary Drug of Choice:		
Program Name:		Legal Entity:
Program Type ☐Mental Health Services Only ☐Alcohol/Drug Services Only ☐Both MHS/ADS	☐Outpatient ☐FSP/ACT ☐Case Mgmt ☐START ☐DAY Treatment ☐Residential Adult ☐Residential Child/Adolescent ☐DUI ☐Drug Court ☐Recovery Center Adult ☐Recovery Center Child/Adolescent ☐Other:	
Date/Time/Location of Incident:		Date Reported to Provider:
Program County Region Location: ☐Central ☐North Central ☐East ☐South ☐North Inland ☐North Coastal ☐Out of County ☐Countywide		Contracting Officer's Tech. Representative (COTR):
Staff Involved with incident:		

CONFIDENTIAL

SERIOUS INCIDENT REPORT (SIR)

County of San Diego Behavioral Health Services (BHS)
QM CONFIDENTIAL FAX: 619-236-1953 Serious Incident Report Line 619-563-2781
Fax LEVEL ONE SIR within 24 hours. Fax Level Two SIR within 72 hours.

CLIENT NAME:

1. SERIOUS INCIDENT TYPE (You may check more than one if applicable):

☐ Incident reported in the media/public domain (e.g. on television, newspaper, internet)

☐ Death of client by suicide (includes overdose by alcohol/drugs/medications, etc)

☐ Death of client under questionable circumstances (includes overdose by alcohol/drugs/medications, etc)

☐ Death of client by homicide

☐ Suicide attempt by client that requires medical attention or attempt is potentially fatal and/or significantly injurious.

☐ Alleged homicide committed by a client (client is perpetrator)

☐ Alleged homicide attempt by a client (client is perpetrator)

☐ Alleged homicide attempt on a client (client is victim)

☐ Injurious assault on a client (client is victim) occurring on the program's premises resulting in severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring hospitalization.

☐ Injurious assault by a client (client is perpetrator) occurring on the program's premises resulting in severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring hospitalization.

☐ Tarasoff Notification, the duty to protect intended victim, is made to the appropriate person(s), police, or other reasonable steps have been taken to protect the intended victim.

☐ Tarasoff Notification, the duty to protect intended victim, is received by the Program that a credible threat of harm has been made against a staff member(s) or Program and appropriate safety measures have been implemented.

☐ Serious allegations of or confirmed inappropriate staff (includes volunteers, interns) behavior such as sexual relations with a client, client/staff boundary issues, financial exploitation of a client, and/or physical or verbal abuse of a client.

☐ Serious physical injury resulting in a client experiencing severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring hospitalization.

☐ Adverse medication reaction resulting in severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring hospitalization.

☐ Medication error in prescription or distribution resulting in severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring hospitalization.

This report contains Protected Health Information and is for the sole use of the intended recipient(s) and may contain information protected by the attorney-client privilege, the attorney work product doctrine or other applicable privileges or confidentiality laws or regulations. If you are not an intended recipient, you may not review, use, copy, disclose or distribute any of the information contained in this report to anyone. If you are not the intended recipient, please contact the sender and destroy all copies of this report. Revised 04 01 2013.

CONFIDENTIAL

SERIOUS INCIDENT REPORT (SIR)

County of San Diego Behavioral Health Services (BHS)
QM CONFIDENTIAL FAX: 619-236-1953 Serious Incident Report Line 619-563-2781
Fax LEVEL ONE SIR within 24 hours. Fax Level Two SIR within 72 hours.

CLIENT NAME:

☐ Apparent overdose of alcohol/illicit or prescriptions drugs, whether fatal or injurious, requiring medical attention.

☐ Major confidentiality breach (e.g. lost or stolen laptop, client files/records accessed, PHI breach)

☐ Use of physical restraints (prone or supine) only during program operating hours (applies only to CYF mental health clients during program operating hours and excludes ADS programs, Hospitals, Long-Term Care Facilities, San Diego County Psychiatric Hospital/EPU, ESU and PERT)

☐ Other:

Notification(s): check one: ☐Verbal or ☐Written and to whom below.

☐Parent ☐Child Welfare Services ☐Adult Protective Services ☐Law Enforcement ☐Probation

☐Public Conservator ☐State Agency ☐Licensing Authority ☐Not Applicable ☐Other

2. DESCRIBE THE SERIOUS INCIDENT: [ADDRESS ALL ITEMS BELOW]
1. Include people involved and precipitating factors; 2. Indicate if client was admitted to acute care medical or psychiatric unit and length; 3. List of stay other behavioral health service providers; 4. Describe any physical or medical concerns.

3. OTHER BEHAVIORAL HEALTH CLIENT SERVICES:
(Outpatient, case management, medication management, day treatment/rehabilitation, residential, etc.)

4. MEDICAL/PHYSICAL HEALTH:

Current prescribed medication(s):
Name of prescribing physician:
Physical or medical concerns:

Report Completed By: Contact Email: Contact Phone:

Date & Time of phone report to QM:

Date & Time of phone report to State Agency (ADS Only):

Program Manager Signature (REQUIRED): _____Date:

Report of Findings shall include a thorough review of the serious incident and relevant findings and interventions/recommendations as appropriate. The Report of Findings shall be submitted within 30 days of the reported serious incident.

This report contains Protected Health Information and is for the sole use of the intended recipient(s) and may contain information protected by the attorney-client privilege, the attorney work product doctrine or other applicable privileges or confidentiality laws or regulations. If you are not an intended recipient, you may not review, use, copy, disclose or distribute any of the information contained in this report to anyone. If you are not the intended recipient, please contact the sender and destroy all copies of this report. Revised 04 01 2013.

A **Root Cause Analysis (RCA)** is required for any serious incident that results in 1) a completed suicide or 2) a major breach of confidentiality. The RCA shall be completed within 30 days of the reported serious incident. After completion of the RCA, the provider shall submit a summary of action items to the QM unit for review. The program COTR, in consultation with the QM unit, may ask the provider to complete an RCA for other serious incidents.

If you have questions about any serious incident, please contact the QM Program Manager for a consultation at 619-563-2747. When in doubt, please call.

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CONFIDENTIAL

SERIOUS INCIDENT REPORT OF FINDINGS (SIRF)

County of San Diego Behavioral Health Services (BHS)
QM CONFIDENTIAL FAX: 619-236-1953

Report of Findings shall include a thorough review of the serious incident and relevant findings and interventions/recommendations as appropriate. The Report of Findings shall be submitted within 30 days of the reported serious incident.

A **Root Cause Analysis (RCA)** is required for any serious incident that results in 1) a completed suicide or 2) a major breach of confidentiality. The RCA shall be completed within 30 days of the reported serious incident. After completion of the RCA, the provider shall submit a summary of action items to the QM unit for review. The program COTR, in consultation with the QM unit, may ask the provider to complete an RCA for other serious incidents.

If you have questions, please contact the QM Program Manager for a consultation at 619-563-2747. When in doubt, please call.

Provider (Program) Name: COTR: Client Name: Client Case Number:	
Date of Incident: RCA Required? ☐YES ☐NO Date RCA Completed:	

1. Summary of Findings:
(Outline any clinical case conferences, meetings or investigations you conducted. Also attach copies of related newspaper articles, coroners and toxicology reports, etc.)

2. Post Committee Recommendations/Planned Improvements:
(Please provide a detailed summary of process/system improvements as a result of the thorough analysis of the incident)

Report Completed By: Date:

Contact Email: Contact Phone:

Program Manager Signature:

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Directions for Root Cause Analysis (RCA)

The goal of the RCA is to identify systemic gaps or failures in systems and processes, not to point fingers or lay blame on individuals. The RCA is not the same as the investigation into the incident, which should be completed prior to the RCA.

Instructions for conducting the RCA:
A Root Cause Analysis (RCA) may be completed for any serious incidents, but must be completed for any incidents of suicide and any major loss of confidential client information.

The RCA worksheet that is attached will provide a structure for completing the RCA.

After identifying the Lead, Facilitator and the Participants of the RCA, schedule at least one meeting for the RCA group to complete the following tasks:

1) The first step in completing the worksheet for the RCA is describing the serious incident. Include who was involved, services that were effected, and other details of the incident. It is recommended that the incident being reviewed be written up a flow diagram as part of the process of describing the incident. A flow diagram is very useful in identifying gaps in systems and processes. Ask participants to come to the RCA meeting with a basic description of the incident from their perspective that includes dates and processes involved.

2) Next step is to note the participants in the RCA. Participants in the RCA may include those involved in the incident but must include those staff who are knowledgeable about the systems and processes that will be analyzed.

3) Next identify the systems and processes that will be analyzed. In general, systems and processes will be those programmatic issues that are defined by policy and procedures. Examples of systems and processes are noted in the worksheet. Not all systems and processes will apply in every case, and there may be others that are not listed on the worksheet that arise in the course of analysis.

4) The next step is to break down each system or process into the steps involved – it is helpful to have a workflow diagram for each system or process as this can assist in uncovering gaps.

5) Identify findings of gaps found in system or process design, how design of system or process compared to the real event, human factors, equipment factors, controllable environmental factors, and uncontrollable external factors. It can help to think about what the system or process would “ideally” look like even if the ideal does not seem possible.

6) Identify if the finding is a “root cause” (yes or no). For each finding of root cause an analysis is to be completed. Many findings that are not a root cause themselves have “roots” that may need to be addressed. Using a “fishbone” or Ishakawa diagram can assist in identifying these “hidden roots”.

7)The next step is to note if actions will be taken to address the issues that are identified as a root cause

8) The final element of the RCA is to note Action Plans that will be taken to address any issues that are identified as a root cause. This portion of the RCA delineates the items that are being addressed, the strategies that will be implemented, and the measures that will be used to determine the effectiveness of the plan.

SERIOUS INCIDENT ROOT CAUSE ANALYSIS WORKSHEET

Date and Time of Serious Incident: _____

(1) Summary of incident:	(List type of serious incident and explain what happened. Include who was involved, services impacted, including any outside parties or witnesses, details of the incident, and the outcome/injury)
(2) Participants:	(List all the participants by position and title {no names} involved in the root cause analysis and action plan. Note the Lead of the RCA and the facilitator.)
(3) Systems and Processes:	(Note systems and processes that were analyzed to determine proximate causes) List of possible systems and processes for review: __ Assessment Process __ Physical Assessment Process __ Medication Protocols __ Staffing resources __Security __Facility __Care Coordination __Availability of information Other: _____ __ Risk Assessment Process __ Reception protocols __ Control of medications, storage, access __ Staff training __ Policies and Procedures __ Communications with client or family __ Communications among staff

QUALITY IMPROVEMENT ACTIVITY

(3) Note each Process to be considered for review and definition	(4) What are the steps in the process as designed? (A flow diagram is recommended)	(5) Findings	(6) Root Cause?		(7) Take Action?
			Yes	No	

(8) Action Plan		
(a) List of Action Items	(b) Risk reduction strategies	(c) Measures of Effectiveness
Action item 1:		
Action Item 2:		
Action item 3:		
Action item 4:		
Etc…as needed		

QUALITY IMPROVEMENT ACTIVITY

SERIOUS INCIDENT ROOT CAUSE ANALYSIS WORKSHEET

Date and Time of Serious Incident: ___Aug 1, 2010_____

(1) Summary of incident:	(List type of serious incident and explain what happened. Include who was involved, services impacted, including any outside parties or witnesses, details of the incident, and the outcome/injury) Client, A.N.O.N, committed suicide Friday night at approximately 9:30 PM. Last appointment at clinic Wednesday for meds support, but client missed appointment. Client came in on Friday to see therapist but Receptionist, told client that therapist was on vacation and tried to set up an appointment the following week. No outside parties or witnesses. Client stepped in front of train. Paramedics were called to the scene
(2) Participants:	(List all the participants by position and title {no names} involved in the root cause analysis and action plan) Program Manager Lead Therapist Director of Clinical Operations Receptionist Supervisor of Clerical Staff Therapist Doctor
(3) Systems and Processes:	(Note systems and processes that were analyzed to determine proximate causes) List of systems and processes: __ Assessment Process __ Physical Assessment Process XX Medication Protocols XX Staffing resources __Security __Facility __Care Coordination __Availability of information Other: _____ XX Risk Assessment Process XX Reception protocols __ Control of medications, storage, access XX Staff training __ Policies and Procedures __ Communications with client or family __ Communications among staff

Sample

QUALITY IMPROVEMENT ACTIVITY

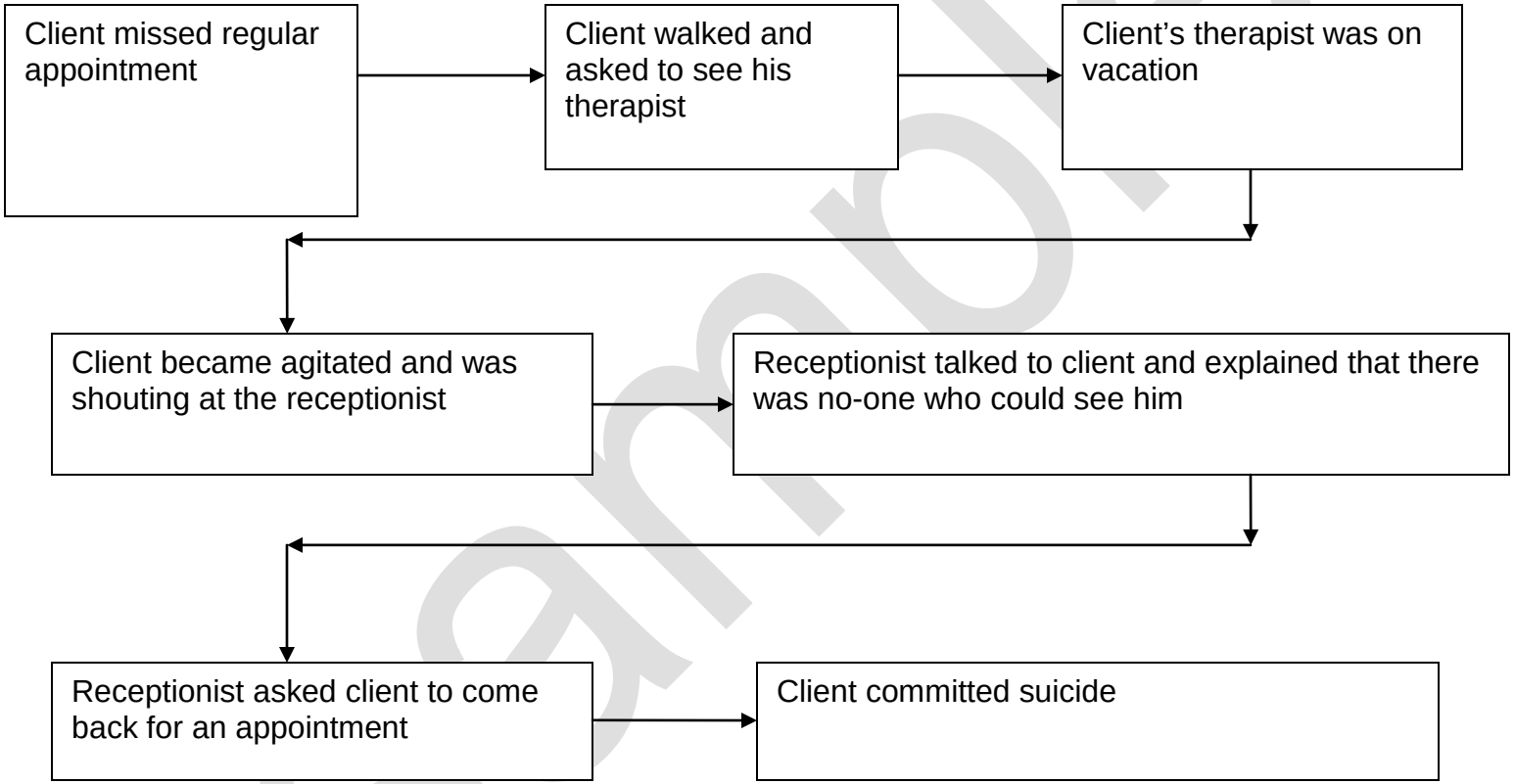
(3) Note each Process to be considered for review and definition	(4) What are the steps in the process as designed? (A workflow diagram is recommended)	(5) Findings	(6) Root Cause?		(7) Take Action?
			Yes	No	
Medication Protocols- Missed Appointment	When a client misses a meds appointment, nurse is to review client record for potential problems with meds	Record was reviewed and protocol for following missed appointment was followed		x	
Reception Protocols- Agitated client	When a client, whose therapist or MD is on vacation or sick, walks in to ask for an urgent appointment reception should contact another therapist to talk with client	Policy is not standardized and there is no current process to have an assigned triage staff on duty.	x		Develop action plan to ensure new policy is drafted and triage process established
Staffing Resources- Therapist on vacation	When a therapist is on vacation a back up system is implemented for all high risk clients	Back up system was implemented, but back up therapist was out sick when client came in.	x		Improve communications (see below)
Risk Assessment Process- High Risk Client	High risk clients are identified and all program staff are aware of potential problems. (see sample workflow)	Process was not followed due to MIS being down.	x		Develop action plan to brainstorm solutions
Staff Training- receptionist	Receptionists shall receive training on how to work with consumers who may be agitated when they come in	Receptionist was not trained as regular trainer is out on maternity leave.	x		Develop action plan to ensure training

sample

(8) Action Plan		
(a) List of Action Items	(b) Risk reduction strategies	(c) Measures of Effectiveness
Action item 1: Develop action plan to ensure new policy is drafted	Draft new policy about coverage to sick days and vacation days. Train all staff	Track number of clients seen by back up when regular therapist/MD is on vacation or sick. Ask clients how satisfied they were with that services
Action Item 2: Establish triage process	Develop new process for “daily triage duty” assignments	Number of contacts made by staff on daily triage duty Ask consumers if the triage process helped Note # of further incidents after daily triage duty process developed
Action item 3: Develop action plan to brainstorm solutions for communicating about high risk clients that addresses possible MIS outages	Plan a workgroup to meet and brainstorm solutions. Post new processes or protocols for all staff	Number of incidents that occur for clients designated as high risk clients
Action item 4: Develop action plan to ensure training for receptionists on handling difficult situations	Train more staff to be able to provide the training for receptionists Establish a policy that all receptionists must be trained before their first day	Number of difficult situations at the reception area Outcome of difficult situations

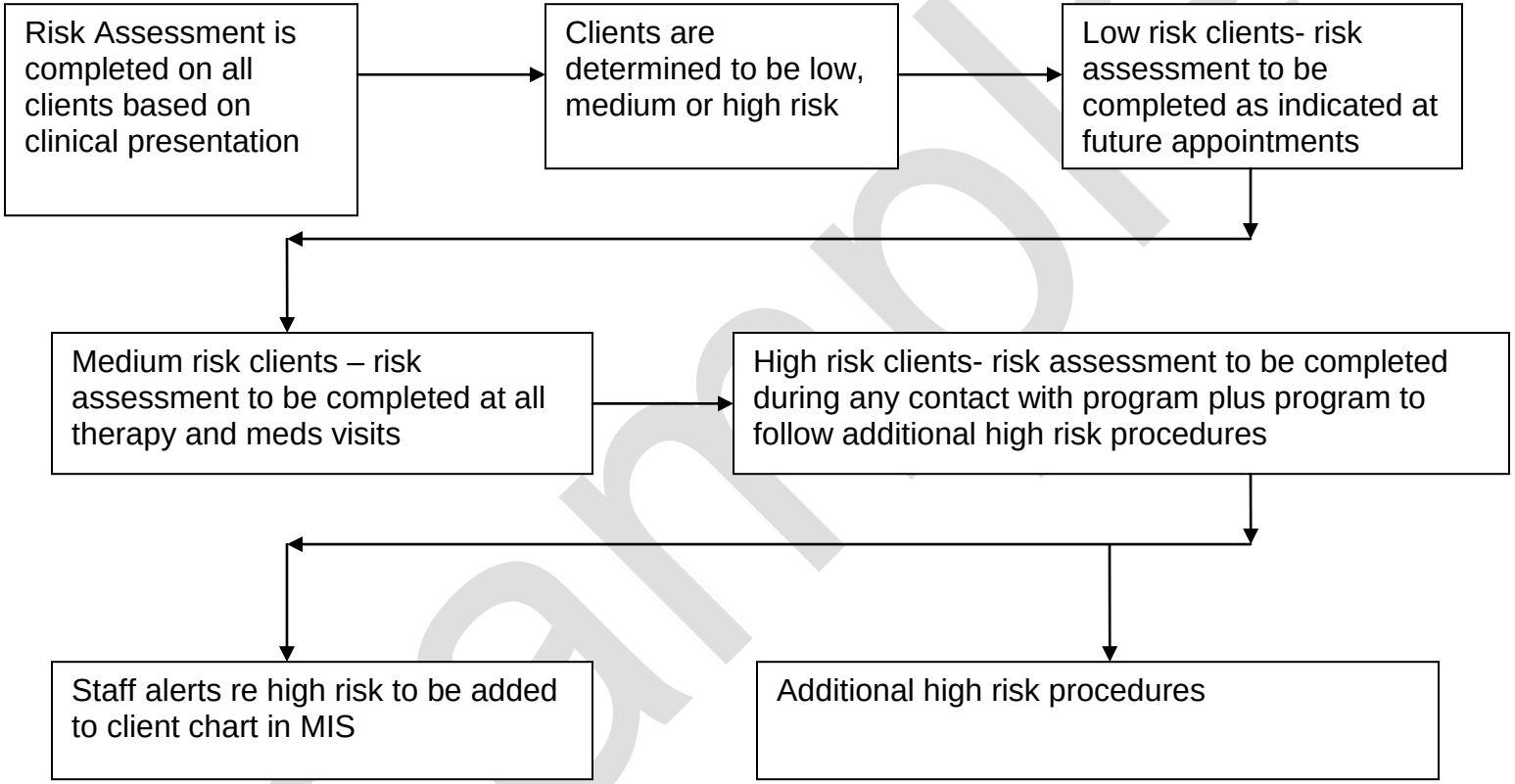
Sample

Workflow for Serious Incident



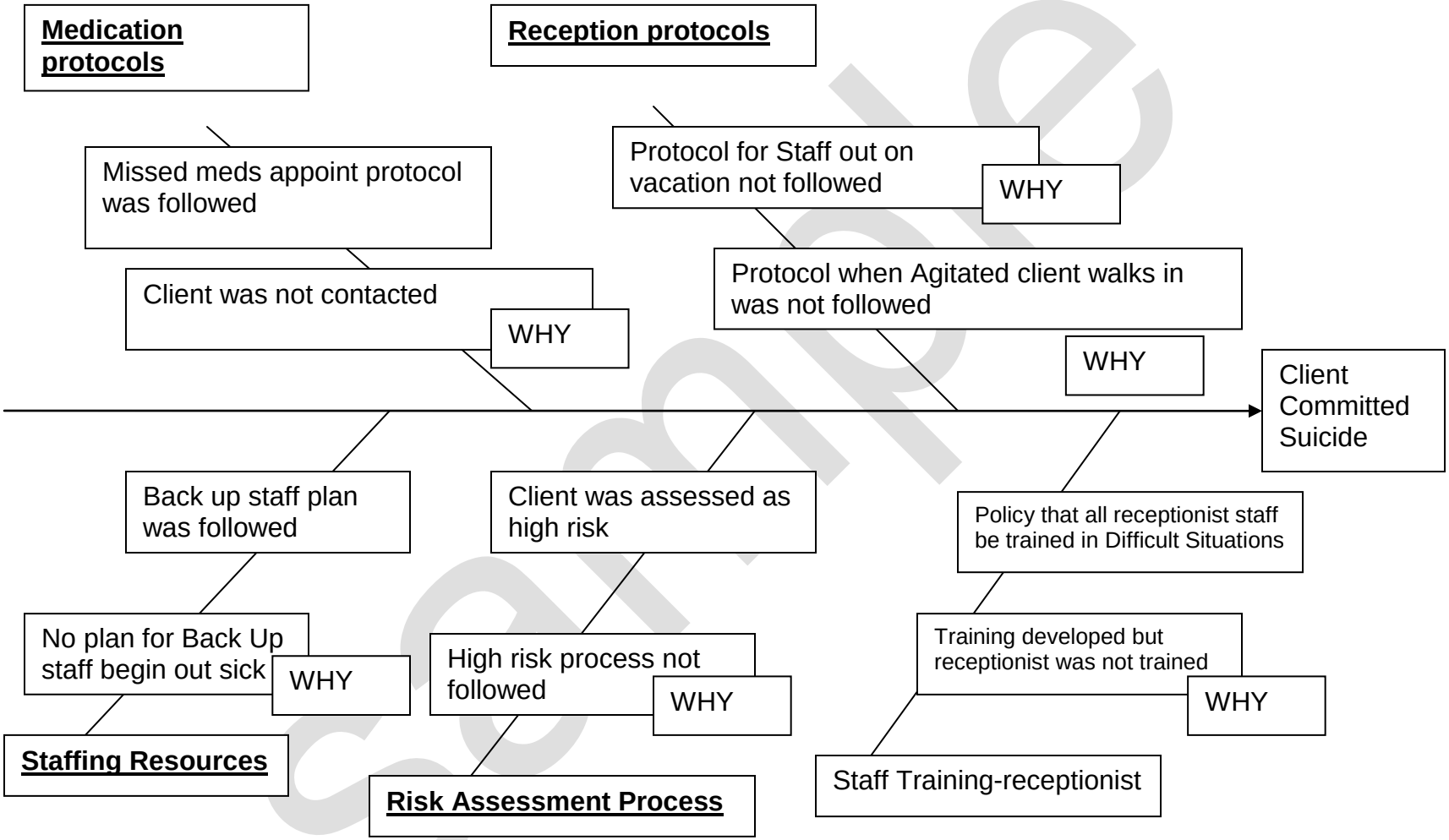
Sample

Workflow for Risk Assessment Process- High Risk Client



Sample

Fishbone Analysis



sample

QI Medication Monitoring Report

Adult Mental Health System of Care

PROGRAM NAME:		
DATE:	UNIT:	SUBUNIT(S):
REPORT SUBMITTED BY:		PHONE:

◉ QUARTER 1	○ QUARTER 2	○ QUARTER 3	○ QUARTER 4
Jul 1 – Sep 30	Oct 1 – Dec 31	Jan 1 – Mar 31	Apr 1 – Jun 30
Due Oct 15	*Due Jan 15*	*Due Apr 15*	*Due Jul 15*

Committee Member _____ Discipline _____

Committee Member _____ Discipline _____

Description of Activities:

	Total number of records screened this quarter
	Total number of variances identified
	Total # of open charts receiving medication at clinic
	# McFloops Disapproved *Disapproved McFloop forms must be faxed in*

	# McFloops Approved/Completed
	# McFloops Outstanding
	Total number of McFloops required

Total number of variances for all records screened this quarter, listed by item:

1	2a	2b	2c	2d	2e	2f	3	4	5	6

7	8a	8b	8c	8d	9	10	11	12	13	14

Email this form to: QIMatters.hhsa@sdcounty.ca.gov

Do not email Med Monitoring Tools *Do not email McFloop Forms*

This form may also be faxed to the QI Unit at 619-236-1953

QI Medication Monitoring Report

Children's Mental Health System of Care

PROGRAM NAME:		
DATE:	UNIT:	SUBUNIT(S):
REPORT SUBMITTED BY:		PHONE:

◉ QUARTER 1	○ QUARTER 2	○ QUARTER 3	○ QUARTER 4
Jul 1 – Sep 30	Oct 1 – Dec 31	Jan 1 – Mar 31	Apr 1 – Jun 30
Due Oct 15	*Due Jan 15*	*Due Apr 15*	*Due Jul 15*

Committee Member	Discipline	Committee Member	Discipline

☐ ***No medication distribution during this quarter***

Description of Activities:

	Total number of records screened this quarter		# McFloops Approved/Completed
	Total number of variances identified		# McFloops Outstanding
	Total number of McFloops required		Total # of open charts receiving medication at clinic
	# McFloops Disapproved *Disapproved McFloop forms must be faxed in*		

Total number of variances for all records screened this quarter, listed by item:

1	2a	2b	2c	2d	2e	2f	3	4

4	4a	4c	4d	4e	4f	5	6	7

8a	8b	8c	8d

Email this form to: QIMatters.hhsa@sdcounty.ca.gov

Do not email Med Monitoring Tools *Do not email McFloop Forms*

This form may also be faxed to the QI Unit at 619-236-1953

Perpetual Inventory Medication Log

Program Name:					Month:
Client Name:					
Date	Medication Name and Doseage	# of Tablets Received	# of Tablets Adm. by Client	Staff Signature	Client Signature

Medication Disposal Log

Program Name:

Date	Client	Medication/Dosage	# of Tablets	Witness Signature #1	Witness Signature #2

Quality Improvement (QI) Provider Orientation

BHS QUALITY IMPROVEMENT UNIT:

QI Director – Tabatha Lang – (619) 563-2741 Tabatha.Lang@sdcounty.ca.gov
QI Program Manager - Steve Jones (619) 563-2747 Steven.Jones@sdcounty.ca.gov
QI Supervisor – Trang Tran (619) 584-5082 Trang.Tran@sdcounty.ca.gov
QI Supervisor – Debbie MacDougall (619) 563-2774 Deborah.MacDougall@sdcounty.ca.gov

MANUALS:

- Organizational Provider Operations Handbook (OPOH) at www.optumhealthsandiego.com
- Uniform Clinical Record Manual available at Technical Resource Library (TRL) http://www.sdcounty.ca.gov/hhsa/programs/bhs/mental_health_services_act/technical_resource_library.html and at the OPTUM Website www.optumhealthsandiego.com
- Financial Eligibility & Billing Procedure Manual available at: www.optumhealthsandiego.com or TRL http://www.sdcounty.ca.gov/hhsa/programs/bhs/mental_health_services_act/technical_resource_library.html
- Anasazi User Manual available at www.optumhealthsandiego.com

DOCUMENTS/HANDOUTS:

- Program Manager QI Orientation Handout available at www.optumhealthsandiego.com
- State Planned Amendment- (SPA) Targeted Case Management and Mental Health Rehabilitation Document available at: http://www.dhcs.ca.gov/formsandpubs/laws/Pages/RecentAmendments.aspx
- Mental Health Publications including informing materials, guides, posters, brochures, provider lists directories, envelopes, etc. Contact Pat Cuadra at pat.cuadra@sdcounty.ca.gov
- Technical Resource Library (TRL): Resource documents referenced in the Statements of Work/Requests for Proposals. http://www.sdcounty.ca.gov/hhsa/programs/bhs/mental_health_services_act/technical_resource_library.html

QI TRAININGS:

- QI Children's Documentation Standards
- QI Adult Documentation Standards
- Root Cause Analysis
- All training registration contact: Tess.Widmayer@sdcounty.ca.gov

ANASAZI TRAININGS:

- **Register on-line: https://www.optumhealthsandiego.com/countystaffandproviders**

SERIOUS INCIDENT REPORTING:

- SIR forms at www.optumhealthsandiego.com
- SIR Telephone Line (619) 563-2781
- QI Confidential Fax 619-236-1953

MEDI-CAL CERTIFICATIONS

- Adults: Ian Rosengarten at (619) 563-2777 or Ian.Rosengarten@sdcounty.ca.gov
- Children: Tesra Widmayer at (619) 584-5026 or Tess.Widmayer@sdcounty.ca.gov

LICENSE WAIVERS:

- Ian Rosengarten at (619) 563-2777 or Ian.Rosengarten@sdcounty.ca.gov

COMMUNICAITONS/EMAIL DISTRIBUTION LISTS:

- To be added to all MIS and QI distribution lists- Contact Tess Widmayer at (619) 584-5026 or Tess.Widmayer@sdcounty.ca.gov

RESOURCES/CONTACTS:

- Optum Website www.optumhealthsandiego.com
- Anasazi Help Desk 1-800-834-3792
- San Diego Access and Crisis Line: 1-888-724-7240
- MH Billing Unit at (619) 338-2612
- Behavioral Health Education & Training Academy (BHETA), Register online at **http://theacademy.sdsu.edu/programs/BHETA/index.htm**
- Technical Resource Library (TRL**):** Resource documents referenced in the Statements of Work/Requests for Proposals. http://www.sdcounty.ca.gov/hhsa/programs/bhs/mental_health_services_act/technical_resource_library.html
- San Diego Network of Care- a "virtual community" that includes a fast, comprehensive service directory and links to pertinent web sites @ www.sandiego.networkofcare.org
- Privacy Officer Notification Bulletin posted at: http://www.sdcounty.ca.gov/hhsa/programs/sd/compliance_office/compliance_bulletins.html
- For translation services contact- Interpreter's Unlimited www.interpretersunlimited.com, 1-800-726-9891
- Send questions to QI email at: QIMatters.hhsa@sdcounty.ca.gov

إذا لم تكن مسجّل للتصويت في المكان الذي تعيش فيه حاليّاً، هل ترغب بتقديم طلب التسجيل للتصويت اليوم؟

(اختر واحد)

☐ مُسجَّل. إني مسجّل للتصويت في مكان إقامتي الحالي.
☐ نعم. أرغب بتقديم طلب التسجيل للتصويت (الرجاء تعبئة طلب التسجيل التالي).
☐ لا. لا أرغب بالتسجيل للتصويت.

ملاحظة: إذا تركت جميع الخيارات فارغة، سيُعتبر أنك غير راغب في التسجيل للتصويت في هذا الوقت. يمكنك أخذ طلب التسجيل للتصويت المرفق والتسجيل في الوقت الذي يناسبك.

_____

اسم المتقدم التاريخ

ملاحظات هامّة

1. طلب التسجيل أو رفض التسجيل لن يؤثر على مدى المساعدة التي ستحصل عليها من قبل هذه الوكالة.
2. إذا كنت تحتاج إلى مساعدة في تعبئة الطلب، يمكننا مساعدتك. القرار بقبول المساعدة أورفضها يعود لك. يمكنك تعبئة الطلب بخصوصية.
3. إذا كنت تعتقد أن شخصاً ما تدخل في حقك بالتسجيل أو الرفض بالتسجيل للتصويت، أو حقك في الخصوصية في اتّخاذ القرار للتسجيل أو التقدم للتسجيل، أو حقك في اختيار حزب سياسي أو تفضيل سياسي آخر، يمكنك تقديم شكوى لمكتب وزير الخارجية عن طريق الاتصال على الرقم المجاني (800)345-8683 أو إرسال بريد على عنوان: وزير الخارجية، 1500 شارع 11، ساكريمنتو، كاليفورنيا 95814. للمزيد من المعلومات عن الانتخابات والتصويت، الرجاء زيارة الموقع الإلكتروني الخاص بوزارة الخارجية: www.sos.ca.gov .

If you are not registered to vote where you live now, would you like to apply to register to vote here today?
(Check One)

☐ Already registered. I am registered to vote at my current residence address.

☐ Yes. I would like to register to vote. (Please fill out the attached voter registration form.)

☐ No. I do not want to register to vote.

NOTE: IF YOU DO NOT CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME. YOU MAY TAKE THE ATTACHED VOTER REGISTRATION FORM TO REGISTER AT YOUR CONVENIENCE.

_____

Applicant Name Date

Important Notices

1. Applying to register or declining to register to vote will **not** affect the amount of assistance that you will be provided by this agency.

2. If you would like help in filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.

3. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party preference or other political preference, you may file a complaint with the Secretary of State by calling toll-free (800) 345-VOTE (8683) or you may write to: Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814. For more information on elections and voting, please visit the Secretary of State's website at www.sos.ca.gov.

SAVE

Si no está inscrito para votar donde vive ahora, ¿quiere solicitar su inscripción para votar hoy aquí?
(Marque uno)

☐ Ya estoy inscrito. Estoy inscrito para votar en mi dirección residencial actual.

☐ Sí. Me quiero inscribir para votar. (Llene la tarjeta adjunta de inscripción para votar.)

☐ No. No me quiero inscribir para votar.

NOTA: SI NO MARCA UNA CASILLA, SE CONSIDERARÁ QUE HA DECIDIDO NO INSCRIBIRSE PARA VOTAR EN ESTE MOMENTO. PUEDE LLEVAR EL FORMULARIO DE SOLICITUD DE INSCRIPCION PARA VOTAR ADJUNTO E INSCRIBIRSE CUANDO LE SEA CONVENIENTE.

_____

Nombre del solicitante Fecha

Avisos importantes

1. Si solicita su inscripción para votar, o decide no hacerlo, ello **no** afectará la cantidad de ayuda provista por esta agencia.

2. Si necesita ayuda para llenar el formulario de solicitud de inscripción para votar, lo ayudaremos a hacerlo. La decisión de solicitar o aceptar ayuda es sólo suya. Puede llenar el formulario de solicitud en privado.

3. Si cree que alguien interfirió con su derecho a inscribirse para votar, o a no inscribirse, su derecho a privacidad para decidir si se inscribe o solicita inscribirse para votar, o su derecho a elegir el partido político u otra preferencia política, puede presentar una queja ante el Secretario de Estado llamando sin cargo al (800) 232-VOTA (8682), o escribiendo a: Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814. Para obtener más información sobre las elecciones y la votación, visite el sitio web del Secretario de Estado en www.sos.ca.gov.

SAVE

Kung hindi ka nakarehistro upang makaboto kung saan ka naninirahan ngayon, gusto mo bang mag-aplay upang magparehistro upang makaboto rito ngayon?
(Lagyan ng Tsek ang Isa)

☐ Nakarehistro na. Ako ay nakarehistro upang makaboto sa aking kasalukuyang direksiyon ng tirahan.

☐ Oo. Gusto kong magparehistro upang makaboto. (Mangyaring kumpletuhin ang kalakip na kard ng pagpaparehistro ng botante.)

☐ Hindi. Hindi ko gustong magparehistro upang makaboto.

TALA: KUNG HINDI KA MAGLALAGAY NG TSEK SA ISANG KAHON, ITUTURING NA IKAW AY NAGPASIYANG HINDI MAGPAREHISTRO UPANG MAKABOTO SA PANAHONG ITO. MAAARI MONG DALHIN ANG NAKALAKIP NA PORMA SA PAGPAPAREHISTRO NG BOTANTE UPANG MAGPAREHISTRO SA SANDALING MAGINHAWA PARA SA IYO.

_____

Pangalan ng Aplikante Petsa

Mahahalagang Paunawa

1. Ang pag-aaplay upang magparehistro o pagtangging magparehistro upang makaboto ay **hindi** makakaapekto sa antas ng tulong na ipagkakaloob sa iyo ng ahensiyang ito.
2. Kung gusto mong tumulong sa pagkumpleto ng porma ng aplikasyon sa pagpaparehistro ng botante, tutulungan ka namin. Ang desisyon kung hihingi o tatanggap ng tulong ay nasa iyo. Maaari mong kumpletuhin ang porma ng aplikasyon nang pribado.
3. Kung naniniwala ka na may humadlang sa iyong karapatan na magparehistro o upang tumangging magparehistro upang makaboto, ang iyong karapatan sa pagkapribado sa pagpapasiya kung magpaparehistro o sa pag-aaplay upang magparehistro upang makaboto, o sa iyong karapatang pumili ng iyong sariling kinakatigang partidong pampulitika o ibang kinakatigang pampulitika, maaari kang magsampa ng reklamo sa Kalihim ng Estado sa pamamagitan ng pagtawag nang walang-bayad sa (800) 339-2957 o maaari kang sumulat sa: Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814. Para sa karagdagang impormasyon tungkol sa mga halalan at pagboto, mangyaring bisitahin ang website ng Kalihim ng Estado sa www.sos.ca.gov.

SAVE

Nếu quý vị chưa ghi danh bỏ phiếu tại nơi quý vị sinh sống hiện nay, quý vị có muốn ghi danh bỏ phiếu ở đây hôm nay hay không?
(Đánh Dấu Vào Một Ô)

☐ Đã ghi danh. Tôi đã ghi danh bỏ phiếu tại địa chỉ cư ngụ hiện nay của tôi.

☐ Có. Tôi muốn ghi danh bỏ phiếu. (Xin điền thẻ ghi danh cử tri đính kèm.)

☐ Không. Tôi không muốn ghi danh bỏ phiếu.

GHI CHÚ: NẾU QUÝ VỊ KHÔNG ĐÁNH DẤU VÀO MỘT Ô, QUÝ VỊ SẼ ĐƯỢC XEM LÀ QUYẾT ĐỊNH KHÔNG GHI DANH BỎ PHIẾU VÀO LÚC NÀY. QUÝ VỊ CÓ THỂ CẦM THEO MẪU GHI DANH CỬ TRI ĐÍNH KÈM ĐỂ GHI DANH BẤT CỨ LÚC NÀO TIỆN CHO QUÝ VỊ.

_____

Tên Đương Đơn Ngày

Các Thông Báo Quan Trọng

1. Việc nộp đơn xin ghi danh hoặc từ chối ghi danh bỏ phiếu sẽ **không** ảnh hưởng đến mức trợ giúp mà quý vị sẽ được cơ quan này cung cấp.
2. Nếu quý vị muốn được giúp điền mẫu đơn ghi danh cử tri, chúng tôi sẽ giúp quý vị. Tùy quý vị quyết định có muốn nhờ giúp hay chấp nhận được giúp hay không. Quý vị có thể điền mẫu đơn trong chỗ riêng tư.
3. Nếu quý vị tin rằng có người đã xâm phạm đến quyền ghi danh hoặc từ chối ghi danh bỏ phiếu, quyền riêng tư của quý vị để quyết định có ghi danh hoặc nộp đơn ghi danh bỏ phiếu hay không, hoặc quyền chọn chính đảng hoặc chọn lựa chính trị nào khác của mình, quý vị có thể nộp đơn khiếu nại với Tổng Thư Ký Tiểu Bang bằng cách gọi số miễn phí (800) 339-8163 hoặc quý vị có thể viết thư đến: Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814. Muốn biết thêm chi tiết về các cuộc bầu cử và bỏ phiếu, xin đến website của Tổng Thư Ký Tiểu Bang tại www.sos.ca.gov.

Appendix H
Cultural Competence

Culturally Competent Program Annual Self-Evaluation

CC-PAS

Culturally Competent Program Annual Self-Evaluation

The Culturally Competent Program Annual Self-Evaluation (CC-PAS) tool has been developed by San Diego County Mental Health to be used by programs to rate themselves as to their current capability for providing culturally competent services. The CC-PAS Protocol is based on expectations and standards recommended by the Cultural Competence Resource Team (CCRT) and endorsed by the Quality Review Council (QRC). Once the CC-PAS has been completed programs should use the space at the end of the CC-PAS to develop new or revised objectives the program's Cultural Competence Plan that will support ratings with improved scores during the next rating period.

Directions for scoring for CC-PAS Protocol:

- Review each item and fill out the description as to the status for your program. Add attachments as possible to support your position.

- Determine if your program has Met, Partially Met or Not Met the stated standard using the description of the standard noted for each category.

- Tally the score in each category using the following scale:
    - 5 points for Met Standard
    - 3 points for Partially Met Standard
    - 1 point for Standard Not Met

- Determine the total score.

- If there are certain topics that your program would benefit from having technical assistance you can note that by checking:

    - o ___ Technical Assistance needed.

- Keep a record of the results of the CC-PAS to use to evaluate your progress over time.

- Repeat the CC-PAS annually

- Some items may not be applicable if program is not a direct service provider.

CC-PAS Protocol:

1) The program/facility has developed a Cultural Competence Plan.
Attach a copy of the Cultural Competence Plan or describe the plan.
_____

☐ Met: Program has a written Cultural Competence Plan that addresses the specific needs of that program.
☐ Partially Met: Legal Entity has a written Cultural Competence Plan but the specific needs of that program are not identified or there is no written Cultural Competence Plan but there is some other evidence of a plan.
☐ Not met: There is no plan to achieve Cultural Competence for the program.

Note: QI Unit will supply a format that may used for developing a Cultural Competence Plan if one is needed

____ Technical Assistance needed Score = ____

2) The program/facility has assessed *the strengths* and needs for services in their community.
Describe the strengths and need for services: _____

☐ Met : The strengths and needs of the community are clearly identified in the Cultural Competence Plan. Community members, Program Advisory Groups, and other stakeholders have participated in the identification of the strengths and needs of the community.
☐ Partially Met: The strengths and needs of the community are not clearly identified in the Cultural Competence Plan but there is evidence that the program is aware of the strengths and needs of the community
☐ Not met: The program is not aware of the strengths and needs of the community

____ Technical Assistance needed Score = ____

3) The staff in the program/facility reflects the diversity within the community.
Attach a report that demonstrates the staff and compares the composition of the staff to the community or describe: _____

☐ Met: The diversity of staff in the program closely matches the demographics in the community, and there is evidence that this is a goal the program is working to achieve.
☐ Partially Met: The diversity of staff in the program somewhat matches the demographics in the community, and there is evidence that this is a goal the program is working to achieve.
☐ Not met: The staff in the program does not closely match the demographics in the community, and there is no evidence that this is a goal the program is working to achieve.

____ Technical Assistance needed Score = ____

4) The program/facility has a process in place for ensuring language competence of direct services staff who identify themselves as bi-or multi –lingual.
Attach or Describe the process: _____

☐ Met: The program has a policy or written process for testing the language competence of direct services staff who identify themselves as bi- or multi –lingual. There is training available for any staff who are bi-lingual or who provide interpreter services to ensure that language needs are being met. The program also surveys clients and family members to assure language competence.
☐ Partially Met: The program has an informal process for testing the language competence of direct services staff who identify themselves as bi or multi –lingual.
☐ Not met: The program does not have process for testing the language competence of direct services staff who identify themselves as bi or multi –lingual.
☐ Not applicable if program is not a direct service provider.

____ Technical Assistance needed Score = ____

5) The program/facility has a process in place for ensuring language competence of support services staff who identify themselves as bi or multi –lingual.
Describe the process: _____

☐ Met: The program has a policy or written process for testing the language competence of support services staff who identify themselves as bi or multi –lingual. There is training available for any staff who are bi-lingual or who provide interpreter services to ensure that language needs are being met.
☐ Partially Met: The program has an informal process for testing the language competence of support services staff who identify themselves as bi or multi –lingual.
☐ Not met: The program has no process for testing the language competence of support services staff who identify themselves as bi or multi –lingual.

____ Technical Assistance needed Score = ____

6) The program/facility supports/provides interpreter training of direct and indirect services staff.
Describe the process: _____

☐ Met: The program has evidence that demonstrates interpreter training of direct and indirect services staff
☐ Partially Met: There is informal interpreter services training of direct services staff
☐ Not met: There has been no interpreter services training of direct services staff

____ Technical Assistance needed Score = ____

7) The program/facility uses language interpreters as needed.
Describe the use of language interpreters and languages used?_____

☐ Met: The program frequently uses language interpreters, and can consistently demonstrate the offer of interpreters in progress notes.
☐ Partially Met : The program occasionally uses language interpreters.
☐ Not met: The program does not use language interpreters and can not demonstrate the offer of interpreters

____ Technical Assistance needed Score = ____

8) The program/facility has a process in place for assessing cultural competence of direct services/ support services staff.

Describe the process: _____

☐ Met: The program/facility has a written/formal process in place for assessing cultural competence of direct services/ support services staff and can demonstrate the results of those assessments. Additionally, the process includes input from clients and family members
☐ Partially Met: The program/facility has a process in place for assessing cultural competence of direct services/ support services staff
☐ Not met: The program/facility has no process in place for assessing cultural competence of direct services/ support services staff

____ Technical Assistance needed Score = ____

9) The program/facility has a process in place for direct services/ support services staff to self assess cultural competence (e.g. California Brief Multi Competence Scale- CBMCS)

Describe the process: _____

☐ Met: The program has a requirement at the time staff are hired, and then periodically after hire, for all staff to complete the CMCBS or a similar tool and has evidence of the results of those evaluations. The program uses the evaluation to identify training needs.
☐ Partially Met: The program encourages staff to complete the CMCBS or a similar tool.
☐ Not met: The program does not support opportunities for staff to complete the CMCBS or a similar tool and has evidence of the results of the those evaluations,

____ Technical Assistance needed Score = ____

10) The program/facility has conducted a survey amongst their clients to determine if the program is perceived as being culturally competent.

Describe the results of the survey: _____

☐ Met: The program/facility has conducted a survey amongst their clients and their family members to determine if the program is perceived as being culturally competent.
☐ Partially Met: The program/facility is using the annual State survey to determine if the program is perceived as being culturally competent
☐ Not met: The program/facility is not using any type of survey to determine if the program is perceived as being culturally competent.

____ Technical Assistance needed Score = ____

11) The program/facility conducted a survey amongst their clients to determine if the program's clinical services are perceived as being culturally competent.

Describe the results of the survey: _____

☐ Met: The program/facility has conducted a survey amongst their clients to determine if the program's clinical services are perceived as being culturally competent
☐ Partially Met: The program/facility uses the annual State survey to determine if the program's clinical services are perceived as being culturally competent

☐ Not met: The program/facility does not use a survey amongst their clients to determine if the program's clinical services are perceived as being culturally competent

____ Technical Assistance needed Score = ____

12) The program utilizes the Culturally Competent Clinical Practice Standards.
Describe how the standards are utilized: _____

☐ Met: The program utilizes the Culturally Competent Clinical Practice Standards and trains all staff and managers at least annually.
☐ Partially Met: The program utilizes the Culturally Competent Clinical Practice Standards but has little or no training.
☐ Not met: The program does not utilize the Culturally Competent Clinical Practice Standards
☐ Not applicable if program is not a direct service provider.

____ Technical Assistance needed Score = ____

13) The program/facility supports cultural competence training of direct services staff.
Describe the process: _____

☐ Met: The program/facility supports cultural competence training of direct services staff and 80 to 100% of staff have attended at least 4 hours of training.
☐ Partially Met : The program/facility supports cultural competence training of direct services staff and 50-79% of staff have attended at least 4 hours of training
☐ Not met: The program/facility does not support cultural competence training of direct services staff

____ Technical Assistance needed Score = ____

14) The program/facility supports cultural competence training of support services staff.
Describe the process: _____
☐ Met: The program/facility supports cultural competence training of support services staff and 80 to 100% of staff have attended at least 4 hours of training.
☐ Partially Met: The program/facility supports cultural competence training of support services staff and 50-79% of staff have attended at least 4 hours of training
☐ Not met: The program/facility does not support cultural competence training of support services staff

____ Technical Assistance needed Score = ____

15) Services provided are designed to meet the needs of the community.
Describe how the services meet the needs of the community:
_____

☐ Met: Services provided include additional hours, child care, transportation or other options that are targeted to meet the specific community needs.
☐ Partially Met: Services provided include groups that are targeted to meet the specific community needs.

☐ Not met: Services provided include do not include options that are targeted to meet the specific community needs.

____ Technical Assistance needed Score = ____

16) The program has implemented the use of any Evidence Based Practices, or best practice guidelines *appropriate for the populations served*.
Describe the practices: _____

☐ Met: The program has implemented the use of Evidence Based Practices, or best practice guidelines *appropriate for the populations served*
☐ Partially Met: The program has implemented the use of any Evidence Based Practices, or best practice guidelines
☐ Not met: The program has not implemented the use of any Evidence Based Practices, or best practice guidelines
☐ Not applicable if program is not a direct service provider.

____ Technical Assistance needed Score = ____

17) The program collects client outcomes *appropriate for the populations served*.
Describe the client outcomes that are collected and how the information is used:
_____

☐ Met: The program collects client outcomes *appropriate for the populations served*
☐ Partially Met: The program collects client outcomes
☐ Not met: The program does not collect client outcomes.
☐ Not applicable if program is not a direct service provider.

____ Technical Assistance needed Score = ____

18) The program conducts outreach efforts *appropriate for the populations in the community*
Describe the outreach efforts: _____

☐ Met : The program conducts effective and on-going outreach efforts *appropriate for the populations in the community*
☐ Partially Met: The program conducts occasional outreach efforts *appropriate for the populations in the community*
☐ Not met: The program does not conducts outreach efforts.

____ Technical Assistance needed Score = ____

19) The program is responsive to the variety of stressors that may impact the communities served.
Examples of responsiveness: _____

☐ Met: The program is responsive to the variety of stressors that may impact the communities served and can demonstrate responsiveness.
☐ Partially Met : The program is aware of the variety of stressors that may impact the communities served

☐ Not met: The program not aware of stressors that may have an impact on the communities served

____ Technical Assistance needed Score = ____

20) The program reflects its commitment to cultural and linguistic competence in all policy and practice documents including it's mission statement, strategic plan, and budgeting practices.
Examples of commitment: _____

☐ Met: The program reflects its commitment to cultural and linguistic competence in all policy and practice documents including it's mission statement, strategic plan, and budgeting practices.
☐ Partially Met: The program reflects its commitment to cultural and linguistic competence in some policy and practice documents including it's mission statement, strategic plan, and budgeting practices.
☐ Not met: The program does not reflects its commitment to cultural and linguistic competence in all policy and practice documents including it's mission statement, strategic plan, and budgeting practices.

____ Technical Assistance needed Score = ____

After completing all of the items, #'s 1- 20 above, add all the individual scores together to come up with a CC-PAS rating for the program

Total score = _____

New or revised objectives for the programs Cultural Competence Plan:
_____

_____

_____

_____

_____

_____

_____

California Brief Multicultural Competence Scale
(CBMCS)

Below is a list of statements dealing with multicultural issues within a mental health context. Please indicate the degree to which you agree with each statement by circling the appropriate number.

		Disagree Strongly	Disagree	Agree	Agree Strongly
1.	I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face.	1	2	3	4
2.	I am aware of how my own values might affect my client.	1	2	3	4
3.	I have an excellent ability to assess, accurately, the mental health needs of persons with disabilities.	1	2	3	4
4.	I am aware of institutional barriers that affect the client.	1	2	3	4
5.	I have an excellent ability to assess, accurately, the mental health needs of lesbians.	1	2	3	4
6.	I have an excellent ability to assess, accurately, the mental health needs of older adults.	1	2	3	4
7.	I have an excellent ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons from different cultural, racial and/or ethnic backgrounds.	1	2	3	4
8.	I am aware that counselors frequently impose their own cultural values upon minority clients.	1	2	3	4
9.	My communication skills are appropriate for my clients.	1	2	3	4
10.	I am aware that being born a white person in this society carries with it certain advantages.	1	2	3	4
11.	I am aware of how my cultural background and experiences have influenced my attitudes about psychological processes.	1	2	3	4
12.	I have an excellent ability to critique multicultural research.	1	2	3	4
13.	I have an excellent ability to assess, accurately, the mental health needs of men.	1	2	3	4
14.	I am aware of institutional barriers that may inhibit minorities from using mental health services.	1	2	3	4
15.	I can discuss, within a group, the differences among ethnic groups (e.g. low socioeconomic status (SES), Puerto Rican client vs. high SES Puerto Rican client).	1	2	3	4
16.	I can identify my reactions that are based on stereotypical beliefs about different ethnic groups.	1	2	3	4
17.	I can discuss research regarding mental health issues and culturally different populations.	1	2	3	4
18.	I have an excellent ability to assess, accurately, the mental health needs of gay men.	1	2	3	4

19.	I am knowledgeable of acculturation models for various ethnic minority groups.	1	2	3	4
20.	I have an excellent ability to assess, accurately, the mental health needs of women.	1	2	3	4
21.	I have an excellent ability to assess, accurately, the mental health needs of persons who come from very poor socioeconomic backgrounds.	1	2	3	4

Gamst, G., Dana, R. H., Der-Karabetian, A., Aragon, M., Arellano, L., Morrow, G., & Martenson, L. (2004). Cultural competency Revised: The California Brief Multicultural Competency Scale. ***Measurement and Evaluation in Counseling and Development, 37, 3,163-187.***

Appendix I
Management Information System

ANASAZI REQUEST FORM (ARF) – MENTAL HEALTH PROGRAMS

MENTAL HEALTH MANAGEMENT INFORMATION SYSTEM (MHMIS)

FAX FORM TO MHMIS UNIT: 858-467-0411

ALL FORMS MUST BE COMPLETE AND TYPED OR THEY WILL BE RETURNED.

[1] USER TYPE REQUEST

☐ **New User** ☐ **Modify Current User**

Anasazi Staff ID#

Citrix Staff ID

☐ **Terminate User; Termination Date:**

Anasazi Staff ID#

Citrix Staff ID

[2] PROGRAM INFORMATION

☐ **County Staff** ☐ **Non-County Staff**

Program Name:

LE/Parent Org:

User Job Title:

Employment Start Date:

[3] USER INFORMATION

* If Name Change, please use new name below and enter previous name here:

First Name: **MI**: **Last Name**: **Work Phone**: **Ext:**

Primary Work Street Address: **Last 5 of SSN**:

City: **State**: **Zip**: **User Work Email**:

[4] MENU GROUP None

If Clinical Menu is selected, enter Assessments Training date

If Data Entry Menu is selected, enter New Hire/Service Entry Training date

If Scheduler Menu is selected, enter Scheduler training date

If Program Manager or 24 Hour Menu is selected, enter Assessments and New Hire/Service Entry dates above.

[5] UNIT/SUBUNIT ACCESS (LIST ALL UNITS AND SUBUNITS TO WHICH USER REQUIRES ACCESS)

Unit: **Subunit(s)**: **Unit**: **Subunit(s)**:

Unit: **Subunit(s)**: **Unit**: **Subunit(s)**:

Unit: **Subunit(s)**: **Unit**: **Subunit(s)**:

[6] CREDENTIAL & CERTIFICATION INFORMATION

☐ **No Credential – Administrative Staff**

OR Select Credential: Unlicensed Blank **OR Select Credential: Licensed** Blank

License or Registration # **state of issuance** **NPI #** **TAXONOMY #**

If User is a Medicare certified provider, provide PTAN and effective date:

[7] LANGUAGES SPOKEN

Language #1: **Language #2:** **Language #3:** **Language #4 :**

[8] COMMENTS:

[9] PROGRAM CONTACT INFORMATION (FOR MHMIS QUESTIONS)

First Name: **Last Name**: **Work Email**: **Phone:**

[10] USER ACCESS AUTHORIZATION

User Signature: _____

First Name: **Last Name**: **Date**:

Pursuant to the contractual agreement on file with the County of San Diego and as designated by my corporate office, I am authorizing access as noted above and affirm that I have personally reviewed the County's Summary of Policies with the above user.

Authorizing Program Manager Signature: _____

First Name: **Last Name**: **Date**:

MHMIS Unit Only: ☐ Anasazi ☐ CSRF ☐ NPI ☐ SESA EFFECTIVE DATE: Staff ID:

COUNTY OF SAN DIEGO

Summary of Policies
Regarding County Data/Information and Information Systems

To aid in the performance of their regular job assignments and duties, County employees, volunteers, agents and contractors are provided access to many County tools and resources. In the electronic age, these tools and resources include County "data/information" in various formats (e.g. on electronic media, paper, microfiche) and County "information systems" (e.g. computers, servers, networks, Internet access, fax, telephones and voice mail), whether owned, provided or maintained by or on behalf of the County.

The County has established policies and procedures based on best business practices to support the performance of the County's business and to protect the integrity, security and confidentiality of the County's data/information and information systems. Users[1] of these resources play a critical role. By carrying out their regular assignments and duties in compliance with all applicable County's policies and procedures, best practices are maintained.

This summary helps users know their responsibilities by highlighting important aspects of policies that govern access to and use of County data/information and information systems. The policies themselves provide further detailed information governing the use of County data/information and information systems and should be reviewed. Most notably, the County Chief Administrative Officer (CAO) Policy *Acceptable Use of County Data/Information* provides additional guidance on protecting County data/information; the CAO Policy *County Information Systems – Management and Use* provides guidance in controlling and using County information systems; and the CAO Policy *Telecommunications – Management and Use* provides guidance in using desktop and cellular telephones.

Access to County data/information or information systems is necessary to the performance of regular assignments and duties. Failure to comply with these policies and procedures may constitute a failure in the performance of regular assignments/duties. Such failure can result in the temporary or permanent denial of access privileges and/or in discipline, up to and including termination, in accordance with Civil Service Rules.

1. County data/information in all formats and information systems are for authorized County use only. Personal use of County information systems is prohibited unless specifically authorized by the Appointing Authority.
2. As part of their regular assignments and duties, users are responsible for protecting any data / information and information systems provided or accessible to them in connection with County business or programs.
3. Users cannot share data/information with others outside of their regular duties and responsibilities unless specifically authorized to do so.
4. Users have no expectation of privacy regarding any data/information created, stored, received, viewed, accessed, deleted or input via County information systems. The County retains the right to monitor, access, retrieve, restore, delete or disclose such data/information.

---

[1] *For purposes of this summary, the term "user" shall refer to any person authorized to use County data/information and information systems to perform work in support of the business, programs or projects in which the County is engaged. It also applies to users accessing other networks, including the Internet, through County information systems.*

5. Attempts by users to access any data or programs contained on County information systems for which they do not have authorization will be considered a misuse.

6. Users shall not share their County account(s) or account password(s) with anyone, use another's account to masquerade as that person, or falsely identify themselves during the use of County information systems.

7. The integrity and security of County data/information depends on the observation of proper business practices by all authorized users. Users are requested to report any weaknesses in County information system security and any incidents of possible misuse or violation of County IT policies to the appropriate County representative.

8. Users shall not divulge Dial-up or Dial-back modem phone numbers to anyone.

9. Users shall not make copies of system configuration files (e.g. password files) for their own unauthorized use or to provide to other people/users for unauthorized uses.

10. Users shall not make copies of copyrighted software or information, except as permitted by law or by the owner of the copyright.

11. Users shall not engage in any activity that harasses, defames or threatens others, degrades the performance of information systems, deprives an authorized County user access to a County resource, or circumvents County security measures.

12. Users shall not download, install or run security programs or utilities that reveal or exploit weaknesses in the security of a County information system. For example, County users shall not run password cracking or network scanning programs on County information systems.

Misuse of workplace tools and resources, including County data/information and/or County information systems, will be reported to a user's management. Misuse may constitute a failure to perform regular duties and assignments. Such failure may result in short-term or permanent loss of access to County data/information or information systems and/or disciplinary action in accordance with Civil Service Rules, up to and including termination. For non County employees, including volunteers and employees of County contractors, misuse may result in a suspension or withdrawal of your access rights, termination of your participation in County programs, or appropriate against the contractor under the contract's terms, or any combination of all or some of the above consequences.

Acknowledgement:
I have received and read the County of San Diego's Summary of Policies Regarding County Data/Information and Information Systems.

Print Name:

_____

Signature: Date Signed:

_____

Supervisor / Manager / Witness: Date Signed:

_____

ALL SIGNERS:	Keep a copy of this summary for your reference
COUNTY SIGNERS:	Department Personnel Representative --- file the original of this form in the authorized user's agency or department personnel file.
NON-COUNTY SIGNERS:	Contract administrator --- file the original form along with the contract

(Rev 7/01/08)

SAN DIEGO COUNTY MENTAL HEALTH SERVICES
ELECTRONIC SIGNATURE AGREEMENT

This Agreement governs the rights, duties, and responsibilities associated with the use of an electronic signature within the San Diego County Mental Health Services Management Information System.

The undersigned (I) understands that this Agreement describes my obligations to protect my electronic signature, and to notify appropriate authorities if it is compromised. I agree to the following terms and conditions:

I understand that my ability to electronically sign medical records is dependent upon utilization of a unique pass phrase that is assigned solely to me. I agree to keep my pass phrase I use to access my electronic signature secret and secure by taking reasonable security measures to prevent it from being compromised, and to prevent unauthorized disclosure of, access to, or use of it or of any media on which information about it is stored. I understand I may not share it with anyone under any circumstances. I agree that access to my electronic signature may be revoked or terminated per the terms of this agreement.

I will use my electronic signature and unique pass phrase to establish my identity and sign electronic documents and forms completed in the course of carrying out my assigned job duties. I am solely responsible for protecting my electronic signature and the pass phrase that allows me access to sign documents and forms electronically. If I suspect or discover that my electronic signature has been used by an unauthorized party, or otherwise compromised, then I will immediately notify the County Mental Health MIS Unit and request that my pass phrase be de-activated. I will then immediately request the ability to create a new pass phrase to use to access my electronic signature. I will immediately request that my electronic signature be revoked if I discover or suspect that it has been or is in danger of being subjected to unauthorized use in any way. I understand that I may also request revocation at any time for any other reason.

If I have requested that my access to my electronic signature be revoked, or I am notified that someone has requested that my access be suspended or revoked, and I suspect or discover that it has been or may be compromised or subjected to unauthorized use in any way, I will immediately cease using my pass phrase and my electronic signature. I will also immediately cease using my electronic signature upon termination of employment or termination of this Agreement.

I further agree that, for the purposes of authorizing and authenticating electronic health records, my electronic signature has the full force and effect of a signature affixed by hand to a paper document.

Requestor Signature _____ Date_____

Requestor Printed Name _____ Anasazi ID_____

Supervisor Signature _____ Date_____

Supervisor Printed Name _____

Appendix J
Provider Contracting

BEHAVIORAL HEALTH SERVICES
PROPERTY INVENTORY FORM

FISCAL YEAR: _____
COUNTY CONTRACT #: _____
PROGRAM NAME _____
PROGRAM SITE ADDRESS _____
COTR NAME: _____

DATE INVENTORY TAKEN: _____
month/date/year

NEW / RECONCILIATION / REVISION
(CIRCLE ONE whichever is applicable)

SIGNATURE:_____ NAME & JOB TITLE: _____

Yellow County Property Tag/ Label Attached? (Yes/ No)	Description	Qty	Make	Model	Serial #	Acq. Date (Mo/Yr)	Original Cost/Funding Source	Date of Disposal of Fixed Assets or Minor Equipment	Date AUD253 completed

REMARKS:

CALIFORNIA DEPARTMENT OF
Mental Health

REASONS FOR RECOUPMENT FOR FY 2011-2012

NON-HOSPITAL SERVICES

MEDICAL NECESSITY:

1. Documentation in the chart does not establish that the beneficiary has a diagnosis contained in California Code of Regulations, (CCR), title 9, chapter 11, section 1830.205(b)(1)(A-R).

   CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R); CCR, title 9, chapter 11, section 1810.345(a); CCR, title 9, chapter 11, section 1840.112(b)(1) and (4)

2. Documentation in the chart does not establish that, as a result of a mental disorder listed in CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R), the beneficiary has, at least, one of the following impairments:

   - A significant impairment in an important area of life functioning
   - A probability of significant deterioration in an important area of life functioning
   - A probability the child will not progress developmentally as individually appropriate
   - For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate

   CCR, title 9, chapter 11, section 1830.205(b)(2)(A – C); CCR, title 9, chapter 11, section 1830.210(a)(3)

3. Documentation in the chart does not establish that the focus of the proposed intervention is to address the condition identified in CCR, title 9, chapter 11, section 1830.205(b)(2)(A),(B),(C)-(see below):

   - A significant impairment in an important area of life functioning
   - A probability of significant deterioration in an important area of life functioning
   - A probability the child will not progress developmentally as individually appropriate
   - For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate

   NOTE: EPSDT services may be directed toward the substance abuse disorders of EPSDT eligible children who meet the criteria for specialty mental health services under this agreement, if such treatment is consistent with the goals of the mental health treatment and services are not otherwise available.

   CCR, title 9, chapter 11, section 1830.205(b)(3)(A); CCR, title 9, chapter 11, section 1840.112(b)(4)

REASONS FOR RECOUPMENT FOR FY 2011-2012

4. Documentation in the chart does not establish the expectation that the proposed intervention will do, at least, one of the following:
   - Significantly diminish the impairment
   - Prevent significant deterioration in an important area of life functioning
   - Allow the child to progress developmentally as individually appropriate
   - For full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition

   CCR, title 9, chapter 11, section 1830.205(b)(3)(B); CCR, title 9, chapter 11, section 1810.345(c)

CLIENT PLAN:

5. Initial client plan was not completed within time period specified in the MHP's documentation guidelines, or lacking MHP guidelines, within 60 days of intake unless there is documentation supporting the need for more time.

   CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract, Exhibit A, Attachment 1, Appendix C

6. Client plan was not completed, at least, on an annual basis as specified in the MHP's documentation guidelines.

   CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract, Exhibit A, Attachment 1, Appendix C

7. No documentation of client or legal guardian participation in the plan or written explanation of the client's refusal or unavailability to sign as required in the MHP Contract with the DMH.

   CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract, Exhibit A, Attachment 1, Appendix C

8. For beneficiaries receiving Therapeutic Behavioral Services (TBS), no documentation of a plan for TBS.

   CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(5); MHP Contract, Exhibit A, Attachment 1, Appendix C; DMH Letter No. 99-03, Pages 6-7

PROGRESS NOTES:

9. No progress note was found for service claimed.

   CCR, title 9, chapter 11, section 1810.440(c); CCR, title 9, chapter 11, section 1840.112(b)(3); CCR, title 22, chapter 3, section 51458.1(a)(3); MHP Contract, Exhibit A, Attachment 1, Appendix C

10. The time claimed was greater than the time documented.

    CCR, title 9, chapter 11, section 1810.440(c); CCR, title 22, chapter 3, section 51458.1(a)(3) and (4); CCR, title 22, chapter 3, section 51470(a); MHP Contract, Exhibit A, Attachment 1, Appendix C

REASONS FOR RECOUPMENT FOR FY 2011-2012

11. The progress note indicates that the service was provided while the beneficiary resided in a setting where the beneficiary was ineligible for Federal Financial Participation. (e.g. Institute for Mental Disease, jail, and other similar settings, or in a setting subject to lockouts per CCR, title 9, chapter 11.)

    CCR, title 9, chapter 11, section 1840.312(g-h); CCR, title 9, chapter 11, sections 1840.360-1840.374; Code of Federal Regulations (CFR), title 42, sections 435.1008 – 435.1009; CFR, title 42, section 440.168; CCR, title 22, section 50273(a)(1-9); CCR, title 22, section 51458.1(a)(8); United States Code (USC), title 42, chapter 7, section 1396d

12. The progress note clearly indicates that the service was provided to a beneficiary in juvenile hall and when ineligible for Medi-Cal. (Dependent minor is Medi-Cal eligible. Delinquent minor is only Medi-Cal eligible after adjudication for release into community).

    CFR, title 42, sections 435.1008 – 435.1009; CCR, title 22, section 50273(a)(1-9)

13. The progress note indicates that the service provided was solely for one of the following:

    a) Academic educational service
    b) Vocational service that has work or work training as its actual purpose
    c) Recreation
    d) Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors

    CCR, title 9, chapter 11, section 1840.312(a-d); CCR, title 9, chapter 11, section 1810.247; CCR, title 22, chapter 3, section 51458.1(a)(5) and (7)

14. The claim for a group activity was not properly apportioned to all clients present.

    CCR, title 9, chapter 11, section 1840.314(c); CCR, title 9, chapter 11, section 1840.316(b)(2)

15. The progress note does not contain the signature (or electronic equivalent) of the person providing the service.

    MHP Contract, Exhibit A, Attachment 1, Appendix C

16. The progress note indicates the service provided was solely transportation.

    CCR, title 9, chapter 11, section 1810.355(a)(2), CCR, title 9, chapter 11, section 1840.312(f); CCR, title 9, chapter 11, section 1810.247; CCR, title 9, chapter 11, section 1840.110(a)

17. The progress note indicates the service provided was solely clerical.

    CCR, title 9, chapter 11, section 1840.312(f); CCR, title 9, chapter 11, section 1810.247; CCR, title 9, chapter 11, section 1840.110(a); CCR, title 9, chapter 11, section 1830.205(b)(3)

18. The progress note indicates the service provided was solely payee related.

    CCR, title 9, chapter 11, sections 1840.312(f); CCR, title 9, chapter 11, section 1810.247; CCR, title 9, chapter 11, section 1840.110(a); CCR, title 9, chapter 11, section 1830.205(b)(3)

REASONS FOR RECOUPMENT FOR FY 2011-2012

19. No service provided: Missed appointment per DMH Letter No. 02-07

CCR, title 9, chapter 11, section 1840.112(b)(3); CCR, title 22, chapter 3, section 51470(a); DMH Letter No. 02-07

20. For beneficiaries receiving TBS, the TBS progress notes overall clearly indicate that TBS was provided solely for one of the following reasons:

    a) For the convenience of the family, caregivers, physician, or teacher
    b) To provide supervision or to ensure compliance with terms and conditions of probation
    c) To ensure the child's/youth's physical safety or the safety of others, e.g., suicide watch
    d) To address conditions that are not a part of the child's/youth's mental health condition

    DMH Letter No. 99-03, Page 4

21. For beneficiaries receiving TBS, the progress note clearly indicates that TBS was provided to a beneficiary in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility.

    DMH Letter No. 99-03, Page 5

HOSPITAL SERVICES

MEDICAL NECESSITY:

22. Documentation in the chart does not establish that the beneficiary has a diagnosis contained in Section 1820.205(a)(1)(A-R).

    CCR, title 9, chapter 11, section 1820.205(a)(1)(A-R)

23. Documentation in the chart does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), the beneficiary requires psychiatric inpatient hospital services for, at least, one of the following reasons:

    - Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction
    - Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing food, clothing or shelter
    - Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health
    - Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function
    - Need for psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the beneficiary is in a psychiatric inpatient hospital
    - Presence of either a serious adverse reaction to medications or the need for procedures/therapies that require continued psychiatric inpatient hospitalization

    CCR, title 9, chapter 11, sections 1820.205(a)(2)(B) and 1820.205(b)

REASONS FOR RECOUPMENT FOR FY 2011-2012

ADMINISTRATIVE DAY:

24. Documentation in the chart does not establish that the beneficiary previously met medical necessity for acute psychiatric inpatient hospital service during the current hospital stay.

    CCR, title 9, chapter 11, sections 1820.220(j)(5) and 1820.225(d)(2)

25. Documentation in the chart does not establish that the hospital made the minimum number of contacts with the non-acute residential treatment facilities as evidenced by a lack of the following:
    a) The status of the placement option(s)
    b) The dates of the contacts, and
    c) The signature of the person making each contact.

    CCR, title 9, chapter 11, sections 1820.220(j)(5) and 1820.225(d)(2)

CLIENT PLAN:

26. The beneficiary record does not contain a client plan.

    CFR, title 42, section 456.180; CCR, title 9, chapter 11, section 1820.210

27. The client plan was not signed by a physician.

    CFR, title 42, section 456.180; CCR, title 9, chapter 11, section 1820.210

OTHER

28. A claim for a day when the beneficiary was not admitted to the hospital.

    CCR, title 9, chapter 11, section 1840.320(b)(1)

Appendix K
Provider Issue Resolution

FORMAL COMPLAINT BY PROVIDER

Provider's Name	
Program Manager	
Agency	
Address	
Phone	
Fax	

FORMAL COMPLAINT BY PROVIDER **Forward Copy to QI Unit**
Date:
To:
From:
Summary and date on which issue(s) was attempted to be resolved informally (if applicable):
Outline of formal complaint/concern including all relevant data and comments, which support issue(s).
Formal complaint shall be submitted within 90 calendar days of original attempt to resolve issues(s) informally. Attach any applicable document(s).

FORMAL RESPONSE TO COMPLAINT	**Forward Copy to QI Unit**
Date:	
To:	
From:	
Response to complaint/concern, which includes a statement of the reason(s) for the decision that addresses each issue, raised by the provider, and any action required by the provider to implement the decision.	
Program Monitor/Chief shall have 60 calendar days from the receipt of the written complaint to inform the provider in writing of the decision.	

FORMAL APPEAL BY PROVIDER	**Forward Copy to QI Unit**
Date:	
To:	
From:	
Formal Provider Appeal may be submitted to the Mental Health Contracts Manager at any time.	
Outline summary of issue(s) and support for appeal with any needed attachment(s).	
When a formal complaint process was utilized, appeal shall be submitted to the Mental Health Contracts Manager within 30 calendar days of formal complaint response.	

FORMAL APPEAL RESPONSE	**Forward Copy to QI Unit**
Date:	
To:	
From:	
Response to complaint/concern which includes a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.	
Mental Health Contracts Manager shall have 60 calendar days from the receipt of the written appeal to inform the provider in writing of the decision.	

Appendix L
Practice Guidelines

Second Generation Antipsychotics – Recommended Monitoring Parameters

Parameter	Frequency
Personal and Family History	Baseline and annually
Weight/Height	Every 3 months
Blood Pressure	Baseline, at 3 months, then annually
Fasting Blood glucose recommended if not able to obtain FBS, then Random Glucose can be done	Baseline, at 6 months, then annually
Fasting Lipid Panel (Cholesterol/Triglycerides)	Baseline, at 6 months, then annually
Electrocardiogram	Baseline and periodic for Ziprasidone (Geodon), Thioridazine (Mellaril): **ONLY** in patients at risk for QT_c prolongation. Periodic monitoring depends on changes in electrolyte status (hypokalemia or hypomagnesemia) as a result of diuretic therapy, diarrhea, etc.
Global AIMS (Abnormal Involuntary Movement Scale)	Baseline and annually at minimum
Prolactin level	Check only if symptomatic of hyperprolactinemia

Mood Stabilizers – Recommended Monitoring Parameters

Carbamazepine (Tegretol®, Carbatrol®), lithium (Lithobid®, Eskalith®), valproic Acid (Depakene®), divalproex sodium (Depakote®)

Parameter	Frequency
Complete Blood Count (CBC)	Carbamazepine: Baseline, then every 3 months Lithium: Baseline Valproic Acid: Baseline, then every 6 months
Electrolytes	Carbamazepine, Lithium, Valproic Acid – Baseline
BUN/Serum Cr	Carbamazepine: Baseline Lithium: Baseline and every 6 months Valproic Acid: Baseline
Liver Function Test (LFT)	Carbamazepine: Baseline Lithium: Baseline, Valproic Acid: Baseline, then every 6 months
Thyroid - Stimulating Hormone (TSH)	Carbamazepine: Baseline Lithium: Baseline, then every 6 months Valproic Acid: Baseline
Electrocardiogram (EKG)	Lithium – Baseline
Serum Drug Level	Once stabilized – Carbamazepine and Valproic Acid: every 6 months, Lithium: every 12 months

Antidepressants – Recommended Monitoring Parameters

Clomipramine (Anafranil®), mirtazapine (Remeron®), duloxetine (Cymbalta®), venlafaxine (Effexor®), nefazadone (Serzone®)

Parameters	Frequency
Weight/Height	All: Baseline, then periodically as clinically indicated
Blood Pressure/Pulse	Clomipramine, duloxetine, and venlafaxine: Baseline, then periodically as clinically indicated
Electrocardiogram	All TCA: Baseline, then periodically as indicated
Liver Function Test	Nefazadone: Baseline, then every 6 months

Monitoring Psychotropic Medications

The following recommendations are not intended to interfere with or replace clinical judgment of the clinician when assessing patients on psychotropic medications. Rather, they are intended to provide guidelines and to assist clinicians with decisions in providing high quality care, ensuring that patients receive the intended benefit of the medications, and to minimize unwanted side effects from the medications.

Antipsychotic Medications

- **Typical Antipsychotics: also know known as First Generation Antipsychotics: such as Chlorpromazine (Thorazine), Fluphenazine (Prolixin), Haloperidol (Haldol), Perphenazine (Trilafon), Prochlorperazine (Compazine), Thiothixene (Navane), Thioridazine (Mellaril), and Trifluoperazine (Stelazine).**
- **Atypical Antipsychotics: also known as Second Generation Antipsychotics: Aripiprazole (Abilify), Clozapine (Clozaril), Olanzapine (Zyprexa), Paliperidone (Invega), Quetiapine (Seroquel), Risperidone (Risperdal), and Ziprasidone (Geodon).**

Clinical Advisory on Monitoring Antipsychotic Medications:

- Ordering labs and monitoring should be tailored to each patient. Patients may require more or less monitoring than these recommendations.
- Geriatric patients may require more frequent monitoring due to changes in metabolism and renal function.
- Obtain baseline assessment for Tardive Dyskanesia and Abnormal Involuntary Movement Scale prior to initiate of antipsychotic and every 6 months.
- Atypical antipsychotics are associated with abnormal blood work such as elevated serum glucose and lipid levels, and increased prolactin levels. They are also associated with weight gain, increased risk of type 2 diabetes, diabetic ketoacidosis, and cardiovascular side effects.
- Avoid using Ziprasidone (Geodon), Haloperidol (Haldol), Thioridazine (Mellaril), and Chlorpromazine (Thorazine) in patients with known history of QT_c prolongation, recent Acute Myocardial Infarction, uncompensated heart failure, taking other medications with prolong QT, and alcoholic patients on diuretics or having diarrhea which may alter electrolytes.
- All patients should be assessed for cardiovascular disease before initiating antipsychotic therapy.
- Refer to TEVA Clozaril Registry for monitoring Clozaril.
- An initial comprehensive baseline assessment should include a thorough personal and family medical history, including risk factors for diabetes, vital signs, weight, body mass index, waist circumference, metabolic laboratory analysis such as fasting glucose, and lipid profile.
- Fasting blood glucose is preferred, but HgA_{1c} is acceptable if fasting glucose test is not feasible.
- Neutropenia uncommonly occurs in patients taking antipsychotic medications. It is recommended to obtain baseline Complete Blood Count and annually.
- Patients with a history of a clinically significant low white blood cell count (WBC) or a drug-induced leukopenia/neutropenia should have their complete blood count (CBC) monitored frequently during the first few months of therapy and discontinuation of medication should be considered at the first sign of a clinically significant decline in WBC in the absence of other causative factors (package insert).

Appendix M
Staff Qualifications and Supervision

MENTAL HEALTH PROFESSIONAL LICENSING WAIVER REQUEST

MH 12 (Rev 06/15/10)

(Please fill-in all boxes below. See reverse side for completion instructions.)

APPLICANT'S FULL NAME (Include aliases and maiden names):

TYPE OF WAIVER REQUEST
(Please check appropriate box)

WITHIN CALIFORNIA/NOT LICENSE ELIGIBLE PSYCHOLOGIST CANDIDATE: (5 years maximum)	OUT-OF-STATE/LICENSING-EXAM-READY: (3 years maximum)		
☐	PSYCHOLOGIST CANDIDATE ☐	LCSW CANDIDATE ☐	MFT CANDIDATE ☐

DATE OF COMPLETION OF REQUIRED COURSEWORK:	EMPLOYMENT START DATE (in the position requiring the waiver):

REQUEST SUBMITTED BY: (SIGNATURE----MENTAL HEALTH DIRECTOR/DESIGNEE)

PRINTED NAME:

DATE:	COUNTY:

DO NOT COMPLETE THE FOLLOWING - FOR STATE DEPARTMENT OF MENTAL HEALTH USE ONLY

DATE COMPLETE WAIVER APPLICATION RECEIVED:	DATE WAIVER BEGINS:
COMMENTS:	DATE WAIVER ENDS:

Approved by:

☐ Program Administrator, Program Compliance OR

☐ Chief, Medi-Cal Oversight

Signature:	Date:

This waiver is granted pursuant to Welfare and Institutions Code Section 5751.2 and with the stipulation that the employer and the applicant assume responsibility for meeting all applicable statutory and regulatory requirements during the approved waiver period.

PROFESSIONAL LICENSING WAIVER REQUEST

Instructions for Completing This Form

1) *Applicant's Full Name, Include Aliases and Maiden Names:* DMH staff need this information, when applicable, to track accurately the applicant's waiver history.

2) *Type of Waiver Request*: Clearly indicate the type of waiver request. To be eligible for the Out-of-State/License-Ready category, an applicant must be both license-ready and recruited from out-of-State. When submitting an application for an Out-of-State/License-Ready waiver, the MHP must submit a letter from the appropriate licensing board which states that the applicant has sufficient experience to gain admission to the licensing examination.

3) *Employment Start Date (In the Position Requiring the Waiver):* Specify the date the applicant will start employment in the position requiring a waiver.

   In order for the DMH to determine if the applicant has been previously employed in a position requiring a waiver, **it is necessary to attach a copy of the applicant's post-degree employment history.** This can take the form of a current, complete resume or recent employment application.

4) *Request Submitted By (Mental Health Director/Designee):* All waiver requests must be submitted, signed and dated by the local county mental health director or the director's designee.

For additional information on the professional licensing waiver process, see DMH Letter No 10-03. .

Appendix N
Data Requirements

This procedure applies only to providers approved for MAA Claiming.

Medi-Cal Administrative Activities (MAA) Procedures

MAA activities in mental health are governed by a set of procedures. These procedures are described in detail in the MAA Instruction Manual developed by the State Department of Mental Health, and are summarized below.

The Claiming Plan

In order to participate in MAA, the County must submit a Claiming Plan to the State for approval by the last day of the quarter in which the first invoice will be submitted. Using a standardized format developed cooperatively by the State and Federal Medicaid agencies, the MAA Claiming Plan must describe in detail each of the MAA activities for which claims will be submitted, by job class. The standardized format can be found in the California Department of Mental Health MAA instruction manual.

The Claiming Plan also describes the units that will be participating in MAA, the type of supporting documentation that will be maintained, and the development and documentation of costs relating to MAA. It indicates which activities will be focused entirely on the Medi-Cal population. If the activities will be focused on a larger population, the Claiming Plan must describe the methodology that will be used to discount the claim by the percentage of Medi-Cal eligibles in the population.

The State Department of Mental Health has established procedures for amending the MAA Claiming Plan. It has also developed a Claiming Plan checklist and a checklist to use when submitting amendments to the Claiming Plan. Copies of these documents, along with a copy of the most recently approved version of the plan, are on file in the Mental Health Plan administrative offices. Claiming plans and any amendments will remain in effect from year to year. A Claiming Plan will not need to be amended, unless the scope of MAA is significantly changed or a new type of activity is undertaken. For example, a Claiming Plan must be amended when a new outreach campaign or program is instituted, or a new claiming unit performing MAA is created.

Claiming Procedures

Claims for MAA reimbursement are submitted quarterly to the State Department of Mental Health (DMH) by HHSA. A detailed quarterly invoice is prepared for each mental health unit participating in MAA, as identified in the claiming plan. County-operated programs are one unit; each participating contractor is a separate unit. A summary invoice is also prepared that aggregates all invoices submitted by mental health. An approved claiming plan covering the period of the claim must be in place before an invoice may be paid.

The County is required to provide DMH with complete invoice and expenditure information no later than December 31, following the fiscal year for which a claim is submitted. Invoice and expenditure information must be submitted to DMH prior to or with the County's cost report for the current fiscal year. DMH may approve the claim, return it for correction and/or revision, or deny the claim. The County may request reconsideration of a denied claim in writing within 30 days of receiving the denial.

The detailed quarterly invoice captures the time spent on MAA, the Medi-Cal percentage, expenditure and revenue information on a single spreadsheet.

MAA Training

All staff participating in MAA, and completing MAA activity logs, will attend MAA training sessions on at least an annual basis. Sign-in sheets will serve as a record of the individual's attendance. Training will be scheduled and provided at the direction of Mental Health Administration.

Reporting MAA Activities

MAA activities are recorded in MH MIS.. The reporting requirements are somewhat different than what is required for direct services. For MAA, staff must report the following each time an MAA activity is performed:

- the day the activity occurred;
- the activity code (as a proxy for the name of the activity);
- the number of minutes spent on the activity;
- the name of the employee performing the activity.

A standardized MAA Activity Log or Service Log has been developed; however, programs can develop their own as long as it contains the essential MAA reporting information. When programs develop their own form, they should forward it to the MAA Coordinator to ensure it covers the basic elements. Each activity log is to be signed by the employee before he/she gives it to the clerical staff responsible for entering data into Mental Health MIS. Activity logs may cover multiple days. Completed logs should be turned in to the person responsible for entering the information into MH MIS on a timely basis, but no later than the fifth working day after the end of each month.

Document Retention

The County of San Diego has adopted a record retention policy that requires these records to be retained for ten (10) years. Program managers are responsible for storing signed, original versions of all MAA activity logs, outreach materials, and all documentation that supports the MAA claimed by their staff.

Becoming an MH MIS User

An MH MIS account is needed to enter MAA into Anasazi. This information can be found in the Anasazi User Manual Page 10 on the Optum Health public sector site: http://www.optumhealthsandiego.com/
.

Quality Assurance; Monitoring

The quality of the MAA program will be monitored through quarterly reports from MH MIS.. The Mental Health Services MAA Coordinator will disseminate these reports to program managers, notifying them of any identifiable discrepancies found. These reports will provide managers with summaries of the amount of time reported to all MAA activities, by staff name. Program managers are expected to use the monitoring reports to:

- ensure that staff is reporting their MAA time accurately, using the correct activity codes;
- ensure that all staff that should be reporting MAA is doing so;
- ensure that MAA time is being reported consistently among staff in same classification.

Managers are required to ensure that corrective action is taken on any discrepancies they find or that have been identified by the MAA coordinator. Random reviews will take place to ensure that staff is reporting MAA correctly.

The MAA Audit File

An MAA audit file will be maintained at Mental Health Administration, and includes the following:

- a copy of the most recently approved MAA claiming plan for the County and for each participating contract agency;
- copies of current SPMP forms, and verification that each SPMP's license, where applicable, is current;
- job descriptions and/or duty statements for all staff participating in MAA;
- electronic or hard copies of the raw data used to calculate each quarterly percentage of MAA activity;
- electronic or hard copies of the reports used to establish the Medi-Cal percentage for each quarterly MAA claim;
- locations (with addresses) where MAA activity logs are kept on file, and where copies of information used in outreach or eligibility assistance activities are kept;
- copies of annual training schedules, training rosters, and materials used in training.

Who Can Claim MAA: An Overview

Clinical staff

- MAA may be used for client-based activities that are not part of a direct service or that are provided to an individual who does not have an open case anywhere within the system. MAA also includes outreach activities to inform individuals or groups about the availability of Medi-Cal and mental health services.

Administrators

- MAA includes program planning and contract administration.
- MAA includes outreach activities to inform individuals or groups about the availability of mental health services.

Clerical staff, Human Service Specialist and all other staff

- MAA includes activities that assist individuals, regardless of their case status, to apply for Medi-Cal or to access services covered by Medi-Cal.
- MAA activities include the administrative support clerical staff provide around outreach, contract administration, program planning, and crisis situations.

The MAA Activity Codes

A set of MAA activity codes has been developed for local mental health programs. The activities include:

Activity Code	
204	Medi-Cal Outreach
205	Mental Health Outreach
203	Facilitating Medi-Cal Eligibility Determinations
201	Case Management of Non-Open Cases
202	Referral in Crisis Situations – Non-Open Cases
209	MAA Coordination and Claims Administration

MAA Activity Code Definitions

204 Medi-Cal Outreach – This code may be used by all staff in county and contract programs. Includes the following:

- informing Medi-Cal eligibles or potential Medi-Cal eligibles about Medi-Cal services, including Short-Doyle/Medi-Cal services;

- assisting at-risk Medi-Cal eligibles or potential Medi-Cal eligibles to understand the need for mental health services covered by Medi-Cal;
- actively encouraging reluctant and difficult Medi-Cal eligibles and potential Medi-Cal eligibles to accept needed health or mental health services;
- performing information and referral activity that involves referring Medi-Cal beneficiaries;
- referring Medi-Cal eligibles to Medi-Cal eligibility workers.

205

457 Mental Health Outreach – This code may be used by all staff in county and contract programs. Includes the following:

- informing at-risk populations about the need for and availability of Medi-Cal and non-Medi-Cal mental health services;
- providing telephone, walk-in or drop-in services for referring persons to Medi-Cal and non-Medi-Cal mental health programs.

203 Facilitating Medi-Cal Eligibility Determinations – This code may be used by all staff in county and contract programs. Includes the following:

- screening and assisting applicants for mental health services with the application for Medi-Cal benefits.

201 Case Management of Non-Open Cases – May be used by all staff in county and contract agencies. Includes the following:

- gathering information about an individual's health and mental health needs.
- assisting individuals to access Medi-Cal covered physical health and mental health services by providing referrals, follow-up and arranging transportation to health care.

202Referral in Crisis Situations - Non-Open Cases – May be used by all staff in county and contract programs. Includes the following:

- intervening in a crisis situation by referring to mental health services.

209 MAA Coordination and Claims Administration – This code may be used by all staff in county and contract programs. Includes the following:

- MAA Training

San Diego County Mental Health Services
MAA/Community Outreach Service Record

Form #:	Client: Generic, Client	Case #: 1
Unit:	☒ Single Contact	

Date of Service	SubUnit	Service Code	Service Time
Date of Service	SubUnit	Service Code	Service Time
Date of Service	SubUnit	Service Code	Service Time
Date of Service	SubUnit	Service Code	Service Time
Date of Service	SubUnit	Service Code	Service Time
Date of Service	SubUnit	Service Code	Service Time

I certify that the service(s) shown on this sheet were provided by me personally.

Print Server Name	Server Signature	Server ID	Date

Community Outreach – Mental Health Services Act			
5	Screening (Non-MAA)	65	Community Services (Non-MAA)
MAA Codes			
201	MAA Case Mgmt/Non Open Non-SPMP	205	MAA Mental Health Outreach
202	MAA Crisis Referral/Non-Open	206	MAA SPMP Case Mgmt/Non-Open (County Only)
203	MAA Medi-Cal Eligibility Intake	207	MAA Program Planning & Development SPMP (County Only)
204	MAA Medi-Cal Outreach	208	MAA Program Planning & Development Non-SPMP
		209	MAA Implementation / Training

REV: 09.30.2008 Attachment-A, Refer to #01-01-221

Appendix O
Training/Technical Assistance

Appendix P
Mental Health Services Act

Appendix Q

Payment Schedule and Budget Guidelines for Contract Only

Appendix R
Quick Reference Guide