

SECTION 1

*Forms and documentation are interspersed in chronological order with the most recent on top

Intake

Preliminary and Legal Forms

- Consent to Treatment
- No Duplicate Service Acknowledgement
- Authorization for Use and Disclosure of Information
- Consumer Rights Form
- Mental Health Advance Directive Acknowledgement
- Receipt of HIPAA Notice of Privacy Practices
- Recipient Orientation Check List
- Foreign Language Acknowledgement (if applicable)
- Client's Signature Verification Form
- Client's ID Documents Verification Form

Copy of Identification Documents

- Copy of Picture ID (Driver's License, State ID or any valid photo ID)
- Copy of Medicaid/Medicare/Health Plan (HMO) ID Card
- Copy of Social Security Card

Miscellaneous/Correspondence

- Nutritional Screen
- Personal Wellbeing Index
- Columbia-Suicide Severity Rating Scale
- Pain Screen

Case Management Intake Form

Intake Date: _____

CLIENT INFORMATION

Client's Name: _____ Case Number: _____

Address: _____ City, State, Zip: _____

Home Phone № _____ Cell Phone № _____ Other _____

Email Address (optional): _____

DOB: _____ Age: _____ SSN: _____ Gender: Male Female

Race: _____ Ethnicity: _____ Marital Status: _____

Educational Level: _____ Religion or Spiritual Beliefs: _____

Primary Language: _____ Other Language: _____ Read Speak Understand

Employment Status: _____ Residential Status: _____

Monthly Family Income: _____ Primary Source of Income: _____

Legal Guardian (if applicable): _____ Phone № _____

Address: _____ City, State, Zip: _____

DIAGNOSIS AND REFERRAL INFORMATION

Referred by: _____ Phone № _____

Address: _____ City, State, Zip: _____

Title/Position: _____ Agency (if applicable): _____

*If Self-Referral, please specify: Walk-in Phone Call

*Is client currently receiving Case Management services through another provider? Yes No

Primary Diagnosis (Axis I): _____
ICD-10 Code: _____ Descriptor: _____

Eligibility Criteria:

INSURANCE INFORMATION

Medicaid №: _____ MMA LTC Health Plan: _____

Medicare №: _____ Health Plan ID: _____

*Other: _____

*If self-pay please complete "Financial Agreement" and "Financial Information Form"

Case Management Intake Form (continued)

Client's Name: _____

Case Number: _____

SCHOOL INFORMATION (only for children)

School: _____ Grade: _____

School Program: Regular ESE EBD ESOL HHIP (Homebound) Other

Teacher or Counselor Name: _____ Phone № _____

IMMIGRATION STATUS

Country of Birth: _____ Year entered USA: _____ Status: Citizen Resident Other

If Other, please explain: _____

EMERGENCY CONTACT INFORMATION

Primary Contact: _____ Ph № _____ Relationship: _____

Secondary Contact: _____ Ph № _____ Relationship: _____

*May we leave/send voice/text messages to the above contacts if necessary? Yes No

CURRENT TREATING PROVIDERS

Psychiatrist: _____ Phone № _____

Address: _____ City, State, Zip: _____

Primary Care Physician (PCP): _____ Phone № _____

Address: _____ City, State, Zip: _____

Other: _____ Phone № _____

Address: _____ City, State, Zip: _____

Need of Special Accommodations? No Yes

Specify:

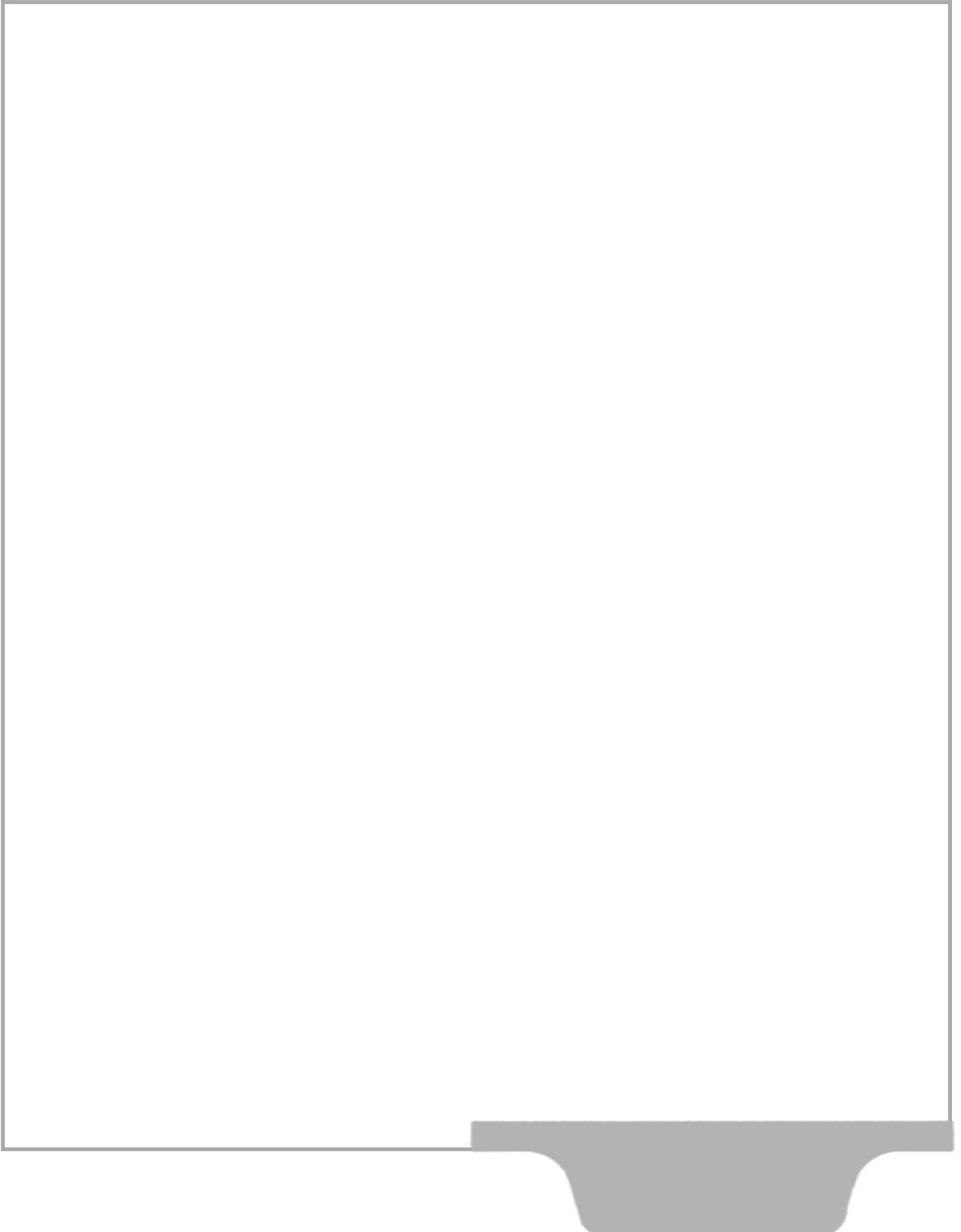
Case Manager's notes:

Employee Print Name

Credentials

Signature

Date



Consent for Treatment

Case N° _____

The main objective of _____ is to provide comprehensive mental health case management services, which are sensitive to the needs of our recipient population.

I, _____, client of _____
and if applicable;

I, _____ representative/guardian of the above named applicant:

- Authorize the staff of _____ to provide Mental Health Targeted Case Management services;
- Authorize release of necessary information from my service record to any insurer, compensation carrier, or other agency providing financial assistance for treatment/ services. Information from clinical records may be used by AHCA, Medicaid, The Department of Children and Families (DCF), and/or Human Rights Advocacy Committee and any other governing and regulatory agency for the purpose of monitoring facility, activity and complaints concerning the facility;
- Understand that, except for the above case, all information that you furnish to the agency _____ will be kept in strictest confidence, as required by law, and will not be shared with any agency or person outside the facility, unless so requested by you;
- Agree that _____ staff may contact me after the completion of treatment/service in order to evaluate its effectiveness;

* By signing this form, I consent to treatment and services and to the use or disclosure of Protected Health Information (PHI) for purpose of treatment, payment and health care operations as described above. I understand that I am signing this consent voluntarily but a refusal to sign it may affect my ability to receive treatment or services. I further understand that I have the right to revoke this consent, in writing, at any time, except when actions have already been taken in reliance on the consent. I also understand that I have the right to receive a copy of this consent.

Recipient's Signature

Date

Parent, Legal Guardian or Authorized Representative's Signature

Date

No Duplicate Services Acknowledgment

Client's Name: _____

Record No: _____

I hereby acknowledge that, at the time of signing this form, I am assuredly not receiving **Adult Mental Health Targeted Case Management** services through any other agency or provider and that I am requesting this type of services only from _____

I certify that the above statement is true and correct to the best of my knowledge. I understand that receiving duplicate services may constitutes fraud under federal and state laws related to Medicaid and that a false statement may disqualify me for services and affect my benefits.

Yo, reconozco que, al momento de firmar esta forma, no estoy recibiendo servicios de **Administración de Casos de Salud Mental para Adultos** a través de otra agencia o proveedor y que estoy solicitando este tipo de servicios solamente de _____

Certifico que la declaración anterior es verdadera y correcta en lo mejor de mi conocimiento. Entiendo que recibir servicios duplicados puede constituir un fraude bajo las leyes federales y estatales relacionadas con Medicaid y que una declaración falsa puede descalificarme para los servicios y afectar mis beneficios.

Client/parent/legal guardian Signature

Date

Witness Signature

Date

AUTHORIZATION FOR USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION

1. CLIENT INFORMATION

Client's Name: _____ DOB: _____ Record No: _____

2. AUTHORIZATION STATEMENT

This document authorizes: _____ covered entity/individual
(Name of the entity/individual authorized to request, use or disclose information)

Address: _____ City, State ZIP: _____

Phone Number: _____ Fax Number: _____

Request and use confidential information **from:** _____ Disclose confidential information **to:** _____

(the

(Name of entity or individual to which or to whom the information will be requested from or disclosed to)

3. SPECIFIC INFORMATION AUTHORIZED FOR REQUEST, USE OR DISCLOSURE

- Medical (Diagnosis, medical history/physical, treatment, reports, laboratory results, hospitalizations, discharge summaries, etc.)
 Mental Health (Psychiatric/Psychosocial evaluations, diagnosis, medication, treatment plan, progress reports, substance abuse)
 Demographic Information (Name, address, DOB, phone numbers, etc.) School Records (children only)
 Other: _____

4. INFORMATION FORMAT

- Verbal Written Facsimile Electronic All of the above

5. PURPOSE OF REQUEST, USE OR DISCLOSURE

- Client/Legal guardian's request Intake/Assessment Coordination of services

Other: _____

6. EXPIRATION OF THE AUTHORIZATION

- This authorization expires on: _____ (specific date or event)
 One (1) year from the date this authorization is signed

7. CLIENT'S RIGHTS, TERMS AND CONDITIONS

By signing this form, I authorize the request, use or disclosure of my individually identifiable personal information as described above. I understand that I am signing this authorization voluntarily and my eligibility for services will not be affected if I refuse to sign this authorization. I understand that I have the right to revoke this authorization, in writing, at any time, except when actions have already been taken in reliance on the authorization. I further understand that it is possible that information requested, used or disclosed pursuant to this authorization may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I also understand that I have the right to receive a copy of this authorization.

8. SIGNATURES

Client's Signature

Date

Client's Legal Representative (if applicable)

Date

Employee / TCM Signature

Date

AUTHORIZATION FOR USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION

1. CLIENT INFORMATION

Client's Name: _____ DOB: _____ Record No: _____

2. AUTHORIZATION STATEMENT

This document authorizes: _____ (*the covered entity/individual*)
(Name of the entity/individual authorized to request, use or disclose information)

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 Demographic Information (*Name, address, DOB, phone numbers, etc.*) School Records (*children only*)
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8. SIGNATURES

Client's Signature

Date

Client's Legal Representative (*if applicable*)

Date

Employee / TCM Signature

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Client's Signature

Date

Client's Legal Representative (*if applicable*)

Date

Employee / TCM Signature

Date

Consumer Rights

Case № _____

The purpose of this pamphlet is to remind and inform you of your **RIGHTS** as a consumer of services.

I. Right to Voluntary Services

If you are 18 years of age or older you have the right to request voluntary (by your own choice) services.

If you are 17 years of age or younger, you usually must have permission of a parent or guardian to receive services.

You do not need parental consent, however, to receive treatment for alcohol or drug abuse, nor, if you are 12 or over, to admit yourself for residential or day treatment.

YOU HAVE A RIGHT TO:

1. Have a staff person assigned specifically to you to work with you in resolving your problems.
2. A personal assessment of your needs.
3. An individualized Service Plan developed with your input and permission which will be reviewed on a regular basis.
4. Services to begin within a reasonable time.
5. Services even if you are unable to pay. Ability to pay is determined by certain standard criteria.
6. Another opinion regarding services provided. However, if you seek services through someone outside _____, it is at your own expense.

II. Right to Refuse Services

YOU HAVE A RIGHT TO:

1. Refuse any form of service unless the service has been ordered by the court, or in emergency situations when necessary to prevent harm to yourself or others.
2. Be informed that without services, your situation may get worse.
3. Refuse to be filmed or taped without written permission.
4. Refuse to take part in experimental studies without your written permission.

III. Right to Confidentiality (Privacy)

All information about you is confidential to protect your privacy. This includes the fact that you have or have not received services. (Exception: the law requires all treatment facilities to notify the Health Department when communicable diseases are uncovered).

YOU HAVE A RIGHT TO:

1. Determine the amount of information to be released either to or from anyone outside _____ by signing a permission form.
2. Determine the length of time that information may be released and cancel your permission at any time. (However, information may be released without your permission in a medical emergency to save lives, to prevent injury to yourself or others, or when court ordered).
3. See your record and/or obtain a copy of it after your written request has been approved by the Executive Director of _____ or designee.

IV. Right to Humane Mental and Physical Environment

YOU HAVE A RIGHT TO:

1. Center facilities which are comfortable and safe, promote dignity, ensure privacy, and contribute to a positive outcome.

TO REPORT ABUSE, NEGLECT OR EXPLOITATION CONTACT: FLORIDA ABUSE HOTLINE
1-800-96-ABUSE (1-800-962-2873)

V. Right to Information

YOU HAVE A RIGHT TO:

1. Be informed, verbally and/or in writing, of your rights.
2. Be informed, verbally and/or in writing, if any rights are being taken away and you have the right to a review of this action by requesting a Grievance Procedure.
3. Be informed of any actions, procedures or decisions which might affect you.

Consumer Rights (continued)

Case No. _____

VI. Rights Pertaining to Medication

YOU HAVE A RIGHT TO:

1. The administration of medication only with the written order of a physician.
2. A complete explanation of the purpose of any medication, the possible side effects it may have on you, and possible results of long-term use, in language you can understand.
3. Full consideration of your opinion and reactions to medication.
4. A regular review of your medication for the purpose of adjustment, as a check for possible side effects, and for possible reduction or elimination of the medication.
5. Have accurate records kept, noting your medication history, which includes any adverse medication reactions or drug allergies.
6. Have medication prescribed for you only when necessary and not as a convenience for others.
7. Refuse medication, except when it is court ordered, or when it is necessary to prevent serious physical harm to yourself or others.

VII. Right to Grievance Procedure

Any consumer or legal representative of a consumer may file a grievance as a formal notice of dissatisfaction regarding center operations and/or staff actions.

Whenever you wish to lodge a formal complaint you must proceed in the following manner:

- STEP 1: Bring your grievance to the attention of your case manager - this may be done verbally or in writing. An answer from your case manager will be presented to you within 5 days. If your grievance involves your case manager and you feel that you do not want to confront him/her directly with this matter, you may proceed to Step 2.
- STEP 2 If your case manager cannot resolve the problem satisfactorily, you may seek out the supervisor of your case manager and present your complaint verbally or in writing. An answer from the supervisor will be presented to you within 5 working days.
- STEP 3: If you are not satisfied with the decision of the director of the unit, you may send the grievance, in writing to the Executive Director of _____

Phone Number: _____ Fax Number: _____

Address: _____ City, State, Zip: _____

Your grievance will be reviewed by the Executive Director and he/she may seek a hearing with you and/or the parties involved. If necessary, the Executive Director will make a decision and will respond to you within thirty (30) days, sending a copy of the response to the director of the unit, the supervisor and your case manager. The decision of the Executive Director will be final.

It is the sincere desire of the staff of _____ to address your grievances with an attitude of open mindedness and without prejudice. Every effort will be made to resolve your grievance at the lowest possible step in the procedure so as not to prolong any difficulty or problem.

I have read and understood my rights as a recipient of _____

Recipient Signature

Date

Parent, Legal Guardian or Authorized Representative Signature

Date

Employee / TCM Signature

Date

Mental Health Targeted Case Management Program

MENTAL HEALTH ADVANCE DIRECTIVE ACKNOWLEDGEMENT
(ADULT CLIENTS ONLY)

Client Name: _____

Client No: _____

A *Mental Health Advance Directive* is a legal document that lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions, or if you want someone else to make those decisions for you even though you are still capable.

The agency (hereinafter "the agency") does not require you to have a *Mental Health Advance Directive*, however the agency will follow the terms of any *Advance Directive* that you may have executed, to the extent permitted by the law.

If you already have a *Mental Health Advance Directive*, please provide the agency with a copy.

- I HAVE** executed a *Mental Health Advance Directive* and will provide the agency with a copy.
The name and contact information for my agent or surrogate is:

- I HAVE NOT** executed a *Mental Health Advance Directive*, however I have read or been explained, and understand my rights to have a *Mental Health Advance Directive*.

Mental Health Targeted Case Management Program

**ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA "Notice of Privacy Practices"**

Case № _____

I, _____, recipient of services,
Print Recipient's Name

and if applicable,

I, _____, legal guardian or authorized representative
Print legal guardian/authorized representative's Name

hereby acknowledge receipt of _____ Notice of Privacy Practices. This Notice of Privacy Practices provides detailed information about how _____ may use and disclose my protected health and confidential information. The Notice contains a Client's Rights section describing your rights under the law. You have the right to review the Notice before signing this form. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations.

I understand that _____ reserves the right to change the privacy practices that are described in the notice. I also understand that a copy of any revised notice will be made available to me upon request.

_____ provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

Client's Signature

Date

Legal guardian/Authorized representative's Signature

Date

Employee / TCM Signature

Date

Orientation Checklist

The following information has been provided as part of the Orientation Process. A check mark next to the item and the signatures below indicate that each area has been fully explained and is understood by:

Recipient: _____ Case No.: _____

- Tour of facility (when applicable)
- Rights and Responsibilities of the Consumer
- Policy on grievance and appeal procedures
- Intent/consent to treat/serve
- Services provided, days and hours of operation, and expected level of participation
- Access to emergency services, including after-hours emergencies
- Code of ethics/conduct
- Confidentiality policy and limits of confidentiality
- Methods, opportunities, and policy on input
- Explanation of financial obligations, fees, and financial arrangements
- Fire, safety, and emergency precautions
- Policy on tobacco products no smoking on premise
- Policy on illicit or licit drugs brought into the facility
- Policy on weapons brought into the facility
- Identification of the staff(s) responsible for service coordination
- Program rules and regulations
- Case Management Assessment
- Individual Service Plan development and the participation of recipient in goal development and explanation of the potential course of treatment/service
- Discharge/transition criteria and procedures
- Agency's Policy regarding response to and identification of potential risk to the recipient
- Agency's expectations for legally required appointments, sanctions, or court notification (if applicable)
- Education on advance directives (if applicable)

Recipient Signature

Date

Parent, Legal Guardian, Authorized Representative Signature

Date

Employee / TCM Signature

Date

Mental Health Targeted Case Management Program

ACUSE DE RECIBO DE IDIOMA EXTRANJERO

FOREIGN LANGUAGE ACKNOWLEDGEMENT

Case Nº _____

Yo, _____, cliente de

y yo, _____, custodio legal o representante autorizado (*en caso de ser aplicable*), mediante la presente reconozco que toda la información presentada ante mí, incluyendo formularios, consentimientos legales y cualquier otro tipo de documentación perteneciente a mi caso, fue debidamente explicada a mí en toda su extensión en **mi idioma primario** (Español) y en términos que yo puedo entender. Mi firma en cada uno de los documentos indica que yo no solo **entiendo** sino que también **estoy de acuerdo** con su contenido. Copias de los documentos disponibles en **mi idioma primario** (Español) fueron ofrecidas a mí.

I, [Recipient's name], recipient of services at [Agency's name] and I, [Legal guardian or authorized representative] (*if applicable*), do hereby acknowledge that all the information presented before me, including forms, legal consents and any other type documentation pertaining to my case, was duly explained to me in all its extent in **my primary language** (Spanish) and in terms that I can understand. My signature on each of the documents indicates that I not only **understand** but also **agree** with all its content. Copy of documents available in **my primary language** (Spanish) were offered to me.

Firma del Cliente / Client's Signature

Fecha / Date

Firma del Custodio Legal o Representante Autorizado
Client's Legal Guardian or Authorized Representative

Fecha / Date

Employee / TCM Name

Firma / Signature

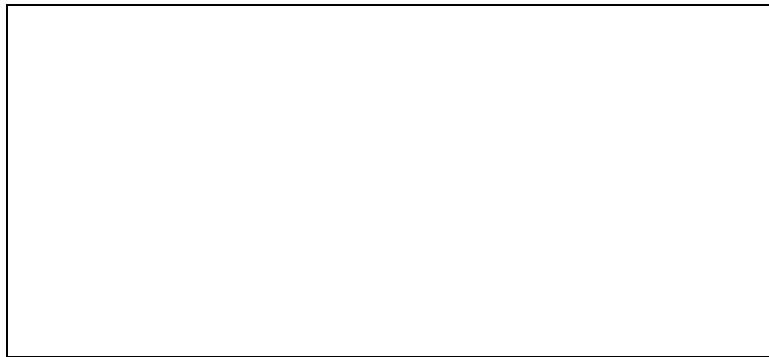
Fecha / Date

Mental Health Targeted Case Management Program

Client's Signature Verification Form

This form is to authenticate the signature(s) of client/parent/legal guardian in order to prevent intentional deception, misrepresentation or unauthorized services provided by a health care provider, which may constitutes fraud under federal and state laws related to Medicaid. This form may be used regularly to verify the authenticity of signatures on forms and documents and will help to eliminate signature discrepancies.

Please sign your name in black or blue ink within the box below and try to keep your signature as consistent as possible:



**By signing below, I _____ (client/parent/legal guardian) agree that my signature as shown above is accurate to the best of my ability. I also agree that this is the signature that I will be consistently using to sign forms and any other legal documentation. I understand that any significant change in my signature or in my ability to sign, must be immediately notified and this verification form must be updated.*

Client/parent/legal guardian Signature

Date

Employee / TCM Signature

Date

Mental Health Targeted Case Management Program

ID Documents Verification Form

Client's Name: _____

Record No: _____

This form is to verify client's identity in order to prevent intentional deception, misrepresentation or unauthorized services, which may constitute fraud under federal and state laws related to Medicaid. The use of this form is mandatory when copies of original documents cannot be obtained (*you must provide reason*). The information on this form is for identity verification purpose only and will be kept in the strictest confidentiality, as required by law, and will not be shared with any entity or person outside the agency, unless so requested by client/legal guardian.

I hereby certify that the following original identification documents were produced/presented to me by client/legal guardian (*check all IDs presented and verified*):

✓	Type of Document	Number
	State ID or Driver's License	
	Social Security Card	
	Medicaid Recipient ID Card	
	Medicare Card	
	Health Plan (HMO) Member ID Card	
	Passport/Residence Card	
	Other:	

Employee / TCM Name

Employee / TCM Signature

Date

Client/parent/legal guardian Signature

Date



Mental Health Targeted Case Management Program

Phone:

Fax:

Dear

I'm more than pleased to welcome you to
On behalf of our dedicated staff, I would like to thank you for choosing our agency
for your case management needs. From now on and for as long as you are our client,
we are going to work tirelessly to assist you with your needs and help you to achieve
your goals.

Within the next days, I will be contacting you and conducting home visits as part
of the process of opening your case for Targeted Case Management services. I look
forward to working with you on this case. Thanks again for giving us the opportunity
to serve you.

If you have any questions, you can reach me at:

Sincerely,

Employee / TCM Signature

NUTRITIONAL SCREEN

Circle the score for each identified area:

Client Name: _____

	Yes (score)
The client has an illness or condition that made him/her change the type and/or amount of food he/she eats	Yes
The client has a history of an eating disorder	Yes
The client eats fewer than 2 meals per day	Yes
The client eats few fruits, vegetables, or milk products	Yes
The client has tooth or mouth problems that make it hard for him/her to eat (Dental problems)	Yes
The client eats alone most of the time	Yes
The client takes 3 or more different prescribed or over the counter medications per day	Yes
Without wanting to, the client has lost over gained 10 pounds in the last 3 months	Yes
The client is always hungry	Yes
The client is always thirsty	Yes
The client vomits on a daily basis	Yes
The client had diarrhea, constipation, or nausea on a daily basis	Yes
The client binges and purges on a weekly basis	Yes
The client's appetite is good	Yes
The client's appetite is fair	Yes
The client's appetite is poor	Yes
The client has food allergies	Yes

Score Range	Assessment	Plan
0-15	Low Risk	Reassess if other issues arise
16-24	Moderate Risk	Monitor eating habits, provide education on nutrition and reassess within 30 days
25 or more	High Risk	Refer client to a Nutritionist

Referred to: _____ Date of Referral: _____

Staff Signature: _____ Date: _____

PERSONAL WELLBEING INDEX

CLIENT NAME: _____

1. How satisfied are you with your standard of living?

No satisfaction at all		Completely Satisfied																			
0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6	<input type="checkbox"/>	7	<input type="checkbox"/>	8	<input type="checkbox"/>	9	<input type="checkbox"/>	10	<input type="checkbox"/>

2. How satisfied are you with your health?

No satisfaction at all		Completely Satisfied																			
0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6	<input type="checkbox"/>	7	<input type="checkbox"/>	8	<input type="checkbox"/>	9	<input type="checkbox"/>	10	<input type="checkbox"/>

3. How satisfied are you with what you are achieving in life?

A horizontal scale representing satisfaction levels from 0 to 10. The scale is marked with integers from 0 to 10 above a series of blue square boxes. The text "No satisfaction at all" is positioned above the first few boxes, and "Completely Satisfied" is positioned above the last few boxes.

Score	Description
0	No satisfaction at all
1	No satisfaction at all
2	No satisfaction at all
3	No satisfaction at all
4	No satisfaction at all
5	No satisfaction at all
6	No satisfaction at all
7	No satisfaction at all
8	No satisfaction at all
9	Completely Satisfied
10	Completely Satisfied

4. How satisfied are you with your personal relationships?

No satisfaction at all	Completely Satisfied									
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>	9 <input type="checkbox"/>	10 <input type="checkbox"/>

5. How satisfied are you with how safe you feel?

No satisfaction at all					Completely Satisfied					
0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>										

6. How satisfied are you with feeling part of your community?

No satisfaction at all					Completely Satisfied					
0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>										

7. How satisfied are you with your future security?

No satisfaction at all					Completely Satisfied					
0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>										

8. How satisfied are you with your spirituality or religion?

No satisfaction at all					Completely Satisfied					
0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>										

Staff Name: _____

Staff Signature: _____

Date: _____

Date: _____

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version - Recent

Client's Name:	Past Month	Lifetime (Worst Point)	
Ask questions that are bolded and <u>underlined</u>.	YES	NO	YES
Ask Questions 1 and 2			
1) <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>			
2) <u>Have you actually had any thoughts of killing yourself?</u>			
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.			
3) <u>Have you been thinking about how you might do this?</u> E.g. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."			
4) <u>Have you had these thoughts and had some intention of acting on them?</u> As opposed to "I have the thoughts but I definitely will not do anything about them."			
5) <u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u>			

How long ago did the Worst Point Ideation occur?

6) <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u> Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	YES	NO
If YES, ask: <u>Was this within the past three months?</u>		

- █ Low Risk
- █ Moderate Risk
- █ High Risk

For inquiries and training information contact: Kelly Posner, Ph.D.

New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

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PAIN SCREEN

Do you suffer from chronic pain? Yes No

Did you use drugs or alcohol to cope with pain? Yes No

**Were your drug abuse problems made worse
by your need for pain medication?** Yes No

**Do you feel concerned that your pain management
needs will not be addressed?** Yes No

Do you believe you will always need narcotic pain medications? Yes No

Where is your pain located?

What causes your pain?

Does your pain effect your daily functioning? If so what? (i.e. sleep, school/work, mood, relationships, eating/drinking, etc..)

Duration of pain? Always There Comes and Goes

Current Pain Score: (0- no pain, 5- moderate pain, 10- severe pain)

□ □ □ □ □ □ □ □ □ □
0 1 2 3 4 5 6 7 8 9 10

Score Range	Assessment	Plan
0- 4	Low Risk	Reassess if other issues arise
5 -10	High Risk	Refer client to a Physician

Referred to: _____ Date of Referral:_____

Staff Signature: _____ **Date:** _____

SECTION 2

*Forms and documentation are interspersed in chronological order with the most recent on top

- Referrals/Transfers**
- Psychiatric/Psychosocial Evaluation(s) ***
- Additional Clinical Documentation ***
- Coordination of Care**
- Medical Reports/History, Medications, Follow-Ups, Hospital Records, Discharge Summary ***

* Items marked with asterisk (*) may require Authorization for Use and Disclosure of Confidential Information signed by client or legal representative



Coordination of Care

Recipient's Full Name:	DOB:	Record Number:
------------------------	------	----------------

□ Information to be released to:

□ Information to be requested from:

Physician name: _____ **PCP** **Specialist:** _____

Address: _____

Physician phone number: _____ **Fax number:** _____

Information received/sent via:

Verbal Written Record Facsimile Electronic Record All before mentioned

Information not known by client/guardian

Dear Physician:

We wish to inform you that the above mentioned client is receiving Targeted Case Management services from our center. Medicaid regulations as well as _____ believe that coordination of care is crucial for our clients. To that effect, the client/guardian has authorized our mutual sharing of health information at the bottom of this letter.

In order to properly and expeditiously coordinate the client's care, we would appreciate you contacting us at _____ with any pertinent information, concern or question.

CLIENT/GUARDIAN AUTHORIZATION OR REFUSAL

I authorize on behalf of myself the above mentioned doctor as well as _____
to mutually share and exchange health information in order to best coordinate care.

I refuse to authorize sharing information between _____ and the above mentioned doctor.

Recipient Print Name:

Signatures

Date _____

Parent/Legal Guardian Print Name

Signature

Date

Employee / TCM Signature

Credentials

Signature

Date

SECTION 3

*Forms and documentation are interspersed in chronological order with the most recent on top

- Case Management Assessment**
- Case Management Certification Form (Appendix J)**
- Service Plan**
- Service Plan Addenda**
- Service Plan Review**
- Discharge Summary**

Case Management Assessment

SECTION I: CLIENT'S INFORMATION

Client's Name: _____ Case Number: _____
Address: _____ City, State, Zip: _____
Home Phone No _____ Cell Phone No _____ Other _____
Email Address (optional): _____
DOB: _____ Age: _____ SSN: _____ Gender: Male Female
Race: _____ Ethnicity: _____ Marital Status: _____
Primary Language: _____ Other Language: _____ Read Speak Understand

Legal Decision-Maker or Authorized Representative (*if applicable*)

None Legal Guardian Guardian-ad-Litem Parent Attorney-in-fact Other: _____

Name: _____ Phone No: _____

Address: _____ City, State, Zip: _____

*Attach copies of Court disposition and support documentation regarding legal representation, custody or guardianship when applicable

Need of Special Accommodations? No Yes Specify: _____

TYPE OF ASSESSMENT

Initial Annual Significant Change Other: _____

*Is client currently receiving Case Management services through another provider? Yes No

SECTION II: REFERRAL AND INFORMATION SOURCES

Referred by: _____ Phone No: _____

Address: _____ City, State, Zip: _____

Title/Position: _____ Agency (*if applicable*): _____

This assessment was based on the information obtained from the following sources (*check all that apply*):

Client's input and own assessment Family and friends Referring Agency/Provider School
 Treating Providers Caregiver Review of client's records Other: _____

Please list individuals/agencies providing information other than client:

Name	Agency (<i>if applicable</i>)	Relationship

*All the information used for the completion of this assessment was obtained with proper consent(s) of the client or legal representative (*if applicable*). Refer to **Authorization for Use and Disclosure of Confidential Information** on Section 1

Client's Name: _____

Case Number: _____

SECTION III: PRESENTING PROBLEMS

Describe reason for referral, elaborating on client's presenting problems and chief complaints. Use client's own words and include prominent symptoms and precipitating events. Describe how current situation and problems are affecting client's normal functioning, emotional stability, safety and wellbeing.

Date of onset of present problem(s): _____ Previous psychiatric problem(s): No Yes**SECTION IV: FAMILY INFORMATION****A. Parents Information** (children only)

What are the child's parent's names? _____

Child's Mother

Child's Father

Parent's marital status: Married Divorced Separated Never marriedAre child's parents living together? Yes No If No, provide the following information for the non-custodial parent:

Name: _____

Phone № _____

Address: _____ City, State, Zip: _____

*May we contact the non-custodial parent if necessary? Yes No N/A**B. Household Composition**

List all family members living in the same household and indicate their ability to support and take care of the client

Name	Age	Relationship	Supporting and Caretaking Ability

SECTION V: PAST AND CURRENT SERVICES AND EFFECTIVENESS

List past and current services provided to client starting with the most recent on top. Identify providers, dates and effectiveness

TYPE OF SERVICE	PROVIDER / AGENCY	DATE RECEIVED	EFFECTIVENESS
		TO	

Additional information: _____

Client's Name: _____

Case Number: _____

SECTION VI: CURRENT MEDICATIONS

List any current medication being taken by client including medical, psychiatric and over-the-counter

MEDICATION	DOSES/FREQUENCY	PRESCRIBING PHYSICIAN	REASON/PURPOSE

How does client remember to take his/her medications? (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> By following directions | <input type="checkbox"/> Pill Organizer | <input type="checkbox"/> Family/Caregiver |
| <input type="checkbox"/> Calendar reminder | <input type="checkbox"/> Electronic reminder | <input type="checkbox"/> RN/HHA Set-up |
| <input type="checkbox"/> Keeping them visible | <input type="checkbox"/> Daily task association | <input type="checkbox"/> Other: _____ |

How well does client self-administer medication?

- | | |
|---|--|
| <input type="checkbox"/> With no help or supervision | <input type="checkbox"/> With a lot of help or constant supervision |
| <input type="checkbox"/> With some help or occasional supervision | <input type="checkbox"/> Unable to administer own medications/caregiver gives them |

Has the client had problems getting the medication dispensed or refilled on time? Yes No

What pharmacy does client use? _____ Phone #: _____

Any other significant medication issue or concern (e.g. medication side effect, drug interaction, adjustment, effectiveness, cost, etc.)?

SECTION V: AREAS OF FUNCTIONING AND NEEDS ASSESSMENT**1. MENTAL HEALTH / BEHAVIORAL / SUBSTANCE ABUSE**Mental Health / Psychiatric History (include client and family history):

Psychiatrist: _____

Phone № _____

Address: _____ City, State, Zip: _____

Primary Diagnosis (Axis I): _____
ICD-10 Code: _____ Descriptor: _____

Client's Name: _____

Case Number: _____

MENTAL HEALTH / BEHAVIORAL / SUBSTANCE ABUSE (Continued)

Does the client currently have or have had any of the following? (Check all that apply)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Self-neglect | <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Aggressiveness |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Loss of interest | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Impulsivity |
| <input type="checkbox"/> Helplessness | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fearfulness | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Negative thoughts | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Paranoia | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Withdrawal | <input type="checkbox"/> Irritability | <input type="checkbox"/> Obsessive behaviors | <input type="checkbox"/> Delusions |

Has the client ever been hospitalized due to mental health/behavior issues? If so, please give the following information:

Hospital or Institution	Date	Reason

RISK ASSESSMENT

Has client ever had or currently has any of the following? (Check all that apply)

- | | | | |
|--|---|---|---------------------------------|
| <input type="checkbox"/> Suicidal Attempt/Ideation | <input type="checkbox"/> Homicidal Attempt/Ideation | <input type="checkbox"/> Abuse/Violence | Physical
Sexual
Emotional |
|--|---|---|---------------------------------|

Provide details:

Describe any risk taking behavior that client may have:

SUBSTANCE ABUSE / CHEMICAL DEPENDENCY HISTORYHave you ever used alcohol or other drugs? Yes No If Yes, complete information below:

Type of Drug/Substance	Date Begin	Age	Frequency	Last Time Used

Have you ever been to any rehab/detox treatment or program? Yes No If Yes, complete information below:

When was the first time?	How many times since then?	Date of most recent	Outcome of treatment

Does the client feel that he/she currently has an addiction problem? Yes No

Describe any other issues related to client's mental health:

Client's Name: _____

Case Number: _____

2. PHYSICAL HEALTH / MEDICAL / DENTAL

Primary Care Physician (PCP): _____ Phone № _____

Place of Practice (*Hospital, Medical Center, Private Practice, etc.*): _____

Address: _____ City, State, Zip: _____

List any medical problems/conditions that client or family currently have or have had in the past

<i>Medical Problem/Condition</i>	<i>Client</i>	<i>Family</i>	<i>Comments</i>
Allergy <input type="checkbox"/> No <input type="checkbox"/> Yes Specify: _____			

Has client undergone any surgical procedure? Yes No If Yes, complete information below:

<i>Type of Surgery</i>	<i>Date</i>	<i>Hospital</i>	<i>Outcome</i>

Hearing:

- No hearing impairment.
- Hearing impairment managed through assistive devices
- Hearing difficulty at level of conversation.
- Hears only very loud sounds.
- No useful hearing.
- Not determined.

Vision:

- Has no impairment of vision.
- Vision impairment managed through assistive devices
- Has difficulty seeing at level of print (far-sighted).
- Has difficulty seeing objects in environment (near-sighted).
- Has no useful vision.
- Not determined.

Pregnancy:Is client currently pregnant? Yes No N/AIs she receiving prenatal care? Yes No Does she understand the risks of pregnancy? Yes No

Issues/complications during pregnancy: _____

Preventive Care:Are all immunizations/vaccines current? Yes No If No, explain: _____Are you on a physician ordered special diet? No Yes Specify: _____

How active are you? I exercise or engage in physical activities _____

(Frequency)

Client's Name: _____

Case Number: _____

PHYSICAL HEALTH / MEDICAL / DENTAL (Continued)

Please indicate the last time (date) the following preventive procedures were conducted:

Physical Exam: _____

Pap and HPV Test: _____

Dental Exam: _____

Mammogram: _____

Lab Works: _____

Colon Cancer Screening: _____

Other (specify): _____

Additional information about medical problems/conditions:

3. VOCATIONAL / EMPLOYMENT

A. Vocational/Employment history (*briefly describe client's work history indicating previous employers, occupations, vocational goals, etc.*):

Is client currently employed? Yes (*Indicate Status and complete section B*) No (*Indicate Status and go to section C*)

Employment Status: _____

B. Current Employer: _____

Address: _____ City, State, Zip: _____

Contact Person: _____ Phone № _____

*May we leave/send voice/text messages to the above contact if necessary? Yes No

C. Is the client able to work or perform any gainful and productive activity? Yes No Yes but with limitations

If Yes, would he/she like to obtain a job? Yes No Not at this time

Does client need assistance or support to seek, obtain and sustain employment? Yes No If Yes, explain:

4. SCHOOL / EDUCATION

A. CHILDREN ONLY (*Go to section B for ADULTS*)

Is client currently attending school or any educational program? Yes No

If No, explain why: _____

School: _____ District: _____ Grade: _____

Address: _____ City, State, Zip: _____

School Program: Regular ESE EBD ESOL HHIP (Homebound) Other

Teacher or Counselor Name: _____ Phone № _____

Client's Name: _____

Case Number: _____

SCHOOL / EDUCATION (Continued)

Has client ever experienced difficulties in any of the following areas? (Check all that apply and indicate in what school level)

Areas of Functioning (Children only)	Pre-School	Elementary	Middle School	High School
Academic performance (low grades, failed subjects)				
Behavior (misconduct, bullying, suspensions)				
Relationship with students, teachers, school staff				
Attendance and punctuality, skipping classes				
Fail to pass the grade, grade retention				
Participation in extracurricular activities				
Learning disabilities				

Is client involved in any extra-curricular activities? Yes No Specify: _____Is there any aide, tutor or mentor assigned to the child? Yes No If Yes, provide the following information:

Name: _____ Phone No: _____

Describe client's educational strengths: (*children only*)Describe any school based weaknesses, adjustment and/or educational placement problems: (*children only*)**B. ADULTS**

What is the highest level of education client has completed?

- | | | |
|--|--|---|
| <input type="checkbox"/> No School | <input type="checkbox"/> GED | <input type="checkbox"/> Some College |
| <input type="checkbox"/> Elementary School | <input type="checkbox"/> Graduated Special Education | <input type="checkbox"/> College Graduate |
| <input type="checkbox"/> Middle School | <input type="checkbox"/> High School Graduate | <input type="checkbox"/> Graduate Degree |
| <input type="checkbox"/> Some High School | <input type="checkbox"/> Trade School | <input type="checkbox"/> Unknown |

Is client interested in furthering his/her education? Yes No

If yes, what area would client want to further his/her education in? _____

Does client need assistance or support in gaining access to educational services? Yes No

Explain: _____

5. SOCIAL / SUPPORT SYSTEM / RECREATIONAL

Describe client's cultural affiliations and/or spiritual/religious beliefs: _____

Does the client currently participate in any social activity or program in the community? Yes No
If Yes provide details:

Client's Name: _____

Case Number: _____

SOCIAL / SUPPORT SYSTEM / RECREATIONAL (Continued)

What activities or things does client enjoy doing or which ones would he/she like to do?

Briefly describe client's social skills (*e.g. ability to interact and get along with others, ability to make and maintain relationships, etc.*)

Describe client's relationships and support system (*family, friends, peers, landlord, neighbors, caretaker, providers, significant others, etc.*)

List any needs or concern related to social functioning / *support system*:

6. ACTIVITIES OF DAILY LIVING (ADLs / IADLs)

Identify the activities that client has difficulties to perform and indicate level of dependency (*check all that apply*):

ACTIVITIES OF DAILY LIVING	Assistive Technology	INDEPENDENT	SUPERVISION AND VERBAL PROMPTS	PHYSICAL ASSISTANCE NEEDED	TOTAL DEPENDENCE
a. Feeding/eating					
b. Grooming and personal hygiene					
c. Bathing/showering					
d. Dressing					
e. Transferring and mobility					
f. Cooking/preparing meals					
g. Doing laundry, housekeeping					
h. Making/answering phone calls					
i. Shopping/errands					

Describe any needs, concerns or safety risks related to the performing of activities of daily living:

7. HOUSING / LIVING ENVIRONMENT

Residential Status: _____

Number of person living in the same house: _____ Number of bedrooms in the house: _____

Person-per-Bedroom (PPB) ratio: _____ (*According to HUD standards, a PPB above 2 is considered household overcrowding and housing assistance may be needed*)

Describe client's living and sleeping arrangements (*rent/own, where client sleeps, whether he/she shares bed/bedroom, etc.*):

Client's Name: _____

Case Number: _____

HOUSING / LIVING ENVIRONMENT (Continued)

Please indicate area(s) where there are potential safety risks or accessibility/mobility barriers:

- | | | |
|--|---|---|
| <input type="checkbox"/> Structural damage | <input type="checkbox"/> Tripping/fall hazards | <input type="checkbox"/> Excessive clutter |
| <input type="checkbox"/> Electrical hazards | <input type="checkbox"/> Unsanitary conditions | <input type="checkbox"/> Insects or other pests |
| <input type="checkbox"/> Poor lighting | <input type="checkbox"/> No air conditioning/heat | <input type="checkbox"/> Flooring/carpet loose |
| <input type="checkbox"/> No hot or running water | <input type="checkbox"/> Stairs/steps unsafe | <input type="checkbox"/> Bathtub/shower unsafe |
| <input type="checkbox"/> Fire hazards | <input type="checkbox"/> No telephone (<i>or not working</i>) | <input type="checkbox"/> Appliances not working |

Describe neighborhood (*urban/rural, location, crime level, safety, accessibility to community resources and services, etc.*):

Does the client feel safe in the current living arrangement? Yes No

If No, explain: _____

Would the client like to continue to live in the current place, or is there somewhere else he/she would prefer to live?

- | | |
|---|---|
| <input type="checkbox"/> Continue to live here | <input type="checkbox"/> Continue to live here only if housing condition improves |
| <input type="checkbox"/> Prefer to live elsewhere | <input type="checkbox"/> Doesn't know / not sure |

If there are any housing needs or concern not listed above, please describe:

8. ECONOMIC / FINANCIAL / BASIC NEEDS (Food, clothing, furniture, household items, etc.)

Monthly Family Income (*include income from all household members*): _____

What is the main source(s) of income for the client and/or family? _____

Other financial resources available to client: _____

Is the client or the client's family currently having any financial difficulties? Yes No If Yes, please describe:

Does the client receive or use any of the following types of food assistance?

Assistance type	Receive/use?	How often?	Provider?
Food Stamps/S.N.A.P.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Food Pantry/Food Banks	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Home delivered meals	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Congregate meals (<i>Meals served in community settings such as senior centers, churches, etc.</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Does the client have other basic needs? (*e.g. utilities, clothing, school uniforms and supplies, furniture, necessary household items, etc.*)

Client's Name: _____

Case Number: _____

9. TRANSPORTATION

How does client get to the places he/she want or need to go? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Walks | <input type="checkbox"/> Friend or family member drives |
| <input type="checkbox"/> Drives | <input type="checkbox"/> Staff/Provider |
| <input type="checkbox"/> Takes a bus or taxi | <input type="checkbox"/> Other: _____ |

How well is client able to use public transportation or drive to places beyond walking distance?

- | | |
|--|--|
| <input type="checkbox"/> Needs no help or supervision | <input type="checkbox"/> Needs a lot of help or constant supervision |
| <input type="checkbox"/> Needs some help or occasional supervision | <input type="checkbox"/> Can't do it at all |

Does the client have any other transportation needs? Yes No

If Yes, explain: _____

10. LEGAL / IMMIGRATION

A. Court / Department of Juvenile Justice (DJJ) Involvement

Has client ever been arrested? Yes No How many times? _____ Last time arrested: _____

If Yes, were there criminal charges pressed against client? Yes No

Is there any current and ongoing legal process: Yes No Probation Officer? Yes No

Name of Probation Officer: _____ Phone № _____

B. Immigration

Country of Birth: _____ Year entered USA: _____ Status: Citizen Resident

Other: _____

Additional information in reference to *legal/immigration* status:

11. OTHERS

SECTION VI: SUMMARY OF CLIENT'S STRENGTHS AND WEAKNESS

A. List client's current and potential strengths, abilities, assets, interests, preferences, resources that may contribute to his/her recovery and wellbeing:

B. List client's current and potential weakness, barriers, challenges, etc. that may interfere with his/her recovery and wellbeing:

Client's Name: _____

Case Number: _____

SECTION VII: RECOMMENDED SERVICES

- Mental Health / Substance Abuse
- Physical Health / Medical / Dental
- Vocational / Employment / Job Training
- School / Education
- Recreational / Social Support
- Activities of Daily Living (*ADLs and IADLs*)
- Housing / Shelter / Living Environment
- Economic / Financial and Basic Needs (*food, clothing, furniture, etc.*)
- Transportation
- Legal / Immigration
- Other (*specify*): _____

SECTION VIII: SIGNATURES

I certify that either one of the following requirements was met prior to the completion of client's Assessment:

- A home visit was conducted prior to the completion of this Assessment on: _____
OR
- Case Manager was unable to complete a home visit due to: _____

However, a face-to-face interview was conducted on: _____ and a required home visit was scheduled for: _____

Targeted Case Manager Name Credentials Signature Date

Senior/Lead Case Manager Name Credentials Signature Date

TCM Supervisor Name Credentials Signature Date



APPENDIX J
ADULT CERTIFICATION
ADULT MENTAL HEALTH TARGETED CASE MANAGEMENT

Recipient's Name: _____ Medicaid ID# _____

Is hereby certified as meeting all of the following adult mental health targeted case management criteria.

1. Is enrolled in a Department of Children and Families adult mental health target population
2. Has a mental health disability (i.e., severe and persistent mental illness) which requires advocacy for and coordination of services to maintain or improve level of functioning;
3. Requires services to assist in attaining self sufficiency and satisfaction in the living, learning, work and social environments of choice;
4. Lacks a natural support system with the ability to access needed medical, social, educational and other services;
5. Requires ongoing assistance to access or maintain needed care consistently within the service delivery system;
6. Has a mental health disability (i.e., severe and persistent mental illness) duration that, based upon professional judgment, will last for a minimum of one year;
7. Is not receiving duplicate case management services from another provider;
8. Meets at least one of the following requirements (*check all that apply*):
 - a. Is awaiting admission to or has been discharged from a state mental health treatment facility;
 - b. Has been discharged from a mental health residential treatment facility;
 - c. Has had more than one admission to a crisis stabilization unit (CSU), short-term residential facility (SRT), inpatient psychiatric unit, or any combination of these facilities in the past 12 months;
 - d. Is at risk of institutionalization for mental health reasons (*provide explanation);
 - e. Is experiencing long-term or acute episodes of mental impairment that may put him or her at risk of requiring more intensive services (*provide explanation); or
9. Has relocated from a Department of Children and Families district or region where he or she was receiving mental health targeted case management services.

Case Manager's Name and Signature

Date

Case Manager's Supervisor's Name and Signature

Date

Form must be filed in the recipient's case record.

AHCA-Med Serv Form 030, July 2006 (incorporated by reference in 59G-4.199, F.A.C.)



Case Management Individualized Service Plan

SECTION I

DATE OF SERVICE PLAN: _____

Recipient Name: _____

Case Number: _____

DOB: _____

Age: _____

Gender: Male Female

Diagnosis Provided by a Licensed Practitioner

CODE (ICD-10)	DESCRIPTOR

Services Provided Prior to Development of Service Plan

SERVICE	DATE	SERVICE	DATE	SERVICE	DATE

Strengths, Abilities, Resources, Interests, Preferences

Weakness, Needs, Barriers, Challenges

--	--

Transition / Discharge Criteria

Specific Individualized Realistic

Recipient Name: _____

Case Number: _____

SECTION II

#	Domains	Date Identified	Needs Identified
1	Mental Health Behavioral Substance Abuse		
2	Physical Health Medical/Dental		
3	Vocational Employment Job Training		
4	School Education Academic		
5	Environmental Recreational Social Support		
6	Activities of Daily Living (ADLs / IADLs)		
7	Housing Shelter		
8	Economic Financial Basic Needs		
9	Transportation		
10	Legal Immigration		
11	Other (specify)		

Recipient Name: _____

Case Number: _____

SECTION III: LONG TERM GOALS / SHORT TERM OBJECTIVES

(Expectations of the individual, where does the individual see himself/herself in the future, what would he/she like to accomplish. It must be realistic and attainable and must be written in conjunction with the individual and family members when applicable)

DOMAIN #

Identified service needs from SECTION II:

Long Term Goal: (include recipient's own words)

Objective	Task/Case Management Strategy (Who Will Do What, When and How)	Start Date	Target Date	End Date
Responsible Provider and Resources				
Objective	Task/Case Management Strategy (Who Will Do What, When and How)	Start Date	Target Date	End Date
Responsible Provider and Resources				
Objective	Task/Case Management Strategy (Who Will Do What, When and How)	Start Date	Target Date	End Date
Responsible Provider and Resources				

Recipient Name: _____

Case Number: _____

SECTION III: LONG TERM GOALS / SHORT TERM OBJECTIVES

(Expectations of the individual, where does the individual see himself/herself in the future, what would he/she like to accomplish. It must be realistic and attainable and must be written in conjunction with the individual and family members when applicable)

DOMAIN #

Identified service needs from SECTION II:

Long Term Goal: (include recipient's own words)

Objective	Task/Case Management Strategy (Who Will Do What, When and How)	Start Date	Target Date	End Date
Responsible Provider and Resources				
Objective	Task/Case Management Strategy (Who Will Do What, When and How)	Start Date	Target Date	End Date
Responsible Provider and Resources				
Objective	Task/Case Management Strategy (Who Will Do What, When and How)	Start Date	Target Date	End Date
Responsible Provider and Resources				

Recipient Name: _____

Case Number: _____

SECTION III: LONG TERM GOALS / SHORT TERM OBJECTIVES

(Expectations of the individual, where does the individual see himself/herself in the future, what would he/she like to accomplish. It must be realistic and attainable and must be written in conjunction with the individual and family members when applicable)

DOMAIN #

Identified service needs from SECTION II:

Long Term Goal: (include recipient's own words)

Objective	Task/Case Management Strategy (Who Will Do What, When and How)	Start Date	Target Date	End Date
Responsible Provider and Resources				
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Recipient Name: _____

Case Number: _____

SECTION IV

Service Plan Signatures

We, the members of the case management team, hereby certify that this recipient is eligible for case management services which will be rendered through
The signatures below indicate that the goals and objectives as outlined in the Service Plan have been developed in partnership with the recipient and the legal guardian/custodian (when applicable) and are valid for a period of six (6) months, unless extended due to reasonable criteria.

The expected review date of this Service Plan should be no later than: _____

This Service Plan has been explained to me in all its extent in terms I can understand, I have agreed with the goals and objectives as written and I have given consent to services involved in its development and implementation. A copy of the Service Plan has been offered to me: Yes No

Recipient's Signature

Date

Parent/Legal Guardian's Signature

Date

Targeted Case Manager Signature

TCM Print Name

Credentials

Date

TCM Supervisor's Signature

TCM Supervisor's Print Name

Credentials

Date







SECTION 4

*Forms and documentation are interspersed in chronological order with the most recent on top

Intervention/Non-clinical Log (Non-billable)

Case Management Progress Notes

Record Audit Log (For office use only)

Intervention / Non-clinical Log

Client Name:		Client Number:	
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* Use this form to record or document non-billable services or activities relevant to treatment or services, e.g.: case assignment, case conference with Supervisor or staff members, change in diagnosis or in any other important or significant information, unsuccessful attempts to contact client, extended gaps in services, discussion of case closing, etc.





Mental Health Targeted Case Management Program

RECORD AUDIT LOG

Client's Name: _____

Record №: _____

----- FOR OFFICE USE ONLY ----- DO NOT REMOVE THIS FORM FROM CLIENT'S FILE -----

AUDIT CODE: **O**- Open **C**- Close **T**- Transfer **R**- Regular Audit

RATING: **5**- Excellent **4**- Good **3**- Fair **2**- Poor **1**- Unacceptable

IMPORTANT: Ratings of 2 or below are subject to immediate correction plan

DATE	AUDIT CODE	AUDITOR NAME	RATING

NO FURTHER REVIEW REQUIRED

(Closed cases only)

Signature