AD 14 102A
Attachment
HEALTHCHOICES MENTAL HEALTH ASSESSMENT

INITIAL PRE-CERTIFICATION REVIEW
CCM Name, Date and Time Request Received:

MEMBER (MBR) IS DESIGNATED AS HIGH RISK:
LOC BEING PRECERTED:

DIAGNOSIS:

PRESENTING ISSUE/MENTAL STATUS
Timeline of Specific Behaviors triggering hospitalization:
History of Relevant Mental Health Symptoms:
History of Trauma/Abuse:
Is mbr able to complete ADL's:

MEDICAL
Current Psychotropic Medications, Compliance and Prescriber:
Current Medical Issues not identified in diagnosis:
Relevant Medical Medications:
Is member adherent with medical medications:

SUBSTANCE ABUSE
Substances used, route, age of first use, frequency, last use:
Urine Drug Screen completed :

CULTURAL/LANGUAGE
Are there Cultural/Language Preferences that impact treatment:

TREATMENT HISTORY
Previous MH/SA IP:
Is this admission a readmission within 30 days:
Current MH/SA Treatment: If Yes, explain:
If yes, current provider notified of admission? Is the mbr compliant with tx?
If no, did CCM request that provider notify treatment provider of the hospitalization:

PRELIMINARY DISCHARGE PLAN
Residence:
Treatment:
Provider:

Exploration of diversion options **are/are not** appropriate based on clinical needs
DIVERSION (Complete only if diversion is a clinically appropriate option)
Diversion discussion:
Housing Status impacting diversion:
Guardian/Power of Attorney impacting diversion:
Assessment of community based alternatives/supports:
Psychiatric Advanced Directives impacting diversion:
Barriers to Discharge/Aftercare:

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MNC DECISION:
Is a PA Consult Needed:
Name of PA Consulted:
Reason for PA Consult:
If PA Consult, PA Comments/Direction:
If LOC denied by PA, was member notified of denial and grievance rights:
If LOC approved by PA, symptoms meeting criteria:
Staff Name, Credentials and Time Review Completed:

MH CONTINUED STAY REVIEW:
CCM Name, Date and Time:
DIAGNOSIS:

MENTAL STATUS EXAM/TREATMENT PLAN PROGRESS:
Current Clinical/ Reason for Continued Stay at this level of care:
Non-symptom additional factors affecting ongoing treatment to request continued stay:
Reported trauma and abuse issues for this member:
Willingness to address trauma/abuse:
Reported substance abuse issues for this member:
Willingness to address SA abuse issues:
Active engagement in treatment (1:1, groups):
Family participation and progress in treatment: **(Yes / No)**
If yes, explain:
If no, what steps is provider taking to engage the member/family in treatment?

MEDICAL:
Current Psychotropic Medications:
Blood levels:
Current Medical Issues not identified in Diagnosis:
Current Medical Medications:
Is member adherent with medications: (Yes / No) If no, barriers to adherence:

CULTURAL/LANGUAGE
Are there Cultural/Language Preferences that impact treatment: **(Yes / No)**

COORDINATION OF CARE:
Complex Case Management involvement/referral:
Outreaches made by provider for collaboration:
PCP/SNU/PH-MCO referral needed:
Recovery Plan:
Discharge Plan and Barriers:

SUMMARY OF UM RECOMMENDATIONS:
UM Concerns including QOCC and Provider Performance:

MNC DECISION:
Is a PA Consult Needed:
Name of PA:

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Reason for PA Consult:
If PA Consult, PA Comments/Direction:
If LOC denied by PA, was member notified of denial and grievance rights:
If LOC approved by PA, symptoms meeting criteria:
Staff Name, Credentials and Time Review Completed:

Discharge Review
CCM Name, Date and Time:

Date of Discharge:

Is mbr returning to address listed in eCura: (Yes/No): If no, discharge address:

Phone:

Guardian/Parent Name, if applicable:

Discharge Psychotropic Medications and Dosages:

Discharge Diagnoses:

Safety/Crisis Plan:

Are there any identified barriers in the aftercare plan that require follow up? (Yes / No)
If yes, explain barrier and plan:

Aftercare Appointments Not Identified in Ecura:

Quality of Care Concerns:
Staff Name, Credentials and Time Review Completed: