SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Date Submitted	

Timely Access to Assessment and Treatment for Specialty Mental Health Services

Name (Last, First, MI)		**DOB**	
Program		**MR#**	
Clinician		**Foster Youth?**	☐ Yes ☐ No

How to Submit form to QM Email this completed form to etsujii@smcgov.org or fax to (650) 525-1762.
Questions: Contact Eri Tsujii at etsujii@smcgov.org.
For Contracted Agencies use a secure email or contact Eri Tsujii at etsujii@smcgov.org to receive a secure email from which you can submit the completed form.

Section 1: Referral Information

Date |Time of First Contact to Request Services			**Type of Service Requested**	☐ Urgent ☐ Non-Urgent ☐ Non-Psychiatry ☐ Psychiatry(MD/NP)

Referral Source

☐ Self (01)	☐ Emergency Room (09)	☐ Street Outreach (16)
☐ Family Member (02)	☐ Mental Health Facility / Community Agency (10)	☐ Juvenile Hall / Camp / Ranch / Division of Juvenile Justice (17)
☐ Significant Other (03)	☐ Social Services Agency (11)	☐ Probation/Parole (18)
☐ Friend / Neighbor (04)	☐ Substance Abuse Treatment Facility / Agency (12)	☐ Jail / Prison (19)
☐ School (05)	☐ Faith-based Organization (13)	☐ State Hospital (20)
☐ Fee-For-Service Provider (06)	☐ Other County / Community Agency (14)	☐ Crisis Services (21)
☐ Medi-Cal Managed Care Plan (07)	☐ Homeless Services (15)	☐ Mobile Evaluation (22)
☐ Federally Qualified Health Center (08)		☐ Other referred (23) ____________

Section 2: Assessment

Assessment: *Appointment Date Offered* is the appointment date that was offered to the client.	Appointment Date Offered*		Appointment Accepted	Appointment Attended
First Assessment Appointment Date | Time Offered			☐ Yes ☐ No	☐ Yes ☐ No
Second Assessment Appointment Date Offered			☐ Yes ☐ No	☐ Yes ☐ No
Third Assessment Appointment Date Offered			☐ Yes ☐ No	☐ Yes ☐ No

Date Client Actually Attended First Assessment Appointment	
Date Assessment Completed	
If client did not start or did not complete the assessment process:	Proceed to Section 5 and select the appropriate closure reason.

Section 3: Medical Necessity Determination

Does client meet medical necessity?	☐ Yes ☐ No

Name (Last, First, MI)		MR#	

*If client **meets** medical necessity, the client **must** be offered a treatment appointment OR be referred to a treatment program.* **If client was referred to another treatment team, which team were they referred to?**	
*If the client **does not meet** medical necessity, issue a NOAB "Denial," send NOAB and this form to QM, and close the client's chart/episodes.* *Indicate where the client was referred for services.*	☐ Client COMPLETED assessment and did not meet medical necessity (06) **Date client was closed**_________________________ **Referred to:** ☐ Managed Care Plan (01) ☐ Fee-For-Service Provider (02) ☐ Other (Specify) (03) ______________________________ ☐ No Referral (04)

Section 4: Initial Treatment Appointment (Post Assessment)

Complete this section **ONLY IF** Assessment was completed. Send form to QM:

Treatment: *Date offered is the appointment date that was offered to the client.	Appointment Date Offered*	Appointment Accepted	Appointment Attended
First Treatment Appointment Date Offered		☐ Yes ☐ No	☐ Yes ☐ No
Second Treatment Appointment Date Offered		☐ Yes ☐ No	☐ Yes ☐ No
Third Treatment Appointment Date Offered		☐ Yes ☐ No	☐ Yes ☐ No

Client Attended Initial Treatment Appointment	☐ Yes, client attended initial treatment appointment. Send this form to QM. **Date client attended first treatment appt** __________________________

Section 5: If Client is LOST TO FOLLOW-UP

Close the client's chart/episodes, and select from the closure reasons below. Send form to QM.

Lost to Follow-Up If client was lost to follow-up at any point during this process, select one of the following options:	☐ Client did not accept any offered assessment appointments (01) ☐ Client accepted offered assessment appt, but did not attend initial assessment appt (02) ☐ Client attended initial assessment appointment, but did not complete assessment (03) ☐ Client completed assessment but declined offered treatment dates (04) ☐ Client accepted offered treatment appt but did not attend initial treatment appt (05) ☐ Out of County / Presumptive Transfer (07) ☐ Unable to contact (e.g., deceased, client unresponsive, etc.) (08) ☐ Other (09) ____
Date Client was Closed	

Please provide any additional comments/information about the reason for closure or delay in meeting timely access standard. (e.g., client's phone was out-of-service, interpreter unavailable, etc.)

Entered into CSI	☐ Yes Date____________ By____

QM Comments: