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 of First Contact to Request Services		**Is this appointment?**	☐ Urgent ☐ Non-Urgent ☐ Psychiatry(MD/NP) ☐ Non-psychiatry

Referral Source

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

Section 2: Assessment

Assessment: **Appointment Date Offered* is the scheduled appointment date that was offered to the client.*	Appointment Date Offered*	Appointment Accepted	Appointment Attended
First Assessment Appointment Date 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 assessment process, select one of the following options:	☐ Client did not accept any assessment appointments (01) – Close the clients chart/episodes. Send this form to QM. **Date client was closed**_____ ☐ Client attended initial assessment appointment, but did not complete assessment (03) – Close the clients chart/episodes. Send this form to QM. **Date client was closed**_____

Name (Last, First, MI)		MR#	

Section 3: Medical Necessity Determination

Client meet medical necessity? *If client meets medical necessity, the client **must** be offered a treatment appointment OR be referred to a treatment program.*	☐ Yes ☐ No
Was the client referred to another treatment team?	☐ Yes ☐ No
If client was referred to another treatment team, which team were they referred to?	
If client completed assessment but will not be continuing to the treatment phase, select one of the following options: ***Note: If the client did not meet medical necessity, issue NOAB "Denial," send NOAB and this form to QM*	☐ Client COMPLETED assessment, but declined offered treatment dates (04) – Close the clients chart/episodes. Send this form to QM. **Date client was closed**_____ ☐ Client COMPLETED assessment, and did not meet medical necessity (06)** - Close the clients chart/episodes. Send this form to QM. **Date client was closed**_____

Section 4: Initial Treatment Appointment (Post Assessment)

Complete this section **ONLY IF** Assessment was completed:

Treatment: *Date offered is the scheduled 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 – Close the clients chart/episodes. Send this form to QM. **Date client attended first treatment appointment** _____
Lost to Follow-Up *** If client was lost to follow-up for initial treatment appointment, select one of the following options:	☐ Client completed assessment but declined offered treatment dates (04) – Close the clients chart/episodes. Send this form to QM **Date client was closed**_____ ☐ Client accepted offered **treatment** date but did not attend any of the offered initial treatment appointments. (05) – Close the clients chart/episodes. Send this form to QM. **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.)

Completed by QM
☐ Fee-For-Service Provider (02) ☐ Managed Care Plan (01) ☐ No Referral (04) ☐ Other (Specify) (03) _____

Entered into CSI	☐ Yes, Date_____By_____

QM Comments: