Questionnaire: PNMI Referral

Office of Behavioral Health PNMI REFERRAL/APPLICATION

Instructions: Please note: All questions within this questionnaire are required to be answered.

1. *Marital Status*
   (Please select one.)
   - ○ Single
   - ○ Married
   - ○ Domestic Partner
   - ○ Divorced
   - ○ Widowed

2. *Income Source*

3. *Amount*

4. *What is the consumers MaineCare Status?*
   (Please select one.)
   - ○ Active MaineCare
   - ○ Applied/Pending
   - ○ Spend Down
   - ○ Other Insurance

   If you answered "Applied/Pending" on question 4

   4.3.1. *Date applied*

   If you answered "Spend Down" on question 4

   4.4.1. *Amount*

4.4.2. *Deductible dates*

5. *Has member applied for Housing Subsidy (BRAP, Shelter + Care, Section 8)?*
(Please select one.)
   - ○ Yes
   - ○ No

If you answered "Yes" on question 5

5.1.1. *Date applied*

If you answered "No" on question 5

5.2.1. *Applied/pending date*

6. *Referral Source*

7. *Referent name, phone number, and email address*

8. *Consumer Area Housing Preference (check all that apply)*
(Please select between 1 and 16 items.)
   - ☐ Aroostook
   - ☐ Hancock
   - ☐ Washington
   - ☐ Penobscot
   - ☐ Piscataquis
   - ☐ Kennebec
   - ☐ Somerset
   - ☐ Knox
   - ☐ Lincoln
   - ☐ Sagadahoc
   - ☐ Waldo
   - ☐ Androscoggin

- ☐ Androscoggin
- ☐ Franklin
- ☐ Oxford
- ☐ Cumberland
- ☐ York

9. *Referral is for (Primary PNMI program choice)*

10. *(Secondary Choice)*

11. *Reason for referral*

12. *Does the consumer have any special considerations/needs/accommodations to be considered for this referral?*
(Please select one.)
    - ○ Yes
    - ○ No

If you answered "Yes" on question 12

12.1.1. *Please note*
(Please select between 1 and 4 items.)
- ☐ 1:1
- ☐ Handicap accessible
- ☐ Medical monitoring
- ☐ Other

If you answered "Handicap accessible" on question 12.1.1

12.1.1.3.1. *Please explain*

If you answered "Medical monitoring" on question 12.1.1

12.1.1.4.1. *Please explain*

If you answered "Other" on question 12.1.1

12.1.1.5.1. *Other*

13. *Please note any prior living arrangements and/or periods of homelessness. What worked? What didn't?*

14. *Does the consumer require ADL assistance?*
(Please select one.)
- ○ Yes
- ○ No

If you answered "Yes" on question 14

14.1.1. *Explain:*

15. *Assistance or supervision of activities of daily living as needed*
- ☐ Bathing
- ☐ Eating
- ☐ Ambulating
- ☐ Grooming
- ☐ Dressing
- ☐ Toileting
- ☐ Personal Hygiene Activities
- ☐ Performance of incidental household tasks essential to the activities of daily living and to the maintenance of resident health and safety

16. *Supervision or assistance with*
- ☐ Administration of physician ordered medication

17. *Personal supervision or being aware of resident's general whereabouts*
    - ☐ Observing or monitoring the resident's general whereabouts
    - ☐ Observing or monitoring the resident while on the premises to ensure their health and safety
    - ☐ Reminding the resident to carry out activities of daily living
    - ☐ Assisting the resident in adjusting to their living environment

18. *Transportation*
    - ☐ Arranging transportation

Current Resources/Supports

1. *Does member have a guardian?*
   (Please select one.)
   - ○ Yes
   - ○ No

   If you answered "Yes" on question 1

   1.1.1. *Select the type of guardian*
   (Please select one.)
   - ○ Public
   - ○ Private
   - ○ Under Study

   1.1.2. *Please indicate guardian status*
   (Please select one.)
   - ○ Full
   - ○ Limited

   If you answered "Limited" on question 1.1.2

   1.1.2.3.1. *What kind of limited guardianship?*

   1.1.3. *Please provide the Guardians First and Last Name and telephone number*

2. *Does the consumer want the services being requested?*
(Please select one.)
   - ○ Yes
   - ○ No

If you answered "No" on question 2

2.2.1. *Explain:*

3. *Does the consumer have a Rep Payee?*
(Please select one.)
   - ○ Yes
   - ○ No

If you answered "Yes" on question 3

3.1.1. *Contact first and last name*

3.1.2. *Rep Payee Telephone Number*

4. *Does the consumer have a Case Manager?*
(Please select one.)
   - ○ Yes
   - ○ No

If you answered "Yes" on question 4

4.1.1. *Case manager first and last name*

4.1.2. *Case Management Agency and Telephone Number*

5. *Does the Consumer have a Primary Care Physician?*
(Please select one.)
○ Yes ○ No ○ In process of obtaining Primary Care Physician

If you answered "Yes" on question 5

5.2.1. *Name of Primary Care Physician*

5.2.2. *PCP Telephone Number*

6. *Family and/or Other Supports (any other pertinent psychosocial information)*

7. *What has family involvement been with consumer?*
(Please select between 1 and 5 items.)
☐ Phone
☐ visits
☐ Treatment Sessions
☐ Other
☐ Consumer Refuses

8. *Is there a current contact person? (please list name and telephone number)*

LEGAL ISSUES

1. *Does the consumer have any current legal issues/charges?*
(Please select one.)
○ Yes
○ No

If you answered "Yes" on question 1

1.1.1. *Explain:*

2. *Does the consumer have any past legal issues?*
(Please select one.)
   - ○ Yes
   - ○ No

If you answered "Yes" on question 2

2.1.1. *Explain:*

3. *Is the consumer involved with pre-trial?*
(Please select one.)
   - ○ Yes
   - ○ No

If you answered "Yes" on question 3

3.1.1. *Please explain*

4. *Does the consumer have a probation officer?*
(Please select one.)
   - ○ Yes
   - ○ No

If you answered "Yes" on question 4

4.1.1. *Probation officer name*

4.1.2. *Phone number*

5. *Does the consumer have conditions of release?*
(Please select one.)
   - ○ Yes
   - ○ No

If you answered "Yes" on question 5

Instructions: Please upload documents

5.1.1. *Explain:*

DIAGNOSIS

1. *Current LOCUS Score*
Min/Max - 0/99999999; No decimal places allowed

2. *LOCUS Rater ID#:*

Instructions: If original date of diagnosis is not known, please enter in the date of the most recent diagnostic assessment.

3. *Date Diagnosed*

4. *Name and License Level of Diagnostician*

5. *Does this member have a co-occurring diagnosis?*
(Please select one.)
   - ○ Yes
   - ○ No

6. *Current Symptoms*

7. *Suicidal?*
(Please select one.)
- ○ Yes
- ○ No

If you answered "Yes" on question 7

7.1.1. *Suicidal*
(Please select between 1 and 6 items.)
- ☐ Ideation
- ☐ Plan
- ☐ Means
- ☐ Intent
- ☐ Attempt
- ☐ Hx of Attempts

8. *Homicidal?*
(Please select one.)
- ○ Yes
- ○ No

If you answered "Yes" on question 8

8.1.1. *Homicidal?*
(Please select between 1 and 6 items.)
- ☐ Ideation
- ☐ Plan
- ☐ Means
- ☐ Intent
- ☐ Attempt
- ☐ Hx of Attempts

9. *Psychosis?*
(Please select one.)
- ○ Yes
- ○ No

If you answered "Yes" on question 9

9.1.1. *Psychosis*
(Please select between 1 and 4 items.)
- ☐ Delusional

- ☐ Paranoid
- ☐ Unable to Care for Self
- ☐ Other

10. *Hallucinations?*
(Please select one.)
- ○ Yes
- ○ No

If you answered "Yes" on question 10

10.1.1. *Hallucinations*
(Please select between 1 and 5 items.)
- ☐ Auditory
- ☐ Olfactory
- ☐ Tactile
- ☐ Taste
- ☐ Visual

11. *Depressed?*
(Please select one.)
- ○ Yes
- ○ No

If you answered "Yes" on question 11

11.1.1. *Signs/symptoms*
(Please select between 1 and 7 items.)
- ☐ Eating
- ☐ Sleeping
- ☐ Energy
- ☐ Isolation
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Other somatic or vegetative symptoms

12. *Are there other areas of risk not previously noted, such as elopement, self-injurious or assaultive behavior that would be helpful to know?*

13. *Does member have Substance Use or Dependence Issues?*

(Please select one.)

- ○ Yes
- ○ No

If you answered "Yes" on question 13

13.1.1. *Substance Misuse or Dependence Issues - please check all that apply:*
(Please select between 1 and 13 items.)

- ☐ Alcohol
- ☐ Cocaine/Crack
- ☐ Marijuana
- ☐ Ecstasy
- ☐ Over the Counter meds
- ☐ Sedatives/Hypnotics
- ☐ Opiates/Pain Killers (Heroin, Methadone, Oxycontin, Oxycodone, etc.)
- ☐ Tobacco
- ☐ Caffeine
- ☐ Amphetamine/Methamphetamine
- ☐ Benzodiazepines
- ☐ Other Street Drugs
- ☐ Other

If you answered "Alcohol" on question 13.1.1

13.1.1.2.1. *Date of Onset*

13.1.1.2.2. *Current Amounts*

13.1.1.2.3. *Date of last use/remission*

If you answered "Cocaine/Crack" on question 13.1.1

13.1.1.3.1. *Date of Onset*

13.1.1.3.2. *Current Amounts*

13.1.1.3.3. *Date of last use/remission*

If you answered "Marijuana" on question 13.1.1

13.1.1.4.1. *Date of Onset*

13.1.1.4.2. *Current Amounts*

13.1.1.4.3. *Date of last use/remission*

If you answered "Ecstasy" on question 13.1.1

13.1.1.5.1. *Date of Onset*

13.1.1.5.2. *Current Amounts*

13.1.1.5.3. *Date of last use/remission*

If you answered "Over the Counter meds" on question 13.1.1

13.1.1.6.1. *Date of Onset*

13.1.1.6.2. *Current Amounts*

13.1.1.6.3. *Date of last use/remission*

If you answered "Sedatives/Hypnotics" on question 13.1.1

13.1.1.7.1. *Date of Onset*

13.1.1.7.2. *Current Amounts*

13.1.1.7.3. *Date of last use/remission*

If you answered "Opiates/Pain Killers (Heroin, Methadone, Oxycontin, Oxycodone, etc.)" on question 13.1.1

13.1.1.8.1. *Date of Onset*

13.1.1.8.2. *Current Amounts*

13.1.1.8.3. *Date of last use/remission*

If you answered "Tobacco" on question 13.1.1

13.1.1.9.1. *Date of Onset*

13.1.1.9.2. *Current Amounts*

13.1.1.9.3. *Date of last use/remission*

If you answered "Caffeine" on question 13.1.1

13.1.1.10.1. *Date of Onset*

13.1.1.10.2. *Current Amounts*

13.1.1.10.3. *Date of last use/remission*

If you answered "Amphetamine/Methamphetamine" on question 13.1.1

13.1.1.11.1. *Date of Onset*

13.1.1.11.1. *Date of Onset*

13.1.1.11.2. *Current Amounts*

13.1.1.11.3. *Date of last use/remission*

If you answered "Benzodiazepines" on question 13.1.1

13.1.1.12.1. *Date of Onset*

13.1.1.12.2. *Current Amounts*

13.1.1.12.3. *Date of last use/remission*

If you answered "Other Street Drugs" on question 13.1.1

13.1.1.13.1. *Date of Onset*

13.1.1.13.2. *Current Amounts*

13.1.1.13.3. *Date of last use/remission*

If you answered "Other" on question 13.1.1

13.1.1.14.1. *Date of Onset*

13.1.1.14.2. *Current Amounts*

13.1.1.14.3. *Date of last use/remission*

14. *Other Pertinent Substance Use or Dependence History*

CURRENT AND PRIOR TREATMENT (Mental Health and/or Co-Occurring)

1. *Inpatient (please note name of hospital and dates)*

2. *Outpatient (please note agency name, provider names, and dates)*

3. *Other*

MEDICAL HX AND UPDATES

1. *MEDICAL HX AND UPDATES (include relevant lab work and any known allergies)*

2. *Has this person ever had a brain injury?*
(Please select one.)
   - ○ Yes
   - ○ No

If you answered "Yes" on question 2

2.1.1. *Please explain*

3. *Does this person have a history of intellectual disability or cognitive challenges?*
(Please select one.)

(Please select one.)

- ○ Yes
- ○ No

If you answered "Yes" on question 3

3.1.1. *Explain:*

4. *Medications (both psychiatric and medical/please note current / any recent changes/who prescribes the medications)*

5. *Baseline behavior? How do you know when the client is doing well? Hobbies? Interests?*

6. *Education History and Current Status*

7. *Vocational History and Current Status*

8. *Please list any recent and pertinent assessments that have been done within the past three to six months such as Occupational Therapy, Neuropsychological, Psychosexual, or Psychiatric, or Psychological, including dates and assessor contact information or other relevant information*

Additional Information

1. *Does the member reside at the address specified on the patient detail page?*
(Please select one.)
   - ○ Yes
   - ○ No

If you answered "No" on question 1

1.2.1. *List the address:*

1.2.2. *List the city/town:*

2. *Is consumer currently experiencing homelessness?*
(Please select one.)
   - ○ Yes
   - ○ No

If you answered "Yes" on question 2

2.1.1. *Please indicate last known address*

2.1.2. *Town/City*

2.1.3. *Please indicate last known phone number*

Rules

Instructions: To keep this application ACTIVE, please call Office of Behavioral Health (OBH) (as provider or as client) to check in every 90 days. This referral will be considered INACTIVE if no contact (email, call or fax) is made by provider or client with SAMHS to follow up on this application. Below is the quoted MaineCare rule for Medical Necessity: 10-144 Chapter 101 Department of Health and Human Services MAINECARE BENEFITS MANUAL Chapter II Section 97 PRIVATE NON-MEDICAL INSTITUTION SERVICES ESTABLISHED 97.02-2 Medical Necessity Services in PNMIs must be medically necessary, as evidenced by meeting the medical eligibility criteria set forth in this section. A physician or primary care provider must also document in writing that this

model of service is medically necessary for the member, and both the physician and the PNMI provider must keep this documentation in the member's file. For all PNMI services, this documentation must be completed as part of the prior authorization process conducted by the Department and/or its Authorized Agent. Additional PNMI Provider Requirements: Accept all Referrals from the Department, in writing to SAMHS staff, within three (3) business days of receipt of Referral. Note: Section 277 of the Bates v. DHHS Consent Decree (Consent Decree) does not allow for the denial of a Referral without the Department's approval. Any such denial, which has not been approved, is a violation of this Agreement and may result in termination of this Agreement. Contact the individual being Referred and/or the legal guardian within seven (7) business days of receipt of this Referral. Confirm in writing to SAMHS Residential Team, once contact with individual and/or legal guardian has been made. Admit all individuals to the PNMI within thirty (30) calendar days of the receipt of Referral.