Behavioral Health CareConnection®

Tier I (Core) Data Collection Form

MEMBER DEMOGRAPHIC INFORMATION

Member Name: _____ Member ID: _____

Request Created By: _____

Clinician Name: _____ Clinician Phone Number: _____

REQUEST INFORMATION

Is this a Retrospective Auth Request? ☐ Yes ☐ No

MEMBER INFORMATION

Member ID: _____ Medicaid Number: _____

CareConnection®

Completion Date: _____ Case Status: ☐ New Admission ☐ Discharge ☐ Update ☐ Readmission of A Discharged Case ☐ Change in Level of Care ☐ Crisis

Member's First Name: _____ Middle _____ Last Name: _____

Member's Mailing Address: _____ City:_____ State:____ Zip Code: _____- _____

Date of Birth: _____ / _____ / _____ (M M D D Y Y Y Y) Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Member's County of Residence: _____ Marital Status: ☐ Single ☐ Divorced ☐ Unknown/Not Available ☐ Married ☐ Widow/Widower ☐ Separated ☐ Never Married

Member Referral Source:

- ☐ Advocacy Agency
- ☐ Alcohol Inpatient/Residential Program
- ☐ Behavioral Health
- ☐ Community Residential Organization
- ☐ Court or Correction Agency
- ☐ Developmental Disabilities Program
- ☐ Drug Abuse Inpatient Residential Program
- ☐ Drug Court
- ☐ Employer/Employee Assistance Program
- ☐ Family or Friend
- ☐ General Hospital Psychiatric Program
- ☐ Homeless/Abuse Shelter
- ☐ Individual / Self
- ☐ Information and Referral Agency
- ☐ Inpatient Residential Organization
- ☐ Mental Hygiene
- ☐ Multi-Disciplinary Team (MDT)
- ☐ Multi-Service Mental Health Agency
- ☐ Nursing Home / Extended Care
- ☐ Other Inpatient/Residential Program
- ☐ Other Physician
- ☐ Other Private Pay Mental Health Practitioner
- ☐ Other Referral Source
- ☐ Outpatient Alcohol Program
- ☐ Outpatient Drug Program
- ☐ Outpatient Psychiatric Agency
- ☐ Partial Day Organization
- ☐ Police
- ☐ Private Psychiatrist
- ☐ School System or Education Agency
- ☐ Social Services Agency
- ☐ State or County Psychiatric Program
- ☐ WV DHHR

Gender: ☐ Male ☐ Female

Member Participation Status: ☐ Voluntary ☐ Involuntary ☐ Emergent ☐ Court Ordered ☐ Observation

RESOURCES

Financial and Household Information (for BHHF Eligibility Only)

Gross Monthly Income: _____ Household Dependents: _____

CLINICAL INFORMATION: EVALUATION AND ASSESSMENT

Disability Group

- ☐ 1=Mental Health
- ☐ 2=Substance Abuse
- ☐ 3=Intellectual Disability/Developmental Disability
- ☐ 4=Mental Health & Substance Abuse
- ☐ 5=Mental Health & ID/DD
- ☐ 6=Substance Abuse & ID/DD
- ☐ 7=Mental Health, Sub Abuse & ID/DD
- ☐ 8=Early Childhood/Intervention
- ☐ 9=Public Inebriate

Diagnoses: Diagnosis One ___ ___ ___ . ___ ___ Diagnosis Two___ ___ ___ . ___ ___ Diagnosis Three ___ ___ ___ . ___ ___

Diagnosis Four ___ ___ ___ . ___ ___ Diagnosis Five___ ___ ___ . ___ ___

TREATMENT PLAN SUMMARY

Indicate the primary problem area to be addressed on the Consumer's current treatment plan

TX Plan Summary:

- ☐ ADL Skill Building
- ☐ Assessment/Evaluation Only
- ☐ Co-Occurring MH and Sub. Abuse Problems
- ☐ Interpersonal relations
- ☐ Maintaining ADL
- ☐ Maladaptive, antisocial behaviors
- ☐ Physical Health
- ☐ Psychiatric Symptoms
- ☐ Psychological Distress
- ☐ Sexualized behaviors
- ☐ Self-injurious or suicidal behaviors
- ☐ Substance abuse behaviors

TREATMENT PLAN STATUS

Indicate the current treatment/service plan status

Treatment Plan Type: ☐ Initial Plan ☐ Master Plan

Treatment Plan Status:

- ☐ Recent admission, initial plan
- ☐ Current plan maintained with no progress
- ☐ Current plan modified with changes in intensity of service.
- ☐ Current plan modified with changes in service array.
- ☐ Current plan modified with changes in both services and intensity
- ☐ Current plan maintained, Progress but goals not met

CASE DISCUSSION