mercy care

Adult HCTC Application

Name: _____ Age: _____

AHCCCS number _____ CIS ID# _____

DOB: _____ Current status: ☐ T19 ☐ NT19 ☐ SMI ☐ Under 18

Treating Doctor/NP, Name and phone number: _____ _____

Phone and email address of requesting physician: _____

SMI/Clinic: _____ Requesting clinician/ title:_____

CM/CC:_____

PLEASE TYPE ALL INFORMATION.

Current LOC: ☐ Connective ☐ Supportive ☐ ACT

Guardian/Advocate if applicable:

_____ DDD Case Manager ☐ Y ☐ N

Describe DDD Involvement:_____

Provide Payee:

_____

COT (Type check all that apply, Date): ☐ DTO ☐ DTS ☐ PAD ☐ GD

Start date _____end date _____

Current living/location of member: (i.e. inpatient, jail, placement, flex care, family, homeless):

Legal History (felony, sex offender (adult/child; level I, II, or III; flyered) :

Diagnosis including substance use /abuse/dependence and active substance use in the past 6 months:

Psychiatric

Diagnosis

Medical

Diagnosis

Please list any medical needs of this individual (wheelchair, CPAP, walker, etc.):

Current Psychiatric Medication List with Dosages and Effect:

Current Psychotropic Medications

Name of medication	Dose	Effect/ duration of trial	Target symptoms/behaviors

Medical Medications:

Name of medication	Dose	Effect/ duration of trial

Current psychiatric and medical services: with frequency of each/ dates of service provided and effect,
Prior services provided with effect (within past year):

Type of Service	Exact Dates of Service	Effect	Targets for TX

Clinical summary including specific symptoms and duration/ stressors/ complicating issues in the past 3 months:

Risk of Harm in the past 3 months: please give dates and examples.
What is current/ imminent risk to self or others (Also include self-harm such as cutting, burning, etc.)? Please include: Suicidal/homicidal ideation i.e. ,with or without plan and/or intent including dates and a detailed description

What is current/ imminent risk to self or others? Please include details/ dates:

What psychiatric behaviors are occurring regarding impulsivity with poor judgment/insight: (for the past 3 months) Include dates and description

What psychiatric behaviors threaten health and functioning?(in the past 3 month)
Include dates and description

Functioning in the past 3 months: please describe serious impairment of function that is directly caused by psychiatric symptoms and persists in the absence of stressors and impairs recovery.

Please specifically identify: Provide information on inability to independently self-administer medically necessary psychotropic and/or medical medications without rehabilitative or habilitative interventions including dates and description

Provide information on neglect or disruption of ability to attend to majority of basic needs (personal safety, hygiene, nutrition, medical care) without rehabilitative or habilitative interventions Including dates and description

ACTIVITIES OF DAILY LIVING ASSESSMENT
Please answer the below items based on the below scale: 1 = Member Is not able to complete/perform the task 2 = Member needs constant oversight to complete/perform the task 3 = Member needs some oversight to complete/perform the task 4 = Member is able to perform the task independently

	1	2	3	4
HOME MANAGEMENT				
Able to keep place of living clean (vacuuming, dishes, dusting, cleaning, bathroom, room, sweeping, moping).	☐	☐	☐	☐
Able to wash clothes (sort clothing, laundry facilities, and money).	☐	☐	☐	☐
Are there any other skills needed in the home management area:				
HEALTH AND SAFETY				
Able to recognize potential dangers and avoid harm	☐	☐	☐	☐
Able to use appropriate emergency services (911, crisis, emergency department, case manager, fire, doctor).	☐	☐	☐	☐
Can identify and complete a plan in case of emergencies (fire, electrical).	☐	☐	☐	☐
Can understand and is knowledgeable of basic first aid without supervision	☐	☐	☐	☐
Is aware of their personal safety (doors locked, use caution with strangers).	☐	☐	☐	☐

	1	2	3	4
Able to handle potentially violent and/or threatening situations in an appropriate manner.	☐	☐	☐	☐
Requires 24 hours monitoring due to overnight dangers (indicate specifics below)	☐	☐	☐	☐

Wandering due to psychiatric symptoms ☐ *(Attach supportive documentation; e.g. progress notes)*	Last date(s) of occurrence
Cognitive Impairments without rehabilitative or habilitative intervention ☐	Last date(s) of occurrence
Cooking on Stove ☐	Last Date(s) of occurrence

Please explain any unsafe overnight behaviors *(attach supportive documentation; e.g. progress notes)*:

PERSONAL HYGIENE, MEDICATION and HEALTH AWARENESS

Able to select an appropriate wardrobe (weather, socially acceptable, events, activities).	☐	☐	☐	☐
Able to recognize and maintain good hygiene habits daily.	☐	☐	☐	☐
Uses hygiene products daily for grooming techniques including hair, dental, bathing.	☐	☐	☐	☐
Can contact the pharmacy for prescriptions and manage his/her prescriptions in their home	☐	☐	☐	☐
Can self-administer and take medications as prescribed (daily) without rehabilitative or habilitative interventions	☐	☐	☐	☐
Able to understand side effects and coordinate/communicate with their prescriber as needed	☐	☐	☐	☐

Are there any other skills needed in the personal hygiene and health awareness area:

MEAL PREPARATION

Understands how nutrition impacts physical and mental health.	☐	☐	☐	☐
Able to grocery shop on their own (budget, grocery list).	☐	☐	☐	☐
Knows how to store and handle food to avoid sanitation concerns or eating unsafe items.	☐	☐	☐	☐
Able to cook simple/basic meals (i.e. stove top or microwave meals)	☐	☐	☐	☐
Able to use a stove, microwave, oven, etc.	☐	☐	☐	☐

	1	2	3	4
Are there any other skills needed in the meal preparation area: area:				
MONEY MANAGEMENT and LEGAL				
Understands the impact of how paying bills on time can impact credit	☐	☐	☐	☐
Can budget their money (daily, weekly or monthly budget, comparison shopping).	☐	☐	☐	☐
Able to open a checking account.	☐	☐	☐	☐
Can maintain their checking account and understand their Benefits (SSI/SSDI, Food stamps)	☐	☐	☐	☐
Does guardianship need to be explored for this member? No ☐ Yes ☐				
Needs a payee? No ☐ Yes ☐				
If payee is needed what is the status of request:				
TIME MANAGEMENT				
Can organize and establish priorities in order of importance.	☐	☐	☐	☐
Is able to manage their time so as to attend appointments and other responsibilities.	☐	☐	☐	☐
Able to use and read a clock to plan activities.	☐	☐	☐	☐
Can use a calendar to schedule appointments (doctor, groups, community activities, work, and school).	☐	☐	☐	☐
Are there any other skills needed in the time management area:				
SOCIALIZATION SKILLS				
Can recognize and avoid dangerous and abusive relationships and friendships.	☐	☐	☐	☐
Able to understand social etiquette (social cues, triggers, boundaries, personal space).	☐	☐	☐	☐
Able to learn how to inter-act and deal with others.	☐	☐	☐	☐
Can use proper coping skills when dealing with stressful situations.	☐	☐	☐	☐
Are there any other skills needed in the socialization skills area:				

	1	2	3	4
COMMUNITY SERVICES AND TRANSPORTATION				
Knows how to find information on and attend social events and activities (12 step, support groups, hobbies, and church groups).	☐	☐	☐	☐
Knows how and where to get identification cards and benefits (Birth certificate, ID, bus card, AHCCCS card, food stamp card, Social security card).	☐	☐	☐	☐
Able to use public services (bus, bus book, maps, cabs, light rail, dial-a-ride, and the orbit).	☐	☐	☐	☐

Provide information on frequency of inpatient psychiatric admissions or legal involvement Including dates and description

Expected improvement: Please provide clear and specific Measurable goals for placement and how this patient will be able to meet these goals given any issues that are a baseline for this patient (i.e.: cognitive disabilities etc.) What will be expected functioning ability at the time of discharge from residential treatment?

What environment will the member transition to at the time of discharge from residential treatment (i.e. living setting : independent living, community living placement, return to family, etc.)?

Discharge Plan: Aftercare plan to include recommendations from all members of the team including treating doctor/ NP ***(Please state specific goals)***

The discharge plan will be provided at the time of admission and reassessed with each concurrent review.

The discharge plan includes a description of the setting /placement that may meet the resident's assessed and anticipated needs after discharge

Please provide a detailed plan for d/c goals for the member from residential treatment?

How will these goals be met and then maintained at d/c from residential treatment?

Where will patient reside after d/c from residential treatment and what treatment will be provided? (Please list 3 prospective placement options post discharge from residential treatment)

The discharge plan will be provided at the time of admission and reassessed with each concurrent review.

The discharge plan includes a description of the setting /placement that may meet the resident has assessed and anticipated needs after discharge.

Please provide information:

- Last 6 months psychiatric practitioner notes
- Psychiatric evaluation in past year
- ISP in the past year from primary provider
- ISP from hospital/ current placement.
  All notes of services provided and effect on target symptoms for last 3 months
- Targeted treatment goals listed
- There is evidence that the individual has agreed to and is willing to participate in treatment. The member/guardian has signed an informed consent acknowledging that residential is a time-limited placement for active treatment prior to authorization of this service.
- Signed informed consent from member /guardian that the member has been informed that residential services is a time-limited placement for active treatment.

Please provide any other information that is pertinent/relevant to this case:

EXCLUSION CRITERIA

The admission to a BH Residential Facility is not used primarily and therefore clinically inappropriately, as:

1. An alternative to incarceration, or as a means to ensure community safety in an individual exhibiting primarily antisocial behavior; or

2. The equivalent of safe housing, permanent placement, or an alternative to guardians' or other agencies' ability or willingness to provide for the adult; or

3. As a behavioral health intervention when other less restrictive alternatives are available and meet the member's treatment needs.

4. As a primary placement to provide ongoing personal care services where habilitative and rehabilitative interventions are required.

NAME of Behavioral Health Medical provider: _____

SIGNATURE/ DATE: _____

NAME of person completing this form:

SIGNATURE/DATE: _____

NAME of member: _____

☐ This application has been reviewed and the member/guardian is in agreement.