

APPENDICES

2008-005

Behavioral Health Services

APPENDIX I

DISCLOSURE STATEMENT

**APPENDIX I
FORMS**
(Behavioral Health)

ORGANIZATION STRUCTURE AND FINANCIAL PLANNING FORM

1) If other than a government agency:

a) When was your organization formed?

b) If your organization is a corporation, attach a list of the names and addresses of the Board of Directors.

2) License/Certification

a) Indicate all licenses and certifications (i.e., Federal HMO status or State certifications) your organization maintains. Use a separate sheet of paper using the following format:

<u>SERVICE COMPONENT</u>	<u>LICENSE /REQUIREMENT</u>	<u>RENEWAL DATE</u>
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b) Have any licenses been denied, revoked or suspended?

Yes _____ No _____ If yes, please explain:

3) Civil Rights Compliance Data

Has any Federal or State agency ever made a finding of noncompliance with any relevant civil rights requirements with respect to your program?

Yes _____ No _____ If yes, please explain:

4) Handicapped Assurance

Does your organization provide assurance that no qualified handicapped person will be denied benefits of or excluded from participation in a program or activity because the offeror's facilities (including subcontractors) are inaccessible to or unusable by handicapped persons?

(note: Check with Local Zoning ordinances for handicapped requirements.)

Yes _____ No _____

If yes, briefly describe how such assurance is provided.

If no, briefly describe how your organization is taking affirmative steps to provide assurance.

5) Prior Convictions

List all felony convictions of any key personnel (i.e., Chief Executive Officer, Plan Manager, Financial Officers, major stockholders or those with controlling interest, etc.). Failure to make full and complete disclosure shall result in the rejection of your proposal as unresponsive.

6) Federal Government Suspension/Exclusion

Has offeror been suspended or excluded from any federal government programs for any reason?

Yes _____

No _____

If yes, please explain:

FINANCIAL PLANNING FORM

- 1) Is the offeror's accounting system based on a cash, accrual or modified method?
- (a) Cash []
(b) Accrual []
(c) Modified [] give brief explanation

- 2) Does the offeror prepare an annual financial statement?
Yes _____ No _____ If yes, provide a copy of the latest report.

- 3) Are interim financial statements prepared? Yes _____ No _____
- a) If yes, how often are they prepared? _____
- b) If yes, are footnotes and supplementary schedules an integral part of the statements? Yes _____ No _____
- c) If yes, are actuals analyzed and compared to budgeted amounts?
Yes _____ No _____
- d) If yes, provide a copy of the latest statements including all necessary data to support your answers in (a) through (c) above.

- 4) Is the offeror audited by an independent accounting firm/accountant?
Yes _____ No _____

- a) If yes, how often are audits conducted? _____
- b) By whom are they conducted? _____
- c) Did this auditor perform the offeror's last audit?
Yes _____ No _____

If no, provide the name, address and telephone number of the firm that performed the offeror's last audit.

d) Are management letters on internal controls issued by the accounting firm?

Yes _____ No _____

If yes, attach a copy of the management letter from the latest audit. This must be on the auditor's letterhead and the offeror, by its submission, certifies the letter is unaltered.

If no, the offeror shall provide a comprehensive description of internal control systems. The offeror is responsible for instituting adequate procedures against irregularities and improprieties and enforcing adherence to generally accepted accounting principles.

e) Do you have any uncorrected audit exceptions? Yes _____ No _____

If yes, provide a copy of the auditor's management letter (see 4 [d] of this form for instructions regarding submittal).

5) Does the offeror have an accounting manual? Yes _____ No _____

If no, the offeror must explain, if it has proper accounting policies and procedures, and how it provides for the dissemination of such accounting policies and procedures within its organization and what controls exist to ensure the integrity of its financial information. The offeror agrees to furnish copies of such written accounting policies and procedures for inspection upon request from DHS.

6) Does the offeror have a formal basis to allocate indirect costs reflected in your financial statement? Yes _____ No _____

Explain principal allocation techniques used or to be used. Note the allocation base used for each type of cost allocated.

7) What types of liability insurance does the offeror have?

(a) With what Company(s)? _____

(b) What is the amount of coverage for each type of insurance?

\$ _____

8) Provide a complete analysis of revenues and expenses by business segment (lines of business) and by geographic area (by county) for the offeror or its owner(s).

- 9) Are there any suits, judgments, tax deficiencies, or claims pending against the offeror? Yes _____ No _____

Briefly describe each item and indicate probable amount.

\$ _____

- 10) Has the offeror or its owner(s) ever gone through bankruptcy?

Yes _____ No _____

When? _____

- 11) Do(es) the offeror's owner(s) intend to provide all necessary funds to make full and timely payments for liabilities (reported or not recognized)?

Yes _____ No _____

If yes, describe the dollar amount(s) and source(s) of all funding.

If no, briefly describe how your organization is taking affirmative steps to provide funding.

- 12) Does the offeror have a performance bonding mechanism in accordance with DHS Rules? Yes _____ No _____

If yes,

Amount of Bond: \$ _____
Term of Bond: _____ Term of Bond: _____
Bonding Company: _____
Restrictions on Bond: _____

If no, describe how the offeror intends to provide a bond and/or security to meet established DHS Rules.

- 13) Does the offeror have a financial management system to account for incurred, but not reported liabilities? Yes _____ No _____

If no, the offeror must describe in detail (and attach this description to this form) how it intends to manage, monitor and control IBNR's. The offeror, regardless of response (either yes or no) must complete items "a" through "h" below.

- a) Is your system capable of accurately forecasting all significant claims prior to receipt of all billing? Yes _____ No _____
- b) How often are IBNR's projected? _____
- c) Identify all major data sources most often used.
- d) Are data from open referrals and prior notifications used?
Yes _____ No _____ If so, how?
- e) Are detailed written procedures maintained? Yes _____ No _____
- f) Are IBNR amounts compared with actuals and adjusted when necessary?
Yes _____ No _____
- g) Is the basis of periodic IBNR estimates well documented?
Yes _____ No _____
- h) The offeror must provide a copy of their IBNR procedures and a summary of their IBNR practices. If these procedures do not adequately support any response to this item the offeror is cautioned to provide additional data.

Please identify the developer and name of any computerized IBNR system utilized. Indicate if it is administered by internal or external staff. If administered by external staff, state by whom, define how the offeror will control this function. Specify what other IBNR estimation methods will be used to test the accuracy of IBNR estimates, along with the primary system previously identified. (For the purposes of this item "administered" refers to either performing computer related operations or to providing direct supervision of staff operating a system).

14) Does the offeror have a full-time (100%) controller or chief financial officer?

Yes _____ No _____ If yes, Enter Name: _____

15) Are the following items reported on the offeror's financial statements?

- a) Medicare Reimbursement Yes _____ No _____
- b) Other third-party recoveries Yes _____ No _____

If no, explain why.

16) Was an actuarial firm used to assist in developing capitation rates?

Yes _____ No _____ If yes, what is the name of actuary and actuarial firm.

_____, _____
Actuary Actuarial Firm

17) Did a firm or organization provide the offeror with any assistance in making this offer (to include developing capitation rates or providing any other technical assistance)?

Yes _____ No _____

If yes, what is the name of this firm?

Name

Address

FINANCIAL PERFORMANCE FORM

The offeror must indicate its current status for each measure (based on their most recent audited financial statements below).

<u>FINANCIAL MEASURES</u>	<u>OFFERORS</u> <u>CURRENT STATUS*</u>		<u>TARGET</u> <u>VIABILITY CRITERIA</u>
	<u>(Audited)</u>	<u>(Unaudited)</u>	
Working Capital Ratio	_____	_____	At Least .90
Equity per Enrollee	_____	_____	At Least \$100.
Net Medical Costs as a % of Capitation Revenues	_____	_____	No More Than 88% (plans over 8,000 members) No More Than 86% (small plans of 8,000 members and under)
Administrative Costs (To include Contingencies) as a % of Capitation Revenues	_____	_____	No More Than 8% (plans over 8,000 members) No More Than 8% (small plans of 8,000 members and under)
Day Claims Outstanding	_____	_____	No More Than 90 days (IBNRs) No More Than 45 Days (RBUCS)
	_____	_____	

*Audited Current Status means measures developed from offeror audited financial statements for the most recently completed fiscal year. Unaudited Current Status means measures developed from the most recent year-to-date offeror internally prepared financial statements. All changes of more than 2% for working capital, \$10 for equity per enrollee, 3% for net medical cost, 2% for administrative cost, or 10 days for claims outstanding must be explained in written narrative and submitted as part of the offeror's response to this request for proposal.

A new offeror is to project these ratios based on its financial plan. Insert the projected ratios in the "Unaudited" column.

DISCLOSURE STATEMENT (CMS REQUIRED)

DHS may refuse to enter into a contract and may suspend or terminate an existing contract, if the offeror fails to disclose ownership or controlling information and related party transaction as required by this policy.

Financial Disclosure requirements in accordance with 42 CFR 455.100 through 455.106 are:

455.104 Information on Ownership & Control

- (1) The name and address of each person with an ownership or controlling interest in the disclosing entity.
- (2) The name and address of each person with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of five (5) percent or more.
- (3) Names of persons named in (a) and (b) above who are related to another as spouse, parent, child or sibling of those individuals or organizations with an ownership or controlling interest.
- (4) The names of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest.

455.105 Information Related to Business Transactions

- (5) The ownership of any subcontractor with whom the offeror has had business transactions totaling more than \$25,000 during the past 12-month period.
- (6) Any significant business transactions between the offeror and any wholly owned supplier or between the offeror and any subcontractor during the past five-year period.

455.106 Information on Persons Convicted of Crimes

- (7) Name of any person who has an ownership or controlling interest in the offeror, or is an agent or managing employee of the offeror, and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

b) Additional information which must be disclosed to DHS is as follows:

- (1) Names and addresses of the Board of Directors of the disclosing entity.
- (2) Name, title and amount of compensation paid annually (including bonuses and stock participation) to the ten (10) highest management personnel.
- (3) Names and addresses of creditors whose loans or mortgages are secured by a five (5) percent or more interest in the assets of the disclosing entity.

c) Additional Related Party Transactions which must be disclosed to DHS is as follows:

- (1) Describe transactions between the disclosing entity and any related party in which a transaction or series of transactions during any one (1) fiscal year exceeds the lesser of \$10,000 or two (2) percent of the total operating expenses of the disclosing entity. List property, goods, services, and facilities involved in detail. Note the dollar amounts or other consideration for each item and the date of the transaction(s). Also include justification of the transaction(s) as to the reasonableness, potential adverse impact on the fiscal soundness of the disclosing entity, and the nature and extent of any conflict of interest. This requirement includes, but is not limited to, the sale or exchange, or leasing of any property; and the furnishing for consideration of goods, services or facilities.
- (2) Describe all transactions between the disclosing entity and any related party which includes the lending of money, extensions of credit or any investments in a related party. This type of transaction requires advance administrative review by the Director before being made.
- (3) As used in this section, "related party" means one that has the power to control or significantly influence the offeror, or one that is controlled or significantly influenced by the offeror. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers,

parent companies, sister companies, holding companies, and other entities controlled or managed by any of such entities or persons.

42 CFR 455.101 DEFINITIONS

- a) "Agent" means any person who has been delegated the authority to obligate or act on behalf of a provider.
- b) "Convicted" means that a judgment of conviction has been entered by a Federal, State or local court, regardless of whether an appeal from that judgment is pending.
- c) "Disclosing entity" means a QUEST provider or health plan.
- d) "Other disclosing entity" means any other QUEST disclosing entity and any entity that does not participate in QUEST but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Social Security Act. This includes:
 - (1) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
 - (2) Any Medicare intermediary or carrier; and
 - (3) Any entity that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XIX of the Social Security Act.
- e) "Fiscal agent" means a contractor that processes or pays vendor claims on behalf of DHS.
- f) "Group of practitioners" means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).
- g) "Indirect ownership interest" means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.
- h) "Managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or

managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

- i) "Ownership interest" means the possession of equity in the capital, the stock, or the profits of the disclosing entity.
- j) "Person with an ownership or controlling interest" means a person or corporation that:
 - (1) Has an ownership interest totaling five (5) percent or more in a disclosing entity;
 - (2) Has an indirect ownership interest equal to five (5) percent or more in a disclosing entity;
 - (3) Has a combination of direct and indirect ownership interests equal to five (5) percent or more in a disclosing entity;
 - (4) Owns an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five (5) percent of the value of the property or assets of the disclosing entity;
 - (5) Is an officer or director of a disclosing entity that is organized as a corporation; or
 - (6) Is a partner in a disclosing entity that is organized as a partnership.
- k) "Significant business transaction" means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and five (5) percent of an offeror's total operating expenses.
- l) "Subcontractor" means:
 - (1) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
 - (2) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the DHS agreement.

- m) "Supplier" means an individual, agency, or organization from which a Provider purchases goods and services used in carrying out its responsibilities under its DHS contract (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).
- n) "Wholly owned subsidiary supplier" means a subsidiary or supplier whose total ownership interest is held by an offeror or by a person, persons, or other entity with an ownership or controlling interest in an offeror.

DISCLOSURE STATEMENT

PLAN NAME/NO. _____
DISCLOSURE STATEMENT FOR THE YEAR ENDED _____

I hereby attest that the information contained in the Disclosure Statement is current, complete and accurate to the best of my knowledge. I also attest that these reported transactions are reasonable, will not impact on the fiscal soundness of the Health Plan, and are without conflict of interest. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the statement may be prosecuted under applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate in QUEST.

Date Signed

Chief Executive Officer
(Name and Title Typewritten)

Notarized

Signature

**DISCLOSURE STATEMENT
OWNERSHIP**

Health Plan Name, Plan No.: _____
Address (City, State, Zip): _____
Telephone: _____

For the period beginning: _____ and ending _____

Type of Health Plan:

- Staff – A health plan that delivers services through a group practice established to provide health services to health plan members; doctors are salaried.
- Group – A health plan that contracts with a group practice to provide health services; the group is usually compensated on a capitation basis.
- IPA – A health plan that contracts with an association of doctors from various settings (some solo practitioners, some groups) to provide health services.
- Network – A health plan that contracts with two or more group practices to provide health services.

Type of Entity:

- | | |
|---|---|
| <input type="radio"/> Sole Proprietorship | <input type="radio"/> For-Profit |
| <input type="radio"/> Partnership | <input type="radio"/> Not-For-Profit |
| <input type="radio"/> Corporation | <input type="radio"/> Other (Specify) _____ |
| <input type="radio"/> Governmental | |

455.104 Information on Ownership and Control

- a. List the names and addresses of any individuals or organizations with an ownership or controlling interest in the disclosing entity. "Ownership interest" means the possession of equity in the capital, the stock, or the profits of disclosing entity, directly or indirectly.

<u>Name</u>	<u>Address</u>	<u>Percent of Ownership of Control</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- b. List the names and addresses of any individuals or organizations with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of five (5) percent or more.

<u>Name</u>	<u>Address</u>	<u>Percent of Ownership of Control</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- c. Names of persons named in (a) and (b) above who are related to another as spouse, parent, child, or sibling of those individuals or organizations with an ownership or controlling interest.

- d. List the names of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest.

455.105 Information Related to Business Transactions

- e. List the ownership of any subcontractor with whom the offeror has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request.

<u>Describe Ownership of Subcontractors</u>	<u>Type of Business Transaction with Provider</u>	<u>Dollar Amount of Transaction</u>

- f. List any significant business transactions between the offeror and any wholly owned supplier or between the offeror and any subcontractor during the five-year period ending on the date of the request.

<u>Describe Ownership of Subcontractors</u>	<u>Type of Business Transaction with Provider</u>	<u>Dollar Amount of Transaction</u>

455.106 Information on Persons Convicted of Crime

- g. List the names of any person who has ownership or controlling interest in the offeror, or is an agent or managing employee of the offeror and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.

<u>Name</u>	<u>Address</u>	<u>Title</u>

2. Additional information which must be disclosed to DHS as follows:

a. List the names and addresses of the Board of Director of the Plan.

Name/Title

Address

b. Names and titles of the ten (10) highest paid management personnel including but not limited to the Chief Executive Officer, the Chief Financial Officer, Board of Chairman, Board of Secretary, and Board of Treasurer:

Name/Title

Address

- c. List names and addresses of creditors whose loans or mortgages exceeding five percent (5) and are secured by the assets of the Health Plan.

<u>Name</u>	<u>Address</u>	<u>Amount of Debt</u>	<u>Description of Security</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DISCLOSURE STATEMENT

a. Instructions

DHS is concerned with monitoring the existence of related party transactions in order to determine if any significant conflicts of interest exist in the offeror's ability to meet QUEST objectives. Related party transactions include transactions which are conducted in an arm's length manner or are not reflected in the accounting records at all (e.g., the provision of services without charge).

Transactions with related parties maybe in the normal course of business or they may represent something unusual for the offeror. In the normal course of business, there may be numerous routine and recurring transactions with parties that meet the definition of a related party. Although each party may be appropriately pursuing its respective best interests, this is usually not objectively determinable. In addition to transactions in the normal course of business, there may be transactions which are neither routine nor recurring and may be unusual in nature or in financial statement impact.

- 1) Describe transactions between the offeror and any related party in which a transaction or series of transactions during any one (1) fiscal year exceeds the lesser of \$10,000 or two (2) percent of the total operating expenses of the disclosing entity. List property, goods, services and facilities in detail noting the dollar amounts or other consideration for each and the date of the transaction(s) including a justification as to the reasonableness of the transaction(s) and its potential adverse impact on the fiscal soundness of the disclosing entity.

- a) The sale or exchange, or leasing of any property:

<u>Description of Transaction(s)</u>	<u>Name of Related Party and Relationship</u>	<u>Dollar Amount for Reporting Period</u>

Justification

b) The furnishing for consideration of goods, services or facilities:

<u>Description of Transaction(s)</u>	<u>Name of Related Party and Relationship</u>	<u>Dollar Amount for Reporting Period</u>
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Justification

2. Describe all transactions between the disclosing entity and any related party which includes the lending of money, extensions of credit or any investments in a related party. This type of transaction requires advance administrative review by the Director before being made.

<u>Description of Transaction(s)</u>	<u>Name of Related Party and Relationship</u>	<u>Dollar Amount for Reporting Period</u>
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Justification

CONTROLLING INTEREST FORM

The offeror must provide the name and address of any individual which owns or controls more than ten percent (10%) of stock or that has a controlling interest (i.e., about to formulate, determine or veto business policy decisions, etc.). Failure to make full disclosure may result in rejection of the offeror's proposal as unresponsive.

<u>NAME</u>	<u>ADDRESS</u>	<u>OWNER OR CONTROLLER</u>	HAS CONTROLLING INTEREST	
			<u>YES</u>	<u>NO</u>

BACKGROUND CHECK INFORMATION

The offeror must provide sufficient information concerning key personnel (i.e., Chief Executive Officer, Medical Director, Financial Officer, Consultants, Accountants, Attorneys, etc.) to enable DHS to conduct background checks. Failure to make full and complete disclosure may result in rejection of your proposal as unresponsive. Attach resumes for all individuals listed below.

<u>NAME**</u>	EVER KNOWN BY ANOTHER NAME*	SOCIAL SECURITY DATE OF BIRTH	PLACE OF BIRTH
YES _____ NO _____	ACCOUNT NUMBER	(DA/MO/YR)	CITY/COUNTRY /STATE

* If yes, provide all other names. Use a separate sheet if necessary.

**For each person listed:

- a) give addresses for the last 10 years
- b) ever suspended from any federal program for any reason?

Yes No If yes, please explain.

NETWORK CERTIFICATION FORM

I hereby certify that _____
will have in place on the commencement date of this contract a network of physicians,
hospitals, clinics and other providers which meets the requirements set forth in the
Request for Proposal.

I understand that the Offeror must notify DHS within one working day of a network
deficiency. Notice will include the emergency arrangements to provide patient care and
the expected resolution of the deficiency. Such notice is required for a deficiency
identified at any time after the contract award is made.

I further understand that compliance with submission of network information in tape
format, in accordance with QIS magnetic tape specifications for providers is mandatory.

I further understand that medical services must be available and accessible and that
failure to make appointments available in accordance with DHS standards may result in
financial sanctions.

I further understand that compliance with network requirements is subject to review and
audit by DHS and deficiencies are subject to sanctions in accordance with DHS Rules.

Authorized Signature

Date

Printed Name

Title

OPERATIONAL CERTIFICATION SUBMISSION

The offeror must complete the attached certification as documentation that it shall maintain member handbook, appointment procedures, referral procedures and other operating requirements in accordance with either DHS rule(s) or policies and procedures.

By signing below the offeror certifies that it shall at all times during the term of this contract provide and maintain member handbook, appointment procedures, referral procedures, quality assurance program, utilization management program and other operating requirements in accordance with either DHS rule(s) or policies and procedures. The offeror warrants that in the event DHS discovers, through an operational review, that the offeror has failed to maintain these operating procedures, the offeror will be subject to a non-refundable, non-waivable sanction in accordance with DHS Rules.

Signature

Date

GRIEVANCE SYSTEM FORM

The offeror must complete the form below and submit with this proposal.

I hereby certify that _____
(Offeror Name)

will have in place on the commencement date of this contract a system for reviewing and adjudicating grievances by recipients and providers arising from this contract in accordance with DHS Rules and as set forth in the Request for Proposal.

I understand such a system must provide for prompt resolution of grievances and assure the participation of individuals with authority to require corrective action.

I further understand the offeror must have a grievance policy for recipients and providers which defines their rights regarding any adverse action by the offeror. The grievance policy shall be in writing and shall meet the minimum standards set forth in this Request for Proposal.

I further understand evaluation of the grievance procedure shall be conducted through documentation submission, monitoring, reporting, and on-site audit, if necessary, by DHS and deficiencies are subject to sanction in accordance with DHS rules.

Authorized Signature

Date

Printed Name

Title

MEDICAL PLAN INFORMATION

This section requests descriptive information about internal clinical management systems. Medical plans should feel free to include additional information which they regard as pertinent.

I. Descriptive Information on the Provider Network

Purpose: The plan physicians have primary responsibility for the delivery of care. This section provides information on the following: qualifications of the medical network, physician turnover, and compensation and risk sharing arrangements.

A. Board Certification

% primary care physician board certified _____
 % specialists board certified in the specialty
 which they predominantly practice _____

B. Turnover in Medical Network

% primary care physicians whose contracts
 were terminated during the last year _____

Please explain any unusual increases in medical turnover.

C. Recredentialing

Which of the following does your plan verify with primary sources:

_____ State licensure
 _____ board certification, if applicable
 _____ current, adequate malpractice insurance

D. Physician Compensation

- Please identify the percentage of primary care physicians in your network that are compensated through each of the following payment mechanisms:

<u>Percent</u>	<u>Payment Mechanism</u>
_____	Salary
_____	Fee-for-service with withhold: _____ % withhold
_____	Fee-for-service with bonus: Range: ___ to ___ % bonus
_____	Capitated
_____	Capitated with withhold: _____ % withhold
_____	Capitated with bonus: Range: ___ to ___ % bonus
_____	Other, please describe: _____

2. If the plan uses capitation:

Are physicians capitated as individuals or as part of an affiliated medical group or pool? _____

If physicians are capitated as individuals, what services are included in the primary capitation? _____

E. Please provide any descriptive information on your plan's provider policies or procedures, or specific circumstances that might be helpful in interpreting the above information. Examples include:

- Method of determining the adequacy of physicians, both in terms of number and geographic location.
- Circumstances surrounding the revocation of any provider privileges or any unusual turnover in the provider network.
- Procedures and processes for medical provider review.
- Continuing medical education programs.

II. Clinical Management

Medical plans have various systems and management programs in place to promote and assure the provision of appropriate patient care. These include: quality assessment and improvement programs, case management programs, utilization management programs and risk management programs. The purpose of this section is to obtain descriptive information on these aspects of the plan's clinical management systems.

Quality Assessment and Improvement

A. Quality Performance Measures

1. What important aspects of care are being monitored and evaluated in an ongoing fashion?
2. Please summarize the QA studies completed in the last three years.
3. In which areas does your plan perceive problems?
4. Please describe the 10 most important actions your plan has taken in the last year, based on QA data, to improve performance.

- B. How does your plan improve the care of the population you service? Include examples of any tools or practice guidelines used, descriptions of programs in place, and any innovative ideas your plan has implemented.

Preventive Care and Health Promotion

- D. Identify the health promotion/education programs provided by your medical plan and the number of enrollees that participated in each program during the prior year.
- E. Please provide a list of any preventive services that your plan monitored during the last year. (Attach summaries of the results of these efforts.)

Utilization Management

- H. Please describe your plan's utilization management policies and procedures with regard to:
- Preauthorization of services, if applicable.
 - Review of appropriateness of denials.
 - Specialty consultation.
 - Concurrent review.
 - Retrospective review.
 - Decision screens and protocols (e.g., updating, validation, availability to providers).
 - Provider and patient appeals processes.
- I. When was the last time your plan critically reviewed its utilization management policies and procedures?

Risk Management

- J. How did risk management activities impact your plan's quality assurance and utilization management activities during the past year? Describe the most significant areas of loss prevention/control identified during the last year and what actions were implemented to improve these areas.

DESCRIPTIVE INFORMATION: ACCESS

Medical plans are asked to provide descriptive information on physician availability, medical plan standards for assuring access, results of access monitoring activities and actions taken to improve access.

1. Number and percent of physicians accepting additional members to their panel as of report date:

_____ # _____ %

2. Does your plan have established standards for access? Please include documentation as an attachment and summarize the information below if applicable:

	<u>Actual</u>	<u>Standard</u>
<input type="checkbox"/> Waiting time for non-urgent, symptomatic office visit?	_____	_____
<input type="checkbox"/> Waiting time for routine visits?	_____	_____
<input type="checkbox"/> Waiting time for urgent care visits?	_____	_____
<input type="checkbox"/> Waiting time for emergency care?	_____	_____

How does your plan measure its performance in each of the areas listed above. Please attach the results of monitoring activities during the prior year.

3. What are your plan's standards for telephone access? Are you meeting them? If not, what is your action plan to meet them?
4. How does a patient access a provider for urgent or emergency care outside normal operating hours?
5. Please describe what actions your plan has taken during the last year to encourage appropriate access to care.

WAGE CERTIFICATION

Pursuant to Section 103-55, Hawaii Revised Statutes, I hereby certify that if awarded the contract in excess of \$25,000, the services to be performed will be performed under the following conditions:

1. The services to be rendered shall be performed by employees paid at wages or salaries not less than wages paid to the public officers and employees for similar work, if similar positions are listed in the classification plan of the public sector.

2. All applicable laws of the Federal and State governments relating to worker's compensation, unemployment insurance, payment of wages, and safety will be fully complied with.

I understand that all payments required by Federal and State laws to be made by employers for the benefit of their employees are to be paid in addition to the base wages required by Section 103-55, HRS.

Offeror: _____

Signature: _____

Title: _____

Date: _____

INSURANCE

Offeror shall provide the following:

1. Commercial General Liability Insurance is provided by:

Insurance Company _____

Coverage _____

2. Reinsurance is provided by:

Insurance Company _____

Coverage _____

3. Other forms of insurance will be provided by:

Type: _____

Insurance Company _____

Coverage _____

Type: _____

Insurance Company _____

Coverage _____

Type: _____

Insurance Company _____

Coverage _____

Offeror: _____

APPENDIX J QUALITY IMPROVEMENT PROGRAM (QIP)

The offeror must provide a copy of its written QIP.

The offeror must describe its QIP by providing responses as indicated. Please be as concise as possible. No other format will be accepted.

WRITTEN QIP DESCRIPTION

- List the QI goals and objectives and a timetable for implementation. Explain how these will be evaluated and the process to be used to do a required annual review of goals and objectives.

RESPONSE:

- Explain how you will address, evaluate, and review both the quality of clinical care and the quality of non-clinical aspects of service such as availability, accessibility, coordination and continuity of care.

RESPONSE:

- Describe the methodology which will be used to review the entire range of care which a MCO provides--all demographic groups, care settings (inpatient, ambulatory, home) and types of services (preventive, primary, specialty care)

RESPONSE:

- Describe the quality of care studies that will be undertaken in the first year. For each study, describe the study and the reason for selecting the study. At minimum, state the time frame, methodology, and person/department responsible for the study.

RESPONSE:

- Describe how you will evaluate the QIP and the performance of QI activities and track critical areas of the QIP over time.

RESPONSE:

- Explain how the QIP will include review by physicians and other health professionals and feedback to physicians and health professionals and plan staff regarding performance and patient results.

RESPONSE:

- Describe how the QIP will address health outcomes.

RESPONSE:

SYSTEMATIC PROCESS OF QA AND QI (QUALITY IMPROVEMENT)

- Provide the QIP's written guidelines that specifically address quality of care studies and related activities.

RESPONSE:

- Describe the specific clinical or health service delivery areas that will be monitored. These areas should be priority areas of concern for Medi caid populations--examples: early prenatal care, preterm deliveries, emergency room utilization, immunizations and preventive health care services for children

RESPONSE:

- Describe how the MCO will identify and utilize objective, measurable quality indicators to monitor the care delivered to its members. Describe methods and frequency of data collection and the process the MCO will use these indicators to evaluate and change its process and QIP.

RESPONSE:

- Describe how the MCO will use clinical care standards/practice guidelines in its quality of care studies and related activities. Explain how the MCO will select standards/guidelines, evaluate them over time, update them, inform providers about them, and measure their effectiveness in improving quality.

RESPONSE:

- Describe how the MCO will assure that service areas that require improvement are identified and that reviews of individual cases and studies are performed by clinicians qualified to evaluate and make appropriate recommendations in their specific areas of expertise.

RESPONSE:

- Cite the section of the QIP which addresses the procedures for corrective action when inappropriate or substandard services are furnished. This section of the QIP must include a listing of the specific types of problems that require corrective action, the person(s)/department responsible for taking the actions, the specific actions that will be taken, and how providers are informed about the corrective actions. Also, please describe how the MCO will assess the effectiveness of the corrective actions. If the QIP citation does not address any of the above areas, please clarify and describe them below.

RESPONSE:

- Describe guidelines for evaluating the continuity and effectiveness of the QIP.

RESPONSE:

ACCOUNTABILITY TO THE GOVERNING BODY

- Cite the section of the QIP that documents the role of the GB in the overall QIP. If the GB's role of overseeing the QIP has been formally assigned to another entity, explain how this entity functions and its relation to the GB.

RESPONSE:

- Explain how and how frequently the GB or its assignee receives written reports from the QIP concerning actions taken, progress in meeting objectives, quality of care studies, etc. and the GB and the process for which the QIP can be amended by the GB.

RESPONSE:

ACTIVE QA COMMITTEE

- Identify the committee/structure responsible for QA functions. Describe the scope of its function and what body they are responsible to. How are its decisions documented?

RESPONSE:

- How frequently does this committee meet (weekly, monthly, etc.)? This committee must meet at least quarterly. Therefore, if it meets no more frequently than quarterly, explain how the MCO evaluates how this committee follows up on all findings and required corrective actions.

RESPONSE:

- Describe the roles of the members. How are they selected? What disciplines do they represent? How many are providers of the MCO?

RESPONSE:

QIP SUPERVISION

- Describe the role of the medical director and his/her function in the administration of the QIP

RESPONSE:

- If the medical director is not responsible for supervision of the QIP, state the position which is and its minimum qualifications

RESPONSE:

ADEQUATE RESOURCES

- Describe how the MCO assesses the staffing (professional and support) and resources needed to effectively carry out QI activities.

RESPONSE:

PROVIDER PARTICIPATION IN THE QIP

- Describe the MCO's procedures for informing participating providers about the QIP and ensuring that the MCO has access to medical records

RESPONSE:

DELEGATION OF QIP ACTIVITIES

- Specify which QIP activities are delegated and the scope of services provided by the delegated agent. For each delegated activity, describe what the MCO does to monitor, evaluate, and ensure that quality of care is being provided and that the delegated agent is conforming to the same contractual and regulatory requirements as the MCO.

RESPONSE:

CREDENTIALING AND RE-CREDENTIALING

- Submit the written policies and procedures for the credentialing and recredentialing of physicians and nonphysician practitioners.
- Explain how these procedures are approved, reviewed and updated.

RESPONSE:

- Describe the function of the credentialing committee.

RESPONSE:

- List specific information that must be submitted and/or validated in the credentialing process; in the recredentialing process.

RESPONSE:

- If unlicensed providers will be used, submit the credentialing criteria requirements for supervision by a licensed provider, and what education, training, and experience will privilege an unlicensed provider for which specific types and levels of services.

RESPONSE:

- Describe how the MCO reviews information from the National Practitioner Data Bank and uses this information in recredentialing.

RESPONSE:

- Describe how the MCO reviews the results of complaints, quality reviews, and utilization management in its decision to recredential a provider. List other factors that are assessed in the recredentialing process.

RESPONSE:

- If credentialing and recredentialing are delegated, describe the activities that are delegated, the qualifications of the delegated agent, and how the MCO evaluates and monitors the agent.

RESPONSE:

- Describe the policies and procedures for the suspension and termination of providers and the quality of care deficiencies that result in suspension or termination and the mechanism for reporting serious quality deficiencies.

RESPONSE:

- Describe the process by which a provider can appeal the suspension or termination.

RESPONSE:

ENROLLEE RIGHTS AND RESPONSIBILITIES

- Submit the MCO's written policies on enrollee rights and responsibilities. Describe who is responsible for ensuring these rights and responsibilities in the MCO.

RESPONSE:

- Describe how these rights and responsibilities are communicated to providers and recipients.

RESPONSE:

- Describe the complaints, grievance, and appeals process.

RESPONSE:

- Describe the MCO's policies and procedures related to confidentiality of patient information and medical records. Describe how the MCO guards against inadvertent or unauthorized release of confidential information. Describe the procedure the MCO will follow to ensure that patients have knowledge of their rights of privacy per ACT 87, 2000.

RESPONSE:

- Submit the MCO's written policies regarding the treatment of minors.

RESPONSE:

STANDARDS FOR AVAILABILITY AND ACCESSIBILITY

- What are the MCO's standards for access to services (routine, urgent, and emergency care) and access to member services

RESPONSE:

- How does the MCO assure that members with disabilities can access services; that there are sufficient providers to deliver services within reasonable distances, that translation services can be obtained, that members understand their benefits and how to access them.

RESPONSE:

MEDICAL RECORD STANDARDS

- Describe the standards used by the MCO for medical records. State the minimum medical record keeping requirements (including documentation standards, access standards, length of time records must be maintained, etc.)of the MCO.

RESPONSE:

- Describe the MCO's procedures and policies regarding the review of medical records to ensure that the records meet the MCO's standards and requirements.

RESPONSE:

UTILIZATION REVIEW

- Submit a copy of the written utilization management program.
- Describe the MCO's Utilization Review Program. Describe the policies and procedures to evaluate medical necessity and the policies and procedures and criteria for authorization of items/services based on medical necessity.

RESPONSE:

- Describe the UR committee. How many persons serve on the committee? Who is the chairman (position held in the organization) and the positions/qualifications of other members of the UR committee? How often does the UR committee meet? How are decisions of the UR committee incorporated into the MCO's QIP?

RESPONSE:

- What are the minimum qualifications of the UR professional staff? How are they supervised and by whom?

RESPONSE:

- How are UR decisions documented? How are providers and recipients notified of decisions and their appeal rights?

RESPONSE:

- What does the MCO do to ensure that appeals are handled correctly and timely?

RESPONSE:

- Describe the procedures for review of the UR program by the MCO for effectiveness, areas that should be improved or modified, etc.

RESPONSE:

CONTINUITY OF CARE SYSTEM

- Describe how continuity of care and case management is addressed in the QIP. How does the QIP monitor continuity of care (follow-up care) and appropriate case management. What are the provisions for after hours coverage of case management --such as would be needed if a patient needs emergency out-of-State transportation?

RESPONSE:

QAP DOCUMENTATION

- Explain how the MCO documents, maintains, and makes available QIP decisions, studies, reports, corrective actions, etc.

RESPONSE:

COORDINATION OF QA ACTIVITY WITH OTHER MANAGEMENT ACTIVITY

- Describe how QA findings, corrective actions, recommendations, etc. are reported within the MCO. Who in the MCO coordinates the release of QA findings to appropriate staff? How are QA activities coordinated with other functions of the MCO such as provider services, member services, patient education, provider information, etc?

RESPONSE:

Care Coordination/Case Management System

The offeror must have a Care Coordination/Case Management (CC/CM) System. The offeror must describe its system by supplying responses to the specific areas requested in the format that follows. Responses must be as concise as possible. No other format will be acceptable.

- In general terms describe the organizational structure of the MCO's CC/CM System. Include the title of the person in charge of the CC/CM system and his/her qualifications; to whom in the organization does this person report and the qualifications of care coordinators/case managers--professional and para-professional; the number of case managers who are certified case managers, and the number who are in the process of being certified; the initial and on-going training and education that the MCO will provide for its CC/CM staff; how changes or modifications in the CC/CM system are made, etc.

RESPONSE:

- Describe the processes which are followed by the CC/CM system to determine the intensity of CC/CM services they receive, and whether CC/CM is performed by a certified case manager, nurse, social worker, or para-professional staff (staffing level).

RESPONSE:

- Describe how the CC/CM system operates to ensure that members have timely access to CC/CM services and that the CC/CM system monitors and assesses that timely and appropriate health care services are being accessed by a member.

RESPONSE:

- Describe Individualized Care Planning. The minimum components of the MCO's ICP (Individualized Care Plan) how the ICP is developed, and the persons involved in the ICP, including PCP, case manager, family, the time frame for the development, implementation of the ICP, a process and timeframe for review, etc.

RESPONSE:

- Describe how the MCO will use the QUEST Medical Information (assessment form completed by members).

RESPONSE:

- Describe how processes by which the CC/CM system will provide and receive information from the member's PCP and other providers to ensure continuity of care and coordination of services.

RESPONSE:

- Describe how cases will be prioritized.

RESPONSE:

- Describe the levels of CC/CM services provided by the MCO and the criteria used to determine a member's need for each level.

RESPONSE:

- Describe the process for monitoring and documentation of CC/CM services, encounters, outcomes, and how the plan will report these services to the MQD.

RESPONSE:

- Describe by whom and by what process the MCO will review the member's treatment status (at least every 6 months) in order to ensure that the member meets SMI criteria for continued eligibility.

RESPONSE:

APPENDIX K SMI CRITERIA

PERSONS WITH SERIOUS MENTAL ILLNESS

Definition

The seriously mentally ill are defined as persons who, as the result of a mental disorder, exhibit emotional, cognitive, or behavioral functioning which is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these persons, mental disability is severe and persistent resulting in a long term limitation in their functional capacities for primary activities of daily living such as interpersonal relationships, self-care, homemaking, employment, and recreation.

Conditions such as mental retardation or substance abuse may cause similar problems or limitations, and are not to be included in this definition unless, in addition to one or more of these disorders, the person has a severe and persistent mental disorder.

Criteria

Assessment:

The person has undergone a comprehensive professional clinical assessment sufficient to establish a diagnosis of mental disorder and a quantitative functional assessment. The combination of diagnosis and level of functioning establishes eligibility for public services through a formula stated below.

Eligible Diagnoses:

The person meets the latest DSM edition criteria for mental disorder in Category I, II, or III.

CATEGORY I

- Schizophrenic Disorders (295.1, 295.2, 295.3, 295.6, 295.9)
- Delusional Disorders (297.1)
- Psychotic Disorders Not Elsewhere Classified
 - Schizo-affective Disorders (295.7)
 - Psychotic Disorders NOS (298.9)
- Mood Disorders
 - Bipolar Disorders (296.4, 296.5, 296.6, 296.7)
 - Depressive Disorders (296.2, 296.3)

Substance Related Disorders Persisting Three Months After Detoxification and Stabilization

- Psychotic Disorders (291.3, 291.5, 292.11, 292.12)
- Mood Disorders (291.89 for mood only, 292.84)

CATEGORY II

Mental Disorders Due to a General Medical Condition

- Psychotic Disorder Due to a General Medical Condition with Delusions (293.81)
- Psychotic Disorder Due to a General Medical Condition with Hallucinations (293.82)
- Mood Disorder Due to a General Medical Condition (293.83)

Anxiety Disorders

- Panic Disorder with Agoraphobia (300.21)
- Panic Disorder without Agoraphobia (300.01)
- Post Traumatic Stress Disorder (309.81)
- Obsessive Compulsive Disorder (300.3)
- Alcohol induced anxiety disorder/mood disorder with depressive features (291.81)

Personality Disorders (these conditions exempted from provisionally qualifying conditions)

- Schizoid (301.20)
- Schizotypal (301.22)
- Borderline Personality Disorder (301.83)

CATEGORY III (these conditions exempted from provisionally qualifying conditions)

Other Disorders Not Listed Above and Not Excluded Below

PERSONS WITH A PROVISIONALLY QUALIFYING CONDITION

These persons are defined as those who have a substance abuse condition and are suspected to suffer from a qualifying condition due to their symptoms and functional limitations. These persons have on-going and recent substance abuse which prevents the clinician from making a definitive qualifying diagnosis.

Excluded Diagnoses:

Unless an eligible disorder listed above is also present, the following disorders are excluded from eligibility under the Adult Behavioral Health Managed Care Plan.

- Delirium, Dementia, and Amnesic and other Cognitive Disorders
- Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence, i.e., Mental Retardation, Pervasive Developmental Disorders, Learning Disorders, Motor Skills Disorder, Communication Disorders.
- Substance Induced Disorders except as otherwise described above.
- Substance Dependence Disorders
- Psychotic Disorders Not Elsewhere Classified. Only the following diagnosis in this category is excluded:
 - Brief Psychotic Disorder (298.8)
- Sexual and Gender Identity Disorders
- Factitious Disorders
- Impulse Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Psychological Factors Affecting Medical Conditions
- V Codes

Comorbidity:

Patients with a substance abuse diagnosis must also meet the diagnostic criteria for an above accepted mental illness to be considered potentially SMI. Those patients who are suspected to suffer from a qualifying condition yet currently are using substances, thus precluding the clear determination of an eligible diagnosis will be provisionally accepted as suffering from a qualifying condition. For those individuals with a dual diagnosis of substance abuse and a severe and persistent mental disorder, the assessment will also need to include a rating using the most current American Society of Addiction Medicine (ASAM) placement criteria. The assessment for dual diagnosis individuals must also include a history of the patient's past and present substance use sufficient to identify and describe its effects on cognitive, psychological, behavioral, and physiological function; a general medical and psychiatric history and psychiatric examination; a history of prior psychiatric treatments and outcomes; a family and social

history; screening of blood, breath, or urine for abused substances. This assessment will be considered if the available information is sufficient to document the patient's appropriateness for SMI status and support a determination. A copy of any recent hospital or treatment facility admission and discharge summaries will aid the MQD reviewer in making a determination.

Patients with DD/MR in addition to an allowable diagnosis will have to be at worst in the mild range (317.00) for eligibility.

Impaired Level of Functioning:

Assessment of impaired role functioning is achieved by the administration of an instrument such as the Client Assessment Record (CAR). At the minimum the Global Assessment of Functioning (GAF) will be provided to the MQD reviewer. A GAF score below 50 will be considered as supportive of an impaired level of functioning in conjunction with the CAR caculated score by the MQD reviewer. If the CAR instrument was used by the provider, CAR scales would be limited to: Medical/Physical, Family/Living Situation, Interpersonal Relations, Role Performance, Socio-Legal, and Self-Care/Basic Needs. The person is assigned to one of the four following levels of impaired functioning:

Level A:

3 or more CAR scale scores of 40 and above or
4 or more CAR scale scores of 30 and above.

Level B:

2 or more CAR scale scores of 40 and above or
3 or more CAR scale scores of 30 and above.

Level C1:

1 CAR scale score of 40 and above or
2 CAR scale scores of 30 and above.

Level C2:

Clinical evidence indicates that level of functioning would rate at the C1 level or lower in the absence of treatment.

Eligibility Determination Formula:

1. a) The patient meets Diagnostic Category 1 and any of the Impaired Role Functioning Levels (A, B, C1 or C2).

b) The patient meets Diagnostic Category II and Impaired Role Functioning Levels A or B.

c) The patient meets Diagnostic Category III and Impaired Role Functioning Level A.

2. As part of the assessment of chronic mental illness, documentation should be provided on historical duration of illness and disability and/or on the presence of risk factors making it likely that the disorder and disability will be present into the foreseeable future.

a, b, or c above must have been present for at least 6 months or must have a 6 month minimal expected duration or must have a combined present and expected duration of 6 months.

Accessible Services:

The person with a clear SMI diagnosis is judged to be in need of a comprehensive planned package of supportive and treatment services requiring intensive case management and interdisciplinary supervision of long-term or indefinite duration. Those with a provisional diagnosis due to limited functioning secondary to substance abuse are judged to be in need of the above services for a limited-term duration in order to establish a clear SMI diagnosis.

CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

Definition

For purposes of Med-QUEST, children with serious emotional disturbance are persons:

- ◆ Birth to age 18
- ◆ who currently or at any time during the past year have had a primary diagnosis of at least one of the following mental, behavioral or emotional disorders:

Pervasive Developmental Disorders (PDD)

299.00	Autistic disorder
299.80	Pervasive developmental disorder NOS

Anxiety Disorders of Childhood or Adolescence

309.21	Separation anxiety disorder
--------	-----------------------------

Schizophrenia

295.2x	Catatonic
295.1x	Disorganized
295.3x	Paranoid
295.9x	Undifferentiated
295.6x	Residual

Delusional (Paranoid) Disorder

297.10	Delusional (Paranoid) disorder
--------	--------------------------------

Psychotic Disorders Not Elsewhere Classified

295.70	Schizoaffective disorder
297.30	Shared psychotic disorder (Folie a deux)
298.90	Psychotic disorder NOS

Bipolar Disorders

296.6x	Mixed
296.4x	Manic
296.5x	Depressed
301.13	Cyclothymia

Depressive Disorders

Major Depression	
296.2x	Single episode
296.3x	Recurrent
300.40	Dysthymia

Anxiety Disorders

300.30	Obsessive compulsive disorder
309.89	Post-traumatic stress disorder

Somatoform Disorders

300.11	Conversion disorder
--------	---------------------

Dissociative Disorders

300.14	Disassociative identity
--------	-------------------------

Impulse Control Not Elsewhere Classified

312.34	Intermittent explosive disorder
--------	---------------------------------

Attention Deficit and Disruptive Behavior Disorders

313.81	Oppositional defiant disorder
--------	-------------------------------

- ◆ that has resulted in functional impairment which substantially interferes with or limits the child's role or functioning in the family, school, or community activities as defined by MQD and CAMHD and measured by the Child and Adolescent Functional Assessment Scale (CAFAS) with a score of 120+.
- ◆ and who has had the above diagnosis or in the absence of a diagnosis has displayed related symptoms for the following duration:

⇒ 6 months for recipients less than age 10 and one year for recipients greater than age 10.

APPENDIX L

SMI EVALUATION PROCESS

APPENDIX L
EVALUATION PROCESS FOR DETERMINATION OF ELIGIBILITY FOR THE
BEHAVIORAL HEALTH MANAGED CARE PLAN FOR SERIOUSLY MENTALLY
ILL (SMI) ADULTS

The purpose of this memorandum is to clarify the QUEST Request for Proposal (RFP) Section 31.100 Plan Referral for an Evaluation relevant to making determinations of eligibility for the QUEST behavioral health managed care plan. The MQD will work with individual QUEST plans to expedite determinations of SMI referrals received before this date.

INPATIENTS

Adults on Oahu

If, after reviewing relevant clinical information, the QUEST plan determines that a member meets the criteria for SMI, the plan should complete and fax to the MQD the referral form “Referral For Serious Mental Illness (SMI). This should be submitted at least two (2) working days before anticipated discharge to:

Medical Standards Branch (MSB-SMI)/MQD
Fax #: 692-8131

If the patient is discharged in advance of his/her projected discharge date, please inform the MQD Psychiatric Consultant and use the processes described under “OUTPATIENTS.”

Adults on Neighbor Islands

Use the processes described under “OUTPATIENTS.”

OUTPATIENTS

- The QUEST plans should mail or fax to the MQD, the “Referral For SMI” form and the form for the assessment of mental state and functional scales. In addition, to expedite the processing of SMI referrals, the plans are asked to include as much of the following information as possible:
 1. Personal history, family history, social history and history of drug use.
 2. Mental health history and educational history.
 3. History of past hospitalizations and other prior psychiatric care.
 4. Local hospital admission and discharge summaries (including medical and psychiatric histories and physical examinations) and discharge summaries.
 5. Most current Psychiatric and psychological assessments to include pertinent history, behavioral observation and presentation, diagnostic impression, reports of

psychological/psychiatric testing, Global Assessment of Functioning (GAF) scores, and substance abuse information using ASAM placement criteria.

- The MQD expects that the Medical Directors of all plans will review and sign all referrals for SMI and any information (such as the assessment of mental state and functional scales) which may have been completed by health plan staff. Thus, MQD will not make a determination that a member is SMI (if referred by the plan) without the signature of the plan's Medical Director. The referrals made by the Child and Adolescent Mental Health Division do not have to be signed by the plan's Medical Director.
- The MQD's psychiatric consultant will make a decision based on the information submitted.
- The Referral Form with the MQD's decision will be returned to the Medical Director of the QUEST plan in most cases within seven (7) business days and as stated in the RFP, not more than 30 days after receipt. The MQD makes one of the following three determinations:
 1. SMI--yes
 2. SMI--no
 3. Additional Information Needed
- If the member is determined to be SMI, the BHMC plan will receive a copy of all pertinent information submitted by the QUEST plan. In addition, the MQD Eligibility Branch will be notified to add the member's eligibility status to the member's eligibility file.
- If a member was not determined to be SMI or if additional information is needed, the MQD will indicate the reason for this decision or the additional information needed on the referral form.
- After a referral has been submitted to the MQD and before the plan is notified of a decision, QUEST plans shall update the MQD in situations including but not limited to the following:
 1. The patient was admitted to the hospital
 2. The patient has an urgent need for behavioral health managed care services
 3. The plan has not received a determination eight (8) working days or more after submission of the referral

Additional clarification which applies to both INPATIENTS and OUTPATIENTS:

- For the BHMC Plan only, if the member is not included in the tape for the month after enrollment, please contact the Med-QUEST Finance Office at 692-7957.
- If no records of prior hospitalizations are available, documentation that the plan paid for inpatient hospitalizations with a primary diagnosis in category I and/or an outpatient treatment plan will be considered by the MQD Psychiatric consultant in determining whether a member had an SMI diagnosis. The following criteria will be used for the determination:

Treatment for at least 6 months or must have a 6 month minimal expected duration, or must have a combined present and expected duration of 6 months.

- Please do not refer the following types of members as they **DO NOT** meet SMI requirements:
 1. Adults with SMI diagnosis or who (in the absence of a diagnosis) have documentation of displaying SMI symptoms for less than 6 months.
 2. Adults whose serious mental illness is not expected to last more than 6 months.
 3. Adults with substance abuse diagnosis(es) and NO independent psychiatric diagnosis that would otherwise qualify for SMI consideration.
 4. Adults with psychiatric diagnosis(es) and developmental disabilities (DD)/mental retardation (MR) (other than mild DD/MR)
 5. Patients with SMI diagnosis(es) who are functioning well in the community.
- To expedite processing, the MQD will return only the referral forms. If a plan wishes to have a determination reconsidered, all applicable information would be resubmitted. A decision on the reconsideration will be rendered within 7 days of receipt in most cases and as stated in the RFP, not more than two (2) weeks after receipt.
- The MQD will return all referral forms to the plan's Medical Director.
- If a plan's Medical Director questions a determination, he/she should contact 692-8124, to arrange a contact with the MQD's psychiatric consultant..
- If a plan's Medical Director and the MQD's psychiatric consultant agree that a patient interview is needed, the name, location and telephone number to the interviewer will be given to the plan's Medical Director. The plan is responsible for all patient arrangements, including patient transportation, if necessary. The MQD will render a decision within two (2) weeks of receipt of the interviewer's report.
- Other individuals such as psychiatrists and psychologists can also make referrals for SMI evaluation.
- Plan staff who need clarification or have questions on SMI referrals should contact 692-8124.

**APPENDIX M BEHAVIORAL HEALTH PROVIDER
NETWORK MATRIX**

	Name (last name, first name, M.I.)	Specialty	Location (Address) (list all that apply separately)	City	Zip Code	QUEST Plan Members	QUEST Members? Y/N	On QUEST Members? Y/N
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34								
35								
36								
37								
38								
39								
40								
41								
42								
43								
44								
45								
46								

Sort behavioral health providers by different provider types and list alphabetically within the different provider type by last name.
Behavioral health providers should be placed on island map.

APPENDIX N

BLANK

APPENDIX O

**HAWAII STATE HOSPITAL POLICY AND
PROCEDURE**

**HAWAII STATE HOSPITAL
POLICY AND PROCEDURE**

CONTINUUM OF CARE

SUBJECT: Admission

REFERENCE: JCAHO CC.1, CC.2, CC.2.1,
HSH Multidisciplinary Admission Assessment P&P
(#04.009), HRS 334-60.2

Number: 04.005
Effective Date: 09/27/96
History: Rev. 10/99, 5/00
Page: 1 of 3

APPROVED:

Title: Administrator

NOTE: Summary of Changes:

1. Reference HRS 334-60.2
2. Addition of Policy #6 that references HRS 334-60.2.

PURPOSE:

To provide guidelines for admission of patients to Hawaii State Hospital.

POLICY:

The following are criteria for admissions to Hawaii State Hospital:

1. DSM IV Axis I diagnosis, and
2. Patient requires 24 hour nursing and psychiatric management, and the provision for the patient's safety or the safety of others, and
3. The Hospital is able to provide the services required for the treatment of the patient's illness, and
4. Less restrictive level of care is inappropriate or unavailable, and/or
5. Patients court ordered to HSH.
6. The criteria for civil commitment is imminent and substantial dangerousness to self or others.

PROCEDURE:

1. All admissions to Hawaii State Hospital must be clinically justified by the Hawaii Evaluation Level of Placement (H.E.L.P.) team unless specifically ordered to HSH by the Court.
2. Patients are referred from the courts and Public Safety Department through the HSH Admissions Coordinator. Patients are referred from the community (hospitals, clinics, and

other treatment facilities) through the Care Manager.

HAWAII STATE HOSPITAL POLICY AND PROCEDURE

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3. The Admissions Coordinator gathers the following information from the referring agency at the time of the referral:
 - a. patient's name
 - b. age
 - c. sex
 - d. legal status
 - e. legal guardian
 - f. current behavior/mental status
 - g. object of admission
 - h. medical status
 - i. medications prescribed
 - j. lower level of care attempted or considered
4. After careful review of available information, approval of admission is determined by the H.E.L.P. team. Documentation of less restrictive levels of service considered or attempted is provided on the H.E.L.P. Referral Form.
5. Once a bed becomes available, the Admissions Coordinator informs the referring agency of the admission date.
6. The Clinical Director/Unit Manager /Nurse Manager are informed of the admission.
7. Patients may be directly admitted to a unit other than the Admissions/PICU when a patient's special needs would be more appropriately met by direct admission to that specific unit than by the admission unit.
8. Once the patient has arrived at Hawaii State Hospital, there will be an initial medical, psychiatric, and nursing evaluation.
 - a. All patients are evaluated face to face by the admitting psychiatrist.
 - b. In an emergency, the admitting psychiatrist may order by telephone whatever measures may be needed for the safety of the patient. The face-to-face evaluation should occur as soon as possible, but no longer than eight (8) hours after an emergency admission.
 - c. All admissions, voluntary or involuntary, must be clinically or legally justified by the attending psychiatrist at the time of admission.
 - d. The multidisciplinary admissions team conducts an initial assessment, suggest the most appropriate future care, and provide, as needed, acute crisis stabilization.

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9. The multidisciplinary team performs initial assessment in accordance with their department scope of services and policies and procedures.
10. The H.E.L.P. team ensures that all available information is supplied to the admitting team (e.g. psychiatrist, nursing staff) to enable a thorough and complete initial assessment.

REVIEW/REVISED: Continuum of Care Function Team

REVIEWING BODY: Medical Executive Committee

**Adult Mental Health Division
(HELP) HAWAII EVALUATION AND LEVEL OF PLACEMENT
ASSESSMENT FORM**

Client Name: _____ BHIS/TEMPORARY # _____

Referral Date: _____ Social Security#: _____

Catchment Area: _____ CMHC Care Mgr. _____

SSI SSDI DHS VA

Medicare # _____ Medicaid # _____

Med Quest # _____ Plan _____

Insurer: # _____ Grp # _____

Admission Legal Status

Voluntary Client:

Self Guardian Name: _____ Ph#: _____

Involuntary Client (Civil):

MH1 MH2 MH4 MH6 MH9

Order to Treat OTT (includes Psychotropic Medication as clinically indicated)

Expires: _____

Committed to:	
<input type="checkbox"/>	DOH
<input type="checkbox"/>	HSH
<input type="checkbox"/>	Other

Involuntary Client (Penal):

404 413(1)
 406 413(3)
 411(1)a 706-603
 411(1)b 706-624

706-607
 Legal Charges 707

HPD Criminal Record #: _____

Order to Treat
 OTT (includes Psychotropic Medication as clinically indicated)

Expires: _____

Committed to:	
<input type="checkbox"/>	DOH
<input type="checkbox"/>	HSH
<input type="checkbox"/>	Other

Court: Circuit District Family

Judge: _____
 Court Appointed Attorney: _____
 Prosecutor: _____
 Probation Officer: _____

Ph#: _____
 Ph#: _____
 Ph#: _____
 Ph#: _____

Return to Court Date (RCD): _____ Attending M.D. Report Needed ___/___/___

"HELP" Staff: _____ Date: _____ Time: _____

**Adult Mental Health Division
(HELP) HAWAII EVALUATION AND LEVEL OF PLACEMENT
ASSESSMENT FORM**

Client Name: _____ BHS/TEMPORARY # _____

BIOPSYCHOSOCIAL INFORMATION

Information Sources: () Client () Family () Guardian () Other

Informant's description of events leading to hospital referral, including current stressors:

Aware of psychiatric diagnosis () Yes () No
 (Circle) Prior psych/addictions/treatment () Yes () No
 Social/Environmental antecedents to relapse:

History of compliance to medication: (Circle) Full / Partial / Non-compliant

Current compliance to medication: (Circle) Full / Partial / Non-compliant

History of engagement in treatment: (Circle) Full / Partial / Non-compliant

Lower levels of services considered, or attempted and failed:

<input type="checkbox"/>	Short term emergency placement	Site: _____	From: _____	To: _____
<input type="checkbox"/>	Crisis	Site: _____	From: _____	To: _____
<input type="checkbox"/>	Mental Health Residential	Site: _____	From: _____	To: _____
<input type="checkbox"/>	Chemical Dependency/Residential	Site: _____	From: _____	To: _____
<input type="checkbox"/>	Partial Hospitalization	Site: _____	From: _____	To: _____
<input type="checkbox"/>	Day Treatment / Clubhouse	Site: _____	From: _____	To: _____
<input type="checkbox"/>	Intensive client (CD)	Site: _____	From: _____	To: _____
<input type="checkbox"/>	Intensive Case Management	Site: _____	From: _____	To: _____
<input type="checkbox"/>	Non clinical Support Housing	Site: _____	From: _____	To: _____
<input type="checkbox"/>	Out client (CMHC/Private)	Site: _____	From: _____	To: _____

Comments: _____

**Adult Mental Health Division
(HELP) HAWAII EVALUATION AND LEVEL OF PLACEMENT
ASSESSMENT FORM**

Client Name: _____ BHIS/TEMPORARY # _____

<p><u>LEVEL OF CONSCIOUSNESS</u></p> <p>___ Client is alert, aware, responsive to surroundings</p> <p>___ Short, long term memory intact</p>	<p>___ lethargic ___ drowsy ___ hyper alert</p> <p>___ memory deficit ___ short term ___ long term</p> <p>___ confabulation</p> <p>Comment: _____</p>
<p><u>ORIENTATION</u></p> <p>___ Oriented x4:</p> <p>Client is aware of self, knows date/ time, aware of place, circumstances</p>	<p>Demonstrates lack of awareness of:</p> <p>___ Person: _____</p> <p>___ Place: _____</p> <p>___ Time: _____</p> <p>___ Situation: _____</p>
<p><u>APPEARANCE</u></p> <p>___ Clothing neat, clean, appropriate</p> <p>___ Clean, well-groomed</p>	<p>___ disheveled ___ dirty</p> <p>___ malodorous ___ odd/bizarre</p> <p>___ overly meticulous: _____</p> <p>___ dirty ___ unkempt ___ provocative</p> <p>Comment: _____</p>
<p><u>BEHAVIOR</u></p> <p><u>Facial Expression</u></p> <p>___ Normal, congruent</p> <p><u>Eye Contact</u></p> <p>___ Meets gaze appropriate to content and cultural background</p> <p><u>Posture</u></p> <p>___ erect, relaxed</p> <p><u>Movement</u></p> <p>___ smooth, relaxed; even, regular gait</p> <p><u>Speech</u></p> <p>___ rate, volume, and inflection normal</p>	<p>___ Abnormal, noncongruent</p> <p>___ elated ___ sad ___ angry</p> <p>___ fearful ___ depressed ___ suspicious</p> <p>Comment: _____</p> <p>___ fair ___ poor ___ lacking</p> <p>___ rigid ___ slumped</p> <p>___ affected ___ bizarre (posturing)</p> <p>___ restless ___ hyperactive ___ retarded</p> <p>___ sluggish ___ catatonic ___ ties</p> <p>___ tremors ___ E.P.S. (Extrapyramidal symptoms)</p> <p>Comment: _____</p> <p>___ slow ___ soft ___ mute</p> <p>___ pressured ___ poverty ___ stutter</p> <p>___ vocal tics ___ clanging ___ blocking</p> <p>Comment: _____</p>

**Adult Mental Health Division
(HELP) HAWAII EVALUATION AND LEVEL OF PLACEMENT
ASSESSMENT FORM**

Client Name: _____ BHIS/TEMPORARY # _____

MENTAL STATUS EXAMINATION

<p><u>AFFECT/MOOD</u></p> <p><input type="checkbox"/> Full</p> <p><input type="checkbox"/> Euthymic (Normal Mood)</p>	<p><input type="checkbox"/> flat <input type="checkbox"/> blunted <input type="checkbox"/> constricted</p> <p><input type="checkbox"/> anxious <input type="checkbox"/> sad <input type="checkbox"/> depressed</p> <p><input type="checkbox"/> hopeless <input type="checkbox"/> helpless <input type="checkbox"/> worthless</p> <p><input type="checkbox"/> withdrawn <input type="checkbox"/> isolative <input type="checkbox"/> guarded</p> <p><input type="checkbox"/> euphoric <input type="checkbox"/> labile <input type="checkbox"/> hypomanic</p> <p><input type="checkbox"/> demanding <input type="checkbox"/> sarcastic <input type="checkbox"/> irritable</p> <p><input type="checkbox"/> angry <input type="checkbox"/> hostile <input type="checkbox"/> threatening</p> <p><input type="checkbox"/> explosive* <input type="checkbox"/> Other</p> <p>Comment: _____</p>
<p><u>THOUGHT PROCESS/CONTENT</u></p> <p><input type="checkbox"/> coherent <input type="checkbox"/> logical</p> <p><input type="checkbox"/> goal - directed <input type="checkbox"/> longitudinal</p>	<p><input type="checkbox"/> incoherent <input type="checkbox"/> illogical <input type="checkbox"/> disorganized</p> <p><input type="checkbox"/> loose association <input type="checkbox"/> tangential</p> <p><input type="checkbox"/> circumstantial <input type="checkbox"/> flight of ideas</p> <p><input type="checkbox"/> racing <input type="checkbox"/> obsessive <input type="checkbox"/> phobic</p> <p><input type="checkbox"/> perseverative <input type="checkbox"/> concrete <input type="checkbox"/> neologisms</p> <p>Comment: _____</p>
<p><u>HALLUCINATIONS:</u></p> <p><input type="checkbox"/> Absent</p>	<p><input type="checkbox"/> auditory <input type="checkbox"/> derogatory <input type="checkbox"/> command</p> <p><input type="checkbox"/> visual <input type="checkbox"/> tactile <input type="checkbox"/> olfactory</p> <p><input type="checkbox"/> self harm <input type="checkbox"/> other harm*</p> <p>Comment: Plan, lethality _____</p>
<p><u>DELUSIONS:</u></p> <p><input type="checkbox"/> Absent</p>	<p><input type="checkbox"/> paranoid <input type="checkbox"/> persecution</p> <p><input type="checkbox"/> grandiose <input type="checkbox"/> religiosity</p> <p><input type="checkbox"/> ideas of reference <input type="checkbox"/> ideas of control</p> <p><input type="checkbox"/> thought broadcasting <input type="checkbox"/> mind reading</p> <p><input type="checkbox"/> thought insertion <input type="checkbox"/> somatic <input type="checkbox"/> déjà vu</p> <p><input type="checkbox"/> fixed <input type="checkbox"/> depersonalization</p> <p>Comment: _____</p>

**Adult Mental Health Division
(HELP) HAWAII EVALUATION AND LEVEL OF PLACEMENT
ASSESSMENT FORM**

Client Name: _____ BHIS/TEMPORARY # _____

Current Medication	Dose	Frequency	Prescribing Clinician

SUBSTANCE USE Hx

Substance:	Yes	No	Name	# Yrs. used	Amount/Frequency	Symptoms of O.D. / Withdrawal
Caffeine						<input type="checkbox"/>
Tobacco						<input type="checkbox"/>
Alcohol						<input type="checkbox"/>
Marijuana						<input type="checkbox"/>
Benzodiazepines						<input type="checkbox"/>
Cocaine						<input type="checkbox"/>
otics/Opiates						<input type="checkbox"/>
Inhalants						<input type="checkbox"/>
Amphetamines						<input type="checkbox"/>
Hallucinogens						<input type="checkbox"/>
Other						<input type="checkbox"/>

1. Would any of your family/friends think you have a problem with drugs/alcohol? () Yes () No
2. Number of DUI's _____ Number of drug related convictions _____
Describe: _____
3. Have you ever been in treatment for drug/alcohol related issues? () Yes () No
4. Do you attend AA/NA? () Yes () No Sponsor: () Yes () No
5. Have you experienced? () Blackouts () Memory Loss () Withdrawal Symptoms () DTs () Seizure
- Hx of Other Addictions: () Spending () Gambling () Stealing () Sexual Behaviors ()
- Other: _____

Evidence of abuse/dependence

- ___ Physical tolerance (need for increasing use) ___ Medicating self ___ Using even though it causes problems
- ___ Unsuccessful efforts to control use ___ Lifestyle change related to use ___ Using more than intended
- ___ Use interferes with responsibilities ___ Withdrawal symptoms ___ Use jeopardizes safety
- Need for consult indicated for any check off

**Adult Mental Health Division
(HELP) HAWAII EVALUATION AND LEVEL OF PLACEMENT
ASSESSMENT FORM**

Client Name: _____ BHIS/TEMPORARY # _____

SAFETY RISK ASSESSMENT

Risk Assessment	Yes	No	Current (Describe)	Past (Describe)
Poor Impulse Control				
Suicidal Ideation				
Suicidal Attempt(s)				
Self-Injurious Behavior				
Homicidal Ideation*				
Violence Toward Others				
() Terrorists Threats * () Hx?				
() TRO violation* () Hx?				
() Crime against a person* () Hx?				
Restraint or Locked Door - Seclusion during hospitalizations				
Victim of Physical, Emotional, Sexual Abuse				
Perpetrator of Physical*, Emotional, Sexual Abuse*				

Abuse previously disclosed: () Yes () No Counseling? () Yes () No

Violence Evaluation Tool indicated: () Yes () No If yes, Dimension 7 Score: _____

Explain: _____

*Violence Evaluation Tool Indicated: _____

	Optimal	Above Average	Below Average	Deficient	Not Applicable
Friendships					
Family of Origin					
Relationship With Spouse/SO					
School and/or Work					
Community					

**Adult Mental Health Division
(HELP) HAWAII EVALUATION AND LEVEL OF PLACEMENT
ASSESSMENT FORM**

Client Name: _____ BHIS/TEMPORARY # _____

Client Participation
 Not Rated Optimal Above Average Average Deficient Markedly deficient

Client Strengths/Assets
 Financial resources Supportive family/friends Stable outpatient treatment program
 Stable living situation Stable work/school Other: _____

CLINICAL PRESENTATION
Fill in the bubbles to indicate all client risk factors currently present.

- EMERGENT - Level 4**
- 1. Diagnosis or impulsive behavior placing self or other at imminent risk
 - 2. Psychiatric illness (e.g., substance dependence, anorexia, etc.) with concomitant acute severe medical complications.
 - 3. Symptoms of psychosis: Hallucinations, delusions, thought disorder, impaired reality testing, etc., which place either client / others at risk.
 - 4. Acute disturbance in consciousness and cognition, that places a person without supervision, at risk.
 - 5. Crime against a person, has multiple priors against a person, Violence Evaluation Tool score is severe, aggressive behavior.

- URGENT - Level 3**
 Symptoms of severe affective disorders (underline any that apply): depressed, elevated or irritable mood, Psychomotor retardation or agitation disrupted sleep appetite, significant weight loss, suicidal or homicidal ideation. If client has access to or possession of a gun, interrupt access during treatment.
- 7. Symptoms of severe anxiety disorder resulting in significant functional impairment (underline any that apply): Panic disorder, Obsessive-compulsive disorder, other: _____
 - 8. Anorexia/bulimia with significant weight loss, signs of malnutrition, or electrolyte imbalance.
 - 9. Current substance abuse/dependence resulting significant functional impairment or medical instability.
 - 10. Incident offense is a crime against a person, has one prior against a person, and has a moderate concern Violence Evaluation Tool score.

- COMPLEX - Level 2**
- 11. Multiple diagnoses, including two or more of the following: mental illness, chemical dependency, co-morbid medical condition which may complicate treatment or increase risk (intractable chronic pain or serious chronic or terminal illness/disability.)
Specify: _____
 - 12. Probable abuse of a minor or vulnerable adult requiring report to protective services (once reported and the situation is stabilized, client needs be categorized as a high risk client.)
 - 13. A history (past 2 years) of hospitalization for detox or mental illness and history of non-compliance with medication or other treatment.
 - 14. Provider or facility requests a psychiatric consult.
 - 15. Current/recent use of mood stabilizer, antipsychotic medication, antidepressant or anti-anxiety medication with indication of poor monitor variable use or adverse or unexpected effects causing discomfort or concern.
 - 16. Prominent Axis II disorder in adults where acute symptoms are present which are the focus of treatment.
 - 17. Significant loss of family member(s), support system or employment (may result in conditions warranting urgent or emergent service level; may stabilize to an extent appropriate to remove client from risk status).
 - 18. Incident offense is a crime against a person, has no prior against a person, and a mild Violence Evaluation Tool score.

**Adult Mental Health Division
(HELP) HAWAII EVALUATION AND LEVEL OF PLACEMENT
ASSESSMENT FORM**

Client Name: _____ BHIS/TEMPORARY # _____

ROUTINE – Level 1

- O 19. "No" answer to all of the above.
- O 20. "No" violence in incident offense, has "No" violence in review of reports, and has a benign Violence Evaluation Tool score.

ASAM PPC-2		MH	SA
Dimension 1	(Acute Intoxication/Withdrawal potential)		
Dimension 2	(Biomedical conditions and complications)		
Dimension 3	(Emotional/Behavioral/Cognitive conditions and complications)		
Dimension 4	(Treatment acceptance/Resistance/readiness to change)		
Dimension 5	(Relapse/Continued use/Continued problem potential)		
Dimension 6	(Recovery environment)		
Dimension 7	(Violence potential)		

	DSM IV Code	Diagnostic Summary
Axis I	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
Axis II	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>

Axis III _____

Axis IV	<input type="checkbox"/> Primary Support Group Problems	<input type="checkbox"/> Housing Problems	<input type="checkbox"/> Other Psychosocial and Environmental Problems
	<input type="checkbox"/> Social Environment Problems	<input type="checkbox"/> Economic Problems	<input type="checkbox"/> No Current Stressors
	<input type="checkbox"/> Educational Problems	<input type="checkbox"/> Healthcare Service Access	
	<input type="checkbox"/> Occupational Problems	<input type="checkbox"/> Legal System or Crime Problems	

Axis V Current: _____ Past Year: _____

Clinical Summary

A. Dx to be treated: _____

 B. Behavioral to control: _____

 C. Safety to secure: _____

**Adult Mental Health Division
(HELP) HAWAII EVALUATION AND LEVEL OF PLACEMENT
ASSESSMENT FORM**

Client Name: _____ BHIS/TEMPORARY # _____

AMHD Eligible: Yes No

- Treatment Coordination**
- Have you communicated with the primary care physicians?
 - Have you communicated with other treatment providers?
 - Have you communicated with the client school or other agency?
 - Are family members involved in the treatment?
 - Have you communicated with prescribing M.D.?
 - Have you communicated with the CMHC care manager?
 - Have you communicated with the case manager?

Yes	No	N/A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Signature: _____ Date: _____

Authorization Level of Service _____ # or Days _____ From: _____ To: _____