Created May 2020

Diversion Tool

This tool is to be started from the first contact with an individual during the diversion process and then follow that individual until they are successfully integrated into the community or withdrawn from the TCL initiative.

Please fill in all areas completely and if information is not applicable put N/A.

SECTION A. DEMOGRAPHICS					
1. Participant Data					
First Name:			**Last Name:**		
Alpha ID#:			**DOB:**		
Street Address:			**City,State,Zip:**		
Phone:	#1		#2		
Medicaid County:		**Medicaid #:**		**County of Residence:**	
2. Guardian/Authorized Rep Data					
Is there a Guardian/Rep?:	Yes☐ No ☐ NA ☐				
If yes, relationship:					
First Name:			**Last Name:**		
Street Address:			**City,State,Zip:**		
Phone:	#1		#2		
3. Emergency Contact Data					
First Name:			**Last Name:**		
Street Address:			**City,State,Zip:**		
Phone:	#1		#2		

Other Friends/Family

Name	**Relationship**	**Address**	**Phone #1**	**Phone #2**

4. Benefits and Payee Contact Data			
Benefits:	**SSI:** Yes☐ No ☐ NA ☐	**SSDI:** Yes☐ No ☐ NA ☐	**Other:**
Payee:	Yes☐ No ☐ NA ☐		

First Name:		Last Name:	
Phone:	#1	#2	
5. Diversion Staff Data			
First Name:		Last Name:	
Phone:	#1	#2	
6. Transition Coordinator Data			
First Name:		Last Name:	
Phone:	#1	#2	
7. Clinical Care Coordinator Data			
First Name:		Last Name:	
Phone:	#1	#2	
8. Current Living Situation:	☐ Private Residence (Owned, rented or leased by individual/family, If checked: ☐ Owned ☐ Rented or Leased ☐ Alternative Family Living (AFL) ☐ Adult Care Home (ACH, ALF, FCH) ☐ Other ☐ 5600 Licensed Group Home		

SECTION B: COMMUNITY INTEGRATION PLANNING
(SEE COMMUNITY INTEGRATION PLANNING GUIDANCE)

SECTION C: MEDICAL AND MENTAL HEALTH INFORMATION (Optional if individual is already known to LME-MCO)			
Doctor # 1 PCP	**Date Updated:**		
a. Doctor's name:			
b. Practice Name:			
c. Street Address:		**d. City, State, Zip**	
e. Phone:	**#1**	**#2**	
f. Why I see this doctor:			
Doctor # 2	**Date Updated:**		
a. Doctor's name:			
b. Practice Name"			
c. Street Address:		**d. City, State, Zip**	
e. Phone"	**#1**	**#2**	
f. Why I see this doctor:			

Doctor # 3	Date Updated:		
a. Doctor's name			
b. Practice Name			
c. Street Address:		d. City, State, Zip	
e. Phone	#1	#2	
f. Why I see this doctor			
Doctor # 4	Date Updated:		
a. Doctor's name			
b. Practice Name			
c. Street Address:		d. City, State, Zip	
e. Phone	#1	#2	
f. Why I see this doctor			

CURRENT HEALTH ISSUES

1.	Medical Issue/Condition – Date Updated:	Medication Prescribed	Date of Onset	Doctor/Practice Treating Issue	Client Perception of Severity of Condition
a.		☐ Yes ☐ No			
b.		☐ Yes ☐ No			
c.		☐ Yes ☐ No			
d.		☐ Yes ☐ No			
e.		☐ Yes ☐ No			

2.	Mental Health Issue/Condition – Date Updated:	Medication Prescribed	Date of Onset	Doctor/Practice Treating Issue	Client Perception of Severity of Condition
a.		☐ Yes ☐ No			
b.		☐ Yes ☐ No			
c.		☐ Yes ☐ No			
d.		☐ Yes ☐ No			
e.		☐ Yes ☐ No			

PHARMACY INFORMATION			
Pharmacy Information			
Pharmacy Name:			
Street Address:		City, State, Zip	

Phone:	#1	#2

Known Allergies	Reaction

MEDICATIONS - Date Updated:

	List Medications (including supplements and over the counter)	Prescribed for condition # above	Dose	Frequency	Date prescribed	Prescribing Physician	Pharmacy
a.							
b.							
c.							
d.							
e.							
f.							
g.							
h.							

SECTION D: SIGNATURES (OPTIONAL)

Signature	Date	Relationship