

RECORDS MANAGEMENT AND DOCUMENTATION MANUAL

For

Providers of Publicly-Funded Mental Health, Intellectual or
Developmental Disabilities, and Substance Use Services

and

Local Management Entities-Managed Care Organizations



North Carolina

Department of Health and Human Services

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services



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APSM 45-2

Effective December 1, 2016



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APPENDIX A

STANDARDIZED FORMS

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- A-3: Person-Centered Plan Template
- A-4: Record Storage Log

Appendix A-1

Certification of Need for Institutional Care for Individual Under Age 21

**DIVISION OF MEDICAL ASSISTANCE
CERTIFICATION OF NEED FOR INSTITUTIONAL CARE
FOR
INDIVIDUAL UNDER AGE 21**

The purpose of this form is to communicate between the county department of social services, attending physician, and Division of Medical Assistance (DMA) about the anticipated duration of treatment for an individual under age 21. The information is required for a determination of financial eligibility for Medicaid.

SECTION A: REQUEST TO PHYSICIAN (Completed by County DSS)

Name of Individual _____ Date of Birth _____

Medicaid coverage has been requested for medical care and treatment in an institutional setting for the above-named individual. The place and the expected duration of care and treatment are required in order to establish financial eligibility for Medicaid.

PHYSICIAN: Please complete SECTION B and also SECTION C, if appropriate, and ATTACH REQUESTED MEDICAL RECORDS AND DOCUMENTATION. **Return as soon as possible to:**

_____ County DSS

Attention: _____ (Caseworker)

Date of Request: _____

SECTION B: RECOMMENDED DURATION OF CARE AND TREATMENT

1. Based on primary diagnosis of _____
and secondary diagnosis of _____
continuous care and treatment are recommended as follows:

a) Medicaid Certified Facilities:

- (1) _____ months, acute care general or psychiatric hospital
- (2) _____ months, inpatient substance abuse hospital
- (3) _____ nursing facility (skilled or intermediate care)
- (4) _____ months, intermediate care/mentally retarded
- (5) _____ months, psychiatric residential treatment facility

b) Non-Medicaid Facilities (not covered by Medicaid):

- (1) _____ months, residential treatment
- (2) _____ months, therapeutic group home
- (3) _____ months, other (specify type): _____

2. Medical records/documentation are needed when continuous care and treatment in a Medicaid-certified medical institution are expected to exceed 12 months or more. The following records and/or documentation are enclosed:

- a) _____ For skilled or intermediate nursing care, FL-2 only
- b) _____ For intermediate care for the mentally retarded, MR-2 only

- c) _____ For acute inpatient care in a general hospital, psychiatric hospital, substance abuse hospital, or psychiatric residential treatment facility, (submit all available records)

History of current illness

- _____ Official medical records for past 6 months
_____ Discharge summaries for all inpatient, residential, or group home placements for past 12 months or dates of same
_____ List of current medications
_____ Plan of care with goals and time frames

3. Care is to be provided at _____
(Name of institution or facility)
beginning on (date) _____

4. I (will / will not) be treating this individual in this institution/facility.

SECTION C: PHYSICIAN CERTIFICATION (Completed by attending physician)

I understand this certification form is for the purpose of establishing financial eligibility for Medicaid and not for the purpose of determining medical necessity for the recommended care and treatment stated in SECTION B.

I certify that the recommended care and treatment and the expected duration of such care and treatment are based on my best judgment and evaluation of the individual's current medical condition and needs and that a false certification or misleading statement which results in Medicaid payments for which the individual would not otherwise have qualified may subject me to civil and criminal penalties.

Physician's Name: _____ Phone No. _____

Physician's Signature: _____ Date: _____

Address: _____

SECTION D: DMA APPROVAL FOR DETERMINATION OF FINANCIAL ELIGIBILITY (Completed by DMA)

This approval authorizes the county DSS to establish financial eligibility of the named individual without regard to the income and resources of the parents. Neither the county DSS nor DMA is making a determination that institutional services are medically necessary. DMA expressly reserves the right to review the medical necessity of institutional services reimbursed by the Medicaid program, to recover improper payments, and to prosecute any person suspected of knowingly and willfully making or causing to be made a false statement or representation of a material fact intended for use in determining entitlement to Medicaid coverage.

Name of authorized agent: _____

Title of authorized agent: _____

Signature of authorized agent: _____

Date: _____

Appendix A-2

Child/Adolescent Discharge/Transition Plan

Consumer Name _____ Service Record # _____

Date the Child and Family Team met to develop this discharge/transition plan: _____

Division of MH/DD/SAS
Division of Medical Assistance

Child/Adolescent Discharge/Transition Plan

This document must be submitted with the completed ITR, the required PCP (i.e. introductory, complete or update) and any other supporting documentation justifying the request for authorization and reauthorization of Residential Levels III and IV. In addition, for reauthorization of Residential Level III and IV, a new comprehensive clinical assessment by a psychiatrist (independent of the residential provider and its provider organization) that includes clinical justification for continued stay at that level of care is required to be submitted. An incomplete ITR, PCP or lack of Discharge/Transition Plan and a new comprehensive clinical assessment (when applicable) will result in a request being "unable to process".

I. The recipient's expected discharge date from the following service is:

- Residential Level III Expected Discharge Date: ___/___/___
- Residential Level IV Expected Discharge Date: ___/___/___

II. At time of discharge the recipient will transition and/or continue with the following services. Please indicate both the planned date of admission to each applicable service and the anticipated provider.

- Natural and Community Supports (Provide details in Section III.)
- Outpatient Individual Therapy ___/___/___ Provider: _____
- Outpatient Family Therapy ___/___/___ Provider: _____
- Outpatient Group Therapy ___/___/___ Provider: _____
- Medication Management ___/___/___ Provider: _____
- Respite ___/___/___ Provider: _____
- Intensive In-Home ___/___/___ Provider: _____
- Multisystemic Therapy ___/___/___ Provider: _____
- Substance Abuse Intensive Outpatient ___/___/___ Provider: _____
- Day Treatment ___/___/___ Provider: _____
- Level II Program Type ___/___/___ Provider: _____
- Therapeutic Foster Care ___/___/___ Provider: _____
- PRTF ___/___/___ Provider: _____
- Other _____ ___/___/___ Provider: _____
- Other _____ ___/___/___ Provider: _____
- Other _____ ___/___/___ Provider: _____

III. The Child and Family Team has engaged the following natural and community supports to both build on the strengths of the recipient and his/her family and meet the identified needs.

| | | |
|-------------------|------------|-------------|
| Name/Agency _____ | Role _____ | Date: _____ |
| Name/Agency _____ | Role _____ | Date: _____ |
| Name/Agency _____ | Role _____ | Date: _____ |
| Name/Agency _____ | Role _____ | Date: _____ |

IV. Input into the Person-Centered Plan developed by the Child and Family Team was received from the following (Check all that apply):

- Recipient
- Family/Caregivers
- Natural Supports
- Community Supports (e.g. civic & faith based organizations)
- Local Management Entity
- Residential Provider
- MH/SA TCM Provider
- Court Counselor
- School (all those involved)
- Social Services
- Medical provider
- Other _____

Consumer Name _____ Service Record # _____

V. Please explain your plan for transition to new services and supports (i.e. engaging natural and community supports, identification of new providers, visits home or to new residence, transition meetings with new providers, etc.) Who will do what by when?

Activity _____ Responsible Party _____ Implementation Date _____

VI. The Child and Family Team updated the Crisis Plan as part of the PCP Revision to include issues of safety at home, at school and in the community.

Yes No

Please explain: _____

VII. For recipients identified as high risk for dangerous or self-injurious behaviors the discharge/transition plan includes admission to the appropriate level of care.

Yes No

Please explain: _____

VIII. The Child and Family Team has identified and addressed the following potential barriers to success of the discharge/transition plan.

IX. The Child and Family Team will meet again on ___/___/___ in order to follow-up on the discharge/transition plan and address potential barriers.

X. Required Signatures

Recipient _____ Date ___/___/___

Legally Responsible Person _____ Date ___/___/___

Qualified Professional _____ Date ___/___/___
(Person responsible for the PCP)

I agree with the Child and Family Team recommendation.

I do not agree with the Child and Family Team recommendation.

(*Please note signature below is required by SOC regardless of agreement with recommendation. Signature does not indicate agreement or disagreement of Child and Family Team recommendation, merely review of discharge plan.)

LME SOC/Representative _____ Date ___/___/___

(Required for residential requests only)

Appendix A-3

Person-Centered Plan

ACTION PLAN

The Action Plan should be based on information and recommendations from: **the Comprehensive Clinical Assessment (CCA), the One Page Profile, Characteristics/Observations/Justifications for Goals, and any other supporting documentation.**

Long Range Outcome: (Ensure that this is an outcome desired by the individual, and not a goal belonging to others).

| |
|--|
| |
|--|

Where am I now in the process of achieving this outcome? (Include progress on goals over the past years, as applicable).

| |
|--|
| |
|--|

| CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: | | | |
|---|------------------------|---------------------|---|
| WHAT (Short Range Goal) | WHO IS RESPONSIBLE | SERVICE & FREQUENCY | |
| | | | |
| HOW (Support/Intervention) | | | |
| Target Date (Not to exceed 12 months) | Date Goal was reviewed | Status Code | Progress toward goal and justification for continuation or discontinuation of goal. |
| / / | / / | | |
| / / | / / | | |
| / / | / / | | |
| Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued | | | |

| CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: | | | |
|---|------------------------|---------------------|---|
| WHAT (Short Range Goal) | WHO IS RESPONSIBLE | SERVICE & FREQUENCY | |
| | | | |
| HOW (Support/Intervention) | | | |
| Target Date (Not to exceed 12 months) | Date Goal was reviewed | Status Codes | Progress toward goal and justification for continuation or discontinuation of goal. |
| / / | / / | | |
| / / | / / | | |
| / / | / / | | |
| Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued | | | |

**** Copy and use as many Action Plan pages as needed.**

CRISIS PREVENTION AND INTERVENTION PLAN

(Use this form or attach your crisis plan.)

Significant event(s) that may create increased stress and trigger the onset of a crisis. (Examples include: Anniversaries, holidays, noise, change in routine, in ability to express medical problems or to get needs met, etc. Describe what one may observe when the person goes into crisis. Include lessons learned from previous crisis events):

Crisis prevention and early intervention strategies that were effective. (List everything that can be done to help this person AVOID a crisis):

Strategies for crisis response and stabilization. (Focus first on natural and community supports. Begin with least restrictive steps. Include process for obtaining back-up in case of emergency and planning for use of respite, if an option. List everything you know that has worked to help this person to become stable):

Describe the systems prevention and intervention back-up protocols to support the individual. (i.e. Who should be called and when, how can they be reached? Include contact names, phone numbers, hours of operation, etc. Be as specific as possible.)

Specific recommendations for interacting with the person receiving a Crisis Service:

PLAN SIGNATURES

I. PERSON RECEIVING SERVICES:

- I confirm and agree with my involvement in the development of this PCP. My signature means that I agree with the services/supports to be provided.
- I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for this PCP.
- For CAP-MR/DD services only, I confirm and understand that I have the choice of seeking care in an intermediate care facility for individuals with mental retardation instead of participating in the Community Alternatives Program for individuals with Mental Retardation/Developmental Disabilities (CAP-MR/DD).

Legally Responsible Person: Self: Yes No

Person Receiving Services: (Required when person is his/her own legally responsible person)

Signature: _____ Date: ____/____/____
(Print Name)

Legally Responsible Person (Required if other than person receiving Services)

Signature: _____ Date: ____/____/____
(Print Name)

Relationship to the Individual: _____

II. PERSON RESPONSIBLE FOR THE PCP: The following signature confirms the responsibility of the QP/LP for the development of this PCP. The signature indicates agreement with the services/supports to be provided.

Signature: _____ Date: ____/____/____
(Person responsible for the PCP) (Name of Case Management Agency)

Child Mental Health Services Only:

For individuals who are less than 21 years of age (less than 18 for State funded services) and who are receiving or in need of enhanced services and who are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the adult criminal court system, the person responsible for the PCP must attest that he or she has completed the following requirements as specified below:

- Met with the Child and Family Team - Date: ____/____/____
- OR** Child and Family Team meeting scheduled for - Date: ____/____/____
- OR** Assigned a TASC Care Manager - Date: ____/____/____
- AND** conferred with the clinical staff of the applicable LME to conduct care coordination.

If the statements above do not apply, please check the box below and then sign as the Person Responsible for the PCP:

- This child is not actively involved with the Department of Juvenile Justice and Prevention or the adult criminal court system.

Signature: _____ Date: ____/____/____
(Person responsible for the PCP) (Print Name)

III. SERVICE ORDERS: **REQUIRED for all Medicaid funded services; RECOMMENDED for State funded services.**

(SECTION A): For services ordered by one of the Medicaid approved licensed signatories (see Instruction Manual).

My signature below confirms the following: (Check all appropriate boxes.)

- Medical necessity for services requested is present, and constitutes the Service Order(s).
- The licensed professional who signs this service order has had direct contact with the individual. Yes No
- The licensed professional who signs this service order has reviewed the individual's assessment. Yes No

Signature: _____ License #: _____ Date: ____/____/____
(Name/Title Required) (Print Name)

(SECTION B): For Qualified Professionals (QP) / Licensed Professionals (LP) ordering:

- CAP-MR/DD or
- Medicaid Targeted Case Management (TCM) services (if not ordered in Section A)
- **OR recommended** for any state-funded services not ordered in Section A.

My signature below confirms the following: (Check all appropriate boxes.) Signatory in this section must be a Qualified or Licensed Professional.

- Medical necessity for the CAP-MR/DD services requested is present, and constitutes the Service Order.
- Medical necessity for the Medicaid TCM service requested is present, and constitutes the Service Order.
- Medical necessity for the State-funded service(s) requested is present, and constitutes the Service Order

Signature: _____ License #: _____ Date: ____/____/____
(Name/Title Required) (Print Name) (If Applicable)

IV. SIGNATURES OF OTHER TEAM MEMBERS PARTICIPATING IN DEVELOPMENT OF THE PLAN:

Other Team Member (Name/Relationship): _____ Date: ____/____/____

Other Team Member (Name/Relationship): _____ Date: ____/____/____

Appendix A-4

Record Storage Log

APPENDIX B

SAMPLE FORMS

B-1: Sample Service Note A

B-2: Sample Service Note B

B-3: Sample Service Note C

B-4: Sample Service Note D

B-5: Sample Grid Form and Instructions for Using a Grid, Including the Sample Grid

B-6: Sample Form for PSR Note

B-7: Sample Juvenile Justice – Behavioral Health Multi-Party Consent for Release of Information form

B-8: Sample Memorandum of Understanding for North Carolina Juvenile Justice and Mental Health/Developmental Disabilities/Substance Abuse Systems

Appendix B-1

Sample Service Note A

| | |
|---------------------|---|
| Name: | 1. Date of Service |
| Medicaid ID Number: | 2. Identification of Recipient – if different from the client |
| Record Number: | 3. Purpose of Contact 4. Description of Intervention(s) 5. Effectiveness of the Intervention(s) 6. Duration of the Service - All periodic, as required by the specific service, or as otherwise required 7. Professional Signature - Degree, credentials, or licensure Paraprofessional Signature – Position |

SAMPLE

Appendix B-2

Sample Service Note B

| | |
|---------------------|--|
| Name : | 1. Date of Service |
| Medicaid ID Number: | 2. Identification of Recipient – if different from the client |
| Record Number: | 3. Purpose of Contact |
| | 4. Description of Intervention(s) |
| | 5. Effectiveness of the Intervention(s) |
| | 6. Duration of the Service - All periodic, as required by the specific service, or as otherwise required |
| | 7. Professional Signature - Degree, credentials, or licensure |
| | Paraprofessional Signature – Position |
| | |
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| | |

SAMPLE

Appendix B-3
Sample Service Note C

| | | | | | |
|--------------|-----------------|--|--|-----------------------|---------------------------------|
| NAME: | | MEDICAID ID #: | | RECORD NUMBER: | |
| Date | Duration | Instructions: Briefly state purpose of contact, describe the intervention(s), and the effectiveness of the intervention(s). | | | *Full Signature Required |
| | | PURPOSE OF CONTACT: | | | |
| | | DESCRIPTION OF THE INTERVENTION(S): | | | |
| | | EFFECTIVENESS OF THE INTERVENTION(S): | | | |
| | | PURPOSE OF CONTACT: | | | |
| | | DESCRIPTION OF THE INTERVENTION(S): | | | |
| | | EFFECTIVENESS OF THE INTERVENTION(S): | | | |
| | | PURPOSE OF CONTACT: | | | |
| | | DESCRIPTION OF THE INTERVENTION(S): | | | |
| | | EFFECTIVENESS OF THE INTERVENTION(S): | | | |
| | | PURPOSE OF CONTACT: | | | |
| | | DESCRIPTION OF THE INTERVENTION(S): | | | |
| | | EFFECTIVENESS OF THE INTERVENTION(S): | | | |

* For professionals - signature, credentials, degree or licensure; for paraprofessionals - signature and position

Appendix B-4
Sample Service Note D

Service Notes

| | | | |
|---------------------------------------|--|-----------------------------|----------------|
| Individual: | | Medicaid ID#: | Record Number: |
| Date: | | *Shift/Duration of Service: | |
| Purpose of Contact: | | | |
| Intervention(s) [what you did]: | | | |
| Effectiveness of the Intervention(s): | | | |
| *Full Signature Required | | | |
| Date: | | *Shift/Duration of Service: | |
| Purpose of Contact: | | | |
| Intervention(s) [what you did]: | | | |
| Effectiveness of the Intervention(s): | | | |
| *Full Signature Required | | | |
| Date: | | *Shift/Duration of Service: | |
| Purpose of Contact: | | | |
| Intervention(s) [what you did]: | | | |
| Effectiveness of the Intervention(s): | | | |
| *Full Signature Required | | | |

* For professionals – signature, credentials, degree or licensure; for paraprofessional - signature & position

Appendix B-5

Sample Grid Form and Instructions for Using a Grid, Including the Sample Grid

North Carolina Division of Mental Health/ Developmental Disabilities/ Substance Abuse Services

Note: This sample grid may only be used for Personal Care [State-Funded], Respite [except for Institutional Respite], and the following NC Innovations services: Community Networking, Day Supports, In-Home Skill Building, Personal Care, Supported Employment Services, and Supported Living (effective 11/1/16). Community Living and Support will replace In-Home Skill Building and Personal Care effective 11/1/16.

Name of Individual: _____ Medicaid ID#: _____ Record #: _____ Month/Year: _____

Specify Service: _____ LME/MCO: _____ Service Provider/ Agency: _____

| Goals | Key | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
|---------------------------|-----|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|
| | (I) | | | | | | | | | | | | | | | |
| | (A) | | | | | | | | | | | | | | | |
| | (I) | | | | | | | | | | | | | | | |
| | (A) | | | | | | | | | | | | | | | |
| | (I) | | | | | | | | | | | | | | | |
| | (A) | | | | | | | | | | | | | | | |
| Duration [when required]: | | | | | | | | | | | | | | | | |
| Date: | | | | | | | | | | | | | | | | |
| Initials: | | | | | | | | | | | | | | | | |

North Carolina Division of Mental Health/ Developmental Disabilities/ Substance Abuse Services

Note: This sample grid may only be used for Personal Care [State-Funded], Respite [except for Institutional Respite], and the following NC Innovations services: Community Networking, Day Supports, In-Home Skill Building, Personal Care, Supported Employment Services, and Supported Living (effective 11/1/16). Community Living and Support will replace In-Home Skill Building and Personal Care effective 11/1/16.

Name of Individual: _____ Medicaid ID#: _____ Record #: _____ Month/Year: _____

Specify Service: _____ LME/MCO: _____ Service Provider/ Agency: _____

| Goals | Key | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---------------------------|-----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| | (I) | | | | | | | | | | | | | | | | |
| | (A) | | | | | | | | | | | | | | | | |
| | (I) | | | | | | | | | | | | | | | | |
| | (A) | | | | | | | | | | | | | | | | |
| | (I) | | | | | | | | | | | | | | | | |
| | (A) | | | | | | | | | | | | | | | | |
| Duration [when required]: | | | | | | | | | | | | | | | | | |
| Date: | | | | | | | | | | | | | | | | | |
| Initials: | | | | | | | | | | | | | | | | | |

APPENDIX B-5

INSTRUCTIONS FOR USING A GRID, INCLUDING THE SAMPLE GRID

Required Elements of a Service Grid

When a grid is used to document a service, it shall be completed per event, or at least per date of service, to reflect the service provided. Any service grid, whether using the sample grid format contained in this appendix or another grid format, shall include all the following required elements:

1. Name of the individual
2. The service record number, Medicaid ID number (as applicable), or unique identifier
3. Full date [month/day/year] that the service was provided
4. Name of the service being provided [e.g., Personal Care Services]
5. Goals addressed
6. A letter as specified in the appropriate key that reflects the intervention, activities, and/or tasks performed
7. A number or symbol as specified in the appropriate key that reflects the assessment of the individual's progress toward goals
8. Duration
9. Initials of the individual providing the service. The initials shall correspond to a full signature and initials on the signature log section of the grid.
10. A comment section for entering additional or clarifying information, e.g., to further explain the interventions/activities provided, or to further describe the individual's response to the interventions provided and progress toward goals. Each entry in the comment section must be dated.

Services That May Be Documented on a Grid

The use of a service grid is limited to the following services:

- Behavioral Health Prevention Education Services in Selective and Indicated Populations (a sample grid is in Appendix C);
- Community Living and Support [NC Innovations] (*effective 11/1/16*);
- Community Networking [NC Innovations];
- Day Supports [NC Innovations];
- In-Home Intensive Supports [NC Innovations] (*ending 10/31/16*);
- In-Home Skill Building [NC Innovations] (*ending 10/31/16*);
- Personal Care [NC Innovations & State-Funded] (This service may be documented using a combination of a grid/checklist and a modified service note, unless provided by a home care agency that is following home care licensure rules.) (*PCS for Innovations is ending 10/31/16*);
- Residential Supports [NC Innovations];
- Respite (all categories, except for Institutional Respite, which shall follow the State Developmental Centers' documentation requirements. Respite may be documented on a modified service note, a service grid, or a combination of the two. SPECIAL NOTE: For Community Respite [YP730], if using a service grid, documentation is required per date of service. If using a modified service note, or a combination of a modified note and a service grid, documentation frequency is per date of service, if the duration of the service was no longer than a day. If longer than a day, documentation shall be for the duration of the event, but not less than weekly.);
- Supported Employment Services [NC Innovations]; and
- Supported Living [NC Innovations] (*effective 11/1/16*).

Purpose: The purpose of a grid is to provide a means of quickly capturing the goal(s) addressed, the staff's intervention/activities and the assessment of the individual's progress toward the goals established.

In addition to the required elements listed above [1-10], the following guidelines should be followed when using a grid:

1. **Page ___ of ___:** The number of sheets that will be needed per 15/16-day cycle will depend on how many goals the individual has in the service plan.
2. **Month/Year:** Enter the month and year for service coverage.
3. **Shift:** When appropriate, enter the shift for which the entries represent.
4. **LME-MCO:** Enter the name of the LME-MCO.
5. **Service Provider/Agency:** Enter the name of the provider/agency.
6. **Goal(s):** Enter the goal as stated in the individual's service plan. The goal should be written as documented in the service plan.
7. **Key:** A key(s) utilizing letters shall be developed to reflect interventions/activities. A key(s) utilizing numbers or symbols shall be developed to reflect the assessment of the individual's progress toward the goals. All keys developed shall be identified in a Key Menu.

On the grid in the Key box, identify in the top part of the box labeled "I" the key to be used to reflect the interventions/activities. On the bottom part labeled "A", the key is used to reflect the assessment of the individual's progress toward the goals.

8. **Numbered Boxes 1-15/16-31:** Each numbered box represents a day of the month. The number of boxes used will depend on how many days are in that particular month. Each box is divided into an upper half and a lower half. The top half of the box represents the intervention/activity provided [noted as an "I" in top half of the key section], and the lower half [noted as an "A"] represents the assessment of the individual's progress toward the goals. Based upon the key identified in the Key box, assign a letter that represents the intervention/activity provided and a number or symbol that represents the assessment of the individual's progress toward goals. A number can be placed in front of the key used to signify how many interventions/activities the staff provided.
9. **Duration:** Enter the total amount of time spent performing the intervention(s).
10. **Date:** Enter the date of service provision the documentation is initialed for services provided to the individual.
11. **Initials:** The provider shall enter his or her initials for each day he or she provides a service to the individual. The initials shall correspond to the section on the back of the form called, "All Staff Persons Working with This Individual Must Fill Out the Information Below."
12. **Comments:** Each entry shall be dated. This section is for entering additional or clarifying information, e.g., to further explain the interventions/activities provided or to further describe the individual's response to the interventions provided and progress toward goals.
13. **All Staff Persons Working With This Individual Must Fill Out The Information Below:** A staff person working with the individual shall complete this section, which includes the staff person's printed name, full signature, and initials.

Appendix B-6

Sample Form for PSR Note

Psychosocial Rehabilitation [PSR] Notes

Name of Individual: _____ Medicaid ID Number: _____ Record Number: _____

| Date: | Duration - Time spent performing the interventions: | Instructions: Briefly state purpose of contact, description of intervention/activity, and the effectiveness of the intervention/activity. | Staff Signature/Position [full signature required] |
|-------|---|--|--|
| | | <p>Purpose of Contact: [Individual's goals may be pre-printed here.]</p> <p>The following Interventions/Activities were provided to the member and participation was encouraged, monitored and/or modeled by staff: <input type="checkbox"/> Pre-vocational <input type="checkbox"/> Recreation/Leisure <input type="checkbox"/> Community Living <input type="checkbox"/> Social Relationships <input type="checkbox"/> Educational <input type="checkbox"/> Personal Care/Daily Living <input type="checkbox"/> Other _____</p> <p>Effectiveness of the Interventions:</p> | |
| | | <p>Purpose of Contact: [Individual's goals may be pre-printed here.]</p> <p>The following Interventions/Activities were provided to the member and participation was encouraged, monitored and/or modeled by staff: <input type="checkbox"/> Pre-vocational <input type="checkbox"/> Recreation/Leisure <input type="checkbox"/> Community Living <input type="checkbox"/> Social Relationships <input type="checkbox"/> Educational <input type="checkbox"/> Personal Care/Daily Living <input type="checkbox"/> Other _____</p> <p>Effectiveness of the Interventions:</p> | |

Appendix B-7

Sample Juvenile Justice – Behavioral Health Multi-Party Consent for Release of Information Form



Juvenile Justice – Behavioral Health

Multiple-Party Consent for Release of Information

Medicaid /Other Insurance #: _____
Medical Record #: _____
NC-JOIN #: _____

Juvenile’s Full Name: _____ DOB: _____
Parent, Guardian, or Custodian: _____ County: _____

I authorize the NC Department of Public Safety, Juvenile Justice (hereinafter, “JJ”) and the following parties:

(1) Mental Health, Developmental Disabilities, or Substance Abuse Services Provider
Name: _____
Address: _____
Phone: _____

(2) Local Management Entity/Managed Care Organization (if necessary to authorize services)
Name: _____
Address: _____
Phone: _____

(3) Agency to facilitate multi-system coordination
Name: _____
Address: _____
Phone: _____

(4) Other
Name: _____
Address: _____
Phone: _____

(5) Other
Name: _____
Address: _____
Phone: _____

(6) Other
Name: _____
Address: _____
Phone: _____

To communicate with and disclose to one another the following information relating to the juvenile named above.

Table with 2 columns: INFORMATION TO BE SHARED: (1-10) and (11-15). Includes a note: 'I authorize all of the foregoing information to be shared unless I indicate here, by number, one or more categories of information not to be shared:'



| | | |
|--|--------------------------------------|--|
| | PURPOSE OF USE AND DISCLOSURE | |
|--|--------------------------------------|--|

The purposes for the disclosures authorized by this form are:

1. To assess the juvenile's need for mental health, developmental disabilities, or substance abuse services (hereinafter, "MH, DD, SA services").
2. To provide, manage, and coordinate JJ and MH, DD, SA services for the juvenile.
3. To develop a Person Centered Plan, Service Plan, and/or Treatment Plan for the juvenile.
4. To make dispositional recommendations for a court-involved juvenile.
5. To establish financial assistance or other payment for services.
6. To assess the quality and effectiveness of JJ and MH, DD, SA services.
7. To improve service and treatment outcomes for juveniles involved in the JJ and MH, DD, SA services systems.
8. Other (please specify): _____

| | | |
|--|---------------------------------|--|
| | REVOCAION AND EXPIRATION | |
|--|---------------------------------|--|

I understand that I have the right to revoke this authorization at any time except to the extent that a person or agency which is to make a disclosure has already taken action in reliance on it. If I want to revoke this authorization, I may sign the ACT TO REVOKE section attached to this form and submit it to one of the agencies named above. In addition, authorization for an MH, DD, SA services provider to disclose information may be revoked by following the procedures described in that provider's Notice of Privacy Practices. If not revoked sooner, this authorization expires automatically upon the termination of either JJ involvement or juvenile court jurisdiction, or one year from the date it is signed, whichever is earlier. Authorization to disclose information for the purpose of continuing established financial benefits will be considered valid until the cessation of benefits.

| | | |
|--|---|--|
| | REDISCLASURE AND CONFIDENTIALITY | |
|--|---|--|

Once health care information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing information to others. However, mental health, developmental disabilities, and substance abuse information protected by state law (G.S. 122C), as well as substance abuse treatment information protected by federal law (42 C.F.R. Part 2), remain confidential and must not be redisclosed by the recipient except as authorized by those laws or this authorization.

| | | |
|--|--------------------------------|--|
| | NOTICE OF VOLUNTARINESS | |
|--|--------------------------------|--|

I understand that I have the legal right to refuse to sign this authorization form. If I choose not to sign this form, I understand that healthcare providers and health plans cannot deny or refuse to provide treatment, payment for treatment, enrollment in a health plan, or eligibility for health plan benefits because of my refusal to sign.



2. I am revoking the authority of the parties named below to disclose and receive information:

I hereby give notice that the authorization to disclose information relating to _____
Print name of juvenile

signed by me _____ on _____ is revoked, effective _____
Print name of person who signed authorization Date of authorization Date

only with respect to the party or parties named below. The authorization remains in effect for other parties named in the authorization.

Authority of _____ to disclose and receive information is revoked.

Authority of _____ to disclose and receive information is revoked.

Authority of _____ to disclose and receive information is revoked.

Authority of _____ to disclose and receive information is revoked.

Signature of person who is revoking authorization Date

Signature of Staff witnessing the revocation Date

B. VERBAL REVOCATION

I, _____, attest that a verbal declaration was made on
Print name of staff receiving revocation

_____ by _____ to revoke this authorization
Date of verbal revocation Print name of person revoking authorization

to disclose information relating to _____.
Print name of juvenile

Signature of staff receiving revocation Date

Appendix B-8

Sample Memorandum of Understanding for North Carolina Juvenile Justice and
Mental Health/Developmental Disabilities/Substance Abuse Systems

Sample Memorandum of Understanding for North Carolina Juvenile Justice and Mental Health/ Developmental Disabilities/Substance Abuse Systems

I. This Agreement supports and facilitates the exchange of information between parties of the agreement in order to effectively coordinate services and provide oversight and evaluation of the quality and effectiveness of services to those children and families involved in the juvenile justice and mental health and/or substance abuse systems, and is made and entered into as of the date set forth below, by and between the following parties whose representatives have signed the agreement:

1. North Carolina Department of Public Safety, Juvenile Justice Section;
2. Mental Health, Developmental Disabilities, or Substance Abuse Services Provider(s) ;
3. Local Management Entity/Managed Care Organization(s);
4. Local Education Authority or School, _____
5. Community Based Organization(s), _____; (s); and 6. Administrative Office of the Courts.

II. Purposes

Whereas, all parties are committed to ensuring that youth involved with both the juvenile justice and mental health/substance abuse systems and their families are afforded the least burdensome delivery of services;

Whereas, the privacy and confidentiality of information regarding youth in the juvenile justice and mental health/substance abuse systems is an important legal and ethical obligation;

Whereas, all parties are committed to improving cooperation, integration, and collaboration at the service delivery, administrative, and evaluative levels for the benefit of youth and families involved with the juvenile justice and mental health and substance abuse systems;

Whereas, all parties agree that improvements to the quality and effectiveness of services can be supported by the sharing of relevant and necessary information;

Whereas, all parties agree that the exchange of information between juvenile justice and mental health/substance abuse systems is allowable and encouraged within the parameters of G.S. 7B-3100, G.S. 90-21.4(b), G.S. 122C, 42 C.F.R. Part 2, 45 C.F.R. 164, 10A N.C.A.C. 26B and 14B N.C.A.C. 11A .0301;

Whereas, all parties mutually agree that this agreement shall be interpreted in light of, and consistent with governing State and Federal laws;

Whereas, all parties agree that information identifying the youth should be shared only to the degree it is necessary for the recipient of the information to perform his or her role and that information shared for evaluation of the quality and effectiveness of services will be used when protections of the youth's identity have been utilized;

Now, therefore, the parties agree that this Memorandum of Understanding reflects their understanding and agreement as to the permitted and prohibited sharing and uses of information in the juvenile justice process.

III. Definitions:

1. "Juvenile Justice information" or "Juvenile Justice Records" means any information, whether recorded or not, relating to an individual's involvement with the juvenile justice system, including confidential records and files maintained by clerks of superior court, law enforcement agencies, and the North Carolina Department of Public Safety, Juvenile Justice Section.
2. "Confidential information" means any information, whether recorded or not, relating to an individual served by a mental health, developmental disabilities, or substance abuse services provider that is received in connection with the performance of any function of the provider.
3. "Mental health, developmental disabilities, or substance abuse services provider" means any person or entity at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers.
4. "Local management entity/managed care organization" or "LME/MCO" means an area mental health, developmental disabilities, and substance abuse authority that is responsible for the management and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level and that is under contract with Department of Health and Human Services to operate the combined Medicaid Waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act.
5. Community Based Provider means any person or entity whose purpose is to provide, support engagement in, and/or coordinate services for the care of a juvenile, which may include assessment, treatment, community service, restitution, positive youth development or recreational activities.
6. Juvenile Justice-Behavioral Health Partnership local team means a cross-agency team, such as Reclaiming Futures or Juvenile Justice Substance Abuse Mental Health Partnership (JJSAMHP) or Juvenile Justice Treatment Continuum (JJTC) that works to improve the system of care for juvenile justice involved youth with mental health, substance abuse or co-occurring disorders.

IV. Each of The Parties Agrees To:

1. Promote a mutual understanding of the allowances and limitations outlined in G.S. 7B-3100, G.S. 90-21.4(b), G.S. 122C, 42 C.F.R. Part 2, 45 C.F.R. 164, 10A N.C.A.C. 26B and 14B N.C.A.C. 11A .0301, and other applicable state and federal laws;
2. Delineate how the agencies will work together to facilitate information sharing and to ensure that confidential information is disseminated only to the appropriate persons or agencies as provided by law or otherwise pursuant to a lawfully obtained consent form;
3. Train relevant staff in procedures for interagency collaboration and information sharing;
4. Comply with relevant state and federal law and other applicable local rules and ethical standards, which relate to records use, dissemination, and retention/destruction;
5. Comply with relevant state and federal law and other applicable local rules and ethical standards, which relate to the dissemination of information, whether written or oral.
6. Develop appropriate internal written policies to ensure that confidential information concerning juveniles is disseminated only to appropriate personnel.

IV. The N.C. Department of Public Safety, Juvenile Justice Section Agrees To:

1. Share juvenile justice information with any party to this agreement, pursuant to a court order or the written consent of the juvenile or the juvenile's parent, guardian, or custodian, in order to assess the juvenile's needs and develop an appropriate service or treatment plan for the juvenile.
2. Share juvenile justice information with any party to this agreement, when required by G.S. 7B3100(a) and 14B N.C.A.C. 11A .0301, upon request and to the extent permitted by federal law and regulations, only for the protection of the juvenile and others or to improve the educational opportunities of the juvenile.
3. Maintain the confidentiality of juvenile justice records and limit disclosure of confidential information concerning juveniles only to authorized persons, in accordance with G.S. 7B-3001(c) and G.S. 7B-3100(b). Authorized persons include the juvenile or the juvenile's attorney, the juvenile's parent, guardian, or custodian, the authorized representative of the juvenile's parent, guardian, or custodian, professionals in the Juvenile Justice Section who are directly involved in the juvenile's case, and juvenile court counselors.
4. Ensure that any statements made by a juvenile during evaluation and intake are protected, pursuant to the juvenile's privilege against self-incrimination and right to counsel under the Fifth and Sixth Amendments to the United States Constitution, and Article I, Section 23 of the North Carolina Constitution.
5. Ensure that no statements made by a juvenile to a juvenile court counselor during intake are admitted at an adjudication hearing, in accordance with G.S. 7B-2408.
6. Ensure that information obtained by a juvenile court counselor during intake, including information shared pursuant to this agreement, is not disclosed to the court prior to a dispositional hearing, in accordance with G.S. 7B-2413.
7. Use information shared pursuant to this agreement to prepare predisposition reports and risk and needs assessments for court-involved juveniles, in order to make dispositional recommendations to the court, in accordance with G.S. 7B-2413.
8. Ensure that no predisposition report or risk and needs assessment is completed prior to an adjudication that a juvenile is delinquent or undisciplined without the written consent of the juvenile, the juvenile's parent, guardian, or custodian, or the juvenile's attorney, in accordance with G.S. 7B2413.
9. Allow only the juvenile or the juvenile's attorney, the juvenile's parent, guardian, or custodian, or the District Attorney to examine the predisposition report and any risk and needs assessments prior to the dispositional hearing, in accordance with G.S. 7B-2413.
10. Ensure that the predisposition report is not disclosed to the court prior to the completion of the adjudication hearing, in accordance with G.S. 7B-2413.
11. Share dispositional information as appropriate with other parties to this agreement, as necessary, in order to comply with any evaluation, assessment, or treatment, ordered by the court in accordance with G.S. 7B-2502.

12. Ensure that juvenile justice records maintained by the Juvenile Justice Section are retained and destroyed, in accordance with G.S. 7B-1706 and G.S. 7B-3200.
13. Maintain in accordance with G.S. 122C and 42 C.F.R. Part 2, as applicable, the confidentiality of mental health, developmental disabilities, and substance abuse services information obtained from an entity whose client information is governed by G.S. 122C and 42 C.F.R. Part 2, which entities include mental health, developmental disabilities, or substance abuse services providers and local management entity/managed care organizations.
14. Use and disclose information obtained under G.S. 7B-3100(a) and 14B N.C.A.C. 11A .0301, whether from a provider of mental health, developmental disabilities, or substance abuse services or from a local management entity/managed care organization, only as permitted or required by G.S. 7B-3100(a) and 14B N.C.A.C. 11A .0301 .
15. Use and disclose mental health, developmental disabilities, and substance abuse information acquired pursuant to an NC Department of Public Safety “Juvenile Justice—Behavioral Health, Multiple-Party Consent For Release of Information” (or any valid consent for release of information) only as permitted by the terms of the executed consent for release of information form, unless otherwise permitted or required by law .

V. Each Mental Health, Developmental Disabilities, or Substance Abuse Services Provider, whether providing assessment/evaluation/diagnostic services or treatment services, or both Agrees To:

1. Disclose confidential information to any party of this agreement who is designated on a validly executed NC Department of Public Safety “Juvenile Justice—Behavioral Health, Multiple-Party Consent for Release of Information” form (or any other valid consent for release of information form) in accordance with the terms and limitations of the consent for release of information form.
2. Share juvenile justice information with any party to this agreement, when required by G.S. 7B3100(a) and 14B N.C.A.C. 11A .0301, upon request and to the extent permitted by federal law and regulations, only for the protection of the juvenile and others or to improve the educational opportunities of the juvenile.
3. Use and disclose juvenile justice information obtained under G.S. 7B-3100(a) and 14B N.C.A.C. 11A .0301 only as permitted or required by G.S. 7B-3100(a) and 14B N.C.A.C. 11A .0301 .
4. Use and disclose juvenile justice information acquired pursuant to a NC Department of Public Safety “Juvenile Justice—Behavioral Health, Multiple-Party Consent For Release of Information” (or any valid consent for release of information) only as permitted by the terms of the executed consent for release of information form, unless otherwise permitted or required by law .

VI. Each Local Management Entity/Managed Care Organization Agrees To:

1. Disclose confidential information to any party of this agreement who is designated on a validly executed NC Department of Public Safety “Juvenile Justice—Behavioral Health, Multiple-Party Consent For Release of Information” form (or any other valid consent for release of information form) in accordance with the terms and limitations of the consent for release of information form. 2. Share juvenile justice information with any party to this agreement, when required by G.S. 7B3100(a) and 14B N.C.A.C. 11A .0301, upon request and to the extent permitted by federal

law and regulations, only for the protection of the juvenile and others or to improve the educational opportunities of the juvenile.

3. Use and disclose juvenile justice information obtained under G.S. 7B-3100(a) and 14B N.C.A.C. 11A .0301 only as permitted or required by G.S. 7B-3100(a) and 14B N.C.A.C. 11A .0301.
4. Use and disclose juvenile justice information acquired pursuant to a NC Department of Public Safety “Juvenile Justice—Behavioral Health, Multiple-Party Consent For Release of Information” (or any valid consent for release of information) only as permitted by the terms of the executed consent for release of information form, unless otherwise permitted or required by law.

VII. Administration of the MOU

Term of Agreement:

This Agreement is effective for one year upon the date of the final signature and shall renew automatically for subsequent one-year terms unless otherwise modified. Any signatory to this Agreement may terminate participation upon thirty days’ notice to all other signatories to the Agreement.

Agency Representatives:

This MOU will be administered by the Juvenile Justice-Behavioral Health Partnership local team which consists of the following agency representation: Division of Mental Health, Developmental Disabilities, and Substance Abuse Services Provider(s), Juvenile Justice team members from the Department of Public Safety, Juvenile Justice Section, Local Management Entity-Managed Care Organization, and/or community based organization(s). The interagency management team shall operate as follows:

1. Meet at least monthly to discuss implementation of information sharing agreements, including training and technical assistance to local team members and their staff;
2. Provide quarterly updates to community partners;
3. Review the MOU at least annually for amendments;
4. Respond to queries from local team members and their staff regarding implementation challenges and ensure consistency within the team;

Modification of Agreement:

Modification of this Agreement shall be made by formal consent of all parties, pursuant to the issuance of a written amendment, signed and dated by the parties, prior to any changes.

Other Interagency Agreements:

This agreement does not preclude or preempt each of the agencies individually entering into an agreement with one or more parties to this agreement, nor does it supplant any existing agreement between such parties.

Signatures of Parties to this Agreement:

In Witness Whereof, the parties hereto have entered into this Agreement as evidenced by their signatures below. A certified copy of the Agreement shall be provided to each signatory to the Agreement. The original Agreement shall be filed with the Clerk of [Enter Name].

NC Department of Public Safety, Juvenile Justice Section, District [Enter District Number]

Date **Signature**

For the Administrative Office of the Court, District [Enter District Number]

Signature **Date**

Enter Agency Name, Local Management Entity/Managed Care Organization

Date **Signature**

Enter Agency Name, Provider of Mental Health, Developmental Disabilities, or Substance Abuse Services

Signature **Date**

Enter Agency Name, Provider of Mental Health, Developmental Disabilities, or Substance Abuse Services

Date **Signature**

Enter Agency Name, Provider of Mental Health, Developmental Disabilities, or Substance Abuse Services

Date **Signature**

Enter Agency Name, Community Based Provider

Date **Signature**

Enter Agency Name, Community Based Provider

Date **Signature**

Enter Agency Name, Community Based Provider

Signature **Date**

ATTACHMENTS

Insert here list of forms or other pertinent documents to implement the above agreement

APPENDIX C

SERVICE SPECIFIC FORMS FOR SUBSTANCE USE SERVICES

- C-1: Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)
- C-2: Alcohol Use Disorders Identification Test (AUDIT)
- C-3: Drug Abuse Screening Tool (DAST-10)
- C-4: Substance Abuse Behavioral Indicator Checklist II
- C-5: Sample Tuberculosis Screening Instrument for Infectious Tuberculosis, and
 Guidance for Completing Sample TB Screening Instrument

Appendix C-1

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient: _____ Date: _____ Time: _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute: _____ Blood pressure: _____

| | |
|---|--|
| <p>NAUSEA AND VOMITING – Ask “Do you feel sick to your stomach? Have you vomited?” Observation.</p> <p>0 no nausea and no vomiting 1 mild nausea with no vomiting 2 3 4 intermittent nausea with dry heaves 5 6 7 constant nausea, frequent dry heaves and vomiting</p> | <p>TACTILE DISTURBANCES – Ask “Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin? Observation.</p> <p>0 none 1 very mild itching, pins and needles, burning or numbness 2 mild itching, pins and needles, burning or numbness 3 moderate itching, pins and needles, burning or numbness 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations</p> |
| <p>TREMOR – Arms extended and fingers spread apart. Observation.</p> <p>0 no tremor 1 not visible, bur can be felt fingertip to fingertip 2 3 4 moderate, with patient’s arms extended 5 6 7 severe, even with arms not extended</p> | <p>AUDITORY DISTURBANCES – Ask “Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?” Observation.</p> <p>0 not present 1 very mild harshness or ability to frighten 2 mild harshness or ability to frighten 3 moderate harshness or ability to frighten 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations</p> |
| <p>PAROXYSMAL SWEATS – Observation.</p> <p>0 no sweat visible 1 barely perceptible sweating, palms moist 2 3 4 beads of sweat obvious on forehead 5 6 7 drenching sweats</p> | <p>VISUAL DISTURBANCES – Ash “Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?” Observation.</p> <p>0 not present 1 very mild sensitivity 2 mild sensitivity 3 moderate sensitivity 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations</p> |
| <p>ANXIETY – Ask “Do you feel nervous?” Observation.</p> <p>0 no anxiety, at ease 1 mildly anxious 2 3 4 moderately anxious, or guarded, so anxiety is inferred 5 6 7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions</p> | <p>HEADACHE, FULLNESS IN HEAD – Ask “Does you head feel different? Does it feel like there is a band around your head?” Do not rate for dizziness or lightheadedness. Otherwise, rate severity.</p> <p>0 not present 1 very mild 2 mild 3 moderate 4 moderately severe 5 severe 6 very severe 7 extremely severe</p> |
| <p>AGITATION – Observation.</p> <p>0 normal activity 1 somewhat more than normal activity 2 3 4 moderately fidgety and restless 5 6 7 paces back and forth during most of the interview, or constantly thrashes about</p> | <p>ORIENTATION AND CLOUDING OF SENSORIUM – Ask “What day is this? Where are you? Who am I?”</p> <p>0 oriented and can do serial additions 1 cannot do serial additions or is uncertain about date 2 disoriented for date by no more than 2 calendar days 3 disoriented for date by more than 2 calendar days 4 disoriented for place or person</p> |

Total **CIWA-Ar** Score _____
 Rater’s Initials _____
 Maximum Possible Score 67

The **CIWA-Ar** is not copyrighted and may be reproduced freely. This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. The maximum score is 67 (see instrument). Patients scoring less than 10 do not usually need additional medication for withdrawal.

Appendix C-2

Alcohol Use Disorders Identification Test (AUDIT)

ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Please Note: Alcohol is inclusive of: beer, wine, liquor or any other alcoholic beverage.

1. How often do you have a drink containing alcohol?
(0) never (1) monthly (2) 2-4 times a month (3) 2-3 times a week (4) 4 or more times a week
2. How many drinks contain alcohol do you have on a typical day when you are drinking?
(0) 1-2 (1) 3 or 4 (2) 5 or 6 (3) 7-9 (4) 10 or more
3. How often do you have six or more drinks on one occasion?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily
4. How often during the last year have you found that you were unable to stop drinking once you started?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily
7. How often during the last year have you felt guilt or remorse after drinking?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of drinking?
(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily
9. Have you or someone else been injured as a result of your drinking?
(0) no (2) yes, but not in the last year (4) yes, during the last year
10. Has a friend, relative, or doctor or other health worker been concerned about your drinking or suggested you cut down?
(0) no (2) yes, but not in the last year (4) yes, during the last year

Total Score: _____

[Saunders JB, Aasland OG, Babor TF *et al.* Development of the alcohol use disorders identification test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption]

SCORING THE AUDIT

Scores for each question range from 0 to 4, with the first response for each question (e.g. never) scoring 0, the second (e.g. less than monthly) scoring 1, the third (e.g. monthly) scoring 2, the fourth (e.g. weekly) scoring 3, and the last response (e.g. daily or almost daily) scoring 4. For questions 9 and 10, which only have three responses, the scoring is 0, 2 and 4 (from left to right).

A score of 8 or more meets the criteria for a positive screen, refer the individual to the Qualified Professional Substance Abuse for further assessment.

(Refer an **individual under age 21** with a score of 1 or more to the Qualified Professional Substance Abuse for further assessment.)

Appendix C-3

Drug Abuse Screening Tool (DAST-10)

DRUG ABUSE SCREENING TOOL (DAST-10)

1982 by the Addiction Research Foundation. Author: Harvey A. Skinner Ph.D.

The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

- | | | |
|---|-----|----|
| 1. Have you used drugs other than those required for medical reasons? | Yes | No |
| 2. Do you abuse more than one drug at a time? | Yes | No |
| 3. Are you always able to stop using drugs when you want to? | Yes | No |
| 4. Have you ever had blackouts or flashbacks as a result of drug use? | Yes | No |
| 5. Do you ever feel bad or guilty about your drug use? | Yes | No |
| 6. Does your spouse (or parents) ever complain about your involvement with drugs? | Yes | No |
| 7. Have you neglected your family because of your use of drugs? | Yes | No |
| 8. Have you engaged in illegal activities in order to obtain drugs? | Yes | No |
| 9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | Yes | No |
| 10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)? | Yes | No |

Score: _____ (A score of 3 or more, refer the individual for Work First Program Substance Use Testing.)

SCORING THE DAST-10

For the DAST-10, score 1 point for each question answered "yes," except for Question 3 for which a "no point" receives 1.

DAST-10 INTERPRETATION

| Score | Degree of Problems Related to Drug Abuse | Suggested Action |
|-------|--|------------------------------------|
| 0 | No problems reported | none at this time |
| 1-2 | Low level | monitor, re-assess at a later date |
| 3-5 | Moderate level | further investigation |
| 6-8 | Substantial level | intensive assessment |
| 9-10 | Severe level | intensive assessment |

Applicant/Recipient Name _____

Date _____

Appendix C-4

Substance Abuse Behavioral Indicator Checklist II

**SUBSTANCE ABUSE
BEHAVIORAL INDICATOR CHECKLIST II**

This form may be completed if a Work First client has a negative screening for substance abuse, but there is reasonable suspicion that substance abuse issues may be present. When there is an observation of actions, appearance or conduct that may be associated with substance abuse issues, refer the Work First client to a Qualified Substance Abuse Professional (WF/QSAP) for further assessment and/or referral.

Name of Client: _____

Name of Observer: _____

Location: _____

Date Observed: _____

Time of Observation: _____ a.m./p.m.

Check all appropriate items. Behavioral indicators require only one check for referral to a WF/QSAP.

APPEARANCE/PHYSICAL SYMPTOMS:

_____ odor of alcoholic beverage on breath

_____ extremely poor hygiene

_____ constricted pupils (pinpoint)

_____ dilated pupils (enlarged)

_____ glazed or glassy eyes

_____ stumbling/staggering

_____ body odor of alcoholic beverage

_____ lethargic/slow movement

_____ swaying gait

HISTORY OF SUBSTANCE ABUSE RELATED PROBLEMS:

_____ pending DWI court case or drug court case

_____ loss of license for DWI

_____ drug or alcohol arrest or conviction

_____ history of or current substance abuse treatment involvement

_____ reports from employer, probation/parole

_____ of positive drug screen/breathalyzer

_____ positive AUDIT or DAST and non-Compliance with referral to QSAP

_____ prior SUDDS-5 diagnosis and non-

compliance with treatment recommendations

SPEECH:

_____ slurred speech

_____ rapid/accelerated speech

_____ incoherent speech

CONDUCT/BEHAVIOR:

_____ loss of inhibitions with no apparent reason (i.e., yelling, screaming, cursing, assaultive)

_____ failure to report for job interview (2 or more)

_____ repeated missed scheduled appointments

If known, how is the Work First client's behavior different from that previously observed? Be specific and describe any other observations about behaviors or actions not listed above:

To the best of my knowledge, this report represents the appearance, behavior and/or conduct of the above named Work First client, observed by me and upon which I base my decision to refer the person to the WF/QSAP for further assessment and/or referral.

Signature of Observer

Date: _____

To be completed by WF/QSAP:

Was SUDDS-5 completed?

Yes _____ No _____

Was Work First client referred to SA treatment?

Yes _____ No _____

WF/QSAP Signature _____

Date: _____

Appendix C-5

Sample Tuberculosis Screening Instrument for Infectious Tuberculosis
Guidance for Completing Sample TB Screening Instrument

SAMPLE SCREENING INSTRUMENT FOR INFECTIOUS TUBERCULOSIS

| | Yes | No | Comments |
|---|-----|----|----------|
| 1. Has it been more than three (3) months since you've seen a doctor or other health care provider? | | | |
| 2. Have you or do you now live in a shelter or on the streets? | | | |
| 3. Have you been in jail or prison in the past year? | | | |
| 4. Has it been more than one (1) year since you've had a TB skin test? What were the results? | | | |
| 5. Have you ever been told you have TB? | | | |
| 6. Have you ever been treated for TB? | | | |
| 7. Within the past thirty days have you had any of the following symptoms for two (2) or more weeks: | | | |
| • Fever | | | |
| • Drenching night sweats (See Guidance page for qualifications.) | | | |
| • Productive cough | | | |
| • Coughing up blood | | | |
| • Shortness of breath | | | |
| • Lumps or swollen glands in the neck or armpits | | | |
| • Unexplained weight loss [losing weight without meaning to] | | | |
| • Diarrhea lasting more than a week | | | |
| 8. Has anyone you know or lived with been told they have TB in the past year? | | | |
| 9. Do you live with anyone who has had either of these symptoms: coughing up blood or drenching night sweats? | | | |

Signature

Date

GUIDANCE FOR COMPLETING SAMPLE SCREENING INSTRUMENT FOR INFECTIOUS TUBERCULOSIS

The following questions in this screening instrument are worded so that an answer of “yes” indicates an increased risk of infection of tuberculosis. Referral to a local health department should be made when an increased risk is identified. Following each question is background information pertaining to the question and the rationale for its conclusion.

1. Has it been more than three (3) months since you’ve seen a doctor or other health care provider?
(This question is a lead-in intended to put the interviewee at ease.)
2. Have you or do you now live in a shelter or on the streets?
(This question is asked because there is an increase in the incidence of TB among homeless individuals that is related to their crowded conditions and limited access to medical care.)
3. Have you been in jail or prison in the past year?
(In certain areas, there is an increased risk of TB exposure among individuals who have been incarcerated. This is related to crowded conditions and to the common occurrence of sexual assault among prison inmates.)
4. Has it been more than one (1) year since you’ve had a TB skin test? What were the results?
(This question is intended to identify individuals with latent TB who are, as a consequence, at risk for active TB. Although most individuals with positive TB skin tests do not have active TB, individuals in outreach populations who have been screened previously and found to have positive skin tests should be referred for evaluation to determine whether they have active TB or should receive preventive chemotherapy.)
5. Have you ever been told you have TB?
(This question is intended to identify individuals with TB who are not already in contact or have fallen out of touch with their treatment facility. In the non HIV- infected population, the highest risk of developing active TB occurs within the first year after exposure and infection. In the HIV- infected population, however, development of active disease does not diminish dramatically with subsequent years.)
6. Have you ever been treated for TB?
(This question is intended to determine if an individual has ever tested positive for and been treated for active TB.)
7. Within the past thirty days have you had any of the following symptoms for two (2) or more weeks: fever; drenching night sweats that were so bad you had to change your clothes or sheets on the bed; productive cough; coughing up blood; shortness of breath; lumps or swollen glands in the neck or armpits; unexplained weight loss (losing weight without meaning to); diarrhea lasting more than a week?
(Although the first four symptoms above are common among individuals with active TB, they are nonspecific and are consistent with other diagnoses, including bacteria pneumonia, acute bronchitis, cancer of the lung, HIV-related lung disease, and others. Other symptoms include lumps or swollen glands in the neck or armpits, which may be present in individuals with Extrapulmonary TB or AIDS-related conditions. Unintentional weight loss may identify individuals with latent or active TB or HIV infection; these are very nonspecific symptoms, however, and multiple other diagnoses are possible. Diarrhea lasting more than a week may identify persons with HIV infection but is also nonspecific.)

8. Has anyone you know or lived with been told they have TB in the past year?
(This question is intended to identify individuals who may be in contact with someone who has TB.)
9. Do you live with anyone who has had either of these symptoms: coughing up blood or drenching night sweats?
(This question is intended to identify individuals who have been in contact with someone who has TB and who thereby have an increased risk of developing latent or active TB. These symptoms have been selected from those in number 7 as being somewhat more specific and more likely to indicate a high degree of infectious risk.)

APPENDIX D

SUBSTANCE USE PREVENTION

D-1: Service Definition for Behavioral Health Prevention Education Services for Children and Adolescents in Selective and Indicated Populations

D-2: Prevention Risk Profile/Assessment

D-3: Prevention Program Service Plan

D-4: Prevention Program Service Grid and Instructions

D-5: Prevention Program Participant Tracking Log and Instructions

Appendix D-1

Service Definition for Behavioral Health Prevention Education Services for Children
and Adolescents in Selective and Indicated Populations

Behavioral Health Prevention Education Services for Children and Adolescents in Selective and Indicated Populations

Behavioral Health Prevention Education Services for children and adolescents who meet eligibility for selective and indicated population criteria are designed to prevent or delay the first use of substances, or to reduce or eliminate the use of substances. This service is provided in a group modality and is intended to meet the substance abuse prevention and/or early intervention needs of participants with identified risk factors for substance abuse problems [Selective] and/or with identified early problems related to substance use [Indicated]. Participants in Behavioral Health Prevention Education Services have identified risk factors or show emerging signs of use and the potential for substance abuse. The most typical program has a provider working directly with participants or parents [in a group setting] in a wide variety of settings including naturally occurring settings (school or community, etc.) on reducing known risk factors and/or enhancing protective factors that occur in that setting. Services are designed to explore and address the individual's behaviors or risk factors that appear to be related to substance use and to assist the individual in recognizing the harmful consequences of substance use. This service includes education and training of caregivers and others who have a legitimate role in addressing the risk factors identified in the service plan. This service includes, but is not limited to, children of substance abuser groups, education services for youth, parenting/family management services, peer leader/helper programs, and small group sessions. *This service is preventive in nature and is not intended for individuals who have been determined to have a diagnosable substance use or mental health disorder that requires treatment.* This service is time-limited, based on the duration of the curriculum-based program used. A provider is required to utilize an evidenced-based program that is listed on the "Pre-Approved Program List" in the *Youth Prevention Education (YPE) Guide* or obtain written approval through the Community Wellness, Prevention and Health Integration Section, DMH/DD/SAS.

The Behavioral Health Prevention Education Services documentation is required for all children and adolescents receiving substance abuse selective and indicated prevention services. The following standardized forms are required in the modified service record:

- **Documentation of Child or Adolescent Risk Profile:** Documentation of the findings of a child or adolescent risk profile that identifies one or more risk factors for substance abuse
- **Assessment and Plan:**
 1. The Prevention Risk Profile/Assessment shall include:
 - a. Documentation of the findings on a child or adolescent risk profile that identifies one or more designated risk factors for substance abuse;
 - b. Documentation of individual risk factor(s), history of substance use, if any; a description of the child's or adolescent's current substance use patterns, if any; and attitudes toward use; and
 - c. Other relevant histories and mental status that are sufficient to rule out other conditions suggesting the need for further assessment and/or treatment for a substance use or dependence diagnosis and/or a co-occurring psychiatric diagnosis.
 2. The Prevention Program Service Plan shall:
 - a. Be based on an identification of the child's, adolescent's, and/or family's problems, needs, and risk factors, with recognition of the strengths, supports, and protective factors;
 - b. Match the child or adolescent risk profile with appropriate evidence-based Selective or Indicated Substance Abuse Prevention goals that address the child's or adolescent's and/or family's knowledge, skills, attitudes, intentions, and/or behaviors; and
 - c. Be signed by the participant and the parent/guardian, as appropriate,

prior to the delivery of services.

- **Consent for Participation:** In all circumstances, the child or adolescent shall sign consent for participation in behavioral health prevention education services.
- **Prevention Program Service Grid:** Following the delivery of each service, the minimum standard for documentation in the service record shall be a Service Grid, which includes:
 - a. Identification of the evidence-based program being implemented;
 - b. Full date and duration of the service that was provided;
 - c. Listing of the individual child or adolescent and/or his or her family members that were in attendance;
 - d. Identification of the curriculum module delivered;
 - e. Identification of the module goal;
 - f. Identification of the activity description of the module delivered;
 - g. Initials of the [lead] staff member providing the service, which shall correspond to a signature with credentials identified on the signature log section of the Service Grid; and
 - h. In addition to the above, notation of significant findings or changes in the status of the child or adolescent that pertain to the appropriateness of provision of services at the current level of care and/or the need for referral for other services shall be documented.
- **Individual and Family Outcomes:** Documentation shall include the findings of the standardized pre-tests and post-tests associated with the evidence-based program being implemented, and the individual and/or family outcomes resulting from the program intervention.

Privacy and Security of Substance Abuse Prevention Services

Providers must adhere to all federal and state laws, rules, regulations and policies that protect and ensure the confidentiality, privacy and security of service records. Chapter 2 – “Privacy and Security of Service Records” provides specific information on the requirements regarding *Confidentiality, Transporting Records, Storage and Maintenance of Service Records* and *Safeguards*.

Appendix D-2

Prevention Risk Profile/Assessment

Second Chance Prevention Services

1212 We Are Better than Alcohol and Drugs Blvd.

There is Hope, NC 27900

Voice: 919-223-HOPE

Fax: 919-223-6000

www.wearebetterthandrugs.com

Prevention Risk Profile/Assessment

Participant Name: _____ Record Number _____ Date of Interview: _____

Date of Birth: _____ Duration of Service: _____

Address _____ City _____ Zip Code _____

Telephone Number: _____

School/Organization Name: _____

Presenting Problem: _____

| Demographics | | |
|--|--|---------------------|
| Gender: | Ethnicity: | |
| <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefers not to answer | <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino | |
| Race: | Age: _____ | Grade: _____ |
| <input type="checkbox"/> Native American/Alaskan <input type="checkbox"/> Asian American <input type="checkbox"/> African American <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> More than one race <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown | | |

| Reason for Referral |
|--|
| <input type="checkbox"/> Is currently experiencing, or in the previous six months has experienced, documented school related problems or educational attainment difficulties including school failure, truancy, suspension or expulsion or dropping out of school. |
| <input type="checkbox"/> Has documented negative involvement within the previous six months with law enforcement or the courts including formal and informal contacts such as arrest, detention, adjudication, warning or escort. |
| <input type="checkbox"/> Has one or both parents, legal guardians, or caregivers who have one or more documented child abuse or neglect reports, investigations, or substantiations involving DSS. |
| <input type="checkbox"/> Has one or both parents, legal guardians, or caregivers who have a documented substance-related disorder. |
| <input type="checkbox"/> Using alcohol, tobacco or other drugs. Alcohol, Tobacco Marijuana Prescription Drugs Other |
| <input type="checkbox"/> Other, Please describe: |

| Medical History | |
|--|------------------------------------|
| Date of last physical exam: | Date/results of last TB skin test: |
| Allergies: | |
| Significant Medical Hx (including hospitalizations and surgeries): | |
| Medications (Hx and current): | |

| Behavioral Observations | |
|--|---|
| Attention, Appearance, Attitude, Behavior, Mood, Orientation, Motor Behavior, Speech, Thought Stream, Thought Content, Memory, Impulse Control, Judgment/Insight | |
| General Appearance: <input type="checkbox"/> Appropriate Dress <input type="checkbox"/> Disheveled <input type="checkbox"/> Unshaven <input type="checkbox"/> Poor Hygiene | Physical Stature: <input type="checkbox"/> Average <input type="checkbox"/> Small <input type="checkbox"/> Large |
| Posture: <input type="checkbox"/> Normal <input type="checkbox"/> Rigid <input type="checkbox"/> Other _____ | Attitude: <input type="checkbox"/> Cooperative <input type="checkbox"/> Resistant <input type="checkbox"/> Guarded <input type="checkbox"/> Hostile <input type="checkbox"/> Sarcastic <input type="checkbox"/> Other |
| Affect/Mood: <input type="checkbox"/> Appropriate <input type="checkbox"/> Inappropriate <input type="checkbox"/> Depressed <input type="checkbox"/> Angry <input type="checkbox"/> Confused | Thought/Speech Form <input type="checkbox"/> Normal <input type="checkbox"/> Problems with Articulation <input type="checkbox"/> Slurred Speech <input type="checkbox"/> Pressured speech <input type="checkbox"/> Other |
| Thought Content <input type="checkbox"/> Normal <input type="checkbox"/> Homicidal <input type="checkbox"/> Suicidal <input type="checkbox"/> Paranoid Trends <input type="checkbox"/> Bizarre Thoughts <input type="checkbox"/> Guilt | |

| Substance Use History and Current Patterns | |
|---|--|
| <input type="checkbox"/> No ATOD use – never used any substance | |
| Youth's perception of substance use/abuse, youth's attitudes/feelings about use: <input type="checkbox"/> ATOD use is negative – harmful to health, function, or success <input type="checkbox"/> ATOD use is neutral – not good or not bad <input type="checkbox"/> ATOD use is positive – glamorous, useful, not a harmful activity <input type="checkbox"/> Other: | |
| <input type="checkbox"/> Regular use of tobacco <input type="checkbox"/> Regular use of alcohol <input type="checkbox"/> Regular use of marijuana <input type="checkbox"/> Regular use of prescription medications <input type="checkbox"/> Regular use of other (list all): | |
| <input type="checkbox"/> Recurrent substance use resulting in a failure of a major role at work, school or home <input type="checkbox"/> Recurrent use in situations in which it is physically hazardous <input type="checkbox"/> Recurrent legal problems related to substance use <input type="checkbox"/> Continued use despite recurrent social problems related to use <input type="checkbox"/> Problems related to use of substances: _____ <input type="checkbox"/> Additional details: | |
| Substance Dependence Criteria (Refer for SA Evaluation, if three main categories are checked.) | |
| <input type="checkbox"/> There is evidence of :(Check all that apply) | |

- Tolerance: Please Specify: _____
- Withdrawal symptoms _____
- Using in larger amounts or more often
- Persistent desire to cut down unsuccessfully.
- A great deal of time spent on activities around obtaining substances

| Substance Abuse History |
|--|
| <input type="checkbox"/> No Substance Abuse issues reported |
| <input type="checkbox"/> Past or current treatment history for SA (explain): |

| MH/SA Diagnosis History |
|--|
| <input type="checkbox"/> Has talked to a therapist, counselor (other than school) about alcohol, or drugs in the past. |
| <input type="checkbox"/> Has a Mental Health or Substance Use diagnosis of _____. |
| <input type="checkbox"/> Not within normal limits or age appropriate (explain): |
| <input type="checkbox"/> Is currently taking a psychotropic medication for _____. |
| <input type="checkbox"/> There is no evidence/history of substances use or dependence |
| <input type="checkbox"/> There is no evidence/history of mental health treatment. |

| |
|---|
| <p>Recipient Groups Served:</p> <ul style="list-style-type: none"> <input type="checkbox"/> General group with no identified risk factors <input type="checkbox"/> Repeat failure in school <input type="checkbox"/> Economically disadvantaged <input type="checkbox"/> Victim of physical, sexual, or psychological abuse <input type="checkbox"/> Has had past mental health problems <input type="checkbox"/> Has had long term physical pain due to injury <input type="checkbox"/> Is physically disabled <input type="checkbox"/> Is a homeless and/or runaway youth <input type="checkbox"/> School dropout <input type="checkbox"/> Pregnant Teen <input type="checkbox"/> Child of a alcohol or drug user/abuser <input type="checkbox"/> Has committed a violent or delinquent act <input type="checkbox"/> Has attempted suicide in the past <input type="checkbox"/> Is a juvenile within a detention facility within the state <input type="checkbox"/> Legally uses alcohol or prescription drugs without evidence of abuse <input type="checkbox"/> Poverty <input type="checkbox"/> Repeated school discipline problems <input type="checkbox"/> Other |
| <ul style="list-style-type: none"> <input type="checkbox"/> Regular use of tobacco <input type="checkbox"/> Regular use of alcohol <input type="checkbox"/> Regular use of marijuana <input type="checkbox"/> Regular use of prescription medications <input type="checkbox"/> Regular use of other (list all): _____ |
| <ul style="list-style-type: none"> <input type="checkbox"/> Recurrent substance use resulting in a failure of a major role at work, school or home <input type="checkbox"/> Recurrent use in situations in which it is physically hazardous <input type="checkbox"/> Recurrent legal problems related to substance use <input type="checkbox"/> Continued use despite recurrent social problems related to use <input type="checkbox"/> Problems related to use of substances: _____ <input type="checkbox"/> Additional details: |

- Further Assessment/Evaluation Needed: *Contact parent that signed parent permission form and inform parent of additional available resources.*

Disposition:

This participant meets the following target population: *Check only one.*

- Indicated* target population: Refer to prevention programming
- Selective* target population: Refer to prevention programming
- Universal* target population: No referral.
- Substance Abuse or Dependence. Refer for substance abuse evaluation and /or treatment.**

Printed Youth Name: _____

Printed Staff Name: _____

Staff Signature: _____ Date: _____

Review (if staff is not CSAPC) _____ **Date:** _____

Appendix D-3

Prevention Program Service Plan

Second Chance Prevention Services

1212 We Are Better than Alcohol and Drugs Blvd.

There is Hope, NC 27900

Voice: 919-223-HOPE

Fax: 919-223-6000

www.wearebetterthandrugs.com

Prevention Program Service Plan

Participant Name: _____ Date of Birth: _____

Record Number: _____ Date of Service: _____

| Strengths/Supports and Protective Factors (check all that apply) | | | |
|--|--|--|--|
| Strong Family or Extended Family Relationships | | Pro-social recreation or leisure activities or during non-school hours | |
| Positive Friends/Peer Group | | Faith Community Involvement/Spirituality | |
| Significant Adults | | Youth Organizations/Clubs | |

| Need(s)/Risk Factors | | | |
|---|--|---|--|
| Selective | | Indicated | |
| Child is at elevated risk for substance abuse | | Uses Drugs /alcohol at a pre-clinical level | |
| Documented school truancy , dropping out, school failure, suspension or expulsion | | Documented school truancy, dropping out, school failure, suspension or expulsion | |
| Formal and informal contacts with law enforcement for arrest, detention, or warning | | Formal and informal contacts with law enforcement for arrest, detention, or warning | |
| One or both parents have a substance use disorder | | Documented child abuse or neglect | |
| | | One or both parents have a substance use related disorder. | |

- | |
|---|
| <input type="checkbox"/> Youth was informed of group times and dates <input type="checkbox"/> Youth does not have any known conflicts with group times and dates |
|---|

Eligibility Determination:

- Child Substance Abuse – Indicated Prevention (CSIP, substance use hx)
- Child Substance Abuse – Selective Prevention (CSSP, no substance use hx)
- Child Substance Abuse – Universal Prevention (none of the 4 risk factors)

Prevention Education Curricula:

| | |
|--|---------------------------------------|
| <input type="checkbox"/> Project TND | <input type="checkbox"/> All Stars |
| <input type="checkbox"/> Project ALERT | <input type="checkbox"/> I'm Special |
| <input type="checkbox"/> Project Success | <input type="checkbox"/> Early Risers |
| <input type="checkbox"/> Other _____ | |

Youth Signature _____ Date _____

Parent Signature _____ Date _____

Staff Signature _____ Date _____

Review (if staff is not CSAPC) _____ **Date** _____

Appendix D-4

Prevention Program Service Grid and Instructions

Second Chance Prevention Services

1212 We Are Better than Alcohol and Drugs Blvd.

There is Hope, NC 27900

Voice: 919-223-HOPE

Fax: 919-223-6000

www.wearebetterthandrugs.com

Modified Prevention Program Service Grid for Participants in SA Prevention Services

| | | | | | | |
|-----------------------|------|---------------------------|--|--|---------------------|-----------------|
| Participant's Name: | | School/Organization Name: | | | Record Number: | |
| Program/Curriculum: | | Eligibility Population: | | | Number of Sessions: | |
| Staff Facilitator(s): | Name | Signature | | Credentials: Highest Degree, Certification(s), License | Start Date: _____ | End Date: _____ |
| | | | | | County: | |
| | | | | | LME-MCO: | |

| Session Number | Date | Duration of Service | Total # of Attendees | Session Unit/Module | Family Member in Attendance | Participant's Initials | Module Goal, Activity Description | Comments | Staff Initials |
|----------------|----------|---------------------|----------------------|---------------------|-----------------------------|------------------------|--|--|----------------|
| 1 | 3/5/2015 | 2 hours | 16 | Lesson 1 | 1 Mother | | Define Media, literacy & media literacy, examples of media, define/describe positive & negative messages, how media messages influence us. | Sammie participated in all group activities. | JD |
| 1 | | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | | | | | | | | | |
| 4 | | | | | | | | | |
| 5 | | | | | | | | | |
| 6 | | | | | | | | | |
| 7 | | | | | | | | | |
| 8 | | | | | | | | | |
| 9 | | | | | | | | | |
| 10 | | | | | | | | | |
| 11 | | | | | | | | | |

Client Name: _____

Page __ of __

INSTRUCTIONS ON HOW TO USE THE SERVICE GRID FOR DOCUMENTATION OF BEHAVIORAL HEALTH PREVENTION EDUCATION SERVICES IN THE SUBSTANCE ABUSE SERVICES RECORD FOR CHILD AND ADOLESCENT SELECTIVE AND INDICATED PREVENTION SERVICES

Purpose: The purpose of this Service Grid is to provide a means to quickly capture the name of the evidence-based substance use selective or indicated prevention program being implemented, the dates and duration of services provided, the individuals in attendance, program modules presented, module activity descriptions, any special notation of changes in client status (as appropriate), and the initials identifying the staff member(s) providing the service.

1. **Participant's Name:** Enter participant's name as recorded in the service record.
2. **School/Organization Name:** Enter the name of the school or organization where the group session is taking place.
3. **Record Number:** Enter the client's service record number.
4. **Program/Curriculum Name:** Enter the name of the evidence-based substance use selective or indicated prevention program being implemented.
5. **Eligibility Population:** Enter the type of population served in the program that is being implemented: Universal, Selective, or Indicated.
6. **Staff Facilitator(s):** Enter the printed name of each staff member who is implementing the program, their full signature, their credentials, including the highest degree earned, certification(s), and/or license(s), and their initials.
7. **Start Date:** Enter the date of the first scheduled session.
8. **End Date:** Enter the date of the last scheduled session.
9. **Full Date and Duration of Service:** Enter the full date (month/day/year) that the service was provided, and enter the duration of the service, in hours and minutes, up to a maximum of two hours and forty-five minutes for a single date.
10. **Total # of Attendees:** Enter the total number of child or adolescent clients present in the group in which the service was delivered.
11. **Session Unit/Module:** Enter the appropriate information to indicate which session is occurring on this date.
12. **Family Member in Attendance:** Enter the family member(s), by relation or name, in attendance with the child/adolescent for the service period.
13. **Participant's Initials:** Have the person initial each entry.
14. **Activity Description:** Enter the activity description(s) of the program module delivered.
15. **Staff Initials:** Enter the initials of the staff member(s) who provided the service on each day a service was provided. The initials should correspond to the name(s) listed on top portion of grid.
16. **Page __ of __:** Enter the page number for this sheet. The number of sheets required will depend on the number of modules in the program being implemented.

Appendix D-5

Prevention Program Participant Tracking Log and Instructions

INSTRUCTIONS ON HOW TO USE PARTICIPANT TRACKING LOG FOR BEHAVIORAL HEALTH PREVENTION EDUCATION SERVICES IN THE SUBSTANCE ABUSE SERVICES RECORD FOR CHILD AND ADOLESCENT SELECTIVE AND INDICATED PREVENTION SERVICES

Purpose: The Participant Tracking Log is a cumulative record of participation in the evidence-based practice provided to the group. This tracking log, which is in the form of an Excel spreadsheet, allows providers to accurately calculate and confirm that program participants have met the required dosage (core curriculum sessions offered at the prescribed length to the majority [80%] of program participants) for successful completion of the program as outlined in the Youth Prevention Education Implementation Standards of the *Youth Prevention Education (Evidence-Based Curricula) Information Guide Series* (August 1, 2016).

1. **Program/Curriculum:** Enter the name of the evidence-based substance use selective or indicated prevention program being implemented.
2. **Eligibility Population:** Enter the type of population served in the program that is being implemented: Universal, Selective, or Indicated.
3. **Total # of Participants:** Enter the total number of children or adolescents scheduled to participate in the designated program for the eligible population.
4. **Number of Sessions:** Enter the total number of sessions for the indicated program.
5. **Start Date:** Enter the date of the first scheduled session.
6. **End Date:** Enter the date of the last scheduled session.
7. **County:** Enter the name of the county where the program sessions are held.
8. **LME-MCO:** Enter the name of the host LME-MCO where the sessions are held.
9. **Participant's Name:** Enter participant's name as recorded in the child or adolescent's service record.
10. **Record Number:** Enter the participant's service record number.

The staff-to-child/adolescent ratio is 1:10 or fewer children or adolescents. If the group size exceeds 10, the group shall be facilitated by at least two staff. The maximum group size is 20 children and/or adolescents.

This log assists in determining the percentage of the content of the curriculum received by each youth. The log lists all the participants enrolled in the program along with each participant's record number. After each session, the staff facilitator records on the tracking log whether the participant was absent or present during the session. The log will calculate the level of participation in the program after the required information is entered. The Participant Tracking Log must be attached to the front of each completed series of sessions along with the individual records of each participant in the series.

APPENDIX E

PATH Forms

E-1: PATH Eligibility Verification

E-2: PATH Plan

E-3: PATH Service Note

E-4: PATH Discharge Summary

E-5: Security Deposits Assistance

E-6: One-Time Rent Assistance

Appendix E-1

PATH Eligibility Verification

PATH Eligibility Verification

Name: _____ NCHMIS Number: _____

Date of First Contact: _____ Date Enrolled: _____

PATH Staff Determining Eligibility: _____

List ALL of the location(s) outreach was provided (be specific):

How many Outreach Contacts were made prior to enrollment? _____

All Outreach Contacts entered in HMIS? Yes No

Outreach Contacts

What did you observe to give you the impression that this person possibly meets PATH eligibility and should be approached for Outreach?

Inappropriate Clothing Behavior Indicative of SMI Other _____

Where did Outreach take place?

Camp Abandoned Building Vehicle Street Other _____

Establishing Serious Mental Illness

*What symptoms did you observe? Facial expression? Dress? * How would you describe the person's speech? What did the person say? * How did the person describe their symptoms? * If person stated they had received treatment, where, what type of services, when? * If person states they took medication, what, when? Why are they not taking it now?*

Establishing Homelessness (Literal)

*Where did the person stay last night? Last week? Past 2 weeks? Past month/3 months/6 months?
How did the person describe their homeless experience? What lead to homelessness?*

Location of person to provide services

What are the locations the PATH staff may find the person during the day?

Where does the person go in the morning?

Where does the person eat lunch?

Where does the person go to get warm/get cool?

Is there anyone that the person sees every day? Did you receive approval to contact this person and was a release of information signed?

Service Note

At Enrollment:

Offered safe place

Survival item.

PATH Plan Developed: Yes No

Signed by Person Enrolled in PATH: Yes No Why not?

Copy of Plan Given to Person: Yes No

Release of Information (ROI):

HMIS Sharing was discussed: Yes No

Permission was granted: Yes No

Copy of permission is placed in record: Yes No

ROI for all referrals have been discussed and permission granted: Yes No

Copy of release is placed in record: Yes No

Services Provided:

Case Management

Housing – Moving Assistance

One-time Rent Assistance for Eviction Prevention

Residential Supportive Services

Security Deposits

Housing – Minor Renovations

Housing – Technical Assistance

Screening/Assessment

PATH Program

Referrals Made:

- Community Mental Health
- Employment Assistance
- Income Assistance
- Medical Assistance
- Relevant Housing Services

- Educational Services
- Housing Placement Assistance
- Job Training
- Primary Health Services
- Substance Use Treatment

Date/Time of Next Scheduled Meeting:

Location:

Purpose of Meeting:

Signature/Title:

Date:

Duration:

Appendix E-2

PATH Plan

PATH PLAN

NAME: _____ **NCHMIS Number** _____ **DATE:** _____

The PATH Plan is developed with the person at the time of enrollment and addresses the immediate basic needs of the person first to ultimately meeting the PATH outcome of receiving community mental health services and permanent housing. Development of the PATH Plan encompasses the information gathered during outreach activities and during the completion of the VI-SPDAT or NAEH Coordinate Assessment Tool. Make copy of blank PATH Plan to be used for additional goals.

Long Range Outcome: State the outcome the person desires to achieve within a year and/or into his/her future.

Short-Range Goal: State goal needed to achieve the long-range outcome.

| Specific measurable steps/ activities /interventions PATH staff will provide to meet goal | Planned Due Date | Complete Date | Review Date | Comments – Provide explanation if not meet Planned Due Date |
|--|-----------------------------|--------------------------|------------------------|--|
| | | | | |

PATH Recipient's Signature _____

Date _____

PATH Staff Signature _____
(Credentials, Position)

Date _____

Appendix E-3

PATH Service Note

PATH Program

| | |
|--|--|
| Name: NCHMIS # | <u>PATH Service(s) Provided:</u> <input type="checkbox"/> Case Management <input type="checkbox"/> Housing – Minor Renovation <input type="checkbox"/> Housing – Moving Assistance <input type="checkbox"/> Housing – Technical Assistance <input type="checkbox"/> Outreach [(Re/)Engagement] <input type="checkbox"/> Residential Supportive Services <input type="checkbox"/> Screening/Assessment |
| Date of Contact: | |
| Duration: | Location of Contact: |
| Purpose of Contact and Description of Specific Intervention/Activity PATH provided. | |
| Consumer Response to Intervention/Activity | |
| Plan for Next Contact 1. Purpose of contact 2. Date/Time of Next Scheduled Contact 3. Location | |
| <u>Referrals Made:</u> <input type="checkbox"/> Community Mental Health <input type="checkbox"/> Educational Services <input type="checkbox"/> Employment Assistance <input type="checkbox"/> Housing Placement Assistance <input type="checkbox"/> Income Assistance <input type="checkbox"/> Job Training <input type="checkbox"/> Medical Assistance <input type="checkbox"/> Primary Health Services <input type="checkbox"/> Relevant Housing Services <input type="checkbox"/> Substance Use Treatment | |
| Signature/Title: | Date: |

Appendix E-4

PATH Discharge Summary

PATH Discharge Summary

Name: _____ NCHMIS #: _____ Date Enrolled: _____

PATH Staff: _____ Date Discharged: _____

Reason for Discharge - Specific Details

PATH Outcomes Status - Outcomes listed below

Community Mental Health Services:

Is the person receiving CMH?

Yes

- Type of Service:
- Name of Provider:
- Date Service Began:

No

- Describe the specific details of efforts made to encourage accepting CMH services:

Substance Use Services

Does the person have a co-occurring substance use disorder?

Yes No

Is the person receiving Substance Use Services?

Yes N/A

- Type of Service:
- Name of Provider:
- Date Service Began:
- Is this service considered Integrated Care to include mental health treatment? Yes No

Housing Status

Is the person living in permanent housing?

Yes

• Address:

• Landlord Name:

• Rent Amount: _____ Estimated Utilities Cost:

No

Describe efforts in obtaining permanent housing:

Where is the person currently living:

Income Status

Was the person assisted by the Benefit Specialist? Yes No

Does the person have income?

Yes

• Amount: _____

• Source of Income: _____

No

• Describe reason person has no income:

Other Financial Assistance:

• SNAP: _____ Amount: _____

Health Insurance Status

Does the person have health insurance?

Yes

What type:

• Medicaid _____

• Medicare _____

• Veterans Benefits _____

- Other _____

No

Describe reason person has no health insurance:

Primary Care Status

Is the person receiving medical care?

Yes

- Name of Doctor/Clinic:

- Address:

No

Describe reason why person is not receiving medical care:

Employment Status

Is the person employed? Yes No

- Name of employer:

- Address:

Is the person receiving employment services from Vocational Rehabilitation of provider of Supported employment?

Yes No

Staff Signature/Title: _____

Date: _____

Appendix E-5

Security Deposits Assistance

Security Deposits Assistance (Rent/Utilities)

Name: _____ NCHMIS#: _____ Date Enrolled: _____

PATH Staff: _____ Date Deposit Paid: _____

Rent Security Deposit? Yes Utility Security Deposit? Yes Both? Yes

Address of Apartment/House to Rent: _____

Name of Landlord: _____ Phone/Cell Number: _____

Monthly Rent: \$ _____ Required Rent Deposit: \$ _____ Cost of Utilities Included: _____

History of PATH Financial Assistance

Have PATH or Match Funds been used on behalf of the person in the past 12 months from current date of enrollment?

Yes No

If Yes:

Enrollment Date (if different from above): _____ Discharge Date (if applicable): _____

Former Address: _____ Rent Cost: _____

Income Source used to pay rent/utilities:

- Voucher - \$ _____
Type _____
- SSI/SSDI - \$ _____
- Earned Income - \$ _____
- Veteran Benefits - \$ _____
- Other Retirement Benefits \$ _____
- Other Income Source \$ _____ Explain:

Type of PATH Financial Assistance: Rent Security Utility Security

Amount Paid on behalf of person: _____

Verification of Housing Safety

Date PATH staff accompanied person to view chosen apartment unit to verify safety of unit (running water, working door locks, cleanliness of unit, bug-free): _____

If PATH Staff did not accompany person to view chosen apartment unit to verify safety of unit, explain why:

Rent Security Deposit

Describe the specific reason PATH or Match Funds are needed to pay for rent security deposit:

Describe income person will use to pay the monthly rent:

- Voucher - \$ _____
Type _____
- SSI/SSDI - \$ _____
- Earned Income - \$ _____
- Veteran Benefits - \$ _____
- Other Retirement Benefits \$ _____
- Other Income Source \$ _____ Explain:

Additional documents required:

- Copy of signed Lease Agreement between Landlord and Person
- Copy of Letter from Landlord indicating the amount person requires for rent deposit
- Copy of PATH Agency Receipt indicating Rent Security Deposit was paid
- Receipt must include:
 - Name of Person Enrolled in PATH
 - Name of Landlord
 - Address of Rental Unit
 - Amount Paid
 - Date Paid

Utility Security Deposit

Describe specific reason PATH or Match Funds are required to pay for utility security deposit (indicate the specific utility funds will be used for):

Describe income person will use to pay the monthly utilities (Do not need to complete this section if information is documented above):

- Voucher - \$ _____
Type _____

PATH Program

- SSI/SSDI - \$ _____
- Earned Income - \$ _____
- Veteran Benefits - \$ _____
- Other Retirement Benefits \$ _____
- Other Income Source \$ _____ Explain:

Additional documents required:

Copy of signed Lease Agreement between Landlord and Person

Copy of Letter from Utility Company indicating the amount person requires for utility deposit

Copy of PATH Agency Receipt indicating Utility Security Deposit was paid

Receipt must include:

- Name of Person Enrolled in PATH
- Name of Utility Company
- Address of Rental Unit
- Amount Paid
- Date Paid

Staff Signature/Title: _____

Date: _____

Appendix E-6

One-Time Rent Assistance

One-time Rent Assistance to Prevent Eviction

Name: _____ NCHMIS# _____ Date Enrolled: _____

PATH Staff: _____ Date One-time Rent Paid: _____

Address of Apartment/House Renting: _____

Name of Landlord: _____ Phone/Cell Number: _____

Justification

Describe in detail the reasons PATH or Match funds are being requested to pay for rent for a person enrolled in PATH. Remember: PATH eligibility must be met and person had to have been enrolled in PATH prior to this request. **People are not enrolled in PATH for the sole purpose of paying their rent.** Please be specific when responding to the following questions:

1. Has the person received an eviction notice? (Place a copy of eviction notice in PATH record.)

2. How long has the person lived in this unit? _____

3. What is the income source the person has been using to pay for this unit?

- Voucher - \$ _____
Type _____
- SSI/SSDI - \$ _____
- Earned Income - \$ _____
- Veteran Benefits - \$ _____
- Other Retirement Benefits \$ _____
- Other Income Source \$ _____ Explain:

4. What is the cost of: Rent - \$ _____ Utilities - \$ _____

5. What is the specific reason person has not paid their monthly rent?

6. Has person been paying their utility bill(s)? Yes _____ No _____

7. If no, why has person not paid their monthly utility bill(s)?

8. What income source will the person use to pay next month's rent and utilities?

- Voucher - \$ _____
Type _____
- SSI/SSDI - \$ _____

PATH Program

- Earned Income - \$ _____
- Veteran Benefits - \$ _____
- Other Retirement Benefits \$ _____
- Other Income Source \$ _____ Explain:

Additional documents required (please indicate date placed in record):

Copy of signed Lease Agreement between Landlord and Person: _____

Copy of Letter from Landlord indicating the amount person owes in back rent: _____

Copy of PATH Agency Receipt* indicating Rent was paid: _____

*Receipt must include:

- Name of Person Enrolled in PATH
- Name of Landlord
- Address of Rental Unit
- Amount Paid
- Date Paid

Staff Signature/Title: _____

Date: _____

APPENDIX F

F-1: Webpage Links

F-2: Glossary

Appendix F-1
Webpage Links

Links to webpages noted in *Records Management and Documentation Manual*:

10A NCAC 26

<http://reports.oah.state.nc.us/ncac.asp?folderName=\Title%2010A%20-%20Health%20and%20Human%20Services\Chapter%2026%20-%20Mental%20Health,%20General>

10A NCAC 27

<http://ncrules.state.nc.us/ncac.asp?folderName=\Title%2010A%20-%20Health%20and%20Human%20Services\Chapter%2027%20-%20Mental%20Health,%20Community%20Facilities%20and%20Services>

42 CFR (Public Health)

http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42tab_02.tpl

45 CFR

http://www.ecfr.gov/cgi-bin/text-idx?SID=424dc4200730108e6579ba89dfb16cfb&mc=true&tpl=/ecfrbrowse/Title45/45tab_02.tpl

APSM 10-5: Records Retention and Disposition Schedule – DMH/DD/SAS Provider Agency

http://archives.ncdcr.gov/Portals/3/PDF/schedules/Local%20Schedules/Local_Provider_Agency_20111026.pdf?ver=2016-03-11-084038-697

APSM 10-6: Records Retention and Disposition Schedule – DMH/DD/SAS Local Management Entity (LME)

http://archives.ncdcr.gov/Portals/3/PDF/schedules/Local%20Schedules/Local_Management_Entity_20111026.pdf?ver=2016-03-11-084038-667

APSM 30-1: Rules for MH/DD/SA Facilities and Services

https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/apsm30-1_11-11_0.pdf

APSM 45-1: Confidentiality Rules

<http://www.ncdhhs.gov/document/apsm-45-1-confidentiality-rules>

APSM 95-2: Client Rights in Community Mental Health, Developmental Disabilities, and Substance Abuse Services

http://www.nasddd.org/uploads/documents/NC_apsm95-2clrights7-03.pdf

Behavioral Health Clinical Coverage Policies, 8-A through 8-P

<http://dma.ncdhhs.gov/document/behavioral-health-clinical-coverage-policies>

Child/Adolescent Discharge/Transition Plan

<https://ncdhhs.s3.amazonaws.com/s3fs-public/Child-Adolescent-Discharge-Plan-rev1-18-11.pdf>

DHHS Policy and Procedure Manual, Section VIII: “Privacy and Security”

<https://www2.ncdhhs.gov/info/olm/manuals/dhs/pol-80/man/>

DHHS Record Retention Policy, & Records Retention and Disposition Schedule for Grants

<http://www2.ncdhhs.gov/control/retention/retention.htm>

Division of Medical Assistance

<http://www.ncdhhs.gov/divisions/dma>

Division of Mental Health/Developmental Disabilities/Substance Abuse

<http://www.ncdhhs.gov/divisions/mhddsas>

Division of MH/DD/SA Services Consumer Data Warehouse/LME Reporting Requirements

<http://www2.ncdhhs.gov/mhddsas/providers/reportingrequirements/cdwreportingrequirements2-11-08v110.pdf>

Division of Public Safety

<http://www.ncdps.gov/Juvenile-Justice/Juvenile-Court-Services/Reclaiming-Futures-NC/Resources-for-Local-Sites/screening-and-assessment>

Division of Vocational Rehabilitation Services, documentation requirements

<https://www.ncdhhs.gov/document/vocational-rehabilitation-program-casework-and-service-delivery-policy>

EPSDT

<https://www.ncdhhs.gov/providers/provider-info/mental-health/early-periodic-screening-diagnostic-and-treatment-medicare-services-for-children>

Global Assessment for Individualized Needs-Short Screened [GAIN-SS]

<http://www.gaincc.org/instruments/>

Government Records Section, NC Archives

<http://archives.ncdcr.gov/>

G.S. § 90-21.5

http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_90/GS_90-21.5.html

G.S. § 122C

<http://www.ncga.state.nc.us/gascripts/Statutes/StatutesTOC.pl?Chapter=0122C>

G.S. § 122C-223

http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_122C/GS_122C-223.html

G.S. § 130A (Public Health)

http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/ByChapter/Chapter_130A.html

G.S. § 130A-143

http://www.ncga.state.nc.us/enactedlegislation/statutes/html/bysection/chapter_130a/gs_130a-143.html

HIPAA Privacy and Security Rules (U.S. DHHS)

<http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/securityruleguidance.html>

HIPAA web site

<http://info.dhhs.state.nc.us/olm/manuals/dhs/pol-80/man/>

HIPAA – Use and Disclosure Policies

<https://www2.ncdhhs.gov/info/olm/>

HIPAA Standards

<https://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf>

Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985

http://www.ncleg.net/enactedlegislation/statutes/html/bychapter/chapter_122c.html

NCDHHS Child and Family Mental Health Services webpage (strengths-based assessment tool)

<https://www2.ncdhhs.gov/mhddsas/providers/childandfamilymhs/FrameworkStrategiesOutcomes/index.htm>

NC-SNAP

<http://www.ncdhhs.gov/providers/provider-info/mental-health/nc-support-needs-assessment-profile>

NC System of Care Handbook for Children, Youth, and Families

<http://nccollaborative.poweredbyeden.com/files/647/27507.pdf>

NC-TOPPS

<http://www.ncdhhs.gov/providers/provider-info/mental-health/nc-treatment-outcomes-and-program-performance-system>

NC-TOPPS Implementation Guidelines, Appendix A

<https://nctopps.ncdmh.net/Nctopps2/docs/nc-toppsguidelinesjuly14.pdf>

NC-TOPPS Support Materials

<https://nctopps.ncdmh.net/dev/GettingStartedWithNCTOPPS.asp>

NC-TOPPS Web Portal

<https://nctopps.ncdmh.net/Nctopps2/Login.aspx>

NCTracks

<http://www.ncdhhs.gov/providers/provider-info/health-care/nctracks>

North Carolina Incident Response Improvement System [NC-IRIS]

<https://iris.dhhs.state.nc.us/>

North Carolina Juvenile Justice – Behavioral Health Information Sharing Guide

<https://www.sog.unc.edu/publications/reports/north-carolina-juvenile-justice-%E2%80%93-behavioral-health-information-sharing-guide>

Office of the National Coordinator [ONC] – Certified HIT product list

<http://oncchpl.force.com/ehrcert>

Person-Centered Planning

<http://www.ncdhhs.gov/document/person-centered-planning>

PSR Guidance for Service Notes

<http://www2.ncdhhs.gov/mhddsas/implementationupdates/Archive/2010/update070/a1-psrguidanceforservicenotes.pdf>

Public Law 102-321 (Title II)

<https://www.congress.gov/bill/102nd-congress/senate-bill/1306>

QM11 – Provider Quarterly Incident Report

<http://www.ncdhhs.gov/document/iris-resources>

Records Management – DMH/DD/SAS

<http://www.ncdhhs.gov/mhddsas/providers/recordsmanagement/resources.htm>

SAMHSA – PATH Projects for Assistance in Transition from Homelessness

<http://www.samhsa.gov/homelessness-programs-resources/grant-programs-services/path>

Secretary of State (electronic signatures)

<http://www.secretary.state.nc.us/Ecomm/ThePage.aspx>

State PATH Contact Welcome Manual

http://www.samhsa.gov/sites/default/files/programs_campaigns/homelessness_programs_resources/state-path-contact-welcome-manual.pdf

State-Funded MH/DD/SA Service Definitions & Enhanced MH/SA Service Definitions

<http://www.ncdhhs.gov/providers/provider-info/mental-health/service-definitions>

Supports Intensity Scale®

<http://www2.ncdhhs.gov/ncinnovations/communications.html>

Uniform Electronic Transactions Act [UETA]

http://www.ncga.state.nc.us/EnactedLegislation/Statutes/pdf/ByArticle/Chapter_66/Article_40.pdf

Appendix F-2

Glossary

Glossary

ACCESS - An array of treatments, services and supports is available; individuals know how and where to obtain them, and there are no system barriers or obstacles to getting what they need, when they are needed.

ACCREDITATION - Certification by an external entity that an organization has met a set of standards.

ADMINISTRATIVE PUBLICATION SYSTEM MANUAL – A reference resource for statewide policies, procedures, requirements and information developed and issued by authoring agencies.

ALCOHOL AND DRUG EDUCATION TRAFFIC SCHOOL [ADETS] – An evidence-based curriculum for someone with a DWI conviction who has not been identified as having a substance use disorder, but may be at risk for this disorder as well as other problems associated with substance use.

AMERICAN SOCIETY OF ADDICTION MEDICINE [ASAM] PLACEMENT CRITERIA - The Patient Placement Criteria for the Treatment of Substance-Related Disorders produced by the American Society of Addiction Medicine. These criteria are used as guides for the provision of substance abuse treatment that is appropriate for the individual.

ARRAY OF SERVICES - Group of services available.

ASSESSMENT - A comprehensive examination and evaluation of a person's needs for psychiatric, developmental disability, or substance abuse treatment services and/or supports according to applicable requirements.

BASIC BENEFITS - Traditional behavioral health services under the Medicaid State Plan, including physician services, often referred to as outpatient treatment or medication management services, which include those services covered in Medicaid's *Clinical Coverage Policy 8C – Outpatient Behavioral Health Services Provided by Direct Enrolled Providers*. These services may also be provided to individuals who meet medical necessity criteria for MH/IDD/SU Community Intervention Services, but for whom services are limited to outpatient and/or medication management services only.

BEST PRACTICE(S) - Interventions, treatments, services, or actions that have been shown to generate the best outcomes or results. The terms, "evidence-based" or "research-based" may also be used.

BLOCK GRANT - Funds received from the federal government [or others], in a lump sum, for services specified in an application plan that meet the intent of the block grant purpose. The Division of MH/DD/SAS receives three block grants: the Mental Health Block Grant, the Substance Abuse Prevention and Treatment Block Grant, and the Social Services Block Grant.

CARE COORDINATION - Care coordination in the 1915(b)(c) waiver is specifically focused on the unique needs of individuals with mental health, substance use, and intellectual/developmental disabilities. Care Coordination in an LME-MCO provides the following supports to individuals:

- Education about all available mental health, intellectual or developmental disabilities, or substance use services and supports, as well as education about all types of Medicaid and state-funded services
- Linkage to needed psychological, behavioral, educational, and physical evaluations
- Development of the Individual Support Plan (ISP) or Person Centered Plan (PCP) in conjunction with the recipient, family, and other service and support providers
- Monitoring of the ISP, PCP, and health and safety of the individual
- Coordination of Medicaid eligibility and benefits.

CATCHMENT AREA - The geographic area of the state served by a specific LME-MCO.

CENTERS FOR MEDICARE AND MEDICAID SERVICES [CMS] - The US federal agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program. This agency approves the North Carolina Medicaid Plan.

CLAIM - An itemized statement of services, performed by a provider network member or facility, which is submitted for payment.

COMPREHENSIVE CLINICAL ASSESSMENT - An intensive clinical and functional face-to-face evaluation of an individual's presenting mental health, developmental disability, and/or substance abuse condition that results in the issuance of a written report, providing the clinical basis for the development of a Person-Centered Plan [PCP] and recommendations for services/supports/treatment.

CONFIDENTIAL INFORMATION - Any information, whether recorded or not, relating to an individual served by a facility that was received in connection with the performance of any function of the facility. Confidential information does not

include statistical information from reports and records or information regarding treatment or services shared for training, treatment, habilitation, or monitoring purposes that does not identify individuals either directly or by reference to publicly known or available information.

CONFIDENTIALITY - Keeping information private. Allowing records or information to be seen or used only by those with legal rights or permission.

CONSENT - Giving approval or agreeing to something. For example, in education, a parent must give consent before a child can be evaluated or placed in a special program. Consent is usually documented in writing and may be given for regular treatment, emergency medical care, or participation as a subject in a research project. The individual giving consent in a particular situation must have the legal authority to do so.

CONSENT FOR PARTICIPATION - A signed agreement to take part in treatment required for children and adolescents receiving substance abuse treatment.

CONSULTATION – A meeting with an expert or professional, such as a medical doctor, in order to seek advice.

CONSUMER DATA WAREHOUSE [CDW] - A database containing data regarding demographic, clinical outcomes, and satisfaction data regarding individuals served by MH/IDD/SU service providers. The data stored in the CDW is the main source of information regarding block grant programs. The information is also used to fulfill legislative requests and for planning and evaluation of services.

CORE SERVICES - Services that are necessary for the foundation of any service delivery system. Core services under the Division of MH/DD/SAS are of two types: front-end service capacity, such as screening, assessment, triage, emergency services, service coordination, and referral; and indirect services, such as prevention, education, and consultation at a community level. Membership in a target population is not required to access a core service.

COUNTERSIGNATURE - Additional signatures, other than the signature of the individual who actually provided the service. Countersignatures are sometimes used to indicate the review and approval of documentation within the context of clinical supervision. Countersignatures are not required by the State, but countersignature entries in the service records may be required based upon the provider agency's policy when such a policy exists.

DAY/NIGHT SERVICES - Services provided on a regular basis, in a structured environment, that are offered to the same individual for a period of three or more hours within a 24-hour period. This term generally refers to services that are a part of daily or regular group programming, but are not 24-hour residential services. Some examples of Day/Night Services are: Substance Abuse Intensive Outpatient Program, Day Treatment Programs and Partial Hospitalization, Developmental Day, Psychosocial Rehabilitation, ADVP, Supported Employment, Community Rehabilitation Program [Sheltered Workshop], and Day/Evening Activity.

DEPARTMENT OF HEALTH AND HUMAN SERVICES [DHHS] - The North Carolina agency that oversees state government human services programs and activities.

DEVELOPMENTAL DISABILITY - A severe, chronic disability of a person which:

1. is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22;
3. is likely to continue indefinitely;
4. results in substantial functional limitations in three or more of the following areas of major life activity; self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self-sufficiency; and
5. reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated; or
6. when applied to children from birth through four years of age, may be evidenced as a developmental delay.

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS [DSM-5] - Published by the American Psychiatric Association, the DSM-5 or any subsequent editions of this reference material is a classification and diagnostic tool consisting of special codes that identify and describe mental health, intellectual or developmental disabilities, and substance use disorders and their symptoms. The DSM-5 supersedes the DSM-IV-TR, and serves as a universal authority for psychiatric diagnoses.

DISCHARGE PLAN - A document generated at the time service is terminated that contains recommendations for further services designed to enable the person to live as normally as possible.

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

[DMH/DD/SAS] - A division of the State of North Carolina's Department of Health and Human Services, responsible for administering and overseeing public mental health, intellectual and developmental disabilities, and substance use programs and services.

DMA - The acronym for the North Carolina Division of Medical Assistance, located in the Department of Health and Human Services. This agency operates the Medicaid Program for North Carolina.

DRUG EDUCATION SCHOOL [DES] - A prevention and intervention service that provides an educational program for drug offenders as provided in the North Carolina Controlled Substances Act and Regulations.

DURATION - The total amount of time spent performing intervention(s). When applicable, this amount of time is documented in service notes and is billed within payer reimbursement guidelines for the service. Duration is required to be recorded:

- for all periodic services, unless the periodic service is billed on a per event basis;
- for all services as required by the Medicaid State Plan;
- for all services as required by Medicaid Clinical Coverage Policies; or
- whenever duration is required by the service definition.

EARLY PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES [EPSDT] - Services provided under Medicaid to children under age 21 to determine the need for mental health, developmental disabilities or substance abuse services. Providers are required to provide needed service identified through screening.

ELECTRONIC RECORD - A computer-based service record that resides in a system specifically designed to support users by providing accessibility to complete and accurate data, alerts, reminders, clinical support systems, links to medical knowledge, and other aids. A record is not considered computer-based if it is only stored electronically in a computer as a word-processing file and not as a part of an electronic database.

ELECTRONIC SIGNATURE - A computer process whereby service documentation authorship and/or approval can be documented by a specific individual. Guidelines for electronic signature must be followed to ensure proper review of documentation, secure passwords, and individual documented agreement with the electronic signature guidelines.

EMPLOYEE ASSISTANCE PROGRAM [EAP] - A worksite-based program designed to assist: [1] work organizations in addressing productivity issues, and [2] employees in identifying and resolving personal concerns, including, but not limited to, health, marital, family, financial, alcohol, drug, legal, emotional, stress-related, or other personal issues that may affect job performance.

EVALUATION - More in-depth than an assessment, examination of specific needs or problems by professionals using specific evaluation tools.

EVIDENCE-BASED PRACTICE - Evidence Based Practice [EBP] refers to a research-based treatment approach or protocol that has been found to have clinical efficacy and effectiveness for individuals with certain emotional or behavioral challenges.

FIRST RESPONDER - The provider designated in the PCP to provide crisis response on a 24/7/365 basis. Typically, the first responder is the provider who has the most sustained contact and familiarity with the clinical dynamics of the individual being served.

FOLLOW-UP - A process of checking on the progress of a person who has completed treatment or other services, has been discharged, or has been referred to other services and supports.

GUARDIAN - An individual who has been given the legal responsibility to care for a child or adult who is incapable of taking care of themselves due to age or lack of capacity. The appointed individual is often responsible for both taking care of the child or incapable adult and their affairs. A legal guardian may provide permission for an individual to receive treatment. Also, a person appointed as a guardian of the person or general guardian by the court under Chapters 7A or 35A or former Chapters 33 or 35 of the General Statutes.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT [HIPAA] - A federal Act that protects people who change jobs, are self-employed, or who have pre-existing conditions. The Act aims to make sure that prospective or current recipient of services are not discriminated against based on health status. HIPAA also protects the privacy and security of an individual's protected health information.

HOME CARE AGENCY - An agency that is licensed by the Division of Facility Services [DFS] to provide home care services and directly-related medical supplies and appliances to an individual at his home. Home care services include

nursing care; physical, occupational, or speech therapy; medical social services; "hands-on" in-home aide services; infusion nursing services; and assistance with pulmonary care, pulmonary rehabilitation, or ventilation.

INCIDENT AND DEATH REPORT - A report of any incident, unusual occurrence, medication error, or death of a person that occurs while an individual is under the care of a service provider. In order to maintain authorization to provide publicly-funded MH/IDD/SU services and good licensure status, a provider must follow the requirements for incident response and reporting as set forth in 10A NCAC 27G .0600, in accordance with Section 4.5 of NC Session Law 2002-164 [Senate Bill 163]. For full details on these requirements, consult the Administrative Code and the [DHHS Incident and Death Reporting Manual](#).

INCIDENT RESPONSE IMPROVEMENT SYSTEM [IRIS] - A web based incident reporting system for reporting and documenting responses to Level II and III incidents involving consumers receiving mental health, developmental disabilities, and/or substance abuse services.

INDEPENDENT PRACTITIONER - A licensed practitioner who does not need to be endorsed by an LME and who may be directly enrolled with Medicaid to provide basic benefit services.

INDIVIDUALIZED EDUCATION PROGRAM [IEP] - A written plan for a child with special education needs. The plan is based on results from an evaluation and is developed by a team that includes the child's parents, teachers, other school representatives, specialists, and the child when appropriate.

INPATIENT - A person who is hospitalized. An inpatient facility may be hospital or non-hospital based, such as PRTF.

INTERMEDIATE CARE FACILITY FOR PERSONS WITH INTELLECTUAL DISABILITIES [ICF/IID] - A facility that functions primarily for the diagnosis, treatment or rehabilitation of individuals with intellectual disabilities or persons with a related condition. It provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his or her greatest ability.

INTERNATIONAL CLASSIFICATION OF DISEASES [ICD-10-CM] - The International Classification of Diseases, Tenth Revision, Clinical Modification, US Department of Health and Human Services, US Government Printing Office, Washington, DC. This document provides diagnostic categorization and coding of illnesses.

LEGALLY RESPONSIBLE PERSON - When applied to an adult, who has been adjudicated incompetent, a guardian; when applied to a minor, a parent, guardian, a person standing in loco parentis, or a legal custodian other than a parent who has been granted specific authority by law or in a custody order to consent for medical care, including psychiatric treatment; or when applied to an adult who is incapable as defined in G.S. 122C-72(c) and who has not been adjudicated incompetent, a health care agent named pursuant to a valid health care power of attorney as prescribed in Article 3 of Chapter 32 of the General Statutes.

LATE ENTRY - An entry in a service record that describes an event or episode of treatment that exceeds the allowable time frames for that documentation to be considered current. Please see Chapter 9 for specific guidance regarding allowable time frames per service type.

LICENSURE - A state or federal regulatory system for service providers to protect the public health and welfare. Examples of licensure include licensure of individuals by professional boards, such as the NC Psychology Board, or the NC Substance Abuse Professional Certification Board. Examples of licensure also include licensure of facilities used to provide MH/IDD/SU services by the NC Division of Facility Services.

LOCAL MANAGEMENT ENTITY [LME] - The local agency that plans, develops, implements, and monitors services within a specified geographic area, according to requirements of the Division of MH/DD/SAS. Includes developing a full range of services that provides inpatient and outpatient treatment, services, and/or supports for both insured and uninsured individuals.

LOCAL MANAGEMENT ENTITY / MANAGED CARE ORGANIZATION [LME-MCO] - The expansion in North Carolina of the functions of Local Management Entities [LMEs] to operate a Medicaid managed care program as a Managed Care Organization [MCO] for MH/IDD/SU services within their catchment area under a Medicaid waiver.

MANAGED CARE ORGANIZATION [MCO] - An organization contracted with the state to manage a health care delivery system designed to manage cost, utilization, and quality. Managed care initiatives are focused on improving care for populations with chronic and complex conditions, and building in accountability for high quality care.

MASTER INDEX - This index is a file of persons served. This list shall be permanently maintained manually or electronically by all service provider agencies.

MEDICAID - A jointly-funded federal and state program that provides hospital and medical expense coverage to low-income individuals, certain elderly people, and people with disabilities.

MEDICAL NECESSITY - Criteria established to ensure that treatment is necessary and appropriate for the condition or disorder for which the treatment is provided in order to meet the specific preventive, diagnostic, therapeutic, and rehabilitative needs of the individual. In order for a service to be eligible for reimbursement by Medicaid or the State, the individual must have an established diagnosis reflecting the medical necessity criteria inherent in the service.

MEDICARE - A federal government hospital and medical expense insurance plan primarily for elderly people and people with disabilities.

MINOR [OR UNEMANCIPATED MINOR] - Any person under the age of 18 who has not been married or has not been emancipated pursuant to Article 35 of Chapter 7B of the General Statutes.

MODIFIED RECORD - A clinical service record which has requirements that are either different from those that are usually associated with a full clinical service record, or which contains only certain components of a full service record. The use of modified records is limited to those approved by DMH/DD/SAS, and used only if there are no other services being provided. When an individual receives additional services, then a full service record shall be merged into the full service record. Modified records may only be used for: Respite [if respite is the only service being provided]; Behavioral Health Prevention Education Services for Children & Adolescents in Selective and Indicated Prevention Services, Universal Prevention Services, and other services, if approved by the Division.

NORTH CAROLINA ADMINISTRATIVE CODE [NCAC] - State rules and regulations. The rules governing MH/IDD/SU services can be found in [10A NCAC](#), Chapters 26-31.

NCTRACKS - NCTracks is a multi-payer Medicaid Management Information System for the NC Department of Health and Human Services. It has three separate portals for specific internet access to different sectors of the business: providers, recipients, and internal operations needs.

NORTH CAROLINA TREATMENT OUTCOMES AND PROGRAM PERFORMANCE SYSTEM [NC-TOPPS] - Refers to the program by which the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services [DMH/DD/SAS] measures outcomes and performance for Substance Abuse and Mental Health service recipients. NC-TOPPS captures key information on a person's current episode of treatment, aids in evaluation of active treatment services, and provides data for meeting federal performance and outcome measurement requirements.

OUTCOMES - At the individual level, events used to determine the extent to which service recipients improve their levels of functioning, improve their quality of life, or attain personal life goals as a result of treatments, services and/or supports provided by the public and/or private systems. At the system level, outcomes are events used to determine if the system is functioning properly.

OVERSIGHT - Activities conducted by a government regulatory or funding agency [or other responsible agency] for the purpose of determining how a provider agency is functioning financially or programmatically. This includes LME activities related to provider endorsement and ongoing monitoring, service authorization, claims payment, and pre- and post-payment reviews. Oversight also includes audits, investigations, and other regulatory activities conducted by DMH/DD/SAS, DHR, DMA, DSS, of other state agencies with responsibility for ensuring compliance with state and federal law, the quality of services, and/or the safety of consumers.

PENDING RECORD - A record that has the potential to become a full service record, once it is determined that the individual meets the requirements that call for the establishment of a full service record, and usually created when an individual presents for screening for possible services, or when there is insufficient, partial, or incomplete information available and a full service record cannot be established. A pending record may be used when there may have been some intervention, such as an initial screening, but the individual is not subsequently enrolled in active treatment. One service that is typically documented in a pending record include: Screening, Triage, and Referral; Court ordered consultation and/or evaluations that do not result in a subsequent MH/IDD/SU service; and Drop-In Center Services.

PERIODIC SERVICES - A service provided on an episodic basis, either regularly or intermittently, through short, recurring visits for persons with mental illness, developmental disabilities, or who are substance abusers.

PERSON-CENTERED PLANNING - An approach in which the individual directs his/her own planning process with the focus being on the expressed preferences, needs, and plans for his/her future. This process involves learning about the

individual's whole life, not just the issues related to the person's disability. The process involves assembling a group of supporters, on an as-needed basis, who are selected by the individual with the disability and who have the closest personal relationship with them and are committed to supporting the person in pursuit of real life dreams. Those involved with the planning process are interested in learning who the person is as an individual and what he/she desires in life. The process is interested in identifying and gaining access to supports from a variety of community resources, one of which is the community NH/IDD/SU service system that will assist the person in pursuit of the life he/she wants. Person-centered planning results in a written individual support plan.

PERSON-CENTERED-PLAN - An individualized and comprehensive plan that specifies all services and supports to be delivered to the individual eligible for mental health and/or developmental disability and/or substance abuse services according to NC Mental Health Reform requirements. A person-centered plan generates action or positive steps that the person can take towards realizing a better and more complete life. Plans also are designed to ensure that supports are delivered in a consistent, respectful manner and offer valuable insight into how to assess the quality of services being provided.

PREVENTION - Activities aimed at teaching and empowering individuals and systems to meet the challenges of life events and transitions by creating and reinforcing healthy behaviors and lifestyles and by reducing risks contributing to mental illness, developmental disabilities and substance abuse. Universal prevention programs reach the general population; selective prevention programs target groups at risk for mental illness, developmental disabilities and substance abuse; indicated prevention programs are designed for people who are already experiencing mental illness or addiction disorders.

PRIOR AUTHORIZATION - A managed care process that approves the provision of services before they are delivered. ValueOptions performs prior authorization for Medicaid legal aliens; Medicaid children 0-3 years of age; Health Choice beneficiaries; and Medicaid admissions to Cumberland Hospital. Other Medicaid-funded services and state funded services that require prior authorization receive this from the LMEs.

PROTECTED HEALTH INFORMATION [PHI] - PHI is individually identifiable health information that is transmitted by, or maintained in, electronic media or any other form or medium. This information must relate to 1) the past, present, or future physical or mental health, or condition of an individual; 2) provision of health care to an individual; or 3) payment for the provision of health care to an individual. If the information identifies or provides a reasonable basis to believe it can be used to identify an individual, it is considered individually identifiable health information. See Part II, 45 CFR 164.501.

PROVIDER - A person or an agency that provides mental health, intellectual or developmental disabilities, and/or substance use services, treatment, supports.

PUBLIC MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES SYSTEM - The network of managing entities, service providers, government agencies, institutions, advocacy organizations, commissions and boards responsible for the provision of publicly-funded services to individuals.

QUALIFIED PROFESSIONAL - Any individual with appropriate training or experience in the fields of mental health, developmental disabilities, or substance abuse treatment as specified by the General Statutes or by rule.

QUALIFIED PROVIDER - A provider who meets the provider qualifications as defined by rules adopted by the Secretary of Health and Human Services.

QUALITY ASSURANCE [QA] - A process to assure that services are minimally adequate, individual rights are protected, and organizations are fiscally sound. QA involves periodic monitoring of compliance with standards. Examples include: establishment of minimum requirements for documentation, service provision, licensure and certification of individuals, facilities, and programs; and investigation of allegations of fraud and abuse. See also, QUALITY MANAGEMENT.

QUALITY IMPROVEMENT [QI] - A process to assure that services, administrative processes, and staff are constantly improving and learning new and better ways to provide services and conduct business.

QUALITY MANAGEMENT [QM] - A framework for assessing and improving services and supports, operations, and financial performance. Processes include: quality assurance, such as external review of appropriateness of documentation, monitoring, and quality improvement, such as design and implementation of actions to address access. See also QUALITY ASSURANCE AND QUALITY IMPROVEMENT.

RECIPIENT - A person authorized for Medicaid or other program or insurance coverage. Also, an individual receiving a given service.

REFERRAL - The process of establishing a link between a person and another service or support by providing authorized documentation of the person's needs and recommendations for treatment, services, and supports. It includes follow-up in a timely manner consistent with best practice guidelines.

SCREENING - An abbreviated assessment or series of questions intended to determine whether the person needs referral to a provider for additional services. A screening may be done face-to-face or by telephone, by a clinician or paraprofessional who has been specially trained to conduct screenings. Screening is a core or basic service available to anyone who needs it, whether or not they meet criteria for target or priority populations.

SCREENING, TRIAGE AND REFERRAL - This process involves a brief interview designed to first determine if there is a mental health, intellectual or developmental disabilities, or substance use service need, the likely area[s] of need, as well as the immediacy of need [emergent, urgent, or routine]. The individual is then connected to an appropriate provider for services based upon the area and level of need indicated.

SENSITIVE HEALTH INFORMATION - According to Community Partnership for eHealth, sensitive health information is information that carries with it unusually high risks in the event of disclosure. Disclosure risks include the possibility of discrimination, social stigma, and physical harm (for example, in the case of information linked to domestic violence or reproductive health). In 45 CFR Parts 160 and 164, a response to public comment on the HIPAA Privacy Rule contains the following: "The Department treats all individually identifiable health information as sensitive and equally deserving of protections under the Privacy Rule." p. 53222

SERVICE GRID - A method of documentation of service provision that is approved for use for specific services.

SERVICE ORDER - Written authorization by the appropriate professional as evidence of the medical necessity of a given service.

SERVICE PROVIDER - Any person or agency giving some type of service to children or their families. A service provider, or service provider agency, is part of the provider community under Mental Health Reform.

SERVICE RECORD - A document that is required to demonstrate evidence of a documented account of all service provision to a person, including pertinent facts, findings, and observations about a person's course of treatment/habilitation and the person's treatment/habilitation history. The individual's service record provides a chronological record of the care and services which the individual has received and is an essential element in contributing to a high standard of care.

SERVICE RECORD NUMBER CONTROL REGISTER - This register controls the assignment of service record numbers. Any person admitted shall retain the same service record number on subsequent admission. This shall be permanently maintained manually or electronically by all service provider agencies.

STAFF - An employee of a governing body, provider agency, owner(s), individuals under contract with a provider agency, or individual behavioral health practitioners in a private practice.

STANDARDS - Activities generally accepted to be the best method of practice. Also, the requirements of licensing, certifying, accrediting, or funding groups.

STATE PLAN [DMH/DD/SAS] - The annually updated statewide plan that forms the basis and framework for MH/IDD/SU services provided across the state.

STATE PLAN [NORTH CAROLINA MEDICAID] - All of the formal policies, processes, and procedures approved by the US federal agency Centers for Medicare & Medicaid [CMS] regarding the Medicaid Program in North Carolina. This includes approval of Medicaid services and service definitions.

TREATMENT ACCOUNTABILITY FOR SAFER COMMUNITIES [TASC] - A service designed to offer a supervised community-based alternative to incarceration or potential incarceration, primarily to individuals who are alcohol or other drug abusers, but also to individuals who are mentally ill or developmentally disabled and who are involved in crimes of a non-violent nature. This service provides a liaison between the criminal justice system and alcohol and other drug treatment and educational services. It provides screening, identification, evaluation, referral, and monitoring of alcohol or other drug abusers for the criminal justice system.

TWENTY-FOUR HOUR FACILITY - A facility wherein a service is provided to the same individual on a 24-hour continuous basis, and includes residential and hospital facilities.

UTILIZATION MANAGEMENT [UM] - A process to regulate the provision of services in relation to the capacity of the system and the needs of individuals. This process should guard against under-utilization as well as over-utilization of

services to assure that the frequency and type of services fit the needs of individuals. UM is typically an externally-imposed process, based on clinically defined criteria.

UTILIZATION REVIEW [UR] - An analysis of services, through systematic case review, with the goal of reviewing the extent to which necessary care was provided and unnecessary care was avoided. UR is typically an internally-imposed process that employs clinically established criteria.