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| **Last Name:** Click or tap here to enter text.**First Name:** Click or tap here to enter text.**Date of Birth:** Click or tap to enter a date.**Age:** Click or tap here to enter text. | Enrollment Date: Click or tap to enter a date.Initial Approved Service Period: Click or tap here to enter text.Extended LOS Service Period: Click or tap here to enter text. |
| **MH, SUD, DD Diagnoses:**Click or tap here to enter text. | **Agency:** Choose an item.**Program for UR:**[ ]  **Adult Non-Medicaid Care Coordination** *(initial = 12 mo./extend = 3 mo.)*[ ]  **Child Non-Medicaid Care Coordination** *(initial = 12 mo./extend = 3 mo.)*[ ]  **Family Peer Support Services** *(initial = 6 mo./extend = 3 mo.)*[ ]  **Community Respite** *(initial = 12 mo./extend = 3 mo.)* |
| **Living Situation** *(specify setting)*: Click or tap here to enter text. | **Number of Visits with Provider** *(within the month)*: Click or tap here to enter text. |
| **Insurance Type:** Click or tap here to enter text. | **Health Home Provider** *(if applicable):* Click or tap here to enter text. |
| **Dates of CPEP Visits** *(within the last year)***:**Click or tap here to enter text. | **Dates of Hospitalizations** *(within the last year)*:[ ]  **Psychiatric** Click or tap here to enter text.[ ]  **Medical** Click or tap here to enter text. |
| **Other Providers/Services:** Click or tap here to enter text. |
| **Describe Relationship with Service Provider(s)** (both with individual and family as applicable): Click or tap here to enter text. |
| ***For Child SPOA Only:*** |
| ***School District:*** Click or tap here to enter text. | ***School Placement:*** Click or tap here to enter text. | ***CSE Status:*** Click or tap here to enter text. |
| ***Describe Relationship with School:*** Click or tap here to enter text. |
| **High Risk Alerts** *(check if current issue)*:

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| [ ] Caretaker Medical/Behavioral Health Issues | [ ]  Non-compliance - Appointments |
| [ ]  Crises – Requiring Intensive Services  | [ ]  Non-compliance - Medication |
| [ ]  Fire Setting  | [x]  Self-Injurious Behaviors  |
| [ ]  Homeless - *Current* | [ ]  Suicidal Ideation/Attempts/Threat |
| [ ]  Homicidal Ideation/Attempts/Threats | [ ]  Victim of Physical/Sexual Abuse or Neglect |
| [ ]  Inappropriate Sexual Behavior  | [ ]  Violence towards Others  |

If checked, provide dates and a brief explanation: Click or tap here to enter text.  |

**Last Name:** Click or tap here to enter text. **First Name:** Click or tap here to enter text. **Date of Birth:** Click or tap to enter a date.

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| **Please Indicate Responses to the Following Challenges:** | YES | **NO** |
| Community Services and/or Supports – *lack of awareness, inappropriate use of, etc.* |[ ] [ ]
| Cultural Issues/Language Barriers |[ ] [ ]
| Criminal Justice – *current charges pending, probation or parole involvement, recent release from incarceration* |[ ] [ ]
| Housing – *changes in, or challenges maintaining*  |[ ] [ ]
| Financial  |[ ] [ ]
| Insurance – *lack of coverage, network availability, etc.* |[ ] [ ]
| Medical – *current health issues,* *unaddressed needs, medication issues, etc.* |[ ] [ ]
| Psychiatric Appointments - *scheduling, keeping, attending, following-up with, etc.* |[ ] [ ]
| Psychiatric Medication Management – *scheduling, co-pay, pharmacy, etc.* |[ ] [ ]
| Transportation |[ ] [ ]
| ***For Child SPOA Only:*** | **YES** | **NO** |
| *Custody Issues – living with adults other than parents* |[ ] [ ]
| *School Placement - recent or anticipated change*  |[ ] [ ]
| **Explain “YES” responses above and any barriers to overcoming identified challenges:**Click or tap here to enter text. |
| **Attach current *Service Plan* or *Plan of Care* –** *If not available, complete the section below.* |
| **Service/Plan Goals** | **Progress Made** | **Outstanding Needs** |
| **1.** Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **2.** Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **3.** Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| ***Comments:* Strengths and Challenges – *Why should this service continue?***Click or tap here to enter text. |
| ***Name of Person Completing Form:*** Click or tap here to enter text. | ***Title:*** Click or tap here to enter text. |
| ***Signature:*** | ***Date:*** Click or tap to enter a date. |
| **SPOA Committee Recommendation(s):** | **Date of SPOA Committee Meeting:**  |
| **[ ]  Approved** for extension of Length of Stay (LOS). | **Remain in program for an additional \_\_\_\_\_\_\_\_\_ months****Next Utilization Review Due** *(date)***:** |
| **[ ]  Discharge Recommended** – *state linkages to be completed:*  |
| **Barriers to Discharge** *(specify)*: |
| **SPOA Coordinator:** *Signature* |

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