

Mental Health Plan for Care
(5122-31-02)

[ACF Facility/Resident/Lead MH Provider Agreement]
[Note – to be distributed with policy memo, including instructions]

1. Name of resident:

2. Agency client identifier: _____

3. Resident's legal status: _____

4. Date of Birth(mm/dd/yyyy): _____

5. Are all necessary authorizations for release of information in place in order to facilitate provision of care? Yes or No If no, comment or list below:

6. Name and address of facility applied to/referred to:

Name: _____

Address: _____

City, State Zip: _____

7. a) Name and address of lead mental health agency:

Name: _____

Address: _____

City, State Zip: _____

b) Name and contact information for current CPST Worker:

Name: _____

Address: _____

City, State Zip: _____

Phone (ext): _____ Cell Phone: _____

Email: _____

8. Name of mental health board contact:

Board Name: _____

Contact Name: _____

Phone (ext): _____ Cell Phone: _____
Fax: _____

9. Does the resident have a guardian? Yes or No If yes, please provide contact information:

Name: _____
Address: _____
City, State Zip: _____
Phone: _____ Cell Phone: _____
Email: _____

10. Does resident have representative payee? Yes or No If yes, provide contact information:

Name: _____
Address: _____
City, State Zip: _____
Phone (ext): _____ Cell Phone: _____
Email: _____

11. Does resident have a parole or probation officer? Yes or No If yes, please provide contact information:

Name: _____
Address: _____
City, State Zip: _____
Phone (ext): _____ Cell Phone: _____
Email: _____

12. Does resident have health insurance, including Medicaid/ Medicare? Yes or No **If yes, attach a copy of insurance card.**

13. Does the resident have advanced directive(s)?

- a. Medical advanced directive? Yes or No **If yes, attach copy.**
- b. Psychiatric advanced directive? Yes or No **If yes, attach copy.**
- c. Declaration for mental health treatment? Yes or No **If yes, attach copy.**

14. Emergency contacts:

Name: _____

Address: _____

City, State Zip: _____

Phone: _____ Cell phone: _____

Name: _____

Address: _____

City, State Zip: _____

Phone: _____ Cell phone: _____

15. Additional information about the resident that will assist in the preparation of the ACF and staff to provide optimal care for the prospective resident:

16. Crisis Plan/Emergency Contact Procedures for ACF regarding mental health related issues:

1. During regular business hours (insert) _____ the lead mental health agency will be contacted:
 - a) Contact CPST Office at (____) _____ ,
 - b) Ask for assigned CPST worker; if not available
 - c) Ask for a Team Leader or CPST supervisor; if not available
 - d) Ask for in-house worker, if not available
 - e) Ask for the Intake or Crisis Department; if not available
 - f) Ask for the Clients Rights Officer; if not available
 - g) Ask for the Clinical Director; if not available
 - h) Contract the Board representative.
2. After business hours, weekends, and holidays, refer to the crisis plan and contact the appropriate on-call person.
3. All emergency medical issues and legal issues should be handled by contacting the appropriate authorities, i.e. by calling 911.

17. Does the resident have any known allergies? Yes No or Unknown
If yes, please list them below:

20. Does the resident have any physical limitations? Yes or No If yes, please list below:

21. Does the resident have any dietary restrictions? Yes or No If yes, please list below:

22. Does the resident smoke? Yes or No If yes, please list house restrictions on when and where to smoke:

23. Please identify additional limitations to care, e.g. language or cognitive, or other factors, e.g. religious or cultural considerations, that are important to care:

24. Date of last medical hospitalization (mm/dd/yyyy):

25. Date of last mental health hospitalization (mm/dd/yyyy):

26. Does resident have a current or past AOD abuse issue? Yes or No If yes, describe:

27. Does resident have a current or past history of violence towards others, including, but not limited to physical violence, sexual violence, use of weapons or homicide? Yes or No If yes, describe:

28. Does resident have a current or past history of self-injury? Yes or No If yes, describe:

29. Does resident have a recent or past history of suicide attempts? Yes or No If yes, describe:

30. Assistance with daily living activities/prompting: Supportive Services Plan – see chart below:

[Note – Supportive Services Plan to be updated as applicable or upon request of resident, ACF Operator or MH treatment provider.]

Resident Need	Yes, No, N/A, or ?	Prompting Assistance Needed or indicate Resident Independent	Responsible Party(s): treatment provider staff, ACF staff member or both
1. Assistance with Hygiene			
2. Medication Assistance			
3. Medical Appointment Transportation			
4. Psychiatric Appointment Transportation			
5. Transportation for Emergency Situations			
6. Nutritional Supplements needed			
7. Assistance with scheduling of appointments			
8. Assistance with Budgeting and Finance			
9. Assistance with contacting case manager			
10. Assistance with contacting family members/friends			
11. Other needs identified by resident			
12. Other needs identified by resident			

Resident's responses to plans to moving into an adult care facility:

ACF Operator's Comments:

Treatment Provider's Comments:

Check here if resident declines treatment through the MH Provider.

Resident's Signature

Date

MH Provider's Signature

Date

ACF Operator's Signature Date

Guardian's Signature

Date

(If applicable)
