MRSS FAMILY INTAKE RECORD

Q1. The referral's county of residence: _____

Q2. MRSS provider agency: _____

Q3. Date of the current referral to the MRSS program: _____

Q4. Name of the data entry staff member OR the person to whom questions about data entry should be directed (first and last name):

_____

Q5. Who made the call to the hotline/agency?

__ Parent/Caregiver
__ Youth/Young Adult
__ Other Family Member
__ School Staff
__ Court Staff
__ Law Enforcement
__ EMT or Emergency Responder
__ Emergency Room/Hospital
__ Other Mobile Crisis Provider
__ Mental Health or Substance Use Provider
__ Child Welfare/Child Protective Services
__ Wraparound/ Service Coordination
__ Intellectual Disabilities Provider
__ Peer Support
__ Unknown
__ Other, please specify _____

Q6. Did the referral come from via your county's mental health crisis hotline?

__ Yes __ No __ Other, please specify _____

Q7. Has this youth/young adult been served (face to face contact) by your MRSS program within the past 12 months and currently no open case with MRSS?

__ Yes __ No

Q8. Please select the triage decision.

__ Non-Immediate (Scheduled at client request, not within 60 minutes)
__ Immediate (Response within 60 minutes)
__ Emergency (911 Call w/ MRSS Follow-up – this includes individuals who were taken directly to the hospital or JDC due to safety concerns and who were subsequently referred to MRSS)

Q9. How long did it take for your MRSS team to make contact with the client/family? (After the referral was received, the length of time for face to face contact)

__ 1 hour or less
__ Greater than 1 hour up to one day
__ Two to four days
__ Five days to one week
__ More than one week
__ Was not able to make contact with Client/Family
__ Family declined MRSS service

Q10. For referrals requiring **immediate** response: If response time was greater than one hour, what were the contributing factors?

_____

_____

_____

Q11. Please select the resulting action implemented from the initial MRSS call or referral.

__ No further action/or not able to reach the family to follow up on referral (Use if you never talked to the family about services) NO SERVICE PROVIDED – If selected, none of the following questions (Q12 and beyond) need to answered.

__ Referred to MRSS but declined (Use if you spoke with the family and they did not want services) NO SERVICE PROVIDED – If selected, go to question 12.

__ 72 hour or less stabilization (Crisis intervention provided but not full MRSS – you went out at least once and provided services during that visit, but the family didn't want to ongoing stabilization services)

__ 72 hour or less stabilization (Crisis intervention provided but not full MRSS - Stabilization services not offered due to inadequate program capacity)

__ 72 hour or less stabilization (Crisis intervention provided but not full MRSS – you went out at least once and provided services during that visit, but the family already receives intensive home based services, e.g. IHBT)

__ 4 to 6 Week Stabilization (MRSS) (You provided services to stabilize the situation beyond the initial crisis response)

Q12. Answer this question only if "Referred to MRSS but declined" is selected. Once answered, none of the following questions (Q13 and beyond) need to answered.

If the client refused MRSS, what was the reason?

__ No further contact made
__ Too time intensive
__ Not interested
__ No reason was given
__ Doesn't think they need help
__ Other reason not listed: _____

Q13. At what location did the MRSS Team meet with the client and/or family for the initial response?

__ Family Home
__ Juvenile Detention Center
__ School
__ Juvenile Court
__ Hospital ER
__ Residential Treatment Center
__ Mental Health/SUD Provider Agency
__ No meeting occurred
__ Police Department
__ Other location, please specify: _____

Q14. Please enter the Consumer ID for this client _____

Q15. What date was this client first served (face to face) by your provider agency for MRSS (The current referral)? _____

Q16. What is the client's gender?

__ Male
__ Transgender
__ Female
__ Self-identified, please specify _____

Q17. Is the client/young adult Hispanic or Latino?

__ Yes
__ No
__ Unknown

If yes, please specify which ethnic group the client/young adult belongs.

__ Central American
__ Dominican
__ Puerto Rican
__ Cuban
__ Mexican
__ South American
__ Other Hispanic or Latino ethnic group, please specify _____

Q18. What race is the client? (select all that apply)

__ African American/Black
__ Alaska Native
__ American Indian
__ Asian
__ Other race not listed above _____
__ Middle Eastern, Arab, or North African
__ Native Hawaiian/Pacific Islander
__ White
__ Refused to Answer

Q19. What is the client's date of birth? _____

Q21. Is this child in foster care/custody of Job & Family Services?

__ Yes __ No __ Unknown

Q22. If the primary language spoken in the home is not English, what is the other primary language spoken by the family in the home?

__ Spanish __ American Sign Language (ASL) __ Korean
__ Arabic __ Chinese __ Vietnamese
__ Other language not listed above, please specify _____

Q23. From the youth and/or family perspective, what led them being referred to your MRSS program? (Be specific)

_____

_____

_____

_____

Q24. With which of the following agencies/systems is the child/young adult involved? (select all that apply)

__ Wraparound/Service Coordination
__ Mental Health Agency/Clinic/Provider
__ Physical Health Care Agency/ Clinic/ Provider due to chronic health issues
__ Substance Abuse Agency/Clinic/Provider
__ Intellectual Disabilities Agency/Provider (Bd. Of DD eligible)
__ Alternative Educational Setting (including online/homeschooled, day treatment, PH, etc.)
__ Child Welfare/Child Protective Services
__ Family Court (i.e. Domestic Rel. Ct, AND unit at Juv. Court)
__ Juvenile Court (Unruly/Delinquency /Diversion) /Probation
__ Adult (criminal) Court/Probation
__ Law enforcement
__ IEP/Special education
__ Early Intervention (i.e. Help Me Grow, Early Headstart, Every Child Succeeds)
__ Kinship Navigator
__ None of the above
__ Other, please specify: _____

Q25. During the past 6 months, was the child/young adult insured through...(select all that apply)

__ Medicaid
__ CHIP
__ SSI
__ Private health Insurance (Not Medicaid)
__ Uninsured
__ Other form of insurance, please specify _____

Q26. What is the client's primary clinical diagnosis? (Diagnosis made by MRSS therapist that is driving or primarily contributing to the involvement of MRSS)

_____

Q27. What is the client's secondary clinical diagnosis? (IF APPLICABLE – LEAVE BLANK IF NONE GIVEN BY MRSS THERAPIST)

_____

Q28. What is the clients tertiary clinical diagnosis? (IF APPLICABLE – LEAVE BLANK IF NONE GIVEN BY MRSS THERAPIST)

_____

Q29. Did the client and/or caregiver sign the Evaluation 'Consent to Contact' form?
*(ONLY ASKED IF 4-6 Week MRSS CASE)

__ Yes __ No

If No,

Q29. If the client refused to sign the consent to contact, what was the reason?

__ Privacy concerns
__ Not interested
__ Time concerns
__ Client only received mobile crisis
__ No specific reason was given
__ Age of child (under age 5 years)

Once answered, none of the following questions (Q30 and beyond) need to answered.

Only complete Q30 through Q33 if the young adult or caregiver signed the consent to contact form:

Q30. Please enter the following information for your client and their primary caregiver. This information will only be used by OhioMHAS evaluators to contact the family or young adult about the MRSS Evaluation and schedule their interview.

Client's MRSS Provider's Name(s): _____

Client's Full Name: _____

Primary Parent/Caregiver Full Name: _____

Client and/or Caregiver Home Address: _____

Parent/Caregiver Primary Phone Number: _____

Client's Primary Phone Number (if applicable): _____

Client's E-mail Address (if applicable): _____