2740 South Jones Blvd, Las Vegas, NV 89146 Phone (702) 248-8866 Ext 226 • Fax (702) 248-0079

E-mail: UM@hbinetwork.com

## **INITIAL MENTAL HEALTH ASSESSMENT**

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received this message in error, please notify the sender infinedi	ialely allu uesliby lile b	nginai message and	ali copies.		
PROVIDER INFORMATION Type 14 17 26 82 0	ther (specify)		Request Date:		
Provider Name:	Credential:		NPI:		
QMHP/Agency/Group Name (If applicable):			NPI:		
Address: Street	City	State	Zip		
Phone:	Fax:				
RECIPIENT/Patient Name:	Health Plan & ID #:		Initial Treatment Date:		
Civil Status: □Single □Married □Divorced □Separated □Dom. Part	. Date of Birth:	Age:	Gender: □ Male □ Female		
Ethnic Background:   Native American   Caucasian   African-Ameri	ican □ Hispanic □ Asi	an ☐ Pacific Islander	☐ Middle-Eastern ☐ Other		
Home Address: Street	City	State	Zip		
Name of Parent/Legal Guardian (if the patient is a minor):		Phone:			
Employment: ☐ Student ☐ Unemployed ☐ Employed as ➤		Name of Employer/Company:			
In State Custody? ☐ Yes ☐ No Case Worker:		Phone:			
Arrangement Homeless Shelter/Halfway House Check box if the patient's Primary Care Physician has a current signed Reference Primary Care Physician's Name and Phone:  1. Presenting Problems: (Include psychiatric symptoms, maladaptive behave)	Release of Information to coo	ordinate treatment.	(Specify):		
Placement/Living Arrangement History: (Include past and current place)	rement, adjustment to home	setting)			
3. Psychosocial History: (Include birth order, birth place, siblings, signification)	ant life events)				

4. Psychiatric Tre	atment History: (Include	past and present inpatient	outpatient treatments and	l compliance)		
5. Medical History	ı: (Include medical, develo	pmental issues and co-mo	orbid conditions – treatmer	nt and compliance)		
	Medication	Dosage	Fi	requency	Pro	escriber
6. Family History:	(Include family medical, p.	sychiatric, developmental,	legal issues, and attitude	towards recipient)		
7. Environmental	Stressors, Family and Co	ommunity Support				
8. Academic (Inclu	ide school performance, sj	pecial accommodations, le	earning and behavioral issu	ues) and Employment H	listory	
9. Legal Issues						
10. Addiction Issu	es (if indicated, client mus	st be evaluated using the S	SUBSTANCE ABUSE ASS	SESSMENT by a qualified	d addiction counselor)	
11. Habits, Streng	ths, and Weaknesses (In	clude recipient's attitude to	owards treatment, desire t	o change and willingnes:	s for intervention)	
12 Dhysical Dob	aggioral And Montal State	ic Evamination				
Appearance	navioral And Mental Statu Eye Contact	Interaction	Speech	Mood	Affect	Consciousness
□ Appropriate	☐ Good	☐ Engaged	☐ Normal	☐ Calm	☐ Appropriate	☐ Alert
<ul><li>□ Overweight</li><li>□ Underweight</li></ul>	☐ Fair ☐ Poor	<ul><li>☐ Withdrawn</li><li>☐ Demanding</li></ul>	☐ Soft ☐ Loud	<ul><li>☐ Remorseful</li><li>☐ Sad</li></ul>	<ul><li>□ Blunted</li><li>□ Labile</li></ul>	<ul><li>☐ Confused</li><li>☐ Distracted</li></ul>
☐ Bizarre			☐ Rapid	☐ Angry	☐ Euphoric	☐ Lethargic
☐ Disheveled				☐ Anxious ☐ Hostile	□ Euthymic □	
1 1	1.1	1.1	1.1	L L DOZIIIE	1.1	1.1

Recipient Name:  $Page\ 2\ of\ 4$  Copyright  $^{\circ}$  HBI 2014  $\bullet$  C:\HBIDocuments\Forms\2014 Updated Forms\HBI-initial-MHA.docx ID#:

Sensory Oriented to			1emory		t Process	Delusions	Hallucinatio	
☐ Person	☐ Focused	☐ No imp		☐ Appropri		Persecutory	☐ Auditory	☐ Good
□ Place	□ Pre-occupied	□ Recent		□ Circumst		Paranoid	☐ Visual	☐ Impaired
□ Time	☐ Short Attention		е	□ Tangenti		Grandiose	□ Somatic	□ Poor
☐ Situation	□ Easily distracted			☐ Loose		Denied	□ Olfactory	
☐ Future							☐ Tactile	
							☐ Denied	
Details:								
13. Current Risk Fa	ctors: (Chack all ita	ome that apply)					No	no
	on with <b>NO</b> plans/att		□ Dan	ngerous behavid	or that places sel	f/others at risk		ysical abuse (by others)
	on <u>with</u> plans/attemp				age of anxiety/p			ysical abuse (to others)
	ation with <b>NO</b> plans/a				omplicating men		□ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	xual abuse (by others)
	ation <u>with</u> plans/atter				self / personal ne			xual abuse (to others)
Explain Details:	pranorano.		0		on , porouna m	9.000	_ 00	nual abuss (is suiters)
r								
14. Current Functio	nina: (Include recin	ient's ability to fund	ction daily in r	relation to scho	ol/work. peers. fa	milv. dailv living.	etc.)	
and the same of th	<b>9.</b> (	a azımıy to rum		2.3 10 00/10	, , , , , , , , , , , , , , , ,		/	
				DSM DIA				
Diagnosis Code		Narrative Descrip	otion	I	Diagnosis Code		Narrative Des	cription
1)				2)				
3)				47				
3)				4,				
DC: 0-3 DIAGNOSIS	If recipient is age 0	)-3 only						
DC: 0-3 Code		Narrative Descrip	tion		DC: 0-3 Code		Narrative Des	cription
1)				2				
ASSESSMENT		Score:	Level	Dat	0.	Clinical A	leeneenr	Credential
		Score.	Level	Dai	ь.	Cililical F	12262201	Creuerillai
□CASII □LOCU	5							
Oth A /		If CASII or LO	CUS score >	19, please sul	mit scoring she	<mark>eet with this ass</mark>	essment.	
Other Assessment (s	specіту):							
	NATION EN		<u> </u>		<u> </u>	" 1 ) 1		
Mental Health Asses	NATION LIYES L	JNO If yes, state	your rational	le here <i>(or iden</i> optact URL at <i>(</i> 7	tity field referenc na) and doke	e # above), and s	submit the SED/SMI de	etermination forms with this
Wellal Health Asses	sinent. II you need	DIATIK SLD/SIVII IUI	ilis, piease ci	uniaci ribi ai ( <i>i</i>	02) 240-0000.			
				NDATION • TR	EATMENT GOA			
Targeted Symp	ptoms	Treatme	ent Goal		Tre	eatment Plan/Ap	proach	Projected Date of Resolution
1)								
2)								
2)								
3)								
4)								
5)								
5)								

Start Date≽		REQUESTED SERVICES  End Date>	Medicaid Plans maximum = 90 days					
Service Type	Code	Service Provider	Units/Day	Days/Week	Total Units	UM Approved		
☐ Initial Evaluation (replaced 90801)	90791			Jan 100m	32. 21.10			
☐ Individual Counseling (30-minute session)	90832							
☐ Individual Counseling (replaced 90806)	90834							
☐ Interactive Complexity Add-on to 90791 / 90832 / 90834	90785							
☐ Family Counseling (w/o the patient)	90846							
☐ Family Counseling (w/ the patient)	90847							
☐ Multi-Family Group Psychotherapy	90849							
Group Psychotherapy (other than a multi-family group)	90853							
☐ Behavioral Health Screening	H0002							
☐ At-home Therapy	H0004							
□ BST	H2014							
□ PSR	H2017							
		ADDITIONAL INFORMATION						
Prior authorization of requested services is not a guarantee for imbursement. Payments are subject to member's eligibility, available benefits, contractual limitations, exclusions, coordination of benefits, and other terms specified in the benefit plan at time of submission of claims. Check this box □ to acknowledge that you have read and understood these terms.  Signature and Title  Date:								
of Coordinating Clinician:								
Data (Time Data da	Th	e following section is for HBI-UM t		D. de d				
Date/Time Received:		UM Reviewer:	Date	Reviewed:				
Determination: Full Authorization Partial Authorization (see Requested Services above) Peer Review: Medical Necessity Administrative			-	Need clinical information Date Submitted for Review:				
COMMENTS:								