**Template 5**

**ALF-LMH Forms**

**Requirement:** *Sections**394.4574, and 429.075, F.S.*

*Guidance Document 8*

**Frequency:** *Ongoing*

**Due Date:** *Data report from monitoring due annually with July data submission*

**Date of Audit:**

**Mental Health Provider:**  **Address:**

**Staff Conducting Audit:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **Record 1 Compliance** | | **Record 2 Compliance** | | **Record 3 Compliance** | |
| **CITATION** |  | **Yes** | **No** | **yes** | **No** | **Yes** | **No** |
| **ELIGIBILITY AND ASSESSMENT** | | | | | | | |
| **394.4574 (1)** | Documentation shows that the individual meets the definition of a mental health resident (the individual receives SSDI; or SSI and Optional State Supplementation (OSS). |  |  |  |  |  |  |
| **394.4574(2)(d)** | Is the documentation that the resident meets the definition of a mental health resident provided to the ALF administrator within 30 days of admission? |  |  |  |  |  |  |
| **394.4574(2)(a)** | Has an assessment been completed by the resident’s Mental Health Provider to document appropriateness for ALF placement? |  |  |  |  |  |  |
| **394.4574(2)(a)** | Was the above assessment conducted by a psychiatrist, clinical psychologist, clinical social worker, or psychiatric nurse (or an individual who is supervised by one of these professionals)? |  |  |  |  |  |  |
| **394.4574(2)(e)** | Has the provider assigned a case manager to the resident?  Note: If the resident refused case management services, there is documented evidence of refusal. |  |  |  |  |  |  |
| **N/A** | Does the case manager visit the resident at least monthly?  Note: During visits, the case manager should also meet with ALF administrator/ staff. |  |  |  |  |  |  |
| **COOPERATIVE AGREEMENT** | | | | | | | |
| **394.4574(2)(b)** | The provider has a current copy of the Cooperative Agreement signed by the provider and the ALF-LMH administrator (Agreement may cover all residents; verify ALF-LMH licensure) |  |  |  |  |  |  |
| **394.4574(2)(b)** | The Cooperative Agreement specifies directions for accessing emergency and after-hours care for the mental health resident(s). |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **Record 1 Compliance** | | **Record 2 Compliance** | | **Record 3 Compliance** | |
| **CITATION** |  | **Yes** | **No** | **yes** | **No** | **Yes** | **No** |
| **COMMUNITY LIVING SUPPORT PLAN (CLSP)** | | | | | | | |
| **394.4574(2)(c)** | The provider has a copy of the Community Living Support Plan for each mental health resident in ALF-LMH? (The CLSP and the Cooperative Agreement may be in one document) |  |  |  |  |  |  |
| **394.4574(2)(c)**  **58A-5.029, FAC** | CLSP was prepared with and signed by:   1. The mental health resident (if refusal, documentation of refusal is found) 2. The mental health case manager 3. The ALF administrator, or the administrator’s designee |  |  |  |  |  |  |
| **394.4574(2)(c)**  **429.02(7)**  **429.075(3)**  **59A-36.020 FAC** | The plan includes information about:   1. The specific needs of the resident 2. Specific services (including frequency and duration) to be provided by mental health provider 3. Other services/activities (including frequency and duration) to be provided by mental health provider 4. Obligations of the ALF to assist/facilitate resident attending appointments 5. Other services provided or arranged by ALF 6. Factors pertinent to the care, safety, and welfare including signs/symptoms that indicate immediate need for mental health services |  |  |  |  |  |  |
| **394.4574(2)(c)**  **59A-36.020(2)(c)(3), FAC** | Was the CLSP completed and given to the ALF administrator within 30 days of admission, or within 30 days after ALF received the placement assessment (whichever is later)? |  |  |  |  |  |  |
| **394.4574(2)(e)** | Is the CLSP updated annually? |  |  |  |  |  |  |

**Assisted Living Facility with Limited Mental Health License**

**Community Living Support Plan and Cooperative Agreement**

Name of the Assisted Living Facility (ALF): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALF Administrator’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALF Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ALF Admission Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident’s current Health Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_

The resident is a recipient of  Medicaid  Medicare  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(check one)

|  |
| --- |
| Resident’s Power of Attorney/Legal Guardian, if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Resident’s Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Resident’s Psychiatrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| Case Management Agency (CMA) or Community Mental Health Center (CMHC):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Resident’s Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Managing Entity (ME) / Substance Abuse Mental Health (SAMH) Program Office Contact:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Behavioral Health Care After-hours and Emergency Contacts:   * 911 for immediate assistance * CMHC 24/7 Hotline: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Health Plan’s Behavioral Health 24/7 Emergency contact #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

In addition to the required health assessment completed within (30) thirty days of admission on AHCA’s 1823 Form, the below assessment was conducted to determine the appropriateness for placement:

* An Alternate Care Certification for Optional State Supplementation (OSS) Form, CF-ES Form 1006 Form
* A discharge statement or form from a State Mental Hospital, completed (90) ninety days prior to admission
* A signed statement that the resident has been assessed and found appropriate for residency in an ALF that was conducted by a psychiatrist, clinical psychologist, clinical social worker, or psychiatric nurse, or a person (clinician) supervised by one of these professionals (under FAC 59A-36.020(2)(c)2)

The resident’s appropriateness for placement assessment was received by the ALF on \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Indicate the specific needs of the resident to enable the resident to live in the Assisted Living Facility.

1. Pursuant to 429.28(1)(j), list below the applicable clinical mental health services to be provided or arranged by the mental health provider in order to meet the resident's needs. (E.g., psychiatrist, ARNP, therapist, substance abuse treatment provider(s), etc.)

|  |  |  |  |
| --- | --- | --- | --- |
| **Agency** | **Service** | **Provider Name** | **Phone #** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. List below other non-clinical support services and activities to be provided by or arranged for by the mental health care provider, case manager or other State Agencies.

|  |  |  |
| --- | --- | --- |
| **Agency/Provider** | **Service** | **Phone #** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. Pursuant to 429.41(3)(h)(4), the responsibilities of the facility are to assist the resident in attending appointments and activities. List below any services arranged for or provided by the ALF.

|  |  |  |
| --- | --- | --- |
| **Type of Appointment**  **or Activity** | **Transportation Provider** | **Frequency** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. List additional services and activities currently available to the resident at the ALF:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List any special needs of the resident (e.g., related to head injuries, special medical, forensic issues, etc.) and any precipitating factors, which may indicate the need for professional services. Please include contact information, if applicable:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please assist the resident with completing Sections I and II.

**Section I - Triggers**

**Please ask the resident the following question:** What are some of the things that make you angry or very upset?

**Please check or \*fill in the answers below:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Being touched |  | Other: |
|  | Loud noises |  | Other: |
|  | Taking my belongings without asking |  | Other: |
|  | Name calling |  | Other: |
|  | Other: |  | Other: |

**Section II - Calming Strategies**

**Please ask the resident the following question:** Please share with us as many activities that you believe will be helpful when you are angry or very upset?

**Please check or \*fill in the answers below:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Listen to music |  | Exercise |
|  | Read a book |  | Do artwork (painting, drawing, etc.) |
|  | Wrap-up in a blanket |  | Hug an object of significance |
|  | Writing my feelings down |  | Drink a beverage |
|  | Watch television |  | Read spiritual material |
|  | Talk to staff |  | Go for a walk |
|  | Talk with peers |  | Other: |
|  | Call a friend or family member |  | Other: |
|  | Take time in a quiet room/comfort room voluntarily |  | Other: |
|  | Take a shower |  | Other: |

1. The following people are peer supports for the ALF resident:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_

1. In accordance with 429.02(8) F.S., the below list of action steps should be used on behalf of the ALF resident to ensure he/she has accesses to emergency, after-hours and weekend behavioral health services:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Identify any barriers that may prevent the resident from receiving services that are deemed necessary and how they will be addressed. (E.g., transportation, insurance coverage, elopement risks, resident’s refusal to sign the plan, etc.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Date of the last Community Living Support Plan on record\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Other comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Signatures: **The signatures below affirm that this document serves as a written statement of understanding between the Mental Health Provider and the Assisted Living Facility (ALF) developed by the Mental Health Case Manager to ensure delivery of the appropriate services for the identified ALF Resident. Upon obtaining consent from the ALF Resident, the ALF Administrator may receive a copy of the Treatment Plan from the Mental Health Provider and a copy of the Service Plan from the Intensive or Targeted Case Manager.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALF Resident Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Power of Attorney/Legal Guardian, if applicable Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALF Administrator or Designee Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Manager Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Manager Supervisor or Designee Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Health Provider or Designee Date