Connecticut BHP
Supporting Health and Recovery

Adult Group Home Registration/Concurrent Review Template

All fields with an * are required.

***Requested Start Date for this Request:** _____ ***Admit Date:** _____
***Type of Service:** □ Mental Health
***Level of Care:** □ Group Home-Adult
***Admit Date:** _____
***Has the member already been admitted to the facility?** □ Yes □ No

***Upload an Attachment** (the Master Treatment plan, Monthly progress notes and Medication list since last review and/or updated Individual rehab plan)

Inpatient Information:
***Calling Provider/Facility:** _____

***Member's LMHA involved, select LMHA:** _____

***Aftercare Follow-Up contact information for member - Please provide at least one method for contacting member for follow-up. If not available, please clarify reason**:

Phone_____ □ Not Available

Email_____ Validate Email_____

***Name of Place/Facility/Institution who referred member (please be specific)**

_____

Diagnosis:

Behavioral Diagnosis (Primary is required)

***Diagnosis Code:** _____ ***Description:** _____
***Diagnostic Category:** _____
Diagnosis Code: _____ Description: _____
Diagnostic Category: _____

Medical Diagnosis (Primary is required or indicate "None" or "Unknown")

***Diagnosis Code:** _____ ***Description:** _____
***Diagnostic Category:** _____

***Social Elements Impacting Diagnoses** (Required - Check all that apply)

□ None □ Financial problems □ Occupational problems
□ Other psychosocial and environmental problems_____
□ Problems with access to health care services □ Problems related to interaction with legal system / crime
□ Problems with primary support group
□ Problems related to social environment □ Unknown

Name:_____ DOB:_____

Functional Assessment (*Optional)*

□ CDC- HRQOL □ CGAS □ FAST □ GAF □ OMFAQ □ SF12 □ SF36
□ WHO DAS

□ OTHER _____ ASSESSMENT SCORE _____

Medical Implications:

***Are there any comorbid medical conditions that impact the treatment of the diagnosed MHSU conditions?**

□ Yes □ No □ Unknown

***Is the individual receiving appropriate medical care for the comorbid medical conditions?**

□ Yes □ No □ Unknown

Metabolic Assessment Tool: *(optional)*

Current Weight: _____ Height: _____ Waist Circumference: _____

Please provide additional information on reason for not obtaining BMI or if recommendation is to follow up, details around the follow-up when available.

_____
_____
_____
_____
_____
_____
_____

Symptomatology:

***Explain the reason for current admission describing symptoms and precipitant (stressor leading to decompensation, Does the member have a conservator? Please include the conservator's name and phone number)**
For concurrent reviews, list any progress that has been made and remaining symptoms.

_____
_____
_____
_____
_____
_____
_____

Name:_____ DOB:_____

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Current Risks:

Key: 0 = None 1 = Mild or Mildly Incapacitating 2 = Moderate or Moderately Incapacitating 3 = Severe or Severely Incapacitating N/A = Not Assessed

***Members Risk to Self:** □ 0 □ 1 □ 2 □ 3 □ N/A ***Members Risk to Others:** □ 0 □ 1 □ 2 □ 3 □ N/A

***Substance Use:** □ 0 □ 1 □ 2 □ 3 □ N/A ***Legal:** □ 0 □ 1 □ 2 □ 3 □ N/A

Urine Drug Screen (UDS) Completed: □ Yes □ No □Unknown Date UDS Completed: _____

Outcome of UDS: □ Positive □ Negative □ Pending

UDS Positive for (Check all that apply):
□ Cannabis □ Opiates □ Cocaine □ Amphetamines □ Tricyclic Antidepressants
□ Phenylpropanolamine □ Benzodiazepines □ Barbiturates □ Methamphetamine □ PCP
□ LSD □ Methadone

***Blood Alcohol:** _____ □ N/A

Primary Issues/Symptoms Addressed in Treatment:

***Indicate primary complex(es) pertinent to this request. You must complete a system complex for the primary behavioral/substance use diagnosis and the primary medical diagnosis (if one was indicated in the Diagnosis section above). Also, if you selected a 2 or 3 for any of the current risks above, you must complete the symptom complex for it below.**

□ Danger to Self □ Danger to Others □ Psychosis □ Child/Adolescent Behavior
□ Eating Disorder □ Neurocognitive □ Substance Use □ Mood Disorder

***Complex Name** (from list above): _____

***Include presenting problem(s), additional details around primary symptoms, history of issue, treatment history, ICM needs, & other information pertinent to member's history and current treatment request:**

_____
_____
_____

If you selected a 2 or 3 for any of the current risks above, you must complete the symptom complex for it below.

Complex Name (from list above): _____

Include presenting problem(s), additional details around primary symptoms, history of issue, treatment history, ICM needs, & other information pertinent to member's history and current treatment request:

_____
_____
_____
_____

Name:_____ DOB:_____

Complex Name (from list above): _____

Include presenting problem(s), additional details around primary symptoms, history of issue, treatment history, ICM needs, & other information pertinent to member's history and current treatment request:

_____
_____
_____
_____

Complex Name (from list above): _____

Include presenting problem(s), additional details around primary symptoms, history of issue, treatment history, ICM needs, & other information pertinent to member's history and current treatment request:

_____
_____
_____

Recovery and Resiliency:

***Describe the recovery and resiliency environment to support this individual's long term recovery plan including their personal strengths and support systems available to the member. Include any needs or supports that must be put in place to assist the member's recovery.**

_____
_____
_____
_____
_____

Current Psychotropic Medications:

Medication 1 Name: _____

Start Date: _____ Date Discontinued: _____ Date Added: _____

For this medication, please enter details concerning side effects, adherence, effectiveness and any specific target symptoms and any additional details that would assist in coordinating care: _____

_____

Medication 2 Name: _____

Start Date: _____ Date Discontinued: _____ Date Added: _____

For this medication, please enter details concerning side effects, adherence, effectiveness and any specific target symptoms and any additional details that would assist in coordinating care: _____

_____

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Medication 3 Name: _____

Start Date: _____ Date Discontinued: _____ Date Added: _____

For this medication, please enter details concerning side effects, adherence, effectiveness and any specific target symptoms and any additional details that would assist in coordinating care: _____

_____

With respect to all medications above, please enter any additional details that would assist in coordinating care:

_____

_____

_____

Medication changes this month: □ Yes □ No Medication requires serum blood levels: □ Yes □ No

Date of Most Recent blood draw: _____ □ Unknown

Best Practices Endorsement:

***I endorse that I follow best practice guidelines for the primary behavioral diagnosis:** □ Yes □ No

If you answered no to the question above, please explain why you will not follow best practice guidelines:

_____

_____

***Care Planning Team Includes:**

□ AO/Parole Staff□DCF □ DDS Case Manager □ Family/Guardian
□ Member □ Milieu Staff □ Medical ASO □ Outpatient Provider □ Peer/FPS □ Psychiatrist/Nurse
□ LMHA

***Is there a child or adult in member's household in need of any support or service:** □ Yes □ No

If Yes, select primary support/services needed: □ Behavioral Health □ Medical □ Social Services
□ Transportation □ Housing

If Yes, describe the support/service that is recommended: _____

_____

***Is service requested for HLOC because appropriate LLOC is not available:** □ Yes □ No

If Yes, what LLOC was needed and not available for the member:
□ Crisis Stabilization □ Obs. Bed □PHP □IOP □Home Health

If Yes, what is the reason why appropriate LLOC is not available:
□ Does not exist in geographic area
□ At capacity/no openings □ Does not provide specialty needed □ Member Declined
□ Hours not Available □ Determine Not Crisis □ Family Decline
□ Other _____

Name:_____ DOB:_____

Discharge Information:

***Planned discharge Level of Care:**

□ Community Support Team □ Outpatient □ Inpatient □ 23 Hour □ Partial Hospitalization
□ Halfway House □ Day Services □ IOP/SOP □ State Bed

***Planned Discharge Residence:**

□ AWOL □ Correctional Facility
□ Group Home (non therapeutic) □ Group Home Pass □ Group Home (therapeutic)
□ Home □ Independent Living □ Nursing Home/SNF/Assisted Living □ State Hospital
□ Supervised/Supportive Housing □ Transfer to Medical □ Unknown
□ Other _____

***Expected Discharge Date:** *(only required on concurrent reviews)* _____

Name:_____ DOB:_____