Connecticut BHP
Supporting Health and Recovery

CT BHP REGISTRATION TEMPLATE

ALL FIELDS WITH * ARE REQUIRED

Provider EDS/CMAP ID # (Medicaid 9-digit ID): _____

Facility/Provider Name: _____ **Contact # & Ext:** _____

Facility/Provider Service Location: _____

Name of clinician who filled out this form: _____ **Credentials/Title**: _____

Member Name: _____

Medicaid/Consumer ID#: _____ **DOB**: _____ **and/or SSN:** _____

LEVEL OF CARE: ☐ **Intensive Outpatient** ☐ **EDT** ☐ **Outpatient** ☐ **Methadone Maintenance** ☐ **Ambulatory Detoxification**
☐ **Home Based Services** ☐ **IICAPS** ☐ **MDFT** ☐ **MST** ☐ **FFT**

QUESTIONS:

1) *** Requested start date** (EX: 09/01/2010): _____
2) *** Is this a new registration for a client already in outpatient treatment within your agency/practice?** ☐ YES ☐ NO
3) *** Is member stepping down to outpatient from a higher level of care within your agency/practice?** ☐ YES ☐ NO ☐ N/A
4) *** Referral Source:** *(who encouraged this member to obtain services?)*
   ☐ Community Collaborative ☐ Court-Ordered/Legal ☐ CT BHP ASO ☐ DCF ☐ DDS ☐ DMHAS ☐ EMPS
   ☐ Hospital Emergency Dept. ☐ Other ☐ Other BH Provider ☐ PCP / Medical Provider ☐ School
   ☐ Self / Family Member ☐ Step Down Inpatient /Intermediate LOC
5) ***First phone or walk-in contact with member or parent/guardian**: **Date:** _____
6) ***First contact was:** ☐ Telephone ☐ Walk-in
7) ***Referral type:** ☐ Emergent ☐ Routine ☐ Urgent
   a. **If Routine or Urgent:**
      Date of 1st Appt. Offered to Member: _____ Date of 1st Appt. Accepted by Member: _____
      Date of 1st Face-to-Face Clinical Evaluation: _____
      If Applicable, Number of no-shows/cancellations prior to first appt.? **(Indicate #)** _____
   b. **If Emergent :** Date and Time Presented at the Clinic:____/_____/_____DATE_____AM / PM
      Date and Time of Clinical Evaluation:_____/_____/_____DATE_____AM / PM
8) **Behavioral Diagnoses (*Primary is required)***
   ***Diagnosis Code:** _____ ***Description**_____
   ***Diagnostic Category:** _____
   Diagnosis Code: _____ **Description**_____
   Diagnostic Category: _____
9) **Primary Medical Diagnoses *(Primary is required or indicate "None" or "Unknown")***
   ***Diagnosis Code:** _____ ***Description**_____
   ***Diagnostic Category:** _____
   Diagnosis Code: _____ **Description**_____
   Diagnostic Category: _____

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

☐ None ☐ Educational problems ☐ Financial problems ☐ Housing problems (Not Homelessness)

☐ Occupational problems ☐ Other psychosocial and environmental problems _____

☐ Problems with access to health care services ☐ Homelessness

☐ Problems related to interaction with legal system / crime ☐ Problems with primary support group

☐ Problems related to social environment ☐ Unknown

11) Functional Assessment *(Optional)*

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

☐ OTHER _____ ASSESSMENT SCORE _____

12) Current Risks

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

A. *Members Risk to Self ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

B. *Members Risk to Others: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

13) Current Impairments

A. *Mood Disturbances (Depression or Mania)
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

B. *Weight Changes Associated with Behavioral Diagnosis
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
For 2 or 3 rating:
Weight ☐ Gain ☐ Loss ☐ N/A
Past 3 mos_____Lbs ☐ N/A
Current Wt_____ Lbs ☐ N/A
Height_____ Ft_____In ☐ N/A

C. *Anxiety
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

D. *Psychosis / Hallucinations / Delusions
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

E. *Medical / Physical Conditions
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

F. *Thinking/Cognitive/Memory/Concentration Problems
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

G. *Substance Abuse / Dependence
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
For 2 or 3 rating: Check all that apply
☐ Alcohol Illegal ☐ Drugs ☐Prescription Drugs

H. *Impulsive/Reckless/Aggressive Behavior
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

I. *Job/School/Performance Problems
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

J. *Activities of Daily Living Problems
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

K. *Social Functioning/Relationships/Marital/Family Problems
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

L. *Impairments Related to Loss/Trauma
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

M. *Legal
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
For 1, 2 or 3 rating: Check all that apply
☐ Juv Jus ☐ Probation ☐ Parole ☐ Other Court

14) Does member have co-occurring mental health and substance abuse conditions? ☐ Yes ☐ No ☐ Not Assessed

Treatment Plan

15. *Is psychiatric medication evaluation or medication management visit indicated? ☐ Yes ☐ No

16. *Have you provided information regarding Peer Support or Self Help Options? ☐ Yes ☐ No

17. *Do family members or significant others actively participate in the member's treatment or recovery? ☐ Yes ☐ No

If yes, are any of the family members/significant others receiving their own MH or SA treatment? ☐ Yes ☐ No

18. Have you obtained consent to contact:

a. *School: ☐ Yes ☐ No ☐ Denied ☐ Adult not attending school

b. *Medical provider: ☐ Yes ☐ No ☐ Denied

c. *Previous behavioral health treatment provider: ☐ Yes ☐ No ☐ Denied ☐ N/A

19. ***The treatment plan was developed with the member (or his/her guardian) and has measurable time limited goals.**
☐ Yes ☐ No

20. ***Does a documented goal oriented treatment plan exist?** ☐ Yes ☐ No

21. ***Anticipated / Target Date for achievement of current treatment plan goal:** _____

SPECIAL POPULATIONS

FEDERAL REPORTING REQUIREMENTS *ONLY* FOR MEMBERS 0-18 YEARS OF AGE

22. **SED (Seriously/Severely Emotionally Disturbed):** ☐ YES ☐ NO ☐ UNKNOWN
23. **Co-Occurring Disorder**: ☐ YES ☐ NO ☐ UNKNOWN
24. **Living Situation:**
☐ Crisis Stabilization Residential ☐ Foster Care (Standard) ☐ Foster Care (Therapeutic or Professional)
☐ Group Home ☐ Homeless ☐ Independent living with Supports ☐ Jail / Correctional Facility ☐ Private Residence
☐ Psychiatric Residential Treatment Facility ☐ Residential Treatment Center ☐ Safe Home ☐ Shelter
25. **Within the past 12 months has the child/youth been arrested?** ☐ YES ☐ NO ☐ UNKNOWN
26. **Within the past 12 months has the child/youth been suspended / expelled?** ☐ YES ☐ NO ☐ UNKNOWN

ADDITIONAL REQUIRED QUESTIONS *ONLY* FOR METHADONE MAINTENANCE/AMBULATORY DETOX:

Methadone Maintenance

*** Is the member currently maintained on Methadone?** ☐ YES ☐ NO

a. **If yes**, how long has the member received Methadone services?
☐ 6 mos or less ☐ 7 mos – 1 yr ☐ 1-3 yrs ☐ 3-5 yrs ☐ 5 yrs >

b. **If no**, what has been the duration of the member's opioid use?
☐ Less than 1 yr ☐ 1-3 yrs ☐ 3-5 yrs ☐ 5 yrs or >

***What other services are included in the treatment plan?**
☐ Community Support (AA/NA) ☐ IOP/PHP ☐ Other Behavioral Health Services ☐ Outpatient Therapy
☐ PCP / MD Follow-up

***What is the ultimate treatment goal?** ☐ Abstinence ☐ Methadone Maintenance

Ambulatory Detox

***From what substance is the member in need of detoxification? (select all that apply)**
☐ Alcohol ☐ Benzodiazepines ☐ Opiates

***Has the member had a previous detox in any setting in the past year?**
☐ YES ☐ NO

If yes, number of detoxes in the past year?
☐ **1** ☐ **2** ☐ **3** ☐ **4+**

***What is the identified discharge plan? (Select all that apply)**
☐ Community Support (AA/NA) ☐ IOP/PHP ☐ Methadone Services ☐ Other Behavioral Health Services
☐ Outpatient Therapy ☐ PCP/MD Follow-up