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Kansas Health Solutions

Outpatient Mental Health Registration

Instructions: Submit within ten (10) business days of first face-to-face contact with member. Incomplete registration forms will not be processed.

Member Name: ____ Date of Birth: __________________
Last First Middle mm/dd/yy

Medicaid Number: ______________________ Social Security Number: ______________________

COMPLETE IF PROVIDER IS PART OF AN AGENCY OR GROUP PRACTICE

Provider Agency: ____

COMPLETE IF PROVIDER IS IN INDEPENDENT PRACTICE (I.E., NOT PART OF AN AGENCY OR GROUP PRACTICE)

Provider Name: ____
Last First Middle

SECTION I – Access Standard Information

Member covered under PAHP contract at the time of Intake Assessment: ☐ Yes ☐ No

Date and Time of Initial Call/Contact: [Not Applicable, if member was not covered under PAHP contract at the time of Intake]

Date: _________________ (mm/dd/yy)
Time: ________________ ☐ AM ☐ PM

If the member is entering outpatient treatment following discharge from inpatient care, indicate date the member was discharged from inpatient care **instead** of date and time of initial call/contact.

Discharge Date from Inpatient Care: [Not Applicable, if member was not covered under PAHP contract at the time of Intake]

Date: _________________ (mm/dd/yy)

Assessed Acuity of Clinical Need/Access Standard:

☐ Post-stabilization in an emergency room (1 hour)
☐ Emergent (3 hours)
☐ Urgent (48 hours)
☐ Post discharge from inpatient care (72 hours)
☐ Routine (9 working days)
☐ N/A – Member not covered under PAHP at Intake

Date and Time of First Face-to-Face Visit (i.e., Intake/Initial Assessment):

Date: _______________ (mm/dd/yy) **[Enter date of first face-to-face regardless of whether member was covered under the PAHP contract at the time of the Intake]**

Time: ______________ ☐ AM ☐ PM **[Not Applicable, if member was not covered under PAHP contract at the time of Intake]**

***If outside of ROUTINE access standard*, account for the exception:**

☐ Specialized treatments not required in licensing or contract (e.g., anger mgmt., sex offender treatment)
☐ Member/Family Choice (i.e., prefers specific time or provider)
☐ Unable to reach member/family
☐ Member/Family cancels or no shows
☐ Member/Family changed mind/declined services
☐ Access standard not met

Phone: 1-877-642-9283
Fax: 1-785-232-2610

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Member Name: ______________________________ Date of Birth: ______________
Last First Middle mm/dd/yy

Date of First Service Following Intake/Initial Assessment (10 working days): [Not Applicable, if member was not covered under PAHP contract at the time of Intake]

Date: ____________ (mm/dd/yy)

***If outside of access standard*, account for the exception:**

- ☐ Specialized treatments not required in licensing or contract (e.g., anger mgmt., sex offender treatment)
- ☐ Member/Family Choice (i.e., prefers specific time or provider)
- ☐ Unable to reach member/family
- ☐ Member/Family cancels or no shows
- ☐ Member/Family changed mind/declined services
- ☐ Access standard not met

SECTION II – Additional PAHP Reporting Requirements

Are any services to be provided court ordered? ☐ Yes ☐ No

If Yes, specify the applicable service category. [More than one option may be checked]

- ☐ Evaluation **[Any court ordered evaluation other than Medication Evaluation]**
- ☐ Outpatient Therapy **[Individual, Group and Family Therapy]**
- ☐ Outpatient Medical Services **[All Medical Services including Medication Evaluation]**
- ☐ Other

Primary Diagnosis:

Indicate Axis Number	Code	Description

Secondary Diagnosis(ses): [At least one secondary diagnosis must be noted, which may include 799.9 or V71.09]

Indicate Axis Number	Code	Description

Functional Level (GAF): __________

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Member declined to disclose ethnicity

Special Needs: **[More than one option may be checked]**

- ☐ Severe and persistent mental illness (SPMI)
- ☐ Serious emotional disturbance (SED)
- ☐ Dual diagnosis (Mental illness/substance abusing)
- ☐ Dual diagnosis (Mental illness/developmental disabilities/mental retardation)
- ☐ Pregnant and using substances
- ☐ Using intravenous drugs
- ☐ Not Applicable

Health Issues as reported by Member/Parent/Guardian:

Health risks? ☐ Yes ☐ No ☐ Member/parent/guardian declined to report

Chronic illness? ☐ Yes ☐ No ☐ Member/parent/guardian declined to report

Visit/check-up with PCP in the past twelve months?
☐ Yes ☐ No ☐ Member/parent/guardian declined to report

Regular preventative health screens?
☐ Yes ☐ No ☐ Member/parent/guardian declined to report

Member/Parent/Guardian participated in the development of the Treatment Plan:
☐ Yes ☐ No ☐ Treatment Plan not yet developed

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Member Name: ______________________________ Date of Birth: ______________
Last First Middle mm/dd/yy

Required Releases of Information:

KHS/Provider release of information authorization must be obtained from the member and appropriately documented within the member's clinical record to insure KHS' and its providers' have the ability to coordinate the member's care within the KHS provider network and across all delivery systems.

Coordination with PCP ☐ Yes* ☐ No ☐ Declined by member/parent/guardian ☐ Not Applicable

***If Yes, has the Initial Treatment Plan been sent to PCP?** ☐ Yes ☐ No

Coordination with Value Options ☐ Yes ☐ No ☐ Declined by member/parent/guardian ☐ Not Applicable

Coordination with Other Treaters ☐ Yes ☐ No ☐ Declined by member/parent/guardian ☐ Not Applicable

Member meets medical necessity criteria (i.e., authority, purpose, scope, evidence, and value) as detailed in the Provider Manual: ☐ ***Yes*** ☐ ***No***

Completed By: ______________________________ Date: ______________ (mm/dd/yy)
First Name Last Name

Contact Number: ______________________________

Discharge

Closing Date: ______________ (mm/dd/yy)

Last Contact Date: ______________ (mm/dd/yy)

Discharge Reason:

- ☐ Evaluation Completed
- ☐ Treatment Completed (Planned discharge by mutual agreement)
- ☐ Treatment Not Completed – Provider/Agency Decision
- ☐ Treatment Not Completed – Member Decision (AMA, No-Show, Unable to Locate)
- ☐ Transfer to Alternative Program
- ☐ Member Moved
- ☐ Member Discharged by/to Court or to Jail
- ☐ Death of Member – Natural Causes
- ☐ Death of Member – Accident
- ☐ Death of Member – Suicide
- ☐ Death of Member – Murder
- ☐ Death of Member – Terminal Illness
- ☐ Death of Member – Other
- ☐ Death of Member – Unknown

Primary Diagnosis at Discharge:

Indicate Axis Number	Code	Description

Secondary Diagnosis(ses) at Discharge: [At least one secondary diagnosis must be noted, which may include 799.9 or V71.09]

Indicate Axis Number	Code	Description

Functional Level at Closing (GAF): __________

Completed By: ______________________________ Date: ______________ (mm/dd/yy)
First Name Last Name

Contact Number: ______________________________

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