**ATTACHMENT B**

**ACCESS STANDARDS**

**IAC 441-25.3(331)**

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| **SERVICE** | **CATEGORY** | **ACCESS STANDARD** |
| **oUTPATIENT** | EMERGENCY | During an emergency, outpatient services shall be *initiated to an individual within 15 minutes of telephone contact.* |
|  | URGENT | Outpatient services shall be provided to an individual *within one hour of presentation or 24 hours of telephone contact.* |
|  | ROUTINE | Outpatient services shall be provided to an individual within four weeks *of request for appointment.* |
| **24 Hour Telephone Crisis Service** | Basic crisis response | *24 hour access, 24 hours per day, seven days per week, 365 days per year.* |
| **CRisis evaluation** | basic crisis response | Crisis evaluation *within 24 hours of call to 24 hour Hotline*, *emergency and urgent outpatient services.* |
| **service coordination** |  | An individual receiving service coordination *shall receive service coordination within 10 days of the initial request for such service or being discharged from an inpatient facility.* |
| **Assessment and Evaluation** | Discharge from inpatient facility | An individual who has received inpatient services *shall be assessed and evaluated within four weeks*. |

**ATTACHMENT C**

**DATA REQUIREMENTS**

|  |  |
| --- | --- |
| **required data set non crisis services** | **time frame** |
| Client Name | To be submitted with request for services. |
| Address |
| Date of Birth |
| Sex |
| Ethnicity |
| Marital status |
| Education |
| Residential living arrangement |
| Current employment status |
| Monthly income |
| Income sources |
| Type of insurance |
| Insurance carrier |
| Veteran status |
| Guardianship status |
| Legal status in the system |
| Source of referral |
| DSM IV diagnosis |
| ICD-9 diagnosis |
| Disability Group (mental retardation, developmental disability, mental illness) |
| **PREFERRED CRISIS DATA**  (Voluntary and Involuntary Hospitalizations, legal and transportation services associated with above) (Emergency outpatient services, mobile crisis team services, jail diversion services, mental health services provided in a county jail, and other services for which the county is required to pay but does not have access to the client to collect the required information.) | 10 days after the end of the fiscal quarter.  (October 10th, January 10th, April 10th,July 10th ) |
| Name (First and Last) |
| Address |
| Phone |
| Date of Birth |
| Follow-up 24hours after initial contact *(Date, time, contacted or attempt, Referrals)* |
| # served |  |
| **MINIMUM CRISIS DATA**  (Voluntary and Involuntary Hospitalizations, legal and transportation services associated with above) (Emergency outpatient services, mobile crisis team services, jail diversion services, mental health services provided in a county jail, and other services for which the county is required to pay but does not have access to the client to collect the required information.) | 10 days after the end of the fiscal quarter.  (October 10th, January 10th, April 10th,July 10th ) |
| Partial Name (First or Last) |
| Follow-up 24 hours after initial contact *(Date, time, contacted or attempt, Referrals)* |
| # served |

This Attachment has been executed by the parties hereto, through their duly authorized officials.

**CROSS Region: PROVIDER:**

By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: Duffy Kester Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Title: CROSS Board Chair Print Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ATTACHMENT C

SUGGESTED FOLLOW UP CRISIS DATA COLLECTION TOOL

|  |  |
| --- | --- |
| Reason Codes for No Contact | |
| 1 | Incorrect contact information given |
| 2 | Refused to leave contact information |
| 3 | No Answer |
| 4 | Refused to Participate in Follow-up |
| 5 | Call answered, Not Individual Served |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| INITIAL  CONTACT | | FOLLOW-UP ON INTIAL CONTACT | | CONTACT MADE | | Reason Code  *(If NO Contact made)* | REFERRAL | | REFERRAL MADE TO |
| DATE | TIME | DATE | TIME | YES | NO | CODE # | DATE | TIME | AGENCY & CONTACT INFO |
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**ATTACHMENT**

**ACCESS STANDARDS BASIC SERVICES**

**IAC 441-25.3(331)**

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| --- | --- |
| **SERVICE** | **ACCESS STANDARD** |
| **support for community living (scl)** | The first appointment shall occur within four weeks of the individual’s request of support for community living. |
| **Support for employment** | The initial referral shall take place within 60 days of the individual’s request of support for employment. |
| **Service Coordination** | An individual shall receive coordination within 10 days of the initial request for such service or being discharged from an inpatient facility. |

This Attachment has been executed by the parties hereto, through their duly authorized officials.

**CROSS Region: PROVIDER:**

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: Duffy Kester Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Title: CROSS Board Chair Print Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_