HUMAN BEHAVIOR INSTITUTE
Full Service Behavioral Health

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INITIAL MENTAL HEALTH ASSESSMENT

PROVIDER INFORMATION Type ☐ 14 ☐ 17 ☐ 26 ☐ 82 ☐ Other (specify)			Request Date:
Provider Name:	Credential:		NPI:
QMHP/Agency/Group Name (If applicable):			NPI:
Address: Street	City	State	Zip
Phone:	Fax:		
RECIPIENT/Patient Name:	Health Plan & ID #:		Initial Treatment Date:
Civil Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Dom. Part.	Date of Birth:	Age:	Gender: ☐ Male ☐ Female
Ethnic Background: ☐ Native American ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Pacific Islander ☐ Middle-Eastern ☐ Other			
Home Address: Street	City	State	Zip
Name of Parent/Legal Guardian (if the patient is a minor):		Phone:	
Employment: ☐ Student ☐ Unemployed ☐ Employed as ➢		Name of Employer/Company:	
In State Custody? ☐ Yes ☐ No	Case Worker:	Phone:	

Living Arrangement	☐ By self at Home/Apt	☐ w/ Parents	☐ w/ Spouse/Partner	☐ w/ Relatives	☐ w/ Friends
	☐ Homeless	☐ Shelter/Halfway House	☐ Foster Home	☐ Group Home	☐ Other (*Specify*):

☐ Check box if the patient's Primary Care Physician has a current signed Release of Information to coordinate treatment.

Primary Care Physician's Name and Phone:

1. Presenting Problems: *(Include psychiatric symptoms, maladaptive behaviors, risky behavior, precipitating events)*

2. Placement/Living Arrangement History: *(Include past and current placement, adjustment to home setting)*

3. Psychosocial History: *(Include birth order, birth place, siblings, significant life events)*

4. Psychiatric Treatment History: *(Include past and present inpatient/outpatient treatments and compliance)*

5. Medical History: *(Include medical, developmental issues and co-morbid conditions – treatment and compliance)*

Medication	Dosage	Frequency	Prescriber

6. Family History: *(Include family medical, psychiatric, developmental, legal issues, and attitude towards recipient)*

7. Environmental Stressors, Family and Community Support

8. Academic *(Include school performance, special accommodations, learning and behavioral issues)* and Employment History

9. Legal Issues

10. Addiction Issues *(if indicated, client must be evaluated using the SUBSTANCE ABUSE ASSESSMENT by a qualified addiction counselor)*

11. Habits, Strengths, and Weaknesses *(Include recipient's attitude towards treatment, desire to change and willingness for intervention)*

12. Physical, Behavioral And Mental Status Examination

Appearance	Eye Contact	Interaction	Speech	Mood	Affect	Consciousness
☐ Appropriate	☐ Good	☐ Engaged	☐ Normal	☐ Calm	☐ Appropriate	☐ Alert
☐ Overweight	☐ Fair	☐ Withdrawn	☐ Soft	☐ Remorseful	☐ Blunted	☐ Confused
☐ Underweight	☐ Poor	☐ Demanding	☐ Loud	☐ Sad	☐ Labile	☐ Distracted
☐ Bizarre	☐	☐	☐ Rapid	☐ Angry	☐ Euphoric	☐ Lethargic
☐ Disheveled	☐	☐	☐	☐ Anxious	☐ Euthymic	☐
☐	☐	☐	☐	☐ Hostile	☐	☐

Sensory Oriented to	Concentration	Memory	Thought Process	Delusions	Hallucination	Insight/Judgment
☐ Person	☐ Focused	☐ No impairment	☐ Appropriate	☐ Persecutory	☐ Auditory	☐ Good
☐ Place	☐ Pre-occupied	☐ Recent	☐ Circumstantial	☐ Paranoid	☐ Visual	☐ Impaired
☐ Time	☐ Short Attention	☐ Remote	☐ Tangential	☐ Grandiose	☐ Somatic	☐ Poor
☐ Situation	☐ Easily distracted	☐	☐ Loose	☐ Denied	☐ Olfactory	☐
☐ Future	☐	☐	☐	☐	☐ Tactile	☐
☐	☐	☐	☐	☐	☐ Denied	☐

Details:

13. Current Risk Factors: *(Check all items that apply)*

- ☐ Suicidal ideation with NO plans/attempts
- ☐ Suicidal ideation with plans/attempts
- ☐ Homicidal ideation with NO plans/attempts
- ☐ Homicidal ideation with plans/attempts
- ☐ Dangerous behavior that places self/others at risk
- ☐ Patient on high dosage of anxiety/pain medication
- ☐ Medical condition complicating mental health
- ☐ Unable to care for self / personal neglect
- ☐ None
- ☐ Physical abuse (by others)
- ☐ Physical abuse (to others)
- ☐ Sexual abuse (by others)
- ☐ Sexual abuse (to others)

Explain Details:

14. Current Functioning: *(Include recipient's ability to function daily in relation to school/work, peers, family, daily living, etc.)*

DSM DIAGNOSIS

Diagnosis Code	Narrative Description	Diagnosis Code	Narrative Description
1)		2)	
3)		4)	

DC: 0-3 DIAGNOSIS If recipient is age 0-3 only

DC: 0-3 Code	Narrative Description	DC: 0-3 Code	Narrative Description
1)		2)	

ASSESSMENT	Score:	Level	Date:	Clinical Assessor	Credential
☐ CASII ☐ LOCUS					
If CASII or LOCUS score > 19, please submit scoring sheet with this assessment.					
Other Assessment *(specify)*: ☐					

SED/SMI DETERMINATION ☐Yes ☐No If yes, state your rationale here *(or identify field reference # above)*, and submit the SED/SMI determination forms with this Mental Health Assessment. If you need blank SED/SMI forms, please contact HBI at (702) 248-8866.

RECOMMENDATION • TREATMENT GOALS/PLAN

Targeted Symptoms	Treatment Goal	Treatment Plan/Approach	Projected Date of Resolution
1)			
2)			
3)			
4)			
5)			

REQUESTED SERVICES						
Start Date➢		**End Date➢**		Medicaid Plans maximum = 90 days		
Service Type	Code	Service Provider	Units/Day	Days/Week	Total Units	UM Approved
☐ Initial Evaluation (replaced 90801)	90791					
☐ Individual Counseling (30-minute session)	90832					
☐ Individual Counseling (replaced 90806)	90834					
☐ Interactive Complexity Add-on to 90791 / 90832 / 90834	90785					
☐ Family Counseling (w/o the patient)	90846					
☐ Family Counseling (w/ the patient)	90847					
☐ Multi-Family Group Psychotherapy	90849					
☐ Group Psychotherapy (other than a multi-family group)	90853					
☐ Behavioral Health Screening	H0002					
☐ At-home Therapy	H0004					
☐ BST	H2014					
☐ PSR	H2017					
☐						
☐						
☐						

ADDITIONAL INFORMATION

Prior authorization of requested services is not a guarantee for imbursement. Payments are subject to member's eligibility, available benefits, contractual limitations, exclusions, coordination of benefits, and other terms specified in the benefit plan <u>at time of submission of claims</u>. Check this box ☐ to acknowledge that you have read and understood these terms.

Signature and Title of Coordinating Clinician:	Date:

The following section is for HBI–UM use only		
Date/Time Received:	UM Reviewer:	Date Reviewed:
Determination: ☐ Full Authorization ☐ Partial Authorization (see Requested Services above) ☐ Need clinical information ☐ Peer Review: ☐ Medical Necessity ☐ Administrative		Date Submitted for Review:
COMMENTS:		