DAVIS BEHAVIORAL HEALTH
Community · Commitment · Change

Policies & Procedures

INTAKE PROCESS

Section: Clinical Policies

Pages: 2

Subject: Intake Process

Effective Date: 12/2005

Revision Date: 07/17/2023

POLICY

To ensure access to DBH treatment services for persons with psychiatric conditions thatare within the legal and ethical mandates of the agency or are within defined service priorities. As well as minimize the potential client access problems due to geographic, cultural, and language barriers, and physical disabilities.

PURPOSE

A DBH intake worker will screen all persons applying for service either by phone or in person. Initial contact may also be made by other healthcare providers, hospitals, nursing homes, community agencies, schools, etc. on behalf of the enrollee. The intakeworker will assess the level of urgency of the need for services along with collaboration withour clinical screener and if the problem description is within agency service priorities.
The person will either be referred for services outside the agency or will be scheduled for a timely appointment with a DBH clinician for an initial assessment. The initial assessment will result in a plan for providing services within the clinically indicated level of care.

PROCEDURE

1. Initial Screening

   - All patients applying for services will receive an initial eligibility screening.
   - The initial screening is not a mental health evaluation. The purpose of the screening is to determine, according to the prospective client's self-report, whether an emergency exists, or if the client otherwise meets service eligibility requirements for admission to DBH.
   - The intake interview will result in:
     i. Prioritization for service
        1. The client or other information providers report that due to a mental condition an emergency exists (the client represents an immediate risk of injury to self or others.)
        2. The client or other information providers report that due to a mental condition an urgent situation exists (the client or others

describe a situation in which symptoms are so severe that their level of functioning is grossly impaired.)

3. The client (or information providers) report that due to a mental condition the client is experiencing distress but is substantially able to perform the normal duties daily living. (A routine situation exists.)
4. The client reports a need for mental health treatment and is eligible for services under a third-party contractual arrangement with DBH.

ii. Scheduling of first appointment or referral

1. Emergent: Within one hour (crisis worker or back-up)
2. Urgent: Within five working days (first available therapist, psychiatrist, or advanced practice nurse when indicated)
3. Client is covered under any plan with a third-party payer with whom DBH has contracted: Within defined contractual time limits.
4. Routine care: Within 15 working days. Services may or may not be provided based upon current resource availability, contractual requirements, and the clinical needs of the client. The intake worker will, based upon current clinician availability do one of the following:
    a. Schedule with a DBH clinician for initial assessment and treatment.
    b. Communicate to the client that they have been placed on a waitlist pending clinician availability and indicate an expected wait time.
    c. Refer the prospective client to a service provider external to DBH, or
    d. Decline to schedule services if the presenting problem does not appear to be the product of a mental condition, (e.g., relationship difficulties or situational difficulties). When possible, a referral will be provided.

iii. Orientation to services—When the client is to be scheduled for a mental health assessment, the intake worker will:

1. Prepare face sheet information as required for the initiation of the clinical record
2. Conduct financial assessment and fee-setting
3. Obtain releases of information as appropriate
4. Provide client a copy of the client's rights and responsibilities, expectations, the DBH grievance and appeal procedure, transportation and the DBH crisis system.
5. Inform client of their right for an Advanced Directive
6. Be knowledgeable of our Informed Consent and Privacy Policy
7. Notify Medicaid enrollee of the purpose of the Member Handbook when reviewing the client's rights. Provide enrollee with a copy of the Member Handbook.
8. Inform clients they may reach their treatment coordinator by leaving a message with the receptionist or on the treatment coordinator's voicemail.

2. DBH staff will provide assistance to callers who have communication impediments or impairments to facilitate proper screening and triage services.
3. DBH will make services available for those who are unable to get to clinic locations during normal working hours; these hours of operation are offered to non-Medicaid clientele and fee for service clientele.

2. Enrollment & Disenrollment

A. Medicaid enrollment is mandatory. The department automatically enrolls members based on county of residence and disenrollment is genally mandatory based on change in county of residence, change in Medicaid eligibility, or loss of Medicaid eligibility resulting in no longer being enrolled in the PMHP. DBH can only request disenrollment in accordance with our PMHP contract article 3.6 which states: "Contractor may not request disenrollment of an Enrollee because of an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from special needs (except when continued enrollment in the PMHP seriously impairs the contractor's ability to furnish services to Enrollees.)"

B. The member may submit an oral or written request for disenrollment with the State or the Contractor as follows:

i. For cause at any time, including:
- The member has moved out of the Contractor's service area.
- The Contractor does not (due to moral or religious objections) cover the service the member seeks.
- The member needs related services to be performed at the same time, not all related services are available from the Contractor's plan, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk.
- Poor quality of care.
- Lack of access to covered services, or lack of access to providers experienced with dealing with the member's specific needs.

ii. Without cause at the following times:
- During the 90 days following the date of the member's initial enrollment.
- At least once every 12 months thereafter.
- Upon automatic re-enrollment if temporary loss of eligibility has caused the member to miss the annual disenrollment opportunity.
- When the Department has imposed sanctions on the Contractor, consistent with 42 CFR §438.702(a)(4).