

Guide to Completing an Intake Assessment in TIER

Intake Assessment

Purpose: To gather psychosocial information in a culturally competent manner that facilitates the demonstration of the three components of Medical Necessity: (Medi-Cal “Included” Diagnosis & Symptoms, Functional Impairment and Interventions).

- ❖ In the event multiple services are needed to complete an assessment, be sure to indicate the date when documenting in the assessment the information added during additional services. This will match the date information is being obtained to the additional assessment billing.

The screenshot shows the 'Intake Assessment (test 3, test 3)' window. The top menu includes File, Edit, Search, and Help. Below the menu is a toolbar with icons for file operations. The main window has a title bar 'test 3, test 3' and buttons for 'Save & Continue', 'Print', 'Save', and 'Cancel'. A tabbed interface is visible with tabs for 'Presenting Problem', 'Psychosocial Functioning/Status', 'Contacts', 'Consents', 'Assessment Domains', 'Diagnosis', 'Summary/Necessity', 'Recommendations/Disposition', and 'Co-sit'. The 'Presenting Problem' tab is active, showing a form with the following fields:

- Intake Assessment not completed. Refer to previous Intake Assessment dated: / /
- See ICARE Assessment
- Start Date: 02/16/2017
- Time In: 11:58 AM
- Time Out: [empty]
- Staff: Frausto, Erika
- Final Intake Date: [empty]
- Assessment Type: Adult Child/Adolescent 0-5
- Service Type: School Linked Field Based
- Agency of Primary Responsibility: Other
- parent

Complete the following information before beginning assessment.

- Intake Assessment not completed box: Check box in the event that a paper version was completed and scanned in to Tier and indicate with appropriate date.
- See ICARE Assessment box: Check the box and document in the Presenting Problem(s) section “Refer to ICARE Assessment” when assessing 0-5 clients. ICARE Assessment will only appear if the client falls within the correct age range.
- Complete the Start Date, Staff, Assessment Type, Service Type (Predominant Focus of Service) and Agency of Primary Responsibility (APR). The APR is to capture the appropriate referral source of how client was linked to the agency. If “other” apply, check box and write in the agency’s name or if none apply check the “other” and parent/family, friend or self-referred.
 - APR Ex. DMH: Access Services; DCFS: DCFS involvement, Family Preservation, WRAP, Child/Adolescent Dependent of the Court; Probation: Probation Officer, Legal Problems; School District: Special Education, IEP, Special Day Class, etc.
- Review information documented by the Call Center: Pre-Intake Screening
 - Revise information as needed to match information previously obtained from the client.
 - Begin documenting added information below written information from the Call Center; including the date of the Initial Assessment and Staff Name/Initials.

This screenshot shows the lower portion of the 'Intake Assessment' window. The 'Presenting Problem(s)' section contains a text area with the text 'Client reports experiencing...'. Below it is the 'History of Presenting Problem and Treatment' section with a text area containing 'Client has received...'. At the bottom, there are two sets of radio buttons: 'Homicidal Thoughts' with 'Yes' and 'No' options, and 'Suicidal Thoughts' with 'Yes' and 'No' options. A 'Suicide Risk Assessment' button is located between these two sets. To the right, there is a 'Risk Evaluation Tool' section with an 'Add New' button and a table with a 'Date' column and several empty rows. The window title and menu are the same as in the previous screenshot.

- **Presenting Problems:**
 - Some information will be carried forward from the Pre-Intake; this field would be editable by the intake clinician.
 - Start to create a diagnostic picture based on the symptoms reported.
 - Keep DSM and/or ICD diagnostic criteria in mind when you are completing this section.
 - Some questions to answer:

Presenting Problem, continued (see screenshot at the bottom of page1)

- What are the symptoms, their *intensity, duration, onset and frequency*? ****Identifying frequency of behaviors and symptoms will make it easier to develop a SMART Objective on the Master Treatment Plan. ****
- How are these symptoms impairing client's functioning? NOTE: Answer the question, "Why now?"
- If client reports being more stable with medication indicate this in documentation in order to support their continued need for medication services (Client report is within clinician scope of practice).
- **Identify client's strengths that will assist them in achieving treatment goals. It is important to document the strengths of the client throughout the Intake Assessment.**

• **History of Presenting Problem and Treatment:**

- Some information will be carried forward from the Pre-Intake; this field would be editable by the intake clinician.
- Have client's episode screens in hand
- Indicate the history and onset of current symptoms
- When did symptoms begin? Explore what events precipitated their seeking treatment or being hospitalized.
- Have symptoms been episodic or chronic over several years? (ex. Major Depressive Disorder, Recurrent vs. Single Episode vs. Dysthymia)
- Did symptoms occur after a specific event? (ex. Adjustment Disorder)
- Inquire about previous inpatient and outpatient episodes
- Obtain information for each episode listed if client can recall. Clients may mention treatment not listed on the episode screen because services were rendered outside of LA County or in private facilities. Be sure to include this information when provided.
- If client denies any past history of treatment, but there are episodes listed, ask about the treatment. Indicate the outcome of their treatment or hospitalization, such as effectiveness of any medications taken, therapy outcomes OR why they stopped or dropped out of treatment.

• **Homicidal/Suicidal Thoughts:**

- ❖ Document reported past/current suicidal/homicidal thoughts/attempts; must include dates, threat, intent, plan, target(s), access to lethal means, method used. Also include specific information, clarifying thoughts and attempts related to dates of occurrence, level of threat, if client had a plan (and what that plan entailed), if specific individual(s)/location(s) were targeted, if they had or have access to lethal means and the method that was or intended to be used. Important to document if client does not remember some of the above details or if client denies a history of previous suicidal/homicidal thoughts and attempts.
 - Homicide Risk Assessment (tab will appear if you mark "Yes" for "Homicidal Thoughts")
 - If marked "yes" must complete the Homicide Risk Assessment Tool.
 - Suicide Risk Assessment (tab will appear if you mark "Yes" for "Suicidal Thoughts")
 - If marked "yes" must complete the Suicide Risk Assessment Tool.
 - These are scored assessments; be sure to answer every question (**do not leave any items blank**).
- ❖ **The Suicide Risk Assessment or Homicide Risk Assessment must be completed for all Hospital Discharges and for any report by the client/guardian of any S/I or H/I within the past year.**

• **Risk Evaluation Tool:**

(Must be completed for clients 6 years of age and older. For clients 0-5 years old complete as clinically indicated)

Click "Add New" button to generate the Risk Evaluation Tool

The Risk Evaluation Tool is used to capture and further assess information regarding any current and or history of risk factors impairing client's daily life functioning as a tool to further assess for suicide, violence, grave disability and school violence.

Be sure all pages are complete before Final Saving, if supervisor review/co-signature is required do not final save until approved by your supervisor.

- ❖ **If further assistance is needed in completing the Risk Evaluation Tool, refer to the Risk Evaluation Tool on the EHRS Intranet site.**

Psychosocial Functioning/Status

- **Marital Status, Ethnic Origin, Race, Preferred Language, Secondary Language, Living Arrangements:**
 - Select from drop-down menu for each, based on client's report use this section to explain any of the above items if needed.
 - If further clarification is needed please use space below: Examples: Indicate identified races for someone who selects "Other" for race because they are Biracial; Indicate with whom a client cohabitates; Indicate a Non-English language not on the list provided; Indicate language client prefers to speak, if client is bilingual.
- **Psychosocial Functioning/Status:**
 - **This is where you want to list and summarize client's functional impairments.** How his/her symptoms affect...

<ul style="list-style-type: none"> * Daily Activity * Educational Social Support * Financial Status/Receiving * Hospitalizations/Crisis Stabilization/ PMRT 	<ul style="list-style-type: none"> * Legal Status * Living Arrangements * Physical Health * Social Support * Vocational (inability to work)
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 - Describe the functional impairment(s) the client is experiencing in his/her Life as a result of their mental health symptoms and behaviors. Examples of how to document functional impairments:
 - Client's sad mood and tendency to isolate led to client quitting soccer team and withdrawing from friends.
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 - Client's irritability leads to increased arguing with parents and siblings as well as with classmates.
 - Client struggles to pay attention in class and has been unable to concentrate in order to complete class work and homework. Client is also disruptive to other students.
 - Client's difficulty controlling anger has led to fighting in school which resulted in expulsion from previous school.
 - Client was fired from last job after missing several days of work due to not getting out of bed during a depressive episode.
 - Client relies on his payee to pay his bills due to client's difficulty organizing and completing tasks.
 - Special Needs, Cultural Consideration, Physically Challenged and Access Issues
(Specify information in space that will appear if selected)
 - Special Needs: Document any Special Needs that Client may be experiencing: hearing impaired, intellectual delays, etc.
 - Cultural Considerations: Document any Cultural matters influencing symptoms, impairments and treatment which are needed to provide culturally competent services. Culture includes: ethnicity, race, language, gender, as well as sub-cultures: gang culture, poverty, etc.
 - Physically Challenged: Document any physical challenges that client may be experiencing. This may include inability to walk, unassisted (e.g. client paralyzed uses a wheelchair, etc.).
 - Access issues: does not relate to client's schedule (times they can attend therapy), this section is focused on issues related to transportation barriers due to distance, disability, financial difficulties related to mental health or lack of transportation.

Contacts

Contact Name	Relationship	Phone	Legal Guardian	Involvement in Treatment	Permission to Visit	Emergency Contact
Dism...	Grandfather	(818)551...		Yes		Yes

- “Add New” for each contact Client/Guardian wants to include.
 - Client contacts would generally be significant friends or family members such as parents (of adults), adult children, partners, close friends, etc. who may be part of the client’s support system or who might be emergency contacts.
 - This may also be the parties who will be contacted in the course of the client’s treatment such as DCFS workers, IHOC workers, GAIN workers, TBS Clinicians, IHSS workers, etc.

test2 . test

Contact | Status | Release of Information | 6338039

Name: _____

Gender: _____

DOB: _____

Relationship Type: _____ Primary Language: English

Relationship to Client: _____

Agency: _____ Credentials: _____

Use Patient Address

Address: _____

Address 2: _____

City: _____

State: _____ Zip: _____

Phone: _____ Cell: _____ Work Phone: _____ Ext: _____

E-Mail: _____

Send Outlook Email

Involvement in Treatment: Yes No Responsible Party

Emergency Contact: Yes No

Conservator: Yes No Foster Care: Yes No

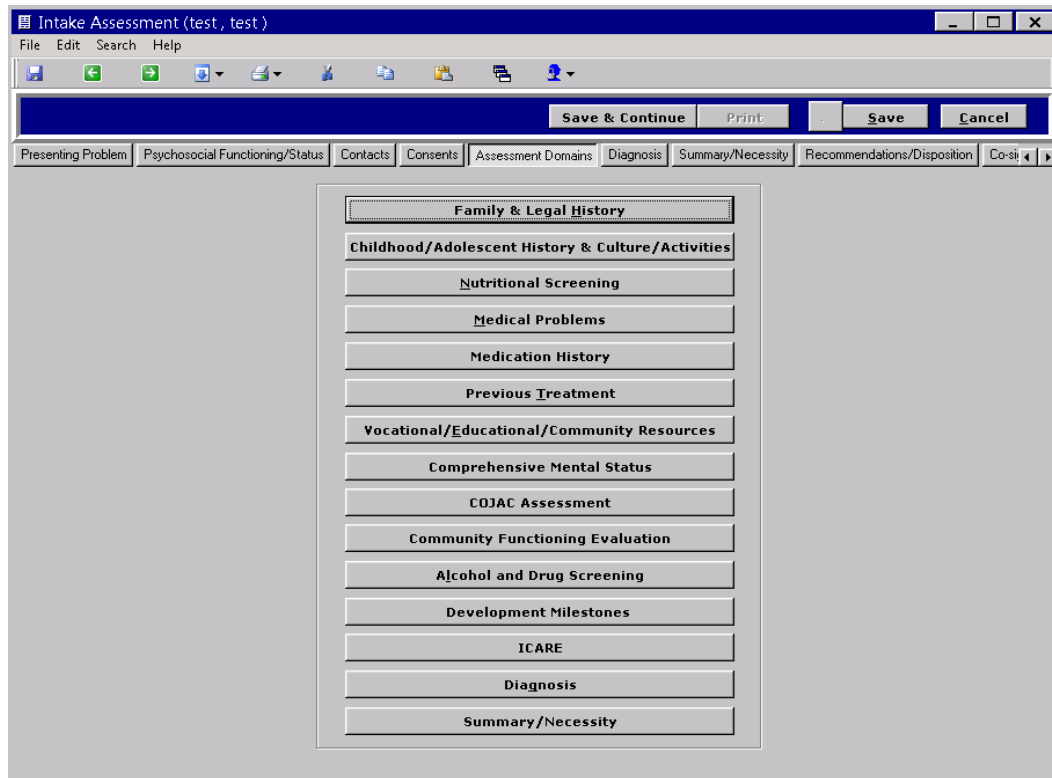
Legal Guardian: Yes No Relative Caregiver: Yes No

Release Information: Yes No Add New Release of Information

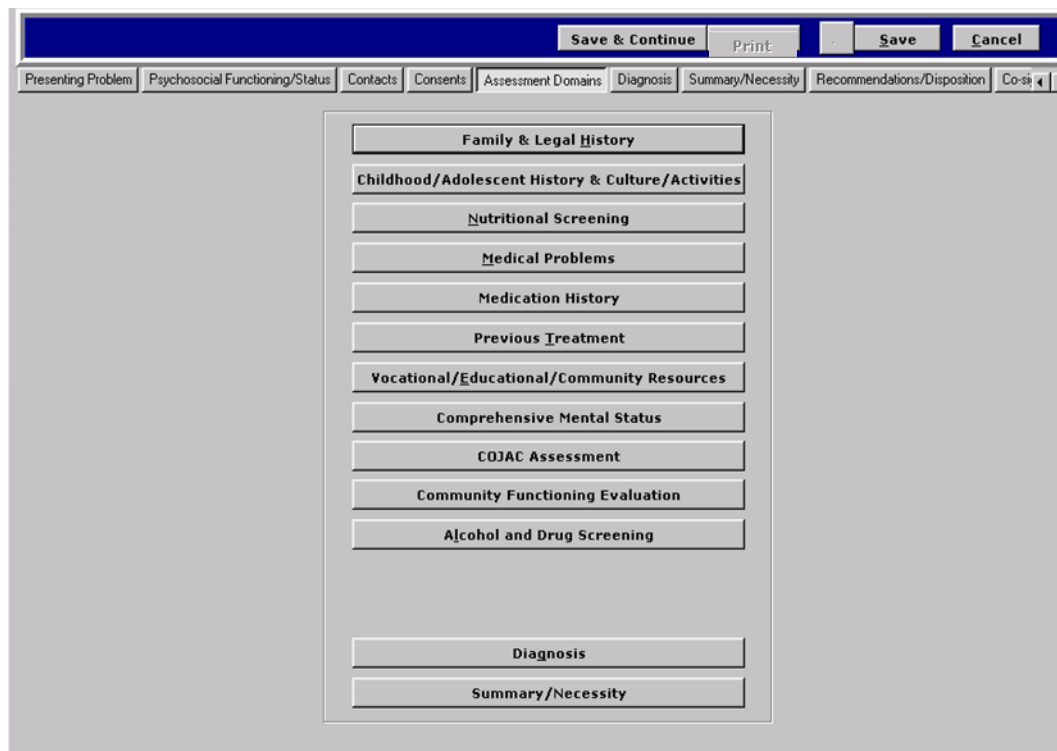
- Fill in information as completely as possible, for each contact identified.
 - You will be able to indicate if consent is given for communication with this party, which will prompt for a consent form to be completed. Be sure to complete the Consent for Release of Confidential Information when applicable.
 - Consents for Release of Confidential Information can be completed from the Clinician Console.
 - It is the assessing clinician’s responsibility to ensure that all consents are complete and have applicable signatures.
 - Be sure to change the status of each consent to “**Active**” before final saving.

Assessment Domains

Child/Adolescent Assessment Domains



Adult Assessment Domains



- **Family History and Relationships/Strengths:**

- ❖ **Include how mental health symptoms/behaviors impact or are impacted by Family Relationships.**

- What does the client's family of origin look like? For children, are they in a different living situation than with their family of origin? What are those relationships like?
 - What does the client's family of origin look like? For children, are they in a different living situation than with their family of origin? What are those relationships like?
 - What is the client's order of birth?
 - Identify family relationships: (Do not use Names).
 - Quality of attachment
 - Disciplinary style
 - Problem solving
 - Is the client's parent's relationship intact? Did they separate? What age was the client? Did the client witness Domestic Violence?
 - Identify family history of:
 - Mental health treated or untreated
 - Alcohol/drug use in immediate family
 - Incarceration
 - Medical issues
 - **Identify family strengths: client/family perspective (to assist in client achieving treatment goals) and assessor's perspective.**
 - **Identify family needs: client/family perspective and assessor's perspective**

- **Dependent Care Issues/Strengths:**

- ❖ **Include how mental health symptoms/behaviors impact or are impacted by Dependent Care Issues.**

- List the number of adults or the number of minor children that client provides care for on a regular basis.
 - List ages of dependent adults and children (initials and ages can be helpful).
 - For dependent adults, describe relationship and the level of need
 - For minor children, indicate impact of dependency issues relevant to school attendance, developmental milestones, behavior problems at home/school, custody issues, parentified client, etc.
 - **Identify family strengths: client/family perspective and assessor's perspective.**
 - **Identify family needs: client/family perspective and assessor's perspective**

- **Current Living Arrangement & Social Support Issues/Strengths:**

- ❖ **Include how mental health symptoms/behaviors impact or are impacted by Current Living Arrangement/Social Support issues.**

- What is the client's living situation like?
 - What kind of dwelling? With roommates, biological family, foster family, adoptive family or group home?
 - Is the client satisfied with this arrangement? Is client at risk of losing this placement?

Family & Legal History, continued (see screenshot on page 6)

- Do mental health factors keep client from living on his or her own, in their own apartment or house or with their family (for children)?
- Does the client need help with housekeeping and chores?
- Is the client getting support for housing (i.e. Section 8, HUD, Board and Care, etc.)?
- If client receives Section 8, does he/she know what kind (City, County, Shelter-Plus Care, etc.)?
- Social Relationships?
 - What is their current relationship like? Any current or past DV whether experienced by them or witnessed by them?
 - Who does the client consider to be their support system? Do they have friends available when they need help? Do they have friends at school?
 - Indicate if there are functional impairments in their ability to maintain their social support systems.
 - **NOTE:** If there was violence occurring in the home, please assess for child's current safety and document this and any need for follow up.
- **Identify family strengths: client/family perspective and assessor's perspective.**
- **Identify family needs: client/family perspective and assessor's perspective.**
- **Legal History/Status:**
 - ❖ **Include how mental health symptoms/behaviors impact or are impacted by Legal History/Status.**
 - Note any legal history, including tickets, arrests, jail/juvenile hall or camp stays or any other placements.
 - Are they on parole, probation or pending a court hearing?
 - Have they been divorced or is there one pending?
 - Are they involved in a custody battle?
 - Are they currently under conservatorship?
 - Do they have an open DCFS case?
 - Indicate why they have an open DCFS case and indicate if/how client is an alleged victim, who was the perpetrator, when the abuse occurred (client's age), etc. If client is a DCFS referral or MAT case, THIS IS A MUST!
 - Indicate if other siblings are currently or have been part of a DCFS case and indicate the information above if known.
 - Note the client and family's verbal and non-verbal responses.
 - Also note if a DCFS report was made during the course of the intake and how the child and family respond.

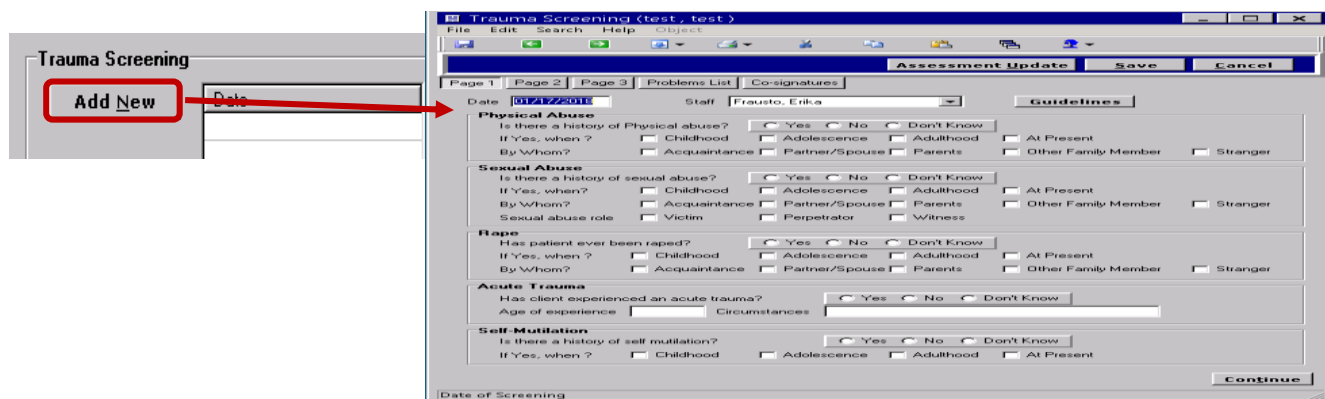
- **Childhood/Adolescent History:**
 - ❖ **Include how mental health symptoms/behaviors relate to client’s Child/Adolescent Development.**
 - Record any other significant life events that occurred during the client’s childhood and adolescence including moves, traumas or losses, separations, changes in socioeconomic status, etc.
 - For adults, you might ask “How would you describe your childhood? Was it peaceful or was there a lot of chaos?”
 - Did the client note any physical or sexual abuse, for adult clients was there any sexual abuse noted on the COJAC? (Note it here).
 - For children, you might ask the caregiver about their general perception of client’s childhood. If the child is old enough, you might also want to ask them directly.
- **Cultural/Ethnic/Religious History/Strengths:**
 - ❖ **Include how mental health symptoms/behaviors impact or are impacted by Cultural/Ethnic/Religious History.**
 - What do they describe as their cultural or ethnic affiliation? What is their level of acculturation? Has culture played a role in how they perceive their mental illness or how they have attempted to access services in the past?
 - Background of Parents, level of education, primary language, etc.
 - Do they identify themselves with a specific religion? Do they actively practice their religion? Do they attend organized religious services on a regular basis? Is their spirituality or religious community a source of support for them? Does it cause any internal/external conflicts?
 - **Identify client/family strengths: client/family perspective and assessor’s perspective.**
 - **Identify client/family needs: client/family perspective and assessor’s perspective.**
- **Leisure and Recreational Activities/Strengths:**
 - ❖ **Include how mental health symptoms/behaviors impact or are impacted by Leisure and Recreational Activities.**
 - How does the client spend their free time? Are they part of any community groups or partake in any sports/activities?
 - Have their mental health symptoms affected their ability to pursue these interests?
 - Personal Strengths individual has, exhibits, etc. (i.e. cooperation, motivation toward treatment, ability to articulate feelings, utilizes exercises as a way to cope when stressed, etc.)
 - **Indicate client’s athletics, clubs, affiliations, social, personal, relations, etc.**
 - **Indicate Caregiver/Family’s strengths toward client achieving planned objectives/goals, if applicable.**
- **Trauma/Exposure to Trauma/Strengths:**
 - ❖ **Include how mental health symptoms/behaviors impact or are impacted by client’s Trauma history.**
 - Describe specific information related to client’s experience of trauma or exposure to trauma.

- Client’s experience of or relationship to Serious Accidental Injury/Close to death from any cause, Illness/Medical Trauma, Community Violence, Domestic Violence, School Violence/Emergency, Physical Assault, Lived through a Disaster, Sexual Abuse, Physical Abuse, Neglect, Psychological Maltreatment/Emotional Abuse, Impaired Caregiver, Sexual Assault/Rape, Kidnapping/Abduction, Bereavement, Separation, Experienced an act of Terrorism, War/Political Violence/Combat Veteran, Forced Displacement, Trafficking/Sexual Exploitation, Victim of Crime, Bullying, Attempted Suicide, Witnessed Suicide, Witnessed Death or the Threat of Violence to someone else.
- If Client is unable to remember the above details, please document this information.
- If there is no history of trauma or exposure to trauma, indicate N/A “No trauma or exposure to trauma reported by client/caregiver”.
- **Identify client/family strengths: client/family perspective and assessor’s perspective.**
- **Identify client/family needs: client/family perspective and assessor’s perspective.**
- Other Issues
 - Provide any additional information that might be relevant to client’s social functioning, including DCFS involvement, issues with social skills, involvement with a Wellness Center or Drop-in Center, etc.

• **Trauma Screening:**

(Must be completed for clients 6 years of age and older. For clients 0-5 years old complete as clinically indicated).

Click “Add New” to generate the Trauma Screening. The Trauma Screening is used to capture, and further assess, any clinically significant information identified during the assessment of Trauma that would be described and clarified in the “Trauma/Exposure to Trauma/Strengths” section of the assessment.



- Be sure all pages are completed before Save/Final Saving. If supervisor review/co-signature is required do not final save until approved by your supervisor.
 - ❖ If further assistance is needed in completed the Trauma Screening, refer to the Trauma Screening guide on the EHRS Intranet site.

Nutritional Screening

- **Nutritional Screening:**

- ❖ **Include how mental health symptoms/behaviors impact or are impacted by Nutrition habits.**
 - Known Eating Disorder(s)/Problem(s)
 - Inquire if client has ever been diagnosed with any of the disorders listed.
 - Mark all that are applicable and describe any marked problems in Comments box below.
 - Known Eating Disorder(s)/Problem(s)
 - Daily Eating Habits
 - Click appropriate choice. Describe any discrepancies in the Comments box below.
 - Weight in past 30 days/Weight in past 6 months
 - Enter any weight loss or gain for client in the boxes indicated. You will want to explore if this coincides with the onset of their mood symptoms (for Major Depressive Disorder)
 - Explanation of any significant weight loss/gain in Comment box below is needed.
 - If none reported, be sure to check “No known Problems.”

Medical Problems

- **Medical Problems:** Click “Add New” to open Medical Problems box, if information is shared (It is within the scope of practice for a clinician to document medical related information/documentation the client provides or shares with us at the time of assessment/treatment.)

- ❖ **Include how mental health symptoms/behaviors impact or are impacted by Medical Problems.**
 - Medical History- indicate the onset, frequency and duration of problem.
 - Diagnosis or Presenting Problem – indicate the diagnosis and indicate where the information is from; Example: Lupus by hospital report; lower back pain following car accident per client report.
 - Treatment for specified physical problem – you don’t have to give any specific procedures unless the client reports them. General descriptions are okay. Example: Client is on twice-daily medication and sees neurologist twice a year; client received physical therapy and is on daily pain medication).

Medical Problems, continued (see screenshot at the bottom of page 10)

- Complete all applicable fields.
- Elaborate on all “yes” answers from this screen, including specific family history, in the “Comments” section under “Medical Problems -2”.
- If none reported, be sure to check, “No known medical problems.”

Medical Problems 2

The screenshot shows the 'Medical Problems 2' form. The 'Allergies' section is active, with the 'Add New' button highlighted. A red arrow points from the 'Add New' button to the 'Allergy' form fields. The 'Allergy' form includes fields for Date (05/30/2017), Staff (Frausto, Erika), Program (BY CGF), Allergy Type (ENVIRONMENTAL), Allergy (CATS), Type (Allergy to substance), Start Date (05/01/2015), Status (Active), Severity (Mild), Reaction (Itching), and Comments (Client experiences itchy and watery eyes, skin irritation and hives). An 'Allergy Search' window is also visible on the right side of the form.

• Allergies

- Click “Add New” to enter any reported Allergies.
 - Complete all required fields: Program, Start Date, Status, Severity, Reaction and Comments box (if applicable).
 - Use “Search” function for a list of medications and common allergens, as reported by client/guardian
 - Select “Add Allergy from Search” tab and the Allergy Type, Allergy and Type fields will auto populate information.
 - If none reported, be sure to check, “No known allergies.”

• Sensory/Motor Impairment, Pap smear, Mammogram, HIV test, and Pregnant sections

- Click “Yes” or “No.” If “Yes” is indicated, a field will open up to the right to either enter a description of the Sensory/Motor Impairment, indicate the date of the last screening, or the pregnancy due date as appropriate.

• Comments

- Elaborate on all “yes” answers from the previous screen or on this screen in the “Comments” section as needed, including specific family history.
- List any medical hospitalizations with dates and date of last physical exam.

Medication History

The screenshot shows the 'Medication History' form. The 'Add New' button is highlighted. A red arrow points from the 'Add New' button to the 'Medication History' form fields. The 'Medication History' form includes fields for Date (08/22/2017), Medication (Haldol Decanoate 100 mg/mL IM), Strength (100 mg/mL), Frequency (Every night), Route (intramuscularly), Dose (100 mg), Date Begun (08/22/2017), and Physician First Name/Last Name. The 'Medication Review Note' section is also visible.

❖ Include how mental health symptoms/behaviors impact or are impacted by Medical/Psychiatric Medication History.

- Click “Add New” to add medication information, as reported by the client/guardian.
- Type in the first letter(s) of the medication and search through the list of medication and dosages provided.

Medication History, continued (see screenshot at the bottom of page 11)

- Once a medication is selected, identify how the medication is taken by the client under “Route.” FYI- For medications in tablet form you have a choice to select “by mouth” or “in mouth.” “By mouth” is when the client is supposed to swallow the whole pill (most people will do so with a few sips of water). However, “in mouth” means he/she is supposed to allow the pill to dissolve in his/her mouth (such as with Zyprexa and Claritin Reditabs).
- Non-prescription medications, vitamins and other over-the-counter medications can be recorded here and are available on the drop-down.
- Complete all areas for each medication reported. If you are unable to find a medication or there are too many choices available for the medication and the client is unsure which one is correct, use the Comments box to explain.
- Identify in comments section client’s perception and experience of having to take medication.
- If none reported, be sure to check, “No known medication.”

Previous Treatment

Previous Treatment

No Previous Treatment

Add New

Date	Treatment Type	Condition Treated	Facility

Comments: Prev. Treatment Comment

Previous Treatment (test2, test)

Date: 09/01/2016 Staff: Frausto, Erika

Treatment type: [dropdown]
Level of care: [dropdown]
Counselor/Therapist name: [text]
Facility name: [text]
Facility address: [text]
City: [text]
State: [dropdown] Zip: [text]
Phone: [text]
Condition treated: [text]
Approximate date of admission: [text]
Approximate date of discharge: [text]
Length of stay (days): [text]
Response: [text]
Discharge type: [dropdown]
May we request treatment records?: Yes No
Release signed?: Yes No N/A
Comments: [text]
Date: [text]

• **Previous Treatment:**

❖ **Include how mental health symptoms/behaviors impact or are impacted by Previous Treatment.**

- Click “Add New” to add previous treatment (fill in as much information as possible).
- Inquire about previous inpatient and outpatient episodes
- Obtain information for each episode listed if client can recall. Clients may mention treatment not listed on the episode screen because services were rendered outside of LA County or in private facilities. Record it here!
- If client denies any past history of treatment, but there are episodes listed, ask about them.
- Indicate client’s perception and experience of previous treatment in comments section.
- In addition to the above, include therapeutic modalities received (ex: individual, family, etc.).
- If none indicated on episode screens or identified by client, be sure to check “No Previous Treatment.”

The screenshot shows a software window titled "Intake Assessment (test . test)". The interface includes a menu bar (File, Edit, Search, Help) and a toolbar with buttons for "Save & Continue", "Print", "Save", and "Cancel". Below the toolbar is a tabbed interface with tabs for "Presenting Problem", "Psychosocial Functioning/Status", "Contacts", "Consents", "Assessment Domains", "Diagnosis", "Summary/Necessity", "Recommendations/Disposition", and "Co-st". The "Assessment Domains" tab is active, showing two main sections:

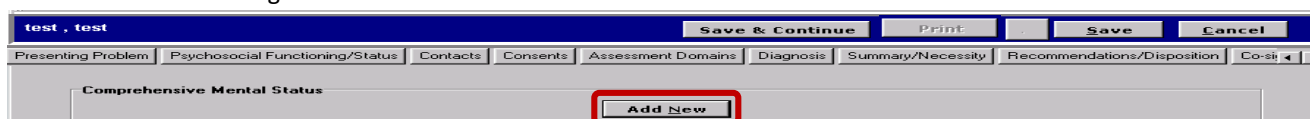
- Vocational/Education/Employment History/Military Experience:** This section contains a dropdown menu for "Highest level of education completed", a dropdown for "Current Employment Type", and a large text area for "Comments".
- Community Resources:** This section features a grid of checkboxes for various resources: Education/Training, In Home Care, Religious Groups, Support Groups, YMCA, Housing/Shelters, Public Aid, Social Clubs, and Transportation. Below this grid is another large text area for "Comments".

At the bottom of the window, there are buttons for "Assessment Domains" and "Comprehensive Mental Status Exam".

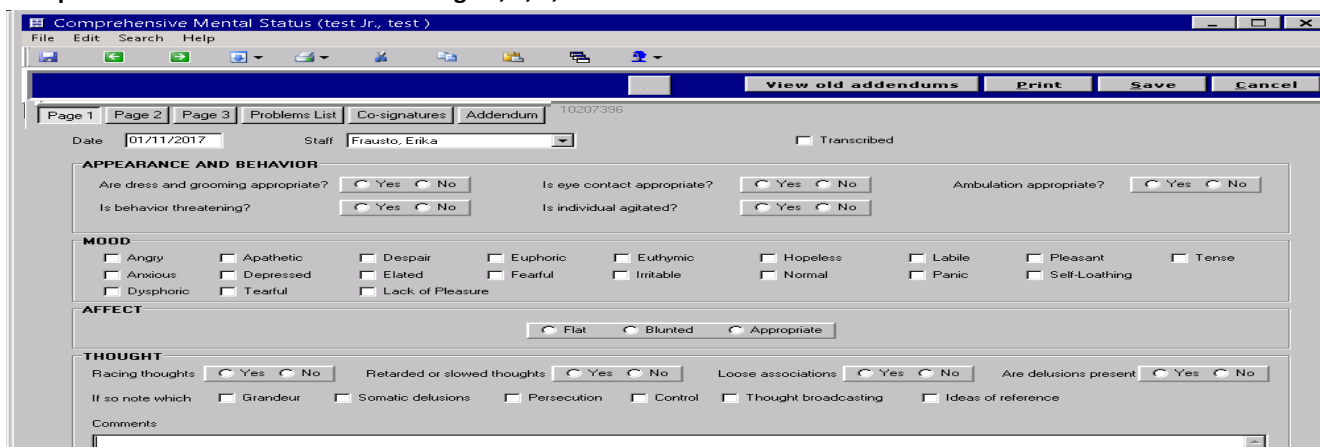
- **Vocational/Educational:**
 - ❖ **Note: If client’s mental health symptoms/behaviors are impacting or are impacted by difficulties in educational, vocational or employment related issues, be sure to document this specifically in this section.**
 - Highest level of education completed - select from list.
 - Current Employment Type- select most applicable to client.
 - Regarding education:
 - Indicate what school and grade level they are currently attending, if any.
 - Specify any certificates, diplomas, vocational training, etc. the client has obtained or is working toward.
 - For Adults, what is their level of literacy? For children, are they achieving at, below or above their grade level?
 - Are/were they in Special Education, RSP, etc.?
 - Is client on an Individualized Education Plan (IEP) services? If so, request a copy.
 - If the client did not achieve their educational goals, would they like to go back to school? Do symptoms keep them from going back to school?
 - **Regarding employment:**
 - For Adults or TAY youth:
 - Has the client ever worked? Have they volunteered?
 - What is/was their usual employment? Full-time? Part-time? What have been their strengths at work?
 - Has the client ever been fired or had to quit because mental health symptoms got in the way?
 - Does the client struggle with managing money on their own because of symptoms?
 - Do they have any military service history?
 - **What are the client’s Mental Health barriers to employment? (Especially important for CalWORKs)**
 - For Children:
 - Ask client about their future plans. For younger children, you may simply ask “What would you like to be when you grow up?” For older children, you may want to ask if they plan on finishing high school or pursuing post-high school training or college.
 - Avoid skipping this section or putting N/A. If the client declines to state or doesn’t know what they want for their future, document that.
- **Community Resources:**
 - Select all that are applicable.
 - Explain all items selected in comments box.
 - Indicate any impairments that impact client’s ability to access these resources, particularly as related to their mental health symptoms.

Comprehensive Mental Status Exam (CMSE) (required for all Clients)

- Click “Add New” to generate the CMSE



Comprehensive Mental Status Exam– Page 1, 2, 3, Problem List

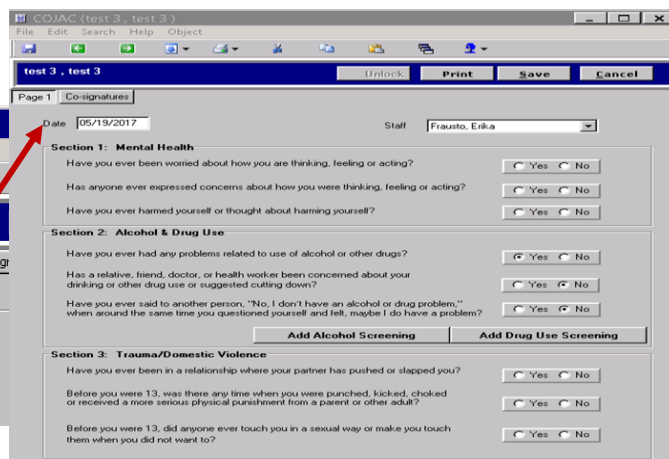
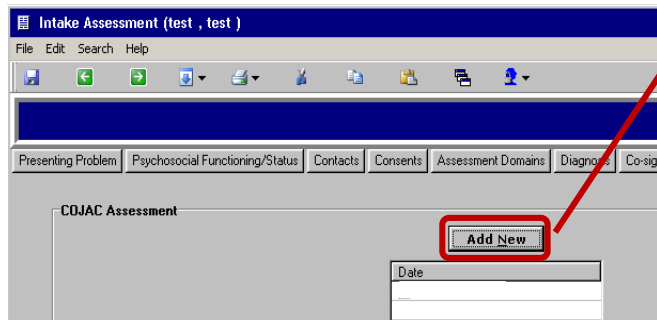


- Be sure all pages are complete before Saving/Final Saving, if supervisor review/co-signature is required do not final save until approved by your supervisor.

- ❖ If further assistance is needed in completing the Comprehensive Mental Status Exam, refer to the Comprehensive Mental Status Exam guide on the EHRS Intranet site.

COJAC (Age 18+ only); if client is not yet 18 years of age click the Community Functioning Evaluation button at the bottom of the page

- Click “Add New,” to generate the COJAC



- Complete all sections of the COJAC by answering the three questions in each section:**
 - Section 1: Mental Health
 - Section 2: Alcohol & Drug Use
 - If client answers “Yes” to any of the questions in Section 2: Alcohol and Drug Use, a link will populate to prompt the completion of an “Alcohol Screening” and/or “Drug Use Screening.” Please complete depending on the clinical/substance related needs of the client.
 - Section 3: Trauma/Domestic Violence
- After completing page 1 of the COJAC, click on Co-signatures tab to add your supervisor (if required).
 - Be sure to complete all sections before Saving/Final Saving, if Co-signature is required do not final save until approved by supervisor.
- ❖ If a fuller clinical assessment is needed, complete the Addiction Severity Index.

Community Functioning Evaluation (CFE)

- Click “Add New,” to generate the CFE

The screenshot shows the top portion of the CFE form. At the top, there are buttons for 'Save & Continue', 'Print', 'Save', and 'Cancel'. Below these are tabs for 'Presenting Problem', 'Psychosocial Functioning/Status', 'Contacts', 'Consents', 'Assessment Domains', 'Diagnosis', 'Summary/Necessity', 'Recommendations/Disposition', and 'Co-si'. The main title is 'Community Functioning Evaluation', and the 'Add New' button is highlighted with a red rectangular box.

Community Functioning Evaluation (CFE) – Page 1, Page 2

The screenshot shows the 'Community Functioning Evaluation (test2, test)' form, Page 1. The top bar includes 'test, test', 'Unlock', 'Print', 'Save', and 'Cancel'. Below are tabs for 'Page 1', 'Page 2', 'Co-signatures', and 'Addendum'. The form includes fields for 'Date' (09/19/2016), 'Staff' (Frausto, Erika), and 'Provider No.' (6459025). The main section is titled 'I. Rehab Service Needs (Check those items which the client needs assistance)'. It lists several skills with checkboxes: Social skills, Independent / Daily Living skills, Communication skills, Concentration skills, Time management skills, Anger management skills, Other, and No Needs. Below the list is a text area for describing the specifics of the need and how it is impacted by mental health.

- Be sure all pages are complete before Saving/Final Saving, if supervisor review/co-signature is required do not final save until approved by your supervisor.
- ❖ If further assistance is needed in completing the Community Functioning Evaluation, refer to the Community Functioning Evaluation guide on the EHRS Intranet site.

Alcohol Screening Test & Drug Use Screening- Complete for ALL CLIENTS 12 years and older and/or as clinically relevant and as required by the COJAC.

The screenshot shows the 'Intake Assessment (test, test)' form. The top bar includes 'test, test', 'Save & Continue', 'Print', 'Save', and 'Cancel'. Below are tabs for 'Presenting Problem', 'Psychosocial Functioning/Status', 'Contacts', 'Consents', 'Assessment Domains', 'Diagnosis', 'Summary/Necessity', 'Recommendations/Disposition', and 'Co-si'. The main section is titled 'Current Use', 'Past Use', and 'Last Use'. It lists various substances with 'Yes' and 'No' radio buttons for each. The substances listed are Tobacco, Caffeine, Alcohol, Marijuana, Cocaine, Stimulants, Hallucinogens, PCP, Opioids, and Do you smoke?. Below the list is a text area for 'Comments re: Substance Use & Abuse History'. At the bottom, there are buttons for 'Assessment Domains', 'Diagnosis', 'Alcohol Screening Test', and 'Drug Use Screening'.

- Indicate yes or no for all sections; indicate date of 1st use/last use if applicable. This information will support identifying if a client is in early or sustained remission of substance use/abuse.
- Indicate in comments box, client’s perception or experience of substance use.

Alcohol Screening Test & Drug Use Screening Continued

- Depending on client's report, complete either Alcohol Screening Test or Drug Use Screening or both.
 - Be sure all pages are complete before Final Saving, if supervisor review/co-signature is required do not final save until approved by your supervisor.

Child Developmental Milestones (Age 0-17)

- Click "Add New" to generate the Child Developmental Milestones Assessment. Ensure that you final save once completed.

- **Medical and Psychiatric History:** (Ensure that each section is completed).
 - Neonatal: Prenatal Care? Indicate if prenatal care was given prior to the birth of the child
 - Document length of pregnancy, birth weight, place of delivery, age of parents and marital status of parents at time of birth.
 - Indicate if mother used substances during pregnancy; Inquire about prescribed medication mother could have been taking during pregnancy.
 - Document any illnesses, accidents, and stresses experienced during pregnancy.
 - Select type of delivery, duration of labor, and any postpartum complications.
 - Under comments state family and environmental stressors during pregnancy: document stressors such as mom having to work long hours, or her being alone, not having support from family, etc.

Developmental Milestones:

- Inquire about each milestone and indicate the age of the client for which the assessment of that stage by the caregiver applies. If milestones were within normal limits indicate the time frame within which they were accomplished (e.g. crawled at 6 months). If the caregiver is unaware of exact timeframes, indicate that.
- Do not simply indicate “Within Normal Limits” or “WNL” as this is not specific to client’s exact level of development.

Environmental Stressors:

- Note any stressors that might have impacted appropriate age development: Early years 4-6 Mother was hospitalized for 5 months when client was 5 years old; after hospitalization client would cry and refuse going to school, these behaviors were not present pre-hospitalization.
- Be sure to complete all sections, obtain Co-signatures from supervisor and Final Save once completed.
 - Be sure to complete all sections before final saving, if Co-signature is required do not final save until approved by supervisor.

Diagnosis

Diagnosis

Primary Secondary Medical/Dual Dx. Func. Impairment

SEND DX TO IBHIS Refresh

Drag a column header here to group by that column

FS	Axis	Status	Rank	Type	Code	Description	Start Date	End Date
<input checked="" type="checkbox"/>	ICD-1	Active	Primary	Admission	F43.10	Post-traumatic stress disorder, unspecified	7/31/2017	
<input checked="" type="checkbox"/>	ICD-2	Active	Secondary	1 Admission	Z69.010	Encounter for mental health services for victim of parental child ab	7/31/2017	
<input checked="" type="checkbox"/>	ICD-3	Active	Medical	Admission	R69	Illness, unspecified	7/31/2017	
<input checked="" type="checkbox"/>	ICD-4	Active	Impairment	Admission	2	Social Support	7/31/2017	

Dual Diag. Code

Add New

Drag a column header here to group by that column

Dual Diagnosis	Dual Diagnosis Code	Status	Date Start	Date End
No Use or History of	30xND	Active	6/9/2016	
No Use or History of	30xND	Active	7/31/2017	

Assessment Domains Summary/Necessity

Primary Diagnosis

- Ensure that you select yes if you provided the client or family with any psycho-education materials regarding diagnosis.
- You can obtain this information by clicking on the Education Material tab.

ICD-10 Primary (test2, test)

File Edit Search Help Object

test2, test

ICD-10 Diagnosis ICD-10 Search Client Crosswalk

Rank: Primary Staff: Frausto, Erika

Diagnosis: [dropdown]

Start Date: 08/30/2016 Status: Active Type: [dropdown]

End Date: [dropdown]

Comments: [text area]

Education Material

Patient education material provided Yes No

Primary

Code	Description
F20.0	Paranoid schizophrenia

Secondary

Code	Description
Z75	1 Problems related to medical facilities and other health services
N52.34	2 Erectile dysfunction following simple prostatectomy
F03	3 Unspecified dementia
F66.20	4 Mood disorder due to known physiological condition

Medical

Code	Description
------	-------------

Functional Impairment

Code	Description
------	-------------

Primary Diagnosis, continued (see screenshot at the bottom of page 17)

• **Primary Diagnosis:**

- Click the button for Diagnosis: Start typing the name of the diagnosis in the “Diagnosis” field and a list of possible diagnosis will drop down.
- The matching code will automatically populate next to the diagnosis you selected.
- Start Date is the date of assessment.
- Status will automatically populate to “Active.”
- For Type, select Admission (this is the Admission Diagnosis).
- Under comments, provide your justification for this diagnosis; summarize symptoms; diagnostic criteria met by client as identified in the DSM; state dynamic formulation.
- Have in hand DMH approved list for Primary Diagnosis Codes- ICD 10.
- Diagnosis should be checked carefully for accuracy before final saving and sending to IBHIS.

- ❖ **If the Client is being closed on the date of admission as a single contact due to not meeting Medical Service Necessity use the code Z03.89 – Encounter for observation for other suspected diseases and conditions ruled out.**

Secondary Diagnosis

- Ensure that you select yes if you provided the client or family with any psycho-education materials regarding diagnosis.

You can obtain this information by clicking on the Education Material tab.

The screenshot shows a software interface for entering a secondary diagnosis. The main form has the following fields: Rank (Secondary), Diagnosis (empty), Start Date (08/30/2016), Status (Active), and Type (empty). A red box highlights the 'Education Material' tab and the 'Patient education material provided' checkbox, which is currently set to 'No'. The right side of the form shows a list of Primary, Secondary, Medical, and Functional Impairment diagnoses. The Primary diagnosis is F20.0 Paranoid schizophrenia. The Secondary diagnosis list includes Z75 Problems related to medical facilities and other health services, N52.34 Erectile dysfunction following simple prostatectomy, F03 Unspecified dementia, and F41.1 Major depressive disorder, single episode.

• **Secondary Diagnosis:**

- Click the button for Diagnosis (other allowed diagnosis/conditions/problems).
- Start typing the name of the diagnosis in the “Diagnosis” field and a list of possible diagnoses will drop down. Multiple Diagnoses can be entered under the secondary diagnosis in accordance with the most impact on client’s functioning.
- Start Date is the date of assessment.
- Status will automatically populate to “Active.”
- For Type, select Admission (this is the Admission Diagnosis).
- Under comments, provide your justification for this diagnosis; summarize symptoms; diagnostic criteria met by client as identified in the DSM; state dynamic formulation.
- Diagnosis should be checked carefully for accuracy before final saving and sending to IBHIS.

Medical Diagnosis (Dual Diagnosis /Reported Medical Conditions)

Substance Abuse/Dependence Diagnosis (Dual Diagnosis)

The screenshot shows the ICD-10 Medical software interface for user Torres, Kaleana J. The 'Type' dropdown menu is set to 'Substance Abuse / Dependence Diagnosis', which is highlighted with a red box. Other fields include Rank: Medical, Staff: Frausto, Erika, Status: Active, and Type: Admission. The right-hand pane displays a list of diagnoses under categories: Primary (F43.10 Post-traumatic stress disorder, unspecified), Secondary (Z69.010 1 Encounter for mental health services for victim of parent), Medical (R69 Illness, unspecified), and Functional Impairment (2 Social Support).

- **Substance Abuse/Dependence Diagnosis:** To be completed as applicable to clients' impairment.
 - Select the Substance Abuse/Dependence Diagnosis radio button.
 - Diagnosis: Input the applicable code to add a Dual Diagnosis.
 - A Dual Diagnosis must be indicated when treating any drug/alcohol issues that are related to mental health.
 - Start Date: is date of assessment.
 - Status button will auto populate to "Active."
 - Type: select "Admission" (this is the Admission Diagnosis).
 - Multiple substance related diagnosis can be entered.
 - Diagnosis should be checked carefully for accuracy before final saving and sending to IBHIS.

Medical Diagnosis continued

Medical Diagnosis (Reported Medical Conditions)

The screenshot shows the ICD-10 Medical software interface for user test, test. The 'Type' dropdown menu is set to 'Medical Diagnosis', which is highlighted with a red box. Other fields include Rank: Medical, Staff: Frausto, Erika, Status: Active, and Type: Admission. The right-hand pane displays a list of diagnoses under categories: Primary (F03.90 Unspecified dementia without behavioral disturbanc), Secondary (F02.90 1 Dementia in other diseases classified elsewhere, witho), Medical, and Functional Impairment.

- **Medical Diagnosis:** As reported by the client/caregiver.
 - Select the Medical Diagnosis radio button.
 - Diagnosis: Input the applicable code (if known, via documentation from a treating MD); otherwise list the medical disorder in the comments with " ____ per client/caregiver report."
 - Document any conditions impacting client's mental health.
 - If client/caregiver report a medical condition that can't be located in the drop down list: use code R69 – "Illness unspecified" (Indicate specific medical conditions reported by client/caregiver in the comments sections).
 - If no medical disorder is reported use code 000-"No medical disorder reported."
 - Start Date: is date of assessment.
 - Status button will auto populate to "Active."
 - Type: select "Admission" (this is the Admission Diagnosis).
 - Multiple diagnoses can be entered under the medical diagnosis section in accordance with report by the client/caregiver.
 - Diagnosis should be checked carefully for accuracy before final saving and sending to IBHIS.

Functional Impairments

- **Functional Impairments:**

- Start date is date of assessment
- For Type, select Admission (this is the admission diagnosis).
- Psychosocial and Environmental Problems: Impairments must be clearly identified in the assessment along with a description of how those impairments are a result of the included diagnosis/diagnoses. Simply stating or describing the impairment is not sufficient.
 - For Type select from drop down feature to select problem area.
 - For “Specify,” **Identify** and describe the functional impairment(s) the client is experiencing in his/her Life Areas as a result of their mental health symptoms/behaviors.
 - Multiple Psycho-Social and Environmental Problems can be entered for Functional Impairments.
- Diagnosis should be checked carefully for accuracy before final saving and sending to IBHIS.

Dual Diagnosis Code

Dual Diagnosis	Dual Diagnosis Code	Status	Date Start	Date End
Alcohol	30uAL	Active	2/23/2016	4/20/2017
Poly-substance Use	30uPS	Inactive	4/15/2017	4/20/2017

- Note: This section of the assessment has been disabled which will allow staff to still view historical information for our clients, but will not allow new information to be entered. Dual diagnosis can be identified under the “Medical” tab.

IBHIS Diagnosis

FS	Axis	Status	Rank	Type	Code	Description	Start Date	End Date
<input checked="" type="checkbox"/>	ICD-1	Active	Primary	Admission	F43.10	Post-traumatic stress disorder, unspecified	7/31/2017	
<input checked="" type="checkbox"/>	ICD-2	Active	Secondary	1 Admission	Z69.010	Encounter for mental health services for victim of parental child ab	7/31/2017	
<input checked="" type="checkbox"/>	ICD-3	Active	Medical	Admission	R69	Illness, unspecified	7/31/2017	
<input checked="" type="checkbox"/>	ICD-4	Active	Impairment	Admission	2	Social Support	7/31/2017	

* Once all required diagnosis have been checked for accuracy, including dates, and each objective final saved, click the “Send DX to IBHIS” button to upload the diagnosis to IBHIS.

* Check the DMH IHBIS Console if you wish to confirm the diagnoses were sent properly.

- Continue to the next page to complete the Summary/Necessity section.

Summary/Necessity

test 4 , test 4

Save & Continue Print Save Cancel

Presenting Problem Psychosocial Functioning/Status Contacts Consents Assessment Domains Diagnosis Summary/Necessity Recommendations/Disposition Co-sit

Diagnostic Summary

[Be sure to include assessment for risk of suicidal/homicidal behaviors, significant strengths/weaknesses, observations/descriptions, symptoms/impairments in life functioning, i.e., Work, School, Home, Community, Living Arrangements, etc, and justification for diagnosis]

Specialty Mental Health Services Medical Necessity Criteria

1. Medi-Cal Specialty Mental Health Included Diagnosis Yes No
2. Significant impairment in life functioning due to the Included Diagnosis Yes No
3. Expectation that proposed interventions can impact the client's condition Yes No
4. Mental Health Condition will not be responsive to physical health care based treatment Yes No

Assessment Domains Recommendation/Disposition

- **Diagnostic Summary:**
 - Summarize the client's demographic information (Example: Client is a 50-year-old Latina woman, divorced with two children who presented with...).
 - Summarize your assessment of client's current risk factors (SI/HI)
 - Identify their significant strengths/weaknesses
 - Summarize any significant observations/descriptions
 - Summarize the client's symptoms, frequency and duration of mental health symptoms and how they meet criteria for the diagnosis/diagnoses you selected (remember to include enough DSM-V criteria to support the client's diagnosis).
 - Summarize their functional impairments and document how mental health symptoms contribute to these specific impairments in the individuals identified Life Areas of functioning.
 - Explain any possible rule-out diagnoses
 - Include Statement of Medical/Service Necessity
- **Specialty Mental Health Services Medical Necessity Criteria:** The below items pertain to medical service necessity. If any of the four responses to these items are "No" the client does not meet criteria for medical service necessity, a reminder will appear "**Must be a Single Contact**".
 - Medi-Cal Specialty Mental Health Included Diagnosis: Select "Yes" if client has an included DSM-V diagnosis (refer to Medi-Cal Included Outpatient ICD-10-CM Diagnosis in the Blue Binder) or refer to Medi-Cal Included Diagnosis List in the Blue Binder).
 - Significant impairment in life functioning due to the Included Diagnosis: Select "Yes" if the client's mental health symptoms/behaviors are interfering with an area of daily life functioning.
 - Expectation that proposed interventions can impact the client's condition: Select "Yes" if the proposed interventions are going to directly impact client's mental health and identified areas of functional impairment(s).
 - Mental Health Condition will not be responsive to physical health care based treatment: Select "Yes" if client's mental health symptoms/behaviors can be treated utilizing mental health interventions. If the client has a general medical condition as a primary diagnosis, they should be referred for medical based treatment with their Primary Care Physician.

Recommendations/Disposition

test , test Save & Continue Print Save Cancel

Contacts Consents Assessment Domains Diagnosis Summary/Necessity Recommendations/Disposition Co-signatures Addendum

Disposition/Recommendation/Plan

Intake Disposition: Appropriate, Admit

Admission

Projected Department: Margarita Mendez Projected Program: MM CGF Projected Facility: Margarita Mendez

Projected Level of Care: III - Intensive Psychiatrist:

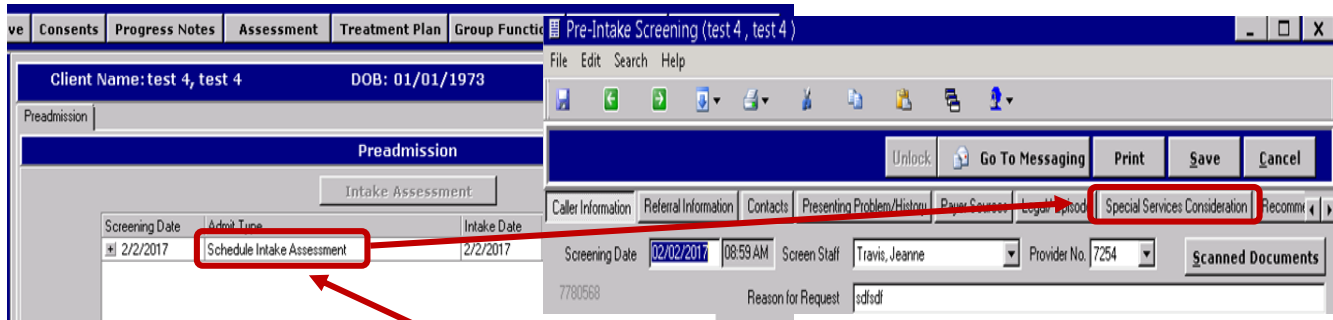
Admission Date: 02/15/2017

Client Strengths

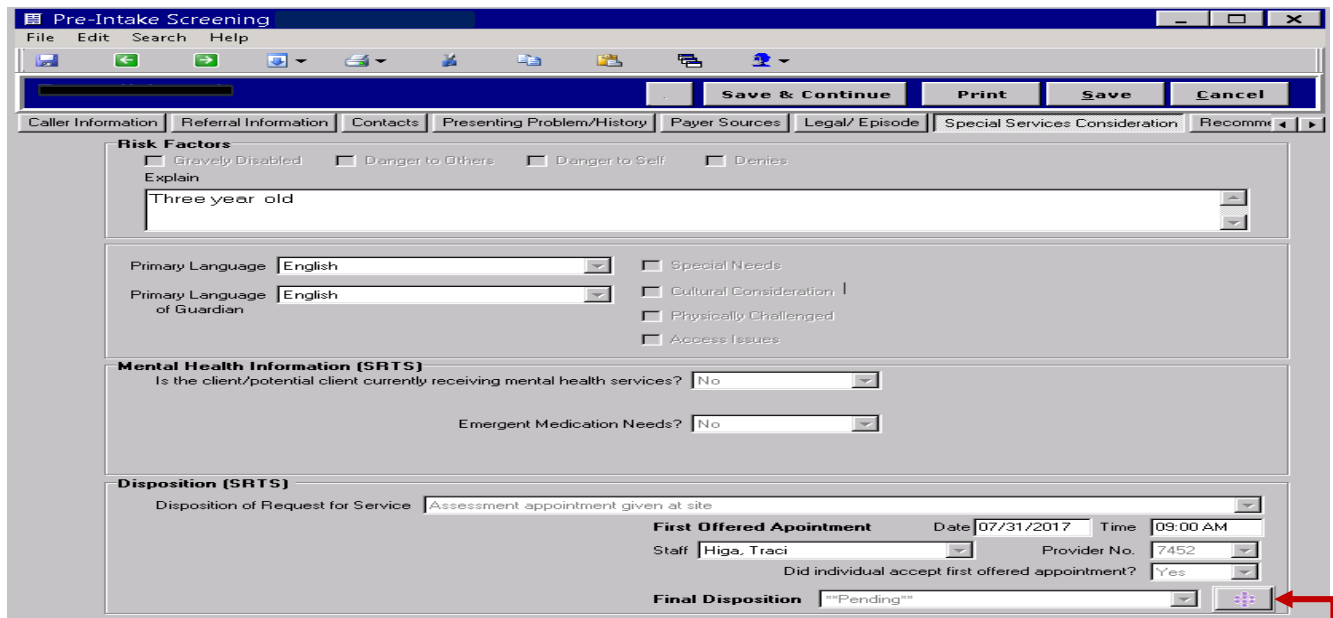
Cancel Admission

- **Disposition/Recommendation/Plan:**
 - Indicate recommendations for treatment according to the information gathered during the assessment, client’s diagnosis and functional impairments.
 - When documenting the interventions, please indicate the target symptoms/behaviors to be addressed.
 - Identify recommended treatment and modality (ex. Individual, family, rehab, medication/psychiatric evaluation, etc.) of services.
- **Intake Disposition:**
 - “Appropriate, Admit” for all clients that meet Medical Necessity.
 - “Not appropriate for Admission/Refer Out” clients who will not continue with services/Single Contact.
 - A “Reason not admitted” will appear; select reason the client was not admitted.
 - Complete an NOA-A.
- **Admission:**
 - Projected Department: clinic name where intake being completed.
 - Projected Program: select program client is being opened in.
 - Projected Facility: select clinic being opened.
 - Projected Level of Care: indicate III – Intensive.
 - Admission Date: date initial assessment was begun.
 - Client’s Strengths: This section is disabled. Client’s Strengths are to be documented throughout the Intake Assessment. The Identified strengths of our client’s become an integral part of the treatment planning process with our client’s and can be incorporated into the development of Master Treatment Plan (MTP).
- **Co-Signature Process:**
 - If Co-signature is required, follow the Co-Signatures procedure. Refer to the *Tier Quick Reference Guide: [Tier Quick Reference for Co-signatures, Staff Instructions on the EHRS Intranet site.](#)*
 - If Co-signatures are required, follow the “**Save**” options on page 24.
 - For further clarification regarding Co-signature requirements refer to the memo “*Co-Signature Requirements*” from Michael Olsen, QA Director in the company f-drive in the “QA Memos and Bulletins” folder in the “Signatures & Co-Signatures” folder.
- **Complete the Final Disposition by accessing client’s Pre-Intake Screening, continue to the next page.**

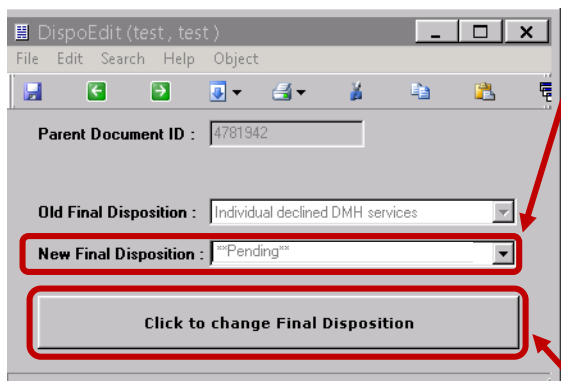
Final Disposition: During the Pre-Intake Screening process the Call Center sets the Final Disposition field as “Pending,” This field is to be changed once clinical staff has determined if client will or will not be admitted for services by selecting the appropriate final disposition.



- **Final Disposition:**
 - From the Clinician Console “double click” the “Schedule Intake Assessment” tab, the Pre-Intake Screening box will open.
 - Next, select the Special Services Consideration tab to open the Final Disposition Field.



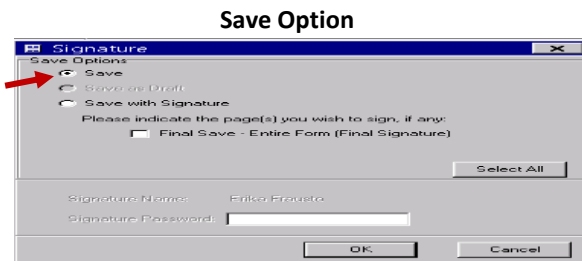
- Select the appropriate final disposition option from the drop down box according to the results of the assessment.
- In the event the Pre-Intake Screening is final saved, single click the “Dispo Edit” button to change the status.



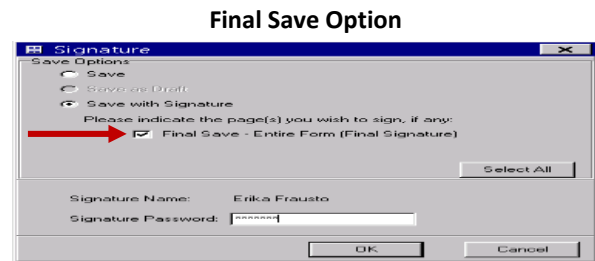
- Dispo Edit page: Select the appropriate “New Final Disposition” option from the drop down box according to the results of the assessment.
 - Individual accepted for DMH services
 - Individual declined DMH services
 - Individual did not show for appointment
 - Individual does not meet program criteria
 - Program is unable to serve individual
- Then click the “Click to Change Final Disposition” button.

Intake Assessment: Save or Final Save Options: Click the “Save” tab at the top of the screen

- ❖ Save the Intake Assessment and all individual assessment related documents when complete and submit for supervisor review within 30 days of admission date.
- ❖ Finalize and Final Save the Intake Assessment within 60 days of admission date.
- **Save Option:** Select the “Save” radio button if further assessment of the client is needed.
- **Final Save Option:** Select the “Final Save” radio button if the intake assessment document has been finalized and supervisor review/signatures have been completed (if applicable).



OR



- **Save:** The “Save” radio button will auto populate (*Do not select the Save with Signature Option or Final Save Option*). Click the “OK” button to save the Intake Assessment this option will allow for the Intake Assessment to be Co-signed by your supervisor.

OR

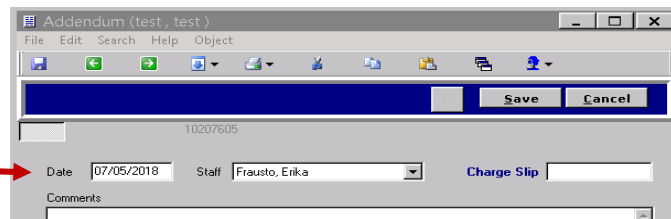
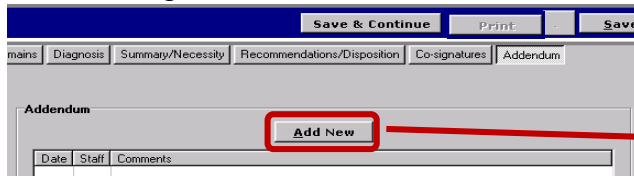
- **Final Save:** Prior to final saving the assessment signature page, ensure all appropriate signatures are gathered and co-signatures have been completed.
 - Click the “Final Save” radio button to enable the “Signature Password” field.
 - (*Do not select the Save with Signature option, Tier will automatically select that option when “Final Save” radio button is selected*).
 - Enter your “Signature Password” to complete the Objective Signature process then “click” the “OK” button.
To open the Addendum page.

Addendum: Click the Addendum tab at the top of the screen to open the Addendum page.

(If unable to view the Addendum tab use the arrow cursor)



Addendum Page: Click the “Add New” button



- **Addendum:** The Addendum is used to add information originally obtained during your initial assessment session(s) that should have been documented during the completion of the Intake Assessment.
 - Date and Staff name auto populates
 - The date will auto populate to the date the Addendum is generated, do not change the date.
 - Document information in the Comments box
 - Final Save the Addendum when completed
 - Click the Save tab at the top of the screen.
 - Click the Final Save checkbox.
 - Enter your signature password and click “Ok” button.
- ❖ **When new information is obtained throughout treatment or there are changes in client’s presentation or functioning that are related to the client’s Mental Health, a new Assessment Addendum must be created.**