

MH Adult Uniform Assessment for Resiliency & Disease Management

Rev11/07

NorthSTAR ID	<input type="text"/>	NPI Number	<input type="text"/>
Last Name	<input type="text"/>	Provider Number	<input type="text"/>
First Name	<input type="text"/>	Vendor Number Location	<input type="text"/>
Middle Name	<input type="text"/>	Component	085 Katrina Evacuee? Y/N
			Original Parish name:

Assessment Type:	Intake <input type="checkbox"/>	Intake Non-Admission <input type="checkbox"/>	Update <input type="checkbox"/>
	Discharge <input type="checkbox"/>	Reason for Discharge _____	Discharge Date <input type="text"/> - <input type="text"/> - <input type="text"/>
	Crisis (temporary) <input type="checkbox"/>		MM DD YYYY

Action Type: Add ___ Correct/Modify ___ Delete ___

Section 1: Adult TRAG & Recommended Level of Care

(Completed by Provider QMHP)

A. Adult-TRAG Dimension Ratings

(Circle one rating for each dimension)

- | | | | | | |
|---|---|---|---|---|---|
| 1. Risk of Harm | 1 | 2 | 3 | 4 | 5 |
| 2. Support Needs | 1 | 2 | 3 | 4 | 5 |
| 3. Psychiatric-Related Hospitalizations | 1 | 2 | 3 | 4 | 5 |
| 4. Functional Impairment | 1 | 2 | 3 | 4 | 5 |
| 5. Employment Problems | 1 | 2 | 3 | 4 | 5 |
| 6. Housing Instability | 1 | 2 | 3 | 4 | 5 |
| 7. Co-occurring Substance Use | 1 | 2 | 3 | 4 | 5 |
| 8. Criminal Justice Involvement | 1 | 2 | 3 | 4 | 5 |
| 9. Depressive Symptomatology (MDD only) | 1 | 2 | 3 | | |

B. Calculated Level of Care Recommended (LOC-R)
C. TCOOMMI Consumer?
D.
--
 MM DD YYYY

Assessed By: _____ **Credentials:** _____

Print Name: _____

Notes: _____

Section 2

Completed by ValueOptions

Section 3: Diagnosis-Specific Clinical Symptom Rating

Scales (Completed by Provider LVN or QMHP staff)

Choose one algorithm and complete all items for that algorithm.

A. Schizophrenia Algorithm (PSRS & BNSA)

Total Positive Symptom Rating Scale (PSRS) (4-28) _____

Total Brief Negative Symptom Assessment (BNSA) (4-24) _____

B. Bipolar Algorithm (BDSS)

Total Brief Bipolar Disorder Symptom Scale (BDSS) (10-70) _____

C. Major Depression Algorithm (QIDS-SR or QIDS-C)

Total Quick Inventory of Depressive Symptomatology (0-27) _____

QIDS Version (1-2) _____

1 = QIDS-SR (Self-Report)

2 = QIDS-C (Clinician)

D. Assessment Date --
 MM DD YYYY

E. Extended Review Period Requested

 a. 6-mth review

 b. 12-mth review
Assessed By: _____ **Credentials:** _____

Print Name: _____

Notes: _____

Section 4: Community Data (Completed by Provider QMHP staff)
A. Residence Type (Current) (Circle one)

- 1 = Independent/Dependent in Family Home/Supported Housing
- 2 = Group Home/Assisted Living/Treatment-Training-Rehab Center
- 3 = Nursing Home/Intermediate Care Facility (ICF)/Hospital
- 4 = Homeless
- 5 = Correctional Facility

B. Paid Employment Type (Current) (Circle one)

- 1 = Independent/Competitive/Supported/Self-employment
- 2 = Transitional/Sheltered Employment
- 3 = Unemployed but wants or needs to work
- 4 = Not in the labor force (Complete Section C below.)

C. Main Reason for Being Out of the Labor Force

(Circle one only if Section B is 4=Not in the labor force)

- 1 = Currently receives SSI/SSDI and can't work
- 2 = Worries that working will affect SSI/SSDI or other benefits
- 3 = Doesn't want or need to work
- 4 = Unable to find or keep a job
- 5 = Stay-at-home parent, homemaker, or full-time student
- 6 = Over 65 or retired
- 7 = Other

D. Assessment Date --
 MM DD YYYY

Form marked as NorthSTAR System

Completed by: _____

NorthSTAR

Uniform Assessment Diagnosis Form

Principal Diagnosis Axis: ___ (1=AXIS I; 2=AXIS II)

Description		DSM Code
AXIS I	Level 1	_____
	Level 2	_____
	Level 3	_____

AXIS II	Level 1	_____
	Level 2	_____
	Level 3	_____

OPTIONAL (AXIS III & IV)

		ICD Code
AXIS III	Level 1	_____
	Level 2	_____
	Level 3	_____
	Level 4	_____
	Level 5	_____
	Level 6	_____
AXIS III Date: ____ - ____ - ____		

AXIS IV: (Check all that apply) ___A ___B ___C ___D ___E ___F ___G ___H ___I

AXIS V: Current: ____ Past Year: ____

Authorized Level Of Care (LOC-A):

Please Check the Box to Indicate Request:

- Med Management Only
- Service Package 1
- Service Package 1S (full state package)
- Service Package 2
- Service Package 3
- Service Package 4
- Service Package 5

Information Box

Provider Number: _____

Vendor Number Location: _____

Form Completion Date: ____ - ____ - ____

Member NorthSTAR ID: _____

MH Adult Uniform Assessment for Resiliency & Disease Management (NorthSTAR)

Field Name	Type	Contents
NORTHSTAR ID	R	NorthSTAR Member Number.
LAST NAME	R	Consumer's last name.
FIRST NAME	R	Consumer's first name.
MIDDLE NAME	O	Consumer's middle name.
NPI NUMBER	R	National Provider Identifier
PROVIDER NUMBER	R	BHO 6 digit Assigned Provider Number.
VENDOR NUMBER LOCATION COMPONENT	R	BHO 7 DIGIT ASSIGNED VENDOR NUMBER (WHERE SERVICE IS PROVIDED SPECIFIC TO LOCATION)
ASSESSMENT TYPE: CRISIS	O/R	Check this box if the purpose of the assessment is to record that the consumer is receiving crisis services and not currently enrolled in a service package. Note: Crisis is no longer an Intake assessment type.
ASSESSMENT TYPE: INTAKE	O/R	Check this box if the purpose of the assessment is the consumer's intake to services.
ASSESSMENT TYPE: INTAKE NON-ADMISSION	---	This option will be automatically entered by the WebCARE screens if the purpose of the assessment is a non-admission due to ineligibility or refusal of services.
ASSESSMENT TYPE: UPDATE	O/R	Check this box if the purpose of the assessment is to update the consumer's care.
ASSESSMENT TYPE: DISCHARGE	O/R	Check this box if the purpose of the assessment is the consumer's discharge.
REASON FOR DISCHARGE	O/R	If discharge, indicate the code that best describes the discharge reason. (C = Level of Care Services Complete, J = Incarcerated in Jail or Prison, M = Moved out of Local Service Area, N = Never Returned for Services within Authorized Service Period, not to exceed 6 months, T = Transferred to Other Community Provider in Local Service Area, P = Elected a new provider, E = Change in NorthSTAR eligibility Z = Other).
DISCHARGE DATE	O/R	If the assessment purpose is discharge, indicate the date of discharge
ACTION TYPE: ADD	O/R	Check this line to add a new Uniform Assessment for the first time.
ACTION TYPE: CORRECT/MODIFY	O/R	Check this line to correct or modify information that has been previously submitted.
ACTION TYPE: DELETE	O/R	Check this line to delete a previously submitted form that was incorrect.

Section 1: Adult TRAG & Recommended Level of Care – Completed by Provider QMHP.

A. ADULT-TRAG DIMENSION RATINGS		
1-8	R	Indicate the individual rating for each of the Adult-TRAG dimensions 1 through 8.
9 DEPRESSIVE SYMPTOMATOLOGY	O/R	If MDD, indicate the rating for this dimension.
B. CALCULATED LEVEL OF CARE RECOMMENDED	D	Indicates the Adult-TRAG Level of Care recommendation (LOC-R), automatically calculated from responses to Section 1, A.
C. TCOOMMI CONSUMER?	O	Check this box if the consumer receives services through a Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) contract.
D. ASSESSMENT DATE	R	Date of the Adult TRAG completion in MMDDYYYY format.
ASSESSED BY	R	Name of the person completing Section 1.
CREDENTIALS	R	Highest credentials of the person completing Section 1 (QMHP-CS, RN, LCSW, LMSW-ACP, LMFT, LPC, LPHD-PSY, RN-APN, PA, MD, DO). LVN is <i>not</i> approved to complete Section 1.
NOTES	O	Used for provider/authority communication and clinical notes. Limited to 6 lines or less

Section 3: Diagnosis-Specific Clinical Symptom Rating Scales – [Also known as the TIMA scales] Completed by Provider LVN or QMHP staff.

Choose one algorithm and complete all items for that algorithm (based on current principle diagnosis).

A. SCHIZOPHRENIA ALGORITHM		Total Positive Symptom Rating Scale (PSRS) and the Total Brief Negative Symptom Assessment (BNSA).
B. BIPOLAR ALGORITHM		Total Brief Bipolar Disorder Symptom Scale (BDSS).
C. MAJOR DEPRESSION ALGORITHM		Total Quick Inventory of Depressive Symptomatology (QIDS) and the QIDS version.
D. ASSESSMENT DATE	R	Date of the rating scales assessment completion in MMDDYYYY format
E. EXTENDED REVIEW PERIOD REQUESTED	O/R	Complete this field for members in package 1 who are eligible for an extended review period. You <i>can not</i> complete this field for consumers receiving their first Uniform Assessment at Intake.
ASSESSED BY	R	Name of the person completing Section 3.
CREDENTIALS	R	Highest credentials of the person completing Section 3 (QMHP-CS, RN, LCSW, LMSW-ACP, LMFT, LPC, LPHD-PSY, RN-APN, PA, MD, DO, LVN).
NOTES	O	Used for provider/authority communication and clinical notes. Limited to 6 lines or less

Section 4: Community Data – Completed by Provider QMHP staff.

- A. RESIDENCE TYPE (CURRENT) R Consumer's current type of residence.
- B. PAID EMPLOYMENT TYPE (CURRENT) R Consumer's current employment status.
- C. MAIN REASON FOR BEING OUT OF THE LABOR FORCE O/R Main reason that the consumer is not in the labor force. Required if Section B is 4=Not in the labor force.
- D. ASSESSMENT DATE R Date the community data was collected in MMDDYYYY format.
- NOTES O Used for the name and credentials of the staff responsible for completion of this section or for provider/authority communication. Limited to 6 lines or less
- FORM MARKED AS COMPLETED BY: R Signature of the person indicating the form is complete ("Complete" or "Provider Complete").

PAGE 2: DIAGNOSIS FORM – COMPLETED BY LVN OR QMHP STAFF.

FOR NON-SUBSTANCE RELATED MENTAL HEALTH DIAGNOSIS

- * PRINCIPAL DIAGNOSIS AXIS R CONSUMER'S PRINCIPAL DIAGNOSIS
- * AXIS I O/R PSYCHIATRIC SYNDROME
- * AXIS II O/R PERSONALITY AND SPECIFIC DEVELOPMENTAL DISORDER OR MENTAL RETARDATION
(SEE THE CURRENT OFFICIAL DSM-IV MANUAL FOR DIAGNOSTIC CODES)
- * AXIS I DIAGNOSIS O/R LEVEL 1 IS REQUIRED IF THE PRINCIPAL DIAGNOSIS AXIS FIELD IS MARKED. LEVEL 1 IS MOST SIGNIFICANT. PLEASE PRINT THE NARRATIVE DESCRIPTIONS FOR EACH LEVEL IN BLOCK CAPITAL LETTERS. (ALL THREE DO NOT HAVE TO BE COMPLETED.)
- * AXIS II DIAGNOSIS O/R LEVEL 1 IS REQUIRED IF THE PRINCIPAL DIAGNOSIS AXIS FIELD IS MARKED. LEVEL 1 IS MOST SIGNIFICANT. PLEASE PRINT THE NARRATIVE DESCRIPTIONS FOR EACH LEVEL IN BLOCK CAPITAL LETTERS. (ALL THREE DO NOT HAVE TO BE COMPLETED.)
- * AXIS III O/R THERE ARE SIX FIELDS FOR RECORDING ICD-9 CODES REPRESENTING THE CONSUMER'S PHYSICAL DIAGNOSES. LEVEL 1 IS MOST SIGNIFICANT. DOCUMENT ANY IDENTIFIED PHYSICAL DIAGNOSIS. PLEASE PRINT THE NARRATIVE DESCRIPTIONS FOR EACH LEVEL IN BLOCK CAPITAL LETTERS. (SEE THE CURRENT OFFICIAL ICD-9 MANUAL FOR DIAGNOSTIC CODES.)
- * AXIS III DATE R DATE OF THE PHYSICIAN'S EXAMINATION IN WHICH THE AXIS III
- * AXIS IV O/R Indicate the individual rating for each of the psychosocial and environment problems A through I. (No selection will indicate no perceived problem.)
- * AXIS V O/R Indicates consumer's psychological, social, and occupational functioning. (Do not include impairment in functioning due to physical or environmental limitations.)
- * AXIS V Current Write in two-digit code to identify the consumer's current level of adaptive functioning.
- * AXIS V Past Year Write in two-digit code to identify the consumer's highest level of adaptive functioning in the past year.