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**Section 3.9 Intake, Assessment and Service Planning**

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**3.9.1 Introduction**

ADHS/DBHS supports a model for intake, assessment, service planning and service delivery that is strength-based, family friendly, culturally sensitive and clinically sound and supervised. The model is based on three (3) equally important components:

- Input from the person and family/significant others regarding their special needs, strengths and preferences;
- Input from other individuals who have integral relationships with the person; and
- Clinical expertise.

The model incorporates the concept of a “team”, established for each person receiving behavioral health services. At a minimum, the team consists of the person, family members in the case of children, and a qualified behavioral health clinician. As applicable, the team would also include representatives from other state agencies, clergy, other relevant practitioners involved with the person and any other individuals requested by the person. In addition, the model is based on a set of clinical, operative and administrative functions, which can be performed by any member of the team, as appropriate. At a minimum, these include:

- Ongoing engagement of the person, family and others who are significant in meeting the behavioral health needs of the person, including active participation in the decision-making process;
- An initial assessment process performed to elicit strengths, needs and goals of the individual person and his/her family, identify the need for further or specialty evaluations that support development of a service plan which effectively meets the person’s needs and results in improved health outcomes;
- Continuous evaluation of the effectiveness of treatment through the ongoing assessment of the person and input from the person and his/her team resulting in modification to the service plan, if necessary;
- Provision of all covered services as identified on the service plan that are clinically sound, including referral to community resources as appropriate and, for children, services which are provided consistent with the Arizona vision and principles;
- Ongoing collaboration, including the communication of appropriate clinical information, with other individuals and/or entities with whom delivery and coordination of covered services is

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important to achieving positive outcomes, (e.g., primary care providers, school, child welfare, juvenile or adult probations, other involved service providers);

- A Clinical Liaison assigned to each enrolled person to provide clinical oversight and ensure clinical soundness of the assessment and service planning processes (see [Section 3.7, Clinical Liaison](#));
- Oversight to ensure continuity of care by taking the necessary steps (e.g., clinical oversight, development of facility discharge plans, or after-care plans, transfer of relevant documents) to assist persons who are moving to a different treatment program, (e.g., inpatient to outpatient setting), changing behavioral health providers and/or transferring to another service delivery system (e.g., out-of-area, out-of-state or to an ALTCS Contractor); and
- Development and implementation of transition plans prior to discontinuation of behavioral health services.

### 3.9.2 References

The following citations can serve as additional resources for this content area:

[9 A.A.C. 20](#)

[9 A.A.C. 21](#)

[AHCCCS/ADHS Contract](#)

[ADHS/Gila River Health Care Corporation Intergovernmental Agreement](#)

[ADHS/Navajo Nation Behavioral Health Program Intergovernmental Agreement](#)

[ADHS/Pascua Yaqui Behavioral Health Program Intergovernmental Agreement](#)

[ADHS/Colorado River Indian Tribes Behavioral Health Program Intergovernmental Agreement](#)

[ADHS/DBHS Covered Behavioral Health Services Guide](#)

[Child and Family Team Practice Improvement Protocol](#)

[Instruction Guide for the Assessment, Service Plan and Annual Update](#)

[Instruction Guide for the Assessment: Birth-5, Service Plan and Annual Update](#)

[Section 3.10, SMI Eligibility Determination](#)

[Section 4.2, Behavioral Health Medical Record Standards](#)

[Section 4.3, Coordination of Care with AHCCCS Health Plans and PCPs](#)

[Section 3.7, Clinical Liaison](#)

[Section 3.20, Credentialing and Privileging](#)

[Section 7.5, Enrollment, Disenrollment and Other Data Submission](#)

[Section 4.1, Disclosure of Behavioral Health Information](#)

[Section 3.6, Member Handbooks](#)

[Section 3.1, Accessing and Interpreting Eligibility and Enrollment Information and Screening and](#)

[Applying for AHCCCS Health Insurance](#)

[Section 3.5, Third Party Liability and Coordination of Benefits](#)

[Section 3.11, General and Informed Consent to Treatment](#)

[Section 3.19, Special Populations](#)

### 3.9.3 Scope

#### To whom does this apply?

This applies to all persons who are receiving services in the ADHS/DBHS behavioral health system.

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**3.9.4 Did you know...?**

There are six basic principles on which this section is based. Behavioral health assessments and service plans:

- Are developed with an unconditional commitment to persons enrolled in the behavioral health system and their families;
- Begin with empathetic relationships that foster ongoing partnerships and expect equality and respect throughout the service delivery system;
- Are developed collaboratively with families to engage and empower their unique strengths and resources;
- Include other individuals important to the person;
- Are individualized, strength-based, culturally appropriate and clinically sound; and
- Are developed with the expectation that the person is capable of positive change, growth and leading a life of value.

ADHS/DBHS has published the [Instruction Guide for the Assessment, Service Plan and Annual Update](#) and [Instruction Guide for the Assessment: Birth-5, Service Plan and Annual Update](#) as resources for T/RBHAs and behavioral health providers.

**3.9.5 Definitions**

[Annual Update](#)

[Assessment](#)

[Intake](#)

[Team](#)

**3.9.6 Procedures**

**3.9.6-A: Intake**

Behavioral health providers must conduct intakes in an efficient and effective manner that is both “person friendly” and ensures the accurate collection of all the required information necessary for enrollment into the system. The intake process must:

- Be flexible in terms of when and how the intake occurs. For example, in order to best meet the needs of the person seeking services, the intake might be conducted over the telephone prior to the visit, at the initial appointment prior to the assessment and/or as part of the assessment; and
- Make use of readily available information (e.g., referral form, AHCCCS eligibility screens) in order to minimize any duplication in the information solicited from the person and his/her family.

What happens during the intake?

During the intake, the behavioral health provider will collect, review and disseminate certain information to persons seeking behavioral health services. Examples can include:

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- The completion of the behavioral health client cover sheet (see [PM Form 3.9.1](#) of the Behavioral Health Assessment and Service Plan or [PM Form 3.9.2](#) of the Behavioral Health Assessment: Birth-5 and Service Plan);
- The collection of required demographic information and completion of client demographic information sheet (see Section [7.5, Enrollment, Disenrollment and other Data Submission](#));
- The completion of any applicable authorizations for the release of information to other parties (see Section [4.1, Disclosure of Behavioral Health Information](#)). This is especially critical for persons referred under the Corrections Officer/Offender Liaison (COOL) Program, who may have substance abuse treatment needs. See Section [3.19, Special Populations](#), for more information;
- The dissemination of a Member Handbook to the person (see Section [3.6, Member Handbooks](#));
- The review and completion of a general consent to treatment (see Section [3.11, General and Informed Consent to Treatment](#));
- The collection of financial information, including the identification of third party payers and information necessary to screen and apply for AHCCCS health insurance, when necessary (see Section [3.1, Accessing and Interpreting Eligibility and Enrollment Information and Screening and Applying for AHCCCS Health Insurance](#), and Section [3.5, Third Party Liability and Coordination of Benefits](#)); and
- The review of the person's rights and responsibilities as a recipient of behavioral health services including an explanation of the appeal process.

The person and/or family members may complete some of the paperwork associated with the intake, if acceptable to the person and/or family members.

#### What staff are qualified to complete an intake?

Behavioral health providers conducting intakes shall be appropriately trained, approach the person and family in an engaging manner and possess a clear understanding of the information that needs to be collected. Staff completing intakes must be behavioral health paraprofessionals, behavioral health technicians or behavioral health professionals but are not required to complete a specified privileging process.

#### What service codes can be encountered for activities associated with the intake?

The following list of service codes could be used when delivering an intake service (see the [ADHS/DBHS Covered Behavioral Health Services Guide](#) for a detailed description of each service code, provider qualifications and other limitations):

- **H0002**-Behavioral health screening
- **T1016**-Case management by a behavioral health professional
- **T1016 with modifier "HN"**- Case management by a behavioral health technician or behavioral health paraprofessional

#### **3.9.6-B: Assessments**

Behavioral health providers must conduct assessments that address the general components described in the introduction subpart of this section. ADHS/DBHS has established two standardized assessments that include a "core" assessment and several additional assessment

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documents, or “addenda” that must be completed as applicable for specific populations (see [PM Form 3.9.1](#), Behavioral Health Assessment and Service Plan and [PM Form 3.9.2](#), Behavioral Health Assessment: Birth-5 and Service Plan). The core assessment (at a minimum) must be completed at the initial appointment by a behavioral health professional or a behavioral health technician privileged and credentialed to do so.

There are possible exceptions to completing the core assessment at the initial appointment. In an emergency or crisis situation, the person’s immediate clinical needs must be initially addressed. To ensure the person’s safety, any person who shows evidence of depressed mood, anxiety, or substance abuse should be specifically assessed for suicidal risk. The assessor should complete the Special Suicide Risk Assessment Addendum at this time (See [PM Form 3.9.1, Part C](#)). At other times, it may be necessary to provide needed behavioral health services before completing the core assessment (e.g., appointments with a behavioral health medical practitioner to assess the need for and/or to provide psychotropic medications). In these cases, the core assessment can be completed at the next appointment.

Additionally, for urgent responses to children removed from their homes by the Department of Economic Security/Child Protective Services (CPS), the priority at the initial interview is to address the child’s immediate needs. At a minimum, the assessor should try and complete the CPS addendum along with the following Core Assessment sections of the General Assessment for children age 5 and older: Risk Assessment, Mental Status Exam, Clinical Formulation and Diagnosis, and Next Steps/Interim Service Plan. For children younger than 5, the assessor should complete the CPS Addendum, Behavioral Health Client Sheet, the Client Demographic Information Sheet and the following sections in the Core Assessment of the Birth-5 Assessment: Risk Assessment, Observations and Reported Observations of the Child (and if possible, Observations of the Family-Child Interaction), Diagnostic Summary and the Next Steps/Interim Service Plan. The remainder of the Core Assessment should only be completed at this time if the child’s clinical condition/circumstances allow. The assessor should make sure that the CPS Specialist’s name and phone number is recorded on the Cover Sheet.

What is included in the “core” assessment?

The Medical and Behavioral Questionnaire (see [PM Form 3.9.1, Part A](#)) and the core assessment (see [PM Form 3.9.1, Part B](#) or [PM Form 3.9.2, Part A](#)) are reviewed and completed at the initial appointment.

The following is a list of sections contained within the core assessment of the Behavioral Health Assessment for children over 5, adolescents and adults:

- Presenting concerns (must be completed at initial appointment);
- Criminal Justice (must be reviewed at the initial appointment and if indicated as necessary, the criminal justice addendum can be completed at a follow-up appointment);
- Substance Related Disorders (Part A must be completed at initial appointment, and Part B and C if indicated as necessary);
- Abuse/Sexual Risk Behavior (must be completed at initial appointment with some questions only completed if appropriate);

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- Risk Assessment (must be completed at initial appointment with some questions only completed if appropriate);
- Mental Status Exam (must be completed at initial appointment);
- Clinical Formulation and Diagnoses (must be completed at initial appointment); and
- Next Steps/Interim Service Plan (must be completed at initial appointment).

The following is a list of sections contained within the core assessment of the Birth-5 Behavioral Health Assessment (see [Instruction Guide for the Assessment: Birth-5, Service Plan and Annual Update](#) for detailed instructions):

- Reason for assessment;
- Child's Routines/Activities;
- Developmental Issues;
- Child's Medical History;
- Risk Assessment;
- Family Information;
- Observation of the Family/Child Interactions;
- Clinical Formulations and Diagnoses; and
- Next Step/Interim Service Plan.

What is included in the additional assessment documents for children over 5, adolescents and adults ("addenda")?

The following addenda (See [PM Form 3.9.1, Part C](#)) may or may not be completed at the initial appointment, but must eventually be completed for specific populations and/or if otherwise deemed appropriate by the assessor based on other information learned during the assessment:

- Living Environment (for all persons);
- Family/Community Involvement (for all persons);
- Educational/Vocational Training (for school age children and adults if appropriate);
- Employment (for persons 16 years and older or as pertinent);
- Developmental History (for all children and for adults who have developmental disabilities);
- Criminal Justice (for persons with legal system involvement);
- Problem Gambling Screening (for persons age 16 and older when applicable);

SMI determination (for persons who request an SMI determination or who have a qualifying SMI diagnosis and a GAF score that is 50 or lower)

- Child Protective Services (used for 24 hour urgent responses for children removed by CPS); and
- Special Suicide Risk Assessment (for persons in crisis situations).

The following addenda (see [PM Form 3.9.2, Part B](#)) are contained within the Birth-5 Behavioral Health Assessment (see [Instruction Guide for the Assessment: Birth-5, Service Plan and Annual Update](#) for detailed instructions):

- Family Culture and History Addenda;

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- Developmental Checklist or Ages and Stages Questionnaire;
- Behavioral Analysis;
- Medical Care; and
- Child Protective Services.

What else must the assessment process include?

- Behavioral health providers must use one of the two ADHS/DBHS core assessments (See [PM Form 3.9.1](#), Behavioral Health Assessment and Service Plan, or [PM Form 3.9.2](#), Behavioral Health Assessment: Birth-5 and Service Plan). Behavioral health providers may reformat the standardized assessment to place it on agency letterhead or to use it in an electronic format; however, the individual questions must be covered in their original order. Any changes or additions to the standardized assessments must be reported to the T/RBHA and ADHS/DBHS for approval. It is understood that questions may be adjusted during the actual interview to account for the level of understanding of the interviewee or the flow of the conversation, however the recorded answers must be placed in the standardized location.
- Assignment of a credentialed and privileged behavioral health technician or credentialed and privileged behavioral health professional qualified to conduct the initial general assessment, and assignment of a credentialed and privileged behavioral health technician or credentialed and privileged behavioral health professional qualified to conduct the Birth-5 Assessment if assessing children birth to 5 (see Section [3.20, Credentialing and Privileging](#)). If a behavioral health technician conducts either of the assessments, the supervising behavioral health professional must sign the appropriate sections indicated in the assessment. The person who conducts the assessment must serve as the Clinical Liaison unless another credentialed and privileged behavioral health technician or behavioral health professional is more appropriately matched to serve permanently in this capacity.
- For persons referred for or identified as needing ongoing psychotropic medications for a behavioral health condition, the assessor must establish an appointment with a licensed medical practitioner with prescribing privileges. If the assessor is unsure regarding a person's need for psychotropic medications, then the assessor must review the initial assessment and treatment recommendations with a licensed medical practitioner with prescribing privileges.
- Be in compliance with timelines for services and appointments as specified in Section [3.2, Appointment Standards and Timeliness of Service, including:](#)
  - Completion of the other required addenda either at the initial appointment or during subsequent meetings. The addenda/modules are completed depending on the individual needs of the person, but it is expected that a comprehensive assessment allowing for sound clinical formulation and diagnostic impression must be completed within 45 days of the initial appointment. For persons seeking a determination for Serious Mental Illness, the assessor should attempt to complete the entire assessment packet (core and all relevant addenda) before making an SMI eligibility determination. If this is not possible, the assessor can either:
    - Ask if the person would agree to an extension of the SMI eligibility determination and if they would agree to reschedule the appointment; or
    - Complete as much of the assessment as possible and make the SMI eligibility determination based on the available information. In either case, the assessor

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- should use the Interim Service Plan to identify the next appointment during which the assessment process will continue. As new information is obtained, the SMI eligibility determination may be revised (see [Section 3.10, SMI Eligibility Determination](#));
- Required data element submission within 45 days (see [Section 7.5, Enrollment, Disenrollment and other Data Submission](#)); and
  - Completion of a person's initial service plan no later than 90 days after the initial appointment.
- Documentation of the assessment information in the comprehensive clinical record (see [Section 4.2, Behavioral Health Medical Record Standards](#));
  - In the event that a behavioral health technician completes the assessment, the information must be reviewed by a credentialed and privileged behavioral health professional; and
  - Coordination with the person's PCP regarding assessment recommendations (see requirements set forth in [Section 4.3, Coordination of Care with AHCCCS Health Plans and PCPs](#)).

When will the general assessment be used for children who have already had the Birth-5 assessment and turn 5 and for children who enter the behavioral health system at age 5?

- After children turn 5, teams may use the Annual Update Form from either the Birth-5 Assessment or the General Assessment for annual updates until the child turns 8. For the annual update done during the child's 8<sup>th</sup> year and beyond, the Annual Update Form from the General Assessment must be used. During the child's 10<sup>th</sup> year, it is required that the full General Assessment be administered; and
- Children who have already turned 5 years old by the time they are referred to the T/RBHA must have the General Assessment (see [PM Form 3.9.1](#)).

**3.9.6-C: Service planning**

Behavioral health providers, in conjunction with the person's team, must develop and implement service plans based on a person's initial and ongoing assessments. The person must be included in the development of the service plan. In addition, family members, designated representatives, agency representatives and other involved parties, as applicable, may be invited to participate in the development of the service plan. The service plan must incorporate the general components described in subsection 3.9.1, Introduction. ADHS/DBHS has established a standardized service plan format (see [PM Form 3.9.1, Part D](#) of the general assessment or [PM Form 3.9.2, Part C](#) of the Birth-5 Behavioral Health Assessment).

What else must the service planning process include?

- Behavioral health providers must incorporate the elements identified within the ADHS/DBHS standardized service plan and review of progress format ([PM Form 3.9.1, Part D](#) or [PM Form 3.9.2, Part C](#)),
- In the event that a behavioral health technician completes the service plan, a credentialed and privileged behavioral health professional must review the service plan,
- Initial service plans must be completed no later than 90 days after the initial appointment,
- Documentation of the service planning information in the comprehensive clinical record (see [Section 4.2, Behavioral Health Medical Record Standards](#)), and

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- Coordination with the person's PCP regarding service planning recommendations (see requirements set forth in [Section 4.3, Coordination of Care with AHCCCS Health Plans and Primary Care Providers](#)).
- NARBHA requires that service planning be conducted in a manner consistent with the requirements of JCAHO. The following must be considered during the service planning process and included when appropriate:
  - When a member's identified needs include the development of skills for activities of daily living, a training program is established specifying the behavioral objectives, the methods used and the training schedule
  - When provided, activity services are incorporated into the service plan
  - When specialized rehabilitation services are identified that are needed to restore or maintain the functional abilities of members with physical, cognitive, social, leisure, vocational impairments, etc., these are included in the service plan.
  - Service plans support the habilitative goals and services provided by DDD.
  - When members are working for the organization as part of the member's treatment and rehabilitation, providers ensure:
    - The mechanisms that are in place to ensure the member's rights are protected at all times.
    - The criteria by which the contracted network provider determines when it is appropriate for the members to work for the organization as an important part of the member's treatment.
    - The process and format for documenting the following:
      - Clinical rationale for member working for the organization;
      - The specific work activities in which the member is engaged;
      - The goals, objectives and desired outcomes of these work activities;
      - The scheduled review of the progress towards goal achievement.
    - NARBHA requires all contracted network providers to have in place an objective review process to ensure member treatment is not compromised by their participation in organization's work activities for the member.
- NARBHA requires that discharge planning be conducted in a manner consistent with the requirements of JCAHO. The following must be considered during the discharge planning process:
  - Discharge planning commences upon admission, at each level of care
  - Discharge, referral or transfer of members to other levels of care, health professionals, or settings within the delivery system are based on the member's assessed needs and the provider's capability to provide needed care
  - The discharge plan includes appropriate transition for members who continue to require services/medications at a different level of care or agency and provides for continuing care to meet the member's assessed needs at discharge
  - The member, and parent/guardian if appropriate, is informed in a timely manner of the need for planning of discharge, referral or transfer to another provider or level of care.

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- To facilitate continuity of care, appropriate information is communicated to any provider to which a member is admitted, referred, transferred, or discharged.
- NARBHA requires that Psychological and psycho-educational evaluations assess a member's ability to process information, evaluate intelligence or ascertain educational discrepancies in order to clarify or establish diagnoses and to identify areas of clinical need. Testing may consist of intellectual, projective, neuropsychological and personality inventories. Members who are children, adolescents, developmentally disabled or cognitively impaired are provided medically necessary services for the clinical needs identified during the course of assessment and treatment.
  - Providers must have policies and procedures that address how the need for psychological and psycho-educational evaluations is determined.
  - This type of testing is only completed by clinicians credentialed or privileged to do so.
  - Recommendations for these evaluations or testing are entered in the member record within five (5) days of determination of need.
  - Copies of prior psychological and psycho-educational evaluations are obtained with proper consent
  - Members are referred to the designated provider for completion of psychological and psycho-educational evaluations or testing and the request is documented in the member's clinical record.
  - Reports from the evaluations or testing are completed and received within two (2) weeks from the date of the scheduled appointment.

What if the person and/or legal or designated representative disagree with the service plan?

Every effort should be taken to ensure that the service planning process is collaborative, solicits and considers input from each team member and results in consensus regarding the type, mix and intensity of services to be offered. In the event that a person and/or legal or designated representative disagree with any aspect of the service plan, the team should take reasonable attempts to resolve the differences and actively address the person's and/or legal or designated representative's concerns.

Despite a behavioral health provider's best effort, it may not be possible to achieve consensus when developing the service plan. The ADHS/DBHS standardized service plan ([PM Form 3.9.1, Part D](#) or [PM Form 3.9.2, Part C](#)) includes an option for the person and/or legal or designated representative to either agree or disagree with some or all of the services included in the service plan.

In cases that the person and/or legal or designated representative disagree with some or all of the Title XIX/XXI covered services included in the service plan, the person and/or legal or designated representative **must** be given:

- A Notice of Action ([PM Form 5.1.1](#)) by the behavioral health representative on the team.

In cases that a person determined to have a Serious Mental Illness and/or legal or designated representative disagree with some or all of the Non-Title XIX/XXI covered services included in the service plan, the person and/or legal or designated representative **must** be given:

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- [PM Form 5.5.1, Notice of Decision and Right to Appeal \(For Individuals With a Serious Mental Illness\)](#), by the behavioral health representative on the team.

In either case, the person and/or legal or designated representative may file an appeal within 60 days of the action.

**3.9.6-D: Annual update**

Behavioral health providers must complete an annual update that records a historical description of the significant events in the person's life and how the person/family responded to the services/treatment provided during the past year. The update process includes the following requirements:

- Use of the ADHS/DBHS standardized annual behavioral health update and review summary (See [PM Form 3.9.1, Part E](#) of the general assessment or [PM Form 3.9.2, Part D](#) of the Birth-5 Behavioral Health Assessment) that is completed by the person's Clinical Liaison or designee with the person and other relevant participants present.
- Behavioral health providers may reformat the annual update and re-order the questions to adjust to individual situations; however, the basic topic areas of each question must be covered.
- Based on the annual update, modify the person's service plan, if appropriate.
- Share, as appropriate, this information with other key individuals or entities such as the person's primary care physician, or DES/DDD case manager.
- Documentation of the annual update in the comprehensive clinical record.

The assessment and service plan may be updated more frequently as needed.