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| **Last Name:** Click or tap here to enter text.  **First Name:** Click or tap here to enter text.  **Date of Birth:** Click or tap to enter a date.  **Age:** Click or tap here to enter text. | | Enrollment Date: Click or tap to enter a date.Initial Approved Service Period: Click or tap here to enter text.Extended LOS Service Period: Click or tap here to enter text. | |
| **MH, SUD, DD Diagnoses:**  Click or tap here to enter text. | | **Agency:** Choose an item.  **Program for UR:**  **Adult Non-Medicaid Care Coordination** *(initial = 12 mo./extend = 3 mo.)*  **Child Non-Medicaid Care Coordination** *(initial = 12 mo./extend = 3 mo.)*  **Family Peer Support Services** *(initial = 6 mo./extend = 3 mo.)*  **Community Respite** *(initial = 12 mo./extend = 3 mo.)* | |
| **Living Situation** *(specify setting)*: Click or tap here to enter text. | | **Number of Visits with Provider** *(within the month)*: Click or tap here to enter text. | |
| **Insurance Type:** Click or tap here to enter text. | | **Health Home Provider** *(if applicable):* Click or tap here to enter text. | |
| **Dates of CPEP Visits** *(within the last year)***:**  Click or tap here to enter text. | | **Dates of Hospitalizations** *(within the last year)*:  **Psychiatric** Click or tap here to enter text.  **Medical** Click or tap here to enter text. | |
| **Other Providers/Services:** Click or tap here to enter text. | | | |
| **Describe Relationship with Service Provider(s)** (both with individual and family as applicable): Click or tap here to enter text. | | | |
| ***For Child SPOA Only:*** | | | |
| ***School District:*** Click or tap here to enter text. | ***School Placement:*** Click or tap here to enter text. | | ***CSE Status:*** Click or tap here to enter text. |
| ***Describe Relationship with School:*** Click or tap here to enter text. | | | |
| **High Risk Alerts** *(check if current issue)*:   |  |  | | --- | --- | | Caretaker Medical/Behavioral Health Issues | Non-compliance - Appointments | | Crises – Requiring Intensive Services | Non-compliance - Medication | | Fire Setting | Self-Injurious Behaviors | | Homeless - *Current* | Suicidal Ideation/Attempts/Threat | | Homicidal Ideation/Attempts/Threats | Victim of Physical/Sexual Abuse or Neglect | | Inappropriate Sexual Behavior | Violence towards Others |   If checked, provide dates and a brief explanation: Click or tap here to enter text. | | | |

**Last Name:** Click or tap here to enter text. **First Name:** Click or tap here to enter text. **Date of Birth:** Click or tap to enter a date.

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| **Please Indicate Responses to the Following Challenges:** | | | | | YES | **NO** |
| Community Services and/or Supports – *lack of awareness, inappropriate use of, etc.* | | | | |  |  |
| Cultural Issues/Language Barriers | | | | |  |  |
| Criminal Justice – *current charges pending, probation or parole involvement, recent release from incarceration* | | | | |  |  |
| Housing – *changes in, or challenges maintaining* | | | | |  |  |
| Financial | | | | |  |  |
| Insurance – *lack of coverage, network availability, etc.* | | | | |  |  |
| Medical – *current health issues,* *unaddressed needs, medication issues, etc.* | | | | |  |  |
| Psychiatric Appointments - *scheduling, keeping, attending, following-up with, etc.* | | | | |  |  |
| Psychiatric Medication Management – *scheduling, co-pay, pharmacy, etc.* | | | | |  |  |
| Transportation | | | | |  |  |
| ***For Child SPOA Only:*** | | | | | **YES** | **NO** |
| *Custody Issues – living with adults other than parents* | | | | |  |  |
| *School Placement - recent or anticipated change* | | | | |  |  |
| **Explain “YES” responses above and any barriers to overcoming identified challenges:**  Click or tap here to enter text. | | | | | | |
| **Attach current *Service Plan* or *Plan of Care* –** *If not available, complete the section below.* | | | | | | |
| **Service/Plan Goals** | **Progress Made** | | | **Outstanding Needs** | | |
| **1.** Click or tap here to enter text. | Click or tap here to enter text. | | | Click or tap here to enter text. | | |
| **2.** Click or tap here to enter text. | Click or tap here to enter text. | | | Click or tap here to enter text. | | |
| **3.** Click or tap here to enter text. | Click or tap here to enter text. | | | Click or tap here to enter text. | | |
| ***Comments:* Strengths and Challenges – *Why should this service continue?***  Click or tap here to enter text. | | | | | | |
| ***Name of Person Completing Form:*** Click or tap here to enter text. | | | ***Title:*** Click or tap here to enter text. | | | |
| ***Signature:*** | | | ***Date:*** Click or tap to enter a date. | | | |
| **SPOA Committee Recommendation(s):** | | **Date of SPOA Committee Meeting:** | | | | |
| **Approved** for extension of Length of Stay (LOS). | | | **Remain in program for an additional \_\_\_\_\_\_\_\_\_ months**  **Next Utilization Review Due** *(date)***:** | | | |
| **Discharge Recommended** – *state linkages to be completed:* | | | | | | |
| **Barriers to Discharge** *(specify)*: | | | | | | |
| **SPOA Coordinator:**  *Signature* | | | | | | |

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