Ohio Mental Health and Addiction Services

Mental Health Plan of Care
(5122-31-02)

Date:

Name of Resident: Age:

Agency Client Identifier: Date of Birth:

Resident's Legal Status: Gender: Male Female

Are all necessary authorizations for release of information in place in order to facilitate provision of care?
Yes No **If no, comment or list below:**

Name and address of facility applied to/referred to:

Name:

Address:

City: State: Zip Code:

County: Telephone:

Name and contact information for current CPST Worker:

Name:

Address:

City: State: Zip Code:

Phone: Ext.: Cell Phone:

E-Mail:

Name of mental health board contact:

Board Name:

Contact Name:

Phone: Ext. Cell Phone:

E-Mail:

Name or Agency Client Identifier:

Does the resident have a guardian? ◯ Yes ◯ No **If yes, please provide contact information:**

Name:

Address:

City: State: Zip Code:

Phone: Ext.: Cell Phone:

E-Mail:

Does the resident have a representative payee? ◯ Yes ◯ No **If yes, please provide contact information:**

Name:

Address:

City: State: Zip Code:

Phone: Ext.: Cell Phone:

E-Mail:

Does the resident have a parole or probation officer? ◯ Yes ◯ No **If yes, please provide contact information:**

Name:

Address:

City: State: Zip Code:

Phone: Ext.: Cell Phone:

E-Mail:

Emergency Contact 1:

Name: Relationship:

Address:

City: State: Zip Code:

Phone: Cell Phone:

E-Mail:

Name or Agency Client Identifier:

Emergency Contact 2:

Name: Relationship:

Address:

City: State: Zip Code:

Phone: Cell Phone:

E-Mail:

Does the resident have:

Health Insurance? ◯ Yes ◯ No If yes, attach a copy.

Medical advanced directive? ◯ Yes ◯ No If yes, attach a copy.

Psychiatric advanced directive? ◯ Yes ◯ No If yes, attach a copy.

Declaration for mental health treatment? ◯ Yes ◯ No If yes, attach a copy.

What will assist with the preparation of the ACF and staff to provide optimal care for the prospective resident?

Crisis Plan/Emergency Contact Procedures for ACF regarding mental health related issues.

During regular business hours (insert) the lead mental health agency will be contacted:

1.) Contact CPST Office at:

2.) Ask for assigned CPST worker, if not available

3.) Ask for a Team Leader or CPST supervisor, if not available

4.) Ask for in-house worker, if not available

5.) Ask for the intake or Crisis Department, if not available

6.) Ask for the Clients Rights Officer, if not available

7.) Ask for the Clinical Director, if not available

8.) Contract the Board representative

After business hours, weekends, and holidays, refer to the crisis plan and contact the appropriate on-call person.

All emergency medical issues and legal issues should be handled by contacting the appropriate authorities, i.e.. by calling 911

Name or Agency Client Identifier:

Does the resident have any known allergies? ○ Yes ○ No ○ Unknown **If yes, please list them below:**

List all diagnosed physical or mental health conditions:

List current medications and most common possible side effects: (Note - this information must be supplied by the agency physician, nurse or staff member with comparable scope of practice) Summer heat can negatively affect individuals taking psychotropic (mental health) medications. Please provide accommodation such as fans, air conditioning when available, wet towels, shade, etc during extremely warm/hot days.

Medications	Dosage	Frequency	Possible Severe Adverse Side Effect(s)	Potential Dangerous Interactions

Additional Comment

Name or Agency Client Identifier:

Does the resident have any physical limitations? ◯ Yes ◯ No

Does the resident have any dietary restrictions? ◯ Yes ◯ No

Does the resident smoke? ◯ Yes ◯ No **If yes, please list house restrictions on when and where to smoke:**

Please identify additional limitations to care, e.g. language or cognitive, or other factors, e.g. religious or cultural considerations, that are important to care:

Date of last medical hospitalization?

Date of last mental health hospitalization?

Does resident have a current or past AOD abuse issue? ◯ Yes ◯ No **If yes, please describe:**

Name or Agency Client Identifier:

Does resident have a current or past history of violence towards others, including, but not limited to physical violence, sexual violence, use of weapons or homicide? ◯ Yes ◯ No **If yes, describe:**

Does resident have a current or past history of self-injury? ◯ Yes ◯ No **If yes, describe:**

Does resident have a recent or past history of suicide attempts? ◯ Yes ◯ No **If yes, describe:**

Resident's responses to plans to moving into an adult care facility:

Treatment provider's comment:

Name or Agency Client Identifier:

Does the resident require?		Assistance	Responsible Party(s)
Assistance with Hygiene	○ Yes ○ No	○ Prompting Assistance Needed ○ Indicate Resident Independent	○ Treatment Provider Staff ○ ACF Staff Member ○ Both
Comment:			
Medication Assistance	○ Yes ○ No	○ Prompting Assistance Needed ○ Indicate Resident Independent	○ Treatment Provider Staff ○ ACF Staff Member ○ Both
Comment:			
Medical Appointment Transportation	○ Yes ○ No	○ Prompting Assistance Needed ○ Indicate Resident Independent	○ Treatment Provider Staff ○ ACF Staff Member ○ Both
Comment:			
Psychiatric Appointment Transportation	○ Yes ○ No	○ Prompting Assistance Needed ○ Indicate Resident Independent	○ Treatment Provider Staff ○ ACF Staff Member ○ Both
Comment:			
Transportation for Emergency Situations	○ Yes ○ No	○ Prompting Assistance Needed ○ Indicate Resident Independent	○ Treatment Provider Staff ○ ACF Staff Member ○ Both
Comment:			
Nutritional Supplements Needed	○ Yes ○ No	○ Prompting Assistance Needed ○ Indicate Resident Independent	○ Treatment Provider Staff ○ ACF Staff Member ○ Both
Comment:			
Assistance with Scheduling Appointments	○ Yes ○ No	○ Prompting Assistance Needed ○ Indicate Resident Independent	○ Treatment Provider Staff ○ ACF Staff Member ○ Both
Comment:			
Assistance with Budgeting and Finance	○ Yes ○ No	○ Prompting Assistance Needed ○ Indicate Resident Independent	○ Treatment Provider Staff ○ ACF Staff Member ○ Both
Comment:			
Assistance w/contacting family and friends	○ Yes ○ No	○ Prompting Assistance Needed ○ Indicate Resident Independent	○ Treatment Provider Staff ○ ACF Staff Member ○ Both
Comment:			
Other:	○ Yes ○ No ○ Unknown	○ Prompting Assistance Needed ○ Indicate Resident Independent	○ Treatment Provider Staff ○ ACF Staff Member ○ Both
Other:	○ Yes ○ No ○ Unknown	○ Prompting Assistance Needed ○ Indicate Resident Independent	○ Treatment Provider Staff ○ ACF Staff Member ○ Both

I, _____, the resident ○ **Accept** ○ **Do Not Accept** treatment through the mental health provider.

Resident's Signature Date

MH Provider's Signature Date

ACF Operator's Signature Date

Guardian's Signature Date