THE UNIQUE CARING FOUNDATION

"BUILDING BRIDGES TO THE COMMUNITY"

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ADULT

SOUTH CAROLINA TCM CLIENT MEDICAL RECORD FACE SHEET

PERSON SERVED: _____ **RECORD #** _____

ADMISSION DATE: _____ **DISCHARGE DATE:** _____

YES	NO	SECTION I: DEMOGRAPHIC INFORMATION	SECTION II: ASSESSMENT & CASE MANAGEMENT AUTHORIZATION	YES	NO
		Freedom of Choice	Case Management Plan/Service Notes/Time-Sheet		
		Client Master Face Referral and Screening			
		MTCM Parent/Guardian Consent **(0-21 ONLY)**			
		Client Orientation			
		Consumer Informed Consent			
		Release of Information and Disclosure			
		Crisis Response Acknowledgement			
		Grievance Procedures			
		HIPPA Policy			
		ADULT Intake Assessment/Services Notes/ Time-Sheet/Authorization			

YES	NO	SECTION III: DATA COLLECTION	SECTION IV: PROGRESS NOTES	YES	NO
		Client Medical, Educational, and Court Paperwork	1st Note Assessment		
			2nd Note Case Management Plan		
			3rd Note Records-compiling records		
			4th Note Referral & Linkage /Follow-Up		

Date Reviewed: **Initials:** **Percentage Outcome:**	**Date Reviewed:** **Initials:** **Percentage Outcome:**	**Date Reviewed:** **Initials:** **Percentage Outcome:**	**Date Reviewed:** **Initials:** **Percentage Outcome:**

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

SECTION I: DEMOGRAPHIC INFORMATION
Freedom of Choice
Client Master Face Referral and Screening
MTCM Parent/Guardian Consent **(0-21 ONLY)**
Client Orientation
Consumer Informed Consent
Release of Information and Disclosure
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HIPPA Policy
ADULT Intake Assessment/Services Notes/ Time-Sheet/Authorization

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Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

CLIENT SCREENING AND REFERRAL DATE: _____

First Name:		Race:	
Middle Initial:		Gender:	Date of Birth:
Last Name:		Check if speaks English: ☐ Yes ☐ No	
Suffix:		If not, primary language:	
SS #:	Marital Status:	Employer (adults only):	
Home Phone Number	Cell Phone Number	Occupation (adult only):	
Medicaid #:		School:	Grade Level
Medicare#		Allergies:	
Other Insurance #:		Symptoms/Adverse Reactions:	
Target Population:		Reason for Referral:	
Emergency Contact Name Address Telephone #			

PERMANENT ADDRESS MAILING ADDRESS

Street:	Street:
City:	City:
State:	State:
Zip:	Zip:
County:	County:
Home Phone Number:	

Revised 04/09/2019

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Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

PRESENT LOCATION	CONTACT PERSON
Facility:	Alternate Contact : ☐ Yes ☐ No
Street:	Name: Relationship:
City State Zip	Primary phone: Alternate phone:
Admission Date: _____/_____/_____	Discharge Date: _____/_____/_____
Any current mental health services (agency, service, and contact information):	
Current Behaviors, Issues or Concerns:	
Past History of behaviors, Issues, or Concerns:	
Is there a current or past substance abuse? __ Yes __No Drug of Choice: _____	
Initial Assessment Appointment with Unique Caring Foundation: __	
Unique Caring Foundation is able to provide services for consumer at this time: YES ____ NO _____	
If NO please provide a brief explanation: _____	

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

South Carolina Department of Health and Human Services

FREEDOM OF CHOICE

This form should be completed after MTCM eligibility determinations have been made.

I have been informed of the Medicaid Targeted Case Management (MTCM) services available to me or my child. I understand I have a right to choose the provider of Medicaid Targeted Case Management services, and I have been given the opportunity to choose between enrolled Medicaid providers in my community setting.

As long as I remain eligible for MTCM services, I will continue to have the opportunity to choose between qualified MTCM providers.

I understand that I have the right to refuse MTCM services. Refusal of MTCM services does not prevent me from receiving other Medicaid services for which I may qualify.

☐ I agree to receive Medicaid Targeted Case Management services for

_____ _____
Beneficiary Name Medicaid Number

I select _____ as my provider for MTCM Services.
Name of Provider

☐ I decline Medicaid Targeted Case Management.Services

_____ _____
Beneficiary Name Medicaid Number

_____ _____
Signature of recipient Date signed *(month, day, year)*

_____ _____
Signature of: *(check one)* __Family Date signed *(month, day, year)*
__ Guardian __ Witness

_____ _____
Signature of Case Manager Date signed *(month, day, year)*

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Departamento de Salud y Servicios Humanos de Carolina del Sur
(South Carolina Department of Health and Human Services)

LIBERTAD DE ELECCIÓN

Este formulario debe completarse después de que se hayan realizado las determinaciones acerca de la elegibilidad para MTCM.

He sido informado/a acerca de los servicios de la Administración de casos específicos de Medicaid (Medicaid Targeted Case Management, MTCM) que se encuentran disponibles para mí o mi hijo/a. Entiendo que tengo derecho a elegir el proveedor de servicios de la Administración de casos específicos de Medicaid y que se me ha dado la oportunidad de elegir entre proveedores inscritos de Medicaid en mi comunidad.

Mientras siga siendo elegible para los servicios de MTCM, continuaré teniendo la oportunidad de elegir entre proveedores de MTCM calificados.

Entiendo que tengo derecho a rechazar los servicios de MTCM. Si rechazo los servicios de MTCM eso no me impedirá recibir otros servicios de Medicaid para los cuales pueda calificar.

☐ Acepto recibir los servicios de la Administración de casos específicos de Medicaid para

_____ _____
Nombre del beneficiario Número de Medicaid

Selecciono a _____ como mi proveedor de servicios de MTCM.
Nombre del proveedor

☐ Rechazo los servicios de la Administración de casos específicos de Medicaid.

_____ _____
Nombre del beneficiario Número de Medicaid

_____ _____
Firma del destinatario Fecha de firma *(mes, día, año)*

_____ _____
Firma de: (*seleccione una opción*) Fecha de firma *(mes, día, año)*
__ Familiar __ Tutor __ Testigo

_____ _____
Firma del Administrador de casos Fecha de firma *(mes, día, año)*

DISTRIBUTION: Original - Provider Case File Beneficiary Copy
12/2012

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Medicaid Targeted Case Management (MTCM)
Parent/Caregiver/Guardian Agreement to Participate in
MTCM Services

Name of Beneficiary: Date of Birth:
Medicaid Number:

What are Medicaid Targeted Case Management (MTCM) Services?
Medicaid Targeted Case Management (MTCM) is a means for achieving beneficiary wellness through communication, education and services identification and referral. MTCM is a time-limited process that provides an organized and structured process for moving beneficiaries toward the goal of self-sufficiency.

- The MTCM process is a shared partnership between the beneficiary's parent/caregiver/guardian and the case manager.
- Parents/Caregivers/Guardians are actively involved in all phases of the process – assessment, planning, problem solving and identification of resources.
- MTCM ensures available resources are efficiently accessed and being used in a timely and cost effective manner.

South Carolina Medicaid allows provision of MTCM services to the following target population(s):

- Individuals with Intellectual and Related Disabilities
- At Risk Children
- Adults with Serious and Persistent Mental Illness
- At Risk Pregnant Women and Infants
- Individuals with Psychoactive Substance Disorder
- Individuals at Risk for Genetic Disorders
- Individuals with Head and Spinal Cord Injuries and Related Disabilities
- Individuals with Sensory Impairments
- Adults with Functional Impairments

The provider has provided adequate explanation to me that my child meets criteria for the following MTCM target population group(s):
(Circle one)
1) Yes 2) No, I need further explanation

What does South Carolina Medicaid expect of you?

A. You will be asked to:
- Whenever possible, access your child's treatment needs on your own; MTCM is **only** for when you are unable to do this on your own or with the support of family and friends.
- Participate in case management planning meetings.
- Monitor your child's case management needs and report these to your child's MTCM case manager

B. You will be provided with links to community resources that may support you and your family and you will be expected to reach out to those organizations.

C. Based on your child's needs, you may be asked to engage in other specific interventions by your child's MTCM service provider

What can you expect of your MTCM provider?
You can expect your provider to:

- Explain the purpose of all interventions in language that you understand
- Explain all known benefits and risks of the interventions in language that you understand
- Treat you and all your family members with respect
- Treat you as an essential member of the treatment team

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

- Coordinate times and frequency of visits with you and to let you know in advance if he/she has to cancel or reschedule a visit
- Discuss the child's progress with you during every visit
- Answer any questions you have regarding the child's treatment
- Respond to all concerns you express to them in a timely and respectful manner
- Provide information about community resources

Because your participation is a key to success, you will be asked to confirm your willingness to participate in these services every ninety (90) days.

By signing this form, I:

- Agree that I as parent/caregiver guardian need MTCM on behalf of my child in the following areas:
- Give permission for , the beneficiary, to participate in the following recommended MTCM Services:
- Acknowledge that the provider has explained the target population(s) in which my child meets criteria and how he or she meets that criteria.

I understand that at any time I can let staff know, either verbally in or writing, that I (a) no longer wish to participate in these services and/or (b) no longer wish for the child to receive these services. I further understand that services can be immediately terminated upon my request unless these services are court ordered.

_____ _____
Printed Name of Parent/Caregiver/Guardian Relationship to Beneficiary

_____ _____
Signature of Parent/Caregiver/Guardian Date

I hereby attest that I have provided adequate explanation of: the criteria for the identified MTCM target population to the Parent/Caregiver/Guardian; how the child meets this criteria; and (as applicable) that the child will be receiving behavioral health services.

_____
Printed Name of Staff

_____ _____
Signature and Credentials of Staff Date

_____
Name of Provider

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Administración de casos específicos de Medicaid (MTCM) Acuerdo del padre/la madre/el cuidador/el tutor para participar en los servicios de MTCM

Nombre del beneficiario: Fecha de nacimiento:
Número de Medicaid:

¿Para qué sirven los servicios de Administración de casos específicos de Medicaid (MTCM)?
Los servicios de Administración de casos específicos de Medicaid (Medicaid Targeted Case Management, MTCM) constituyen un medio para alcanzar el bienestar del beneficiario mediante la comunicación, la educación, y la identificación y la derivación de servicios. MTCM es un proceso de tiempo limitado que proporciona un proceso organizado y estructurado para ayudar a los beneficiarios a alcanzar el objetivo de la autosuficiencia.

- El proceso de MTCM constituye una asociación compartida entre el padre/la madre/el cuidador/el tutor del beneficiario y el administrador de casos.
- El padre/la madre/los cuidadores/tutores participan activamente en todas las fases del proceso (la evaluación, planificación, resolución de problemas e identificación de los recursos).
- MTCM garantiza el acceso eficiente a los recursos disponibles y que se los utilice de forma oportuna y rentable.

Medicaid de Carolina del Sur (South Carolina Medicaid) permite el suministro de los servicios de MTCM a la siguiente población específica:

- Personas con discapacidades intelectuales o relacionadas.
- Niños en riesgo.
- Adultos con enfermedades mentales graves o persistentes.
- Embarazadas y bebés en riesgo.
- Personas con trastorno por el consumo de sustancias psicoactivas.
- Personas en riesgo de sufrir trastornos genéticos.
- Personas con lesiones en la cabeza o en la médula ósea y discapacidades relacionadas.
- Personas con discapacidades sensoriales.
- Adultos con discapacidades funcionales.

El proveedor me ha explicado de manera adecuada que mi hijo/a cumple con los requisitos para el siguiente grupo de población específica para MTCM:
(Encierre en un círculo una sola opción)
1) Sí 2) No, necesito más explicaciones

¿Qué espera Medicaid de Carolina del Sur de usted?
A. Se le pedirá que:
   - Cuando sea posible, acceda por sí mismo a las necesidades de tratamiento de su hijo/a; MTCM **solamente** debe utilizarse para cuando usted no pueda hacerlo por sí mismo o con el apoyo de familiares o amigos.
   - Participe en las reuniones de planificación de la administración de casos.
   - Supervise las necesidades de administración de casos de su hijo/a e infórmelas al administrador de casos de MTCM de su hijo/a.

B. Se le proporcionará información sobre enlaces para obtener recursos de la comunidad que le puedan ayudar a usted y a su familia, y usted deberá comunicarse con esas organizaciones.
C. Con relación a las necesidades de su hijo/a, el proveedor de servicios de MTCM de su hijo/a podría pedirle que participe en otras intervenciones específicas.

¿Qué puede esperar usted de su proveedor de MTCM?
Usted puede esperar que su proveedor:

- Explique el propósito de todas las intervenciones utilizando un lenguaje que usted pueda entender.
- Explique todos los beneficios y riesgos conocidos de las intervenciones utilizando un lenguaje que usted pueda entender.
- Lo trate con respeto a usted y a todos los miembros de su familia.
- Lo trate como miembro imprescindible del equipo de tratamiento.

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

- Coordine con usted el momento y la frecuencia de las visitas, y que le informe con anticipación si debe cancelar o reprogramar una visita.
- Analice el progreso de su hijo/a con usted en cada visita.
- Responda cualquier pregunta que usted tenga en relación con el tratamiento de su hijo/a.
- Responda a todas las inquietudes que usted exprese de manera oportuna y respetuosa.
- Le brinde información acerca de los recursos de la comunidad.

Debido a que su participación es clave para conseguir un resultado satisfactorio, cada noventa (90) días se le pedirá que confirme su voluntad para participar en estos servicios.

Al firmar este formulario, yo:

- Acepto que como padre/madre/cuidador/tutor, y en nombre de mi hijo/a, necesito los servicios de MTCM en las siguientes áreas:
- Brindo mi autorización para que , el beneficiario, participe en los siguientes Servicios de MTCM recomendados:
- Reconozco que el proveedor me ha explicado la población específica para la cual mi hijo/a cumple los requisitos y la manera en que él o ella cumple dichos requisitos.

Entiendo que en cualquier momento puedo informar al personal, ya sea de forma escrita o verbal, que yo (a) ya no deseo participar en estos servicios; o (b) ya no deseo que mi hijo/a reciba estos servicios. También entiendo que el suministro de los servicios puede interrumpirse de forma inmediata cuando yo lo solicite, a menos que un tribunal ordene que se brinden estos servicios.

_____ _____
Nombre en letra de molde del padre/madre/persona a cargo del cuidado/tutor Relación con el beneficiario

_____ _____
Firma del padre/madre/persona a cargo del cuidado/tutor Fecha

Por el presente certifico que he explicado de manera adecuada lo siguiente: los criterios de identificación para la población específica de MTCM al padre/madre/cuidador/tutor; la manera en que el niño/la niña cumple los requisitos; y (según corresponda) que el niño/la niña recibirá servicios de salud conductual.

_____
Nombre en letra de molde del personal

_____ _____
Firma y credenciales del personal Fecha

_____
Nombre del proveedor

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

CLIENT ORIENTATION FORM

As a client of Unique Caring Foundation, upon admission I have been instructed in or given written materials regarding:

- Rights and responsibilities of the person served.
- Grievance and appeal procedures.
- Ways in which input is given regarding:
  - (a) The quality of care.
  - (b) Achievement of outcomes.
  - (c) Satisfaction of the person served.
- An explanation of the organization's:
  - (1) Services and activities.
  - (2) Expectations.
  - (3) Hours of operation.
  - (4) Access to after-hour services.
  - (5) Code of ethics.
  - (6) Confidentiality policy.
  - (7) Requirements for follow-up for the mandated person served, regardless of his or her discharge outcome.
- An explanation of any and all financial obligations, fees, and financial arrangements for services provided by the organization.
- Familiarization with the premises, including emergency exits and/or shelters, fire suppression equipment, and first aid kits.
- The program's policies regarding:
  - (1) The use of seclusion or restraint.
  - (2) Smoking.
  - (3) Illicit or licit drugs brought into the program.
  - (4) Weapons brought into the program.
  - (5) Abuse and Neglect

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

- Identification of the person responsible for service coordination.
- A copy of the program rules to the person served that identifies the following:
  (1) Any restrictions the program may place on the person served.
  (2) Events, behaviors, or attitudes that may lead to the loss of rights or privileges for the person served.
  (3) Means by which the person served may regain rights or privileges that have been restricted.
- Education regarding advance directives, if appropriate.
- Identification of the purpose and process of the assessment.
- A description of how the individual plan will be developed and the person's participation in it.
- Information regarding transition criteria and procedures.
- When applicable, an explanation of the organization's services and activities include:
  (1) Expectations for consistent court appearances.
  (2) Identification of therapeutic interventions, including:
    (a) Sanctions.
    (b) Interventions.
    (c) Incentives.
    (d) Administrative discharge criteria.

Consumer: _____ Date: _____

Legal Guardian: _____ Date: _____

Unique Caring Foundation Staff: _____ Date: _____

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Consumer Informed Consent

Program Consent: After clear explanation of program structure, rules, and expectations, I give consent for _____to receive **MTCM**:

I understand that this consent is voluntary and that it may be withdrawn with written notification at any time.

_____**Interventions:** I agree to allow Unique Caring Foundation staff to implement professionally accepted methods of interventions as indicated by the consumer's and programs mutually agreed upon therapeutic treatment/goal plans. It is the policy of Unique Caring Foundation that physical restraint of consumers and isolation time-out will be avoided. In an emergency where the staff member has exhausted verbal de-escalation techniques and a consumer is still being physically aggressive, a threat to self and others, or destroying property, the staff member will call 911 and request intervention by law enforcement. The potential benefits of interventions, though not guaranteed, are the alleviation of mental health and/or substance abuse symptoms necessitating the need for treatment. The risks of the service are discussing and addressing challenging symptoms associated with diagnoses and the potential emotional discomfort that this may cause. Unique Caring Foundation does not condone the use of experimental interventions or medications. You have the right to be informed about the potential risks and benefits of all services and interventions provided by Unique Caring Foundation

_____**Missed Appointments:** The importance of regular attendance in treatment services has been explained to me. I understand that if I fail to keep appointments or attend treatments regularly, Unique Caring Foundation staff will meet with me for consideration of program options, up to and including service termination.

_____**Transport:** I give permission and consent for the consumer named to be transported by program personnel. Transportation allows the consumer named to participate in outings, events, appointments, and be transported to and from home and other program activities. I release Unique Caring Foundation and its employees from any liability for accident/injury to the consumer named and give permission for transportation.

_____**First Aid/Medication Administration:** I authorize Unique Caring Foundation to provide and render first aid assistance to the consumer as deemed necessary by trained and certified staff. I understand that, during the time staff is with the identified consumer, outside of services in which professionals trained in the administration of medication are present, staff will not administer medication.

_____**Emergency Care:** I authorize Unique Caring Foundation to obtain emergency medical, dental or mental health care for this consumer, if needed, until such times that I can be reached to authorize further care.

_____**Emergency Contact:** I have received a copy of the Emergency Contact sheet that provides me with information on how to get assistance if a behavioral health crisis should occur.

_____**HIPAA/Confidentiality:** I have received a copy of Unique Caring Foundation's Notice of Privacy Practices and understand that Unique Caring Foundation has the right to revise these practices as necessary and will notify me of any such changes. I am aware that I may request a copy of a notice of privacy practices at any time.

_____**Clients' Rights:** I have received a copy of Unique Caring Foundation's Clients Rights and Handbook for Persons Served which includes a summary of program rules, policies and guidelines for Unique Caring Foundation My rights have been explained and I had the opportunity to ask questions. I understand that if I feel my rights have been violated, I am encouraged to seek assistance or file a complaint with the QM Director of Unique Caring Foundation, The LME or Disability Rights of South Carolina.

_____**Acceptance:** I (we) have read and/or have been clearly explained the terms, conditions, and agreements of this informed consent agreement and voluntarily accept them as stated or amended as specified below. This agreement may be withdrawn at any time, but will not exceed one year after the date signed.

****Preferred Physician:** _____
Address: _____
Phone Number: _____

****Preferred Dentist:** _____
Address: _____
Phone Number: _____

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Preferred Hospital: _____
Address: _____
Phone Number: _____

Consumer: _____ **Date:** _____
Legal Guardian: _____ **Date:** _____
Unique Caring Foundation Staff: _____ **Date:** _____

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Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Crisis Response Notification for Unique Caring Consumers

In order to best serve the needs of our clients, Unique Caring has established a crisis response system for emergency situations involving our clients. At the time of intake/admission, a crisis number will be given to consumers, parents, guardians & or family members. In the event of an after-hours emergency the client, parent, guardian & or family member can call this number & the call will be returned by a Qualified Professional. The client, parent guardian &/or family member will be asked to detail the nature of the emergency and respond accordingly including face to face. This crisis number is to be used for emergencies that are urgent/critical in nature and cannot wait until the next business day. If the emergency situation is life threatening or a medical in nature the client should call **911** for immediate response. **(Please enter a call back number that does not block private numbers)**

Crisis Line Number (SC): **803-329-9625**

The undersigned have read and agree to follow this Crisis Response plan:

Consumer: _____ Date: _____

Legal Guardian: _____ Date: _____

Unique Caring Foundation Staff: _____ Date: _____

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Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Release of Information

Client's Name:__ Record Number _ MID #:

Address: _____ City:

State: SC Zip: Phone:

I, _____, authorize _____ to:

___ (send) ___ (receive) the following ____ (to) ___ (from)

Name: **Unique Caring Foundation** **518 North Ave, Suite D_** **Rock Hill, SC 29732**

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR *PSYCHOTHERAPY NOTES.

__ Academic testing results
__ Behavior programs
__ Progress reports
__ Intelligence testing results
__ Medical reports
__ Personality profiles
__ Psychological reports
__ Psychological testing results
__ Service plans
__ Summary reports
__ Vocational testing results
__ Entire record, except progress notes
__ *Psychotherapy Notes
__ other, specify _____

The above information will be used for the following purposes:

__ Planning appropriate treatment or program
__ Continuing appropriate treatment or program
__ Determining eligibility for benefits or program
__ Case review __ Updating files
__ Other (specify) _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patients Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipients may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.
I also understand that this information may be further protected as it pertains to HIV/AIDS information under G.S. 130A-143. **I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (1 year) this consent automatically expires.** I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: __ Self __ Parent/legal guardian

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client/Guardian's Signature: _____ Date: _____

UCF Staff/Contractor Signature: _____ Date: _____

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__ Case review __ Updating files
__ Other (specify) _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patients Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipients may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.
I also understand that this information may be further protected as it pertains to HIV/AIDS information under G.S. 130A-143. **I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (1 year) this consent automatically expires.** I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: __ Self __ Parent/legal guardian

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client/Guardian's Signature: _____ Date: _____

UCF Staff/Contractor Signature: _____ Date: _____

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

PERSON SERVED GRIEVANCE POLICY & PROCEDURE FORM

NAME OF PERSON SERVED: _____**DOB**_____**MED REC. #**_____

Providers of Unique Caring Foundation, Inc. will at all times respect the rights of clients as individuals. If at any time a client wishes to express dissatisfaction with services or feels that his/her rights or the rights of another have been violated, he/she shall have access to a process through which the grievance will be fairly considered, investigated and appropriately acted upon. Unique Caring Foundation, Inc. shall give high priority to being responsive to appropriate requests for help.

PROCEDURE:

A. Clients have the right to make a grievance about any aspect of Unique Caring Foundation, Inc. services or operation.

B. Clients will be informed of the grievance procedure at first face to face contact and anytime upon client's request. Where a client may be incapable of making or pursuing a grievance because of mental disability, mental retardation, or as an effect of treatment, staff shall act on the client's behalf in accordance with this policy. At the time a complaint is initiated, the client will receive a new copy of the detailed grievance procedure.

C. The manner of dealing with the grievance serves as a vital source of information for assessing and improving the quality of service therefore, Unique Caring Foundation, Inc. has established a mandatory reporting requirement. Any employee or other staff, who is the recipient of, is witness to, or who otherwise becomes aware of a complaint is required to facilitate the reporting of it in writing according to procedures defined under this policy. Where clients or others may have difficulty registering a complaint, employees of Unique Caring Foundation, Inc. are required to help them.

D. There shall be no penalty or retaliation direct or indirect, for any action reasonably taken by any employee or other staff acting in compliance with this policy.

E. Review and response to client grievances shall be investigated through established administrative channels as follows:
   a. Client shall present complaint to any staff or provider and/or to the Executive Director. The person receiving the complaint must forward it to Human Resources within 1 – 2 working days. Human Resources will respond to the complaint and to the consumer within 1 to 2 working days of receipt, or sooner if clinically indicated. Response may include one or all of the following: letter, meeting, or specific action as documented on the client complaint form.

F. Upon its completion of "Step E", the Grievance and Complaint Report must be received by the Executive Director who shall take one of the following actions within 2 to 5 days of receiving the complaint:
   1. Determine that there is *no reasonable cause for complaint*. If the Executive Director determines the complaint was unfounded and documents this in writing, by checking the appropriate line on the bottom of the complaint form. The complainant must sign the complaint form again indicating that they have been informed of this determination.
   2. If the Executive Director is *able to offer a resolution that is acceptable to the complainant*, this resolution will be documented on the complaint form. The complainant must check the appropriate line on the complaint

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

form and sign the bottom of the complaint form indicating that they agree that the proposed resolution is acceptable.

3. *Attempt to resolve the complaint, but finds that his/her proposed resolution is not satisfactory to the complainant.* If the Executive Director is unable to resolve the complaint, this will be indicated on the complaint form and forwarded to the Quality Assurance/Quality Improvement Committee.

If it is determined that an investigation is required or that the matter cannot be resolved no later than five (5) days. If a lengthy investigation is anticipated, the Quality Assurance/Quality Improvement Committee should document on the complaint from the expected length and scope of the investigation.

G. A summary of all complaint reports and their resolutions shall be submitted to the Quality Improvement Committee at the first meeting of this body after report is received by the Executive Director.

H. Right of Appeal: The complainant or other party involved in the complaint may appeal the decision which will be processed through the Executive Director and Quality Improvement Committee. All parties will receive notification of results of appeals.

I. This procedure does not preclude or prohibit the client from contacting advocates who are outside of the agency. At any point during the client's care, he will be afforded the opportunity to contact officials from the Department of Social Services, Disability Rights North Carolina, formerly (the Governor's Advocacy Council for Persons with Disabilities Council) – Voice 919-856-2195, Toll Free Voice 877-235-4210, TTY 888-268-5535 or Email: Info@disabilityrightsnc.org, an attorney and/or Guardian Ad item.

J. A file of complaints shall be maintained by the owner and shall remain on file until the end of the second calendar year after the one in which complaint was filed.

_____ _____
Signature of Person Served/Guardian/Legally Responsible Person Date

_____ _____
Signature of Witness Date

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Person Served Name: _____ Record # _____

I hereby acknowledge that I have received The Unique Caring Foundation Notice of Privacy Practices. These practices have been explained to me and I understand that if I have further Questions, I can call 704-569-8654.

_____ _____
Person Served Signature Date

_____ _____
Guardian/Responsible Person Signature Date

_____ _____
Witness Signature Date

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

SECTION II: ASSESSMENT & CASE MANAGEMENTAUTHORIZATION
Case Management Plan/Service Notes/Time- Sheet

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Adult Assessment

Referral Date: _____ **Screening Date:** _____

Intake Category: ☐New Client ☐Returning Client ☐Transfer

General Information:

Name: _____
(Last) (First) (Middle Initial)

DOB: _____ Age: _____ Sex: _____ Race: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Guardian/Next of Kin:

Information provided is for – ☐Guardian ☐Next of Kin

Is the client legally competent? (Check One): ☐ Yes ☐ No ☐Minor

Name: _____
(Last) (First) (M.I)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Legal History:

Past or current legal issues ***(If Yes, please provide details below)*****: ☐Yes ☐No**	**DSS Involvement: ☐Yes ☐No**

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Has family had any previous/past department of social services (DSS) involvement? ___Yes ___No Has the family had any children removed by DSS now or in the past? ___Yes ___No If yes, explain: Does the child (beneficiary) live in foster care? ___Yes ___No If yes, explain (Include reason and date of removal)

Medical:

Medical Diagnosis/Existing Health Problems ***(If Yes, please include all health problems, including surgeries, medical and dental problems)*****: ☐Yes ☐No**

Current Medications ***(If Yes, please include name, dosage and purpose of medication)*****: ☐Yes ☐ No**

Referral Source: _____
(Name) (Title/Position) (Phone)

Reason For Referral/Presenting Problem:

Any current or past medical or legal problems of anyone in the home needing to be documented for safety purposes:
☐Yes ☐ No

THE UNIQUE CARING FOUNDATION

"BUILDING BRIDGES TO THE COMMUNITY"

www.uniquecaringfoundation.com

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Case Management Service Requested:

☐At-Risk Children ☐Adults w/Serious and Persistent Mental Illness ☐At-risk Pregnant Women and Infants ☐Individuals with Psychoactive Substance Disorders

☐Individuals with Intellectual and Related Disabilities ☐Individuals at risk for Genetic Disorders ☐Adults with Functional Impairments

☐Other Services Needed: _____

Referral to another agency to meet the client-presenting need: ☐Yes ☐ No

Agency Name Receiving Referral: _____

Services Recommended: _____

Date and Time of Referral: _____

_____

Unique Caring Foundation
Life and Home Community Assessment

Admission Date:		**Time of Admission:**		
Admitted:	☐Yes ☐No	**Funding/Insurance Type:**		
Consumer's Name:		**Funding/Insurance ID #:**		
Physical Address:		**City:**	**State:**	**Zip:**
Mailing Address:		**City:**	**State:**	**Zip:**
Home Phone #:		**Alternate Phone #:**		
Is the consumer a minor? ☐Yes ☐No		**If Yes, state name and relationship:**		

Type of Contact: ☐Telephone ☐Face to Face ☐After-Hours

Referred by: ☐ Self ☐Family ☐Friend ☐Court ☐School ☐Other:

Priority: ☐ Emergency/1 Hour ☐Urgent/48 Hours ☐Routine/7 Days

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Age: _____ **DOB:** _____ **SS#:** _____ ☐ **Male** ☐ **Female**

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Separated

Primary Language/Mode of Communication: ☐ English ☐ Spanish ☐ TTDY ☐ Other:

Employment Status: ☐ Employed F/T ☐ Employed P/T ☐ Unemployed ☐ Retired ☐ Student ☐ Disabled

☐ Occupation: _____

Parent/Guardian Involved: _____
Did they help with Assessment: Y ____ N _____?
Others that provided information**:** _____

EMERGENCY CONTACT:
Name: _____ Relationship to Beneficiary: _____

Address:
_____
Street City State Zip Code

Home Phone: _____ Cell: _____ Email: _____

MEDIA:
What forms of communication does beneficiary prefer? (Choose as many as you want)
___face to face visits ___telephone calls ___assistive technology (ex., TTY, TDD)
___Computer/email ___texting ___CHAT
___Facebook ___Twitter

Is beneficiary comfortable with someone?
___dropping by to see them ___setting up an appointment before they come

TRANSPORTATION:
What type of transportation does beneficiary use?
___Have own care ___family or friends take me ___bus or public transportation

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

___walk ___bicycle ___Medicaid Van
___Other: _____

Does beneficiary need help with transportation? ___Yes ___No

If beneficiary uses public transportation, how much assistance does beneficiary need?
___Independent ___Need some assistance ___Total supervision
___Unable to use at all Please explain:
_____

What are the beneficiary's needs or wants related to transportation?

Medical History (pregnancy status, nutritional/dietary needs, seizures, previous/current medical conditions, diabetes, heart disease, surgeries):

1-Primary Care Physician: ___Yes ___No
Physician's Name: _____ Phone Number: _____
Address:

If no Primary Care Physician, does beneficiary have a Physician in mind they would like to see? ___Yes ___No

Overall, How does beneficiary rate their physical health? ___Excellent ___Good ___Fair ___Poor

List all Diagnosed Health Problems:

Medical history:	☐None ☐Arthritis ☐Cardio vascular problems ☐Sensory deficits ☐Asthma ☐HIV/AIDS ☐STD ☐Cerebral Palsy ☐Cancer ☐Circulatory problems ☐Liver disease ☐Tuberculosis ☐Diabetes ☐Seizures ☐Headaches ☐Neurological diseases ☐Visual impairment ☐Gastrointestinal problems ☐Fibromyalgia ☐Orthopedic problems ☐Chronic Fatigue Syndrome ☐Hearing impaired ☐disabled ☐recent illness ☐HIV ☐Hep C ☐diabetes ☐pregnant ☐cancer ☐glaucoma ☐heart disease ☐kidney disease ☐liver disease or damage ☐thyroid or goiter trouble ☐epilepsy ☐difficult urinating ☐urinary incontinence ☐blood pressure ☐surgeries ☐Hx of head injury ☐Allergies ☐ Details or Other:

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

List all current Medications:

Medications	Dosage/How often	Reason	Physician

Does Beneficiary have any health problems that require assistance to manage? ___Yes ___No

Does Beneficiary receive care with any health concerns? ___Yes ___No
If yes, explain with name and agency, if applicable:

Does Beneficiary have any specialized medical equipment? ___Yes ___No
Please List:

List any Hospitalizations? When/Where/Why

List any surgeries? When/Where/Why

Is child's immunizations updated? ___Yes ___No ___N/A

Does beneficiary have any known allergies (food, animals, medicine, other)? ___Yes ___No
Please list known allergies/reactions:

Does beneficiary or other family members have a genetic disorder? ___Yes ___No
If yes, please describe:

Does the beneficiary have a history of seizures? ___Yes ___No
If yes, what type of seizures?
Date of Last Seizure?
Medication used for seizures:

VISION:
Does beneficiary have issues with vision? ___Yes ___No

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Vision Tested? ___Yes ___No If yes, last vision test/follow up date: _____
Physician's Name: _____
Results of Vision evaluation:
___No vision problems ___Some impairment, but correct with assistive devices (glasses)
___difficulty seeing close up (far-sighted) ___difficulty seeing far away (near sighted)
___Legally blind

HEARING:
Does beneficiary have issues with hearing: ___Yes ___No?
Hearing Tested? ___Yes ___No If yes, last hearing test/follow up date:
_____
Physician's Name: _____
Result of Hearing Evaluation:

(For the Assessor)
Does the individual have issues with hearing?
___No hearing impairment ___Hearing impairment, but managed through hearing aids
___hearing difficulty at the conversation level ___hears only very loud sounds
___no useful hearing

ORAL HEALTH:
Has beneficiary seen a dentist: ___Yes ___No
Last dental exam: _____ Physician's Name:
_____
List any dental issues or procedures/dates:

SPEECH:
Does beneficiary have issues with speech or communication? ___Yes ___No
___Independent in speech ___Some difficulty in speech, but can be understood
___communicates with sign language, symbol board, written message, gestures or interpreter
___communicates with inappropriate speech, garbled sounds and/or displays echolalia
___no communication

Child:
___tracts movement ___smiles
___babbles ___imitates words/actions of others
___points/gestures ___uses single words/phrases

SENSORY IMPAIRMENT:
Does beneficiary have issues with sensory impairment? (taste, smell, touch, spatial) ___Yes ___No

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

If yes, explain:

Does beneficiary have texture issues with food or touch? ___Yes ___No
If yes, explain:

GROSS/FINE MOTOR IMPAIRMENT:
Does beneficiary have any fine or gross motor skill concerns?
___No impairment ___impaired muscle tone
___upper/lower body weakness ___scoliosis
___hemiplegia (Total or partial paralysis of one side ___paraplegia (paralysis of lower half of the body/both legs)
___quadriplegia (paralysis of both arms and both legs)

Child:
___roll over ___sit independently
___crawl ___pull to stand
___walk

Is there any diagnosis of head or spinal cord injury or other similar disability? ___Yes ___No
If yes, explain including date and diagnosis:

Child:
What age was your child weaned off the bottle?
_____
What age was your child weaned off the pacifier?
_____

NUTRITION/DIET:
How is beneficiary's appetite: ___Good ___Fair ___Poor
Any unexplained weight loss or gain in the last year or so? ___Yes ___No
If yes, explain:

Does beneficiary have any health concerns related to nutrition? ___Yes ___No
If Yes, explain:

Is beneficiary on a special diet? ___Yes ___No
If Yes, please check below:
___low salt ___gluten free ___lactose free/milk ___low calorie
___low fat ___G-Tube ___continuous feed ___bolus
___low sugar ___Other:

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Child:
Does your child have feeding issues? (choking, picky eater) ___Yes ___No
If Yes, explain:

___soft food only ___solid food ___needs assistance with eating ___holds own bottle
___finger feeds independently ___uses fork/spoon

PHYSICAL HEALTH:
1-List beneficiary's strengths and abilities to their physical health?

2-Does beneficiary's health limit their ability to move, work or play in anyway?

(For the Assessor):
Does beneficiary have a history of missing doctor appointments or having to reschedule appointments?
___Yes ___No ___Unsure
If yes, explain including frequency:

3-What does the beneficiary see as the biggest obstacle that prevents them from keeping their medical appointments?

MATERNAL-INFANT DATA: (For women or young women who are child bearing age)
1-Is beneficiary pregnant or could they be pregnant at this time?
___Yes ___No ___Unsure

Pregnancy History:
How many pregnancies: ___
How many births? _____ vaginal deliveries _____ C-Section _____ Multiple births _____

Has beneficiary ever had a (Check as many as apply):
___still birth ___miscarriage ___abortion
Has beneficiary had any family planning education in the past? ___Yes ___No
If no, are they interested in receiving education in this area? ___Yes ___No
Comments:

CURRENT PREGNANCY:
Normal Pregnancy: ___YES ___No
High Risk Pregnancy: ___YES ___NO
Prenatal Care: ___YES ___NO
What month of the pregnancy did beneficiary start prenatal care? _____
Is beneficiary experiencing any of the following:
___Anemia ___Heart Disease ___Gestatational Diabetes

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

___Bleeding ___Tobacco Use ___Premature Labor (wk)
___Elevated Blood Pressure ___Alcohol Use ___Toxemia/Pre-eclampsia
___Vomiting ___Rx Drugs ___Viral Infection
___MD-Ordered Bedrest ___OTC Drugs ___STD
___Other
OB Provider: _____
Delivery Hospital: _____
Type of Delivery:
___Vaginal ___C-Section ___Breech ___Multiple Birth
DOB: _____
Birth Weight: _____ Gestational Age: _____
Prematurity: _____ (WK) _____Birth WT <2500 Grams _____Birth WT <1200 Grams
___Jaundice ___Breathing Problems
___Delayed Crying ___Ventilator - ___Wks.
___Seizures ___Cord around the neck

Post Delivery Concerns? ___Yes ___No
If yes, explain:

Other Children in the home: ___Yes ___No
List names, DOB, and Sex of the other children in the home

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

MENTAL HEALTH AND BEHAVIORAL:

Presenting Problems:

Prior MH/DD/SA History **(Previous Hospitalization/Treatment):**	☐Yes ☐No	
☐State MH/SA Hospital	☐Outpatient	☐VA Hospital
☐Private MH/SA Professional	☐Community Supports	☐Other :
☐Facility Based Crisis	☐Detox	
Please specify the name of facility/agency, year admitted, and length of stay:		

Is Beneficiary currently receiving any mental health services? ___Yes ___No
If yes, explain. With who/where/when last contact:
Does Beneficiary or any family members have any history of psychiatric or behavioral diagnosis or show any mental health concerns? ___Yes ___No If yes, Explain: Is the parent of child (beneficiary) following through with their mental health treatment? ___Yes ___No _____ N/A If yes, explain:

Has beneficiary attempted suicide/thoughts of suicide/plan/intent of suicide? ___YES ___NO
Explain, if yes:

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

History of trauma that needs to be addressed in treatment: ☐ None	
History of adjustment concerns and/or other factors that need to be addressed in treatment: ☐ None	

Has beneficiary experienced any of the following (do not include a direct result of drug or alcohol usage)

Depressive symptoms:	☐None ☐sadness ☐fatigue ☐hopelessness ☐loss of interest ☐increased sleep ☐decreased sleep ☐feelings of worthlessness ☐guilt ☐increased appetite ☐decreased appetite ☐agitation ☐poor concentration ☐crying ☐anger ☐social isolation ☐irritability	Other and/or Details:
Anxiety:	☐None ☐excessive worries ☐restlessness ☐irritability ☐difficulty concentrating ☐muscle tension ☐sleep disturbance ☐nightmares ☐panic attacks ☐separation anxiety ☐soiling ☐hypervigilance ☐phobia ☐compulsions ☐obsessions ☐PTSD symptoms ☐self-soothing behaviors	Other and/or Details:
Somatoform:	☐None ☐ somatic complaints ☐body dysmorphic ☐hypochondriasis ☐conversion: (☐motor ☐sensory ☐seizure ☐convulsion)	Other and/or Details:
Manic behavior:	☐None ☐periods of elevated, expansive, or irritable mood ☐over talkative ☐pressured speech ☐flight of ideas ☐distractibility ☐racing thoughts ☐ decreased need for sleep ☐grandiosity ☐increase in goal directed activity ☐extravagance ☐ mood cycles ☐ high risk behaviors	Other and/or Details:
Psychotic symptoms:	☐None ☐unmanageable ☐inability to care for self ☐memory deficits ☐withdrawn ☐wanders off ☐ paranoia ☐suspiciousness ☐poor personal hygiene ☐does not make sense ☐sleep loss ☐poor judgment ☐forgetfulness ☐confusion ☐auditory hallucinations ☐visual hallucinations ☐delusions ☐disorientation	Other and/or Details:
Antisocial:	☐None ☐frequent lying ☐stealing ☐excessive fighting ☐destroys property ☐fire setting ☐arrests ☐convictions ☐imprisoned ☐sexually inappropriate ☐exhibitionism ☐uses assumed names ☐acts alone in peer group ☐probation ☐parole ☐pending charges	Other and/or Details:

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

	☐physically cruel to animals	

Other agencies currently working with the consumer:	☐Yes ☐No
☐DSS ☐Social Security Admin. ☐Probation ☐Other : ☐Health Department ☐Vocational Rehabilitation	
Information obtained from other collateral sources (please be sure a consent is completed before completing this section):	

ALCOHOL/SUBSTANCE ABUSE:

Substance Use/Abuse:	☐ No (Skip to next page) ☐Yes (complete section below)

	Substance	Onset Age / Duration	Method	Frequency	Amount / Last Use
Primary	☐ Alcohol ☐Crack/Cocaine ☐Heroin ☐Inhalants ☐Barbiturates ☐Non-prescription Methadone ☐Methamphetamine ☐Over the Counter ☐Other Opiates & Synthetics ☐Other Hallucinogen ☐Other Amphetamine ☐Other Tranquilizer ☐Other Sedatives/Hypnotics ☐Benzodiazepine ☐Cannabis ☐PCP ☐Other Stimulates ☐Other:		☐Oral ☐Smoking ☐Inhalation ☐Injection ☐Other ☐Unknown	☐None Past Mo ☐1-3x Past Mo. ☐1-2 Past Week ☐3-6 Past Week ☐Daily ☐Unknown	
Secondary	☐ Alcohol ☐Crack/Cocaine ☐Heroin ☐Inhalants ☐Barbiturates ☐Non-prescription Methadone ☐Methamphetamine ☐Over the Counter ☐Other Opiates & Synthetics ☐Other Hallucinogen ☐Other Amphetamine ☐Other Tranquilizer ☐Other Sedatives/Hypnotics ☐Benzodiazepine ☐Cannabis ☐PCP ☐Other Stimulates ☐Other:		☐Oral ☐Smoking ☐Inhalation ☐Injection ☐Other ☐Unknown	☐None Past Mo ☐1-3x Past Mo. ☐1-2 Past Week ☐3-6 Past Week ☐Daily ☐Unknown	

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Tertiary	☐ Alcohol ☐Crack/Cocaine ☐Heroin ☐Inhalants ☐Barbiturates ☐Non-prescription Methadone ☐Methamphetamine ☐Over the Counter ☐Other Opiates & Synthetics ☐Other Hallucinogen ☐Other Amphetamine ☐Other Tranquilizer ☐Other Sedatives/Hypnotics ☐Benzodiazepine ☐Cannabis ☐PCP ☐Other Stimulates ☐Other:		☐Oral ☐Smoking ☐Inhalation ☐Injection ☐Other ☐Unknown	☐None Past Mo ☐1-3x Past Mo. ☐1-2 Past Week ☐3-6 Past Week ☐Daily ☐Unknown	

Substance abuse / dependency details:	
Outpatient SA treatment history:	
Family problems, job loss, abuse related arrests, other:	
What withdrawal symptoms has she/he had in the past? DTs, blackouts, seizures, other (explain and give details):	
Current withdrawal symptoms: None, vomiting, sweating, agitation, tactile disturbances, visual disturbances, headache, tremors/shakes (please explain and give details):	

1-Has Benificiary evert attended AA, NA, or AL-ANON? ___Yes ___NO
Does beneficiary live with or live close-by someone that has alcohol/prescription drugs/substance abuse concerns?
___YES ___NO
If yes, explain:

2-(For the Assessor)
Does this individual appear to need education related to substance/alcohol abuse? ___YES ___NO
Does the beneficiary appear to be under the influence of a substance/alcohol? ___YES ___NO
If yes, esplain:

THE CAGE AND CAGE-AID QUESTIONNAIRE

1. Have you ever felt you should to cut down on your drinking *or drug abuse*? __Yes __ No
2. Have people annoyed you by criticizing your drinking *or drug use*? __ Yes __ No
3. Have you ever felt bad or guilty about your drinking *or drug use*? __ Yes __ No
4. Have you ever had a drink *or used drugs* first thing in the morning to steady your nerves or get rid of a hangover? __Yes __No

ASAM Criteria

1. Intoxicated/Withdrawal Potential __Low __Medium __High
2. Biomedical Conditions __Low __Medium __High
3. Emotional/Behavioral/Cognitive Changes __Low __Medium __High
4. Readiness to Change __Low __Medium __High
5. Relapse Potential __Low __Medium __High
6. Recovery Environment __Low __Medium __High

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

DSM V and ICD 10 codes

Multi-Axial Assessment:		**Eligible for Services** ☐ **Specify Service:**	
Axis I		**Ineligible for Services** ☐ See below for alternative referrals	
Axis II			
Axis III			
Axis IV			
Axis V	**GAF=**		

Family/Legally Responsible Person/Informal Support Interview:

1-How many people currently live in the home?_____

Name	Relationship	ge	May we contact?	Lives in Home

2-Other members of the family that is important to the beneficiary:

3-Close friends that are important to the beneficiary(List them, indicate where the beneficiary sees their friends and if parents agree with their friends):

4-Is there a dependable neighbor that the beneficiary can call on if needed? __Yes __No

5- What type of housing does beneficiary currently live in?

___public housing ___Own House ___Rent house
___Own mobile home ___Rent mobile home ___Own apartment/condo
___rent apartment ___Other:

6-Does Beneficiary feel safe in the home? ___Yes ___No

7-Are there structural or functional inadequacies in the home?

___inadequate for family size ___inadequate furnishings ___inadequate structure
___infestation ___sanitation problems
___environmental/safety hazards
___inadequate sleeping arrangements ___unaffordable

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

___inadequate provisions for emergency/smoke alarms ___Criminal activity in the surrounding neighborhood

8-Would beneficiary like to move: ___Yes ___No ___Unsure
If yes, what changes would the beneficiary like to make?

9-Does beneficiary have any pets? ___Yes ___No

Family Issues:

Does beneficiary have any of the following stressors:

___illness/death
___parenting issues
___financial difficulties
___divorce
___self-esteem
___single parenting
___isolation
___relationship issues
___legal issues
___change in family composition
___past childhood experiences
___sibling rivalry

If yes, explain:

Within the last year has beneficiary been hit, slapped, kicked or otherwise physically hurt by someone?
___Yes ___No If yes, by whom? Number of times?

Within the last year, has any other family member been hit, slapped, kicked or otherwise physically hurt by someone?
___Yes ___No If yes, by whom? Number of times?

If beneficiary is under the age of 17, is the beneficiary having difficulty with relationships within the family unit?
___Yes ___No
Comments:

EDUCATION:

What is the highest level of education completed by beneficiary?

___Primary School
___Secondary School
___Middle School
___High School
___Special Education
___GED
___Associate Degree
___Bachelor Degree
___Graduate Degree
___PhD
___Some College
___Trade School

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Is beneficiary currently in school? ___Yes ___No
Where?

(Child)
What Grade? ____
If child is not currently in school, explain:

Has the client ever repeated any grade? ☐Yes ☐No

If yes, which grade levels were repeated? _____

Reason/problems that resulted in the client repeating the grade level(s)? _____

_____

_____

What grades has the client been making this school term? _____

Last year? _____

Does the beneficiary have any of the following: ____IFSP ___IEP ___504 Plan ____Behavior Plan
If the client does not have an IEP, 504 plan, PEP, or Behavioral Plan, has there ever been a time when there was consideration for a plan but not approved?
What is the exceptionality of the client's plan (i.e., Learning Disability, Speech & Language, BED, etc.):
Does the beneficiary have an aide assigned to them? ___Yes ___No
Is the beneficiary on target to graduate with their class? ___Yes ___No ___N/A
Is the beneficiary following the school attendance policy? ___Yes ___No
If no, explain:
Does the beneficiary like school? ___Yes ___No
If no, explain:

What behaviors has the client been displaying at school this year? Describe all problems and how the school and/or you have tried to handle these problems.

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Are copies of the paperwork from previous meetings available? If available, arrange to make copies and provide to medical records for inclusion into the client's medical record. ☐Yes ☐No

Additional comments regarding the client and the education history that will assist in providing Precision care and support to meet the client's needs.

Special barriers to learning (check all that apply):

___no intellectual problems
___Has difficulties but is able to function with minimal assistance
___unable to tell time well
___unable to read survival signs or words
___difficulty reading
___problems writing
___limited math skills
___difficulty with reasoning and problem solving
___memory problems
___other-specify:

Is beneficiary interested in furthering their education? ___Yes ___No
Comments:

Does the beneficiary need support in going back to school? ___Yes ___No
If yes, explain what type of assistance is needed:

What are the beneficiary's educational goals?

As a student, what does the beneficiary see as their greatest strength/weaknesses?

(For Assessor)
Is the beneficiary able to: ___Read ___Write ___Sign Name
Comment:

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

EMPLOYMENT AND JOB SEARCH:

Is the beneficiary currently employed? ___Yes ___No
If no, explain:

(Currently not employed)
Is the beneficiary able to work in the community? ___Yes ___No
If no, explain:

Does the beneficiary want to work in the community? ___Yes ___No
If no, explain and describe what job they would be interested in:

What strengths does beneficiary have regarding employment?:

What improvements does the beneficiary need help with?

What areas do beneficiary need assistance with? (check all that apply)

	Yes	No
Finding and applying for employment		
Needs assistance with interviewing for employment		
Showing up to work on time		
Transportation to and from employment		
Being dressed and groomed appropriately for work		
Arriving to work on time		
Following work tasks without distractions		
Understanding and following written directions		
Performing a single work tasks		
Performing 2-step work tasks		
Communicating wants and needs		
Informing employer when they will be absent from work		
Getting along with co-workers		
Being able to positively implement changes in their routine		
Other:		

Employment Status (check as many as apply)
___competitive employment: full time ___competitive employment: part time
___supported employment ___sheltered workshop
___enclave ___volunteer
Employer: _____
Occupation: _____ Job title: _____

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Is beneficiary happy with their current employment? ___Yes ___No
If no, what would the beneficiary like to do? If yes, Why?

Does beneficiary have any other wants related to employment and/or job search not mentioned above?
___Yes ___No

FINANCIAL MANAGEMENT:

Annual household income: _____

Fixed monthly income sources	Fixed monthly income expenses	Monthly savings
Annual Total:	Annual Total:	Annual Total

(i.e., housing, SNAP, WIC, Child support, retirement, pension, disability)
Does beneficiary ever have a money crisis and need assistance? ___Yes ___No
If yes, explain:

ACTIVITIES OF DAILY LIVING (ADL) AND INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL):

Describe the individual's ability to function in the following areas:

ADL or IADL	Do they need assistance?	Type of assistance needed	Source of assistance received
Ambulatory			
Feeding			
Toileting			
Bathing			
Grooming			
Dressing			
Housecleaning			
Laundry			
Shopping			
Medication management			
Money management			

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Use of the phone			
Meal preparation			
Other:			

SOCIAL SKILLS:

Describe average day for beneficiary:

Does the beneficiary attend a daycare setting/private baby sitter? ___Yes ___No
If yes, name of daycare/sitter: _____
Hours/days attend: _____
What would beneficiary like to change about their day?

What does the beneficiary enjoy doing/hobbies?

Are there activities the beneficiary would like to do more often than they are doing now?
___Yes ___No

Does the beneficiary talk to their friends, family or loved ones as often as they would like?
___Yes ___No
If no, why/how often would they like to speak to them?

How does beneficiary contact them (phone, in person etc.)?

How does the beneficiary describe his/her relationship with his/her family?

What does the beneficiary consider to be their strengths related to their social skills?

Does the beneficiary have any wants or needs related to improving social functioning?

SPIRITUALITY:

What is beneficiary's faith or belief?

Does religion play a role in the beneficiary's life: ___Yes ___No ___N/A

What gives the beneficiary life purpose or meaning?

Is beneficiary part of a religious or spiritual community? ___Yes ___No

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

If beneficiary would like to go to church, do they have transportation? ___Yes ___No

Services currently being received			
Provider/Agency	**Services Rendered**	**Location**	**Phone Number**

Overall, what does beneficiary feel they need help with?

RECOMMENDATIONS/GOALS to assist with case management plan:	REFERRALS:

OVERALL IMPRESSION / ASSESSMENT SUMMARY (Include Beneficiary's Level of Readiness & motivation to engage in services)
ALSO INCLUDE: Medical, Educational, Behavioral, Social, Risk of harm; functional status, co-morbidity, recovery, environment, treatment and recovery history, supports, etc.

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

THE UNIQUE CARING FOUNDATION
"BUILDING BRIDGES TO THE COMMUNITY"
www.uniquecaringfoundation.com

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

The Beneficiary must meet all 6 of the South Carolina Medicaid coverage criteria from below to qualify for Targeted Case Management as an Individual with Intellectual and Related Disabilities. Please check each criteria that applies to the Beneficiary:

Individuals with intellectual and related Disabilities	Medicaid eligible individuals with a suspected diagnosis of Intellectual Disability defined as significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental phase prior to age 22 years, or a related disability defined as a severe, chronic condition found to be closely related to Intellectual Disability and meet the six (6) following conditions. Check **each** criteria the applies:

☐ **1.** It is manifested before 22 years of age for Intellectual Disability and related disabilities

☐ **2.** It is likely to continue indefinitely

☐ **3.** It results in substantial functional limitation in 3 or more of the following areas of major life activities: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

☐ **4.** The person's needs require supervision due to impaired judgment, limited capabilities, behavior problems, abusive or assaultive behavior, or because of drug effects/medical monitoring; and

☐ **5.** The person is in need of services directed toward acquiring skills to function as independently as possible or to prevent regression or loss of current optimal functional status

☐ **6.** Specific symptoms or disturbances make the member unable to access behavioral health, medical, educational, social, developmental or other supportive services required.

I agree that the Beneficiary meets Medicaid criteria for Targeted Cased Management for the following targeted group_____ based on the assessment that I completed.

Case Manager Signature:_____ **Date:**_____

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Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

The Beneficiary must meet **ALL** of the South Carolina Medicaid coverage criteria from below to qualify for Targeted Case Management as an Adult With Serious and Persistent Mental Illness. Please check each criteria that applies to the Beneficiary:

Adults with Serious and Persistent Mental Illness	Medicaid eligible adults with serious and persistent mental illness must meet all of the following criteria:

☐ **1.** Medicaid eligible individuals age 21 and older who have a major mental disorder included in the current edition of the Diagnostic and statistical Manual of Mental Disorders classification under schizophrenia disorders, major affective disorders, severe personality disorders, psychotic disorders, and delusional (paranoid) disorders or a diagnosis of a mental disorders and at least on hospitalization within the past 12 months for treatment of a mental disorder

☐ **2.** Specific symptoms or disturbances make the member unable to access behavioral health, medical, educational, social, developmental or other supportive services required

I agree that the Beneficiary meets Medicaid criteria for Targeted Cased Management for the following targeted group_____ based on the assessment that I completed.

Case Manager Signature:_____ Date:_____

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Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

The Beneficiary must have identified **ALL** of the risk factors from below to qualify as an Adult With Functional Impairments for Targeted Case Management. Please check each criteria that applies to the Beneficiary:

Adults with Functional Impairments	Coverage is limited to Medicaid eligible individuals in need of services and who meet all the following criteria: ☐ • Individuals who are 18 years of age or older ☐ • Individuals who lack formal or informal resources to address their mental and physical needs. ☐ • Individuals who have at least **two** functional dependencies or one functional dependency and a cognitive impairment. (The potential effect of social networks is crucial in older adults with high degree of **functional**, **mental** or economic **dependency**. **Dependency** means that people require social, family or institutional support, due to temporary or definitive loss of their abilities). ☐ • Individuals who require TCM assistance to obtain needed services. ☐ • Individuals who are at risk for institutionalization.

I agree that the Beneficiary meets Medicaid criteria for Targeted Cased Management for the following targeted group_____ based on the assessment that I completed.

Case Manager Signature:_____ Date:_____

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www.uniquecaringfoundation.com

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Unique Caring Foundation Service Provided: Targeted Case Management

Use PIE Format (Goal, Intervention, Outcome)

Assessment Purpose	Staff Intervention Include what staff did to assist consumer and how the consumer responded. Indicate progress towards the goal. ***Please indicate where the service took place.**	Total Time for This Goal
	Description of Intervention(s): *Person with who contact occurred and relationship to beneficiary.*	
Type of Contact:		
Face to face ☐	**Effectiveness/Outcome:**	
Over the Phone ☐		
Other ☐ **Explain:**		
Type of Case Management: ⇨		
Target Group: ⇨		
***Please see types below*: #**	**Next Step:**	
Location address of the face to face contact with *Beneficiary/Guardian*:		

***Type of Case Management*:**

1. Assessment 2. Care Planning 3. Referral & Linkage 4. Monitoring & Follow Up

***Target Group*:**

1. Individuals with Intellectual and Related Disabilities 2. Adults with Serious and Persistent Mental Illness 3. Adults with Functional Impairments.

Case Manager Name (Printed):_____Case Manager Signature: _____Date:_____

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

THE UNIQUE CARING FOUNDATION
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www.uniquecaringfoundation.com

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

UNIQUE CARING FOUNDATION- SOUTH CAROLINA TIME SHEET

NAME: _____ Week Ending: _____

Directions: Please be as specific as possible and indicate what you accomplished each day. **ONLY BILLABLE HOURS ARE TO BE NOTED ON TIME SHEET. Remember that travel time is NOT billable time.**

TIME IN/OUT	DATE:_____ CONSUMER NAME & ACTIVITIES:	TIME IN/OUT	DATE:_____ CONSUMER NAME & ACTIVITIES:
	Today's Total Hours:		**Today's Total Hours:**
TIME IN/OUT	**DATE:_____ CONSUMER NAME & ACTIVITIES:**	**TIME IN/OUT**	**DATE:_____ CONSUMER NAME & ACTIVITIES:**
	Today's Total Hours:		**Today's Total Hours:**
TIME IN/OUT	**DATE:_____ CONSUMER NAME & ACTIVITIES:**	**TIME IN/OUT**	**DATE:_____ CONSUMER NAME & ACTIVITIES:**
	Today's Total Hours:		**Miscellaneous:**

TOTAL NUMBER OF HOURS WORKED: _____ **Signature**: _____

- A= Assessment CP= Care Planning RL= Referral & Linkage MFU= Monitoring & Follow-Up
- FF=Face to Face NFF=Non Face to Face Services are billed in 15 min increments

Before submitting timesheets for Targeted Case Management please verify that:

1) An Assessment include an intake packet 2) Case Management Plan include Plan & Progress Notes 3) Case Management Follow-Up include Progress Notes

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

SECTION II: ASSESSMENT & CASE MANAGEMENT AUTHORIZATION

Case Management Plan/Service Notes/Time- Sheet

THE UNIQUE CARING FOUNDATION

"BUILDING BRIDGES TO THE COMMUNITY"

www.uniquecaringfoundation.com

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

CASE MANAGEMENT PLAN

Name:	Name: **Unique Caring Foundation**
DOB:	Site: ☒ South Carolina
Medicaid #:	Date of Plan:
Record #:	

Strengths, natural supports, and/or community supports:
Specific Needs Identified by consumer/family:
Medical or Health History: A brief summary of medical history to include present medication, medical issues, any safety services and supports systems (a safety net).
Contact Information: A list of all emergency contacts.
Family or Social Support: A brief family or psycho social summary of the beneficiary to identify support systems available to aid the beneficiary in achieving goals.

Educational Support:

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

ACTION PLAN

The Action Plan should be based on information and recommendations from: **the Assessment the One Page Profile, Characteristics/Observations/Justifications for Goals, and any other supporting documentation.**

Long Range Outcome: (Ensure that this is an outcome desired by the individual, and not a goal belonging to others).

Where am I now in the process of achieving this outcome? (Include progress on goals over the past years, as applicable).

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: #1		
WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
Goal #1:		
HOW (Support/Intervention) **Targeted Case Management Staff will:**		

Target Date (Not to exceed 12 months)	Date Goal was reviewed	Status Code	Progress toward goal and justification for continuation or discontinuation of goal.
	/ /		

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

/ /	/ /		
/ /	/ /		
Status Codes:	R=Revised	O=Ongoing	A=Achieved D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: #2

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
Goal #2:		

HOW (Support/Intervention)

Targeted Case Manager will:

Target Date (Not to exceed 12 months)	Date Goal was reviewed	Status Codes	Progress toward goal and justification for continuation or discontinuation of goal.
	/ /		
/ /	/ /		
/ /	/ /		
Status Codes:	R=Revised	O=Ongoing	A=Achieved D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THER GOAL:

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Goal #3:		

HOW (Support/Intervention)

Targeted Case Manager will:

Target Date (Not to exceed 12 months)	Date Goal was reviewed	Status Codes	Progress toward goal and justification for continuation or discontinuation of goal.
	/ /		
/ /	/ /		
/ /	/ /		

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THER GOAL:

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
Goal #4:		

HOW (Support/Intervention)

Targeted Case Manager will:

Target Date (Not to exceed 12 months)	Date Goal was reviewed	Status Codes	Progress toward goal and justification for continuation or discontinuation of goal.
	/ /		
/ /	/ /		
/ /	/ /		

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THER GOAL:

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
Goal #5:		

HOW (Support/Intervention)

Targeted Case Manager will:

Target Date (Not to exceed 12 months)	Date Goal was reviewed	Status Codes	Progress toward goal and justification for continuation or discontinuation of goal.
	/ /		
/ /	/ /		
/ /	/ /		

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THER GOAL:

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
Goal #6:		

HOW (Support/Intervention)

Targeted Case Manager will:

Target Date (Not to exceed 12 months)	Date Goal was reviewed	Status Codes	Progress toward goal and justification for continuation or discontinuation of goal.
	/ /		
/ /	/ /		
/ /	/ /		

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Signatures

By signing, I attest that I actively participated in the development of this Plan of Care (POC). Further, I agree to engage in-treatment and updates to this treatment plan as necessary.

Beneficiary Name – print	**Beneficiary Signature**	**Date**
Legal Guardian Name –print	**Legal Guardian Signature**	**Date**

THE UNIQUE CARING FOUNDATION

"BUILDING BRIDGES TO THE COMMUNITY"

www.uniquecaringfoundation.com

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Unique Caring Foundation

Service Provided: Targeted Case Management

Use PIE Format (Goal, Intervention, Outcome)

Case Management Plan Purpose	Staff Intervention Include what staff did to assist consumer and how the consumer responded. Indicate progress towards the goal. ***Please indicate where the service took place.**	Total Time for This Goal
	Description of Intervention(s): *Person with who contact occurred and relationship to beneficiary.*	
Type of Contact:		
Face to face ☐	**Effectiveness/Outcome:**	
Over the Phone ☐		
Other ☐ **Explain:**		
Type of Case Management: ⇨		
Target Group: ⇨		
***Please see types below*: #**	**Next Step:**	
Location address of the face to face contact with *Beneficiary/Guardian*:		

***Type of Case Management*:**

1. Assessment 2. Care Planning 3. Referral & Linkage 4. Monitoring & Follow Up

***Target Group*:**

1. Individuals with Intellectual and Related Disabilities 2. Adults with Serious and Persistent Mental Illness 3. Adults with Functional Impairments.

Case Manager Name (Printed):_____Case Manager Signature: _____Date:_____

UNIQUE CARING FOUNDATION- SOUTH CAROLINA TIME SHEET

THE UNIQUE CARING FOUNDATION

"BUILDING BRIDGES TO THE COMMUNITY"

www.uniquecaringfoundation.com

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

NAME: _____ Week Ending: _____

Directions: Please be as specific as possible and indicate what you accomplished each day. **ONLY BILLABLE HOURS ARE TO BE NOTED ON TIME SHEET. Remember that travel time is NOT billable time.**

TIME IN/OUT	DATE:_____ CONSUMER NAME & ACTIVITIES:	TIME IN/OUT	DATE:_____ CONSUMER NAME & ACTIVITIES:
	Today's Total Hours:		**Today's Total Hours:**
TIME IN/OUT	**DATE:_____ CONSUMER NAME & ACTIVITIES:**	**TIME IN/OUT**	**DATE:_____ CONSUMER NAME & ACTIVITIES:**
	Today's Total Hours:		**Today's Total Hours:**
TIME IN/OUT	**DATE:_____ CONSUMER NAME & ACTIVITIES:**	**TIME IN/OUT**	**DATE:_____ CONSUMER NAME & ACTIVITIES:**
	Today's Total Hours:		**Miscellaneous:**

TOTAL NUMBER OF HOURS WORKED: _____ **Signature**: _____

- A= Assessment CP= Care Planning RL= Referral & Linkage CFU=Monitoring & Follow-Up
- FF=Face to Face NFF=Non Face to Face Services are billed in 15 min increments

Before submitting timesheets for Targeted Case Management please verify that:

1) An Assessment include an intake packet 2) Case Management Plan include Plan & Progress Notes 3) Case Management Follow-Up include Progress Notes

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

SECTION III: DATA COLLECTION

Client Medical, Educational, and Court Paperwork

Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

SECTION IV: PROGRESS NOTES

1st Note Assessment
2nd Note Case Management Plan
3rd Note Records-compiling records
4th Note Referral & Linkage /Follow-Up

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Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

Unique Caring Foundation

Service Provided: Targeted Case Management

Use PIE Format (Goal, Intervention, Outcome)

Purpose/Goal # ___from the Case Management Plan	**Staff Intervention Include what staff did to assist consumer and how the consumer responded. Indicate progress towards the goal.** ***Please indicate where the service took place.**	**Total Time for This Goal**
	Description of Intervention(s): ***Person with who contact occurred and relationship to beneficiary.***	
Type of Contact:		
Face to face ☐	**Effectiveness/Outcome:**	
Over the Phone ☐		
Other ☐ **Explain:**		
Type of Case Management: ⇨		
Target Group: ⇨		
***Please see types below*: #**	**Next Step:**	
Location address of the face to face contact with *Beneficiary/Guardian*:		

***Type of Case Management*:**

1. Assessment **2. Care Planning** **3. Referral & Linkage** **4. Monitoring & Follow Up**

Target Group:

1. Individuals with Intellectual and Related Disabilities **2. Adults with Serious and Persistent Mental Illness** **3. Adults with Functional Impairments.**

Case Manager Name (Printed):_____Case Manager Signature: _____Date:_____

THE UNIQUE CARING FOUNDATION

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Consumer Name: _____ _____ **Record #:** _____ **MID #:** _____

UNIQUE CARING FOUNDATION- SOUTH CAROLINA TIME SHEET

NAME: _____ Week Ending: _____

Directions: Please be as specific as possible and indicate what you accomplished each day. **ONLY BILLABLE HOURS ARE TO BE NOTED ON TIME SHEET. Remember that travel time is NOT billable time.**

TIME IN/OUT	DATE:_____ CONSUMER NAME & ACTIVITIES:	TIME IN/OUT	DATE:_____ CONSUMER NAME & ACTIVITIES:
	Today's Total Hours:		**Today's Total Hours:**
TIME IN/OUT	**DATE:_____ CONSUMER NAME & ACTIVITIES:**	**TIME IN/OUT**	**DATE:_____ CONSUMER NAME & ACTIVITIES:**
	Today's Total Hours:		**Today's Total Hours:**
TIME IN/OUT	**DATE:_____ CONSUMER NAME & ACTIVITIES:**	**TIME IN/OUT**	**DATE:_____ CONSUMER NAME & ACTIVITIES:**
	Today's Total Hours:		**Miscellaneous:**

TOTAL NUMBER OF HOURS WORKED: _____ **Signature**: _____

- A= Assessment CP= Care Planning RL= Referral & Linkage CFU=Monitoring & Follow-Up
- FF=Face to Face NFF=Non Face to Face Services are billed in 15 min increments

Before submitting timesheets for Targeted Case Management please verify that:

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