CARE

Client Assignment and Registration System

CARE-UA-RDM **MH Adult Uniform Assessment for Resiliency and Disease Management** (Action Code 346) Rev. 09/12

Last Name | Client ID

Suffix | Local Case Number

First Name | Component

Middle Name | Location

Assessment Type: Crisis ☐ Intake ☐ Intake Non-Admission ■ Update ☐ Discharge ☐ Referred To _____

Discharge Date ☐☐–☐☐–☐☐☐☐ (MM DD YYYY)

Reason for Discharge _____

Action Type: Add ___ Correct/Modify ___ Delete ___

Section 1: Adult TRAG & Recommended Level of Care

(Completed by LMHA QMHP at Intake or Provider QMHP at Update)

A. Adult-TRAG Dimension Ratings

(Circle one rating for each dimension)

1. Risk of Harm	1	2	3	4	5
2. Support Needs	1	2	3	4	5
3. Psychiatric-Related Hospitalizations	1	2	3	4	5
4. Level of Functioning	1	2	3	4	5
5. Employment	1	2	3	4	5
6. Housing	1	2	3	4	5
7. Co-Occurring Substance Use	1	2	3	4	5
8. Criminal Justice Involvement	1	2	3	4	5
9. Quick Inventory of Depressive Symptomatology (enter in Section 3)					

B. Calculated Level of Care Recommended (LOC-R) ■

C. LOC-D Provider Recommended Deviation ☐

D. TCOOMMI Consumer? ☐

E. Assessment Date ☐☐–☐☐–☐☐☐☐ (MM DD YYYY)

Assessed By: _____ **Credentials**: _____

Notes: _____

Section 2: Authorized Level of Care (LOC-A)

(Completed by LMHA Utilization Management staff)

A. Authorized Level of Care (LOC-A) *(Circle the actual LOC-A)*

0 = Crisis Services
1 = Service Package 1
2 = Service Package 2
3 = Service Package 3
4 = Service Package 4
5 = Transitional Services
6 = Consumer Refuses Services
8 = Waiting for All Authorized Services
9 = Not Eligible for Services

B. Reasons for Deviation from LOC-R

(If LOC-A is different from LOC-R, check appropriate reasons below)

1. Resource Limitations ☐
2. Consumer Choice ☐
3. Consumer Need ☐
4. Continuity of Care per UM Guidelines ☐
5. Other ☐

C. Authorization Date ☐☐–☐☐–☐☐☐☐ (MM DD YYYY)

Subject to Medicaid Fair Hearing ☐

Authorized By: _____ **Credentials**: _____

Notes: _____

Section 3: Diagnosis-Specific Clinical Symptom Rating Scales

(Completed by Provider LVN or QMHP staff)

Choose one algorithm and complete all items for that algorithm.

A. Schizophrenia Algorithm (PSRS & BNSA)

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

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

B. Bipolar Algorithm (BDSS)

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

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

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

QIDS Version (1-2) _____

1 = QIDS-SR (Self-Report)
2 = QIDS-C (Clinician)

D. Assessment Date ☐☐–☐☐–☐☐☐☐ (MM DD YYYY)

E. Extended Review Period Requested *(LOC-A SP 1 Only)* ☐

Assessed By: _____ **Credentials**: _____

Notes: _____

Section 4: Community Data (Completed by Provider QMHP staff)

A. Residence Type (Current) ***(Circle one)***

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

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

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

C. Main Reason for Being Out of the Labor Force

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

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

D. Number of Arrests in Last 30 Days: 0-96, 97 Unknown ☐☐

E. Is there a child under 18 in the household? Y or N

F. Current or Highest Grade Level _____

G. Assessment Date ☐☐–☐☐–☐☐☐☐ (MM DD YYYY)

Notes _____

Form marked as completed by: _____

Field Name	Type	Contents
LAST NAME	R	Individual's last name.
SUFFIX	O	Individual's last name suffix. (e.g., Jr, Sr, II)
FIRST NAME	R	Individual's first name.
MIDDLE NAME	O	Individual's middle name.
CLIENT ID	O	Individual's statewide identification number.
LOCAL CASE NUMBER	R	Individual's local case number.
COMPONENT	R	Component code.
LOCATION	O/R	Location or Unit ID for Component. If a Location ID is entered, the ID must match an ID entered in the Location table in mainframe CARE.
ASSESSMENT TYPE: CRISIS	O/R	Check this box if the purpose of the assessment is to record that the person is receiving crisis services and not enrolled in a service package. **Note:** Crisis is no longer an Intake assessment type.
ASSESSMENT TYPE: INTAKE	O/R	Check this box if the purpose of the assessment is the individual's intake to services.
ASSESSMENT TYPE: INTAKE NON-ADMISSION	----	This option will be automatically entered by WebCARE if the purpose of the assessment is a non-admission due to ineligibility or refusal of services.
ASSESSMENT TYPE: UPDATE	O/R	Check this box if the purpose of the assessment is to update the individual's care.
ASSESSMENT TYPE: DISCHARGE	O/R	Check this box if the purpose of the assessment is the individual's discharge.
REASON FOR DISCHARGE	O/R	If discharge, indicate the code that best describes the discharge reason. (C = Level of Care Services Complete, E = Elected a new provider, J = Incarcerated in Jail or Prison, M = Moved out of Local Service Area, N = Never Returned for Services within Authorized Service Period, not to exceed 6 months, P = Change in NorthSTAR provider, or Z = Other).
DISCHARGE DATE	O/R	If the assessment type is discharge, indicate the date of discharge.
REFERRED TO	O/R	Select where the consumer has been referred to following discharge (1=Private Practitioner, 2=Federally Qualified Health Center [FQHC], 3=Community Indigent Health Clinic, 5=Residential Treatment Placement, 6=Adult Criminal or Juvenile Justice System, 7=Different Center, 8=Nursing Home, 9=No Service, 10=Unknown, 11=Other Public or Charity-based Provider).
ACTION TYPE: ADD	O/R	Check this line to add a new Uniform Assessment for the first time.
ACTION TYPE: CORRECT/MODIFY	O/R	Check this line to correct or modify information that has been previously submitted.
ACTION TYPE: DELETE	O/R	Check this line to delete a previously submitted form that was incorrect.

Section 1: Adult TRAG & Recommended Level of Care – *Completed by LMHA QMHP at Intake or Provider QMHP at Update.*

A. ADULT-TRAG DIMENSION RATINGS 1-8	R	Indicate the individual rating for each of the Adult-TRAG dimensions 1 through 8.
9 QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY	O/R	Enter in Section 3.
B. CALCULATED LEVEL OF CARE RECOMMENDED	D	Indicates the Adult-TRAG Level of Care recommendation (LOC-R), automatically calculated from responses to Section 1, A.
C. LOC-D PROVIDER RECOMMENDED DEVIATION	O/R	Indicates the recommended deviation when different from LOC-R.
D. TCOOMMI CONSUMER?	O	Check this box if the person receives services through a Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) contract.
E. ASSESSMENT DATE	R	Date of the Adult TRAG completion in MMDDYYYY format.
ASSESSED BY	R	Name of the person completing Section 1.

Sections, Continued

Field Name	Type	Contents
CREDENTIALS	R	Highest credentials of the person completing Section 1 (QMHP-CS, RN, LCSW, LMSW-ACP, LMFT, LPC, LPHD-PSY, RN-APN, PA, MD, DO). LVN is *not* approved to complete Section 1.
NOTES	O	Used for provider/authority communication and clinical notes. Limited to 6 lines or less.

Section 2: Authorized Level of Care (LOC-A) – *Completed by LMHA Utilization Management staff.*

A. AUTHORIZED LEVEL OF CARE (LOC-A)	R	Indicate the actual Level of Care Authorized (LOC-A) by your facility for the individual.
B. REASONS FOR DEVIATION FROM LOC-R	O/R	If LOC-A is different from LOC-R, check the box next to every applicable reason for the deviation.
C. AUTHORIZATION DATE	R	The date the LOC-A becomes effective in MMDDYYYY format.
SUBJECT TO MEDICAID FAIR HEARING	O/R	This box should only be checked when the effective date of a level of care has been delayed because the individual is: (1) Medicaid eligible, (2) the new level of care authorized will result in a reduction in either rehabilitative services or case management services, and (3) the individual is within the 10 to 14-day notification period specified by the Medicaid Fair Hearing requirements.
AUTHORIZED BY	R	Name of the person authorizing the LOC-A.
CREDENTIALS	R	Highest credentials of the person completing Section 2 (QMHP-CS, RN, LCSW, LMSW-ACP, LMFT, LPC, LPHD-PSY, RN-APN, PA, MD, DO). LVN is *not* approved to complete Section 2.
NOTES	O	Used for provider/authority communication and clinical notes. Limited to 6 lines or less.

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

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

A. SCHIZOPHRENIA ALGORITHM	O/R	Total Positive Symptom Rating Scale (PSRS) and the Total Brief Negative Symptom Assessment (BNSA).
B. BIPOLAR ALGORITHM	O/R	Total Brief Bipolar Disorder Symptom Scale (BDSS).
C. MAJOR DEPRESSION ALGORITHM	O/R	Total Quick Inventory of Depressive Symptomatology (QIDS) and the QIDS version.
D. ASSESSMENT DATE	R	Date of the rating scales assessment completion in MMDDYYYY format.
E. EXTENDED REVIEW PERIOD REQUESTED	O/R	Used for Update assessments only. This field is completed for the small number of highly stable ongoing consumers in Service Package 1 who are not scheduled to see a provider for another 180 days. You *cannot* complete this field for consumers receiving their first Uniform Assessment at Intake. Choices are Y, A (Annual), N, or blank.
ASSESSED BY	R	Name of the person completing Section 3.
CREDENTIALS	R	Highest credentials of the person completing Section 3 (QMHP-CS, RN, LCSW, LMSW-ACP, LMFT, LPC, LPHD-PSY, RN-APN, PA, MD, DO, LVN).
NOTES	O	Used for provider/authority communication and clinical notes. Limited to 6 lines or less.

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

A. RESIDENCE TYPE (CURRENT)	R	Individual's current type of residence. If **4** (Homeless), the following applies: **Literally Homeless**: Those who are actually without shelter, except for emergency shelter provided by such organizations as the Salvation Army. Literally homeless people are most frequently found in shelters or on the streets. **Marginally Homeless**: Those who are at imminent risk of becoming homeless. A marginally homeless person is in a temporary living situation that is unstable or is about to be terminated, causing the person to be literally homeless.
B. PAID EMPLOYMENT TYPE (CURRENT)	R	Individual's current employment status.

Sections, Continued

Field Name	Type	Contents
C. Main Reason for Being Out of the Labor Force	O/R	Main reason that the person is not in the labor force. Required if Section B is 4=Not in the labor force.
D. Number of Arrests in last 30 days	R	Values are 0-96, 97=Unknown
E. Is There a child Under 18 in Household	R	**Y** or **N**
F. Current or Highest Grade Level	R	00 no years in schooling, 01 grade 1, 02 grade 2, 03 grade 3, 04 grade 4, 05 grade 5, 06 grade 6, 07 grade 7, 08 grade 8, 09 grade 9, 10 grade 10, 11 grade 11, 12 grade 12 or GED, 13 nursery school, pre-school including head start, 14 kindergarten, 15 self contained special education, 16 vocational, 17 college undergraduate freshman, 18 college undergraduate sophomore, 19 college undergraduate junior, 20 college undergraduate senior, 21 graduate or professional school, 97 unknown and 99 not collected.
G. Assessment Date	R	Date the community data was collected in MMDDYYYY format.
Notes	O	Used for the name and credentials of the staff responsible for completion of this section or for provider/authority communication. Limited to 6 lines or less.
Form Marked as Completed by:	R	Signature of the person indicating the form is complete (“Complete” or “Provider Complete”).