MOBILE RESPONSE AND STABILIZATION SERVICES | DISCHARGE FORM

MRSS ID for this client _____

PROVIDER INFORMATION

MRSS Provider Agency: _____

Name of the **DATA ENTRY** Staff Member (first and last name): _____

TYPE OF SERVICE

Please select the service outcome of the referral you are entering.

- ☐ **3 DAYS OR LESS** Intervention Services
- ☐ **4 DAYS OR MORE** Stabilization Services (You provided services to stabilize the situation beyond the initial crisis)

From the perspective of the staff, which issues were addressed with the family during their involvement with your MRSS program? (**Select all that apply**)

- ☐ Suicide-related thoughts or actions
- ☐ Substance use, abuse, and drug dependency behaviors (caregiver)
- ☐ Substance use, abuse, and drug dependency behaviors (youth)
- ☐ Self-injury
- ☐ Learning disabilities
- ☐ Depression
- ☐ Eating disorders (including anorexia, bulimia)
- ☐ Conduct/delinquency-related behaviors
- ☐ Sleeping problems
- ☐ Hyperactive and attention-related behaviors
- ☐ Current home unable to meet young adult's needs
- ☐ Anxiety
- ☐ Maltreatment (child abuse and neglect)
- ☐ Adjustment-related issues
- ☐ Behavioral concerns
- ☐ Trauma
- ☐ Parenting Skills
- ☐ Persistent noncompliance (when directed by caregivers/adults)
- ☐ School/Educational performance
- ☐ Attachment problems
- ☐ Intellectual and developmental disabilities
- ☐ Running away
- ☐ Psychosis
- ☐ Behavior consistent with Autism/ASD
- ☐ High family stress levels
- ☐ Foster care placement
- ☐ Lack of family resources
- ☐ Guardian/caregiver exhaustion
- ☐ Guardian/caregiver mental health issue needs
- ☐ Other concerns/issues that are related to child/youth's health
- ☐ Other concerns/issues that are related to child/youth's health _____

FREQUENCY OF CONTACT

Date of last face-to-face service provided _____

How long was the family engaged in MRSS Service ☐ 3 Days or Less ☐ 4 Days to 42 Days ☐ 43 days or more

How many times did you see the child/young adult and/or parent/caregiver(s) face-to-face in the community? _____

How many times did you see the child/young adult and/or parent/caregiver(s) face-to-face at the providers office? _____

How many times did you see the child/young adult and/or parent/caregiver(s) using telehealth (Zoom, Skype, etc. **NOT TELEPHONE CONTACT**) _____

MRSS ESSENTIAL SERVICES

Was the initial crisis assessment and safety plan done at the first face-to-face contact with the child/young adult and/or parent/caregiver(s)? ☐ Yes ☐ No

Was the Ohio Brief CANS and individualized crisis plan with an updated safety plan completed prior to stabilization?
☐ Yes ☐ No

Did the child/young adult receive Youth Peer Support Services? ☐ Yes ☐ No

If No, If Youth Peer Support Services were not received, please indicate the reason why:
- ☐ Youth Peer Support not available
- ☐ Youth/Young Adult declined the service
- ☐ Other _____

Did the parents and/or caregivers receive Adult Caregiver Peer Support Services? ☐ Yes ☐ No

If No, Please indicate the reason why the parents and/or caregivers did not receive Peer Support Services
- ☐ Adult Parent/Caregiver Peer Support not available
- ☐ Adult Parent/Caregiver declined the service
- ☐ Other _____

The child/young adult and/or parent/caregiver(s) received the following services during MRSS Engagement (**Select All That Apply**)

- ☐ Initial crisis assessment and safety planning
- ☐ Ongoing re-assessment and planning
- ☐ Skill building
- ☐ Care coordination
- ☐ Ohio Brief CANS
- ☐ Crisis de-escalation, avert future crisis
- ☐ Coaching, mentoring, peer support
- ☐ Linkages to professional services and natural supports
- ☐ Crisis planning
- ☐ Short-term counseling

Was the family referred to high-fidelity wraparound or service coordination? ☐ Yes ☐ No

LINKAGES TO PROFESSIONAL SERVICES AND NATURAL SUPPORTS

Were services initiated **PRIOR** to the MRSS closure (Please indicate the services and supports to which you referred the family and/or child/young adult) (**Select All that Apply**)

- ☐ Substance Abuse Treatment
- ☐ Residential Treatment/Crisis Stabilization Unit
- ☐ Youth Support Group
- ☐ Young Adult Peer Support
- ☐ Job & Family Service Income Support/Financial Services
- ☐ Transportation
- ☐ Youth Mentoring
- ☐ Parent Support Group
- ☐ Parent Peer Support
- ☐ Mental Health Therapy
- ☐ Medication Management
- ☐ Primary Care Physician/Physical Health Care Provider
- ☐ Positive Recreation/Pro-social Activities
- ☐ Parenting Classes/Coaching
- ☐ Skill Development Group/Training
- ☐ Case Management
- ☐ Adult Recovery Peer
- ☐ Housing/Clothing/Food Support
- ☐ Respite Care
- ☐ Faith-based Supports
- ☐ Natural Supports
- ☐ Intellectual and developmental disabilities
- ☐ Self-care activities
- ☐ Veterans' Benefits
- ☐ Employment Supports
- ☐ Education Advocate
- ☐ Transition to Independence Program
- ☐ IHBT
- ☐ Alternative School
- ☐ Equestrian
- ☐ Kinship Navigator
- ☐ Other, please specify _____

LINKAGES TO PROFESSIONAL SERVICES AND NATURAL SUPPORTS cont.

Which services were referred prior to MRSS closure, but services **WERE NOT** initiated? (**Select All That Apply**)

- ☐ Substance Abuse Treatment
- ☐ Residential Treatment/Crisis Stabilization Unit
- ☐ Youth Support Group
- ☐ Young Adult Peer Support
- ☐ Job & Family Service Income Support/Financial Services
- ☐ Transportation
- ☐ Youth Mentoring
- ☐ Parent Support Group
- ☐ Parent Peer Support
- ☐ Mental Health Therapy
- ☐ Medication Management
- ☐ Primary Care Physician/Physical Health Care Provider
- ☐ Positive Recreation/Pro-social Activities
- ☐ Parenting Classes/Coaching
- ☐ Skill Development Group/Training
- ☐ Case Management
- ☐ Adult Recovery Peer
- ☐ Housing/Clothing/Food Support
- ☐ Respite Care
- ☐ Faith-based Supports
- ☐ Natural Supports
- ☐ Intellectual and developmental disabilities
- ☐ Self-care activities
- ☐ Veterans' Benefits
- ☐ Employment Supports
- ☐ Education Advocate
- ☐ Transition to Independence Program
- ☐ IHBT
- ☐ Alternative School
- ☐ Equestrian
- ☐ Kinship Navigator
- ☐ Other, please specify _____

Which services where needed by the family, but where **NOT** available in the community (**Select All That Apply**)

- ☐ Substance Abuse Treatment
- ☐ Residential Treatment/Crisis Stabilization Unit
- ☐ Youth Support Group
- ☐ Young Adult Peer Support
- ☐ Job & Family Service Income Support/Financial Services
- ☐ Transportation
- ☐ Youth Mentoring
- ☐ Parent Support Group
- ☐ Parent Peer Support
- ☐ Mental Health Therapy
- ☐ Medication Management
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- ☐ Transition to Independence Program
- ☐ IHBT
- ☐ Alternative School
- ☐ Equestrian
- ☐ Kinship Navigator
- ☐ Other, please specify _____