MOBILE RESPONSE AND STABILIZATION SERVICES | INTAKE FORM

MRSS ID for this client _____

PROVIDER INFORMATION

MRSS Provider: _____

Name of the **DATA ENTRY** STAFF MEMBER (first and last name): _____

INITIAL MRSS CONTACT

Date of the **current referra**l to the MRSS program: _____

Time of Referral Call: _____ am pm

Was the initial MRSS contact, after referral call, a face-to-face visit in the community with the child/young adult and/or parent/caregiver(s)? ○ Yes ○ No

What date was this child/young adult and/or parent/caregiver(s) first served **face-to-face in the community** by your MRSS staff for the current referral? _____

What was the time the initial face-to-face contact started? _____ am pm

Has this child/young adult been served face-to-face by your MRSS program **within the past 12 months**? ○ Yes ○ No

Who made the call to the Provider?

- ○ County Hotline
- ○ Call Center
- ○ Emergency Room/Hospital
- ○ Youth/Young Adult
- ○ Parent/Caregiver
- ○ Other Family Member
- ○ Mental Health or Substance Use Provider
- ○ School Staff
- ○ Child Welfare/Child Protective Services
- ○ Court Staff
- ○ Wraparound/ Service Coordination
- ○ Law Enforcement
- ○ Intellectual and Developmental Disabilities Provider
- ○ EMT or Emergency Responder
- ○ Peer Supporter
- ○ Respite/ Short-term Unit
- ○ Unknown
- ○ Other crisis line (Runaway, suicide prevention line, etc.)
- ○ Other, please specify _____

Please select the triage recommendation based on established criteria of the referral (**Designated by the Call Center if that was the referral; Designated by the Provider if any other method**)

- ○ Non-Immediate (**Scheduled at client request, typically within 24 Hours**)
- ○ Immediate (**Response typically within 60 minutes**)
- ○ Emergency (911 Call w/ MRSS Follow-up – this includes individuals who were taken directly to the hospital or JDC due to safety concerns)

After the referral was received, how long did it take for your MRSS team to start the initial **face-to-face contact in the community** with the child/young adult and/or parent/caregiver(s)?

○ 60 Minutes or Less ○ 8 Hours or Less ○ 9-24 Hours ○ More than 24 Hours ○ Could not make contact

Date of initial face-to-face contact: _____

Time of initial face-to-face contact: _____ am pm

INITIAL MRSS CONTACT cont.

For referrals requiring **immediate** response: If greater than 60 minutess, what were the contributing factors?

- ○ Family Request
- ○ No Staffing on Nights and Weekends
- ○ All staff on other calls
- ○ Weather related issues
- ○ Distance-related Issues
- ○ Traffic/ Road work
- ○ Other Please specify: _____

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

- ○ No further action/or not able to reach the family to follow up on referral (Use if you never talked to the family about services) **No face-to-face** service provided
- ○ Referred to MRSS but declined (Use if you spoke with the family and they did not want services) No service provided
- ○ **3 DAYS OR LESS** Intervention Services
- ○ **4 DAYS OR MORE** Stabilization Services (You provided services to stabilize the situation beyond the initial crisis response)

CLIENT INFORMATION

What is the child/young adults date of birth? _____

What is the child/young adults age at the time of the referral? _____

The referral's county of residence _____

What is the child/young adults primary clinical diagnosis? *(Diagnosis made by MRSS therapist that is driving or primarily contributing to the involvement of MRSS)* _____

What is the child/young adults secondary clinical diagnosis? (leave blank if none given by MRSS therapist) _____

During the past 6 months, was the child/young adult insured through...

- ○ Medicaid
- ○ Private Health Insurance
- ○ Unisured
- ○ Unknown

What is the child/young adults gender?

- ○ Male
- ○ Transgender
- ○ Female
- ○ Non-binary
- ○ Self-identified, please specify _____

Is the child/young adult Hispanic or Latino?

- ○ Yes
- ○ No
- ○ Unknown

If yes, please specify which ethnic group the child/young adult belongs.

- ○ Central American
- ○ Cuban
- ○ Dominican
- ○ Mexican
- ○ Puerto Rican
- ○ South American
- ○ Other Hispanic or Latino ethnic group, please specify _____

What race is the child/young adult? (select all that apply)

- ○ African American/Black
- ○ American Indian
- ○ Middle Eastern, Arab, or North African
- ○ White
- ○ Alaska Native
- ○ Asian
- ○ Native Hawaiian/Pacific Islander
- ○ Other race not listed above _____

CLIENT INFORMATION cont.

Is this child/young adult in foster care/custody of Job & Family Services?

○ Yes ○ No ○ Unknown

With which of the following agencies/systems is the child/young adult involved, at time of intake (**Select All That Apply**)

- ○ Wraparound/Service Coordination/ Family Children First Coordinator
- ○ Child Welfare/Child Protective Services
- ○ Mental Health/ Substance Use Agency/Clinic/Provider
- ○ Family Court (i.e. Domestic Rel. Ct, AND unit at Juv. Court)
- ○ Physical Health Care Agency/ Clinic/ Provider due to chronic health issues
- ○ Juvenile Court (Unruly/Delinquency /Diversion) /Probation
- ○ None of the above
- ○ Other, please specify _____
- ○ Intellectual and Developmental Disabilities Provider (Bd. Of DD eligible)
- ○ Law enforcement
- ○ Alternative Educational Setting (including online/home schooled, day treatment, PH, etc.)
- ○ IEP/Special education
- ○ Early Intervention (i.e. Help Me Grow, Early Headstart, Every Child Succeeds)
- ○ Kinship Navigator

Family Satisfaction Interview

Did the family sign the OhioMHAS 'Consent to Contact' form?

○ Yes ○ No

If No, If the family refused to sign the consent to contact, what was the reason?

- ○ Privacy concerns
- ○ Time concerns
- ○ No specific reason was given
- ○ Not interested
- ○ Client only received mobile crisis
- ○ Age of child (under age 5 years)

Only complete these questions if the family signed the consent to contact form:
Please enter the following information for your client and their primary caregiver. This information will only be used by OhioMHAS evaluators to contact the family or young adult about the MRSS services.

MRSS Provider's Name(s): _____

Child/Young Adult Full Name: _____

Primary Parent/Caregiver Full Name: _____

Primary Parent/Caregiver Primary Phone Number: _____

Primary Parent/Caregiver E-mail Address: _____

Home Address For Gift Card: _____