Q1. The referral's county of residence: ____________________________________________

Q2. MRSS provider agency: ______________________________________________________

Q3. Date of the current referral to the MRSS program: ____________________________

Q4. Name of the data entry staff member OR the person to whom questions about data entry should be directed (first and last name):
__________________________________________________________________________

Q5. Who made the call to the hotline/agency?

__ Parent/Caregiver __ Other Mobile Crisis Provider
__ Youth/Young Adult __ Mental Health or Substance Use Provider
__ Other Family Member __ Child Welfare/Child Protective Services
__ School Staff __ Wraparound/ Service Coordination
__ Court Staff __ Intellectual Disabilities Provider
__ Law Enforcement __ Peer Support
__ EMT or Emergency Responder __ Unknown
__ Emergency Room/Hospital __ Other, please specify ____________________________

Q6. Did the referral come from via your county's mental health crisis hotline?

__ Yes __ No __ Other, please specify _________________________________________

Q7. Has this youth/young adult been served (face to face contact) by your MRSS program within the past 12 months and currently no open case with MRSS?

__ Yes __ No

Q8. Please select the triage decision.

__ Non-Immediate (Scheduled at client request, not within 60 minutes)
__ Immediate (Response 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 and who were subsequently referred to MRSS)

Q9. How long did it take for your MRSS team to make contact with the client/family? (After the referral was received, the length of time for face to face contact)

__ 1 hour or less __ More than one week
__ Greater than 1 hour up to one day __ Was not able to make contact with Client/Family
__ Two to four days __ Family declined MRSS service
__ Five days to one week

Q10. For referrals requiring immediate response: If response time was greater than one hour, what were the contributing factors?
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Q11. Please select the resulting action implemented from the initial MRSS call or referral.

___ 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 SERVICE PROVIDED – If selected, none of the following questions (Q12 and beyond) need to answered.

___ Referred to MRSS but declined (Use if you spoke with the family and they did not want services) NO SERVICE PROVIDED – If selected, go to question 12.

___ 72 hour or less stabilization (Crisis intervention provided but not full MRSS – you went out at least once and provided services during that visit, but the family didn’t want to ongoing stabilization services)

___ 72 hour or less stabilization (Crisis intervention provided but not full MRSS - Stabilization services not offered due to inadequate program capacity)

___ 72 hour or less stabilization (Crisis intervention provided but not full MRSS – you went out at least once and provided services during that visit, but the family already receives intensive home based services, e.g. IHBT)

___ 4 to 6 Week Stabilization (MRSS) (You provided services to stabilize the situation beyond the initial crisis response)

Q12. Answer this question only if “Referred to MRSS but declined” is selected. Once answered, none of the following questions (Q13 and beyond) need to answered.

If the client refused MRSS, what was the reason?

___ No further contact made

___ Too time intensive

___ Not interested

___ No reason was given

___ Doesn’t think they need help

___ Other reason not listed: __________________________________________

Q13. At what location did the MRSS Team meet with the client and/or family for the initial response?

___ Family Home

___ Juvenile Detention Center

___ School

___ Juvenile Court

___ Hospital ER

___ Residential Treatment Center

___ Mental Health/SUD Provider Agency

___ No meeting occurred

___ Police Department

___ Other location, please specify: __________________________________

Q14. Please enter the Consumer ID for this client ______________________________

Q15. What date was this client first served (face to face) by your provider agency for MRSS (The current referral)? ______________________________

Q16. What is the client’s gender?

___ Male

___ Transgender

___ Female

___ Self-identified, please specify __________________________________________

Q17. Is the client/young adult Hispanic or Latino?

___ Yes

___ No

___ Unknown

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

___ Central American

___ Dominican

___ Puerto Rican

___ Cuban

___ Mexican

___ South American

___ Other Hispanic or Latino ethnic group, please specify __________________________
Q18. What race is the client? (select all that apply)

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

Q19. What is the client's date of birth?

Q21. Is this child in foster care/custody of Job & Family Services?

- Yes
- No
- Unknown

Q22. If the primary language spoken in the home is not English, what is the other primary language spoken by the family in the home?

- Spanish
- American Sign Language (ASL)
- Korean
- Arabic
- Chinese
- Vietnamese
- Other language not listed above, please specify

Q23. From the youth and/or family perspective, what led them being referred to your MRSS program? (Be specific)

_____________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________

Q24. With which of the following agencies/systems is the child/young adult involved? (select all that apply)

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

Q25. During the past 6 months, was the child/young adult insured through...(select all that apply)

- Medicaid
- Private health Insurance (Not Medicaid)
- CHIP
- Uninsured
- SSI
- Other form of insurance, please specify
Q26. What is the client’s primary clinical diagnosis? (Diagnosis made by MRSS therapist that is driving or primarily contributing to the involvement of MRSS)

_____________________________________________________________________________________________________________________

Q27. What is the client’s secondary clinical diagnosis? (IF APPLICABLE – LEAVE BLANK IF NONE GIVEN BY MRSS THERAPIST)

_____________________________________________________________________________________________________________________

Q28. What is the client’s tertiary clinical diagnosis? (IF APPLICABLE – LEAVE BLANK IF NONE GIVEN BY MRSS THERAPIST)

_____________________________________________________________________________________________________________________

Q29. Did the client and/or caregiver sign the Evaluation ‘Consent to Contact’ form? *(ONLY ASKED IF 4-6 Week MRSS CASE)

___ Yes  ___ No

If No,

Q29. If the client refused to sign the consent to contact, what was the reason?

___ Privacy concerns  ___ Not interested

___ Time concerns  ___ Client only received mobile crisis

___ No specific reason was given  ___ Age of child (under age 5 years)

Once answered, none of the following questions (Q30 and beyond) need to be answered: Only complete Q30 through Q33 if the young adult or caregiver signed the consent to contact form:

Q30. 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 Evaluation and schedule their interview.

Client’s MRSS Provider’s Name(s): ________________________________________________________________

Client’s Full Name: __________________________________________________________________________

Primary Parent/Caregiver Full Name: __________________________________________________________________________

Client and/or Caregiver Home Address: __________________________________________________________________________

Parent/Caregiver Primary Phone Number: __________________________________________________________________________

Client’s Primary Phone Number (if applicable): __________________________________________________________________________

Client’s E-mail Address (if applicable): __________________________________________________________________________