# North Carolina Department of Health and Human Services

Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

**Division of Mental Health, Developmental Disabilities and Substance Abuse Services**
3001 Mail Service Center
Raleigh, North Carolina 27699-3001
Tel 919-733-7011• Fax 919-508-0951
Michael Moseley, Director

**Division of Medical Assistance**
2501 Mail Service Center
Raleigh, North Carolina 27699-2501
Tel 919-857-4011• Fax 919-733-6608
L. Allen Dobson, Jr. MD, Assistant Secretary for Health Policy and Medical Assistance

August 10, 2006

**MEMORANDUM**

TO: Legislative Oversight Committee
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
MH/DD/SAS Professional and Stakeholder Organizations

FROM: Allen Dobson, MD LAD mb

Mike Moseley

SUBJECT: Enhanced Services Implementation Update # 14: Uniform Screening and Registration

As we've worked to transform our public mental health, developmental disabilities, and substance abuse services system, one of the goals that we have tried to achieve is increased consumer choice. Consistent with that goal, we have designed an access system based upon the principle of "no wrong door." Individuals may enter the system by calling or visiting the LME's Access unit or they may choose to initiate services through direct contact with a provider agency. Under either scenario, we must ensure that the person receives the same standardized screening to assess their need for services, thus complying with the legislative requirement to have a "uniform portal." In order for LMEs to fulfill their responsibilities as managers of the local system, there is also a need for the LME to receive timely notice that a consumer has entered into service through direct contact with a service provider. We have developed a standardized screening interview and registration document that will be used to achieve both of these objectives.

The attached two-page screening interview form has been thoroughly reviewed by the Office of the Attorney General to ensure that it is in compliance with all HIPAA and 42 CFR, Part 2 confidentiality requirements. The language in the attached instructions speaks to this specifically.

Effective September 1, 2006, this standardized screening form must be used by all LMEs and all providers of enhanced benefits to screen individuals for the appropriate level of service. [Note: as used in this correspondence, the term "providers of enhanced benefits" applies to providers enrolled as Community Intervention Services providers (except those only enrolled in the Early Intervention Program), CAP-MR/DD providers and children's residential services providers.] The form is to be used whether the person seeking services makes contact in person or by telephone and when an intermediary makes contact on behalf of an

individual. In addition, the form will be used by all providers of enhanced benefits to register consumers with the LME when the consumer initiates services directly with the provider. This form is only to be used with consumers who have not previously received services through the public system or for consumers seeking to reinstate services after a lapse in service of 60 days or more.

In cases where a Medicaid-eligible consumer contacts an enhanced benefit provider directly without going through the LME screening process, the provider must complete the registration fields of this form and submit it electronically to the LME within five business days of initiating services to the consumer. This will inform the LME that the consumer is receiving services and alert the LME to expect to receive a Person Centered Plan on the consumer in the future, and permit the LME to submit the Client Data Warehouse (CDW) data required by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

LMEs and providers may not make changes or additions to this form. It must be a standardized, consistent statewide document. It is our intent to "field test" this form for at least six months. During that period, LMEs or providers wishing to suggest additions, deletions, or modifications may submit their suggestions to contactdmh@ncmail.net. At the end of the "field test" it is our intent to finalize the form and convert it to a web-based form in order to expedite submission by the provider and eliminate duplicate data entry on the part of LMEs.

Prior Authorization for Diagnostic Assessment and Community Support

As we have indicated in multiple training events, the initial Diagnostic Assessment and the first 30 days of Community Support do not require a prior authorization for Medicaid eligible consumers. This lack of prior authorization was designed intentionally to allow the consumer to quickly access services and begin receiving treatment while the PCP is being developed. Community Support following the first 30 days and beyond does require prior authorization by ValueOptions, based upon the completed, signed PCP. Although this has been our consistent position, we have heard from public providers who are subject to the requirements of the Sarbanes-Oxley Act of 2002 that they need documentation of the policy in a signed communication to fulfill the requirements of that Act. This update accomplishes that purpose.

If you have any questions concerning these matters, please email contactdmh@ncmail.net.

cc: Secretary Carmen Hooker Odom
Allyn Guffey
Dan Stewart
DMH/DD/SAS Executive Leadership Team
William Lawrence, MD
Tara Larson
Carol Robertson
Angela Floyd
Lynette Tolson
Kaye Holder
Wayne Williams

# ✦✦✦ Standardized Consumer STR Interview and Registration Form ✦✦✦

*First Name, M.I., and Last Name of Consumer* — *MM DD YYYY* — *Complete as indicated by LME, or may be assigned by LME upon receipt.*

**A. Consumer Name ®** **B. Consumer DOB ®** **C. LME Name ®** **D. LME Facility Code ®** **E. LME Consumer Record No. ®**

*Complete All Applicable Provider Identification Numbers.*

**F. Name of Provider Agency or LME Completing Form ®** **G. Medicaid Provider Enrollment No. ®** **H. IPRS Attending Provider No. ®** **I. National Provider Identifier (NPI) No. ®** **J. Provider Consumer Record No. ®**

**Instructions: The Consumer STR Interview and Registration Form is required to be completed by all LMEs operating or contracting for STR, and by all Enhanced Benefits Service providers.**

- STR Interview items (1 - 48) are required to be completed by all facilities performing STR. STR is appropriate only for all new applicants for services, or for inactive consumers seeking services in a new episode of care (minimum of no billable services within prior 60 days). STR is required to be conducted by a Qualified Professional (QP) as defined by NC Administrative Code.
- STR is designed as a brief inquiry, not an in-depth assessment, to determine need and to facilitate access to a more intensive clinical service by a provider.
- STR is intended to identify the nature of a presenting mh/dd/sas problem, recommend a Triage Severity of Need Determination, and facilitate referral to a provider of choice or other resource.
- STR is to be conducted as efficiently and effectively as possible, within the Screening method and time available, while imposing a minimum burden on the consumer or other requestor.
- Upon Determination of a Triage Severity of Need, prompt consumer referral to a provider of choice or other resource should be facilitated, with no delay in referral for services based on missing data.
- Registration items (1 & 49 - 55) are designated by "®", and are required to be completed for all new or previously inactive consumers initiating an Enhanced Benefits Service.
- This form is required to be submitted to the LME within five business days of Screening or service initiation, per Division guidelines and HIPAA, 42 CFR, Part 2, and G.S. 122C regulations. Any electronic transmittal is required to conform to HIPAA standards for electronic health care transactions, and conform to a uniform format specified by the Division, including required encryption for secure transmission of data. For further reference, see current DMHDDSAS CDW Reporting Requirements and CDW Data Dictionary at http://www.dhhs.state.nc.us/mhddsas/manuals/index.htm.

**1. ® Entry Type:** *(✓ One)* ☐ STR Only *(Items A-J & 1–48)* ☐ Registration Only *(Items A-J & 1 & 49–55)* ☐ STR & Registration *(Items A-J & 1–55)*

**2. Date of Consumer Screening:** ☐☐/☐☐/☐☐☐☐ *(MM/DD/YYYY)*

**3. Consumer Co. of Residence:** ☐☐☐☐☐☐☐☐☐☐☐☐ or ☐☐☐
*(Enter county name or county code from CDW Data Dictionary.)* *Co. Code*

**4. Is consumer currently enrolled in Medicaid?** *(✓ One)* ☐ Yes ☐ No

**5. Screening Referral Source of consumer:** _____ or ☐☐
*(Enter referral source name or source code from attached instructions.)* *Code*

**6. Time Screening Began:** ☐☐:☐☐ *(Enter 24 Hr. Military Time) HH MM*

**7. Time Screening Ended:** ☐☐:☐☐ *(Enter 24 Hr. Military Time) HH MM*

**8. Screening Method:** *(✓ One)* ☐ Face-to-Face ☐ Telephone

**9. Name of Person Initiating Request for Services and Relationship to Consumer:**
(May be the consumer)_____

**10. Phone # of Person Initiating Request:** ☐☐☐-☐☐☐-☐☐☐☐

**11. Brief Description of Presenting Problem(s):** *(Attachment should be included)*

**12. Presenting Problem(s) by Consumer Age/Disability:** *(Not Target Population determination)*

| | | | | | | |
|---|---|---|---|---|---|---|
| 12a) 1st: *(✓ One only)* | ☐AMH | ☐CMH | ☐ADD | ☐CDD | ☐ASA | ☐CSA |
| 12b) 2nd: *(✓ One, if applic.)* | ☐AMH | ☐CMH | ☐ADD | ☐CDD | ☐ASA | ☐CSA |
| 12c) 3rd: *(✓ One, if applic.)* | ☐AMH | ☐CMH | ☐ADD | ☐CDD | ☐ASA | ☐CSA |

**13. Current Risk to Consumer Safety (especially for DD or MH consumer):**
*(✓ One box for each row)*

| | NONE | MILD | MOD. | SEV. | NOT SCREENED |
|---|---|---|---|---|---|
| 13a) Instability of Care Provider Supervision | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13b) Safety Issues in Living Arrangement | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13c) Aggression or Self-Injurious Behaviors | ☐ | ☐ | ☐ | ☐ | ☐ |

**14. Does Screening indicate consumer is in need of Detox due to risk for acute alcohol or drug withdrawal symptoms?** *(If "Yes", ✓ All that apply)* ☐ Yes ☐ No ☐ N/A
☐ Agitation ☐ Nausea and Vomiting ☐ Sweats ☐ Seizures
☐ Tremors ☐ Other (Describe)_____

**15. Current Risk of Potential Harm to Self or Others:**
**SCALE:** **NONE,** no current ideation *(within past 30 days)*
**MILD,** current ideation only to hurt self or others *(within past 30 days)*
**MODERATE,** ideation with EITHER plan or history of attempts to hurt self or others
**SEVERE,** ideation AND plan, with EITHER intent or means to hurt self or others
*(✓ One box for each row)*

| | NONE | MILD | MOD. | SEV. | NOT SCREENED |
|---|---|---|---|---|---|
| 15a) Consumer's Potential Risk to Self | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15b) Consumer's Potential Risk to Others | ☐ | ☐ | ☐ | ☐ | ☐ |

**16. Triage Severity of Need Determination with Response Timeline:** *(✓ One)*
Determine appropriate severity of need. Clinical judgment may override criteria below to indicate higher level of need determination. All consumers presenting with a potential substance-related problem should receive at least an "Urgent" level of need determination, and be scheduled for appointment or service initiation within 48 hours.

☐ **Emergent:** *(2 hours maximum for service initiation)*
a. Consumer has a moderate or severe risk related to safety or supervision, or
b. Consumer is at moderate or severe risk for substance abuse withdrawal symptoms, or
c. Consumer presents a mild, moderate, or severe risk of harm to self or others, or
d. Consumer has **severe incapacitation** in one or more area(s) of physical, cognitive, or behavioral functioning related to mh/dd/sa problems.

☐ **Urgent:** *(48 hours maximum for service initiation)*
Consumer presents with **moderate risk or incapacitation** in one or more area(s) of physical, cognitive, or behavioral functioning related to mh/dd/sa problems.

☐ **Routine:** *(7 calendar days maximum for service initiation)*
Consumer presents with **mild risk or incapacitation** in one or more area(s) of safety, or physical, cognitive, or behavioral functioning related to mh/dd/sa problems.

☐ **Non-Threshold Clinical Need:** *(Referral to Community Resources only)*
Consumer presents with a problem that **does not meet** any of the above minimum required thresholds of clinical need for referral to an assessment by a professional provider through the state or federally funded MH/DD/SAS system.

**17. Where Consumer is Being Referred for Response After Triage:** *(✓ Best One only)*
☐ **B = Basic Benefits Service Provider** ☐ **E = Enhanced Benefits Service Provider**
☐ **R = Crisis Service Provider** ☐ **C = Community Resources**
*(Specify Name of Community Resource)*_____

***Note:** Information is fully protected as a consumer health record under HIPAA, 42 CFR, Part 2, and G.S. 122C and contains individually identifiable health information. Disclosure of HIPAA protected information between providers and other covered entities may require consumer authorization. For consumers with substance abuse problems, written consent is required under 42 CFR, Part 2, for disclosure of confidential consumer information, unless such disclosure is permitted as an exception to the General Confidentiality Rule, including a medical emergency that poses an immediate threat to health and requires immediate medical intervention. Redisclosure of SA consumer information is prohibited under 42 CFR, Part 2.*

# ✦✦✦ Standardized Consumer STR Interview and Registration Form ✦✦✦

*First Name, M.I., and Last Name of Consumer* — A. Consumer Name ®

*MM DD YYYY* — B. Consumer DOB ®

C. LME Name ®

*Complete as indicated by LME, or may be assigned by LME upon receipt.* — D. LME Facility Code ® — E. LME Consumer Record No. ®

***If Item No. 17 above is checked for "Community Resources", skip to Item 26.***

**18. What initial service(s) does Screener recommend for consumer?** *(✓All that apply)*
☐ Diagnostic Assessment ☐ Community Support ☐ Targeted Case Mgt. ☐ Other
☐ Clin. Intake/Eval. (90801) ☐ Beh. Hlth. Assess. (H0001) ☐ Men. Hlth. Assess. (H0031)

**19. Has provider appointment date and time (or crisis service) *been offered* to consumer?**
☐ Yes ☐ No ☐ N/A ***If "Yes", complete Item 20. If "No" or "N/A", skip to 26.***

**20. Has provider appointment (or crisis service) that was offered *been accepted* by the consumer?**
☐ Yes ☐ No ***If "Yes", complete Items 21 – 22. If "No", skip to Item 26.***

**21. Provider Agency Referred to and Location:** _____

**22. Phone No. of Provider Referred to:** ☐☐☐-☐☐☐-☐☐☐☐

***Complete Item 23 only for Enhanced Benefits Service or Crisis Service, based on appointment or actual initiation of a service.*** *(Enter date and time)*

**23. Appointment Date & Time Scheduled:** ☐☐/☐☐/☐☐☐☐ *MM DD YYYY* **and** ☐☐:☐☐ *HH MM (Enter 24 Hr.)*
**(or Crisis Service Initiated)**

**24. How was Provider Chosen?** *(✓One only)*
☐ Consumer Choice ☐ Family/Legal Guardian Choice ☐ Screener Decision
☐ Other Person Decision (Identify): _____

**25. Why was Provider Chosen?** *(✓All that apply)* ☐ Consumer Coverage Benefits
☐ Crisis or Urgent Access ☐ 1st Available ☐ Hours ☐ Location
☐ Cultural Reasons ☐ Reputation/Recommended by Others ☐ Provider Specialty
☐ Other Reason (Describe) _____

**26. Accommodation of Special Consumer Needs:** *(✓All that apply)* ☐ ***Not Applic.***
☐ Wheelchair/Mobility Needs ☐ Interpreter (Sign Language) ☐ Deaf/Hearing Impaired
☐ Intellectual Disability ☐ Childcare ☐ Visually Impaired ☐ Physical Disability
☐ Frail Senior ☐ Other (Describe) _____

**27. Primary Care Medical Provider:**
***(List name & practice of licensed MD, PA, or NP)*** _____

**28. What special arrangements were made for services access?** *(✓All that apply)*
☐ None ☐ Transportation ☐ Site Accessibility ☐ Other (Describe): _____

**29. Ethnicity:** *(✓ One)* ☐ Hispanic, Mexican American ☐ Hispanic, Puerto Rican
☐ Hispanic, Cuban ☐ Hispanic, Other ☐ Not Hispanic Origin ☐ Unknown

**30. Race:** *(✓ One)*
☐ Black/Afric. Amer. ☐ White/Anglo/Cauc. ☐ Amer. Ind./Native American
☐ Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander
☐ Unknown ☐ Other (Describe): _____

**31. Is consumer proficient in English?** *(✓ One)* ☐ Yes ☐ No

**32. Primary Language:** *(✓ One)* ☐ English ☐ Sign Language ☐ French
☐ Spanish ☐ Other ☐ None ☐ Unknown

**33. Gender:** ☐ Male ☐ Female **34. Veteran Status:** ☐ Yes ☐ No ☐ Unk.

**35. National Guard or Military Reserve (or Military Family) Status in OIF or OEF:**
Has the consumer or immediate family member (parent, grandparent, sibling, spouse, partner, child, or other significant person in the family constellation) served in the National Guard or Military Reserve in support of Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF)?
☐ Yes ☐ No

**36.** Consumer's St. Address/City/State: _____

**37.** Consumer's Phone # (_____) _____

**38.** Mailing Address/City/State/Zip Code: _____

**39.** Consumer's Legal Guardian (if applicable): _____

**40.** Phone # of Legal Guardian (if applicable): (_____) _____

**41.** Emergency Contact Name & Relationship: _____

**42.** Phone # of Emergency Contact: (_____) _____

**43. Consumer Unique Identifier:** ☐☐☐☐☐☐☐☐☐☐-☐

**44. Type of Agency Hosting STR:** *(✓All that apply)*
☐ LME Operated or Contracted STR ☐ Enhanced Benefits Service Enrolled Provider
☐ LME Contracted Service Provider ☐ Crisis Service Provider

**45.** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
**First & Last Name of Qualified Professional (QP) who Conducted STR Interview**

**46. STR Staff Qualifications:** ☐ QP in MH ☐ QP in SA ☐ QP in DD

**47.** ☐☐☐-☐☐☐-☐☐☐☐-☐☐☐☐ **48.** ☐☐/☐☐/☐☐☐☐
**STR Staff Area Code, Phone No., & Extension** — **Date Form Submitted to LME**

**CONSUMER REGISTRATION FOR ENHANCED BENEFITS PROVIDERS**

**49. ® Date of Consumer Service Initiation:** ☐☐/☐☐/☐☐☐☐
***Complete ID Nos. (as applicable & available)*** *MM DD YYYY*

**50. ® Consumer Social Security Number:** ☐☐☐-☐☐-☐☐☐☐
***(Needed for cross referencing with CNDS)***

**51. ® Consumer Medicaid Number:** ☐☐☐☐☐☐☐☐☐☐

**52. ®** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
**First and Last Name of Registration Provider Staff Submitting this Form to LME**

**53. ®** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
**E-Mail Address of Registration Provider Staff**

**54. ®** ☐☐☐-☐☐☐-☐☐☐☐-☐☐☐ **55. ®** ☐☐/☐☐/☐☐☐☐ *MM DD YYYY*
**Registration Provider Area Code, Phone No., & Ext.** — **Date Form Submitted to LME**

***Note:*** ***Information is fully protected as a consumer health record under HIPAA, 42 CFR, Part 2, and G.S. 122C and contains individually identifiable health information. Disclosure of HIPAA protected information between providers and other covered entities may require consumer authorization. For consumers with substance abuse problems, written consent is required under 42 CFR, Part 2, for disclosure of confidential consumer information, unless such disclosure is permitted as an exception to the General Confidentiality Rule, including a medical emergency that poses an immediate threat to health and requires immediate medical intervention. Redisclosure of SA consumer information is prohibited under 42 CFR, Part 2.***

# INSTRUCTIONS FOR STANDARDIZED CONSUMER STR INTERVIEW AND REGISTRATION FORM

A. Consumer Name: Enter consumer's First Name, Middle Initial, and Last Name: *up to 15 characters.*

B. Consumer DOB: Enter consumer's date of birth, by month, day, and year: *8 characters.*

C. LME Name: Enter name of consumer's Local Management Entity (LME): *up to 12 characters.*

D. LME Facility Code: LME Facility Code may be completed as indicated by LME, or may be assigned by LME upon receipt of Form: *5 characters.*

E. LME Consumer Record No: LME Consumer Record Number may be completed as indicated by LME, or may be assigned by LME upon receipt of Form: *10 characters.*

F. Name of Provider Agency or LME Completing Form; Enter name of provider agency or LME completing this Form: *up to 15 characters.*

G. Medicaid Provider Enrollment No: Enter provider's Medicaid Provider Enrollment No., if applicable: *8 characters.*

H. IPRS Attending Provider No: Enter provider's IPRS Attending Provider No., if applicable: *8 characters.*

I. National Provider Identifier (NPI) No: Enter provider's National Provider Indentifier (NPI) No., if applicable: 10 *characters.*

J. Provider Consumer Record No: Enter provider's Consumer Record No: 10 *characters.*

1. Entry Type: Indicate whether the Form is being completed for a STR Interview Only, a Consumer Registration Only, or both a STR Interview and Consumer Registration: *(✓ One).*

2. Consumer Screening Date: Enter month, day, and year which represents the date that this consumer was screened for the current episode of care: 8 characters.

3. Consumer Co. of Residence: Enter a county name (*up to 12 characters)* or valid county code (*3 characters*) for the state of North Carolina as listed in the CDW Data Dictionary.

4. Consumer Enrollment in Medicaid: Indicate whether the consumer is currently enrolled in Medicaid: *(✓ One).*

5. Screening Referral Source: Enter the appropriate Screening Referral Source code from the below for principal source that referred the consumer to the facility for the screening: *2 characters.*

| | |
|---|---|
| 01= | Self or no referral |
| 10= | Family or friends |
| 21= | Other outpatient and residential non-state facility |
| 22= | State facility |
| 23= | Psychiatric service, General hospital |
| 32= | Non-residential treatment/habilitation program |
| 41= | Private physician |
| 44= | Nursing home board and care |
| 46= | Veteran's Administration |
| 48= | Other health care |
| 60= | Community agency |
| 71= | Court, corrections, prisons |
| 80= | Schools |
| 99= | Other |

6. Time Screening Began: Enter the time, in hours and minutes, using a 24 hour time clock format to indicate when the STR Interview began: *4 characters.*

7. Time Screening Ended: Enter the time, in hours and minutes, using a 24 hour time clock format to indicate when the STR Interview ended: *4 characters.*

8. Screening Method: Indicate whether the Screening Method was in-person face to face or by telephone: *(✓ One).*

9. Name of Person Initiating Request for Services: Enter the name of the individual who is initiating this request for services, and the individual's relationship to the consumer. This individual may be the consumer who is making a direct request on their own behalf.

10. Phone Number of Person Initiating Request for Services: Enter the phone number of the individual who is initiating this request for services: *8 characters.*

11. Brief Description of Presenting Problem: Provide a brief description of the consumer's presenting problem. *(Complete narrative).*

12. Presenting Age/Disability Problem(s) of Consumer: Indicate the presenting age/disability problem(s) in order of importance. This item is not a determination of Target Population eligibility. *(✓ One box for first row for primary problem, and up to one box each for the second and third rows for secondary and tertiary problems).*

13. Current Risk to Consumer Safety: Indicate the current risk to the consumer's safety using the five point Scale provided: *(✓ One box for each of three dimensions).*

14. Need for Detox Services: Indicate whether the consumer is in need of detox services due to risk for acute alcohol or drug withdrawal symptoms. If "yes", check all symptoms that apply.

15. Current Risk of Potential Harm to Self or Others: Indicate the current risk of potential harm to self or others using the five point Scale and the criteria provided: *(✓ One box for each of two dimensions).*

16. Triage Severity of Need Determination: Indicate the consumer's Triage Severity of Need Determination of Emergent, Urgent, Routine, or Non-Threshold Clinical Need: *(✓ One)*

17. Consumer Referral after Triage: Indicate where the consumer is referred for response after Triage: *(✓ One).*
*If Item No. 17 above is checked for "Community Resources", skip to Item 26.*

18. Initial Services(s) Recommended for Consumer: Indicate what initial services are recommended by the Screener for the consumer. *(✓ All that Apply).*

19. Offer of Provider Appointment to Consumer: Indicate whether an appointment date and time (or crisis service) has been offered to the consumer by the provider: *(✓ One). If "Yes", complete Item 20. If "No" or "N/A", skip to 26.*

*Note: For reference, see current DMHDDSAS CDW Reporting Requirements and CDW Data Dictionary at http://www.dhhs.state.nc.us/mhddsas/manuals/index.htm.*

# INSTRUCTIONS FOR STANDARDIZED CONSUMER STR INTERVIEW AND REGISTRATION FORM

20. Acceptance of Provider Appointment by Consumer: Indicate whether the appointment date and time that has been offered to the consumer by the provider has been accepted by the consumer: *(✓ One). If "Yes", complete Items 21 – 22. If "No", skip to Item 26.*
21. Provider Agency Referred to and Location: Identify the provider agency and location that the consumer has been referred to.
22. Phone Number of Provider Referred to: Identify the phone number of the provider that the consumer has been referred to.

    *Complete Item 23 only for Enhanced Benefits Service or Crisis Service, based on appointment or actual receipt of a Crisis Service.* (Enter date and time)
23. Appointment Date and Time Scheduled: Enter the provider scheduled appointment date and time in a 24 hour format, or the date and time that the crisis service was initiated: *8 characters followed by 4 characters.*
24. How Provider was Chosen: Indicate how the provider was selected. *(✓ One Only).*
25. Why Provider Was Chosen: Indicate how the provider was selected. *(✓ All that apply).*
26. Accommodation of Special Consumer Needs: Indicate any accommodation made to meet special needs of the consumer. *(✓ All that apply).*
27. Consumer's Primary Medical Provider: Enter the name of the consumer's primary health care provider – physician, physician's assistant, or nurse practitioner.
28. Special Arrangements for Services Access: Indicate any special arrangements made for services access. *(✓ All that apply).*
29. Ethnicity: Indicate the consumer's Hispanic origin: *(✓ One).*
30. Race: Indicate the consumer's primary racial affiliation: *(✓ One).*
31. English Proficiency: Indicate whether English is spoken and understood by the consumer at a relatively high level of proficiency, e.g. no interpreter is required: *(✓ One).*
32. Primary Language: Indicate the language spoken and/or understood by the consumer: *(✓ One).*
33. Gender: Indicate the consumer's sex: *(✓ One).*
34. Veteran Status: Indicate whether the individual has served on active duty in the armed forces of the U.S., including the Coast Guard: *(✓ One).*
35. National Guard or Military Reserve: Indicate whether the consumer or an immediate family member (parent, grandparent, sibling, spouse, partner, child, or other significant person in the family constellation) has served in the National Guard or Military Reserve in support of Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF): *(✓ One).*
36. Consumer's Street Address/City/State: Enter this information for consumer as appropriate and available.
37. Consumer's Phone Number: Enter this information for consumer as appropriate and available.
38. Consumers' Mailing Address/City/State/Zip Code: Enter this information for consumer as appropriate and available.
39. Consumer's Legal Guardian (if applicable): Enter this information for consumer as appropriate and available.
40. Phone No. of Consumer's Legal Guardian (if applicable): Enter this information for consumer as appropriate and available.
41. Emergency Contact Name and Relationship for Consumer: Enter this information for consumer as appropriate and available.
42. Phone Number of Emergency Contact for Consumer: Enter this information for consumer as appropriate and available.
43. Consumer Unique Identifier: Enter consumer number: *10 or 11 characters.* The unique identifier consists of the first three characters of last name, 1st character of first name, 6 character birth date, and an identifier if more than one LME consumer has the same unique identifier number.
44. Type of Agency Hosting STR: Indicate type of agency hosting STR. *(✓ All that apply).*
45. Name of Qualified Professional (QP) conducted STR Interview: List first and last name of the QP staff who conducted the STR Interview.
46. STR Staff Qualifications: Indicate the QP qualifications by disability group. *(✓ All that apply).*
47. STR Staff Area Code, Phone No., & Extension: Enter the area code, phone number, and extension of the provider staff who conducted the STR Interview.
48. Date Form Submitted to LME: Enter the date by month, day, and year that this form was submitted to the LME.

**********

## CONSUMER REGISTRATION FOR ENHANCED BENEFITS PROVIDERS

49. ® Date of Consumer Service Initiation: Enter the date by month, day,and year that services to the consumer were initiated: *8 characters.*
50. ® Consumer Social Security Number: Enter consumer number: *9 characters.* This number is needed for cross-referencing with the Department's Common Name Database Services (CNDS). A consumer SSN will not always be available to a provider when completing this Form.
51. ® Consumer Medicaid Number: Enter consumer number: *10 characters.*
52. ® First and Last Name of Provider Staff submitting this Form to LME: Enter first and last name of staff submitting this form to LME: *up to 24 characters.*
53. ® E-Mail of Provider Staff submitting this Form to LME: Enter e-mail address of staff submitting this form to LME: *up to* 24 characters.
54. ® Area Code and Phone No.: Enter area code and phone number of staff submitting this form to the LME: *10 characters.*
55. ® Date Form Submitted to LME: Enter date by month, day, and year that this form was submitted to the LME by the provider: *8 characters.*

*Note: For reference, see current DMHDDSAS CDW Reporting Requirements and CDW Data Dictionary at http://www.dhhs.state.nc.us/mhddsas/manuals/index.htm.*