**Section 132.148 Evaluation and Planning Services**

a) Mental health assessment (MHA) service is a formal process of gathering information regarding a Client's mental and physical status and presenting problems through face-to-face, video conference or telephone contact with the Client and Collaterals, resulting in the identification of the Client's mental health service needs and recommendations for service delivery. MHA services may be provided without appearing on an ITP.

1) An Admission Note may be used to initiate services prior to the completion of a mental health assessment for a Client who is admitted to a specialized substitute care living arrangement; a residential facility designated by the Public Payer for the purpose of stabilizing a crisis; or Assertive Community Treatment (ACT) prior to the completion of a comprehensive assessment as required in Section 132.150(h)(2)(A). An Admission Note must be completed within 24 hours after a Client's admission and is effective for a maximum of 30 days.

A) An Admission Note is a written report of an initial assessment and treatment plan and shall include the following:

i) Identifying information: name, gender, date of birth, primary language and method of communication, date of initial assessment;

ii) Client's current mental health functioning level;

iii) Provisional diagnosis;

iv) Pertinent history;

v) Precautions (e.g., suicidal risk, homicidal risk, flight risk) and special programming to meet the Client's needs;

vi) Initial treatment plan, including a list of Part 132 services that will be provided and the staff responsible for those services; and

vii) Other relevant information.

B) An Admission Note shall be completed by at least an MHP following a face-to-face or video conference meeting with the Client.

C) A QMHP shall be responsible for approving the completed Admission Note as documented by the QMHP's dated original signature with credentials on the Admission Note.

2) An HFS approved Healthy Kids mental health screen may be used to initiate services prior to the completion of a mental health assessment by a Provider certified under this Part for a Client who is under age 21.

A) A Healthy Kids screen remains effective for the initiation of services for 60 days from the date the physician completed it as indicated by physician dated signature.

B) A Healthy Kids screen may be used by a certified Provider for a maximum of 30 days from the initial face-to-face contact with the Client while the mental health assessment is being completed.

3) A mental health assessment is required prior to the development and implementation of an ITP. A mental health assessment is not required prior to the initiation of psychological evaluation services described in subsection (b), crisis services described in Section 132.150(b) and case management services described in Section 132.165(a)(1).

4) The Provider shall complete a mental health assessment report within 30 days after the first face-to-face contact for services not initiated with an Admission Note or Healthy Kids mental health screen. When a Client is hospitalized for crisis services, the first face-to-face contact shall be the initial contact following discharge from the hospital.

5) A written mental health assessment report shall be a compilation of the following:

A) Identifying information: name, gender, date of birth, primary language and method of communication, name and contact information of Client's primary care physician, and guardian;

B) Reasons for seeking or being referred for current mental health treatment, including symptoms of mental illness;

C) DSM-5 or ICD-10-CM diagnosis;

D) Family history, including the history of mental illness in the family;

E) Mental status evaluation;

F) Client preferences relating to services and desired treatment outcomes;

G) Personal history of symptoms of mental illness and mental health treatment, date of most recent psychiatric evaluation, and whether the Client has taken or is now taking psychotropic medication;

H) History of abuse/trauma (childhood sexual or physical abuse, intimate partner violence, sexual assault or other forms of interpersonal violence);

I) Social adjustment and daily living skills;

J) Legal history and status, including guardianship and current court involvement;

K) Identification of factors in the current environment that may create threats to Client's personal safety (e.g., gang involvement, domestic violence, elder abuse);

L) Strengths and resources (e.g., education and vocational skills, current employment and employment history, interests/hobbies, financial and material resources, and supportive social relationships with family and friends, as well as more intrinsic resources, including hope, motivation, self-confidence and sense of belonging within a community of one's peers);

M) History of and current alcohol or other substance use, abuse or dependence, and any previous substance use treatment/recovery efforts;

N) Client's report on general physical health, including date of last physical examination; and

O) Summary analysis and conclusions regarding the medical necessity of services.

6) If a definitive diagnosis has not been determined per the DSM-5 or the ICD-10-CM by the time the MHA report is completed or a rule out diagnosis is given, the MHA report must contain documentation as to what evaluations will occur in order to provide a definitive diagnosis. A definitive diagnosis shall be determined within 90 days after the completion of the MHA report.

7) A QMHP who has had, at a minimum, one face-to-face or video conference contact with the Client shall be responsible for the completed mental health assessment report as documented by his/her dated original signature with credentials on the mental health assessment. MHPs may participate in the mental health assessment.

8) The Client's family or guardian may participate in the mental health assessment during which the family will be given the opportunity to provide pertinent information or support. Participation by the family and other interested persons must be in accordance with the Confidentiality Act and HIPAA.

9) The mental health assessment report shall be reviewed and approved by the LPHA as documented by the LPHA's dated original signature with credentials on the mental health assessment. The LPHA shall determine in writing if any additional evaluations are required to assess the Client's functioning or service needs.

10) The mental health assessment shall be updated annually by the QMHP who has, at a minimum, one face-to-face contact with the Client to complete the updated mental health assessment. The annual update must occur within 12 months after the LPHA's original signature on the mental health assessment report or the previous update. The QMHP shall be responsible for the completed update as documented by his or her dated original signature with credentials on the updated mental health assessment. The LPHA shall review and approve the assessment as documented by the LPHA's dated original signature with credentials on the updated mental health assessment. MHPs may participate in the mental health assessment update.

11) For services initiated by an Admission Note or Healthy Kids mental health screen, the Provider shall complete a mental health assessment report or a comprehensive assessment for an ACT Client within 30 days after the Client's admission.

12) The annual update of the mental health assessment shall minimally include all requirements specified under subsection (a)(5) with the exception of requirements listed under subsections (a)(5)(A), (D), (G) and (H). Providers may include requirements under subsections (a)(5)(A), (D), (G) and (H) as medically necessary and clinically indicated as part of the mental health assessment update. Following review of a requirement, Providers may also indicate "no change" where applicable on the mental health assessment update if there has been no change in status.

13) Specific documentation of the delivery of mental health assessment service must include a description of the time spent with the Client or Collateral gathering information.

b) Psychological Evaluation

1) A psychological evaluation service, if recommended, shall:

A) Be completed within 90 days after completion of the MHA report, be documented by the Provider, and be consistent with the Clinical Psychologist Licensing Act [225 ILCS 15] using nationally standardized psychological assessment instruments; a master's level professional may assist;

B) Be conducted face-to-face or video conference with the Client; and

C) Result in a written report that includes a formulation of problems, tentative diagnosis and recommendations for treatment or services.

2) Specific documentation of the delivery of psychological evaluation service must identify the specific nationally standardized psychological assessment instruments used.

c) Treatment plan development, review and modification service is a process that results in a written ITP, developed with the participation of the Client and the Client's parent/guardian, as applicable, and is based on the mental health assessment report and any additional evaluations. The ITP may be known also as a rehabilitation treatment plan or a recovery treatment plan. Active participation by the Client and the Client's parent/guardian, as applicable, is required for all ITP development, whether it is the initial ITP or subsequent reviews and modifications. The Client may choose to actively involve Collaterals in the ITP process. Participation by the Client and the Client's parent/guardian, as applicable, shall be documented in the plan and confirmed by the Client's and the parent's/guardian's, as applicable, dated original signature on the ITP. In the event that a Client or the Client's parent/guardian, as applicable, refuses to sign the ITP, the LPHA, QMHP or MHP shall document the reason for refusal and indicate by his or her dated original signature with credentials on documentation in the record that the ITP was developed with the active participation of the Client and the Client's parent/guardian, as applicable, and that the Client or the Client's parent/guardian, as applicable, refused to sign the ITP.

1) The initial ITP shall be completed within 45 days after the completion of the mental health assessment as documented by the LPHA's dated original signature with credentials on the ITP. When an Admission Note or Healthy Kids mental health screen was completed to initiate services, the ITP shall be developed, following the completion of a mental health assessment, within 30 days after the Client's date of admission.

2) A written ITP is a compilation of the following:

A) The goals/anticipated outcomes of services;

B) Intermediate objectives to achieve the goals;

C) The specific Part 132 mental health services to be provided;

D) The amount, frequency and duration of Part 132 services to be provided; and

E) Staff responsible for delivering services.

3) The ITP shall include a definitive diagnosis per the DSM-5 or the ICD‑10‑CM. If the diagnosis cannot be determined by the time the ITP is completed or a rule out diagnosis is given, the Client's clinical record must include the diagnosis determined as a result of additional evaluations recommended in the MHA report within 90 days after completion of the MHA report.

4) Responsibility for development, review and modification of the ITP shall be assumed by a QMHP as documented by his/her dated original signature with credentials on the ITP. MHPs may participate in the development of the ITP. An LPHA shall provide the clinical direction of mental health services identified in the ITP as documented by his/her dated original signature with credentials on the ITP.

5) The LPHA and the QMHP shall review the ITP no less than once every 6 months from the date of the LPHA original signature on the most recent ITP to determine if the goals set forth in the ITP are being met and whether each of the services described in the plan has contributed to meeting the stated goals. The ITP shall be modified if it is determined that there has been no measurable reduction of disability or restoration of functional level.

6) The ITP review shall include continuity of care planning with the Client or the Client's parent/guardian. The ITP review shall also include an estimated transition or discharge date and identify goals for continuing care.

7) The results of crisis assessments, reassessments or additional evaluations after the Client's ITP is completed shall be incorporated into a modified ITP, if appropriate, within 30 days.

8) The Provider shall explain to the Client and/or persons of the Client's choosing, which may include a parent/guardian, as applicable and as evidenced by a signed and dated statement by the Provider and the Client or parent/guardian, the process for the development, review and modification of the contents of the ITP.

9) The ITP and all its revisions shall be signed by the parent or guardian if the Client is under 12 years of age. If the Client is 12 through 17 years of age, the ITP shall be signed by the Client and by the parent/guardian, as applicable, unless the Client is an emancipated minor. A Client 18 years of age or older or an emancipated minor shall sign the ITP. If the Client is 18 years of age or older and has been adjudicated as legally incapable, the ITP shall be signed by the legally appointed guardian.

10) Pursuant to the Mental Health and Developmental Disabilities Confidentiality Act [740 ILCS 110], a copy of the signed ITP shall be given to the Client and the Client's parent/guardian, as applicable. The ITP and documentation that the signed ITP has been provided to the Client or parent/guardian shall be incorporated into the Client's clinical record.

11) Commencement of Services

A) Mental health services may be provided concurrently with ITP development if:

i) The mental health assessment report is completed, signed and dated by the LPHA or the Admission Note is signed and dated by the QMHP or a Healthy Kids mental health screen completed by a physician is in the Client record;

ii) The specific Part 132 service is recommended as medically necessary on the completed mental health assessment or Admission Note or Healthy Kids mental health screen; and

iii) The specific Part 132 services provided are included in the completed ITP, signed by an LPHA as required by this Part.

B) If services are provided prior to completion of the ITP, and the Client terminates services before the ITP is completed and signed, the Provider must complete the ITP and document that the Client terminated services and was unavailable to sign the ITP.

12) Specific documentation of delivery of treatment plan development, review and modification service must include a description of the time spent with the Client or Collateral developing, reviewing or modifying the ITP.

(Source: Amended at 39 Ill. Reg. 13684, effective October 1, 2015)