



## The Massachusetts Department of Mental Health Expedited Admission Referral Form

**Referral Form  
Instructions to  
Request DMH  
Assistance at 96  
hours**

Please use the following instruction to complete the form to request -  
DMH assistance for individuals without a placement plan at 96 hours into an Emergency Department visit.

Field #	Field Name	Field Description	
<b>Referring Org Information</b>	1	Referring Organization Type	<p>Using the drop down, select the one of the following values that represent the Organization submitting the request.</p> <p>Emergency Department – The department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care. Emergency department personnel may also respond to certain situations within the hospital such cardiac arrests.</p> <p>ESP – The Emergency Services Program (ESP) provides crisis assessment, intervention, and stabilization services 24 hours per day, seven days per week, and 365 days per year (24/7/365) to Members of all ages who are experiencing a behavioral health crisis. The purpose of the ESP is to respond rapidly, assess effectively, and deliver a course of treatment intended to promote recovery, ensure safety, and stabilize the crisis in a manner that allows a Member to receive medically necessary services in the community, or if medically necessary, in an inpatient or 24-hour diversionary level of care.</p> <p>Insurance Carrier – A company that offers and/or underwrites insurance policies.</p>
	2	Referring Organization Name	Insert the name of the Organization submitting the form.
	3	Referring Organization Leadership Contact For DMH	
	3a	Title	Insert the title of the person that DMH should contact related to this request.
	3b	First Name	Insert the first name of the person that DMH should contact related to this request.
	3c	Last Name	Insert the last name of the person that DMH should contact related to this request.
	3d	Phone Number	Insert the phone number of the person that DMH should contact related to this request.
	3e	Email Address	Insert the email address of the person that DMH should contact related to this request.



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Field #	Field Name	Field Description
<b>4</b>	<b>Client Demographic Information</b>	
<b>4a</b>	First Name	Insert the First Name of the Member/Patient.
<b>4b</b>	Middle Name (Optional)	Insert the Middle Name of the Member/Patient.
<b>4c</b>	Last Name	Insert the Last Name of the Member/Patient.
<b>4d</b>	DOB (mm/dd/yyyy)	Insert the 8 digit birthday of the Member/Patient in the following format mm/dd/yyyy. Example: 01/14/2016
<b>4e</b>	Age (Calculated Field, Read Only )	This field is automatically populated based on the results entered in field 4d of this form.
<b>4f</b>	Race	Using the drop down, select the appropriate race of the Member/Patient.  American Indian Asian Black/African American Native Hawaiian or Other Pacific Islander White Unknown Other
<b>4g</b>	Race – Other Specify	If “Other” was selected from the drop down in field 4f on this form, insert the name of the race of the Member/Patient.
<b>4h</b>	Gender	Using the drop down, select the appropriate gender of which the Member/Patient identifies as.  Female Male Transgender Other
<b>4i</b>	Is Member Hispanic	Using the drop down, select the appropriate answer.  Yes – Member/Patient identifies as Hispanic. No – Member/Patient does not identify as Hispanic N/A – The answer to the question is not applicable
<b>5</b>	Guardian	Using the drop down, select the appropriate answer as to if the Member/Patient is their own Guardian or if another person has been identified as the Member/Patient’s guardian.  Self – Member/Patient is their own Guardian Other – Another person has been identified as the Member/Patient’s guardian
<b>6</b>	Guardian - Other Specify	If “Other” was selected from the drop down in field 5 on this form, insert the name of the Member/Patient’s Guardian.
<b>7a</b>	Does the member have insurance?	Using the drop down, select the appropriate answer.  Yes – Member/Patient does have health insurance No – Member/Patient does not have health insurance
If "No", skip to section 8		If “No” was selected in field 7a of this form, skip fields 7b – 7h and then proceed to field 8 of this form.
<b>7b</b>	Insurance Carrier	Using the drop down, select the name of the Insurance Carrier that the Member/Patient is covered under.  If the Health Insurance Carrier’s name does not appear on the drop down, select “Other”.

**Client Related Information**



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Field #	Field Name	Field Description	
<b>Client Related Information Continued</b>	<b>7c</b>	Insurance Carrier - Other Specify	If "Other" was selected from the drop down in field 7b of this form, insert the name of Insurance Carrier.
	<b>7d</b>	Insurance Plan Type	Using the appropriate drop down, select the type of Health Insurance plan the Member/Patient is enrolled in.
	<b>7e</b>	Mass Health Id	If any of the following plan types were selected from the drop down on field 7d of this form, insert the Member/Patient's MassHealth Identification Number.  MassHealth – ACO/MCO MassHealth – Fee For Service MassHealth – Plan Unspecified  If the Member/Patient is not enrolled in MassHealth or the ID number is unavailable, leave field blank.
	<b>7f</b>	Request for Assistance to Insurance Carrier Date (mm/dd/yyyy)	Insert the date the Health insurance Carrier was requested to assist with the placement of the Member/Patient in the following format mm/dd/yyyy. Example: 01/14/2016
	<b>7g</b>	Request for Assistance to Insurance Carrier Time (23:00 is 11:00 pm)	Insert the time the Health insurance Carrier was requested to assist with the placement of the Member/Patient in the following format hh:mm AM/PM using Military time. Example: 1:00 PM Regular time, insert 01:00 PM as Military time.
	<b>7h</b>	Please describe any services authorized by Carrier to support admission (E.g. 1:1, single room, enhanced medical supports etc.)	Insert any services authorized by the Carrier.
	<b>8</b>	State Agencies Involved	Using the drop down, select the appropriate Agency or Agencies that are involved in the care and/or supervision of the Member/Patient.  DCF – Department of Children and Families DDS – Department of Developmental Services DMH – Department of Mental Health DYS – Department of Youth Services IEP – Individualized Education Plan None Unknown



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Field #	Field Name	Field Description
9	Boarding Facility	Using the drop down, select the name of the facility that the Member/Patient is currently boarding at. If the name of the facility is not listed on the dropdown OR if the Member/Patient is boarding at home, select "Other".
10	Boarding Facility - Other Specify	If "Other" was selected from the drop down in field 9 of the form, insert the location where the Member/Patient is boarding.
11	ESP Information	
11a	ESP If Applicable?	Using the drop down, select the appropriate answer.  Yes – An ESP is working on placing the Member/Patient No – An ESP is not working on placing the Member/Patient
If "No", skip to section 12		If "No" was selected in field 11a of this form, skip fields 11b and 11c and then proceed to field 12 of this form.
11b	ESP Name	If yes, was selected from the drop down in field 11a of this form, insert the name of the ESP.
11c	ESP Phone Number For Immediate Access	Insert the phone number of the ESP.
12	Initial Evaluation Date (mm/dd/yyyy)	Insert the date the initial evaluation of the Member/Patient was completed in the following format mm/dd/yyyy. Example: 01/14/2016
13	Initial Evaluation Time (23:00 is 11:00 p.m.)	Insert the date the initial evaluation of the Member/Patient was completed in the following format hh:mm AM/PM using Military time. Example: 1:00 PM Regular time, insert 01:00 PM as Military time.
14	Primary Diagnosis	Using the drop down, select the primary diagnosis of the Member/Patient. If the Diagnosis is not listed on the drop down, select "Other".
15	Primary Diagnosis - Other Specify	If "Other" was selected from the drop down in field 14 of this form, insert the diagnosis.
16	Secondary Diagnosis	Using the drop down, select the secondary diagnosis of the Member/Patient. If the Member/Patient has more than 2 diagnosis, select the most appropriate secondary diagnosis and then add the additional diagnosis in field 17 of this form. If the Diagnosis is not listed on the drop down, select "Other".
17	Secondary Diagnosis - Other Specify	If "Other" was selected from the drop down in field 16 of the form or to list additional diagnosis than what was added in Field 14 – 16 of this form, insert the diagnosis.
18	Primary Barrier to Placement	Using the drop down, select the primary barrier experienced when attempting to place the Member/Patient. If there are multiple barriers, insert the other barriers in field 19 of this form. If a Barrier is not listed on the drop down, select "Other".
19	Primary Barrier to Placement - Other Specify	If "Other" was selected in field 18 of this form OR if additional barriers have been identified and was not selected in field 18 of this form, insert the barriers.
20	Presenting concerns & precipitating events (clinical formulation- if available) *SUMMARY ONLY*	Insert a brief summary of concerns and/or events. Include clinical documentation or formulations if available.

**Boarding Related Information**



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<b>Bed Search Efforts By Referring Organization</b>	<b>Field #</b>	<b>Field Name</b>	<b>Field Description</b>
	22	<b>Please Provide Today's (Most Recent) Bed Search Details. (Minimum Of 5 Bed Search Results, Required. More than 5 is good. )</b>	
		Placement Facilities	Locate each Facility that has been contacted to explore availability of placement for the Member/Patient.
		Beds Available?	For each Facility that has been contacted, select the most appropriate answer using the drop down.  Yes – There are beds available at the facility No – There are no beds available at the facility
	Reason For Refusal	For each of the Facilities contacted and there were beds available, insert the reason(s) the facility refused to accept the Member/Patient.	