Expedited Psychiatric Inpatient Admission
96-Hour Notice to DMH:

DMH REFERRAL TOOL
Survey Definitions

Date Created: 1/31/2018

Information provided on this survey shall be submitted to the Department of Mental Health via the secured website at https://eohhs.ehs.state.ma.us/ReviewSurvey/ReviewSurvey.aspx?id=442 to request assistance with placement after 96 hours.

All Fields with an (*) are mandatory.

Question#:	Field Name:	Definition:
***1**	Referring Entity/Organization	Select the type of organization that is seeking help with assistance to place a member/patient
***2**	Name of referring Entity/Organization	Insert the name of the organization that is seeking help with assistance to place a member/patient
Provide senior leadership information at the referring entity below that DMH should contact:		
3	First Name	Insert the First Name of the person DMH should contact related to this request
4	Last Name	Insert the Last Name of the person DMH should contact related to this request
5	Title of the person above	Insert the Title of the person listed in field 3 and field 4
6	Contact telephone number of the person above	Insert the phone number of the person listed in field 3 and field 4
7	Contact email of the person above. Please use all lowercase letters- NO CAPITAL letters/ No blank spaces- Please select the checkbox to send an email confirmation of this submission to the above contact person.	Insert the email address of the person listed in field 3 and field 4 and check the box to have an email confirmation of the submission sent to the contact person listed above
Please provide member demographic Information below:		
***8**	First Name	Insert the First Name of the member/patient
9	Middle Name	Insert the Middle Name of the member/patient
***10**	Last Name	Insert the Last Name of the member/patient
11	DOB (mm/dd/yyyy)	Insert the Date of Birth of the member/patient
12	Gender	Select the Gender the member/patient classifies as
13	Guardian/Custody	Insert the name of the Guardian or primary custodial authority of the member/patient

Question#:	Field Name:	Definition:
14	Insurance Carrier	Insert the name of the Insurance Company covering the member/patient
15	Insurance Plan Type (Check all those that apply)	Select the type of coverage of which the member/patient is enrolled
16	Insurance ID#/MassHealth ID# (If applicable)	Insert the Insurance ID number or MassHealth ID number
17	State agency involvement (Check all those that apply)	Select any state agency or agencies that is involved with the member/patient
Please provide boarding details below:		
18	Where is the Member boarding?	Insert the name of the place where the member/patient is currently located. (example: Hospital Name, ER name, Home)
19	Which ESP is involved (if applicable)?	Insert the name of the ESP involved with the member/patient
20	Date of initial evaluation(mm/dd/yyyy)	Insert the initial evaluation date performed by the ED
21	Time of evaluation (Please use military format e.g. 2300 is 11PM)	Insert the time of the evaluation performed by the ED
22	Date of request for assistance to insurance carrier (mm/dd/yyyy)	Insert the date of which the facility contacted the Insurance Company with a request for assistance
23	Time of request to the insurance carrier (Please use military format e.g. 2300 is 11PM)	Insert the time of when the facility contacted the Insurance Company with a request for assistance
24	Diagnosis	Select the primary diagnosis of the member/patient
25	Diagnosis option "Other" description	Insert additional diagnosis descriptions, if other was selected in field 24
26	Secondary Diagnosis	Insert the secondary diagnosis of the member/patient that was not provided in field 24 and/or field 25 above
***27**	Is there a personal and/or family preference for placement?	Select whether or not the patient, family, guardian and/or primary custodial authority has a personal preference for placement
28	Identify the primary barrier to placement other than personal/family preference. (If applicable)	Select the primary barrier of placement that has been identified. Do not include personal or family preference in this field
29	Please describe "other" barriers here	Insert additional barriers not identified in field 28

Question#:	Field Name:	Definition:
30	Provide presenting concerns & precipitating events (clinical formulation- if available)	Insert any additional concerns, events, and/or clinical formulation that has been identified
31	Please describe any services authorized by Carrier to support admission (e.g., 1:1, single room, enhanced medical supports etc...)	Insert all services authorized by the Insurance Company to support admission
32	Out of network facilities considered (if any)	Insert all out of network providers considered by the Insurance Company
---------------------------- FACILITIES TO TARGET FOR DMH INTERVENTION ----------------		
Facilities where senior leadership and/or CMO were contacted by insurance carrier to have follow-up discussions, doc-to-doc, etc...to advocate for admission and escalation results		
-------- FACILITIES I --------		
33	Contacted facility name	Insert the name of the facility that was contacted by the Insurance Company, ED or ESP
34	Facility contact information	Insert the name of the facility contact person and phone number that was contacted by the Insurance Company, ED or ESP
35	Facility response	Insert the facility's final response or disposition received by the Insurance Company, ED or ESP
-------- FACILITIES II --------		
36	Contacted facility name	Insert the name of the facility that was contacted by the Insurance Company, ED or ESP
37	Facility contact information	Insert the name of the facility contact person and phone number that was contacted by the Insurance Company, ED or ESP
38	Facility response	Insert the facility's final response or disposition received by the Insurance Company, ED or ESP
-------- FACILITIES III --------		
39	Contacted facility name	Insert the name of the facility that was contacted by the Insurance Company, ED or ESP
40	Facility contact information	Insert the name of the facility contact person and phone number that was contacted by the Insurance Company, ED or ESP
41	Facility response	Insert the facility's final response or disposition received by the Insurance Company, ED or ESP

Question#:	Field Name:	Definition:
-------- FACILITIES IV --------		
42	Contacted facility name	Insert the name of the facility that was contacted by the Insurance Company, ED or ESP
43	Facility contact information	Insert the name of the facility contact person and phone number that was contacted by the Insurance Company, ED or ESP
44	Facility response	Insert the facility's final response or disposition received by the Insurance Company, ED or ESP
PLEASE NOTE: The secure email account (expedited.admission@massmail.state.ma.us) is limited to receiving ONLY clinical and/or administrative summaries.		
***45**	Is clinical and/or administrative document(s) being submitted to the secure email account? (expedited.admission@state.ma.us)	Select yes or no to confirm whether or not the referring organization will be sending additional content related to this request via email
46	Contact email of the person submitting this form. Please use all lowercase letters- NO CAPITAL letters/ No blank spaces. REMINDER: select the checkbox to receive an email confirmation of this submission.	Insert the name of the person that is submitting this request and then check the box if the person would like to receive a copy of the submitted survey
IMPORTANT NOTE: To confirm this referral is a valid request requiring immediate DMH assistance, please copy the email exactly "as is" from below-no CAPITAL letters- and paste in the text field. Remember the checkbox next to the email MUST be selected for a prompt response.		
***47**	Copy and paste email- NO CAPITAL LETTERS- exclude quotation marks- "expedited.admission@state.ma.us" PLEASE REMEMBER TO SELECT THE CHECKBOX	Copy and paste the below email address expedited.admission@state.ma.us in the box and check the box to receive a copy of the submitted survey. *Note: When you click send at the bottom of the survey, the survey will be sent to the email address listed in this field