POLICY 1020, ATTACHMENT A- PSYCHIATRIC SECURITY REVIEW BOARD/GEI CONDITIONAL RELEASE MONTHLY REPORT

Any violation of the Conditional Release, psychiatric decompensation, or use of alcohol, illegal substances, or prescription medication not prescribed to the patient shall be reported to the PSRB *immediately*.

REPORT FOR THE MONTH OF: _____ ***YEAR:*** _____

MEMBER NAME: _____

DATE (MM/YYYY): _____

OPEN UNTIL 05/29/2020

DEMOGRAPHICS		
Name:		AHCCCS ID#
Date of Birth:	Current Psychiatric Diagnosis: Phone:	
Crime:		
Sentence:		Sentence Expiration: ZIP Code:
Patient Address: Monthly payment or rent: How long?		
Residence phone:		Personal Phone : ZIP Code:
Type of Placement: Monthly payment or rent: How long?		
AzSH Admission Date:	Last AzSH Discharge Date:	Number AzSH Admissions:
CONTACTS		
Contractor, RBHA:		
Primary Behavioral Health Provider Name: How long?		
County:	Phone:	Fax:
Full Provider Address: State: ZIP Code:		
Case Manager:	Email:	Phone:

Effective Dates: 04/01/17, 07/01/17, 10/01/18, 10/01/19, 10/01/20
Approval Dates: 02/08/17, 07/26/17, 07/10/18, 09/19/19, 04/02/20

Member Name: _____

Date (MM/YYYY): _____

Compliance With The Standard Conditions Of Release		
Answer all questions and provide explanatory comments for each section when potential concern is indicated. ***All Non-Compliant responses require comment***	Compliant	Non-Compliant
1. Cooperating with all treatment recommendations	☐	☐
2. Keeping all required appointments	☐	☐
3. Providing personal and employer contact information to the PSRB	☐	☐
4. Not violating any local / state/ federal law	☐	☐
5. Not using/possessing drugs, alcohol or toxic vapors	☐	☐
6. Not leaving residence for more than 24 hours without the approval of the treating psychiatrist	☐	☐
7. Not leaving residence for more than 72 hours or left the state of Arizona without the approval of the PSRB	☐	☐
8. Not changing his/her residence without the approval of the PSRB	☐	☐
9. Not possessing weapons	☐	☐
10. Adhering to restrictions on contacting victims	☐	☐
Click here to enter text.		
Overall Impression Of Patients Compliance With Approved PSRB Conditional Release Plan (CR Plan)		
Fully Compliant ☐ Partially Compliant ☐ Non-Compliant ☐		
Click here to enter text.		

OPEN UNTIL 05/29/2020

MEMBER NAME: _____

DATE (MM/YYYY): _____

PSYCHIATRIC PRESENTATION		
Provide a narrative summary of the patient's psychiatric presentation. Click here to enter text.		
	YES	NO
Has there been any crisis or signs of decompensation since the last monthly report?	☐	☐
Has there been any need of outreach interventions to maintain the patient in treatment?	☐	☐
Has the patient presented any signs OR made any statements of DTS/DTO?	☐	☐
If yes to any of the above questions, please provide the date PSRB and AHCCCS were immediately notified / /		
Click here to enter text.		
ANSWER ALL QUESTIONS AND PROVIDE EXPLANATORY COMMENTS FOR EACH SECTION WHEN POTENTIAL CONCERNS ARE INDICATED		
INDIVIDUALIZED CONDITIONS OF RELEASE		
List the Specific Conditions of Release Click here to enter text.		
	YES	NO
1. Has the patient complied with ALL residence conditions outlined in the approved CR Plan?	☐	☐
2. Has the patient's residence contacted the clinical team with any concerns?	☐	☐
3. Has the treatment team spoken with staff/family members at the residence?	☐	☐
Click here to enter text.		

OPEN UNTIL 03/29/2020

Member Name: _____

Date (MM/YYYY): _____

Psychiatric Treatment And Monitoring (Attach The Psychiatrist's Progress Notes For This Reporting Period To This Report)		
	Yes	No
1. Has the patient complied with ALL psychiatric treatment conditions outlined in the approved CRP?	☐	☐
2. Dates of psychiatric visits this month:		
Click here to enter text.		

Medications and Monitoring		
List all current medications including dosage and frequency. Click here to enter text.		
	Yes	No
1. Have there been any problems obtaining psychotropic medications for the patient?	☐	☐
2. Have there been any changes in medication since the last report?	☐	☐
3. Does the patient take medication independently? If so, how is medication adherence and medication	☐	☐
Click here to enter text. Address: Phone:		

Outpatient Provider		
	Yes	No
Has the patient complied with ALL Outpatient Provider conditions outlined in the approved CR Plan?	☐	☐
Click here to enter text.		

OPEN UNTIL 03/20/2020

Member Name: _____

Date (MM/YYYY): _____

Case Management		
	Yes	No
1. Has the patient complied with ALL case management conditions outlined in the approved CR Plan?	☐	☐
2. Dates of case management contact this month:		
Click here to enter text. Address: Phone:		

Contractor Monitoring		
	Yes	No
Has the patient complied with ALL Contractor monitoring conditions outlined in the CR Plan?	☐	☐
Click here to enter text. Address: Phone:		

Employment/Education/Volunteering		
	Yes	No
1. Is the patient volunteering, employed or attending school?	☐	☐
2. If yes, please provide the name and address and hours per week spent on volunteering/employment/education.		
Click here to enter text.		

Community Meetings		
	Yes	No
1. Has the patient complied with ALL community meeting(s) conditions outlined in the approved CR Plan?	☐	☐
2. Dates of community meetings this month.		
Click here to enter text.		

OPEN UNTIL 03/29/2020

MEMBER NAME: _____

DATE (MM/YYYY): _____

SUBSTANCE USE TESTING (ATTACH THE SUBSTANCE TESTING LABORATORY RECORDS FOR THIS REPORTING PERIOD TO THIS REPORT)		
	YES	NO
1. Has the patient complied with ALL random, unannounced substance testing conditions outlined in the approved CR Plan?	☐	☐
2. Date(s) of substance testing this month		
3. Was any drug screen positive this month?	☐	☐
If yes. What date was the PSRB notified of positive drug screen?		
Click here to enter text.		
THERAPEUTIC INTERVENTIONS		
	YES	NO
1. Has the patient complied with ALL therapeutic intervention conditions outlined in the approved CR Plan?	☐	☐
2. Dates of therapy and other therapeutic interventions this month:		
Click here to enter text.		
VICTIM CONTACT		
Enter contact restrictions. Click here to enter text.	YES	NO
Has the patient complied with ALL victim contact restrictions outlined in the approved CR Plan?	☐	☐
Click here to enter text.		
RETURN VIA EMAIL BY THE 5TH OF THE MONTH TO		
psrb@azhs.gov		
Medicalmanagement@azahcccs.gov		
Patient's Attorney Name and email address:		

DRAFT UNTIL 03/29/2020

MEMBER NAME: _____

DATE (MM/YYYY): _____

REPORTER INFORMATION:	
Name of Provider Case Manager Completing Report:	Date:
Title Provider Case Manager:	
1. I have included monthly prescriber treatment note and results of required lab testing, where applicable; 2. I have verified the member's attendance in treatment requirements not solely on the report of the client; 3. I have reported all non-compliance with the Board's order, either in this report or separately in writing, all significant incident(s) and/or change(s) in mental health status since the last monthly report; and 4. I have verified that all services were provided to the client as required in the Board's order/treatment plan, or I have explained in this report why services were not provided.	
By Signing I am attesting the above to be true: Provider Case Manager Signature:	Date:
Name of Attending Practitioner:	
Name of Contractor Care Manager:	Date:

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