The Illinois Mental Health Collaborative for Access and Choice

NOTICE OF DISCONTINUATION OF COMMUNITY SUPPORT TEAM (CST)

NOTE: Fax Forms to the Collaborative at (866) 928-7177

Agency: ________________________________ **Name of Referred:** ________________________________
Agency Location:__________________________ **Date of Birth:** ____________________________________
Agency FEIN: ____________________________ **RIN:** ____
Team Name: ____

Male: ☐ **Female:** ☐

Date CST service started: ______________________ **Date CST was discontinued:** ____________________

PLEASE PRINT *(Must Include)*
Staff to contact with any CLINICAL questions: ____

Phone: ______________________________ **Secure Fax Number:** __________________________________

Encrypted Email Address: ____

I. DISCONTINUANCE CRITERIA *(Please check only one)*

☐	Person requests termination from CST and is stable.
☐	Person has improved to the extent that CST is no longer needed and recovery goals have been met. *(No medical necessity for CST – please attach transition plan.)*
☐	Person has moved out of the CST Team's geographic area. *(provide linkage information to new CST Team or community service.)*
☐	Person has moved out of State. *(make attempts to link with other CST or community services.)*
☐	Person cannot be located, in spite of repeated efforts. *(Describe efforts to locate and continue CST services such as number of failed contacts, time elapsed since last contact: lack of leads on whereabouts from the person's emergency contact list.)*
☐	Person requests termination from CST despite the clinical recommendation of the team.
☐	Person has been incarcerated.
☐	Person is in need of hospitalization that may exceed 90 days.
☐	Person is in need of nursing facility level of care that may exceed 90 days.
☐	Deceased.

II. DIAGNOSIS ON EXIT

PRIMARY BEHAVIORAL DIAGNOSIS (DSM-5) *Required Field

*Diagnostic Category 1	*Diagnosis Code 1	*Description

ADDITIONAL BEHAVIORAL DIAGNOSIS (DSM-5)

Diagnostic Category 2	Diagnosis Code 2	Description
Diagnostic Category 3	**Diagnosis Code 3**	**Description**
Diagnostic Category 4	**Diagnosis Code 3**	**Description**

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AGENCY: ______________________________ RIN: ____

Diagnostic Category 5	Diagnosis Code 5	Description

PRIMARY MEDICAL DIAGNOSIS (DSM-5) *Required Field

*Diagnostic Category 1	Diagnosis Code 1	Description
Diagnostic Category 2	**Diagnosis Code 2**	**Description**
Diagnostic Category 3	**Diagnosis Code 3**	**Description**

SOCIAL ELEMENTS IMPACTING DIAGNOSIS (DSM-5) *Check all that apply (Required)

☐ None	☐ Problems with access to health care services	☐ Housing Problems (Not Homelessness)	☐ Problems related to the social environment
☐ Educational problems	☐ Problems related to interaction w/legal system/crime	☐ Occupational problems	☐ Homelessness
☐ Financial Problems	☐ Problems with primary support group	☐ Medical disabilities that impact diagnosis or must be accommodated for in treatment	☐ Unknown
☐ Other psychosocial and environmental problems			

FUNCTIONAL ASSESSMENT (DSM-5) Required

Assessment Measure	Assessment Score	Secondary Assessment Measure	Assessment Score
☐ GAF ☐ CGAS		☐ Not Applicable	

III. LOCUS SCORE FOR ADULTS AT TIME OF DISCONTINUATION
MUST Complete all domains from the LOCUS tool)

DOMAIN SCORES:

Risk of Harm: _____ Recovery Environment-Environmental Stressors: _____

Recovery Environment-Environmental Support: _____ Functional Status: _____

Co-morbidity: _____ Recovery and Treatment History: _____ Acceptance and Engagement: _____

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AGENCY: ______________________________ **RIN:** ______________________________

LOCUS SCORE RECOMMENDED AT TIME OF DISCONTINUATION: **Composite Score:** _____

☐ Level I ☐ Level II ☐ Level III ☐ Level IV ☐ Level V ☐ Level VI

IV. OHIO SCALE FOR YOUTH AT TIME OF DISCONTINUATION

Worker Ohio problem severity scale (0-100): ______________________________

IV. TRANSITION PLAN (NARRATIVE) – If applicable *(Please write legibly)*

TRANSITION START DATE: ___________________ **TRANSITION END DATE:** ___________________

PLEASE NOTE THAT INCOMPLETE FORMS WILL BE RETURNED