

# **Williams Class Transition Coordination Process**

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## **Presenters:**

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Patricia Hill & Joanne Rosenberg**

## **Author:**

**Patricia Hill**

## **Summary:**

**This document will step through the Williams Class  
Transition Coordination Process through the use of  
ProviderConnect**

**Revised 12-19-12**

# Getting Started

ILLINOIS  
MENTAL HEALTH COLLABORATIVE  
FOR ACCESS AND CHOICE

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Services

Feedback

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for providers



Provider Online Services

- Home
- **Provider Home**
- Provider Manual
- Provider Forms
- ReferralConnect
- Provider Information

## Provider Online Services

Welcome to Provider Online Services!

### ProviderConnect

Login or register with ProviderConnect, an online tool that allows you to submit and check claims status, check member eligibility, update your provider profile, request inpatient and outpatient authorizations and more. ProviderConnect is easy to use, secure and available 24/7.

Log into  
ProviderConnect

LOG IN

REGISTER

DEMO

Here you will find a wealth of information developed specifically for you, which include ProviderConnect, the Provider Manual, and links to mental health resources.

[ProviderConnect Helpful Resources](#) links you to a ProviderConnect User guide, HIPAA information, software downloads, important forms and helpful phone numbers to assist with the use of this tool!

# Home Page

- Home
- Specific Member Search
- Register Member
- Authorization Listing
- Enter an Authorization Request
- View Clinical Drafts
- Claim Listing and Submission
- Enter EAP CAF
- Enter a Special Program Application
- Complete Provider Forms
- Enter a Comprehensive Service Plan
- Review Referrals
- Enter Bed Tracking Information
- Search Beds/Opening
- EDI Homepage
- Enter Member Reminders
- On Track Outcomes
- Reports
- Print Spectrum Release of Information Form
- My Online Profile
- My Practice Information
- Provider Data Sheet
- Compliance
- Handbooks

Welcome S OF CHICAGO COMM COUNSELING CNTR . Thank you for using ValueOptions ProviderConnect.

YOUR MESSAGE CENTER

Click link to enter  
Williams Transition Outcome  
Tracking Information Form



Your Recent Inquiries box is empty

WHAT DO YOU WANT TO DO TODAY?

▼ [Eligibility and Benefits](#)

- [Find a Specific Member](#)
- [Register a Member](#)

▼ [Enter or Review Authorization Requests](#)

- [Enter an Authorization Request](#)
- [Enter a Special Program Application](#)
- [Enter a Comprehensive Service Plan](#)
- [Review an Authorization](#)
- [View Clinical Drafts](#)

▶ [Enter Member Reminders](#)

CLINICAL SUPPORT TOOLS

▼ [Enter or Review Claims](#)

- [Enter EAP CAF](#)
- [Review a Claim](#)
- [View My Recent Provider Summary Vouchers](#)

[Enter or Review Referrals](#)

- [Enter a Referral](#)
- [Review Referrals](#)

▶ [Enter Bed Tracking Information](#)

▶ [Search Beds/Opening](#)

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▶ [Complete Provider Forms](#)

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Useful Links

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▶ [Enter Bed Tracking Information](#)

▶ [Search Beds/Opening](#)

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▶ [Complete Provider Forms](#)

▶ [Williams Transition Outcome Tracking Information](#)

CLINICAL SUPPORT TOOLS

# Search A Member

## Eligibility & Benefits Search

Required fields are denoted by an asterisk ( \* ) adjacent to the label.

Verify a patient's eligibility and benefits information by entering search criteria below.

\*Consumer ID

*(No spaces or dashes)*

Last Name

First Name

\*Date of Birth

*(MMDDYYYY)*

As of Date

*(MMDDYYYY)*

Search

Enter as much info as possible  
to narrow the search.  
Member ID and Date of Birth  
are **required** fields  
(Note: Member ID is the Consumer RIN)

# Demographics Verification

Demographics

Enrollment History

COB

Benefits

Additional Information

Consumer ID is the Consumer RIN

Consumer eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

## Consumer?

Consumer ID

123456026

Alternate ID

Consumer Name

TEST26, ILLTESTMBR

Date of Birth

01/01/1990

Address

26 TEST ST.  
CHICAGO, IL 60290

Alternate Address

Marital Status

-

Home Phone

Work Phone

Relationship

1

Gender

M - Male

After confirming the correct consumer has been located, click "Next"

## Eligibility

Effective Date

07/01/2008

Expiration Date

COB Effective Date?

[View Funding Source Enrollment Details](#)

## Subscriber

Subscriber ID

123456026

Subscriber Name

TEST26, ILLTESTMBR

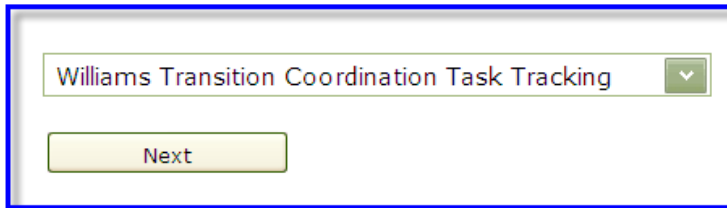
Next

# Williams Class Transition Coordination Form Landing Page

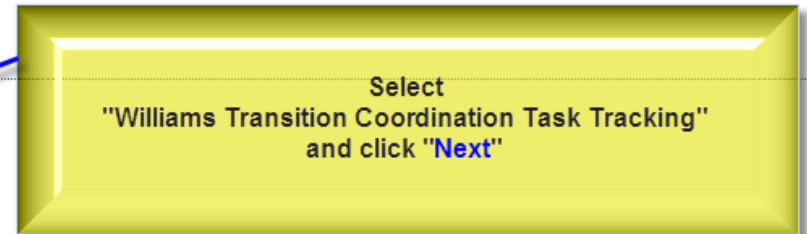
---

S OF CHICAGO COMM COUNSELING CNTR . Thank you for using ValueOptions ProviderConnect.

## PROVIDER FORMS



A screenshot of a web form. At the top, there is a dropdown menu with the text "Williams Transition Coordination Task Tracking" and a small downward-pointing arrow icon. Below the dropdown is a yellow button with the text "Next". The entire form area is enclosed in a blue rectangular border.



Select  
"Williams Transition Coordination Task Tracking"  
and click "Next"

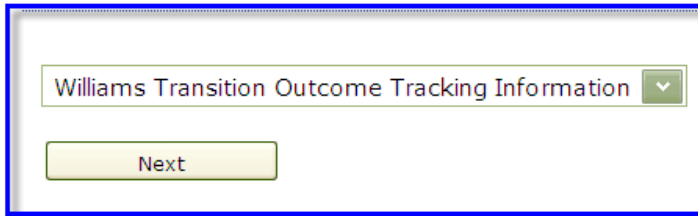
A yellow rectangular box with a 3D effect and a drop shadow. It contains the instruction text. A blue arrow points from the left side of this box to the dropdown menu in the form screenshot.

# Williams Class Transition Coordination Form Landing Page

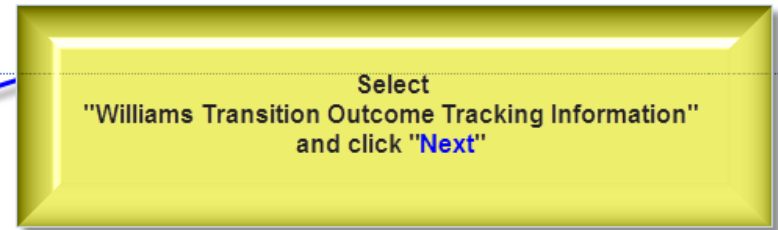
---

S OF CHICAGO COMM COUNSELING CNTR . Thank you for using ValueOptions ProviderConnect.

## PROVIDER FORMS



A screenshot of a web form titled "PROVIDER FORMS". The form contains a dropdown menu with the text "Williams Transition Outcome Tracking Information" and a small downward arrow icon. Below the dropdown is a button labeled "Next". The entire form area is enclosed in a blue rectangular border.





# Williams Class

## Transition Coordination Form

### Pre-Transition Planning and Functions

#### Complete Provider Forms

Consumer Name      Consumer ID  
ILLTESTMBR TEST25    123456025

All fields with an asterisk are **required** fields and must be completed

#### Outcome Tracking Information

All fields marked with an asterisk (\*) are required.

Note: Disable pop-up blocker functionality to view all appropriate links.

#### Pre-Transition Planning and Functions

This section tracks the coordination of other transition plans.

\*Risk Assessment & Mitigation Plan - High-level plan elements to be tracked completed?

Yes  No

\*24-hour Backup Plan Created?

Yes  No

\*Quality Life Survey Created?

Yes  No

Completion Date

Date Created

Date Created

This section tracks the coordination of other transition plans

# Williams Class Outcomes Tracking Form

## Transition Coordinator Transition Task Tracking

### Transition Coordinator Transition Task Tracking

This section is a checklist that tracks coordination of resources, services and activities to ensure a smooth transition to a community setting.

*Linkage/scheduling for psychiatric appointment? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>	*Ensure two week supply of medicine available? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>
*Scheduling for medical? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>	*Scheduling for dental? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>
*Establishment of representative payee (if applicable)? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>	*Coordinating medical transportation/transportation travel to appointments? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>
*Coordination of benefits/entitlement application? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>	*Is housing search complete? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>
*Secure recommended housing? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Housing Type <input type="text" value="SELECT..."/>	Completion Date <input type="text"/>	
*Schedule staffing with the primary services provider? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>	*Medication management & administration? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>
*Application for food stamps complete? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>	*Ensure two weeks of food on hand (if PSH and applicable only) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>
*Processing paperwork for bridge subsidy housing? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>	*Activation of Day Time Activity supports? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>
*Meetings with family/collaterals, etc? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>	*Other services as applicable? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>
*Shopping for essentials? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>	*Allowable purchases checklist review? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>
*Secure transition funds? (Amount depends on type of housing) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>		

**This section is a checklist that tracks coordination of resources, services and activities to ensure a smooth transition to a community setting.**  
**(All fields with an asterisk are **required** fields)**

# Williams Class Outcomes Tracking Form

## Outcome Tracking Information

### Outcome Tracking Information

\*Date of contact with individual

\*Type of Contact

\*Is individual still residing in initial residence?

 Yes  No

If No, please indicate his or her status below

Date Provided

If the tenant was evicted or asked to leave the unit by the landlord using official processes, please indicate the reason for eviction and provide below:

- Refusal to pay rent
- Argumentative/combative with neighbors/others
- Disturbing privacy
- Destruction of landlord property
- Destruction of others' property
- Physical violence/aggression

**This section of the Williams Class Tracking Form will be completed at a later time in your process. If there are any fields that are **required** and you know the answers, you may enter them at this time. They will then pre-populate when you submit an update to this section.**

\*Is the individual paying his/her rent on time?

If No, reason for not paying rent on time

\*Have any critical incidents occurred during the reporting period?

 Yes  No

If Yes, how many?


Specify (check) all critical incident types that occurred during the reporting period and provide the date of the incident.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Inpatient Treatment/Hospital Visit                    | <input type="checkbox"/> Nursing Facility Placement      | <input type="checkbox"/> Alleged Fraud/Misuse of Funds            |
| <input type="checkbox"/> Property Damage                                       | <input type="checkbox"/> Criminal Activity/Incarceration | <input type="checkbox"/> Contact with Law Enforcement             |
| <input type="checkbox"/> Fire/Arson  | <input type="checkbox"/> Missing Person/Disappearance    | <input type="checkbox"/> Behavioral Incident Involving Individual |
| <input type="checkbox"/> Suspected Mistreatment (abuse, neglect, exploitation) | <input type="checkbox"/> Physical Altercation            | <input type="checkbox"/> Serious injury to individual             |
| <input type="checkbox"/> Death   | <input type="checkbox"/> Assault                         | <input type="checkbox"/> Suicide Attempt                          |
| <input type="checkbox"/> Repeated Critical Incidents                           |  |   |

# Williams Class Transition Coordination Form (Continued)

\*Is the individual still receiving community mental health services?  
 Yes  No

\*What is the individual's current monthly income?

What was the outcome of the wellness check?  
SELECT... 

Did the individual engage in any of the following activities during the reporting period? (check all that apply)

<input type="checkbox"/> Paid employment (full or part time)	<input type="checkbox"/> Supported employment	<input type="checkbox"/> Vocational Training
<input type="checkbox"/> Volunteer work	<input type="checkbox"/> Education (GED prep, ESL, etc.)	<input type="checkbox"/> None
<input type="checkbox"/> Other		

If other please specify

**All fields with an asterisk are **required** fields**

**Once you complete the Transition Coordination Section of the "Outcomes Tracking Form", click "**Submit**"**

**Permanent Subsidy Information**

Has the individual applied for a Section 8 Waiting List or other permanent housing subsidy waitlist?  
 Yes  No

# Williams Class Transition Coordination Form Submission Landing Page

Home

Click "Home" to return to the Home Page

- Specific Consumer Search
- Register Consumer
- Authorization Listing
- Enter an Authorization Request
- View Clinical Drafts
- Claim Listing and Submission
- Enter a Special Program Application
- Complete Provider Forms
- Enter a Comprehensive Service Plan

JANET WATTLES MENTAL HEALTH CENTER . Thank you for using ValueOptions ProviderConnect.

## PROVIDER FORMS

The Williams Class Tracking Form has been saved successfully

SELECT

Next

This message will display once you have successfully completed the "Williams Class Tracking Form"

# Home Page

Home

Specific Member Search

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Search Beds/Opening

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Enter Member Reminders

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Print Spectrum Release of Information Form

My Online Profile

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Provider Data Sheet

Compliance

Home

Welcome S OF CHICAGO COMM COUNSELING CNTR . Thank you for using ValueOptions ProviderConnect.

YOUR MESSAGE CENTER

INBOX

SENT

Your Recent Inquiries box is empty

WHAT DO YOU WANT TO DO TODAY?

Eligibility and Benefits

- Find a Specific Member
- Register a Member

Enter or Review Claims

- Enter EAP CAF
- Review a Claim
- View My Recent Provider Summary Vouchers

Enter or Review Authorization Requests

- Enter an Authorization Request
- Enter a Special Program Application
- Enter a Comprehensive Service Plan
- Review an Authorization
- View Clinical Drafts

Enter or Review Referrals

- Enter a Referral
- Review Referrals

Enter Member Reminders

- Enter Bed Tracking Information
- Search Beds/Opening
- View My Recent Authorization Letters
- Complete Provider Forms
- Williams Transition Outcome Tracking Information

CLINICAL SUPPORT TOOLS

Click either link to search for a specific consumer

# Search A Member

## Eligibility & Benefits Search

Required fields are denoted by an asterisk ( \* ) adjacent to the label.

Verify a patient's eligibility and benefits information by entering search criteria below.

\*Consumer ID

*(No spaces or dashes)*

Last Name

First Name

\*Date of Birth

*(MMDDYYYY)*

As of Date

02142012

*(MMDDYYYY)*

Search

Enter as much info as possible  
to narrow the search.  
Member ID and Date of Birth  
are **required** fields  
(Note: Member ID is the Consumer RIN)

# Demographics Page

Consumer eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

Authorization Listing

Enter an Authorization Request

View Clinical Drafts

Claim Listing and Submission

Enter a Special Program Application

Complete Provider Forms

Enter a Comprehensive Service Plan

EDI Homepage

Enter Member Reminders

On Track Outcomes

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My Practice Information

Provider Data Sheet

Performance Report

Compliance

Handbooks

Forms

Network Specific Information

Education Center

ValueSelect Designation

Contact Us

## Consumer <sup>?</sup>

Consumer ID **123456025**  
Alternate ID  
Consumer Name **TEST25, ILLTESTMBR**  
Date of Birth **01/01/1990**  
Address **25 TEST ST.  
CHICAGO, IL 60290**  
Alternate Address  
Marital Status -  
Home Phone  
Work Phone  
Relationship **1**  
Gender **M - Male**

## Eligibility

Effective Date **07/01/2008**  
Expiration Date  
COB Effective Date <sup>?</sup>  
[View Funding Source Enrollment Details](#)

## Subscriber

Subscriber ID **123456025**  
Subscriber Name **TEST25, ILLTESTMBR**

To view a completed  
"Williams Class Tracking Form"  
click "**Provider Forms**"

View Consumer Auths

View Consumer Claims

View Empire Claims

View GHI-BMP Claims

Enter Auth Request

Send Inquiry

View Clinical Drafts

Comprehensive Service Plan

Enter Member Reminders

View Consumer Registrations

Special Program Applications

Provider Forms



# Demographics Page

## (Submitted Provider Forms)

Complete Provider Forms

Enter a Comprehensive Service Plan

EDI Homepage

Enter Member Reminders

On Track Outcomes

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Handbooks

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Network Specific Information

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ValueSelect Designation

Contact Us

Date of Birth **01/01/1990**  
Address **25 TEST ST.  
CHICAGO, IL 60290**  
Alternate Address  
Marital Status **-**  
Home Phone  
Work Phone  
Relationship **1**  
Gender **M - Male**

[View Funding Source Enrollment Details](#)

### Subscriber

Subscriber ID **123456025**  
Subscriber Name **TEST25, ILLTESTMBR**

Locate the "Application Type"  
for "Williams Class Outcomes Tracking (WCOTC)"

[View Consumer Auths](#) [View Consumer Claims](#) [View Empire Claims](#) [View GHI-BMP Claims](#)  
[Enter Auth Request](#) [Send Inquiry](#) [View Clinical Drafts](#) [Comprehensive Service Plan](#)  
[Enter Member Reminders](#) [View Consumer Registrations](#) [Special Program Applications](#) [Provider Forms](#)

[Complete Provider Forms](#)

### Consumer Provider Forms

Application Type	Date Application Submitted
<a href="#">WCOTC</a>	02/16/2012

# Outcomes Tracking Information History

## Complete Provider Forms

Consumer Name      Consumer ID  
**ILLTESTMBR TEST25    123456025**

## Outcome Tracking Information History

*All fields marked with an asterisk (\*) are required.  
Note: Disable pop-up blocker functionality to view all appropriate links.*

This page displays the  
Outcome Tracking Information History

## Pre-Transition Planning and Functions

This section tracks the coordination of other transition plans.

Risk Assessment & Mitigation Plan - High-level plan elements to be tracked completed? <b>YES</b>	Date Created <b>02162012</b>
24-hour Backup Plan Created? <b>YES</b>	Date Created <b>02162012</b>
Quality Life Survey Created? <b>YES</b>	Date Created <b>02162012</b>

## Transition Coordinator Transition Task Tracking

This section is a checklist that tracks coordination of resources, services and activities to ensure a smooth transition to a community setting.

Linkage/scheduling for psychiatric appointment? <b>YES</b>	Completion Date <b>02162012</b>	Ensure two week supply of medicine available? <b>YES</b>	Completion Date <b>02162012</b>
Scheduling for medical? <b>YES</b>	Completion Date <b>02162012</b>	Scheduling for dental? <b>YES</b>	Completion Date <b>02162012</b>
Establishment of representative payee (if applicable)? <b>YES</b>	Completion Date <b>02162012</b>	Coordinating medical transportation/transportation travel to appointments? <b>YES</b>	Completion Date <b>02162012</b>
Coordination of benefits/entitlement application? <b>YES</b>	Completion Date <b>02162012</b>	Is housing search complete? <b>YES</b>	Completion Date <b>02162012</b>

**Q & A**

---

**QUESTIONS ???**

# **Williams Class PSH Outcome Tracking**

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**This section will step through  
the process of submitting a  
Williams Class PSH Outcomes Tracking  
through the use of ProviderConnect**

# Getting Started

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MENTAL HEALTH COLLABORATIVE  
FOR ACCESS AND CHOICE

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for providers



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# Home Page

Welcome S OF CHICAGO COMM COUNSELING CNTR . Thank you for using ValueOptions ProviderConnect.

YOUR MESSAGE CENTER

Click either link to enter  
Outcomes Tracking



Your Recent Inquiries box is empty

WHAT DO YOU WANT TO DO TODAY?

▼ [Eligibility and Benefits](#)

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- [Register a Member](#)

▼ [Enter or Review Authorization Requests](#)

- [Enter an Authorization Request](#)
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[Enter or Review Referrals](#)

- [Enter a Referral](#)
- [Review Referrals](#)

▶ [Enter Bed Tracking Information](#)

▶ [Search Beds/Openings](#)

▶ [View My Recent Authorization Letters](#)

▶ [Complete Provider Forms](#)

▶ [Williams Transition Outcome Tracking Information](#)

CLINICAL SUPPORT TOOLS

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Last Name

First Name

\*Date of Birth

*(MMDDYYYY)*

As of Date

*(MMDDYYYY)*

Search

Enter as much info as possible  
to narrow the search.  
Member ID and Date of Birth  
are **required** fields  
(Note: Member ID is the Consumer RIN)

# Demographics Verification

Demographics

Enrollment History

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Consumer ID is the Consumer RIN

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Consumer ID

123456026

Alternate ID

Consumer Name

TEST26, ILLTESTMBR

Date of Birth

01/01/1990

Address

26 TEST ST.  
CHICAGO, IL 60290

Alternate Address

Marital Status

-

Home Phone

Work Phone

Relationship

1

Gender

M - Male

After confirming the correct consumer has been located, click "Next"

## Eligibility

Effective Date

07/01/2008

Expiration Date

COB Effective Date?

[View Funding Source Enrollment Details](#)

## Subscriber

Subscriber ID

123456026

Subscriber Name

TEST26, ILLTESTMBR

Next

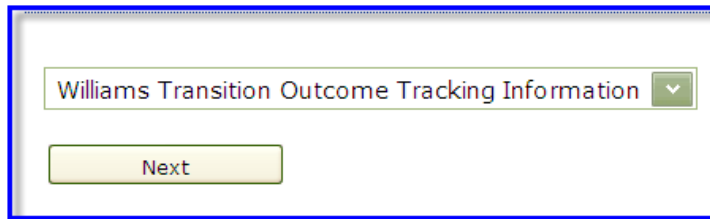


# Williams Class Outcomes Tracking Form Landing Page

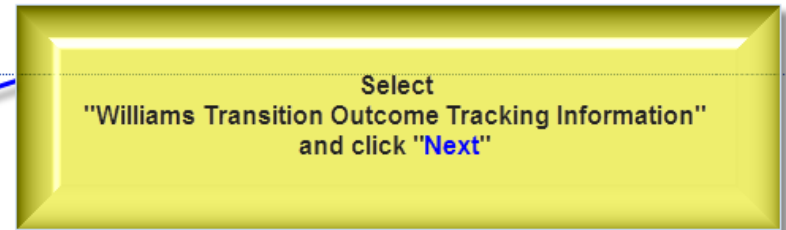
---

S OF CHICAGO COMM COUNSELING CNTR . Thank you for using ValueOptions ProviderConnect.

## PROVIDER FORMS



Williams Transition Outcome Tracking Information



Select  
"Williams Transition Outcome Tracking Information"  
and click "Next"

# Williams Class Outcomes Tracking Form

## Pre-Transition Planning and Functions

### Complete Provider Forms

Consumer Name      Consumer ID  
**ILLTESTMBR TEST25    123456025**

### Outcome Tracking Information

All fields marked with an asterisk (\*) are required.

Note: Disable pop-up blocker functionality to view all appropriate links.

All fields with an asterisk are **required** fields and must be completed

### Pre-Transition Planning and Functions

This section tracks the coordination of other transition plans.

\*Risk Assessment & Mitigation Plan - High-level plan elements to be tracked completed?

Yes  No

Completion Date



\*24-hour Backup Plan Created?

Yes  No

Date Created



\*Quality Life Survey Created?

Yes  No

Date Created



This section tracks the coordination of other transition plans and will be pre-populated from the Transition Coordination Process

# Williams Class Outcomes Tracking Form

## Transition Coordinator Transition Task Tracking

### Transition Coordinator Transition Task Tracking

This section is a checklist that tracks coordination of resources, services and activities to ensure a smooth transition to a community setting.

*Linkage/scheduling for psychiatric appointment? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>	*Ensure two week supply of medicine available? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>
*Scheduling for medical? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>	*Scheduling for dental? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>
*Establishment of representative payee (if applicable)? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>	*Coordinating medical transportation? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>
*Coordination of benefits/entitlement application? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>	*Is housing search complete? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>
*Secure recommended housing? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Housing Type SELECT... <input type="button" value="v"/>	Completion Date <input type="text"/>	
*Schedule staffing with the primary services provider? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>	*Medication management & administration? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>
*Application for food stamps complete? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>	*Ensure two weeks of food on hand (if PSH and applicable only) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>
*Processing paperwork for bridge subsidy housing? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>	*Activation of Day Time Activity supports? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>
*Meetings with family/collaterals, etc? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>	*Other services as applicable? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>
*Shopping for essentials? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>	*Allowable purchases checklist review? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>
*Secure transition funds? (Amount depends on type of housing) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	Completion Date <input type="text"/>		

This section will be pre-populated from the "Transition Coordination Process" data that was entered earlier

# Williams Class Outcomes Tracking Form

## Outcome Tracking Information

### Outcome Tracking Information

\*Date of contact with individual

\*Type of Contact

\*Is individual still residing in initial residence?

 Yes  No

If No, please indicate his or her status below

Date Provided

If the tenant was evicted or asked to vacate the unit by the landlord using official recourse, please indicate the reason for eviction and explain below.

- Refusal to pay rent
- Argumentative/combatative with neighbors/others
- Disturbing privacy
- Destruction of landlord's property
- Destruction of others' property
- Physical violence/aggression

All fields with an asterisk are **required** fields

- Fire setting
- Drug trafficking
- Other

If Other, please explain

\*Is the individual paying his/her rent on time?

If No, reason for not paying rent on time

\*Have any critical incidents occurred during the reporting period?

 Yes  No

If Yes, how many?

Specify (check) all critical incident types that occurred during the reporting period and provide the date of the incident.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Inpatient Treatment/Hospital Visit                       | <input type="checkbox"/> Nursing Facility Placement      | <input type="checkbox"/> Alleged Fraud/Misuse of Funds            |
| <input type="checkbox"/> Property Damage  | <input type="checkbox"/> Criminal Activity/Incarceration | <input type="checkbox"/> Contact with Law Enforcement             |
| <input type="checkbox"/> Fire/Arson   | <input type="checkbox"/> Missing Person/Disappearance    | <input type="checkbox"/> Behavioral Incident Involving Individual |
| <input type="checkbox"/> Suspected Mistreatment<br>(abuse, neglect, exploitation) | <input type="checkbox"/> Physical Altercation            | <input type="checkbox"/> Serious injury to individual             |
| <input type="checkbox"/> Death  | <input type="checkbox"/> Assault                         | <input type="checkbox"/> Suicide Attempt                          |
| <input type="checkbox"/> Repeated Critical Incidents                              |  |   |

# Williams Class Outcomes Tracking Form

## Outcome Tracking Information (Continued)

---

\*Is the individual still receiving community mental health services?

Yes  No

\*What is the individual's current monthly income?

What was the outcome of the wellness check?

SELECT...



Did the individual engage in any of the following activities during the reporting period? (check all that apply)

Paid employment (full or part time)

Supported employment

Vocational Training

Volunteer work

Education (GED prep, ESL, etc.)

None

Other

If other please specify

All fields with an asterisk  
are **required** fields

### Permanent Subsidy Information

Has the individual applied for a Section 8 Waiting List or other permanent housing subsidy waitlist?

Yes  No

Back

Submit

Once you complete the  
"Outcomes Tracking Form", select "**Submit**"



# Williams Class Outcomes Tracking Form Submission Landing Page

Home

Click "Home" to return to the Home Page

- Specific Consumer Search
- Register Consumer
- Authorization Listing
- Enter an Authorization Request
- View Clinical Drafts
- Claim Listing and Submission
- Enter a Special Program Application
- Complete Provider Forms
- Enter a Comprehensive Service Plan

JANET WATTLES MENTAL HEALTH CENTER . Thank you for using ValueOptions ProviderConnect.

## PROVIDER FORMS

The Williams Class Tracking Form has been saved successfully

SELECT

Next

This message will display once you have successfully completed the "Williams Class Tracking Form"

# Home Page

Home

Specific Member Search

Register Member

Authorization Listing

Enter an Authorization Request

View Clinical Drafts

Claim Listing and Submission

Enter EAP CAF

Enter a Special Program Application

Complete Provider Forms

Enter a Comprehensive Service Plan

Review Referrals

Enter Bed Tracking Information

Search Beds/Opening

EDI Homepage

Enter Member Reminders

On Track Outcomes

Reports

Print Spectrum Release of Information Form

My Online Profile

My Practice Information

Provider Data Sheet

Compliance

Headline

Welcome S OF CHICAGO COMM COUNSELING CNTR . Thank you for using ValueOptions ProviderConnect.

YOUR MESSAGE CENTER

INBOX

SENT

Your Recent Inquiries box is empty

WHAT DO YOU WANT TO DO TODAY?

Eligibility and Benefits

- Find a Specific Member
- Register a Member

Enter or Review Authorization Requests

- Enter an Authorization Request
- Enter a Special Program Application
- Enter a Comprehensive Service Plan
- Review an Authorization
- View Clinical Drafts

Enter Member Reminders

Enter or Review Claims

- Enter EAP CAF
- Review a Claim
- View My Recent Provider Summary Vouchers

Enter or Review Referrals

- Enter a Referral
- Review Referrals

Enter Bed Tracking Information

Search Beds/Opening

View My Recent Authorization Letters

Complete Provider Forms

Williams Transition Outcome Tracking Information

CLINICAL SUPPORT TOOLS

Click either link to search for a specific consumer

# Search A Member

## Eligibility & Benefits Search

Required fields are denoted by an asterisk ( \* ) adjacent to the label.

Verify a patient's eligibility and benefits information by entering search criteria below.

\*Consumer ID

*(No spaces or dashes)*

Last Name

First Name

\*Date of Birth

*(MMDDYYYY)*

As of Date

*(MMDDYYYY)*

Search

Enter as much info as possible  
to narrow the search.  
Member ID and Date of Birth  
are **required** fields  
(Note: Member ID is the Consumer RIN)



# Demographics Page

Consumer eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

Authorization Listing

Enter an Authorization Request

View Clinical Drafts

Claim Listing and Submission

Enter a Special Program Application

Complete Provider Forms

Enter a Comprehensive Service Plan

EDI Homepage

Enter Member Reminders

On Track Outcomes

Reports

My Online Profile

My Practice Information

Provider Data Sheet

Performance Report

Compliance

Handbooks

Forms

Network Specific Information

Education Center

ValueSelect Designation

Contact Us

## Consumer <sup>?</sup>

Consumer ID **123456025**  
Alternate ID  
Consumer Name **TEST25, ILLTESTMBR**  
Date of Birth **01/01/1990**  
Address **25 TEST ST.  
CHICAGO, IL 60290**  
Alternate Address  
Marital Status -  
Home Phone  
Work Phone  
Relationship **1**  
Gender **M - Male**

## Eligibility

Effective Date **07/01/2008**  
Expiration Date  
COB Effective Date <sup>?</sup>  
[View Funding Source Enrollment Details](#)

## Subscriber

Subscriber ID **123456025**  
Subscriber Name **TEST25, ILLTESTMBR**

To view a completed  
"Outcomes Tracking Form"  
click "**Provider Forms**"

View Consumer Auths

View Consumer Claims

View Empire Claims

View GHI-BMP Claims

Enter Auth Request

Send Inquiry

View Clinical Drafts

Comprehensive Service Plan

Enter Member Reminders

View Consumer Registrations

Special Program Applications

Provider Forms

# Demographics Page

## (Submitted Provider Forms)

### Complete Provider Forms

[Enter a Comprehensive Service Plan](#)

[EDI Homepage](#)

[Enter Member Reminders](#)

[On Track Outcomes Reports](#)

[Reports](#)

[My Online Profile](#)

[My Practice Information](#)

[Provider Data Sheet](#)

[Performance Report](#)

[Compliance](#)

[Handbooks](#)

[Forms](#)

[Network Specific Information](#)

[Education Center](#)

[ValueSelect Designation](#)

[Contact Us](#)

Date of Birth **01/01/1990**

Address **25 TEST ST.  
CHICAGO, IL 60290**

Alternate Address

Marital Status **-**

Home Phone

Work Phone

Relationship **1**

Gender **M - Male**

[View Funding Source Enrollment Details](#)

### Subscriber

Subscriber ID **123456025**

Subscriber Name **TEST25, ILLTESTMBR**

Locate the "Application Type"  
for "Williams Class Outcomes Tracking (WCOTC)"

[View Consumer Auths](#)

[View Consumer Claims](#)

[View Empire Claims](#)

[View GHI-BMP Claims](#)

[Enter Auth Request](#)

[Send Inquiry](#)

[View Clinical Drafts](#)

[Comprehensive Service Plan](#)

[Enter Member Reminders](#)

[View Consumer Registrations](#)

[Special Program Applications](#)

[Provider Forms](#)

[Complete Provider Forms](#)

### Consumer Provider Forms

Application Type

[WCOTC](#)

Date Application Submitted

02/16/2012

# Outcomes Tracking Information History

## Complete Provider Forms

Consumer Name      Consumer ID  
**ILLTESTMBR TEST25    123456025**

## Outcome Tracking Information History

*All fields marked with an asterisk (\*) are required.  
Note: Disable pop-up blocker functionality to view all appropriate links.*

This page displays the  
Outcome Tracking Information History

## Pre-Transition Planning and Functions

This section tracks the coordination of other transition plans.

Risk Assessment & Mitigation Plan - High-level plan elements to be tracked completed? <b>YES</b>	Date Created <b>02162012</b>
24-hour Backup Plan Created? <b>YES</b>	Date Created <b>02162012</b>
Quality Life Survey Created? <b>YES</b>	Date Created <b>02162012</b>

## Transition Coordinator Transition Task Tracking

This section is a checklist that tracks coordination of resources, services and activities to ensure a smooth transition to a community setting.

Linkage/scheduling for psychiatric appointment? <b>YES</b>	Completion Date <b>02162012</b>	Ensure two week supply of medicine available? <b>YES</b>	Completion Date <b>02162012</b>
Scheduling for medical? <b>YES</b>	Completion Date <b>02162012</b>	Scheduling for dental? <b>YES</b>	Completion Date <b>02162012</b>
Establishment of representative payee (if applicable)? <b>YES</b>	Completion Date <b>02162012</b>	Coordinating medical transportation/transportation travel to appointments? <b>YES</b>	Completion Date <b>02162012</b>
Coordination of benefits/entitlement application? <b>YES</b>	Completion Date <b>02162012</b>	Is housing search complete? <b>YES</b>	Completion Date <b>02162012</b>

**Q & A**

---

**QUESTIONS ???**

# **Williams Class PSH Comprehensive Service Plan**

---

**This section will step through the process  
of submitting a Williams Class PSH  
Comprehensive Service Plan  
through the use of ProviderConnect**

# Getting Started

ILLINOIS  
MENTAL HEALTH COLLABORATIVE

FOR ACCESS AND CHOICE

for providers



Provider Online Services

- Home
- **Provider Home**
- Provider Manual
- Provider Forms
- ReferralConnect
- Provider Information

About

Services

Feedback

Contact

## Provider Online Services

Welcome to Provider Online Services!

### ProviderConnect

Login or register with ProviderConnect, an online tool that allows you to submit and check claims status, check member eligibility, update your provider profile, request inpatient and outpatient authorizations and more.

ProviderConnect is easy to use, secure and available 24/7.

Log into  
ProviderConnect

LOG IN

REGISTER

DEMO

Here you will find a wealth of information developed specifically for you, which include ProviderConnect, the Provider Manual, and links to mental health resources.

[ProviderConnect Helpful Resources](#) links you to a ProviderConnect User guide, HIPAA information, software downloads, important forms and helpful phone numbers to assist with the use of this tool!

# Home Page

Home

[Specific Member Search](#)

[Register Member](#)

[Authorization Listing](#)

[Enter an Authorization Request](#)

[View Clinical Drafts](#)

[Claim Listing and Submission](#)

[Enter EAP CAF](#)

[Enter a Special Program Application](#)

[Complete Provider Forms](#)

[Enter a Comprehensive Service Plan](#)

[Review Referrals](#)

[Enter Bed Tracking Information](#)

[Search Beds/Opening](#)

[EDI Homepage](#)

[Enter Member Reminders](#)

[On Track Outcomes](#)

[Reports](#)

[Print Spectrum Release of Information Form](#)

[My Online Profile](#)

[My Practice Information](#)

[Provider Data Sheet](#)

[Compliance](#)

[Handbook](#)

Welcome S OF CHICAGO COMM COUNSELING CNTR . Thank you for using ValueOptions ProviderConnect.

YOUR MESSAGE CENTER

Click either link to enter a "Comprehensive Service Plan"



Your Recent Inquiries box is empty

WHAT DO YOU WANT TO DO TODAY?

▼ [Eligibility and Benefits](#)

- [Find a Specific Member](#)
- [Register a Member](#)

▼ [Enter or Review Authorization Requests](#)

- [Enter an Authorization Request](#)
- [Enter a Special Program Application](#)
- [Enter a Comprehensive Service Plan](#)
- [Review an Authorization](#)
- [View Clinical Drafts](#)

▶ [Enter Member Reminders](#)

▼ [Enter or Review Claims](#)

- [Enter EAP CAF](#)
- [Review a Claim](#)
- [View My Recent Provider Summary Vouchers](#)

[Enter or Review Referrals](#)

- [Enter a Referral](#)
- [Review Referrals](#)

▶ [Enter Bed Tracking Information](#)

▶ [Search Beds/Opening](#)

▶ [View My Recent Authorization Letters](#)

▶ [Complete Provider Forms](#)

▶ [Williams Transition Outcome Tracking Information](#)

CLINICAL SUPPORT TOOLS

# Search A Member

## Eligibility & Benefits Search

Required fields are denoted by an asterisk ( \* ) adjacent to the label.

Verify a patient's eligibility and benefits information by entering search criteria below.

\*Consumer ID

*(No spaces or dashes)*

Last Name

First Name

\*Date of Birth

*(MMDDYYYY)*

As of Date

*(MMDDYYYY)*

Search

Enter as much info as possible  
to narrow the search.  
Member ID and Date of Birth  
are **required** fields  
(Note: Member ID is the Consumer RIN)



# Demographics Verification

Demographics

Enrollment History

COB

Benefits

Additional Information

**Consumer ID is the Consumer RIN**

Consumer eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

## Consumer?

Consumer ID	<b>123456026</b>
Alternate ID	
Consumer Name	<b>TEST26, ILLTESTMBR</b>
Date of Birth	<b>01/01/1990</b>
Address	<b>26 TEST ST. CHICAGO, IL 60290</b>
Alternate Address	
Marital Status	-
Home Phone	
Work Phone	
Relationship	<b>1</b>
Gender	<b>M - Male</b>

## Eligibility

Effective Date	<b>07/01/2008</b>
Expiration Date	
COB Effective Date?	

[View Funding Source Enrollment Details](#)

## Subscriber

Subscriber ID	<b>123456026</b>
Subscriber Name	<b>TEST26, ILLTESTMBR</b>

**After confirming the correct consumer has been located, click "Next"**

Next

# Comprehensive Service Plan Landing Page

## Comprehensive Service Plan Header

All fields marked with an asterisk (\*) are required.  
Note: Disable pop-up blocker functionality to view all appropriate links.

This field auto-populates

\* Comprehensive Service Plan Start Date (MMDDYYYY)

02142012

\*Level of Service

SELECT...

### Provider

Tax ID  
362862928

Provider ID  
299084

Provider Last Name  
HEALTH CENTER

This is a **required** field

### Consumer

Consumer ID  
123456025

Last Name  
TEST25

First Name  
ILLTESTMBR

Date of Birth (MMDDYYYY)  
01011990

Back

Next

Click "Next" to proceed


# Comprehensive Service Plan Landing Page (Continued)

## Comprehensive Service Plan Header


All fields marked with an asterisk (\*) are required.

Note: Disable pop-up blocker functionality to view all appropriate links.


\* Comprehensive Service Plan Start Date (MMDDYYYY)

02142012 


\*Level of Service

OUTPATIENT 

\*Type of Service

MENTAL HEALTH 

\*Level of Care

ASSERTIVE COMMUNITY TREATMENT 

These are **required** fields

Provider

Tax ID  
362862928

Provider ID  
299084

Provider Last Name  
HEALTH CENTER

Vendor ID

Consumer

Consumer ID  
123456026

Last Name  
TEST26

First Name  
ILLTESTMBR

Date of Birth (MMDDYYYY)  
01011990

Back

Next

Click "Next" to proceed

# Comprehensive Service Plan

## Section 1

### Comprehensive Service Plan

Comprehensive Service Plan Info & Header

Provider Name  
**JANET WATTLES MENTAL HEALTH CENTER**

Provider ID  
**299084**

Save Plan as Draft

[Authorized User](#)

Consumer Name  
**ILLTESTMBR TEST26**

Consumer ID  
**123456026**

Date of Birth  
**01/01/1990**

Address  
**26 TEST ST.  
CHICAGO, IL 60290**

Phone  
--

County  
**031**

Level of Service  
**OUTPATIENT/COMMUNITY BASED**

Type of Service  
**MENTAL HEALTH**

Level of Care  
**ASSERTIVE COMMUNITY TREATMENT**

Type of Care

All fields with an asterisk are **required**

### General Referral Information

\*Transition Coordination Referral Date



\*Residential Transition Recommendation



\*Residential Transition Status



\*Introductory Letter Signed?  Yes  No

Introductory Letter Date



\*Interim Service Plan/Skill Development Plan Created?  Yes  No

Interim Service Plan/Skill Development Plan Date



# Comprehensive Service Plan

## Section 2

### Service Plan

All fields with an asterisk are **required**

*Specify whether or not each of the following services will be required for the consumer.*

\*MH Services  Yes  No

\*SA Services  Yes  No

\*Medical  Yes  No

\*Dental  Yes  No

\*Ancillary Services  Yes  No

\*Podiatry  Yes  No


\*Vocational  Yes  No


Other  Yes  No

Other  Yes  No

\*Coordination with Social Support  Yes  No


\*Coordination with Other Public Resources  Yes  No


Estimated Start Date  

Estimated Start Date  

Estimated Start Date  


Estimated Start Date  

Estimated Start Date  

Estimated Start Date  

Estimated Start Date  

Estimated Start Date  

Estimated Start Date  

Estimated Start Date  

Estimated Start Date  

Provided By

Provided By

Provided By

Provided By

Provided By

Provided By

Provided By

Provided By

Provided By

Provided By

Provided By

Cancel

Submit

After all info has been entered,  
click "**Submit**"

# Comprehensive Service Plan Printing Options

## Submission Status:

\*\*\*\*\* SUBMITTED \*\*\*\*\*

Consumer Name <b>ILLTESTMBR TEST45</b>	Consumer ID <b>123456045</b>	Consumer DOB <b>01/01/1990</b>	Subscriber Name <b>ILLTESTMBR TEST45</b>	Subscriber ID <b>123456045</b>
Comprehensive Service Plan Number <b>01-021612-1-5-1</b>	Comprehensive Service Plan Start Date <b>02162012</b>	<b>Once the Comprehensive Service Plan is submitted successfully, the "Submission Status" page will appear</b>		
Level of Service <b>OUTPATIENT/COMMUNITY BASED</b>	Type of Service <b>MENTAL HEALTH</b>			
Provider Name & Address <b>JANET WATTLES MENTAL HEALTH CENTER 526 W STATE ST ROCKFORD IL 61101 -1214</b>	Provider ID <b>299084</b>	<b>You have the option to <a href="#">Print</a> or <a href="#">Download</a> the "Comprehensive Service Plan Data" If you choose not to use them, they will not be available once you leave this page</b>		

## Comprehensive Service Plan Printing & Downloading Options

*(For the best print results, please print in 'Landscape' format)*

Print Comprehensive Service Plan Data  
*Print Comprehensive Service Plan*

Download Comprehensive Service Plan Data  
*Download the entire Comprehensive Service Plan*

# Comprehensive Service Plan Print Screen

The entire form can now be viewed or printed;  
to print, click the "Print" button  
at the top of the page

Print Comprehensive Service Plan

(For the best print results, please print in 'Landscape' format)

## Comprehensive Service Plan

Comprehensive Service Plan Header

Provider Name  
**HEALTH CENTER JANET WATTLES MENTAL**

Provider ID  
**299084**

Comprehensive Service Plan Number  
**01-021612-1-5-1**

Comprehensive Service Plan Start Date  
**02162012**

Consumer Name  
**ILLTESTMBR TEST45**

Consumer ID  
**123456045**

Date of Birth  
**01/01/1990**

Address  
**45 TEST ST.  
CHICAGO, IL 60290**

## General Referral Information

Transition Coordination Referral Date  
**02162012**

Residential Transition Recommendation  
**Permanent Supportive Housing**

Residential Transition Status  
**In Process**

Introductory Letter Signed?  
**Yes**

Introductory Letter Date  
**02162012**

Interim Service Plan/Skill Development Plan Created?  
**Yes**

Interim Service Plan/Skill Development Plan Date  
**02162012**

## Service Plan

MH Services  
**Yes**

Estimated Start Date  
**02162012**

Provided By  
**Janet Wattles**

# Comprehensive Service Plan Download Option

01-021612-1-5-1

02162012

Level of Service

Type of Service

Level Of Care

Type of Care

**OUTPATIENT/COMMUNITY BASED**

**MENTAL HEALTH**

**COMMUNITY SUPPORT TEAM**

Provider Name & Address

Provider ID

**JANET WATTLES MENTAL HEALTH CENTER**  
**526 W STATE ST**  
**ROCKFORD IL 61101 -1214**

**299084**

The entire form can be downloaded; to download, click the "Download" button and select the format

## Comprehensive Service Plan Printing & Downloading Options

*(For the best print results, please print in 'Landscape' format)*

Print Comprehensive Service Plan Data

*Print Comprehensive Service Plan*

Download Comprehensive Service Plan Data

*Download the entire Comprehensive Service Plan*

Download file in 'PDF' or 'XML' format.  
Please select a file format.

PDF?

XML?

Continue



**Q & A**

---

**QUESTIONS ???**

# **Williams Class PSH Electronic Application Process**

---

**This section will step through the process of submitting an electronic application for Williams Class Permanent Supportive Housing through the use of ProviderConnect**

# **Glossary of Terms**

---

**PSH – Permanent Supportive Housing**

**WCPSH – Williams Class Permanent Supportive  
Housing**

# **Preparing to Submit a Williams Class PSH Electronic Application**

---

- ▶ **Before submitting a Williams Class PSH electronic application**
  - **Consumers must be registered with the Collaborative**
  - **Only DMH Designated Transition Coordinators will be allowed to submit Williams Class PSH applications**

# Getting Started

ILLINOIS  
MENTAL HEALTH COLLABORATIVE

FOR ACCESS AND CHOICE

for providers



Provider Online Services

- Home
- **Provider Home**
- Provider Manual
- Provider Forms
- ReferralConnect
- Provider Information

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Feedback

Contact

## Provider Online Services

Welcome to Provider Online Services!

### ProviderConnect

Login or register with ProviderConnect, an online tool that allows you to submit and check claims status, check member eligibility, update your provider profile, request inpatient and outpatient authorizations and more.

ProviderConnect is easy to use, secure and available 24/7.

Log into  
ProviderConnect

LOG IN

REGISTER

DEMO

Here you will find a wealth of information developed specifically for you, which include ProviderConnect, the Provider Manual, and links to mental health resources.

[ProviderConnect Helpful Resources](#) links you to a ProviderConnect User guide, HIPAA information, software downloads, important forms and helpful phone numbers to assist with the use of this tool!

# Home Page

Home  
Specific Member Search  
Register Member  
Authorization Listing  
Enter an Authorization Request  
View Clinical Drafts  
Claim Listing and Submission  
Enter EAP CAF  
**Enter a Special Program Application**  
Complete Provider Forms  
Enter a Comprehensive Service Plan  
Review Referrals  
Enter Bed Tracking Information  
Search Beds/Openings  
EDI Homepage  
Enter Member Reminders  
On Track Outcomes  
Reports  
Print Spectrum Release of Information Form  
My Online Profile  
My Practice Information  
Provider Data Sheet  
Compliance

**Welcome S OF CHICAGO COMM COUNSELING CNTR . Thank you for using ValueOptions ProviderConnect.**

**YOUR MESSAGE CENTER**

**Click either link to enter an application for Williams Class PSH**

**INBOX** **SENT**

Your Recent Inquiries box is empty

**WHAT DO YOU WANT TO DO TODAY?**

- Eligibility and Benefits
  - Find a Specific Member
  - Register a Member
- Enter or Review Authorization Requests
  - Enter an Authorization Request
  - Enter a Special Program Application**
  - Enter a Comprehensive Service Plan
  - Review an Authorization
  - View Clinical Drafts
- Enter Member Reminders

- Enter or Review Claims
  - Enter EAP CAF
  - Review a Claim
  - View My Recent Provider Summary Vouchers
- Enter or Review Referrals
  - Enter a Referral
  - Review Referrals
- Enter Bed Tracking Information
- Search Beds/Openings
- View My Recent Authorization Letters
- Complete Provider Forms
- Williams Transition Outcome Tracking Information

**CLINICAL SUPPORT TOOLS**

# Disclaimer Page

---

## Disclaimer

---

Please note that ValueOptions recognizes only fully completed and submitted requests as formal requests for a special program application. Exiting or aborting the process prior to completion will not result in a completed request. ValueOptions does not recognize or retain data for partially completed requests. Upon full completion of the "Enter a Special Program Application" process, you will receive a screen noting the pending or approved status of your request. Receipt of this screen is notification that your request has been received by ValueOptions.



Next

**After reading the disclaimer  
click "Next"**

# Search a Member

## Eligibility & Benefits Search

Required fields are denoted by an asterisk ( \* ) adjacent to the label.

Verify a patient's eligibility and benefits information by entering search criteria below.

\*Consumer ID

*(No spaces or dashes)*

Last Name

First Name

\*Date of Birth

*(MMDDYYYY)*

As of Date

*(MMDDYYYY)*

Search

Enter as much info as possible  
to narrow the search.  
Member ID and Date of Birth  
are **required fields**  
(Note: Member ID is the Consumer's RIN)



# Demographics Verification

Demographics

Enrollment History

COB

Benefits

Additional Information

Consumer eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

Consumer ID is the Consumer RIN

## Consumer <sup>?</sup>

Consumer ID **123456025**

Alternate ID

Consumer Name **TEST25, ILLTESTMBR**

Date of Birth **01/01/1990**

Address **25 TEST ST.  
CHICAGO, IL 60290**

Alternate Address

Marital Status -

Home Phone

Work Phone

Relationship **1**

Gender **M - Male**

Effective Date **07/01/2008**

Expiration Date

COB Effective Date <sup>?</sup>

[View Funding Source Enrollment Details](#)

## Subscriber

Subscriber ID **123456025**

Subscriber Name **TEST25, ILLTESTMBR**

Next

After confirming the correct consumer has been located, click "Next"

# Application Landing Page

## Special Program Application

All fields marked with an asterisk (\*) are required.

Note: Disable pop-up blocker functionality to view all appropriate links.

### \*Application Type

Please only select the Special Program Application Type for which your agency is authorized.

WILLIAMS CLASS PSH

Select  
Williams Class PSH

### Provider

Tax ID	Provider ID <b>299084</b>	Provider Last Name <b>JANET WATTLES MENTAL</b>	Vendor ID <b>IL1000000</b>
--------	------------------------------	---	-------------------------------

### Consumer

Consumer ID <b>123456025</b>	Last Name <b>TEST25</b>	First Name <b>ILLTESTMBR</b>	Date of Birth (MMDDYYYY) <b>01011990</b>
---------------------------------	----------------------------	---------------------------------	---

## Attach a Document

Complete the form below to attach a document with this Request

The following fields are only required if you are uploading a document

This section allows you to upload multiple supporting documents to the application. Skip this section if you want to fax all documents

\*Document Type:

Does this Document contain clinical information about the Consumer?

Yes  No

\*Document Description

SELECT...

UploadFile Click to attach a document

Delete Click to delete an attached document

If the document contains clinical information, then it will be encrypted

Select a document description, then click "Upload File"

Back Next

# Attaching Documents

## Special Program Application

All fields marked with an asterisk (\*) are required.

Note: Disable pop-up blocker functionality to view all appropriate links.

### \*Application Type

Please only select the Special Program Application Type

WILLIAMS CLASS PSH

### Provider

Tax ID

### Consumer

Consumer ID

123456025

ID  
0000

(MMDDYYYY)  
1990

## Attach a Document

Complete the form below to attach a document with this Request

The following fields are only required if you are uploading a document

\*Document Type:

Does this Document contain clinical information about the Consumer?

Yes  No

\*Document Description

ADDITIONAL CLINICAL

UploadFile

Click to attach a document

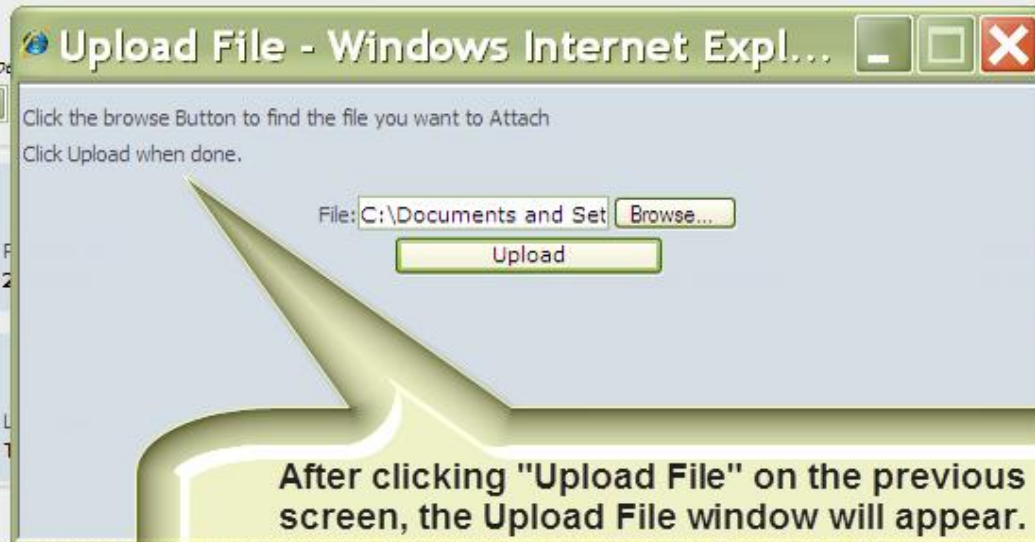
Delete

Click to delete an attached document

Attached Document:

Back

Next



After clicking "Upload File" on the previous screen, the Upload File window will appear. Click the browse button to find the file that you want to attach and click Upload when done

# Application Landing Page (after uploading a document)

## Special Program Application

All fields marked with an asterisk (\*) are required.

Note: Disable pop-up blocker functionality to view all appropriate links.

### \*Application Type

Please only select the Special Program Application Type for which your agency is authorized.

WILLIAMS CLASS PSH

### Provider

Tax ID	Provider ID <b>299084</b>	Provider Last Name <b>JANET WATTLES MENTAL</b>	Vendor ID <b>IL1000000</b>
--------	------------------------------	---	-------------------------------

### Consumer

Consumer ID <b>123456025</b>	Last Name <b>TEST25</b>	First Name <b>ILLTESTMBR</b>	Date of Birth (MMDDYYYY) <b>01011990</b>
---------------------------------	----------------------------	---------------------------------	---

## Attach a Document

Complete the form below to attach a document with this Request

The following fields are only required if you are uploading a document

\*Document Type:

Does this Document contain clinical information about the Consumer? Yes  No

\*Document Description

SELECT...

UploadFile

Click to attach a document

Delete

Click to delete an attached document

Attached Document:

(PSH Clinical.doc) - Secure-Clinical Document - PCRFS04

Back Next

Click Next when finished

The "Document Type" and "Document Description" fields have cleared. This allows you to repeat the uploading process as many times as necessary.


As each document is uploaded it will appear in this area

# Special Program Application

## (Section 1)

### Application

Intake Request Date  
(applicable for PSH application only) (MMDDYYYY)

**Williams Class PSH  
will not require an Intake, so  
this field does not apply**

#### Section 1: Applicant (Head of Household) Information

Phone #

Mobile #

Work #  
   Ext

Pager #

Email

Fax #

\*Race

- |   |  |
|---|--|
| <input type="checkbox"/> White                                    | <input type="checkbox"/> Black or African American                 |
| <input type="checkbox"/> Asian                                    | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> American Indian or Alaskan Native        | <input type="checkbox"/> Asian and White                           |
| <input type="checkbox"/> American Indian/Alaskan Native and White | <input type="checkbox"/> American Indian/Alaskan Native and Black  |
| <input type="checkbox"/> Black/African American and White         | <input type="checkbox"/> Other <input type="text"/>                |

**At least one checkbox must be  
marked. If consumer refuses to  
answer, check "Other"  
and enter "Refused"**

Consumer's Ethnicity (Please select "yes" or "no" for Hispanic Origin. Consumer should select both a "Race" category and a "yes" or "no" for Hispanic Origin):

\*Hispanic Origin

Yes  No

\*United States Veteran

Yes  No

**Fields marked with an  
asterisk are **required**  
fields**

# Special Program Application

## (Section 2)

### Section 2: Eligibility for Bridge Subsidy Initiative

\*1. Has a mental health assessment been completed by a Division of Mental Health contracted community health center within the last 12 months?

Yes  No

If yes, name of mental health center

Care Manager/Therapist Name

Care Manager/Therapist Address

If "Yes" is answered to question #1, then these are **required fields**

City

State

SELECT...



Zip

Phone number of care manager/therapist

Care Manager/Therapist Email Address

Mailing address if different than above

City

State

SELECT...



Mailing Zip

1a. For MFP Applicants: Applicant has been in a nursing home (non-IMD) on a continuous/concurrent basis for six (6) months or longer

Yes  No

1b. For RRP Applicants: Applicant has been in a nursing home (non-IMD) for 12 months or less

Yes  No

**Required For  
MFP or RR  
Applicants Only**

\*2. Does consumer have an Axis 1 diagnosis of serious mental illness or co-occurring mental illness and substance abuse diagnosis? [Information must be completed for all five axes:](#)

Yes  No

# Special Program Application

## (Section 2-Continued)

### Diagnosis

Please indicate primary diagnosis.

At least one entry is  
**required** for  
Axes I - IV

#### Axis I

\* Diagnosis Code 1

Description

Diagnosis Code 2

Description

Diagnosis Code 3

Description

#### Axis II

\* Diagnosis Code 1

Description

Diagnosis Code 2

Description

Diagnosis Code 3

Description

#### Axis III

\*Diagnosis Code 1

SELECT...



Diagnosis Code 2

SELECT...



Diagnosis Code 3

SELECT...



#### \*Axis IV

Check all that apply

None

Financial problems

Housing Problems

Occupational problems

Problems with Primary support group

Unknown

Educational problems

Problems with access to health care services

Problems related to interaction w/legal system/crime

Other psychosocial and environmental problems

Problems related to the social environment

# Special Program Application

## (Section 2-Continued)

---

**Axis V - Both fields are required**

**Axis V**

\*Current GAF Score

Highest GAF Score in the Past Year

For any Axis III diagnosis or condition listed, please describe how consumer is being assisted to manage this condition:

\*Does consumer have a dual diagnosis mental illness and developmental disability (MI-DD)?  Yes  No

If yes, please identify the DD Diagnosis

**This field is required**

```
graph TD; A["Axis V - Both fields are required"] --> B["*Current GAF Score"]; A --> C["Highest GAF Score in the Past Year"]; D["This field is required"] --> E["DD Diagnosis"];
```



# Special Program Application

## (Section 2-Continued)

### LOCUS Results

#### Functional Impairment Domain Scores:

\*Risk of Harm

SELECT... ▼

\*Recovery - Environment Stressors

SELECT... ▼

\*Functional Status

SELECT... ▼

\*Recovery - Environment Supports

SELECT... ▼

\*Co-Morbidity

SELECT... ▼

\*Recovery and Treatment History

SELECT... ▼

\*Acceptance and Engagement

SELECT... ▼

Composite Score

0

Level Of Care Recommended - Locus

Level Of Care Recommended - Assessors

SELECT... ▼

Reason for deviation of recommended Level Of Care

This section is **required**

# Special Program Application

## (Section 2-Continued)

\*3. Please indicate which of the following categories best apply to the consumer. At least one must be checked for the application to be considered eligible for the DMH Bridge Subsidy Initiative.

Resident of a Long Term Care Facility (nursing facility)

Name of Facility

Location of Facility (City/State)

SELECT...



At risk of placement in a Long Term Care Facility.  
To qualify for this priority population category, you must also answer "yes" to the following question:

Has the applicant had a recent (within 60 days) Pre-Admission Screening/Mental Health and been either determined to be appropriate for Long Term Care admission on a time limited basis or at risk of Long Term Care admission due to the lack of community resources/residential alternatives?

Yes  No

Extended long-term (more than 6 months) patient in a State Psychiatric Hospital

Name of Hospital

Location of Hospital (City/State)

SELECT...



An aging out adolescent or young adult in the Individual Care Grant (ICG) program

ICG Location (City/State)

SELECT...



If you are in an ICG program, in how many months will you age out?

An aging out ward of Department of Child and Family Services guardianship

DCFS Location (City/State)

SELECT...



If you are in an DCFS program, in how many months will you age out?

Resident of a DMH contracted supervised or supported (including MH-CILA) residential treatment setting

Name of Provider Operating the Program:

DMH Location (City/State)

SELECT...



Currently experiencing chronic homelessness as defined by DMH. To qualify for this priority population category, consumer must also answer "yes" to the following two questions:

1. Has consumer been continuously homeless for a year or more OR have had a least four (4) distinct episodes of homelessness in the past three (3) years?

Yes  No

2. Is consumer currently residing in a place not meant for human habitation (e.g., living on the street), a safe haven, or in an emergency shelter? (In rural communities that utilize hotel/motel vouchers in lieu of emergency shelter, individuals making use of such vouchers may check "yes" to this item only if the hotel/motel stay is time limited and funded by a third party.)

Yes  No

**Check this box for  
Williams Class PSH**

# Special Program Application

## (Section 2-Continued)

---

4. In order to qualify for the DMH PSH Bridge Subsidy initiative, the consumer must have a current household income at or below 30% of Area Median Income(AMI). Household income includes any regular income or benefits received by all adult member(s) of the consumer's household. If the consumer does not know the AMI for his/her area, please visit the following link: <http://www.huduser.org/Datasets/IL/IL09/il.pdf>

**These fields are  
required**

\*4a. Is the consumer's income level currently at or below 30% of the Area Median Income (AMI)?

Yes  No

\*4b. Please estimate the total combined monthly income for everyone who will live in the household. Please fill out the application appendix document containing the Household Income chart and attach it to the application via the secure clinical attachment function or fax it.

\*5. If you are accepted into the DMH PSH Bridge Subsidy Initiative you must be currently on a waiting list for a Section 8 Housing Choice Voucher (HCV) or comparable rental subsidy OR agree to register/apply for a HCV or comparable permanent rental subsidy when such opportunities are available. Does consumer agree to maintain his/her status on such a waitlist or apply for open lists when possible?

Yes  No

\*6. In addition to maintaining consumer's status on or applying for an HCV or other rental subsidy list, the consumer must agree to accept an HCV voucher or other comparable tenant-based rental subsidy if it is offered to the consumer. Does the consumer agree to accept a tenant-based HCV voucher or other comparable rental subsidy if it is offered to the consumer?

Yes  No

# Special Program Application

## (Section 3)

### Section 3: Household Information

This question is **required**

If there are no additional household members, please check "None"

\*7. List all other persons (immediate family, only) who will be living in the unit and their relationship to the applicant. Complete the information in the chart for all members of the household.

None

First Name	Last Name	Relationship to Applicant	Birth Date (MMDDYYYY)	Age	Sex	Social Security # (No dashes)	No SSN	Unknown
<input type="text"/>	<input type="text"/>	SELECT...	<input type="text"/>	<input type="text"/>	SELECT...	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>	<input type="text"/>	SELECT...	<input type="text"/>	<input type="text"/>	SELECT...	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>	<input type="text"/>	SELECT...	<input type="text"/>	<input type="text"/>	SELECT...	<input type="text"/>	<input type="radio"/>	<input type="radio"/>
<input type="text"/>	<input type="text"/>	SELECT...	<input type="text"/>	<input type="text"/>	SELECT...	<input type="text"/>	<input type="radio"/>	<input type="radio"/>

When entering data for additional household member(s), every field is **required**

If there is not a Social Security Number to enter, please choose "No SSN" or "Unknown"

# Special Program Application

## (Section 3-Continued)

8. Criminal History: An answer of "yes" to any of the following questions will not necessarily result in a denial of your application for the Bridge Subsidy initiative. This information is being requested to evaluate if adequate supports could be provided in order to ensure the consumer's success in permanent supported housing.

\*Does consumer or any member of consumer's household who will live in the unit have a criminal record?

Yes  No

If "Yes" to the above please indicate whether any of the following statements apply to the consumer or any member of the consumer's household.

8a. Charged or convicted of fire setting/arson within the past 3 years.

Yes  No

If "yes" please indicate if the statement applies to the applicant or household member (please specify)

Applicant

Household Member (please specify)

8b. Charged or convicted of child sexual abuse within the past 3 years.

Yes  No

If "yes" please indicate if the statement applies to the applicant or a household member:

Applicant

Household Member (please specify)

8c. Charged or convicted of sexual violence or assault within the past 3 years.

Yes  No

If "yes" please indicate if the statement applies to the applicant or a household member:

Applicant

Household Member (please specify)

8d. Charged or convicted of violent crime within the past 3 years.

Yes  No

If "yes" please indicate if the statement applies to the applicant or a household member:

Applicant

Household Member (please specify)

8e. On the Sexual Violent Crime Registry.

Yes  No

If "yes" please indicate if the statement applies to the applicant or a household member:

Applicant

Household Member (please specify)

8f. Other criminal charges or convictions in the last 3 years not specified in 8a-e.

Yes  No

If "yes" please indicate if the statement applies to the applicant or a household member:

Applicant

Household Member (please specify)

Explanation of any "yes" statements checked above

**#8 is Required**  
**Questions 8a-8f are only required**  
**if you answer "Yes" to #8**

# Special Program Application

## (Section 3-Continued)

If you choose to fax supporting documents, they must be faxed within one business day of submitting the application. The application will not be complete until all documents are submitted

Application Checklist (Please indicate if document is attached as a secure clinical attachment or is being faxed)

All required supporting documents for this application, including the Mental Health Assessment, LOCUS Assessment, and Individual Treatment Plan, must either be attached as "secure clinical" documents to this application or faxed to the Collaborative (at 866-928-7177) within one business day of this application completion. Should the required documents not be faxed to the Collaborative within one business day, the application will not be considered for processing. The provider will be required to request a new intake for application and to submit a new application.

### Attached Faxed

<input type="radio"/>	<input type="radio"/>	*A copy of the Mental Health Assessment within one year from its origination date. A one page addendum is required if there have been significant clinical changes during this time frame. The document should be titled <u>Mental Health Assessment Addendum</u> .
<input type="radio"/>	<input type="radio"/>	*A copy of the LOCUS assessment completed within the last sixty (60) days. A LOCUS dated later than sixty days will not be accepted.
<input type="radio"/>	<input type="radio"/>	*A copy of the Treatment Plan completed within six (6) months of the application.
<input type="radio"/>	<input type="radio"/>	If "at risk of nursing home placement" is selected as the priority population for this application, A Copy of the Determination Letter for the Pre-Admission Screening/Mental Health (PAS/MH) must be submitted. The PAS/MH must have been completed within 60 days of the application.
<input type="radio"/>	<input type="radio"/>	*Completed application appendix document: Household Income Chart
<input type="radio"/>	<input type="radio"/>	*Documentation of income such as a pay stub or social security letter

It is **required** that you select how each supporting document will be submitted

Intakes do not apply to Williams Class PSH

# Special Program Application

## (Section 4)

Signature Page with applicant signature must be faxed within one business day of submitting the application

### Section 4: Signatures

Signature page with applicant signature must be faxed to the Collaborative within one business day of this application completion, at 866-928-7177. Should the signature page not be faxed to the Collaborative within one business day, the application will not be considered for processing. The provider will be required to request a new intake for application and to submit a new application.

Please confirm your acknowledgement of these conditions.

I understand and affirm that if the applicant is approved for a Bridge Subsidy and is currently residing in a DMH contracted supervised or supported residential treatment setting (including MH-CILA) he or she will move out of this setting to execute the Bridge Subsidy:

*Enter Applicant's Name <input type="text"/>	Signature <input type="text" value="Enter on printed form"/>	*Date (MMDDYYYY) <input type="text"/>
*Enter Care Manager's Name <input type="text"/>	Signature <input type="text" value="Enter on printed form"/>	*Date (MMDDYYYY) <input type="text"/>

I authorize the Division of Mental Health and its contracted entities, the Mental Health Collaborative for Access and Choice and/or the Permanent Supportive Housing Bridge Subsidy Administrators, to utilize the information contained in this application to determine eligibility for the Bridge Subsidy Initiative and to contact my care manager with questions or information regarding this application. I agree to complete additional forms/documentation that may be required to finalize my application. I certify that all information contained in this form is true to the best of my knowledge.

All of these are required fields

*Enter Applicant's Name <input type="text"/>	Signature <input type="text" value="Enter on printed form"/>	*Date (MMDDYYYY) <input type="text"/>
*Enter Care Manager's Name <input type="text"/>	Signature <input type="text" value="Enter on printed form"/>	*Date (MMDDYYYY) <input type="text"/>

I certify that I have reviewed all information contained in this referral with the Applicant and that all information is true to the best of my knowledge.

Thank you for completing the Division of Mental Health Permanent Supportive Housing Bridge Subsidy Initiative. The information you have provided will be reviewed and a response will be mailed to you within 10 business days of the receipt of the Application.

Once you select "Submit" you can no longer attach any documentation. If you need to attach additional documents, click "Back" to do so

# Printing Options

The Determination Status is shown

## Determination Status:

\*\*\*\*\* APPROVED \*\*\*\*\*

Inquiry: 02142012-7288659-020000

Provider ID  
299084

Once the application is submitted successfully, the Determination Status Page will appear

Subscriber Name  
ILLTESTMBR TEST25

Subscriber ID  
123456025

Provider Alternate ID  
0204

Consumer Name  
ILLTESTMBR TEST25

Consumer ID  
123456025

Consumer DOB  
01/01/1990

Provider Name & Address  
HEALTH CENTER JANET WATTLES MENTAL  
526 W STATE ST  
ROCKFORD IL 61101-1214

Approved Application  
01-021412-1-7-1

The Signature Page must be printed, signed and faxed to the Collaborative within one business day of submitting the application

Application Type  
WCP SH - Williams Class PSH

## Attached Documents

Document Title

Document Description

**There are no documents attached with the Special Program Application**

## Application Printing Options

*(For the best print results, please print in 'Landscape' format)*

Print Application Result

Click to print the entire Special Program Application

Print Signature Page

Click to print the signature page

Print Results

Click to print the Results (this) page

Return to Provider Home

Click to return to the

These are print functions for your internal use

This will return you to the Provider Home Page



# View a Submitted Application in ProviderConnect

Home

- Specific Consumer Search
- Register Consumer
- Authorization Listing
- Enter an Authorization Request
- View Clinical Drafts
- Claim Listing and Submission
- Enter a Special Program Application
- Complete Provider Forms
- Enter a Comprehensive Service Plan

---

EDI Homepage

---

Enter Member Reminders

---

On Track Outcomes

---

Reports

---

My Online Profile

---

My Practice Information

---

Provider Data Sheet

---

Performance Report

---

Compliance

---

Handbooks

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Forms

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Network Specific Information

---

Education Center

---

ValueSelect Designation

---

Contact Us

Welcome JANET WATTLES MENTAL HEALTH CENTER . Thank you for using ValueOptions ProviderConnect.

YOUR MESSAGE CENTER

**To view a previously submitted application, click either of these links**

**Your Recent Inquiries box is empty**

WHAT DO YOU WANT TO DO TODAY?

- Eligibility and Benefits
  - Find a Specific Consumer
  - Register a Consumer
- Enter or Review Authorization Requests
  - Enter an Authorization Request
  - Enter a Special Program Application
  - Enter a Comprehensive Service Plan
  - Review an Authorization
  - View Clinical Drafts
- Enter Member Reminders

CLINICAL SUPPORT TOOLS

- View My Outcomes with On Track

- Enter or Review Claims
  - Review a Claim
  - View My Recent Provider Summary Vouchers
- View My Recent Authorization Letters
- Complete Provider Forms

INBOX

SENT

# Search A Member

## Eligibility & Benefits Search

Required fields are denoted by an asterisk ( \* ) adjacent to the label.

Verify a patient's eligibility and benefits information by entering search criteria below.

\*Consumer ID

(No spaces or dashes)

Last Name

First Name

\*Date of Birth

(MMDDYYYY)

As of Date

(MMDDYYYY)

Search

Enter as much info as possible  
to narrow the search.  
Member ID and Date of Birth  
are **required fields**  
(Note: Member ID is the Consumer's RIN)

# View a Submitted Application in ProviderConnect (Continued)

Demographics

Enrollment History

COB

Benefits

Additional Information

Consumer eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

## Consumer <sup>?</sup>

Consumer ID **123456025**  
Alternate ID  
Consumer Name **TEST25, ILLTESTMBR**  
Date of Birth **01/01/1990**  
Address **25 TEST ST.  
CHICAGO, IL 60290**  
Alternate Address  
Marital Status -  
Home Phone  
Work Phone  
Relationship **1**  
Gender **M - Male**

## Eligibility

Effective Date **07/01/2008**  
Expiration Date  
COB Effective Date <sup>?</sup>  
[View Funding Source Enrollment Details](#)

## Subscriber

Subscriber ID **123456025**  
Subscriber Name **TEST25, ILLTESTMBR**

To view a previously submitted Williams Class PSH application, click "Special Program Applications"

View Consumer Auths

View Consumer Claims

View Empire Claims

View GHI-BMP Claims

Enter Auth Request

Send Inquiry

View Clinical Drafts

Comprehensive Service Plan

Enter Member Reminders

View Consumer Registrations

Special Program Applications

Provider Forms

# View a Submitted Application in ProviderConnect (Continued)

Alternate ID  
 Consumer Name **TEST25, ILLTESTMBR**  
 Date of Birth **01/01/1990**  
 Address **25 TEST ST.  
 CHICAGO, IL 60290**  
 Alternate Address  
 Marital Status -  
 Home Phone  
 Work Phone  
 Relationship **1**  
 Gender **M - Male**

Expiration Date  
 COB Effective Date   
[View Funding Source Enrollment Details](#)

**Subscriber**  
 Subscriber ID **123456025**  
 Subscriber Name **TEST25, ILLTESTMBR**

Click the Williams Class PSH you would like to view

- View Consumer Auths
- View Consumer Claims
- View Empire Claims
- View GHI-BMP Claims
- Enter Auth Request
- Send Inquiry
- View Clinical Drafts
- Comprehensive Service Plan
- Enter Member Reminders
- View Consumer Registrations
- Special Program Applications
- Provider Forms

Enter a Special Program Application

Application Type	Date Application Submitted	Application Status	Appeal	Follow Up
<a href="#">WCPSH</a>	12/02/2011	APPR		<input type="button" value="Complete Follow Up"/> Followup Completed 02/09/2012
<a href="#">WCPSH</a>	02/14/2012	APPR		<input type="button" value="Complete Follow Up"/>

# View a Submitted Application in ProviderConnect (Continued)



[Print Special Program Application](#)

(For the best print results, please print in 'Landscape' format)

## Special Program Application

Application Number <b>01-021412-1-7-1</b>	Application Date <b>02/14/2012</b>	Application Type <b>WCPSH</b>	Consumer Name <b>ILLTESTMBR TEST25</b>	Provider Name <b>HEALTH CENTER JANET WATTLES MEDICAL</b>	Provider Alternate ID
			Consumer ID <b>123456025</b>	Provider ID <b>299084</b>	

**The entire application can now be viewed or printed. To print, click the "Print" button at the top of the page**

Intake Request Date  
(applicable for PSH application only) (MMDDYYYY)

### Section 1: Applicant (Head of Household) Information

Phone #  
**312 453 9000**

Work #  
**312 453 9000**

Email  
**testmember@yahoo.com**

Mobile #

Pager #

Fax #

\*Race

N- White	Y- Black or African American
N- Asian	N- Native Hawaiian or Other Pacific Islander
N- American Indian or Alaskan Native	N- Asian and White
N- American Indian/Alaskan Native and White	N- American Indian/Alaskan Native and Black
N- Black/African American and White	N- Other

Consumer's Ethnicity (Please select "yes" or "no" for Hispanic Origin. Consumer should select both a "Race" category and a "yes" or "no" for Hispanic Origin):

Hispanic Origin **No**

United States Veteran **No**

# Q & A

---

**QUESTIONS ???**

# **Williams Class PSH Outcomes Follow Up Process**

---

**This section will step through  
the process of submitting a  
Williams Class PSH Outcomes Follow Up  
through the use of ProviderConnect**

# Getting Started

ILLINOIS  
MENTAL HEALTH COLLABORATIVE

FOR ACCESS AND CHOICE

for providers



Provider Online Services

- Home
- **Provider Home**
- Provider Manual
- Provider Forms
- ReferralConnect
- Provider Information

About

Services

Feedback

Contact

## Provider Online Services

Welcome to Provider Online Services!

### ProviderConnect

Login or register with ProviderConnect, an online tool that allows you to submit and check claims status, check member eligibility, update your provider profile, request inpatient and outpatient authorizations and more.

ProviderConnect is easy to use, secure and available 24/7.

Log into  
ProviderConnect

LOG IN

REGISTER

DEMO

Here you will find a wealth of information developed specifically for you, which include ProviderConnect, the Provider Manual, and links to mental health resources.

[ProviderConnect Helpful Resources](#) links you to a ProviderConnect User guide, HIPAA information, software downloads, important forms and helpful phone numbers to assist with the use of this tool!



# Home Page

Home

[Specific Member Search](#)

[Register Member](#)

[Authorization Listing](#)

[Enter an Authorization Request](#)

[View Clinical Drafts](#)

[Claim Listing and Submission](#)

[Enter EAP CAF](#)

[Enter a Special Program Application](#)

[Complete Provider Forms](#)

[Enter a Comprehensive Service Plan](#)

[Review Referrals](#)

[Enter Bed Tracking Information](#)

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[Enter Member Reminders](#)

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[Reports](#)

[Print Spectrum Release of Information Form](#)

[My Online Profile](#)

[My Practice Information](#)

[Provider Data Sheet](#)

[Compliance](#)

[Headlines](#)

**Welcome S OF CHICAGO COMM COUNSELING CNTR . Thank you for using ValueOptions ProviderConnect.**

**YOUR MESSAGE CENTER**

**Your Recent Inquiries box is empty**

**WHAT DO YOU WANT TO DO TODAY?**

▼ [Eligibility and Benefits](#)

- [Find a Specific Member](#)
- [Register a Member](#)

▼ [Enter or Review Claims](#)

- [Enter EAP CAF](#)
- [Review a Claim](#)
- [View My Recent Provider Summary Vouchers](#)

▼ [Enter or Review Authorization Requests](#)

- [Enter an Authorization Request](#)
- [Enter a Special Program Application](#)
- [Enter a Comprehensive Service Plan](#)
- [Review an Authorization](#)
- [View Clinical Drafts](#)

▼ [Enter Member Reminders](#)

[Enter or Review Referrals](#)

- [Enter a Referral](#)
- [Review Referrals](#)

▶ [Enter Bed Tracking Information](#)

▶ [Search Beds/Opening](#)

▶ [View My Recent Authorization Letters](#)

▶ [Complete Provider Forms](#)

▶ [Williams Transition Outcome Tracking Information](#)

**CLINICAL SUPPORT TOOLS**

**Click either link to search for a specific consumer**

# Search A Member

## Eligibility & Benefits Search

Required fields are denoted by an asterisk ( \* ) adjacent to the label.

Verify a patient's eligibility and benefits information by entering search criteria below.

\*Consumer ID

*(No spaces or dashes)*

Last Name

First Name

\*Date of Birth

*(MMDDYYYY)*

As of Date

*(MMDDYYYY)*

Search

Enter as much info as possible  
to narrow the search.  
Member ID and Date of Birth  
are **required** fields  
(Note: Member ID is the Consumer RIN)

# Demographics Verification

- Home
- Specific Consumer Search
- Register Consumer
- Authorization Listing
- Enter an Authorization Request
- View Clinical Drafts
- Claim Listing and Submission
- Enter a Special Program Application
- Complete Provider Forms
- Enter a Comprehensive Service Plan
- EDI Homepage
- Enter Member Reminders
- On Track Outcomes
- Reports
- My Online Profile
- My Practice Information
- Provider Data Sheet
- Performance Report
- Compliance
- Handbooks
- Forms
- Network Specific Information
- Education Center
- ValueSelect Designation
- Contact Us

Demographics Enrollment History COB Benefits Additional Information

Consumer eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

Consumer ID is the Consumer RIN

## Consumer <sup>?</sup>

Consumer ID **123456025**

Alternate ID

Consumer Name **TEST25, ILLTESTMBR**

Date of Birth **01/01/1990**

Address **25 TEST ST.  
CHICAGO, IL 60290**

Alternate Address

Marital Status -

Home Phone

Work Phone

Relationship **1**

Gender **M - Male**

## Eligibility

Effective Date **07/01/2008**

Expiration Date

COB Effective Date <sup>?</sup>

[View Funding Source Enrollment Details](#)

## Subscriber

Subscriber ID **123456025**

Subscriber Name **TEST25, ILLTESTMBR**

- |  |   |  |  |
|--|---|--|--|
| <a href="#">View Consumer Auths</a>    | <a href="#">View Consumer Claims</a>        | <a href="#">View Empire Claims</a>           | <a href="#">View GHI-BMP Claims</a>        |
| <a href="#">Enter Auth Request</a>     | <a href="#">Send Inquiry</a>                | <a href="#">View Clinical Drafts</a>         | <a href="#">Comprehensive Service Plan</a> |
| <a href="#">Enter Member Reminders</a> | <a href="#">View Consumer Registrations</a> | <a href="#">Special Program Applications</a> | <a href="#">Provider Forms</a>             |

To view a previously entered application, click the "Special Program Applications" button

# View a Submitted Application in ProviderConnect to Complete Follow Up

Consumer Name **TEST25, ILLTESTMBR**  
Date of Birth **01/01/1990**  
Address **25 TEST ST.  
CHICAGO, IL 60290**  
Alternate Address  
Marital Status -  
Home Phone  
Work Phone  
Relationship **1**  
Gender **M - Male**

COB Effective Date [?](#)

[View Funding Source Enrollment Details](#)

## Subscriber

Subscriber ID **123456025**

Subscriber Name **TEST25, ILLTESTMBR**

The completed Williams Class PSH form will be displayed below for review; click the "Complete Follow Up" button to complete a one-time follow up

View Consumer Auths

View Consumer Claims

View Empire Claims

View GHI-BMP Claims

Enter Auth Request

Send Inquiry

View Clinical Drafts

Comprehensive Service Plan

Enter Member Reminders

View Consumer Registrations

Special Program Applications

Provider Forms

Enter a Special Program Application

Application Type	Date Application Submitted	Application Status	Appeal	Follow Up
<a href="#">WCPSH</a>	12/02/2011	APPR		<a href="#">Complete Follow Up</a> Followup Completed 02/09/2012
<a href="#">WCPSH</a>	02/14/2012	APPR		<a href="#">Complete Follow Up</a>

# Follow Up Form

## Special Program Application

Application Number <b>01-021412-1-7-1</b>	Application Date <b>02/14/2012</b>	Application Type <b>WCPSH</b>	Consumer Name <b>ILLTESTMBR TEST25</b>	Provider Name <b>JANET WATTLES MENTAL HEALTH CENTER</b>	Provider Alternate ID
		Consumer ID <b>123456025</b>	Provider ID <b>299084</b>		

## Application

All fields with an asterisk  
are **required** fields and must be completed

### Williams consent Decree One Time Follow-up Form

\*Date Housing Application/Request submitted

\*Housing Approval Date

\*Date the individual moved into housing

\*Housing Type in Which Individual Resides

\*Number of bedrooms in unit

\*Number of persons living in unit

\*Monthly Rental Amount  
(total if applicable)

Rent Subsidy Amount  
(if PSH)

\*Individual's Rent Contribution  
Amount (if PSH)

\*Date Lease signed

\*Lease Period Date Range

 to 

\* Landlord Name

\* Landlord Telephone Number

\* Consumer Access to telephone

 Yes  No

Date Transition Fund Bank Card  
Request Mailed to ICCA

Date Transition Fund Card Received  
by Transition Coordination Agency

After completion of the entire  
form  
click "Submit" to enter the  
Confirmation Screen

Back

Submit

# Confirmation Screen

## Determination Status:

\*\*\*\*\* APPROVED \*\*\*\*\*

Provider ID  
**299084**

Subscriber Name  
**ILLTESTMBR TEST25**

Subscriber ID  
**123456025**

Provider Alternate ID

Provider Name & Address  
**JANET WATTLES MENTAL HEALTH CENTER  
526 W STATE ST  
ROCKFORD IL 61101**

Consumer Name  
**ILLTESTMBR TEST25**

Consumer ID  
**123456025**

Consumer DOB  
**01/01/1990**

Approved Application  
**01-021412-1-7-1**

Follow Up Date  
**02/14/2012**

Application Type  
**WCPSH - Williams Class PSH**

When the entire application is printed, it will now contain the Follow Up information as well

## Application Printing Options

*(For the best print results, please print in 'Landscape' format)*

Print Application Result

*Click to print the entire Special Program Application*

Print Signature Page

*Click to print the signature page*

Print Results

*Click to print the Results (this) page*

Return to Provider Home

*Click to return to the ProviderConnect home page*

# Demographic Verification

## (Follow Up Confirmation Date)

- EDI Homepage
- Enter Member Reminders
- On Track Outcomes
- Reports
- My Online Profile
- My Practice Information
- Provider Data Sheet
- Performance Report
- Compliance
- Handbooks
- Forms
- Network Specific Information
- Education Center
- ValueSelect Designation
- Contact Us

CHICAGO, IL 60629

Alternate Address  
 Marital Status -  
 Home Phone  
 Work Phone  
 Relationship 1  
 Gender M - Male

### Subscriber

Subscriber ID 123456025  
 Subscriber Name TEST25, ILLTESTMBR

**NOTE:**  
 Now when you view the WCP SH,  
 the "Complete Follow Up" button is disabled.  
 The confirmation date for completed Follow Up is shown

- View Consumer Auths
- View Consumer Claims
- View Empire Claims
- View GHI-BMP Claims
- Enter Auth Request
- Send Inquiry
- View Clinical Drafts
- Comprehensive Service Plan
- Enter Member Reminders
- View Consumer Registrations
- Special Program Applications
- Provider Forms

Enter a Special Program Application

Application Type	Date Application Submitted	Application Status	Appeal	Follow Up
<a href="#">WCP SH</a>	12/02/2011	APPR		<input type="button" value="Complete Follow Up"/> Followup Completed 02/09/2012
<a href="#">WCP SH</a>	02/14/2012	APPR		<input type="button" value="Complete Follow Up"/> Followup Completed 02/14/2012

# Technical Issues

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- ▶ **EDI Help Desk (888) 247-9311**
- ▶ **7AM to 5PM CST (Monday-Friday)**
  - **Examples of Technical Issues:**
    - Account disabled
    - Forgot password
    - System “freezing” or crashing
    - System unavailable errors
- ▶ **If you have questions regarding the content of the application, you may contact Lindsay Huth, DMH Statewide Housing Coordinator at (312) 814-4822**





**Q & A**

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**QUESTIONS ???**