Williams Class
Transition Coordination Process

Presenters:
Patricia Palmer, Callie Lacy
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

About | Services | Feedback | Contact

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

Provider Online Services

Log into ProviderConnect

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 IN
REGISTER
DEMO

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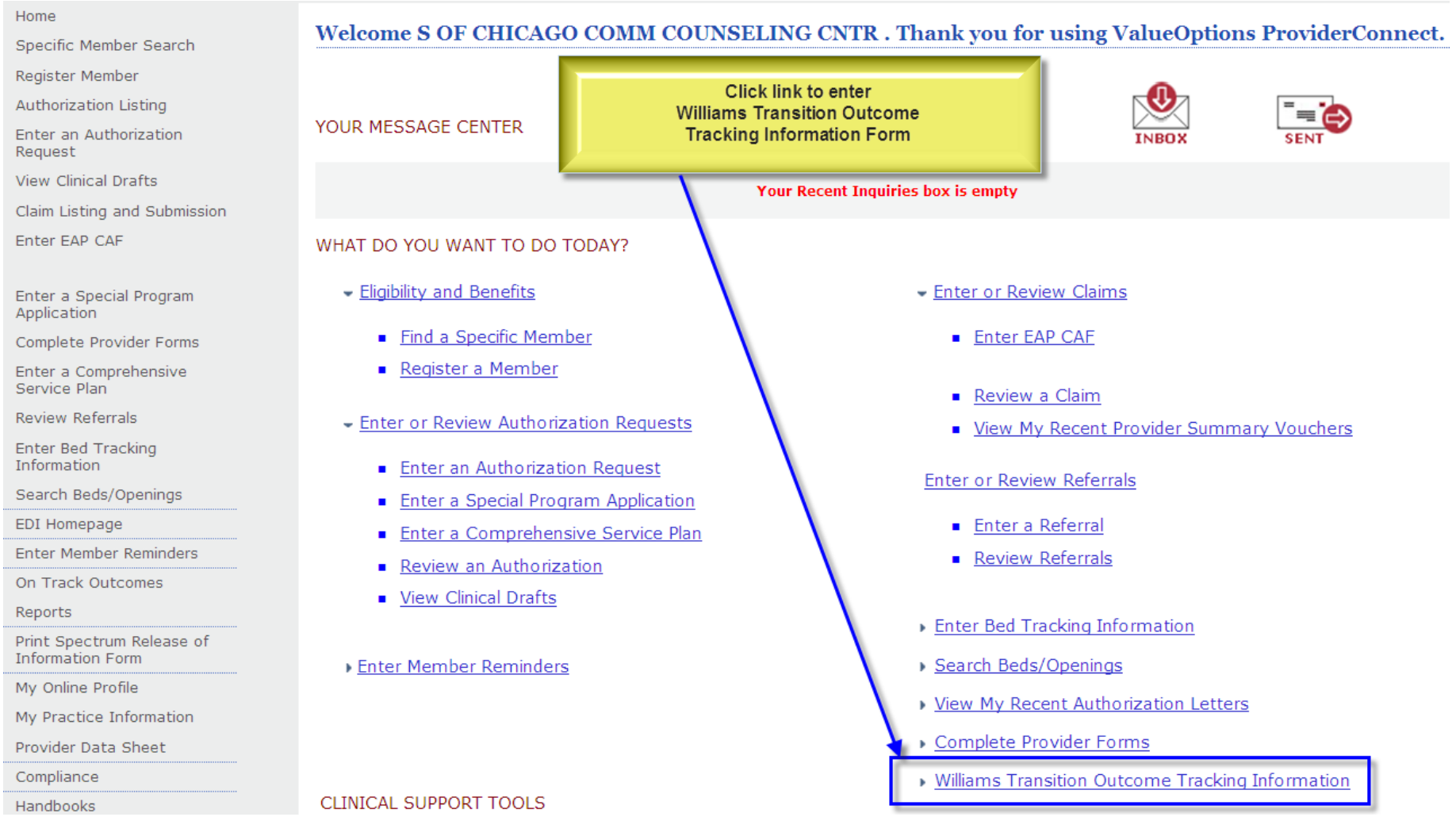
ProviderConnect Helpful Resources links you to a ProviderConnect User guide, HIPAA information, software downloads, important forms and helpful phone numbers to assist with the use of this tool!

Home Page


Home
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Authorization Listing
Enter an Authorization Request
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On Track Outcomes
Reports
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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
INBOX
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Your Recent Inquiries box is empty
WHAT DO YOU WANT TO DO TODAY?
Eligibility and Benefits
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CLINICAL SUPPORT TOOLS

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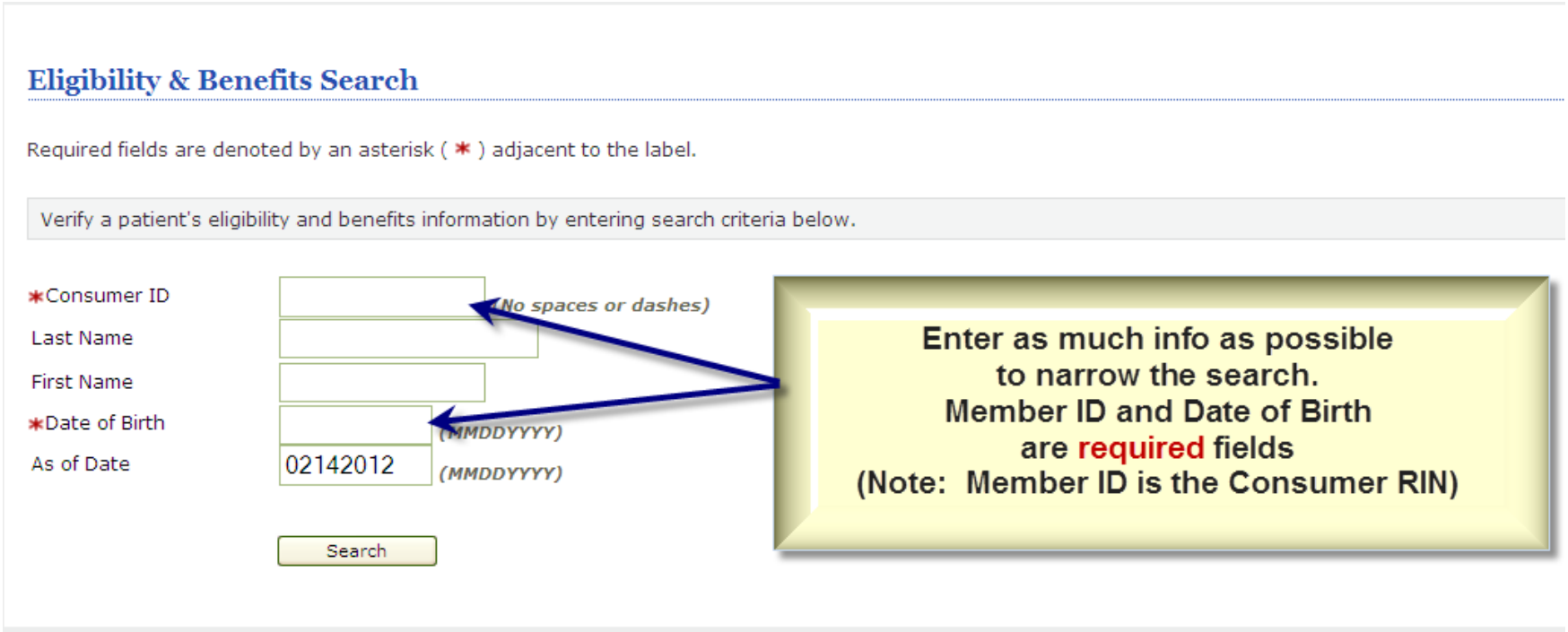
Search A Member



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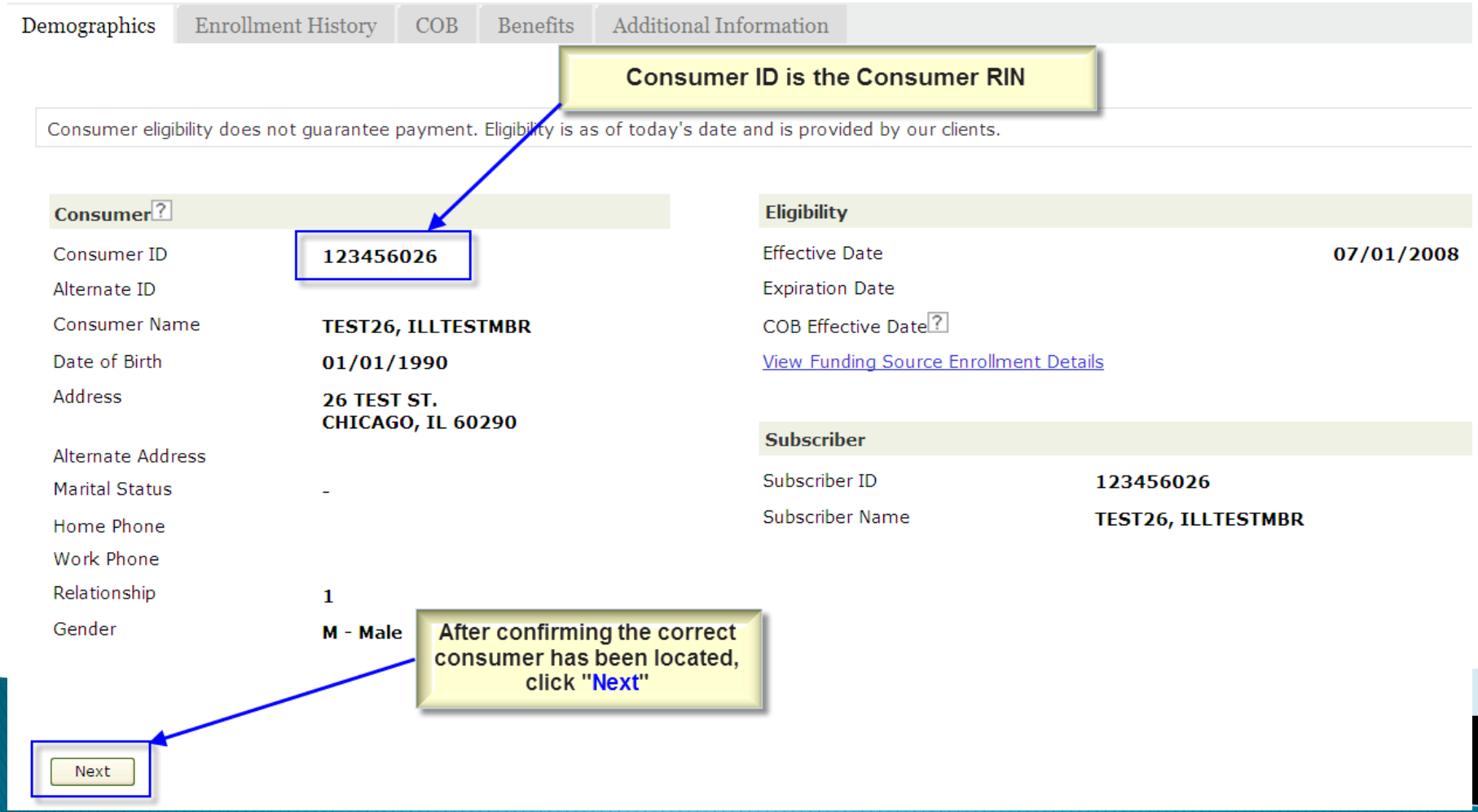
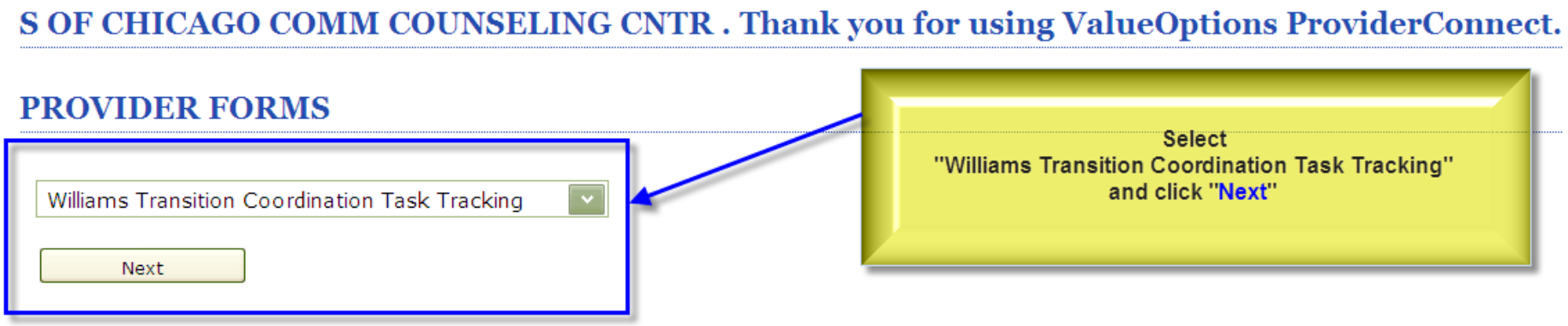


Williams Class
Transition Coordination Form
Landing Page



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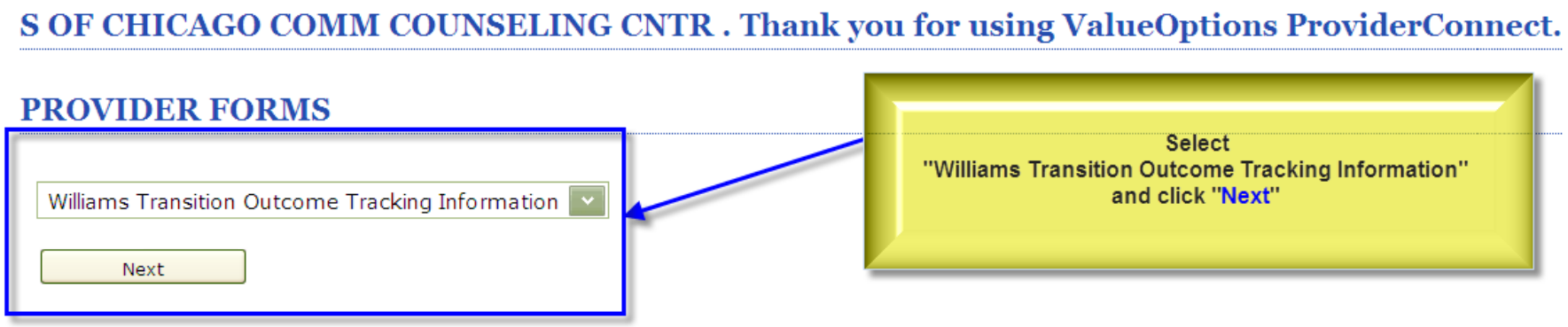

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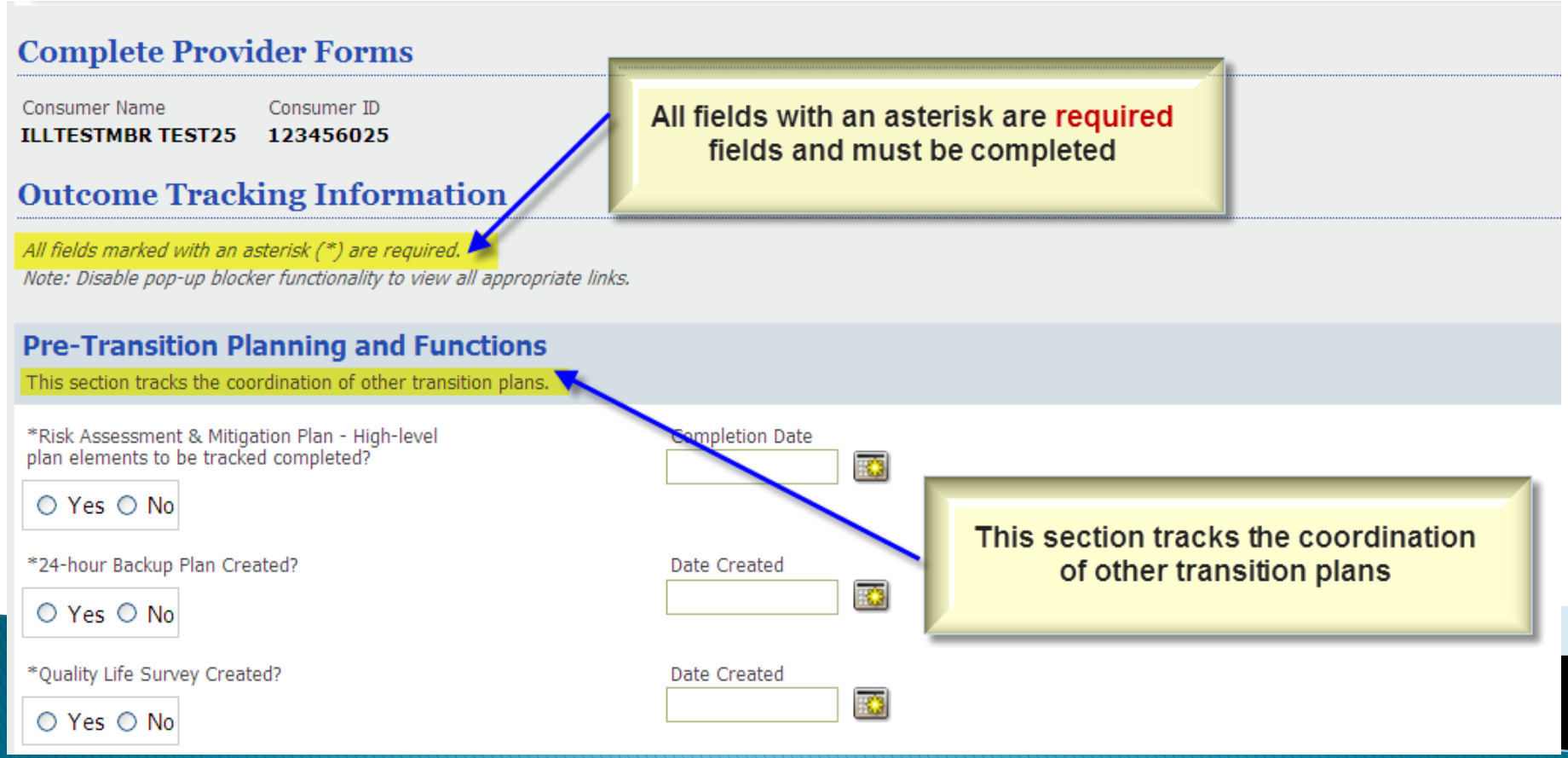
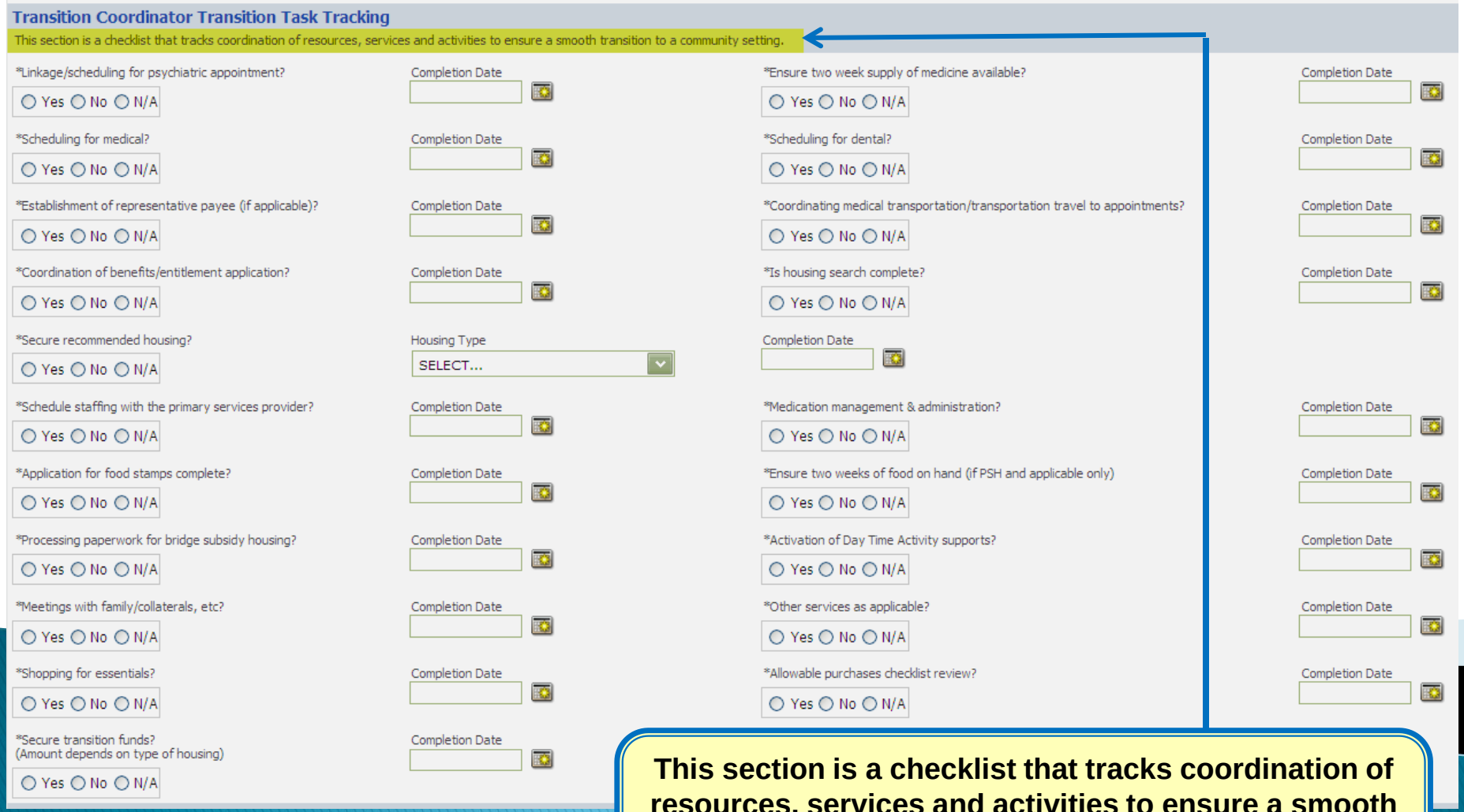
Pre-Transition Planning and Functions



Williams Class Outcomes Tracking Form

Transition Coordinator Transition Task Tracking



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(All fields with an asterisk are required fields)

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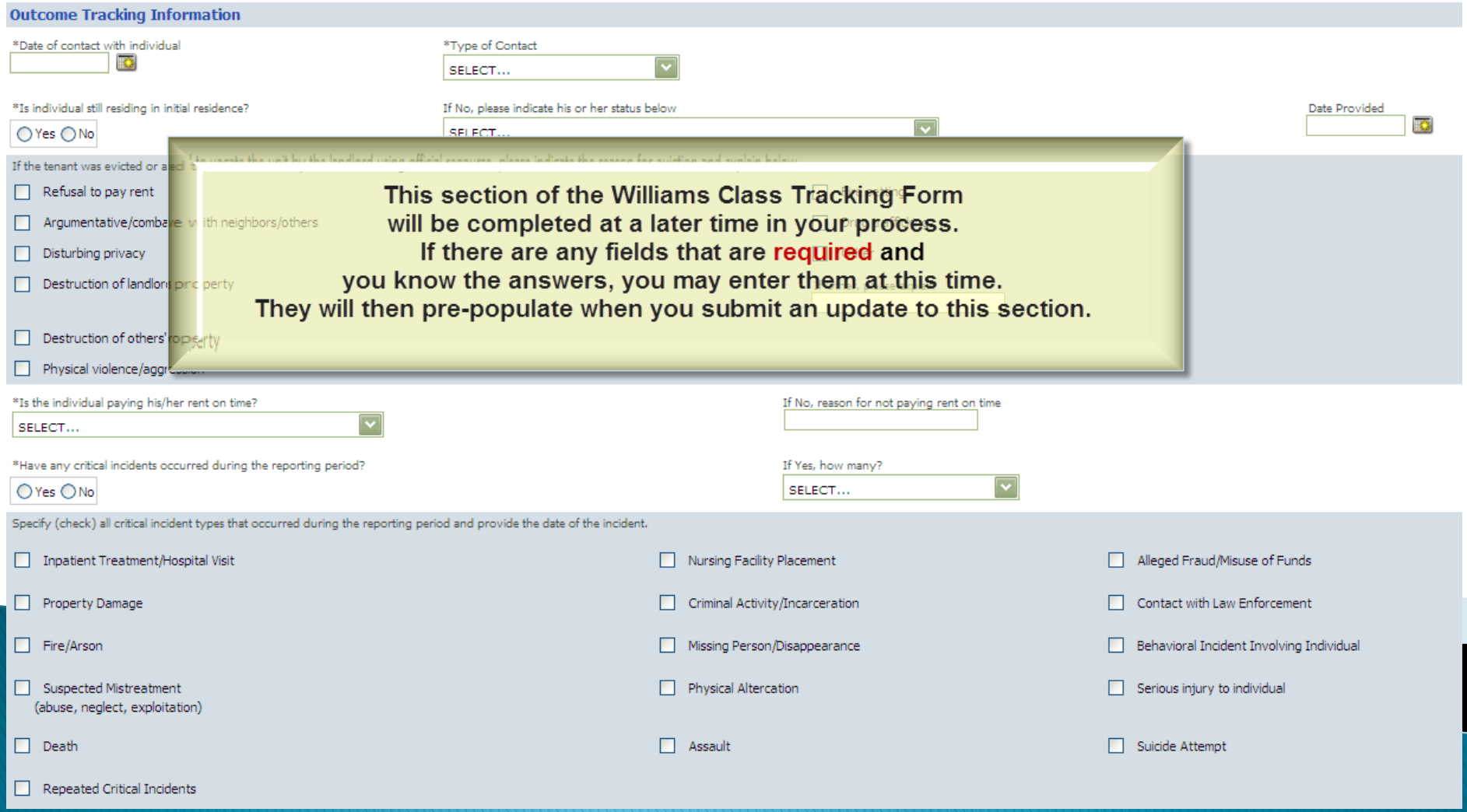

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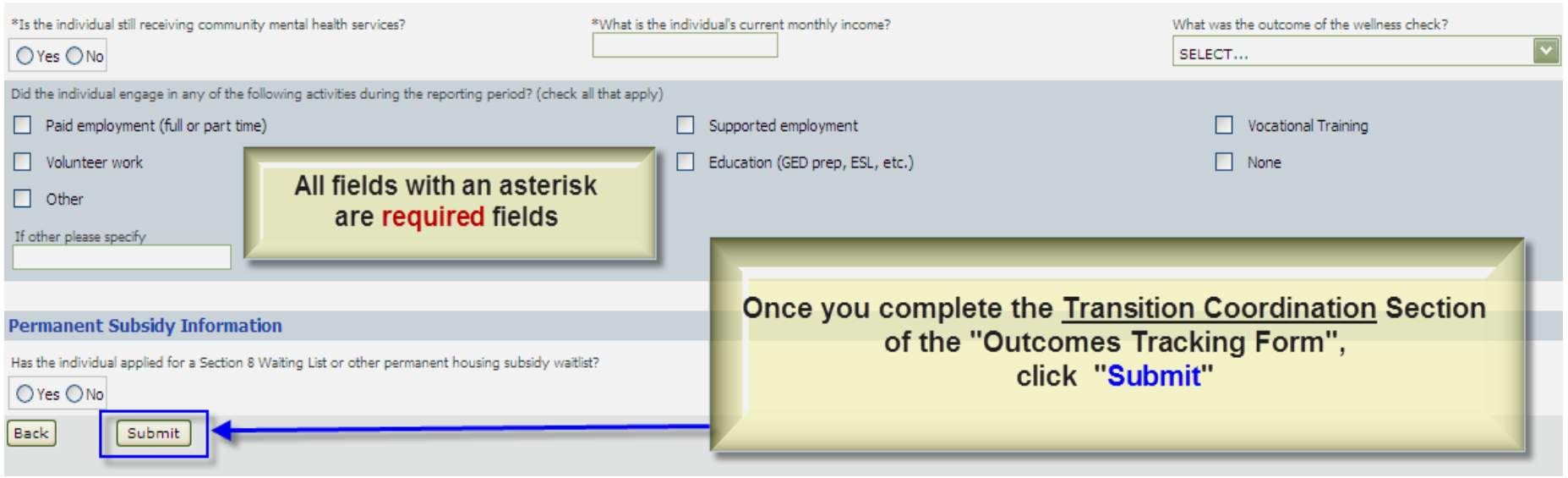
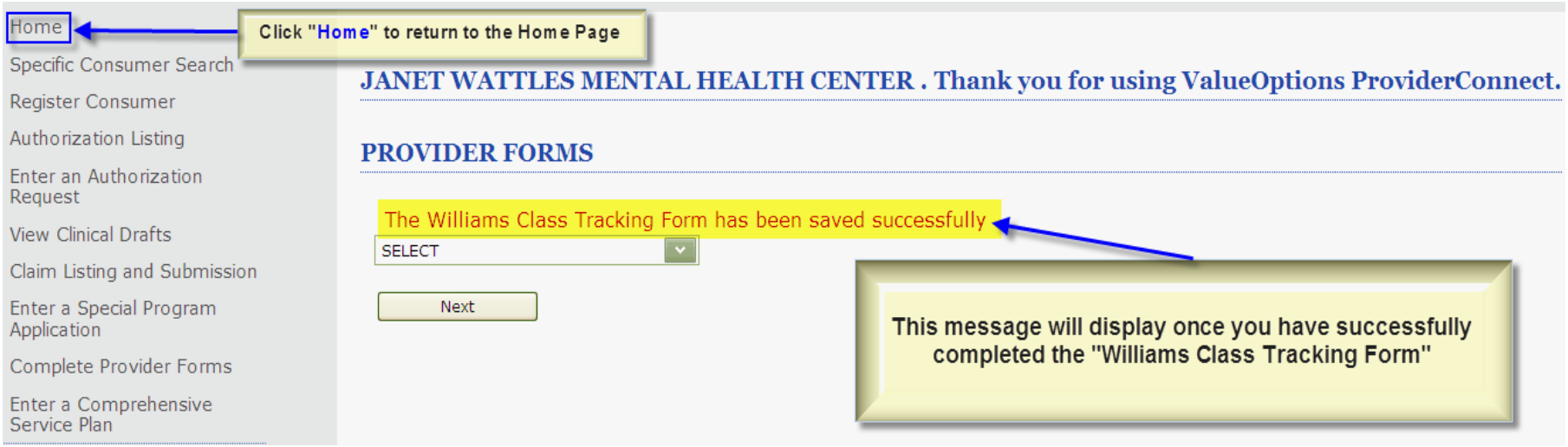


Williams Class Transition Coordination Form

Submission Landing Page



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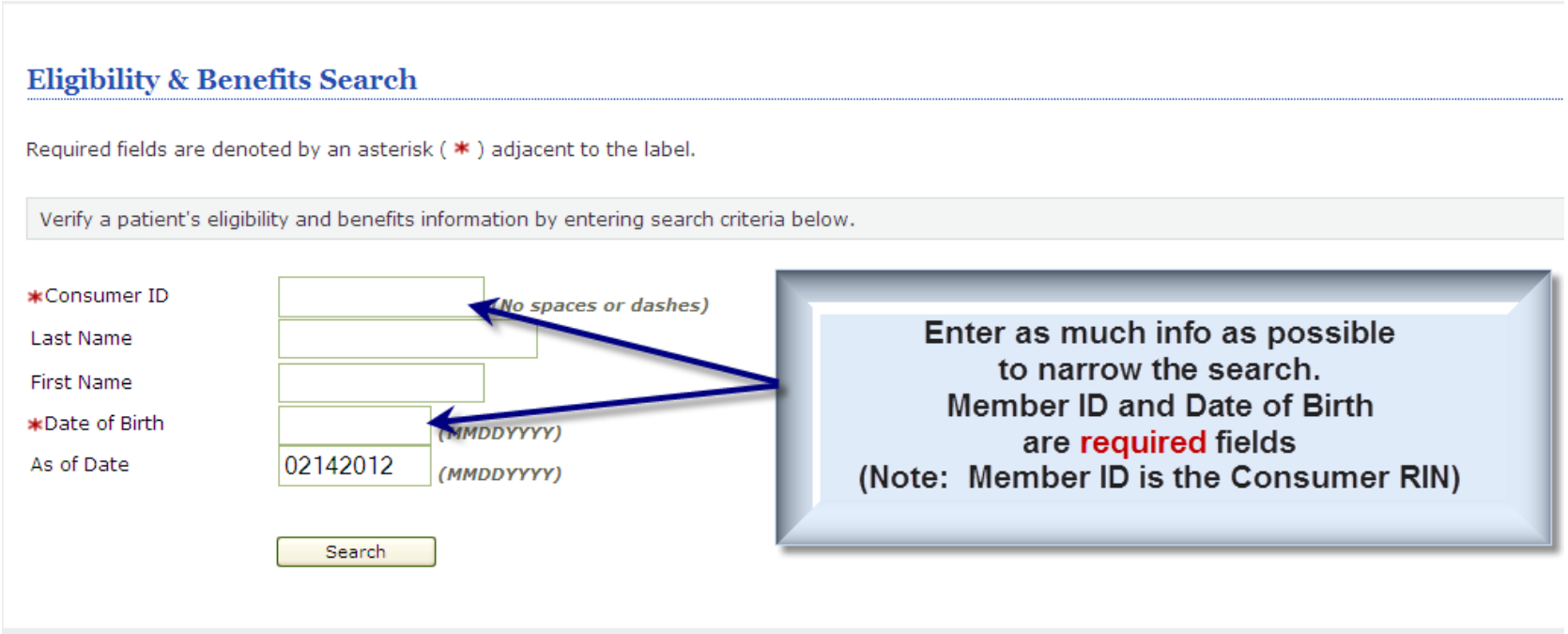
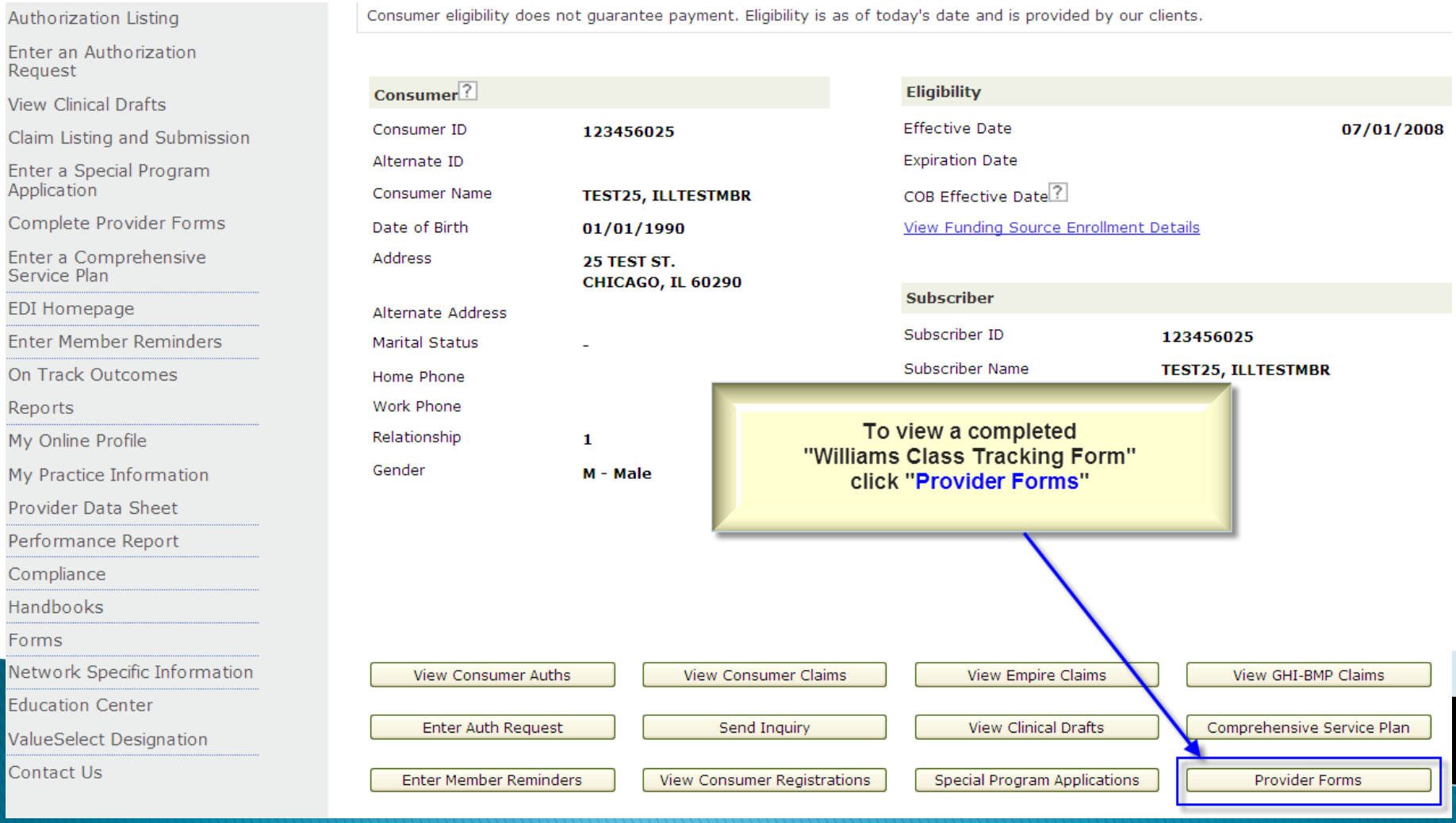


Demographics Page



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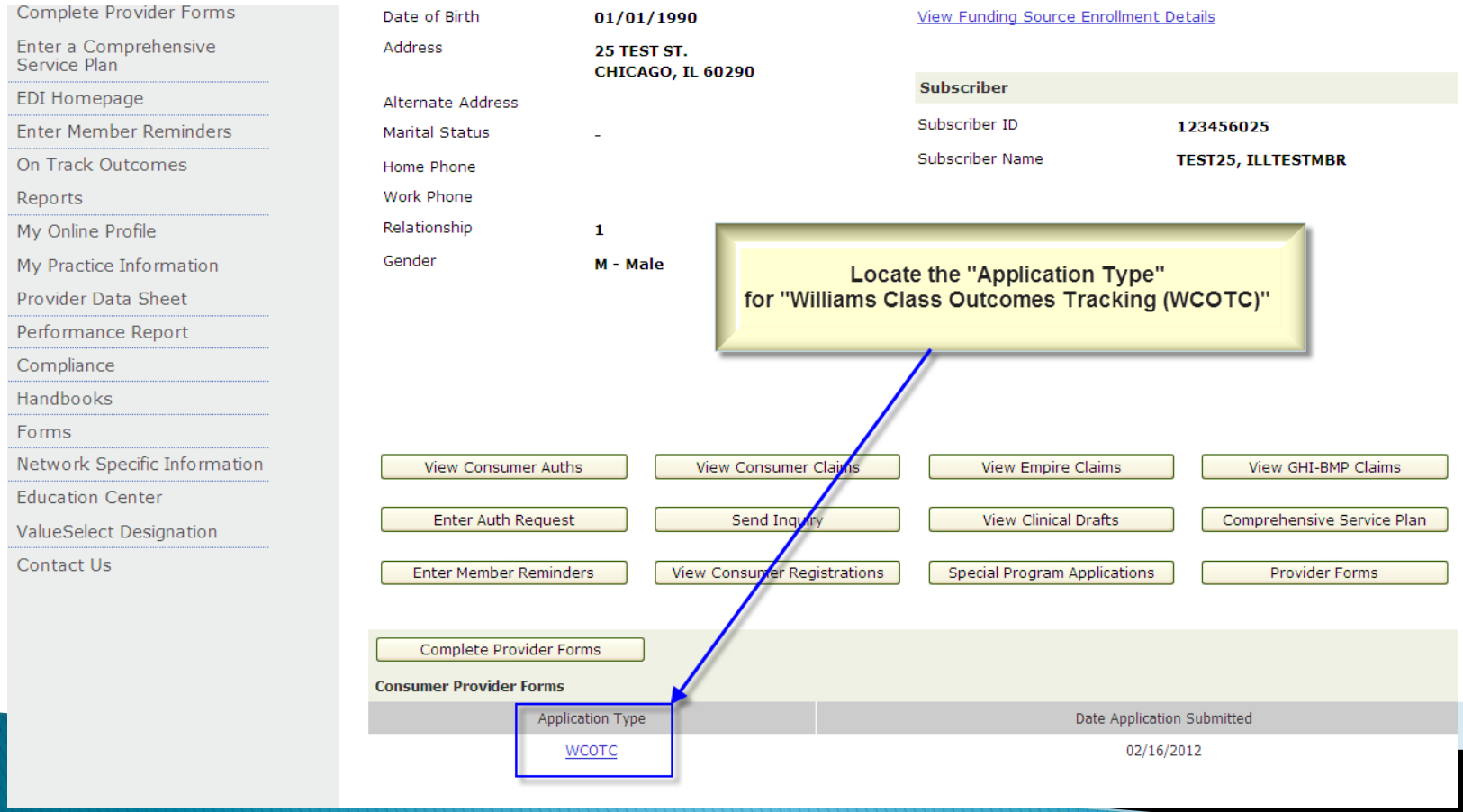
(Submitted Provider Forms)



Outcomes Tracking Information History

Complete Provider Forms

Consumer Name
ILLTESTMBR TEST25

Consumer ID
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?
YES
Date Created
02162012

24-hour Backup Plan Created?
YES
Date Created
02162012

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Date Created
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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.

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Q & A

QUESTIONS ???

Williams Class PSH Outcome Tracking

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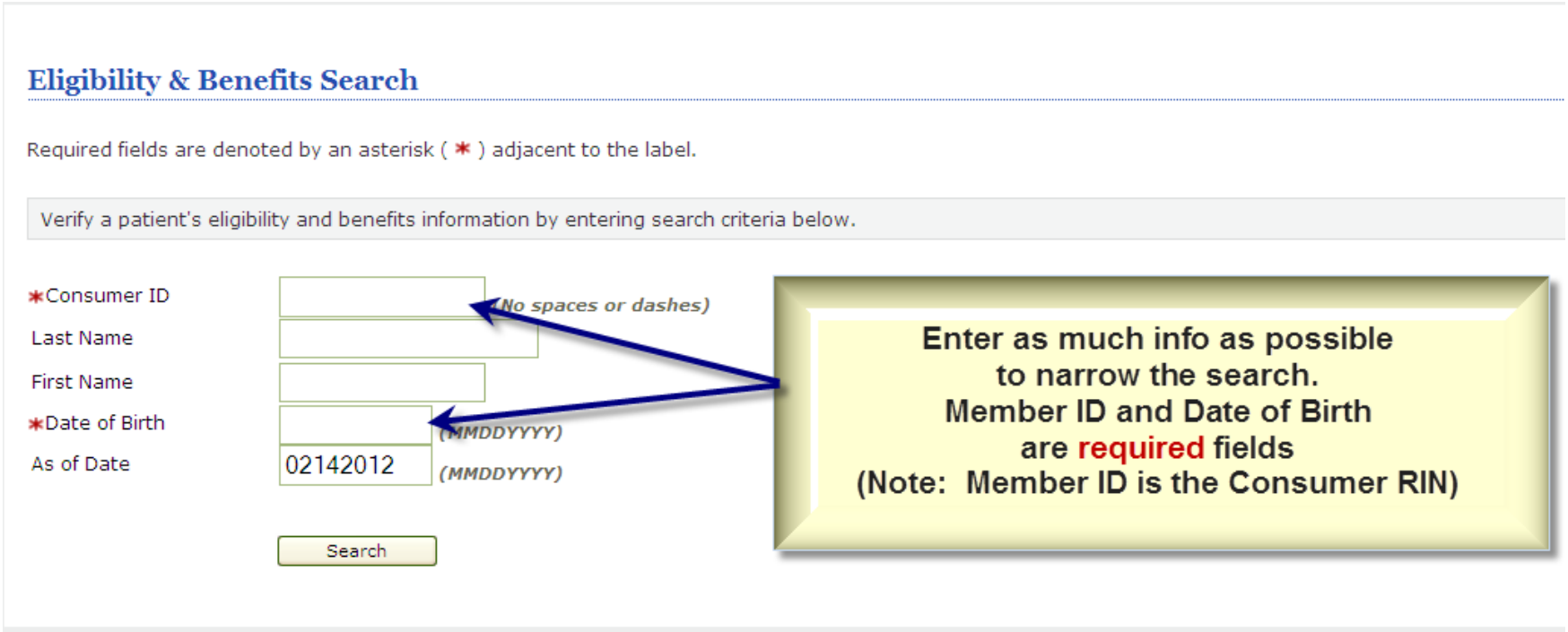

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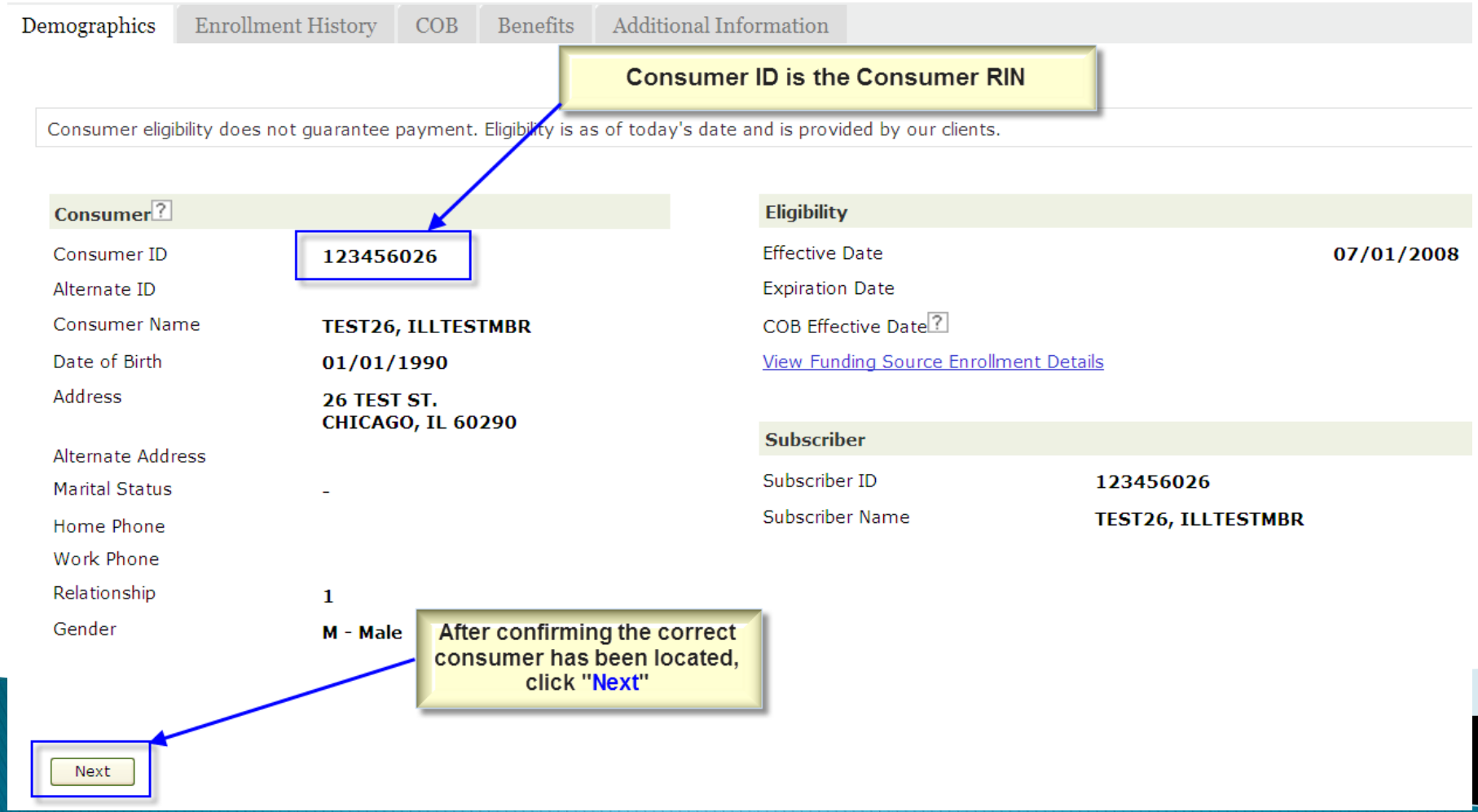
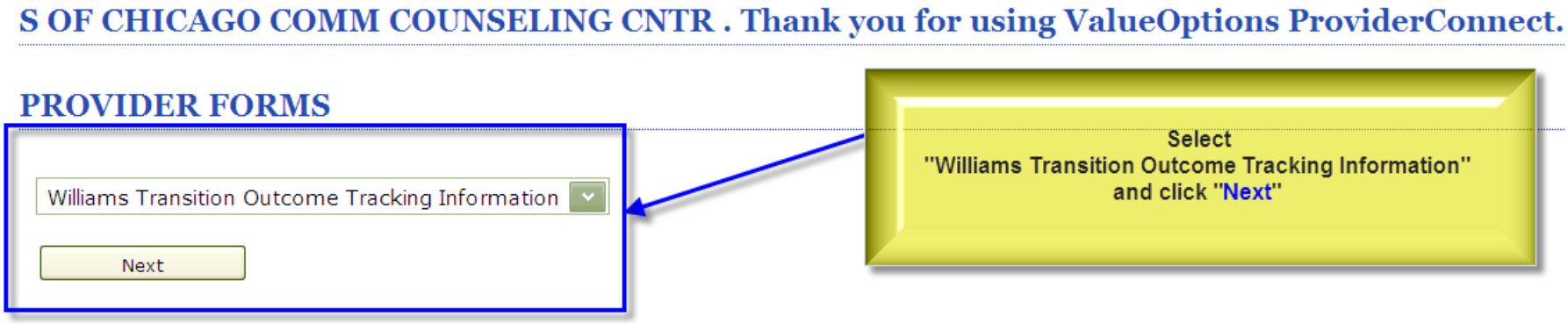
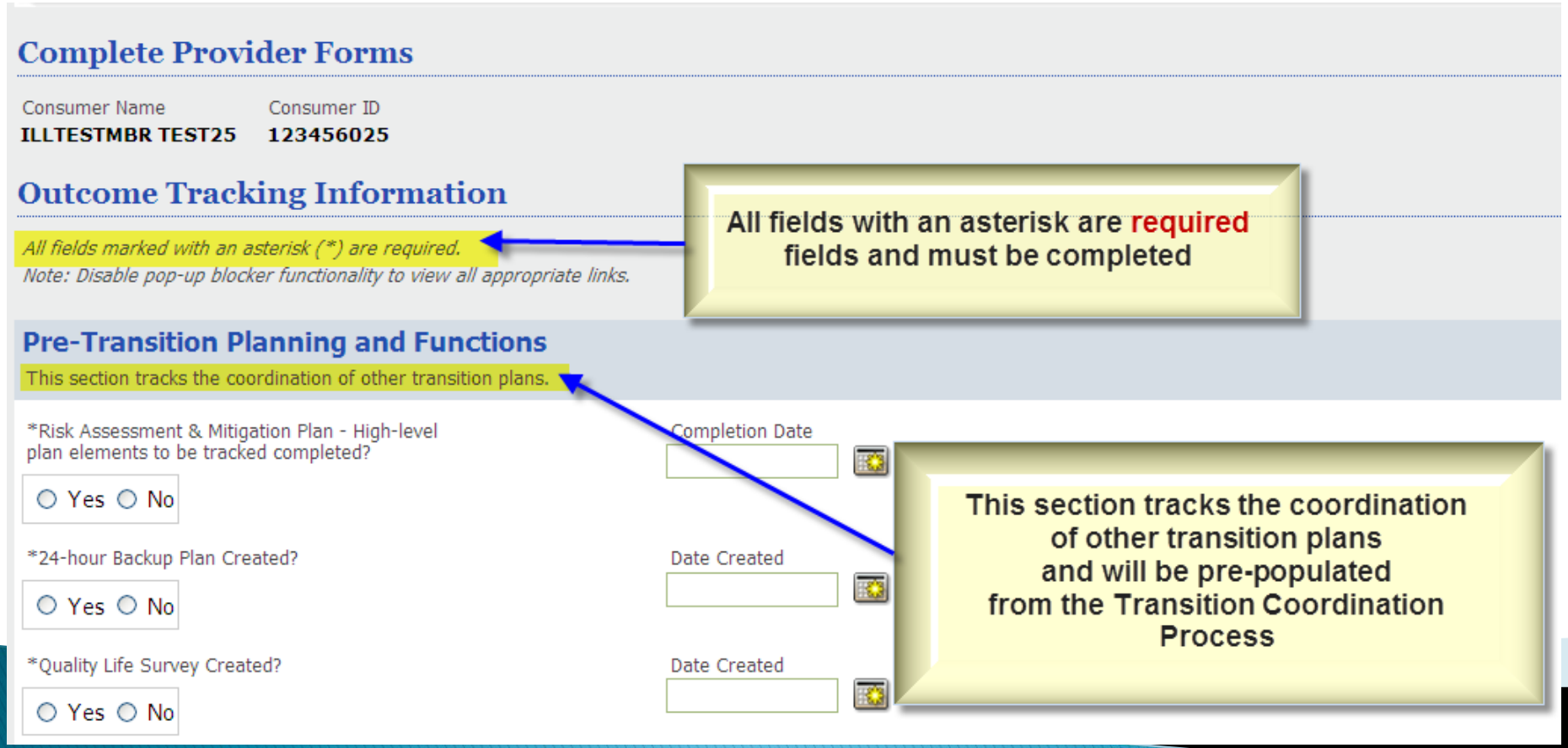


Williams Class Outcomes Tracking Form
Landing Page



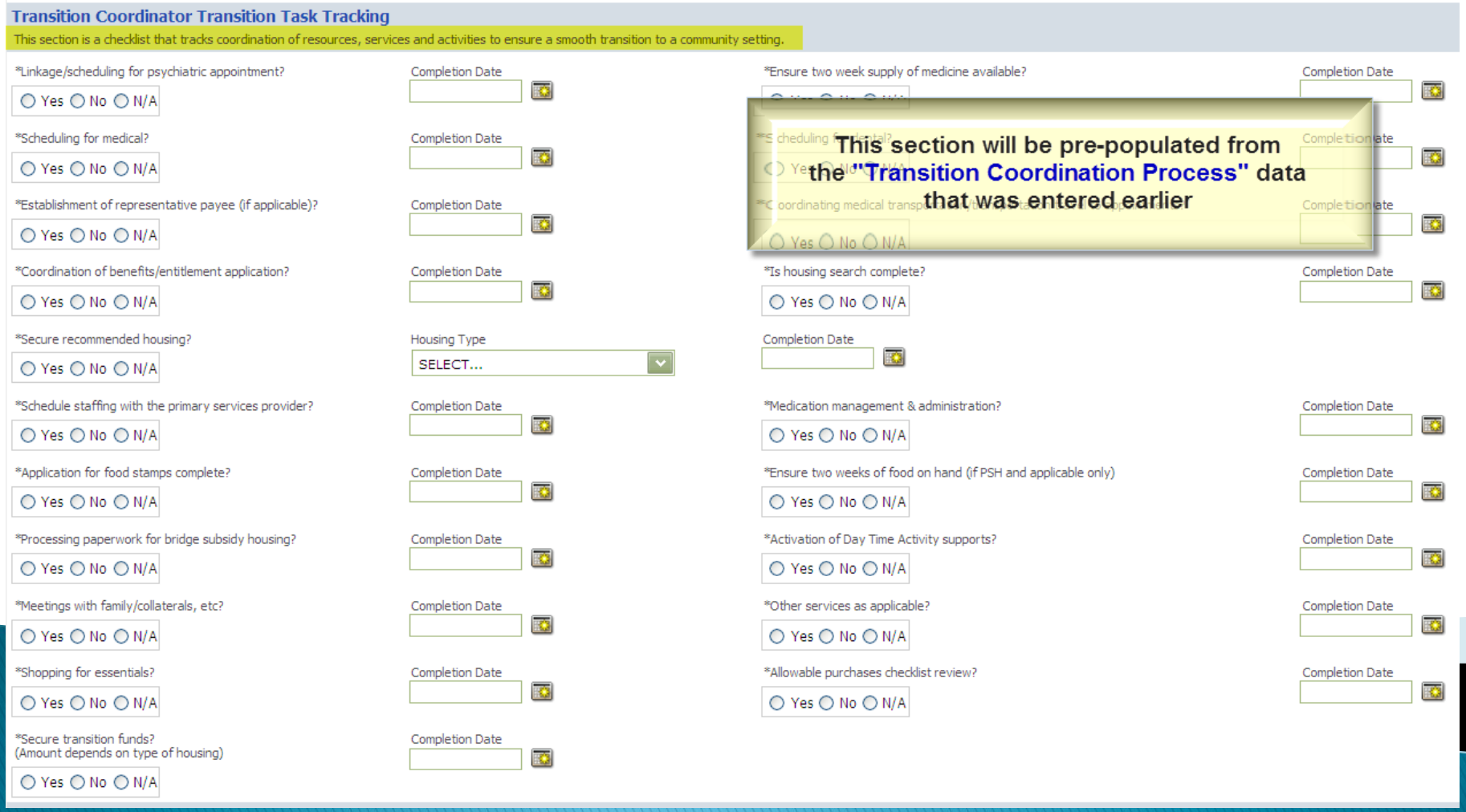
Williams Class Outcomes Tracking Form

Pre-Transition Planning and Functions



Williams Class Outcomes Tracking Form

Transition Coordinator Transition Task Tracking



Williams Class Outcomes Tracking Form

Outcome Tracking Information

Outcome Tracking Information

*Date of contact with individual

*Type of Contact
SELECT...

*Is individual still residing in initial residence?
Yes No

If No, please indicate his or her status below
SELECT...

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/combative with neighbors/others
- Disturbing privacy
- Destruction of landlord's property
- Destruction of others' property
- Physical violence/aggression
- Fire setting
- Drug trafficking
- Other

If Other, please explain

All fields with an asterisk are required fields

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

If No, reason for not paying rent on time

*Have any critical incidents occurred during the reporting period?
Yes No

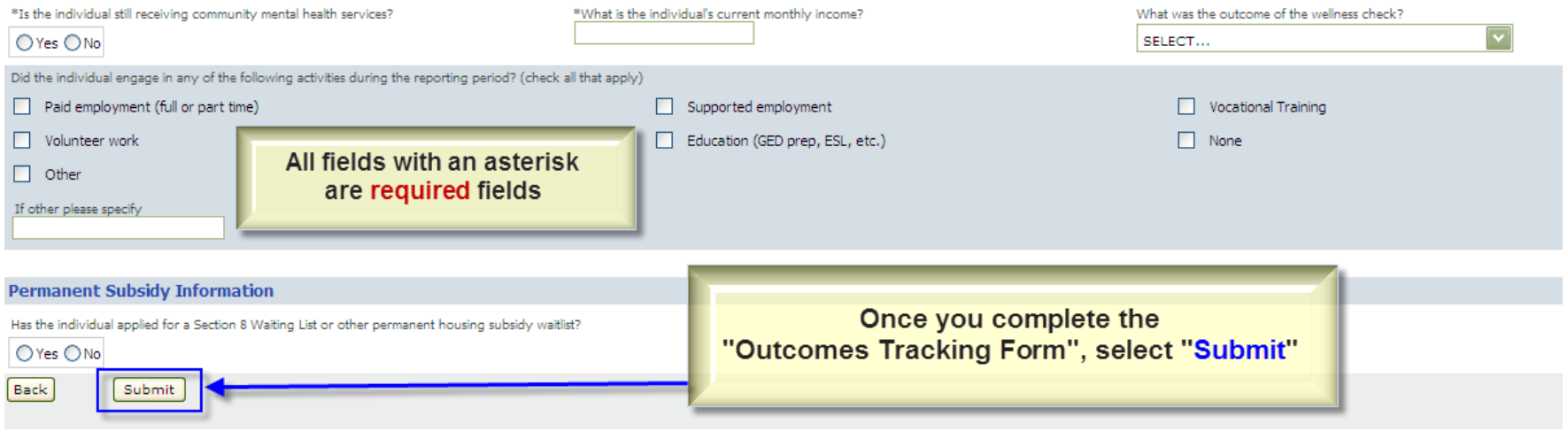
If Yes, how many?
SELECT...

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

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

Williams Class Outcomes Tracking Form

Outcome Tracking Information (Continued)



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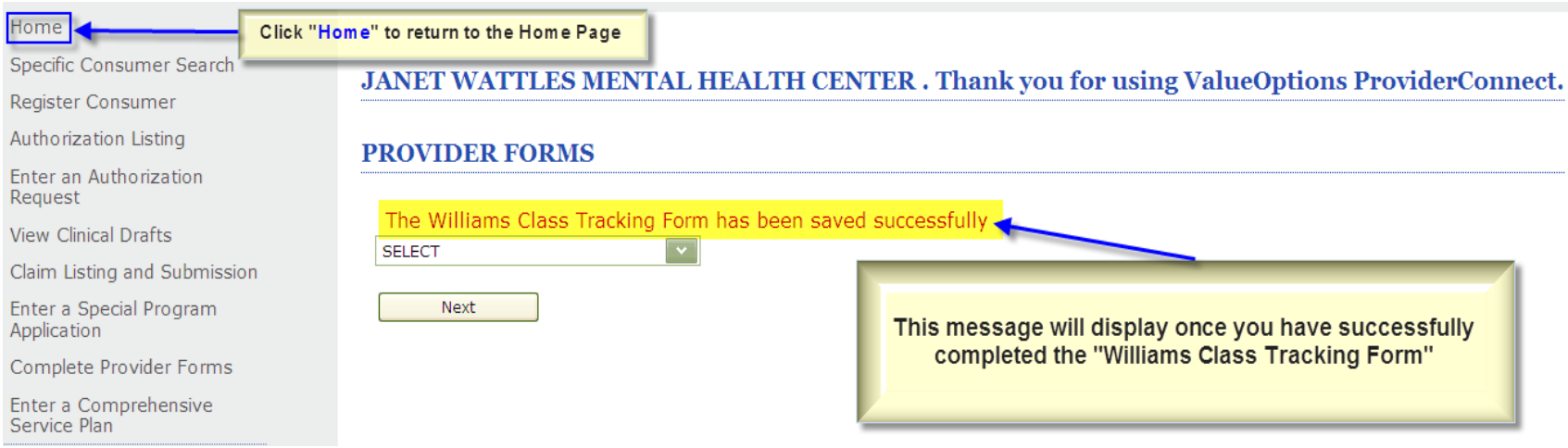
Submission Landing Page



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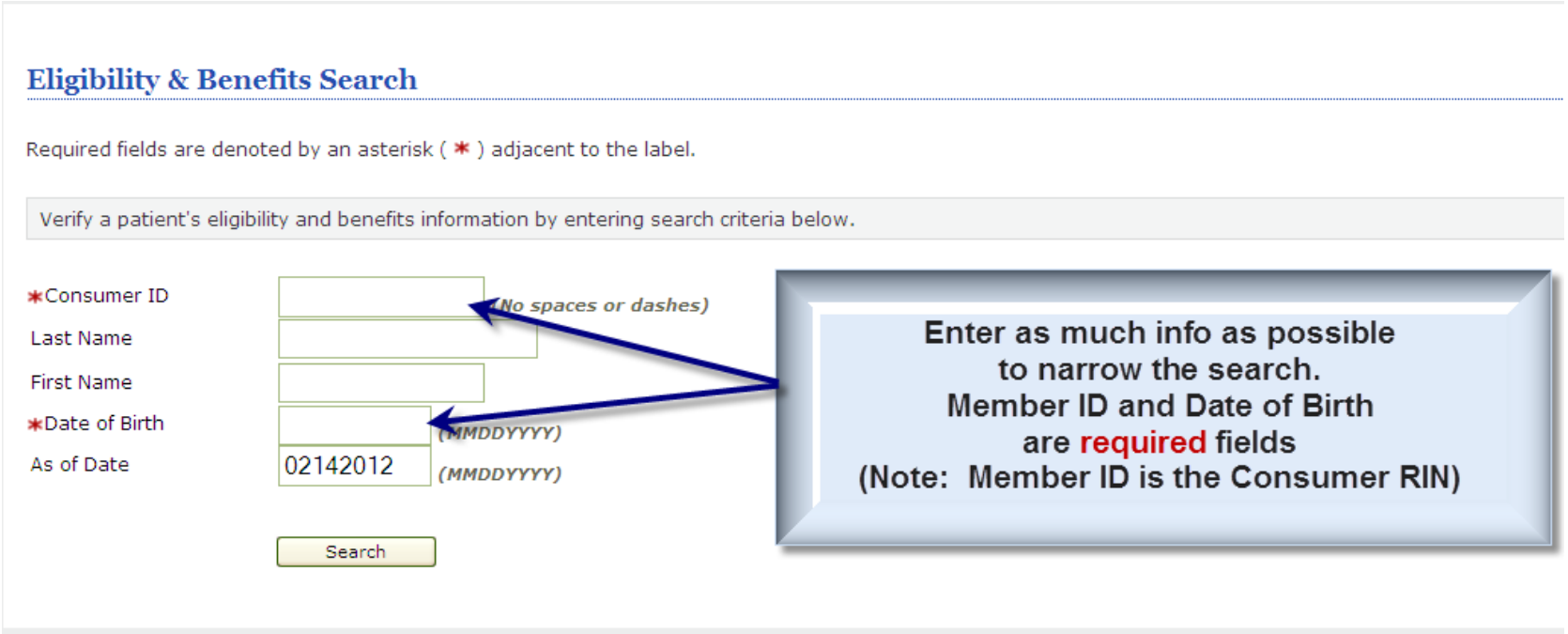

Demographics Page

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- Network Specific Information
- Education Center
- ValueSelect Designation
- Contact Us

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

Consumer

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	

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

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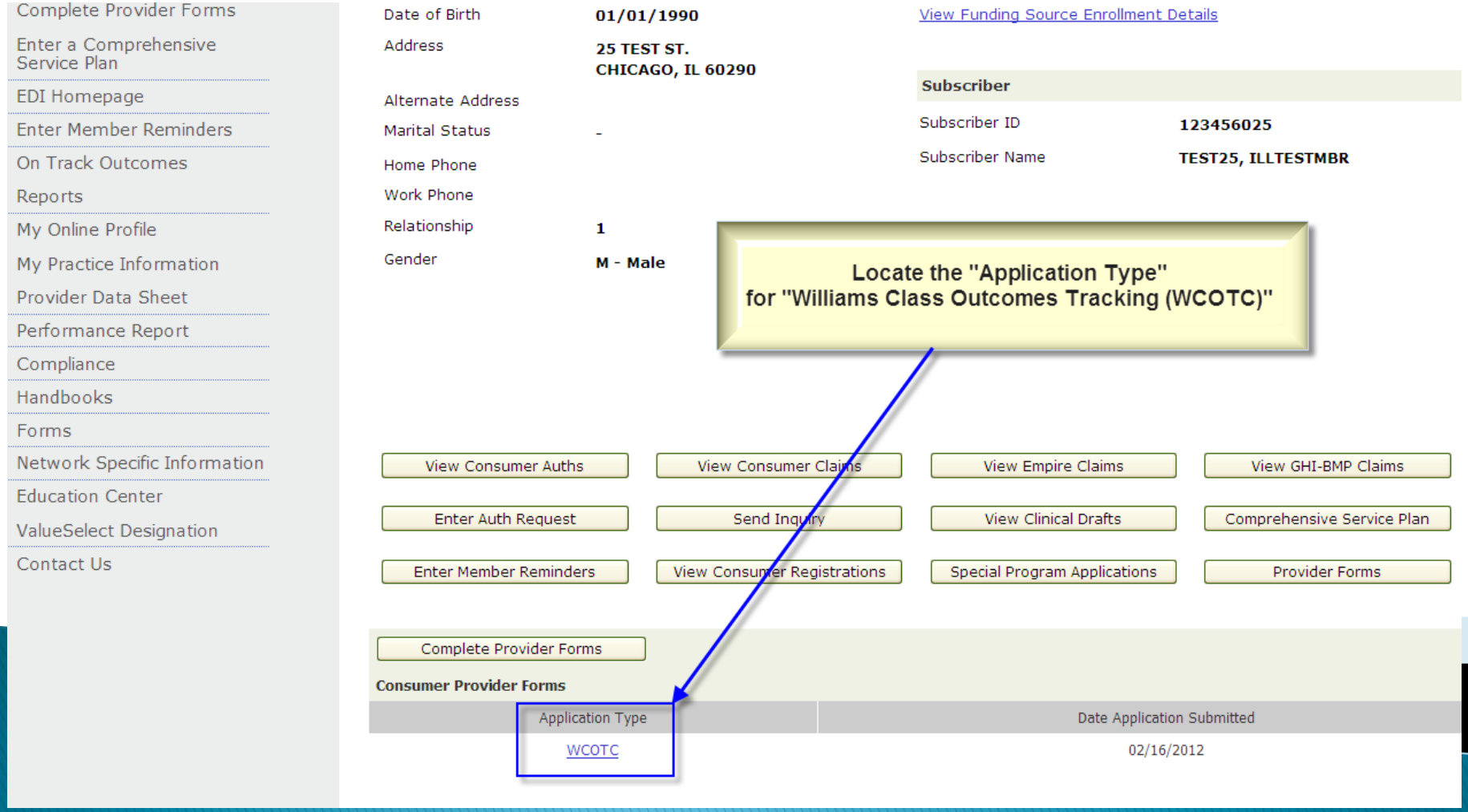
(Submitted Provider Forms)



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

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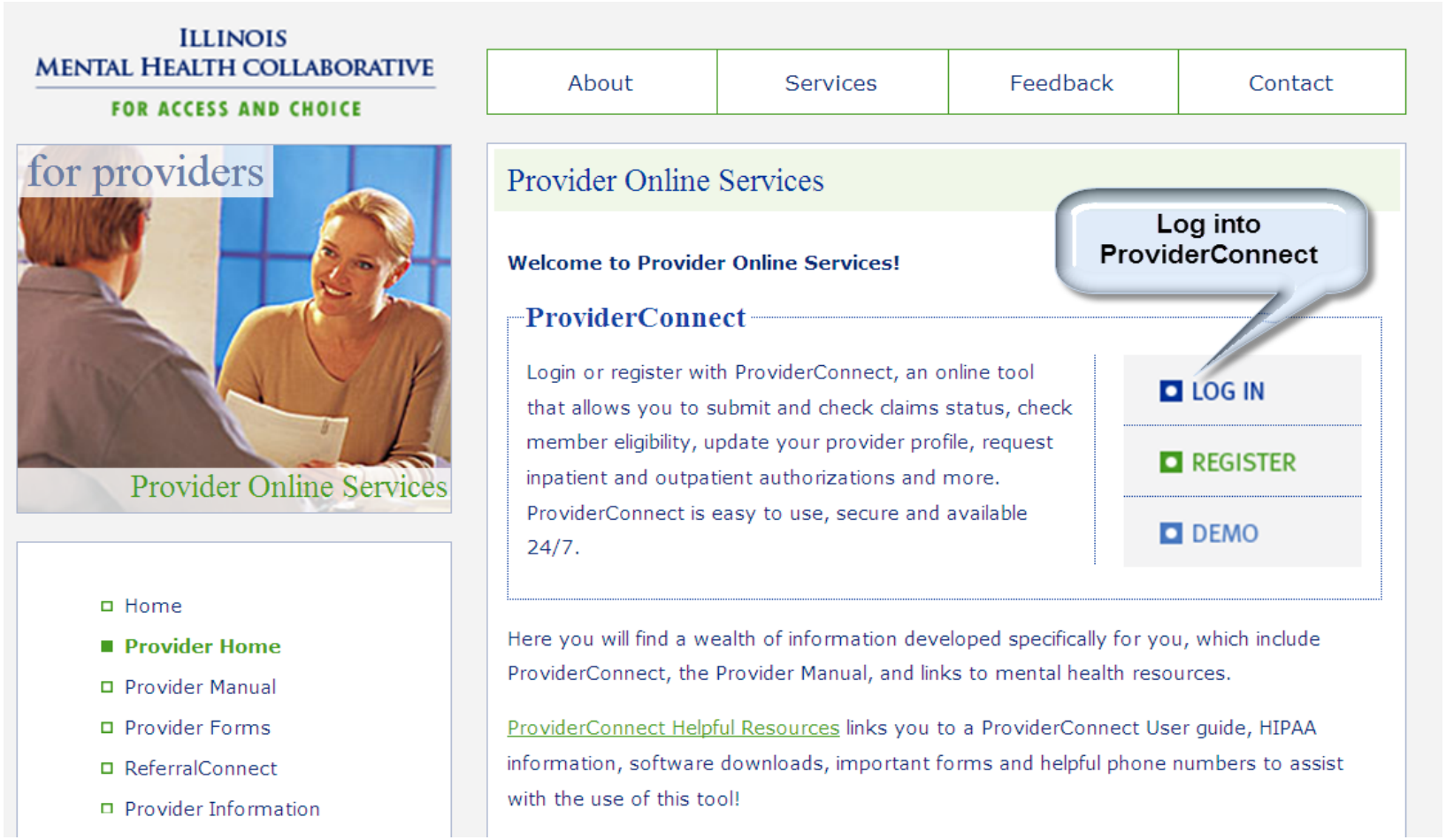

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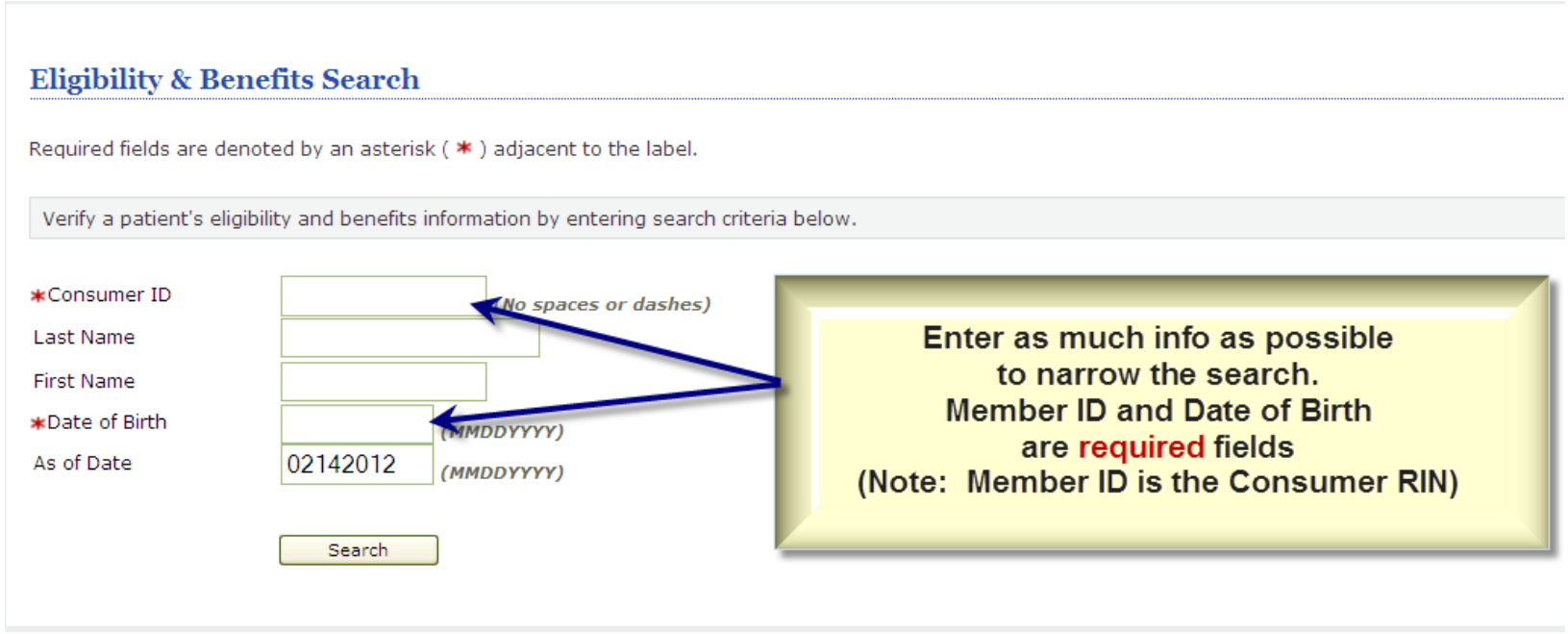

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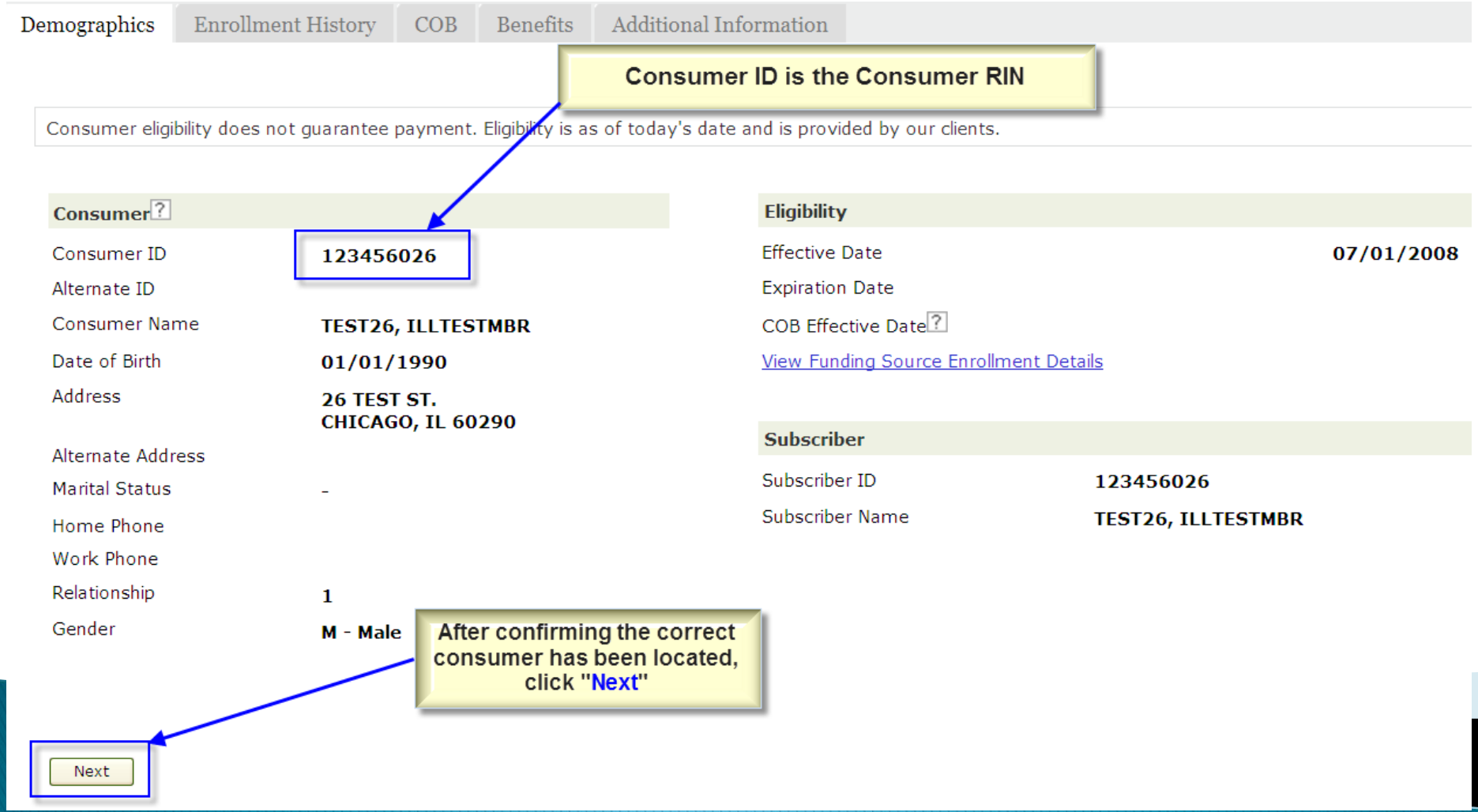
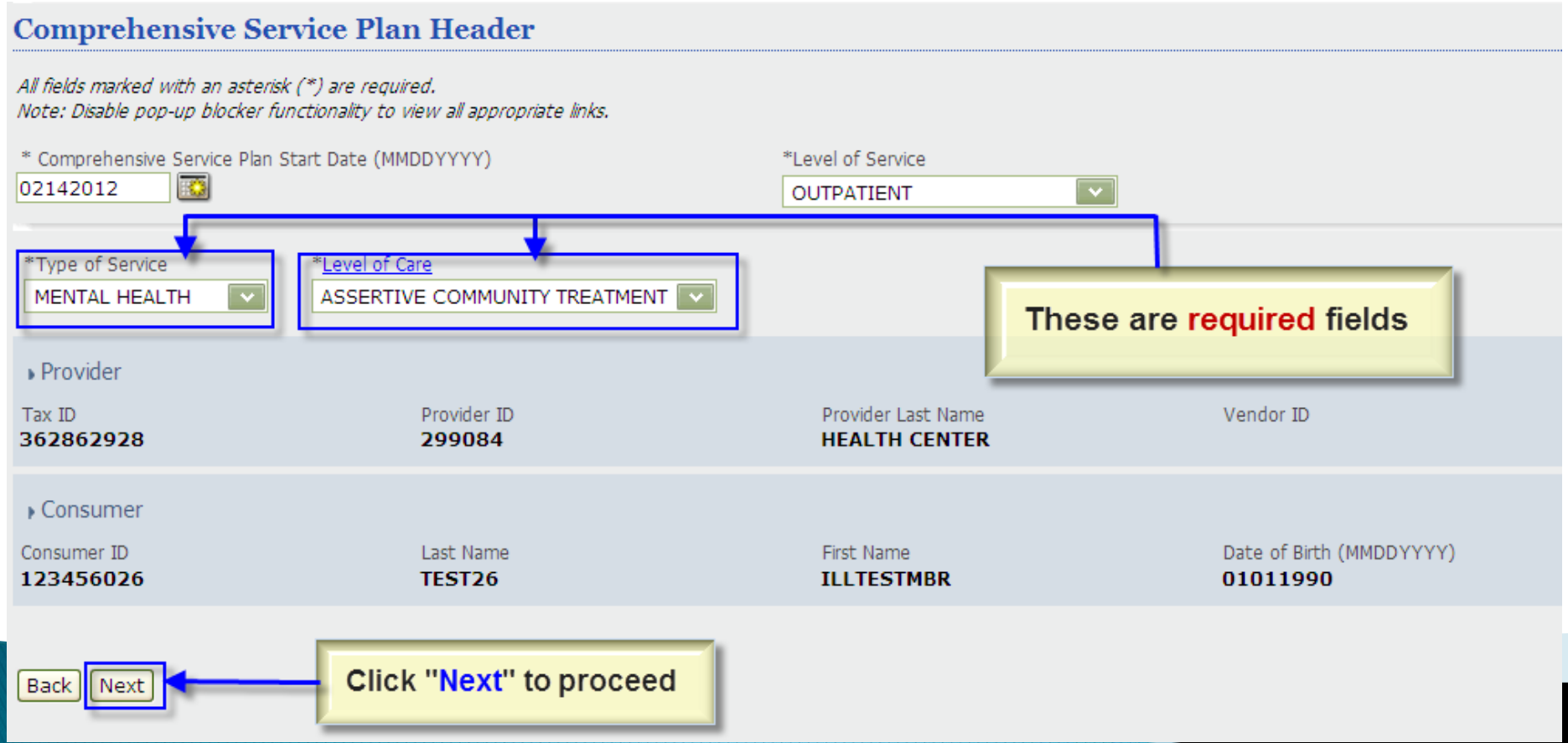
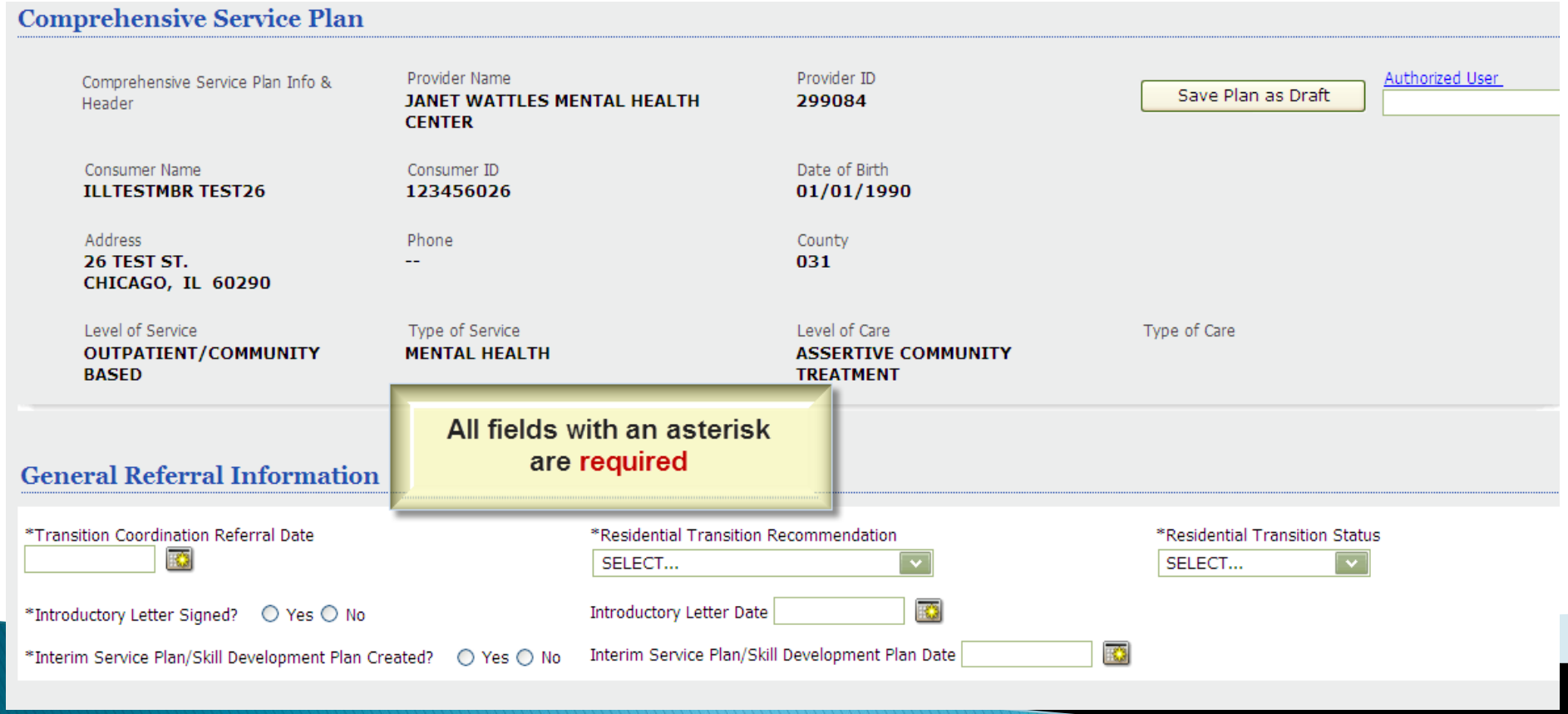


Comprehensive Service Plan
Landing Page

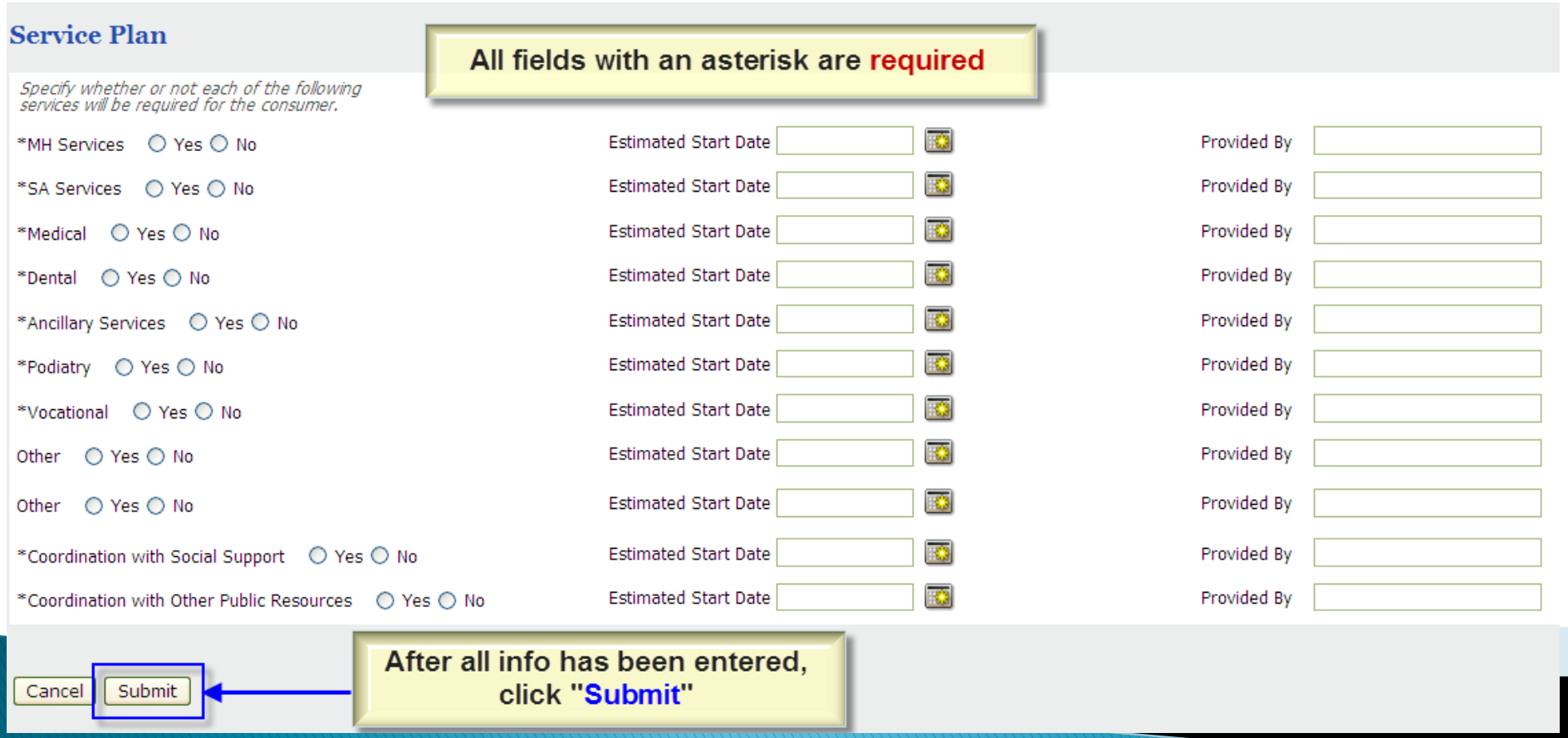
Comprehensive Service Plan
Landing Page (Continued)



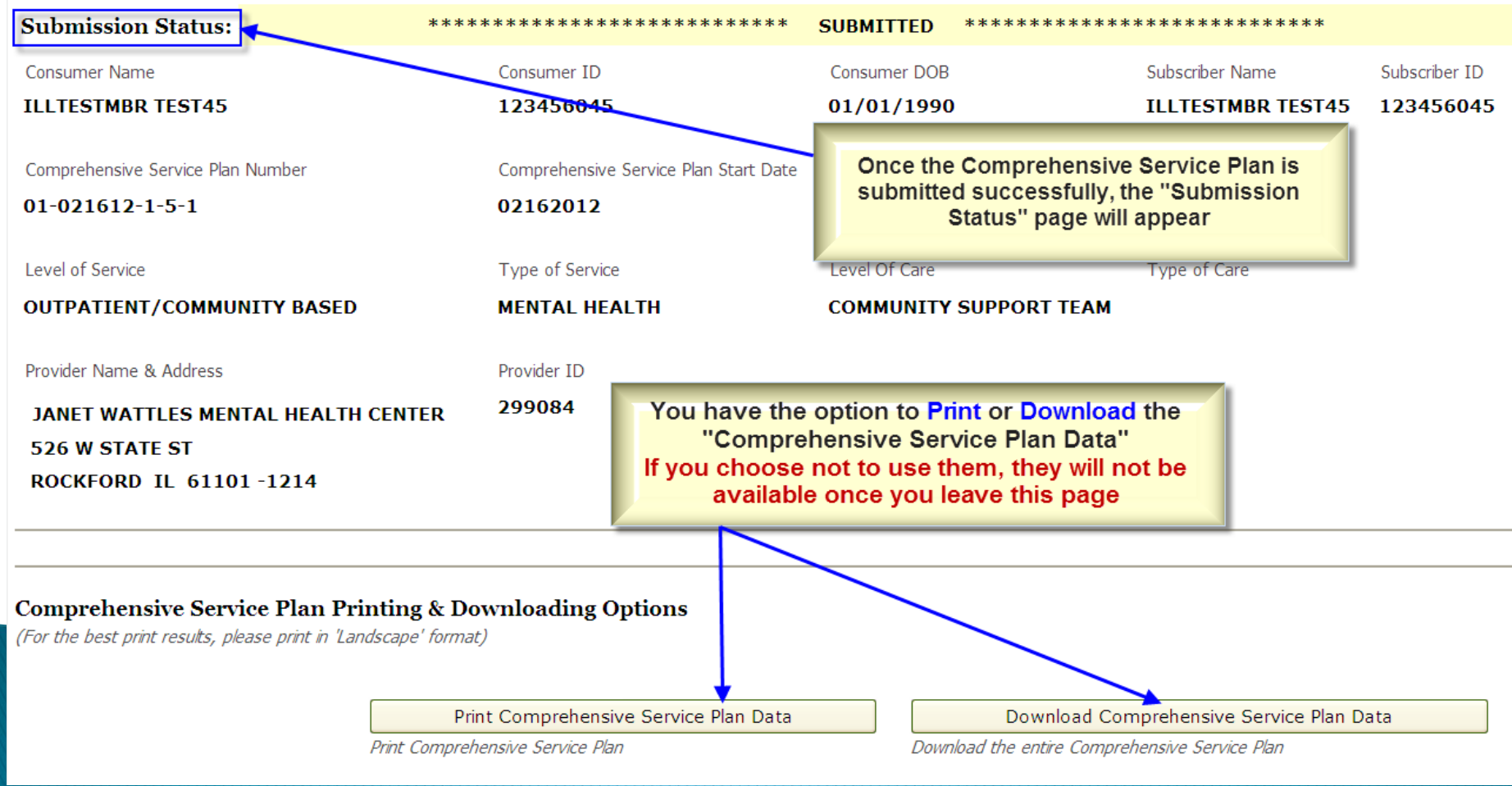
Comprehensive Service Plan
Section 1



Comprehensive Service Plan
Section 2



Comprehensive Service Plan
Printing Options



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

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

Provider ID

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

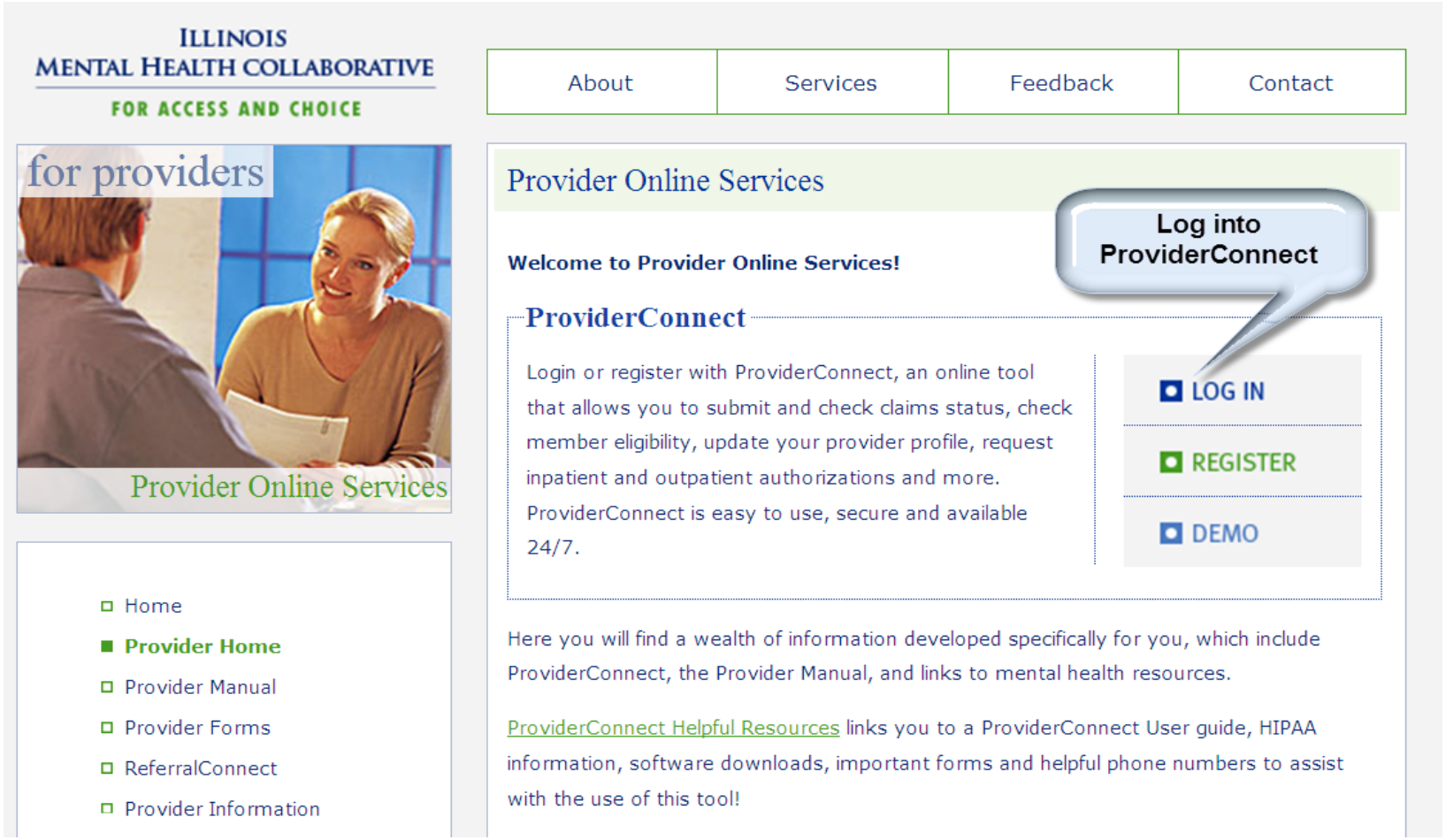
PSH – Permanent Supportive Housing

WCPSH – Williams Class Permanent Supportive Housing

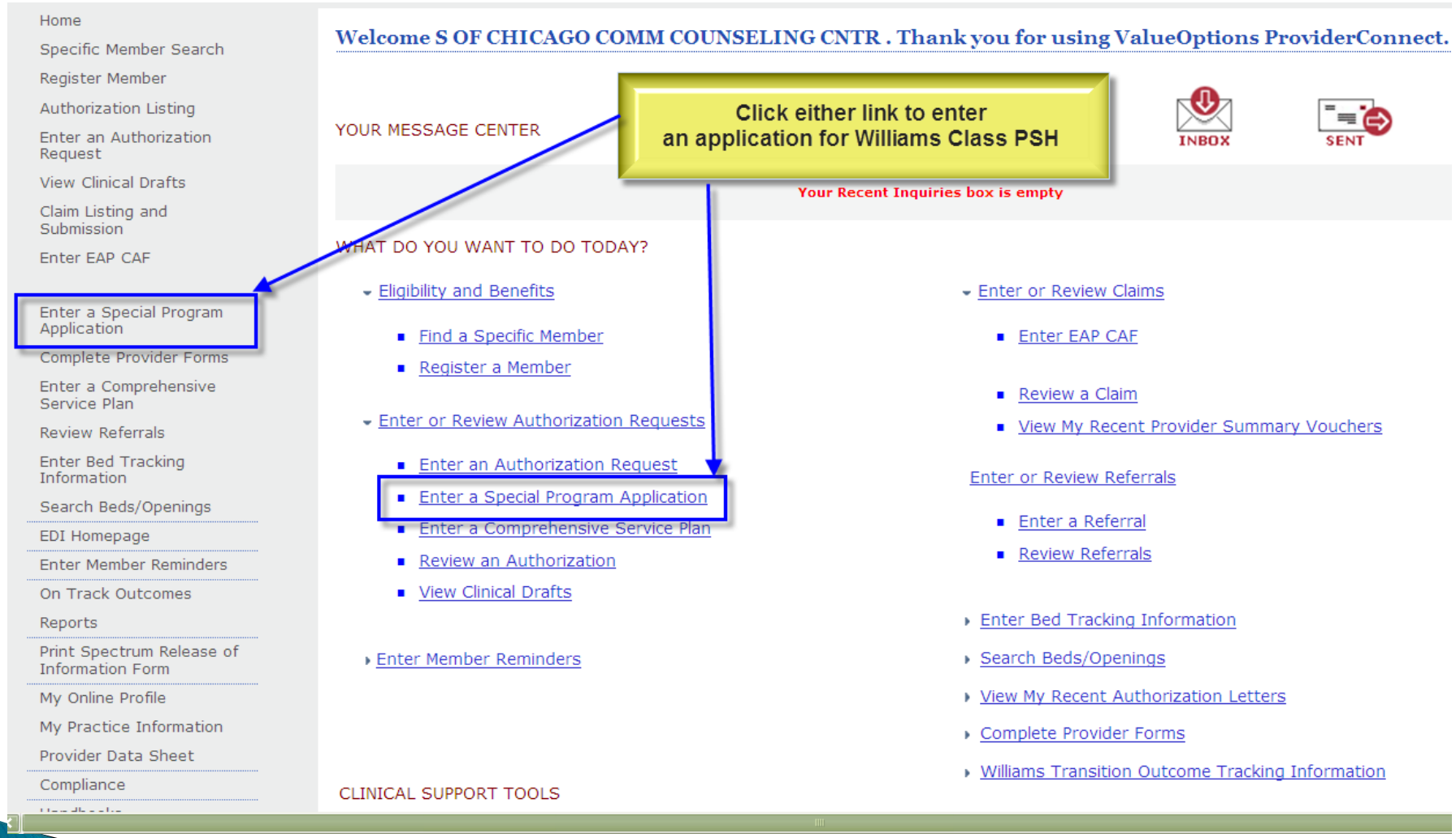
Preparing to Submit a Williams Class PSH Electronic Application

- **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**

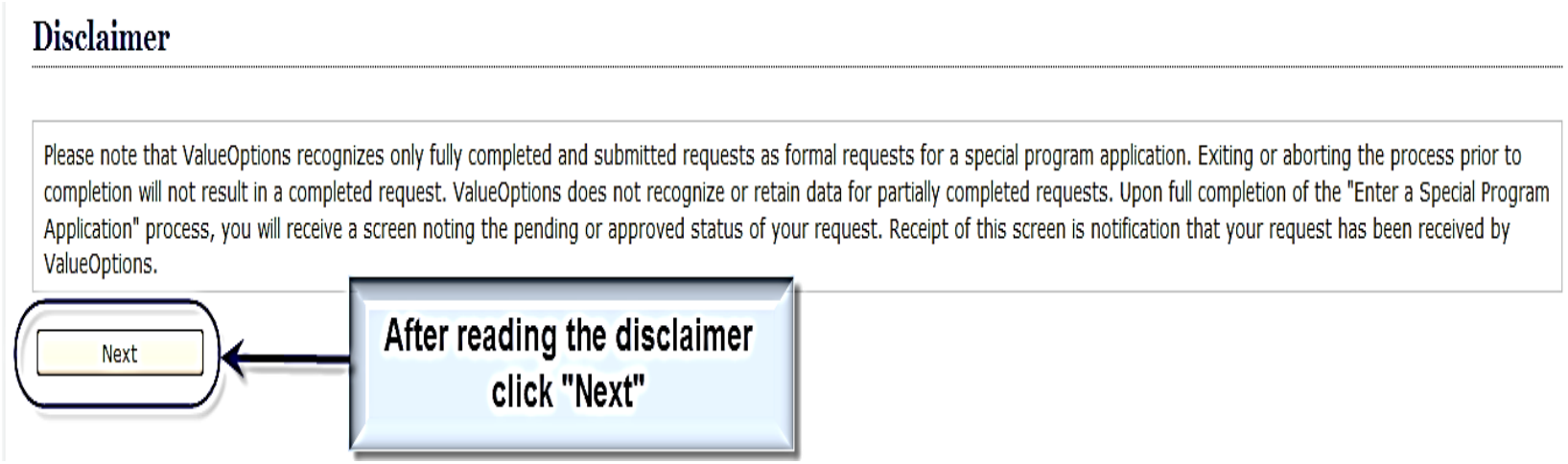
Getting Started



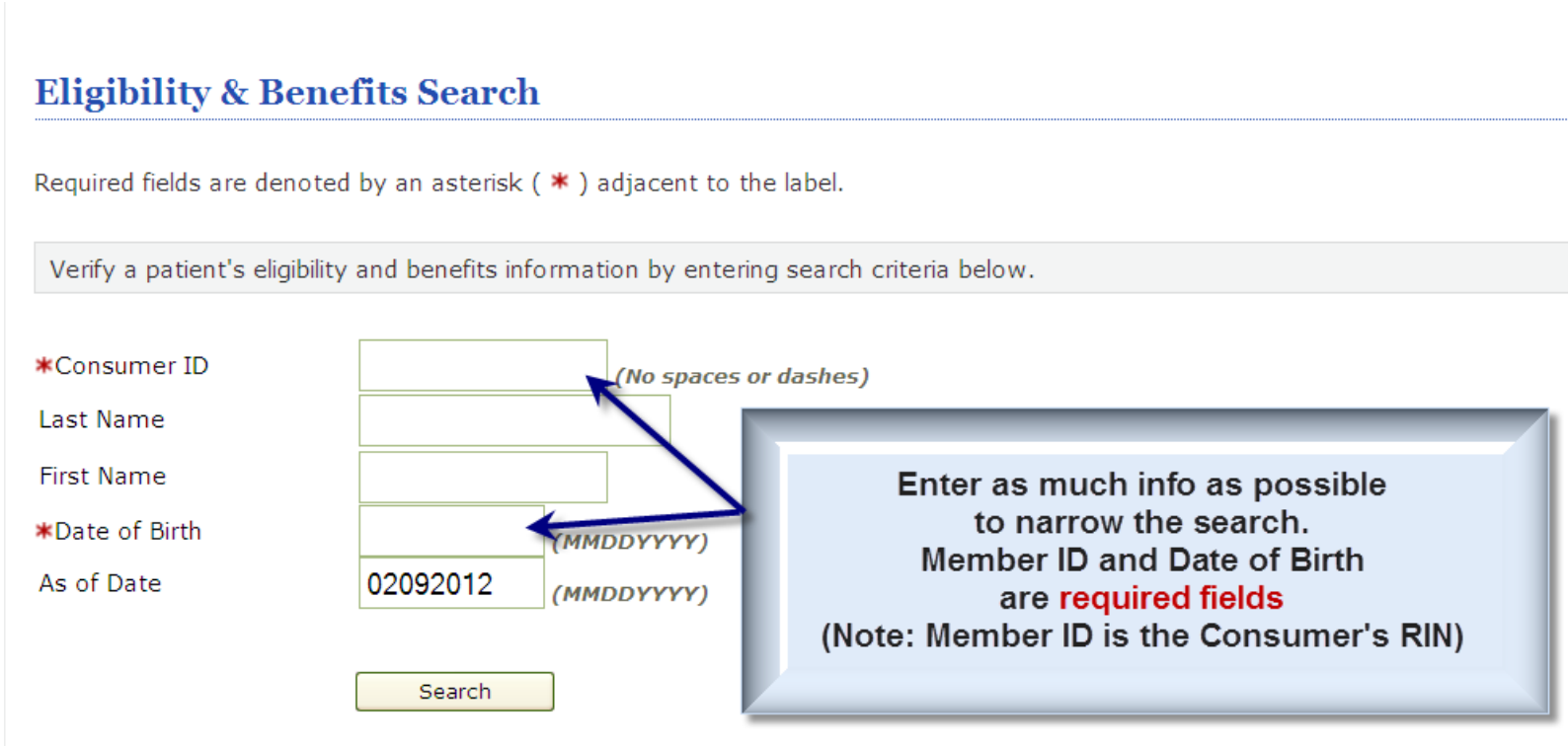
Home Page


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

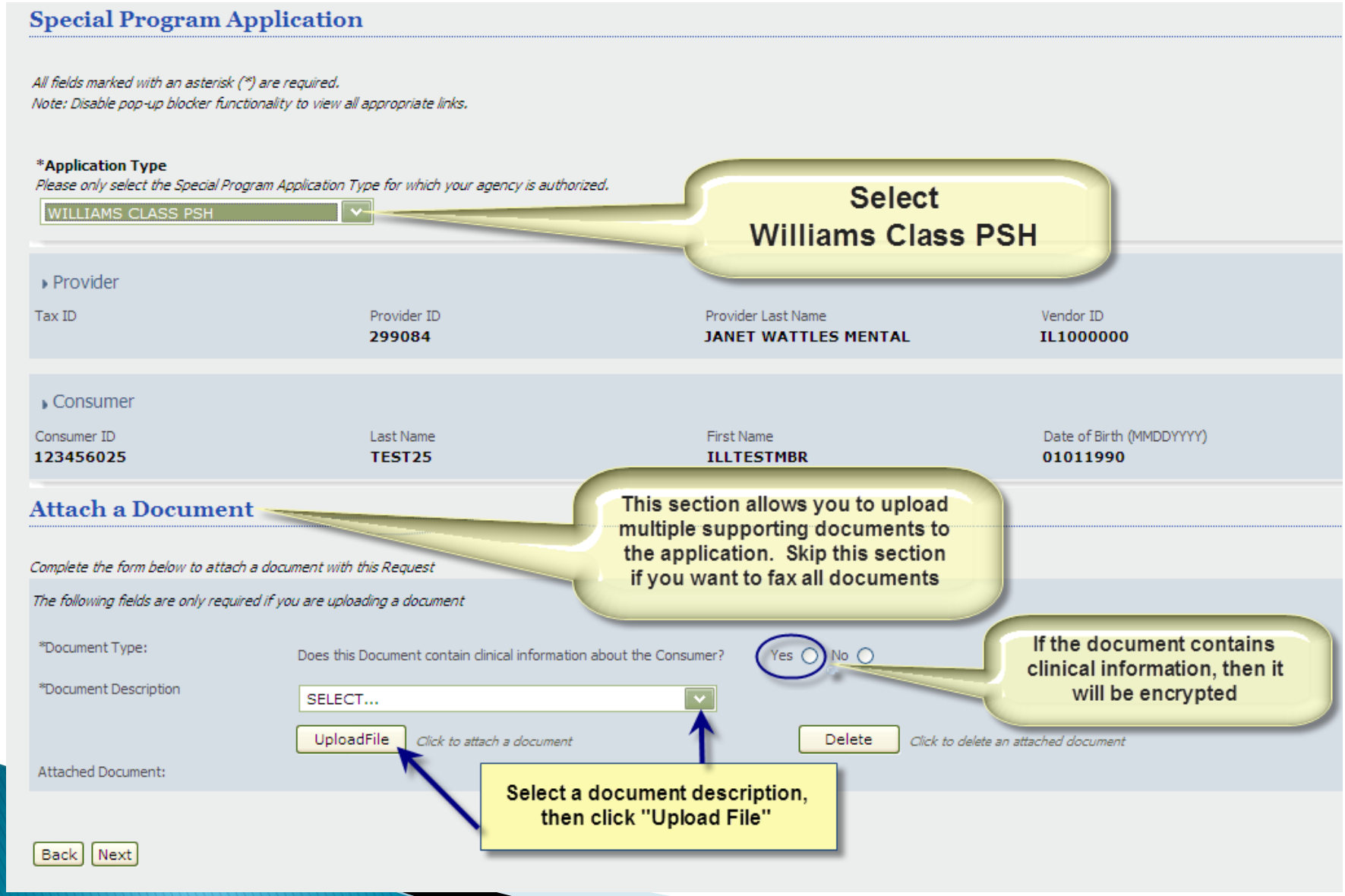


Search a Member

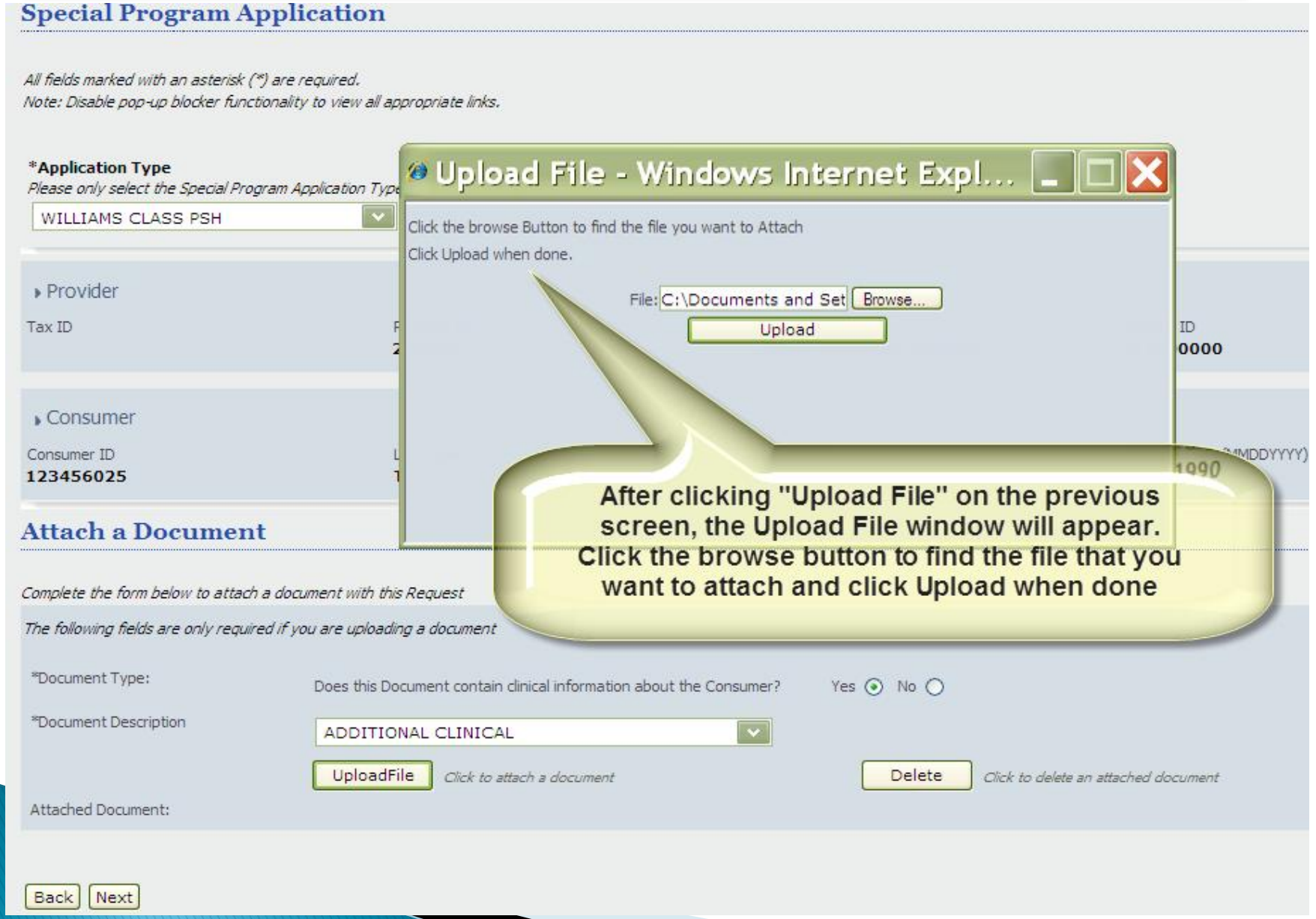


Demographics Verification

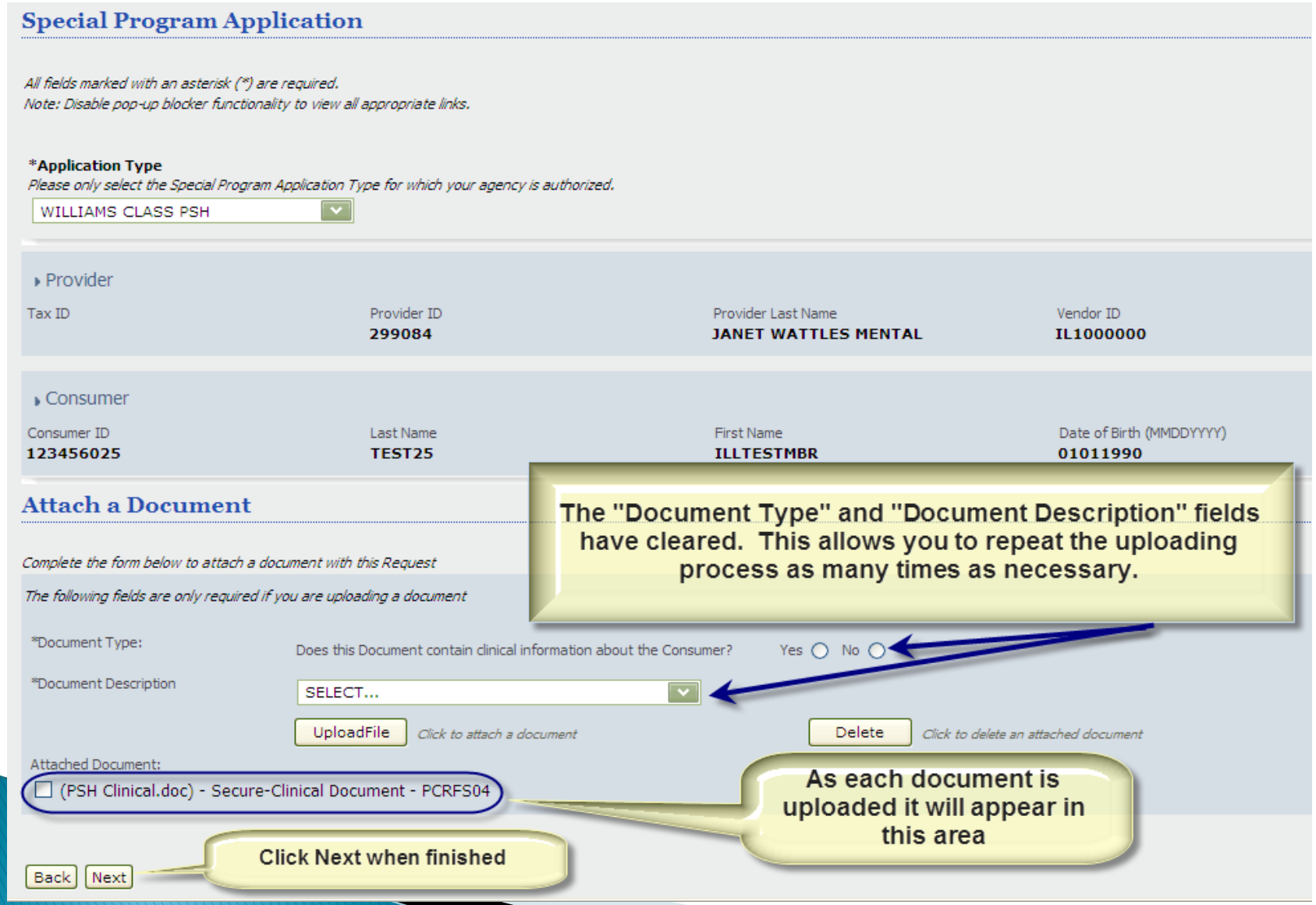
Application Landing Page



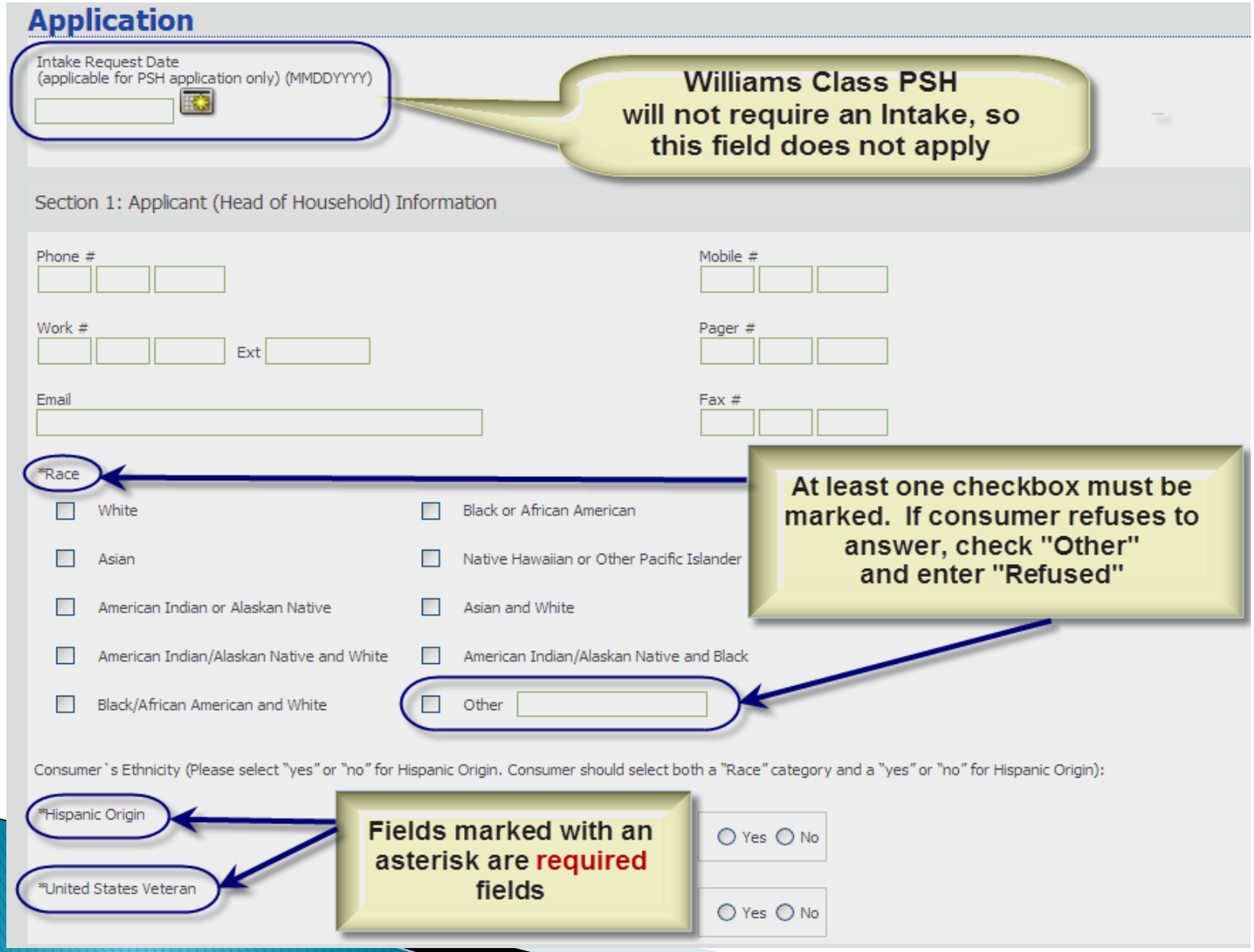
Attaching Documents



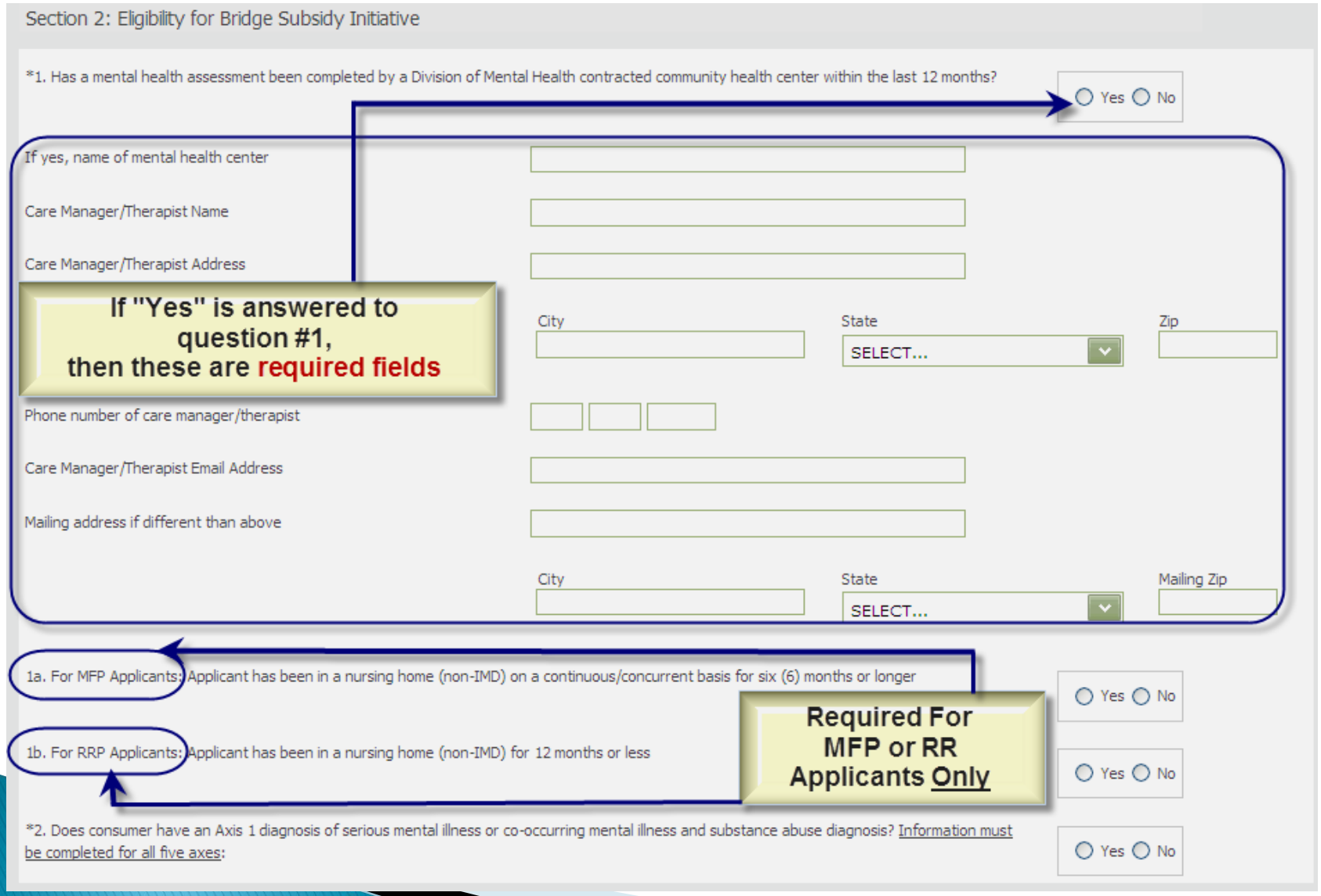
Application Landing Page
(after uploading a document)



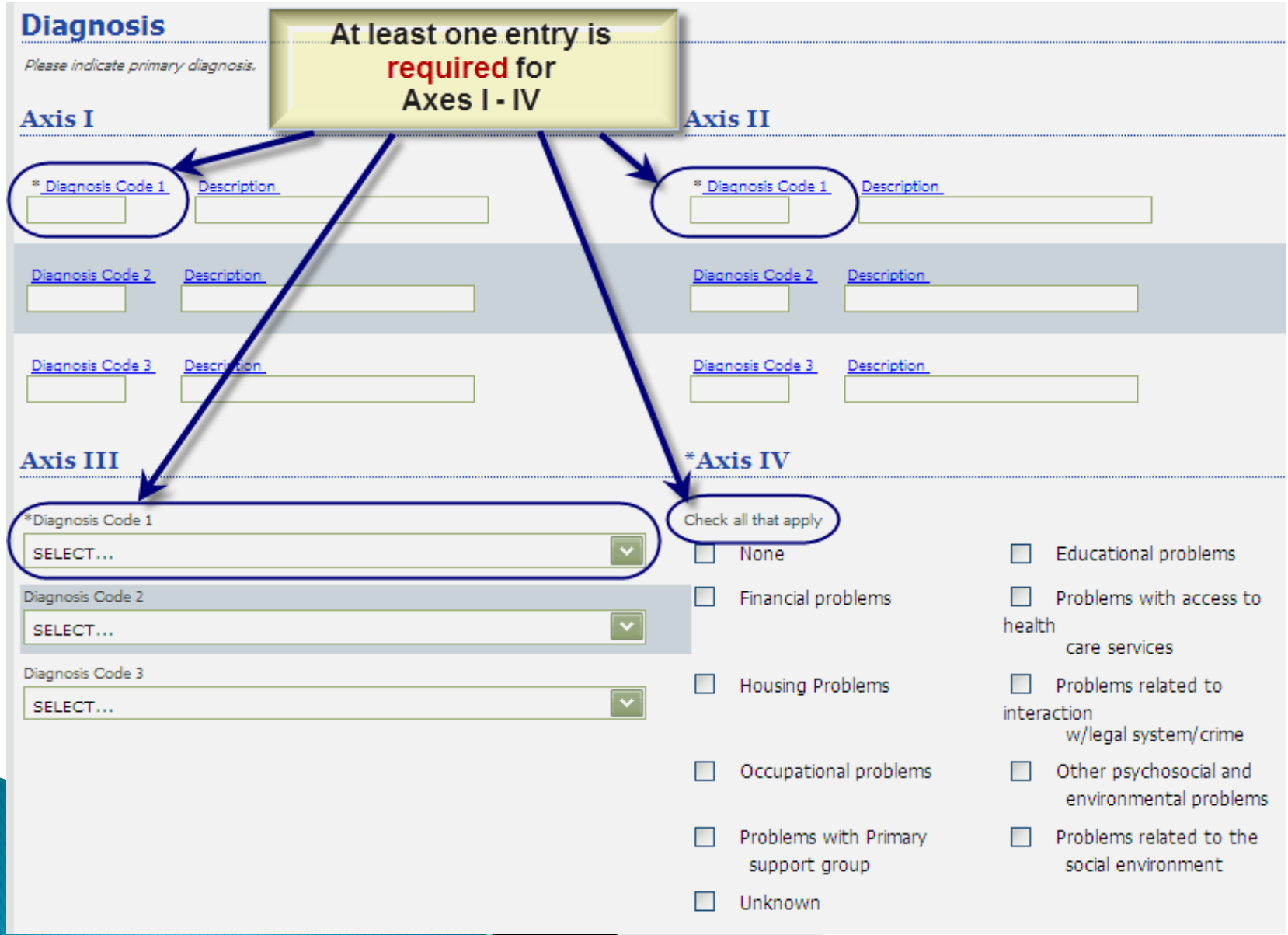
Special Program Application
(Section 1)



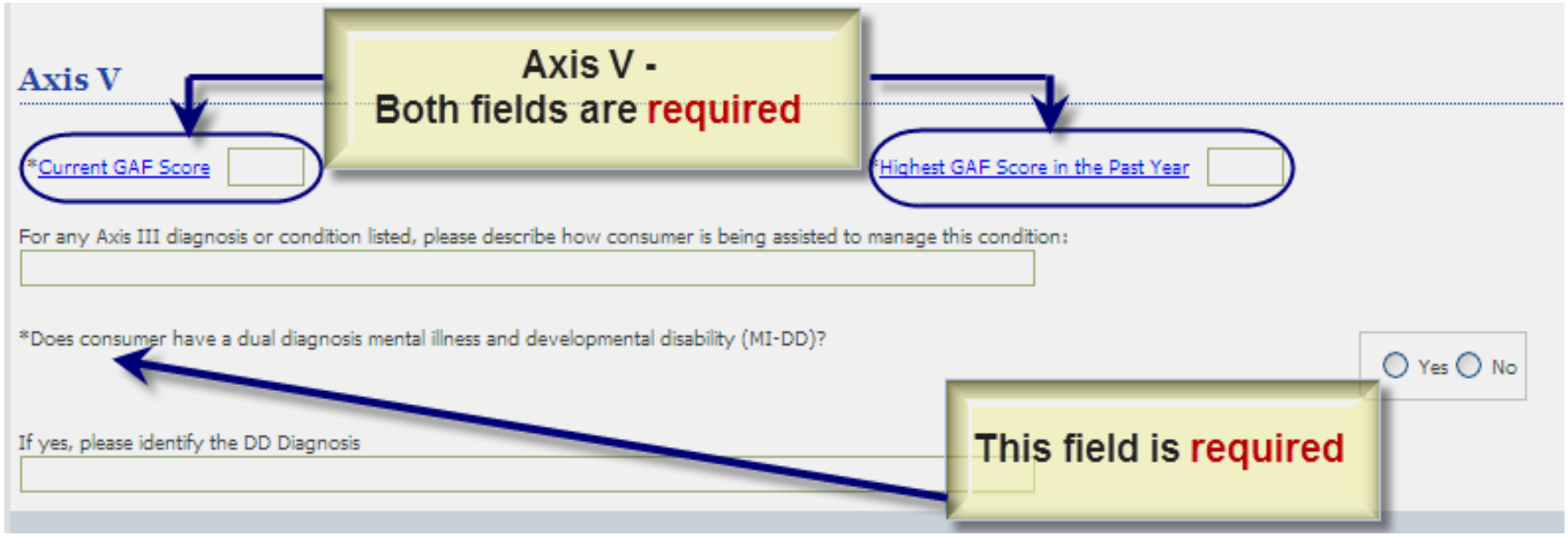
Special Program Application
(Section 2)



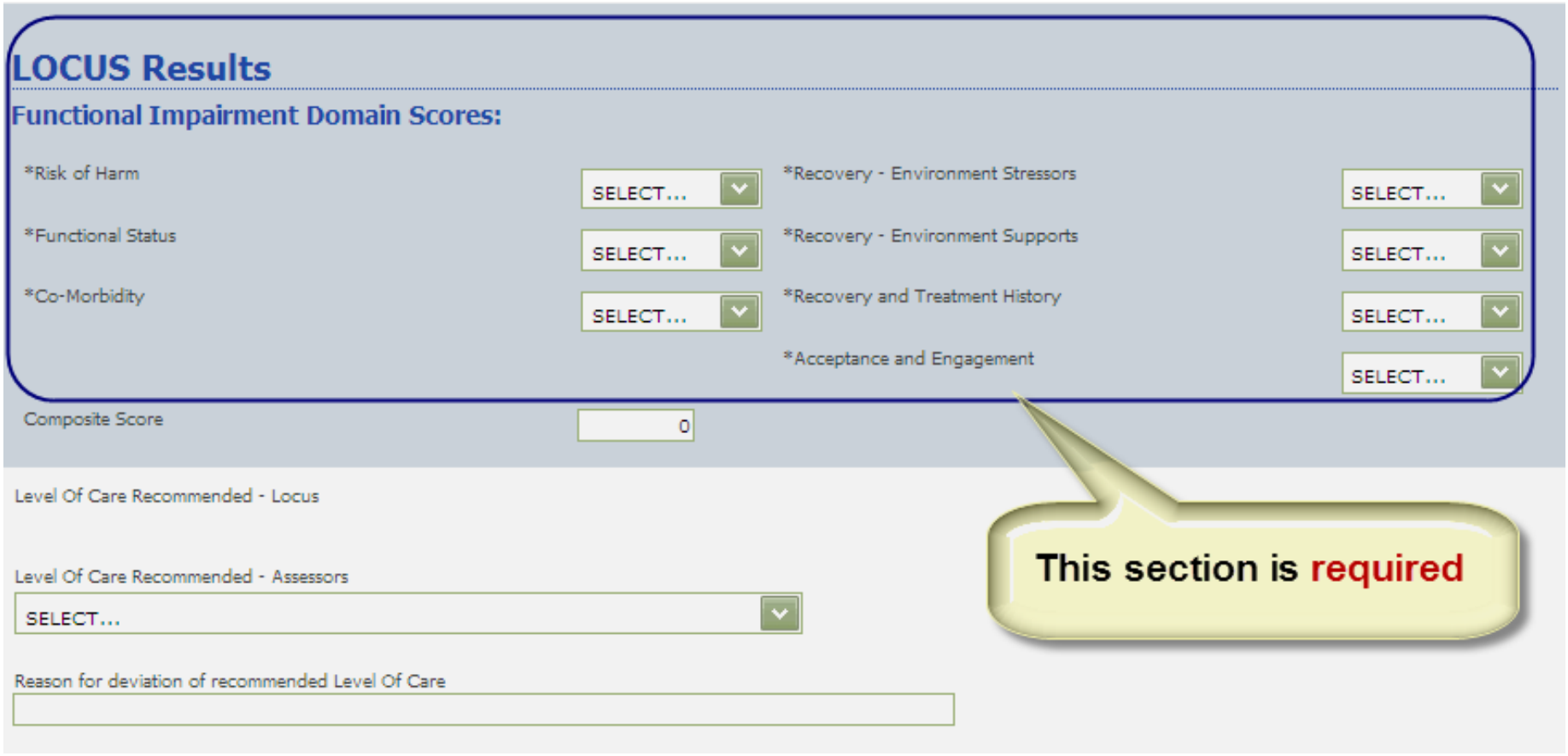
Special Program Application
(Section 2-Continued)



Special Program Application
(Section 2-Continued)



Special Program Application
(Section 2-Continued)



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...

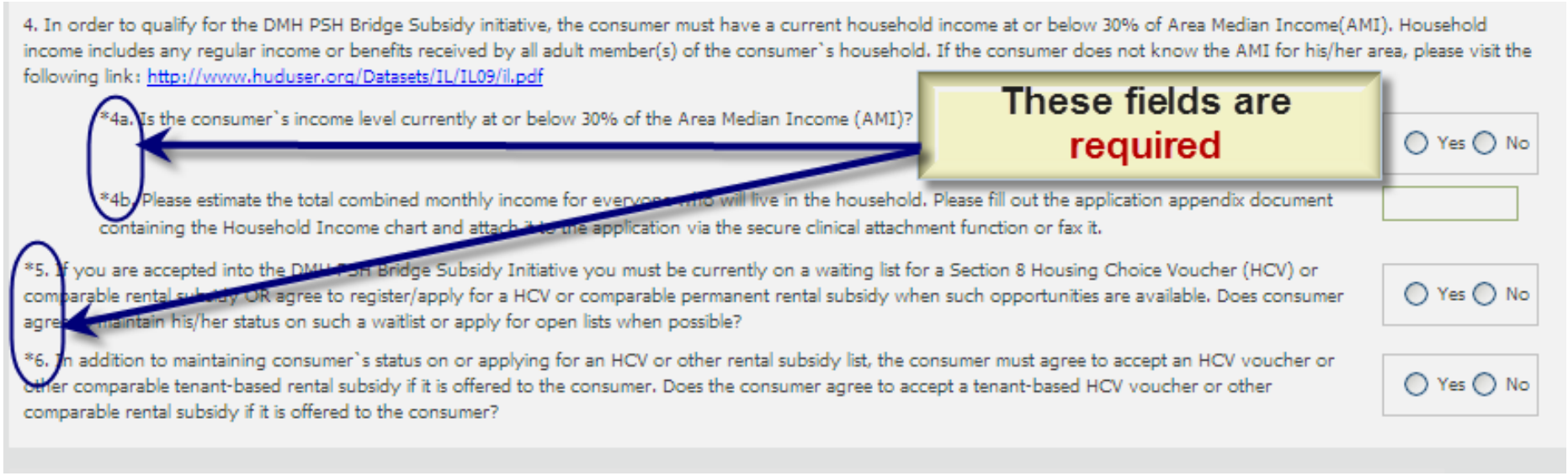
☐ Currently experiencing chronic homelessness as defined by DMH. To qualify for this priority population category, consumer must also answer "yes" to the following two questions:

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

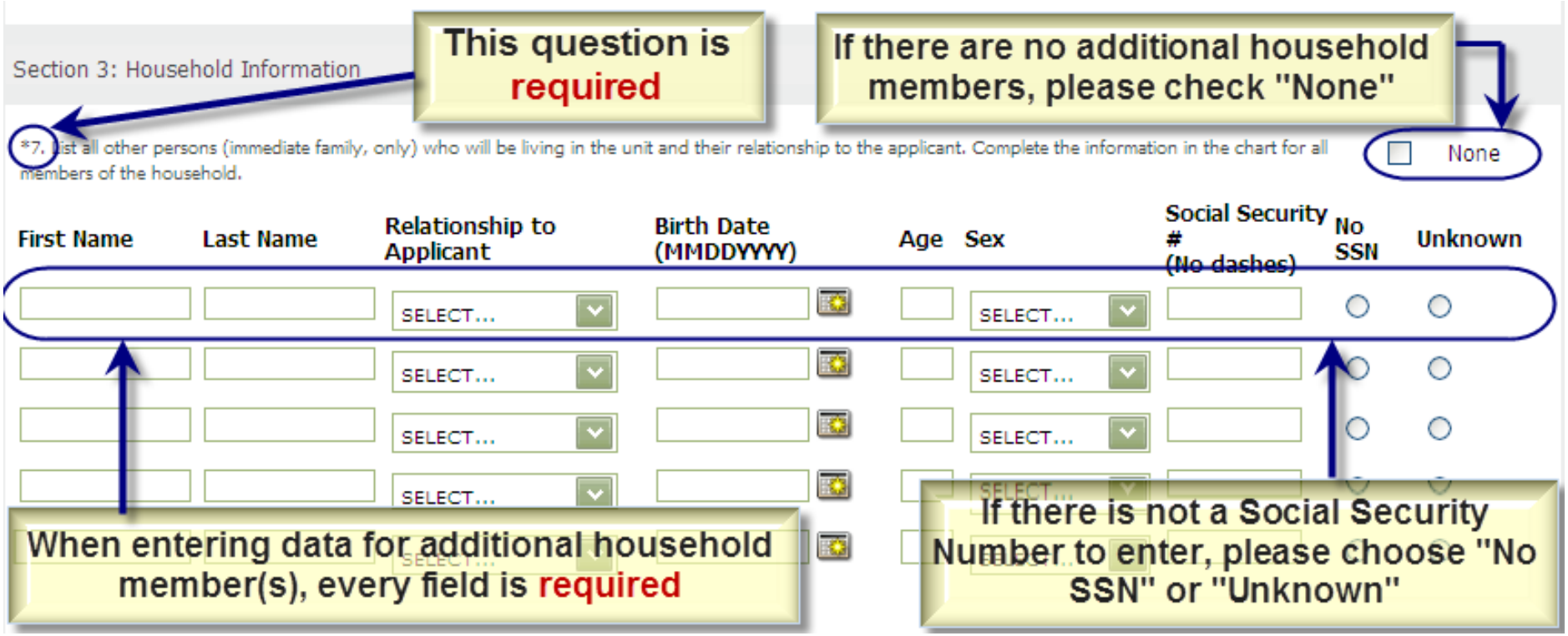
2. Is consumer currently residing in a place not meant for human habitation (e.g., living on the street), a safe haven, or in an emergency shelter? (In rural communities that utilize hotel/motel vouchers in lieu of emergency shelter, individuals making use of such vouchers may check "yes" to this item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



Special Program Application
(Section 3)



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 a household member:

☐ Applicant ☐ Household Member (please specify)

#8 is Required

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

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

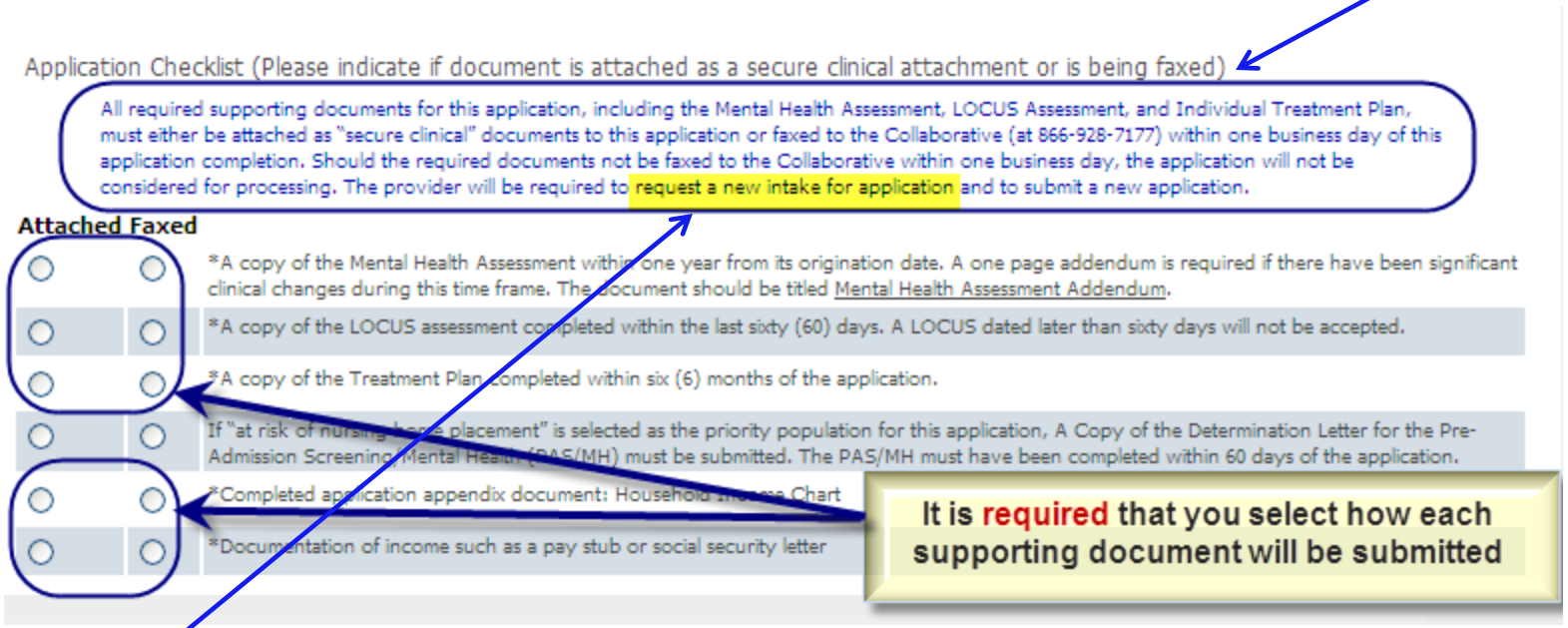
If "yes" please indicate if the statement applies to the applicant or a household member:

☐ Applicant ☐ Household Member (please specify)

Explanation of any "yes" statements checked above

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

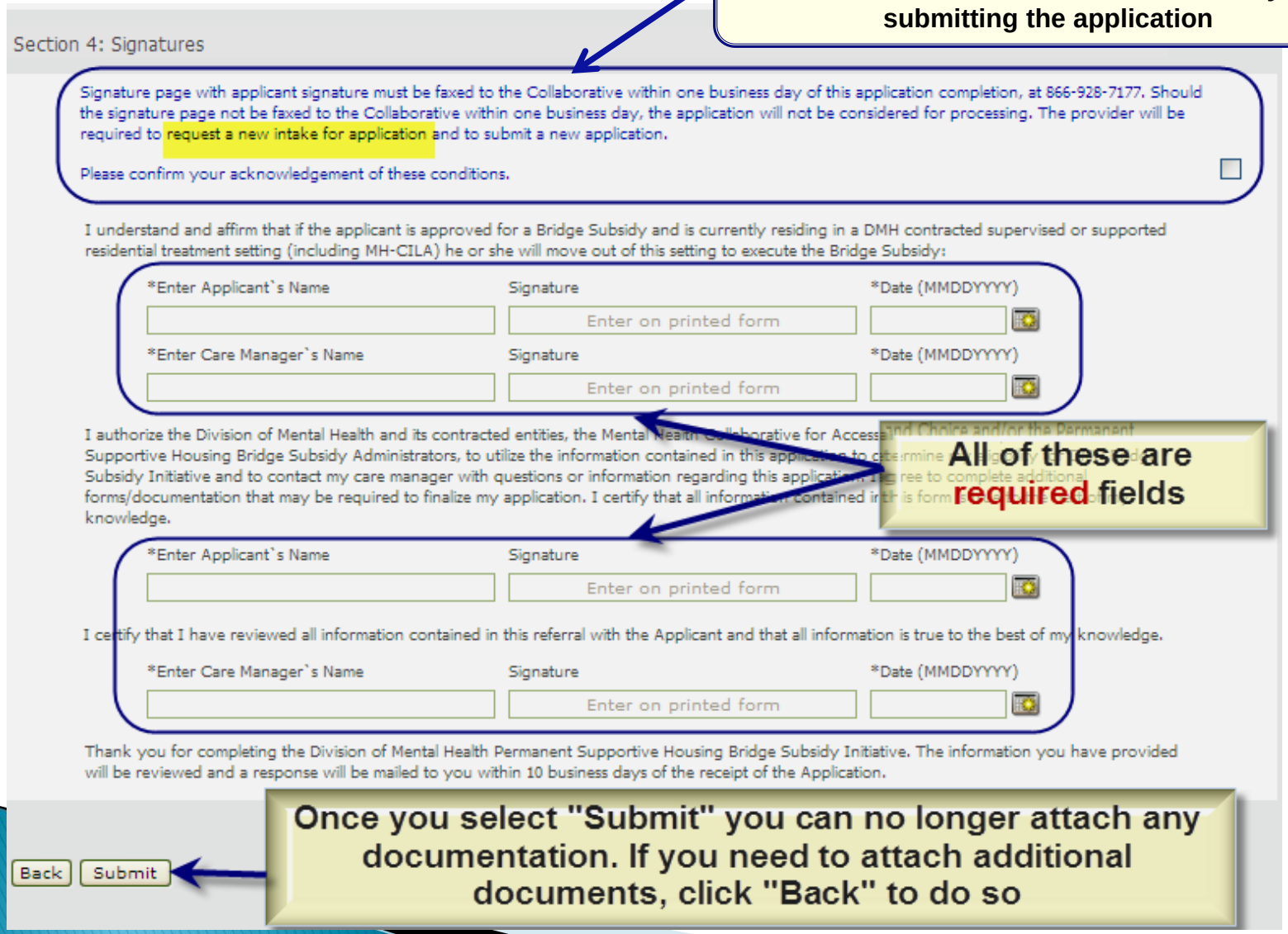


It is required that you select how each supporting document will be submitted

Intakes do not apply to Williams Class PSH

Special Program Application
(Section 4)

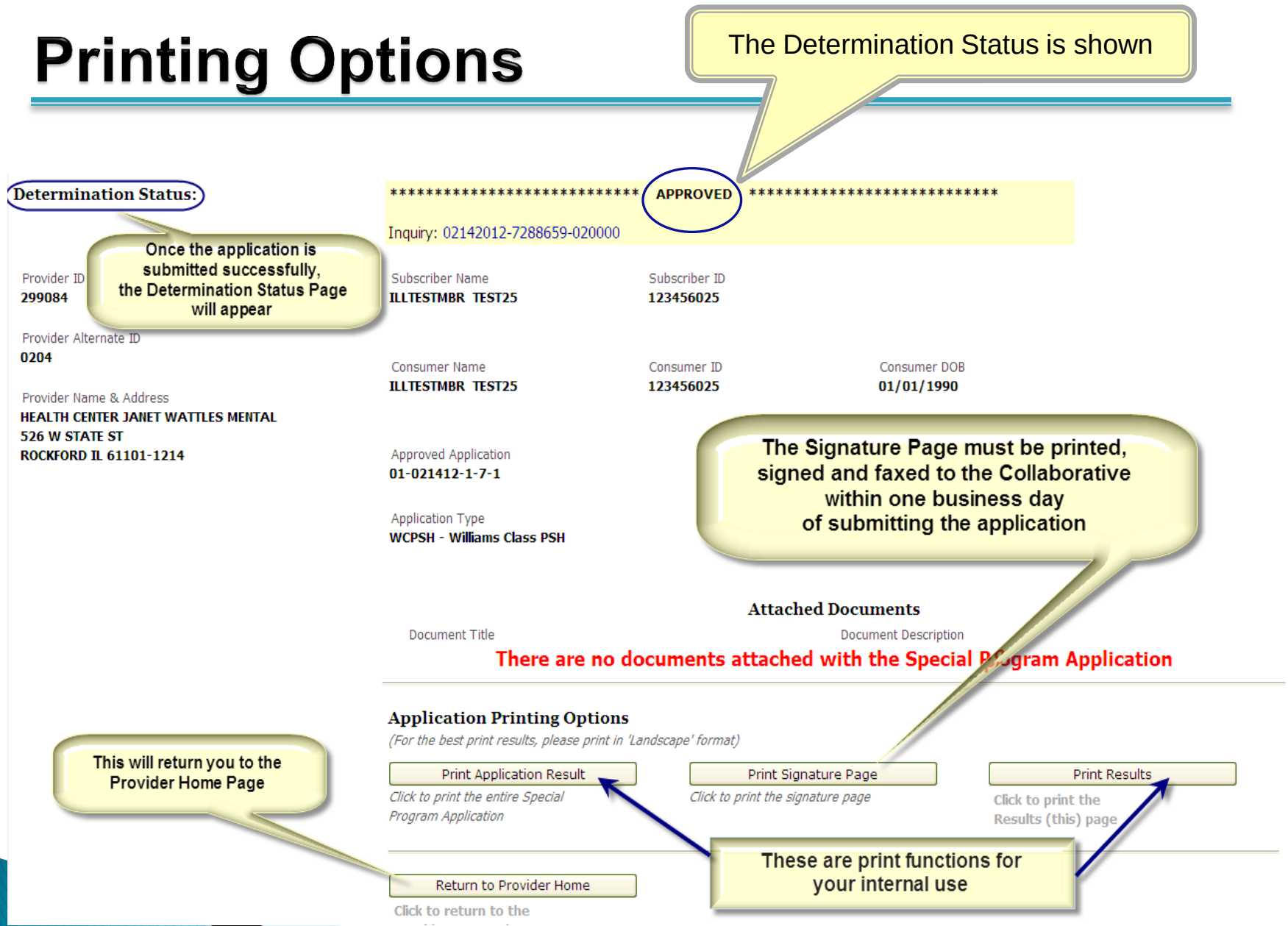
Signature Page with applicant signature must be faxed within one business day of submitting the application



All of these are required fields

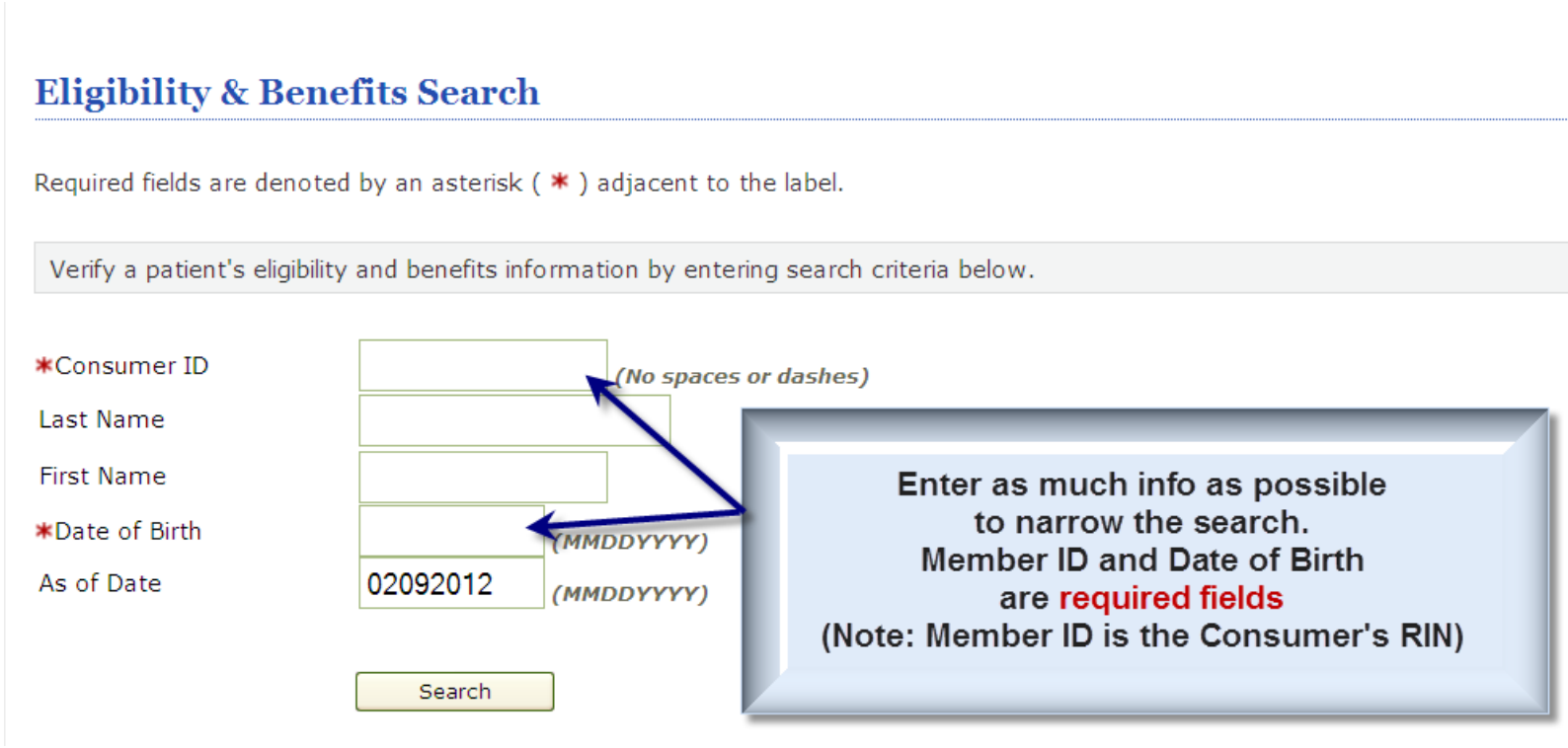
Once you select "Submit" you can no longer attach any documentation. If you need to attach additional documents, click "Back" to do so

Printing Options

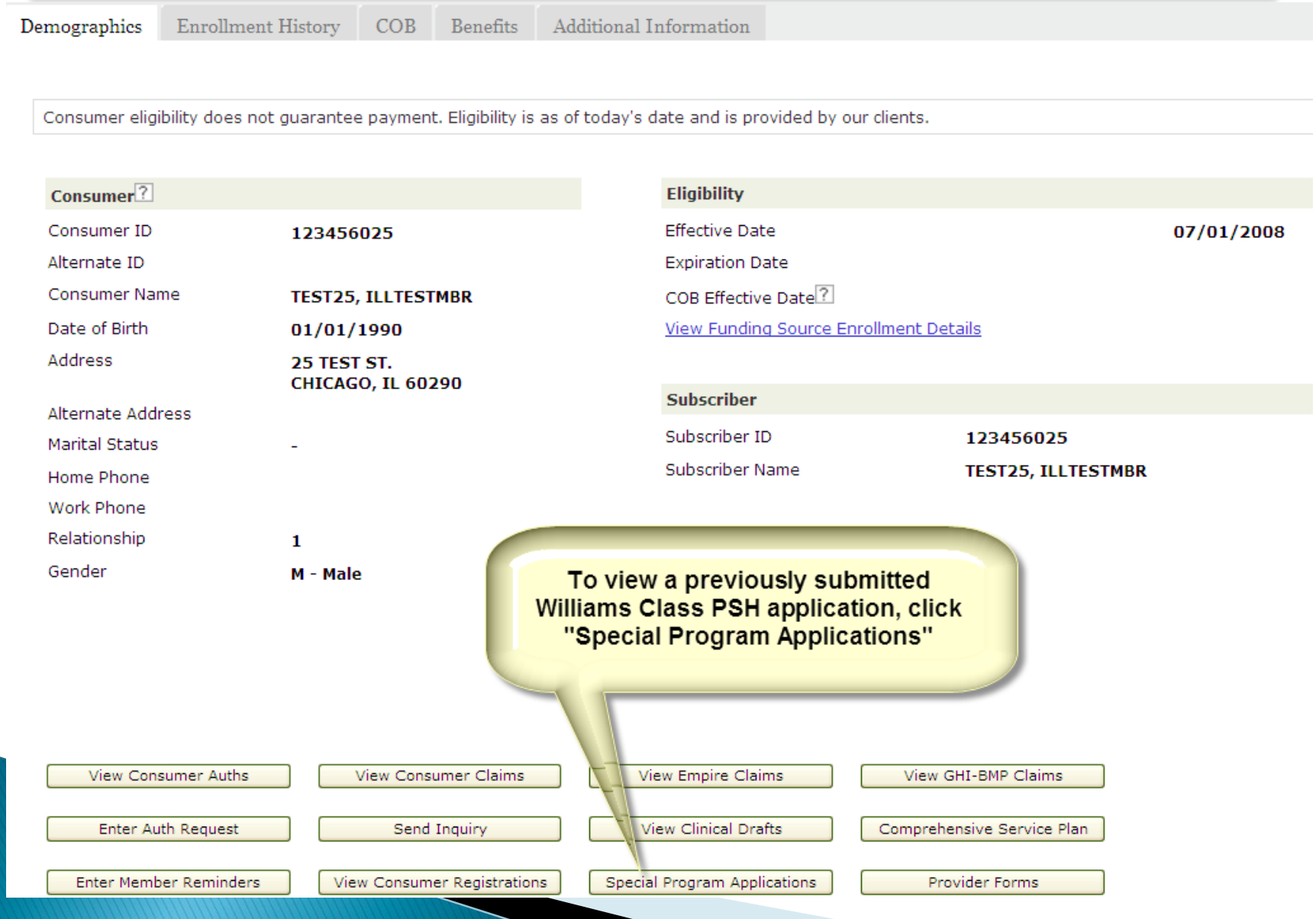


View a Submitted Application in ProviderConnect

Search A Member



View a Submitted Application in ProviderConnect (Continued)



View a Submitted Application in ProviderConnect (Continued)

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	Application Date	Application Type	Consumer Name	Provider Name	Provider Alternate ID
01-021412-1-7-1	**02/14/2012**	**WCPSH**	**ILLTESTMBR TEST25**	**HEALTH CENTER JANET WATTLES MEMORIAL**	
			Consumer ID **123456025**	Provider ID **299084**	

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

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

Section 1: Applicant (Head of Household) Information

Phone #
312 453 9000

Mobile #

Work #
312 453 9000

Pager #

Email
testmember@yahoo.com

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**

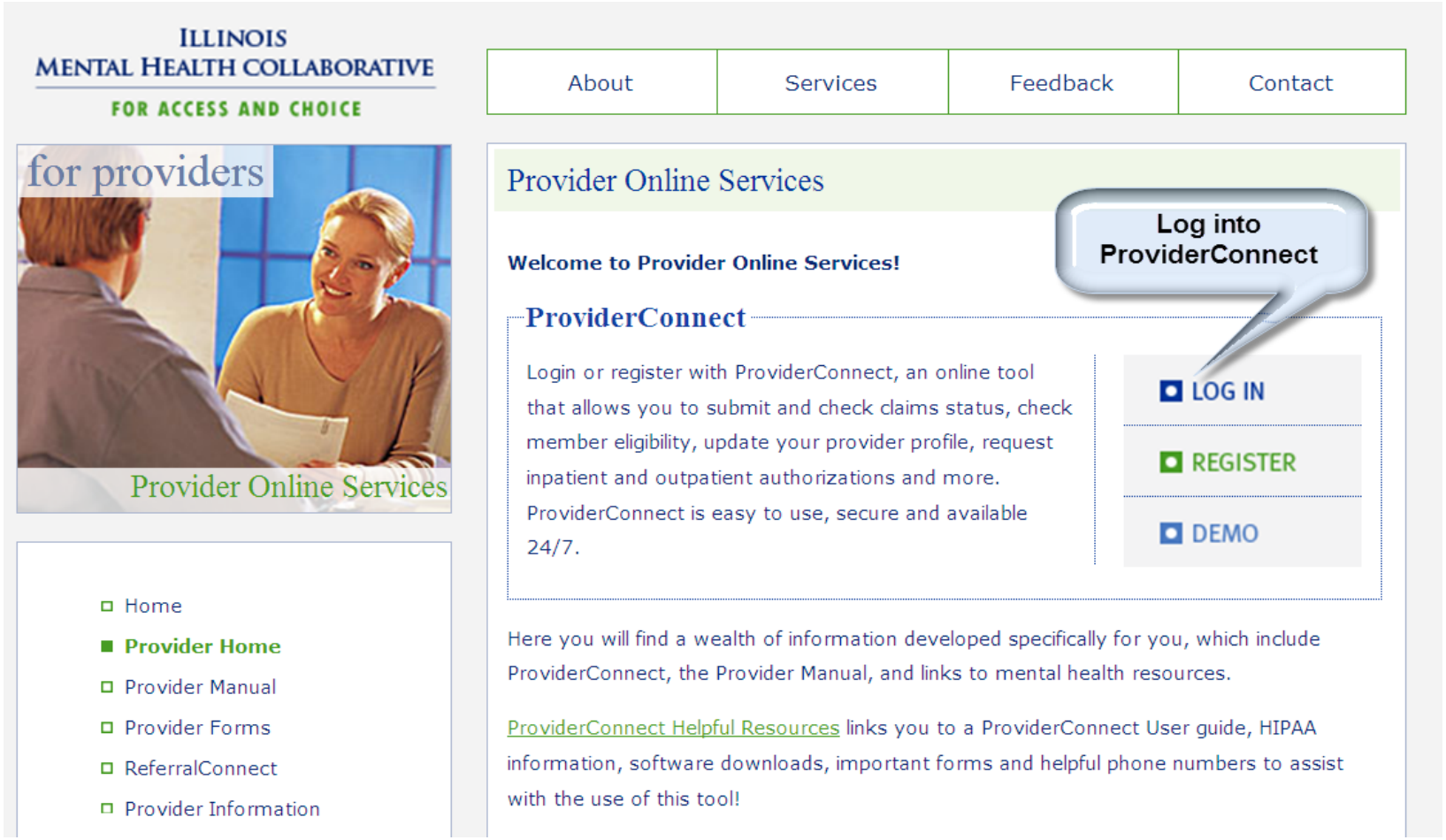
Q & A

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

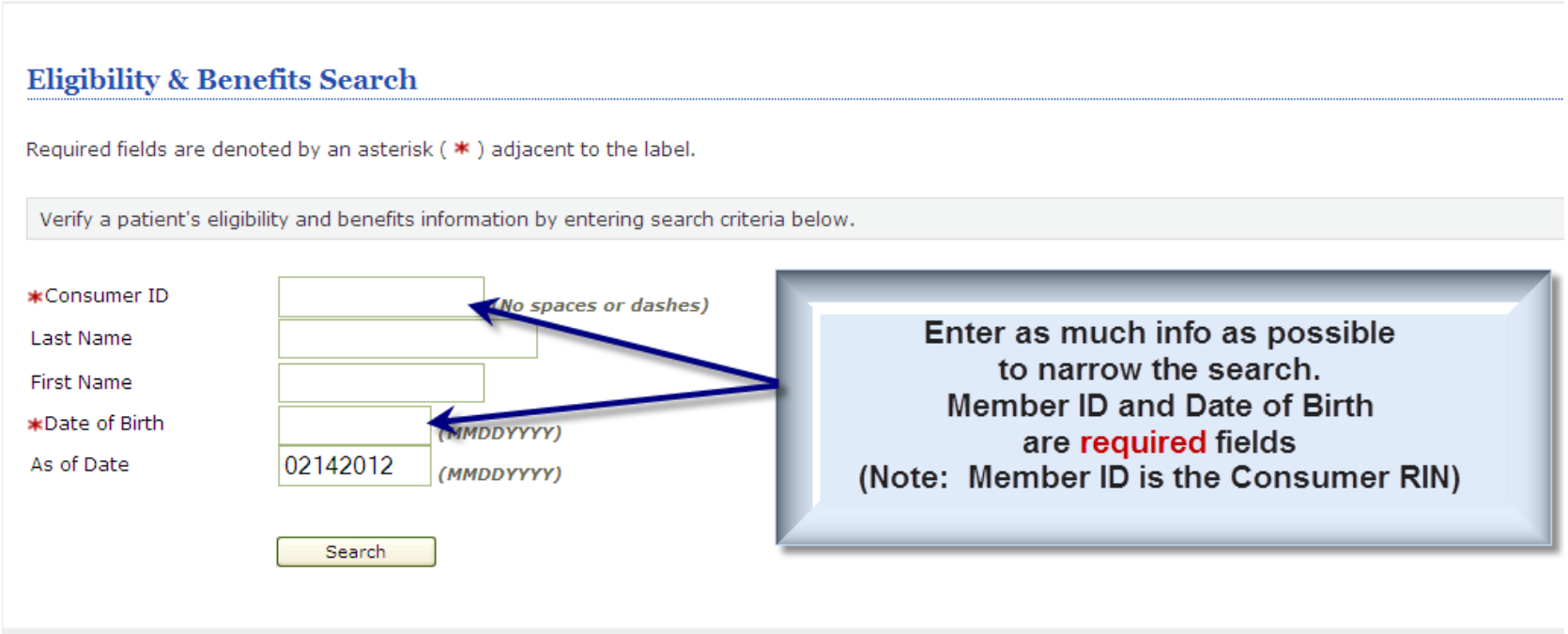
Getting Started



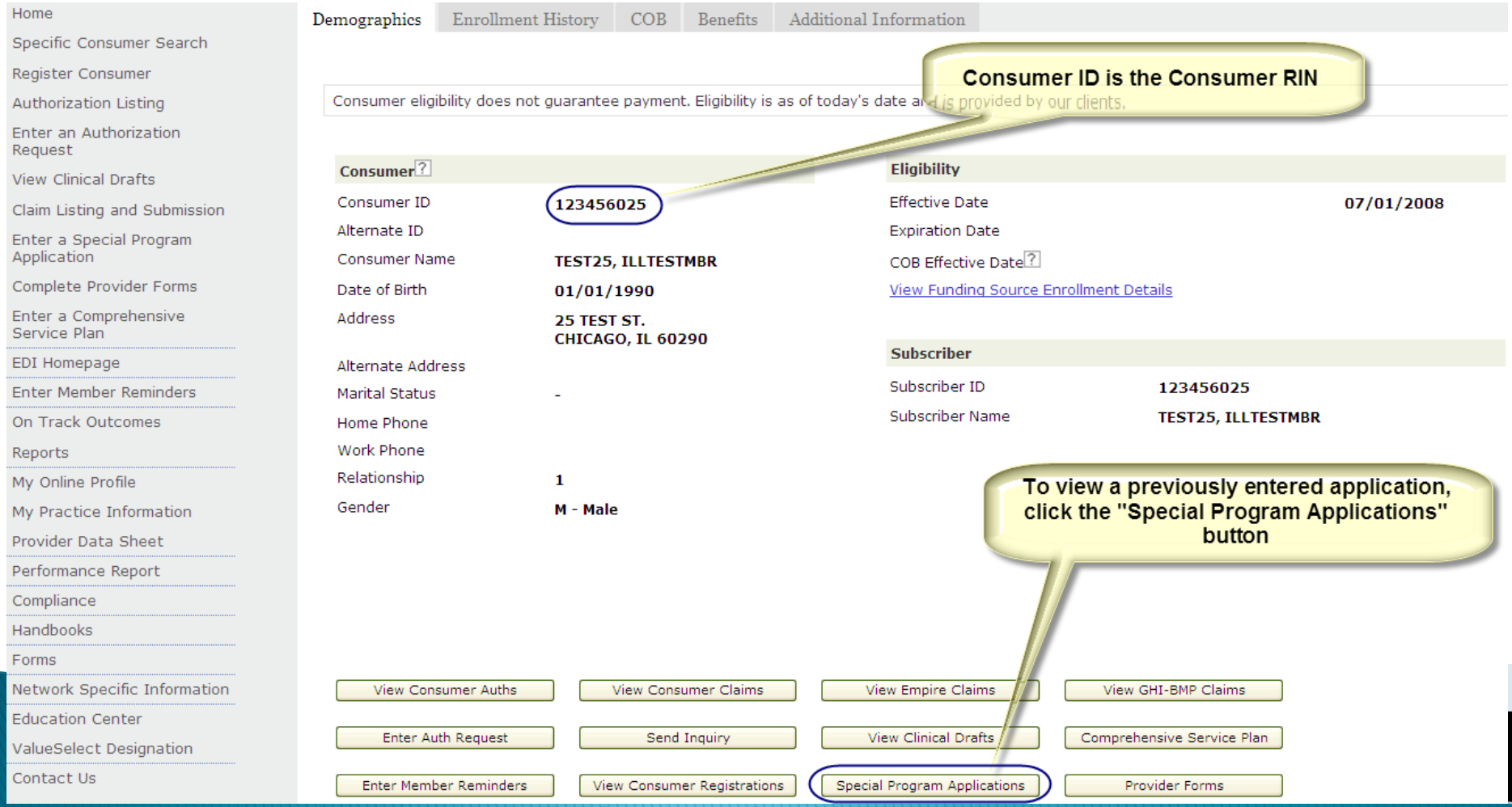
Home Page


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.
Click either link to search for a specific consumer
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/Openings
View My Recent Authorization Letters
Complete Provider Forms
Williams Transition Outcome Tracking Information
CLINICAL SUPPORT TOOLS

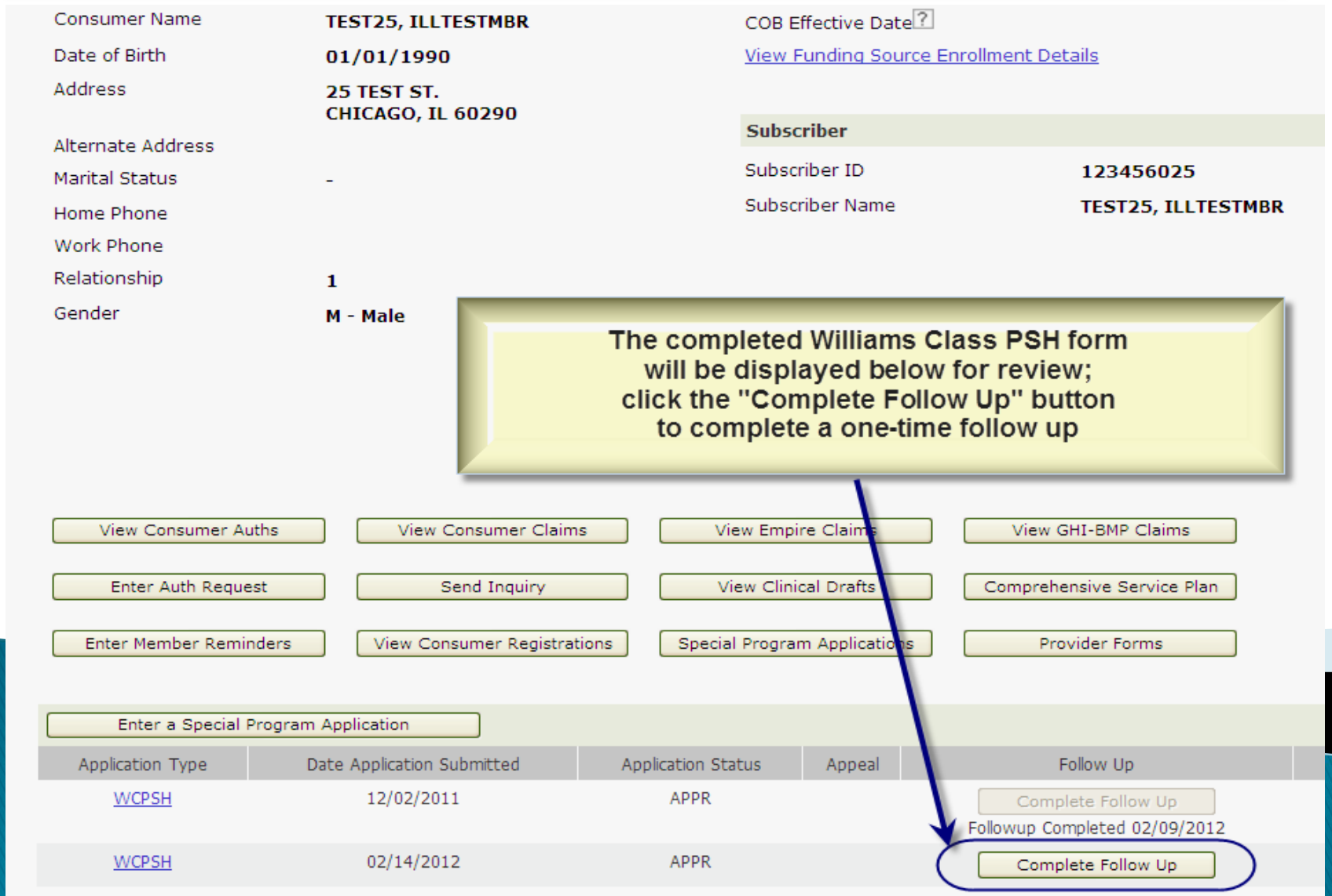
Search A Member



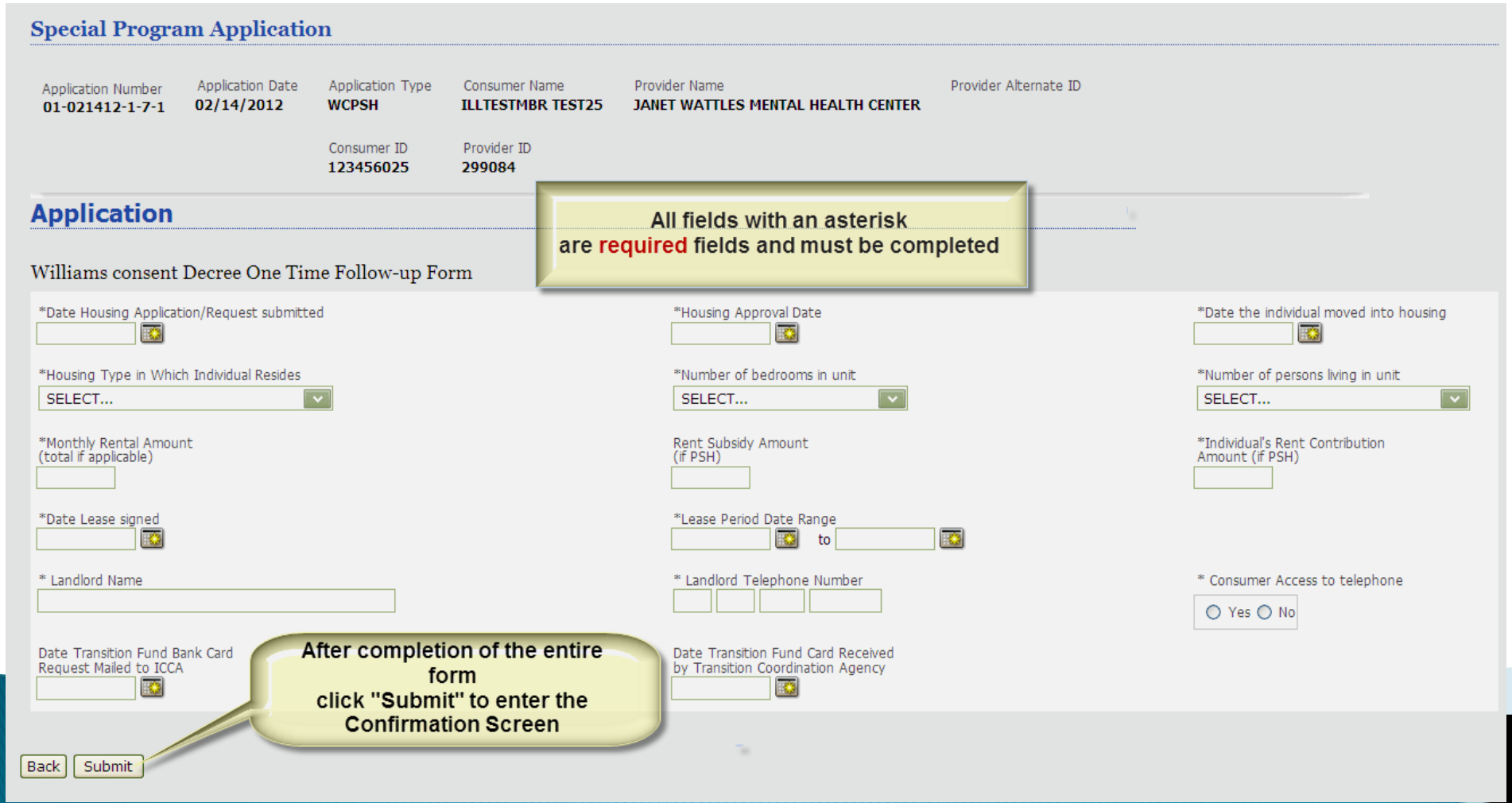
Demographics Verification



View a Submitted Application in ProviderConnect to Complete Follow Up



Follow Up Form



Confirmation Screen

Determination Status:

********** APPROVED **********

Provider ID
299084

Provider Alternate ID

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

Subscriber Name
ILLTESTMBR TEST25

Subscriber ID
123456025

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 'Landscape' format)

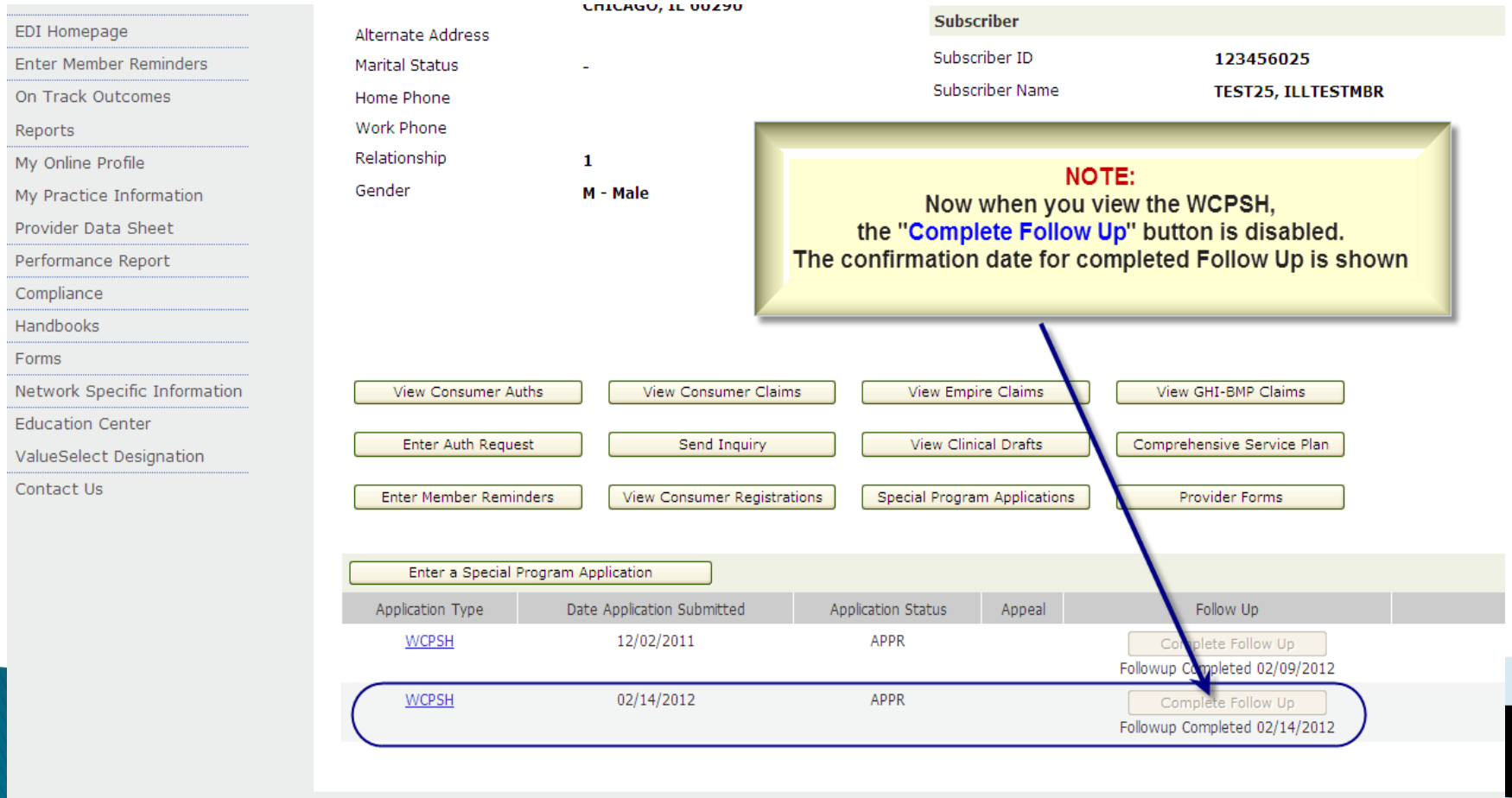
Print Application Result
Click to print the entire Special Program Application

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)



Technical Issues

- **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

QUESTIONS ???