

Screening for Intensive Social Support Services (ISSS)

This form must be completed and filed in the client's medical/clinical record.

This program is for clients who are covered by PC+ VHAP and VHAP Limited ONLY – does not include FFS or PC+ Medicaid. **Please check eligibility.**

1. Name of Client _____ DOB _____ Medicaid ID # _____
2. Requesting Provider Name _____ VT Medicaid Provider # _____
3. Supplying Provider Name _____ VT Medicaid Provider # _____
4. How long have you been working with this client? _____
5. Diagnostic Impression (DSM IV)
 Axis I: Clinical Disorder(s) + Code(s) _____
 Axis II: Personality Disorder(s) + Code(s) _____
 Axis III: Physical Disorder(s) _____
 Axis IV: Psychosocial Stressors (circle) No Info None Mild Moderate Severe Extreme
 Axis V: Current GAF score _____ Highest GAF score in past 12 months _____
6. Does this client display dangerous or impulsive behavior placing self at risk of injury to self or others (including dissociative symptoms and self-injurious behavior)? Yes _____ No _____
 When was the most recent occurrence? _____ How was this behavior resolved? _____
7. Is this client currently being prescribed a psychiatric medication regimen? Yes _____ No _____
 If yes, is this client compliant with the regimen? Yes _____ No _____
8. Does this client display evidence of psychosis, thought disorder, impaired reality testing with acute onset placing self/others at risk? Yes _____ No _____
 How is this being managed currently? _____
9. Has this client been hospitalized within the past ninety days (psychiatric or medical)? Yes ___ No ___
 Date and duration of last hospitalization _____
10. Has this client required any face-to-face encounters with crisis intervention/emergency services personnel within the past twelve months? Yes _____ No _____
 If yes, how were issues resolved? _____

Please specify Intensive Support Service you intend to provide (from list below) and include a copy of the treatment plan.

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| <input type="checkbox"/> Outreach | <input type="checkbox"/> Service coordination, case conferences and referral to community resources |
| <input type="checkbox"/> Facilitation of crisis intervention services | <input type="checkbox"/> Assistance and referral in meeting basic human needs |
| <input type="checkbox"/> Referral for social and vocational rehabilitation | <input type="checkbox"/> Arranging housing and living arrangements |
| <input type="checkbox"/> Family and community support, assistance and education | |
| <input type="checkbox"/> Referral for protection and advocacy | <input type="checkbox"/> Assessment and plan development |

CPT code: G9008, one unit = 15 minutes SVC.CAT: 64 # units/week requested _____

_____	_____	_____
Signature	Title	Date
_____	_____	
Print Name	Print Title	