

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



Getting Started

ILLINOIS
MENTAL HEALTH COLLABORATIVE
FOR ACCESS AND CHOICE



- 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 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

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

YOUR MESSAGE CENTER

Click either link to enter
Williams Class Tracking 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](#)

▼ [Enter or Review Claims](#)

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

[View My Recent Authorization Letters](#)

▶ [Complete Provider Forms](#)

CLINICAL SUPPORT TOOLS

▶ [View My Outcomes with On Track](#)

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

Last Name

First Name

*Date of Birth

As of Date

(No spaces or dashes)

(MMDDYYYY)

(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

Eligibility

Effective Date

07/01/2008

Expiration Date

COB Effective Date?

[View Funding Source Enrollment Details](#)

Subscriber

Subscriber ID

123456026

Subscriber Name

TEST26, ILLTESTMBR

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

Next

Williams Class Transition Coordination Form Landing Page

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

[JANET WATTLES MENTAL HEALTH CENTER . Thank you for using ValueOptions ProviderConnect.](#)

PROVIDER FORMS

Williams Class Tracking Form 

Next

Select
"Williams Class Tracking Form"
and click "Next"

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

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

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

- ☐ Paid employment (full or part time)
- ☐ Volunteer work
- ☐ Other

- ☐ Supported employment
- ☐ Education (GED prep, ESL, etc.)

- ☐ Vocational Training
- ☐ None

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

If other please specify

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

Williams Class Transition Coordination Form Submission Landing Page

The screenshot shows a web application interface. On the left is a vertical navigation menu with links: 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, and Enter a Comprehensive Service Plan. The 'Home' link is highlighted with a blue box and a blue arrow points to it from a yellow callout box that says 'Click "Home" to return to the Home Page'. The main content area has a blue header with the text 'JANET WATTLES MENTAL HEALTH CENTER . Thank you for using ValueOptions ProviderConnect.'. Below this is a section titled 'PROVIDER FORMS'. A yellow message box with orange text says 'The Williams Class Tracking Form has been saved successfully'. A blue arrow points from this message box to a larger yellow callout box on the right that says 'This message will display once you have successfully completed the "Williams Class Tracking Form"'. Below the message box is a dropdown menu with 'SELECT' and a downward arrow, and a 'Next' button.

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 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](#)

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

YOUR MESSAGE CENTER

**INBOX**

**SENT**

Click either link to search for a specific consumer

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](#)

- [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](#)

▶ [View My Recent Authorization Letters](#)

▶ [Complete Provider Forms](#)

▶ [Enter Member Reminders](#)

CLINICAL SUPPORT TOOLS

▶ [View My Outcomes with On Track](#)

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

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 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
"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

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

[View Funding Source Enrollment Details](#)

Address

25 TEST ST.
CHICAGO, IL 60290

Alternate Address

Marital Status

-

Home Phone

Work Phone

Relationship

1

Gender

M - Male

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?
YES Date Created
02162012

24-hour Backup Plan Created?
YES Date Created
02162012

Quality Life Survey Created?
YES Date Created
02162012

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

Q & A

QUESTIONS ???

Williams Class PSH Comprehensive Service Plan

Presenters:

Patricia Palmer, Callie Lacy & Patricia Hill

Author:

Patricia Hill


Summary:

This document 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
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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 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

Welcome JANET WATTLES MENTAL HEALTH CENTER . 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 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](#)

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**

Eligibility

Effective Date **07/01/2008**

Expiration Date

COB Effective Date?

[View Funding Source Enrollment Details](#)

Subscriber

Subscriber ID **123456026**

Subscriber Name **TEST26, ILLTESTMBR**

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
ILLTESTMBR TEST45

Consumer ID
123456045

Consumer DOB
01/01/1990

Subscriber Name
ILLTESTMBR TEST45

Subscriber ID
123456045

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

Comprehensive Service Plan Start Date
02162012

Once the Comprehensive Service Plan is submitted successfully, the "Submission Status" page will appear

Level of Service
OUTPATIENT/COMMUNITY BASED

Type of Service
MENTAL HEALTH

Level Of Care
COMMUNITY SUPPORT TEAM

Type of Care

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

Provider ID
299084

You have the option to **Print** or **Download** the "Comprehensive Service Plan Data"
If you choose not to use them, they will not be available once you leave this page

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

OUTPATIENT/COMMUNITY BASED

Type of Service

MENTAL HEALTH

Level Of Care

COMMUNITY SUPPORT TEAM

Type of Care

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

Presenters:

Patricia Palmer, Callie Lacy, Patricia Hill & Joanne Rosenberg

Author:

Patricia Hill

Summary:

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

Created on 2/16/2012

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

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 a Special Program
Application

EDI Homepage

Enter Member Reminders

On Track Outcomes

Reports

My Online Profile

My Practice Information

Provider Data Sheet

Performance Report

Compliance

Handbooks

Forms

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

YOUR MESSAGE CENTER

Click either link to enter
an application for Williams Class PSH



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](#)
- [Review an Authorization](#)
- [View Clinical Drafts](#)

▼ [Enter or Review Claims](#)

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

▶ [View My Recent Authorization Letters](#)

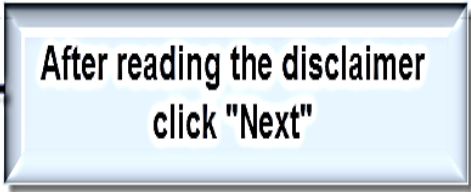
Disclaimer Page

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?

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?

[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

299084

Provider Last Name

JANET WATTLES MENTAL

Vendor ID

IL1000000

Consumer

Consumer ID

123456025

Last Name

TEST25

First Name

ILLTESTMBR

Date of Birth (MMDDYYYY)

01011990

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:

*Document Description

Does this Document contain clinical information about the Consumer?

Yes ☐ No ☐

SELECT...

UploadFile

Click to attach a document

Delete

Click to delete an attached document

Attached Document:

Back Next

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

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

Select a document description, then click "Upload File"

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

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



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

299084

Provider Last Name

JANET WATTLES MENTAL

Vendor ID

IL1000000

► Consumer

Consumer ID

123456025

Last Name

TEST25

First Name

ILLTESTMBR

Date of Birth (MMDDYYYY)

01011990

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

☐ White

☐ Black or African American

☐ Asian

☐ Native Hawaiian or Other Pacific Islander

☐ American Indian or Alaskan Native

☐ Asian and White

☐ American Indian/Alaskan Native and White

☐ American Indian/Alaskan Native and Black

☐ Black/African American and White

☐ Other

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 (MMDDYY)	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 a 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

Signature

*Date (MMDDYYYY)

Enter on printed form

*Enter Care Manager's Name

Signature

*Date (MMDDYYYY)

Enter on printed form

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

Signature

*Date (MMDDYYYY)

Enter on printed form

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.

*Enter Care Manager's Name

Signature

*Date (MMDDYYYY)

Enter on printed form

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

Back

Submit

Printing Options

The Determination Status is shown

Determination Status:

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

Provider ID
299084

Provider Alternate ID
0204

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

***** APPROVED *****

Inquiry: 02142012-7288659-020000

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

Application Type
WCP SH - Williams Class PSH

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

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

This will return you to the Provider Home Page

These are print functions for your internal use

View a Submitted Application in ProviderConnect

The screenshot shows the ProviderConnect website. A blue arrow points from the 'Specific Consumer Search' link in the left sidebar to a yellow callout box. Another blue arrow points from the 'Find a Specific Consumer' link in the 'WHAT DO YOU WANT TO DO TODAY?' section to the same yellow callout box. The callout box contains the text: 'To view a previously submitted application, click either of these links'. The website header includes a welcome message for JANET WATTLES MENTAL HEALTH CENTER. The left sidebar lists various navigation options. The main content area has sections for 'YOUR MESSAGE CENTER', 'WHAT DO YOU WANT TO DO TODAY?', and 'CLINICAL SUPPORT TOOLS'. The 'YOUR MESSAGE CENTER' section shows 'INBOX' and 'SENT' icons. The 'WHAT DO YOU WANT TO DO TODAY?' section has several expandable menus with links. The 'CLINICAL SUPPORT TOOLS' section has a single link.

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

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

INBOX SENT

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 Claims
 - 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

CLINICAL SUPPORT TOOLS

- View My Outcomes with On Track

- View My Recent Authorization Letters
- Complete Provider Forms

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[?]

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 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

[WCP SH](#)

12/02/2011

APPR

Complete Follow Up

Followup Completed 02/09/2012

[WCP SH](#)

02/14/2012

APPR

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 01-021412-1-7-1	Application Date 02/14/2012	Application Type WCPSH	Consumer Name ILLTESTMBR TEST25	Provider Name HEALTH CENTER JANET WATTLES MEDICAL	Provider Alternate ID
			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 Outcome Tracking

Presenters:

Patricia Palmer, Callie Lacy, Patricia Hill & Joanne Rosenberg

Author:

Patricia Hill

Summary:

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

Getting Started

ILLINOIS
MENTAL HEALTH COLLABORATIVE
FOR ACCESS AND CHOICE



- 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 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

Welcome JANET WATTLES MENTAL HEALTH CENTER . 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](#)

- [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](#)

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

▶ [View My Recent Authorization Letters](#)

▶ [Complete Provider Forms](#)

CLINICAL SUPPORT TOOLS

▶ [View My Outcomes with On Track](#)

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

Last Name

First Name

*Date of Birth

As of Date

(No spaces or dashes)

(MMDDYYYY)

(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

Eligibility

Effective Date

07/01/2008

Expiration Date

COB Effective Date?

[View Funding Source Enrollment Details](#)

Subscriber

Subscriber ID

123456026

Subscriber Name

TEST26, ILLTESTMBR

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

Next

Williams Class Outcomes Tracking Form Landing Page

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

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

PROVIDER FORMS

Williams Class Tracking Form



Next

Select
"Williams Class Tracking Form"
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?

☐ Yes ☐ No ☐ N/A

Completion Date



*Scheduling for medical?

☐ Yes ☐ No ☐ N/A

Completion Date



*Establishment of representative payee (if applicable)?

☐ Yes ☐ No ☐ N/A

Completion Date



*Coordination of benefits/entitlement application?

☐ Yes ☐ No ☐ N/A

Completion Date



*Secure recommended housing?

☐ Yes ☐ No ☐ N/A

Housing Type



*Schedule staffing with the primary services provider?

☐ Yes ☐ No ☐ N/A

Completion Date



*Application for food stamps complete?

☐ Yes ☐ No ☐ N/A

Completion Date



*Processing paperwork for bridge subsidy housing?

☐ Yes ☐ No ☐ N/A

Completion Date



*Meetings with family/collaterals, etc?

☐ Yes ☐ No ☐ N/A

Completion Date



*Shopping for essentials?

☐ Yes ☐ No ☐ N/A

Completion Date



*Secure transition funds?
(Amount depends on type of housing)

☐ Yes ☐ No ☐ N/A

Completion Date



*Ensure two week supply of medicine available?

☐ Yes ☐ No ☐ N/A

Completion Date



*Scheduling for dental?

☐ Yes ☐ No ☐ N/A

Completion Date



*Coordinating medical transportation to medical appointments?

☐ Yes ☐ No ☐ N/A

Completion Date



*Is housing search complete?

☐ Yes ☐ No ☐ N/A

Completion Date



Completion Date



*Medication management & administration?

☐ Yes ☐ No ☐ N/A

Completion Date



*Ensure two weeks of food on hand (if PSH and applicable only)

☐ Yes ☐ No ☐ N/A

Completion Date



*Activation of Day Time Activity supports?

☐ Yes ☐ No ☐ N/A

Completion Date



*Other services as applicable?

☐ Yes ☐ No ☐ N/A

Completion Date



*Allowable purchases checklist review?

☐ Yes ☐ No ☐ N/A

Completion Date



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/combative 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
(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](#)
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[Enter an Authorization Request](#)
[View Clinical Drafts](#)
[Claim Listing and Submission](#)
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[Compliance](#)
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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

**INBOX**

**SENT**

Click either link to search for a specific consumer

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](#)

- [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](#)

► [View My Recent Authorization Letters](#)

► [Complete Provider Forms](#)

► [Enter Member Reminders](#)

CLINICAL SUPPORT TOOLS

► [View My Outcomes with On Track](#)

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

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 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

Demographics Page

(Submitted Provider Forms)

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](#)

Date of Birth

01/01/1990

[View Funding Source Enrollment Details](#)

Address

25 TEST ST.
CHICAGO, IL 60290

Alternate Address

Marital Status

-

Home Phone

Work Phone

Relationship

1

Gender

M - Male

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?
YES Date Created
02162012

24-hour Backup Plan Created?
YES Date Created
02162012

Quality Life Survey Created?
YES Date Created
02162012

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

Q & A

QUESTIONS ???

Williams Class PSH Outcomes Follow Up Process

Presenters:

Patricia Palmer, Callie Lacy & Patricia Hill

Author:

Patricia Hill

Summary:


This document 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

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[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](#)

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

YOUR MESSAGE CENTER

**INBOX****SENT**

Click either link to search for a specific consumer

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](#)

- [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](#)

▶ [View My Recent Authorization Letters](#)

▶ [Complete Provider Forms](#)

▶ [Enter Member Reminders](#)

CLINICAL SUPPORT TOOLS

- ▶ [View My Outcomes with On Track](#)

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

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Enter a Comprehensive Service Plan

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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 [?]

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 previously entered application, click the "Special Program Applications" button

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 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

[WCPSH](#)

12/02/2011

APPR

Complete Follow Up

Followup Completed 02/09/2012

[WCPSH](#)

02/14/2012

APPR

Complete Follow Up

Follow Up Form

Special Program Application

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

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

Alternate Address

Marital Status

Home Phone

Work Phone

Relationship

Gender

CHICAGO, IL 60620

-

1

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

[WCP SH](#)

12/02/2011

APPR

Complete Follow Up

Followup Completed 02/09/2012

[WCP SH](#)

02/14/2012

APPR

Complete Follow Up

Followup Completed 02/14/2012

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 ???