EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
Institution for Mental Diseases (IMD) Assessment Worksheet

Name of Person Completing Form: **Date:**

NPI Number:

Facility/Provider Name:

Facility Provider Type:

Facility Provider Specialty:

Address of the Facility:

Contact Phone: **Contact:**

Name and Title of Person Providing Responses:

Name of Owner of the Facility:

Owner Address:

Owner Contact Information:(telephone & email)

Total Number of beds:
Number of Beds designated for psychiatric services:

Percent of total population with a primary mental health diagnosis:

Description of population served (i.e. age 18-21; 65 and older; psychiatric etc.):

_____

Does the Facility/Provider have multiple service locations: ☐Yes ☐ No

If "YES" PLEASE BE SURE TO COMPLETE DETAIL CHART ON Page #3.

SECTION 1: Please complete this section to determine if the facility should be assessed as having a separate facility/component or as a single entity:

Does the facility have more than one service location? ☐ Yes ☐ No

1. Are the components of the facility certified as different types of providers? i.e. NFs and hospitals.
   ☐Yes ☐ No

2. Are all components controlled by one owner or one governing body?
   ☐Yes ☐ No

3. Is one chief medical officer responsible for the medical staff activities in <u>all</u> components?
   ☐Yes ☐ No

4. Does one chief executive officer control all administrative activities in <u>all</u> components?
   ☐Yes ☐ No

5. Are any of the components separately licensed?
   ☐Yes ☐ No

6. Are the components so organizationally separate that it is not feasible to operate as a single entity? ***Please answer a, b & c in response to this question***
   a. Does each component have separate administrative staff?
      ☐Yes ☐ No

   b. Does each component have a separate Executive Director, Chief Operating Officer, Chief Executive Officer or Finance Director?
      ☐Yes ☐ No

   c. Does each component have a separate central office building?
      ☐Yes ☐ No

7. Are the components so geographically separate that it is not feasible to operate as a single entity? ***Please answer a & b in response to this question***
   a. Are the components located within the same county:
      ☐Yes ☐ No

   b. Are the components more than 50 miles away from each other?
      ☐Yes ☐ No

8. Are two or more of the components participating under the same provider category (such as NFs)?
   ☐Yes ☐ No
   a. If **NO**, go onto next question
   b. If **YES**, can each component meet the conditions of participation independently?
      ☐Yes ☐ No

9. Is the facility licensed/designated as a psychiatric facility?
   ☐Yes ☐ No

10. Is the facility accredited as a psychiatric facility?

☐Yes ☐ No

SECTION 2: Please complete the following section if the facility has more than 16 beds and there is more than one location.

Please list each of the Service Locations in the column headings below and answer the questions for each:

FACILITY **NAME**								
Number of total beds								
Number of beds designated for psychiatric patients								
Type of facility								
NPI if available								
11 Does this facility provide services to mentally ill persons?								
12 Is the facility under the jurisdiction of the State's mental health authority?								
13 Does the facility specialize in providing psychiatric/ psychological care and treatment?								
13a Do more than 50% of staff have specialized psychiatric/psychological training?								
13b Do more than 50% of patients receive psychopharmacological drugs?								
13c Are goals related to treating a mental health disorder included in the treatment plans?								
13d Are more than 50% of staff hours dedicated to treating a mental health disorder?								
14 Does the <u>current</u> need for institutionalization for more than 50% of the patients in the facility result from mental disease? **If it is not possible to make a determination solely on the basis of an individual's current diagnosis, classify the patient according to the diagnosis at the time of <u>admission</u> if the patient was admitted within the <u>last year</u>. <u>Do not</u> include a patient in the mentally ill category when no clear cut distinction is possible*								
14a Was the patient admitted to the facility because of an issue resulting from a mental disease								
14b Does the patient's current need for institutionalization result from a mental disease?								

SECTION 3: For Nursing Facilities Only

15. What is the average age of the patients in this Nursing Facility?

16. Do more than 50% of residents in this Nursing Facility require specialized services for the treatment of serious mental illnesses? **When making this determination, please focus on the basis of the patient's current need for NF care, rather than the nature of the services being provided.**

☐Yes ☐ No

SECTION 4. Signature

I certify that the responses in this document are accurate, complete, and current as of this date to the best of my knowledge. As an official representative of this facility, I am authorized to answer the questions herein.

Electronic signature: Date: