Clinical Guidelines and Service Definitions
Mental Health Needs Assessment (MHNA)

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Reviewed 03/09
Revised 7/10
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Revised 11/13

Funding Stream
Private insurance or Medicaid should be accessed first to pay for a MHNA. The individual should call private insurance company to determine whether or not it is a covered service.

Definition of Service
- **Service goals are centered on promoting child and family safety and family protective capacity.**
- The Mental Health Needs Assessment (MHNA) is a pretreatment assessment and, as such, should be utilized to get an initial picture of the mental health functioning of an individual. A MHNA is not indicated if it has already been determined that an individual needs Mental Health Treatment. This assessment should not be utilized concurrently with on-going mental health therapy, as the current provider can report on the mental health needs of the individual.
- **The report should contain the following information:** Identifying Information, Referral Source, Reason for Referral, Treatment History, Relevant History, Mental Status, Diagnosis and Justification, Additional Clinical Impressions/Strengths/Resources, Immediate Mental Health Concerns, and Collateral Contacts. Recommendations will be made for interventions/goals that can be achieved immediately or within the next thirty to sixty days. Long-term goals should be left to the ongoing treatment team.

_Recommendations for psychological testing or neuropsychological evaluations must be reviewed by the Care Coordinator prior to inclusion in the assessment._

Estimated Length of Treatment:
One or two sessions for one hour each

Frequency of Services:
Once per year

Provider Credentials:
- Licensed Master’s level clinician or higher or, supervised by licensed Master’s level clinician.

Provider Responsibilities:
Report required within ten business days of completed evaluation – both the Caseworker and Care Coordinator are to receive copies of the report.
The collection and review of collateral information must be obtained prior to completing the report and documentation of the collateral information must be included in the final written report. If unable to obtain collateral data within one week of the referral, the provider must outreach to caseworker/supervisor/Health Network care coordinator to facilitate collection of collateral information. Reports written without obtaining collateral information will not be reimbursed without prior approval from AspenPointe Health Network.

**Caseworker Responsibilities:**
Caseworker is responsible for providing specific referral question(s) to the Care Coordinator on the referral form; this will enable the provider to most effectively address the relevant issues.

**Staffing:**
Not applicable.