

TCOOMMI Refusal of Services

TCOOMMI Case Management / LMHA Services

Adult Services

LOC-R

LOC-A

Adult SP 1:
Pharmacological Mgmt; Medication Training & Supports; Routine Case Mgmt; Skills Training

Adult SP 2:
Pharmacological Mgmt; Medication Training & Supports; Rehabilitative Counseling & Psychotherapy; Routine Case Mgmt.

Adult SP 3:
Pharmacological Mgmt.; Medication Training & Support Services; Psychosocial Rehabilitative Services; Supported Employment (as indicated); Medical Services – RN

Adult SP 4:
Pharmacological Mgmt.; Psychosocial Rehabilitative Services; Medication Training & Support Services; Supported Employment (as indicated); Housing Services (as indicated)

Child/Adolescent Services

LOC-R

LOC-A

C/A SP 1.1:
Skills Training; Medication Training & Supports; Routine Case Mgmt; Family Support Group; (Add-on Pharm. Mgmt.)

C/A SP 1.2:
Counseling (Card Svs); Medication Training & Supports; Routine Case Mgmt; Family Support Group; (Add-on Pharm. Mgmt.)

C/A SP 2.2:
Training; Medication Training & Support; Family Partner; Family Support Group (Add-on Pharm. Mgmt.)

C/A SP 2.3:
Counseling; Intensive Case Mgmt; Med. Training & Support; Family Partner; Family Support Group (Add-on Pharm. Mgmt.)

C/A SP 2.4:
Intensive Case Mgmt; Med. Training; Family Partner; Med. Mgmt; Family Support Group

C/A SP 4:
Med. Mgmt; Routine Case Mgmt; Family Support Groups

Offender Name: _____		TDCJ#: _____		SID#: _____	
<input type="checkbox"/>	Probation	<input type="checkbox"/>	Parole	<input type="checkbox"/>	TJJD
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	SNDP
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	Medical COC
<input type="checkbox"/>	I understand I am eligible to receive the above listed mental health services from _____ MHMR. I elect to refuse all services offered to me.				
<input type="checkbox"/>	My signature below indicates that I have had explained to me the recommended Services Package _____, but I have chosen to receive a less intensive Service Package _____.				
<input type="checkbox"/>	I understand that this decision IS / IS NOT “against medical advice” and if so, this has also been explained to me. (please circle one)				
I understand this information can be shared with my Community Supervision Officer for the purpose of Continuity of Care.					
Signature of Offender/Youth: _____			Date: _____		
Signature of LAR : _____			Date: _____		
Staff Signature/Credential: _____			Date: _____		
Signature of Community Supervision Officer: _____			Date: _____		

Center Name: _____

TCOOMMI Refusal of Services

TCOOMMI Case Management and Continuity of Care Service Eligibility

Adult Services

Intensive Case Management
Minimum of 3.5 face to face contact hours per month. Services include: case management, nurse, psychiatrist, benefits specialist, and/or skills trainer, and group. At least one contact per month shall be provided in a community setting. Assistance with benefits applications.

Transitional Case Management
Minimum of 1.5 face to face contact hours per month. Services include case management, nurse, psychiatrist, benefits specialist, and/or skills trainer and group. Assistance with benefits applications.

Continuity of Care
Minimum of one face to face contact per month, medication assistance, linking to natural and community supports, assistance with benefits applications.

Medical Continuity of Care
Minimum of one face to face contact per month, medication assistance, benefits application, assistance locating medically appropriate placement, assistance accessing medically necessary services.

Juvenile Services

SNDP Case Management
Core Team services to include 24 hour crisis intervention by a team member, case management, skills training, family support, in-home family skills training, medication support, physician services, benefits application assistance.

Continuity of Care
Minimum of one face to face contact per month, medication assistance, linking to natural and community supports, assistance with benefits applications.

Offender Name: _____ TDCJ#: _____ SID#: _____

Probation Parole TYC Parole SNDP Medical COC

I understand I am eligible to receive the above listed mental health services from _____ MHMR. I elect to refuse all services offered to me.

My signature below indicates that I have had explained to me the recommended Services Package _____, but I have chosen to receive a less intensive Service Package _____.

I understand that this decision IS / IS NOT "against medical advice" and if so, this has also been explained to me. (please circle one)

I understand this information can be shared with my Community Supervision Officer for the purpose of Continuity of Care.

Signature of Offender/Youth: _____ Date: _____

Signature of LAR : _____ Date: _____

Staff Signature/Credential: _____ Date: _____

Signature of Community Supervision Officer: _____ Date: _____

Center Name: _____