|  |  |
| --- | --- |
| **Date Reported** | Click or tap to enter a date. |
| **Name of Facility** |  |
| **Name Facility Representative telephone number and email** |  |
| **Name of Individual** |  |
| **Individual’s DOB, DCN and SSN** |  |

**Facility to complete form and email to:** **DMHNotifications@dmh.mo.gov**

**Provide the ID/MI diagnosis. Describe the individual’s change in condition or status. Describe how the CIS / CIC meets the criteria for reporting the change to DMH.**

Click or tap here to enter text.

**Did the facility access the Behavioral Health Crisis Line for assistance with unsafe behaviors?**

[**https://dmh.mo.gov/mental-illness/programs/behavioral-health-crisis-hotline-numbers**](https://dmh.mo.gov/mental-illness/programs/behavioral-health-crisis-hotline-numbers)

Yes [ ]  No [ ]

**Provide the date of the most current PASRR evaluation. Describe how the previous PASRR evaluation differs from the individual’s current condition:**

Click or tap here to enter text.

**DMH to Complete:**

**DMH determined that the Individual requires a resident review performed by Bock Associates**

Yes [ ]  No [ ]  MI evaluation [ ]  ID evaluation [ ]

Click or tap here to enter text.

Bock Associates [ ]  Nursing Facility [ ]  COMRU [ ]  Open File [ ]  Enter in Dbase [ ]