

Employment Mental Health Services

Human
Services



Peoplefirst

E2

Public Hospital Quarterly Return

This form is used to report workforce data clinical staff funded by Mental Health Services. The form should be completed at the end of each quarter and forwarded within *21 days* to the Department of Human Services. Submission of this form by the due date is a condition of funding.

Hospital:	Area Mental Health Service:		
Agency:	Agency Code:	Quarter:	Year:

Service Setting	Clinical EFT
1 <i>Adult</i> CAT Services	
2 <i>Adult</i> Mobile Support Services	
3 <i>Adult</i> Continuing Care, Clinical & Consultancy	
4 <i>Adult</i> Integrated Community Service	
5 <i>Adult</i> Other Community Service	
6 <i>Adult</i> Acute Inpatient Unit	
7 <i>Adult</i> Secure Extended Care Unit	
8 <i>Adult</i> Residential, Rehabilitation, Community Care Unit/Open Rehabilitation	
9 Other <i>Adult</i> bed-based Service	
10 <i>Child & Adolescent</i> Community Assessment & Treatment Team	
11 <i>Child & Adolescent</i> Day Program	
12 <i>Child & Adolescent</i> Psychiatric Intensive Case Manager	
13 <i>Child & Adolescent</i> Acute Inpatient Unit	
14 <i>APMHS</i> Assessment & Treatment Service (PGAT)	
15 <i>APMHS</i> Acute Inpatient Unit	
16 <i>APMHS</i> Extended Care Unit (Nursing Home)	
17 <i>APMHS</i> Extended Care Unit (Hostel)	
18 TOTAL (1 to 17)	

Signed (Area Mental Health Service Manager)	Date:
Signed (Chief Executive Officer):	Date: