MANAGED CARE-ASSESSMENT & CLIENT PLAN

Confidential Patient Information: See California Welfare and Institutions Code Section 5328

CLIENT NAME____MH#_____________________DOB________________
PROVIDER_____________________________PROVIDER PHONE #_____________ASSESSMENT DATE___________

Client Address: ____**Age**______

Phone Number: Home #______________________**Cell #** _____________________ **Work #** _____________

Emergency Contact: Name ____**Phone Number**___________
Source of Information: ☐ **Client interview** ☐ **Previous Records** ☐ **Other**_______________

Ethnicity ______________________________**Primary Language Client**_________________________

Language of Family___________________ If Primary Language is not English, how will language needs be met?__________
Is Client able to communicate in English? ☐ **Yes** ☐ **No** **Interpreter Name** (if needed) __________________

Other people or agencies actively involved in the client's care:
(Name): ______________________________Other____
Case Manager (from where):_________________________Other____

Presenting Problem and Current Symptoms:

Psychosocial History
(Include current living situation, family history, legal issues, strengths, cultural and spiritual information)

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Psychiatric and Medical History (Include changes in the past year, medication changes, current medication, psychiatric treatment, hospitalization)

Overall Concerns / RISK ☐ Yes ☐ No ☐ Undetermined

Suicide/Harm to Self ☐ Yes ☐ No **Homicide/Harm to Others** ☐ Yes ☐ No

Substance Abuse History ☐ **Assessed** ☐ **No Use**

Substance	Age of 1st Use	Highest Usage Amount and Frequency during time period	Current Usage with Amount/Frequency/Route	Date of Last Use	Rating of current abuse 0 – 4 minimal- severe
Alcohol					
Amphetamines					
Cocaine					
Opiates					
Sedatives					
PCP					
Hallucinogens					
Inhalants					
Marijuana					
Cigarettes					
RX Drugs					

Does TRAUMA Impact Functioning or Presenting Problems
☐ Yes ☐ No ☐ Unknown

Overall Summary/Evaluation of current Risk/Trauma/AOD Use

How does client identify their gender?
☐ Female ☐ Male ☐ Transgender
☐ Intersex ☐ Decline to state
☐ Other ☐ Unknown

How does client identify their sexual orientation?
☐ Bisexual ☐ Gay/Lesbian ☐ Heterosexual
☐ Questioning ☐ Decline to state
☐ Other ☐ Unknown

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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Mental Status Exam: General Appearance
☐Appropriate ☐Disheveled ☐Bizarre
☐Inappropriate ☐Other

Affect
☐Within Normal Limits ☐Constricted
☐Blunted ☐Flat
☐Angry ☐Sad
☐Anxious ☐Labile
☐Inappropriate ☐Other

Physical and Motor
☐Within Normal Limits ☐Hyperactive
☐Agitated ☐Motor Retardation
☐Tremors/Tics ☐Unusual Gait
☐Muscle Tone Issues ☐Other

Mood
☐Within Normal Limits ☐Depressed
☐Anxious ☐Expansive
☐Irritable ☐Other

Thought Content and Process
☐Within Normal Limits ☐Aud. Hallucinations
☐Vis. Hallucinations ☐Delusions
☐Paranoid Ideation ☐Bizarre
☐Suicidal Ideation ☐Homicidal Ideation
☐Flight of Ideas ☐Loose Associations
☐Poor Insight ☐Attention Issues
☐Fund of Knowledge ☐Other

Speech
☐Within Normal Limits ☐Circumstantial
☐Tangential ☐Pressured
☐Slowed ☐Loud
☐Other

Cognition
☐Within Normal Limits ☐Orientation
☐Memory Problems ☐Impulse Control
☐Poor Concentration ☐Poor Judgment
☐Other

MSE Summary:

Clinical Formulation: (Include current presenting issues, course of treatment, impairments, diagnostic criteria, strengths, and treatment recommendations)

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General Medical Conditions					
17 = Allergies		12 = Diabetes		29 = Muscular Dystrophy	
16 = Anemia		09 = Digest-Reflux,Irrit'lBowel		15 = Obesity	
01 = Arterial Sclerotic Disease		34 = Ear Infections		21 = Osteoporosis	
19 = Arthritis		26 = Epilepsy/Seizures		30 = Parkinson's Disease	
35 = Asthma		02 = Heart Disease		31 = Physical Disability	
06 = Birth defects		18 = Hepatitis		08 = Psoriasis	
23 = Blind/Visually Impaired		03 = Hypercholesterolemia		36 = STD/STI	
22 = Cancer		04 = Hyperlipidemia		32 = Stroke	
20 = Carpal Tunnel Syndrome		05 = Hypertension		33 = Tinnitus	
24 = Chronic Pain		14 = Hyperthyroid		10 = Ulcers	
11 = Cirrhosis		13 = Infertility		00 = No Gen. Medical Cond'n	
07 = Cystic Fibrosis		27 = Migraines		99 = Unk/Not Report'd. GMC	
25 = Deaf/Hearing Impaired		28 = Multiple Sclerosis			
37 = Other: (Please list)					

DSM5 Diagnosis	ICD-10
Primary:	

As a result of the Principal Diagnosis, the client has the following functional impairments:
Treatment is being provided to address, or prevent, significant deterioration in an important area of life functioning.

☐School/Work Functioning ☐Social Relationships ☐Daily Living Skills
☐Ability to Maintain Placement ☐Symptom Management

Provider Signature ______________________________ License No.______________Date________________

Fax to: 650-596-8065 or mail to Access Call Center – 310 Harbor Blvd., Bldg. E, Belmont, CA 94002 (rev. 2.2019)

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CLIENT TREATMENT AND RECOVERY PLAN

Complete and submit prior to expiration of initial authorization. Submitting at least two weeks in advance will prevent any gaps in service as all services must be preauthorized.

PLAN START DATE [ ] **PLAN END DATE (1 yr.max)** [ ]

CLIENT'S OVERALL GOAL/DESIRED OUTCOME: *What the client wants from treatment, in client's words.*

DIAGNOSIS/PROBLEMS/IMPAIRMENTS – Signs, symptoms and behavioral problems resulting from the diagnosis that impede client from achieving desired outcome. Impairments related to the diagnosis must be addressed in all **medical necessity** goals.

GOAL - Development of new skills/behaviors and reduction, stabilization, or removal of symptoms/impairments.

OBJECTIVES - Client's next steps to achieving goal. Must be **observable, measurable and time-limited** objectives that address **symptoms/impairments** linked to the **primary diagnosis**.

INTERVENTIONS – Describe in detail the interventions proposed for each service type: Individual Therapy, Medication Support…etc. (E.g. – Clinician will provide individual therapy, utilizing cognitive-behavioral techniques, to assist client with decreasing his depressive symptoms.)

Client Signature: ____ **Date:** _______________

Parent/Guardian Signature:____ **Date:**_______________

Provider Signature:____ **License No.**___________ **Date:** ______________

☐Copy offered to client/accepted, ☐Copy offered/declined, ☐Unable to offer Copy-See prog. note dated: ______________

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TREATMENT AUTHORIZATION REQUEST

CPT Code	Bilingual Differential Yes/No	Number of Services	Frequency	Authorization Begin Date