COUNTY OF SAN MATEO
HEALTH SYSTEM
BEHAVIORAL HEALTH
& RECOVERY SERVICES

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
☐ Hetero ☐ Intersex ☐ Decline to state
☐ Other ☐ Unknown

How does client identify their sexual orientation?

☐ Bisexual ☐ Gay/Lesbian
☐ Questioning ☐ Decline to state
☐ Other ☐ Unknown

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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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Health Condition:

17 = Allergies		12 = Diabetes	
16 = Anemia		09 = Digest-Reflux,Irrit'lBowel	
01 = Arterial Sclerotic Disease		34 = Ear Infections	
19 = Arthritis		26 = Epilepsy/Seizures	
35 = Asthma		02 = Heart Disease	
06 = Birth defects		18 = Hepatitis	
23 = Blind/Visually Impaired		03 = Hypercholesterolemia	
22 = Cancer		04 = Hyperlipidemia	
20 = Carpal Tunnel Syndrome		05 = Hypertension	
24 = Chronic Pain		14 = Hyperthyroid	
11 = Cirrhosis		13 = Infertility	
07 = Cystic Fibrosis		27 = Migraines	
25 = Deaf/Hearing Impaired		28 = Multiple Sclerosis	

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_____

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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