



MANAGED CARE-ASSESSMENT & TREATMENT 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 1 st 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



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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 _____



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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