Contra Costa County Clinical Documentation Manual
For Outpatient Specialty Mental Health Services

Sources of information

This documentation manual has been revised March, 2014. It is to be used as a reference guide and is not a single source of information regarding chart documentation requirements. This manual includes information based on the following sources: California Code of Regulations, Title 9, Department of Health Care Services (DHCS) letters/notifications, and Contra Costa County Behavioral Health Division-Mental Health Plans policies and procedures. Please note this is a “living” document. Updates and revisions will be made as necessary in accordance with State regulations and county policies and procedures.

For further information or questions regarding clinical documentation standards the Utilization Review Team members are available to answer questions about this manual and other general documentation policies and requirements.

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Revised March, 2014 by Charlene Bianchi, MFT, Utilization Review Program Supervisor, Christine Catabay, MFT, UR-Mental Health Clinical Specialist, and David Cassell, LCSW, Quality Improvement Coordinator
4/4/14

CCMHP Clinical Documentation Forms/Changes -2013-2014

The following mental health forms have been revised and updated. Please read below for explanation and instruction.

The Progress Note/ Billing Form (MHC 115 revised 09/13) has been updated. The Treatment Goals and Reasons for Contact are now separated into their own sections to ensure each area is addressed. The section titled, Reason for Contact is where you provided a description of current situation, client's presentation and clinical impressions. Billing notes will now add in a DSM Diagnosis. Space is provided between Treatment Goal and Reason for Contact. This is now required by the state.

The Partnership Plan for Wellness (MHC 116 revised 09/13) only had minor changes added to meet state requirements. The Treatment Goals section is now titled Clinical Treatment Goals and greater description is offered to help clinician provide the information requested. Strategies were separated to clearly identify the strategies used to meet goals. The section for Targeted Case Management (TCM) was added and then removed after directive from the state and consultation with four other counties and discussion with management staff. TCM and Case Management can be documented together and with the same procedure code. The signature section moved to the end of page two. UR staff will know to turn it over for signature verification. The rest of page two is the same. The focus of page two is on revisions and additions to the plan. There is a section for the date of revision and the client can initial near original signature or date for updates. The state mandates the client must be part of creating the Partnership Plan. This is not a form to be completed by the clinician alone. Since most clinicians are not sitting at a computer typing when they meet with clients we did not create a template for this form. At some point, one will be available when we go electronic, and after we carefully explore how this will impact compliance with state requirements. Per, state regulations, Partnership Plans are due annually and should be completed by the end of the last day of the 12th month of the UR track.

The Initial Psychiatric Assessment (MHC 113 revised 09/13) form was revised with Dr. Andelman’s suggestions. It has now been consolidated into one form that can be used in both the children's and adult clinics by the psychiatrists. A few new check boxes have been added, and the order of the Risk Factors check boxes have been adjusted to flow more smoothly. The form now includes a section for identifying Targeted Case Management as required by the state. Per Dr. Andelman's request we are revisiting the forms and will revise within the next couple months.

The Psychiatric Assessment Annual Update (MHC 114 revised 09/13) form was also modified and consolidated. There is now only one Psychiatric Annual Update form that can be used in both the children and adult clinics. Also up for revision per Chief of Outpatient Psychiatry request.
The Initial Clinical Assessment for Adults (MHC 100 revised 09/13) form was significantly modified after many months of discussion among Forms Committee members and clinic staff piloting the drafts and providing feedback. To align with Behavioral Health Integration guidelines the form has been expanded and updated to include a detailed section for substance use. We added in a section addressing Criminal Justice History. Some check boxes have been updated or added to be more inclusive in the Identifying Information section on the first page. More space has been provided for documenting the Presenting Problem and Relevant Family History. Per the feedback from clinic staff, we moved the Treatment History and Risk Assessment to the page before Medical History. The diagnosis section remains the same until the state advises on usage of the DSM-5 diagnosis codes. Target Symptoms and Therapeutic Considerations have been removed. Separate sections have been added to better clarify the Initial Treatment Plan and Clinical Summaries. A section for a Preliminary Discharge Plan was added. The final page is a Strengths Assessment Check list for the beneficiary.

The Adult Annual Clinical Assessment (MHC 102 revised 09/13) form has been modified similar to the initial assessment, but it’s much shorter since it’s an update. See above for specifics.

The Children’s Initial CANS Assessment (pending finalization) has been significantly modified and now uses the CANS formula. All staff will be required to use this form. Staff must be certified to use this form. Every child’s mental health clinician who conducts assessments will need to complete the CANS on-line certification course or get certified by attending training before using this form. The goal is to have all children’s clinicians certified by May 1, 2014. Staff can take on-line training, and we will set up refresher trainings at each clinic within the next two months. Please discuss the deadlines for completing the CANS on-line course, or attending a live training with your supervisor or program manager.

The Katie A Progress Note/Billing (MHC 017-9 revised 01/13) form is cherry red in color and clearly identifies this is exclusive for Katie A classified clients. The title reads: Katie A Progress Note/Billing Form. This is the only progress note in circulation that lists the two specific Katie A sub-class procedures codes for ICC and IHBS. The rest of the note is identical to the standard/revised blue progress note. According to the Katie A. written policy dated December 11, 2013, by Sandra Marsh (former Program Manager), all services provided (ICC, individual therapy, etc.) for Subclass members are to be documented on the Katie A. progress note. These are notes that would normally be documented on the related to subclass members will be filed under the Katie A. tab, except TBS, medication notes, and Wraparound plans. Certain restrictions apply to the ICC and IHBS codes.

ICC services are locked out for youth in hospitals, group homes, psychiatric health facilities, or psychiatric nursing facilities except for the purposes of coordinating placement of the youth transitioning from those facilities for a maximum of 30 days—for no more than 3 non-consecutive 30 day periods. IHBS may not be provided to youth in the group home facility; however, they can be provided
to youth outside the group home to facilitate transition. IHBS can be provided in the community (homes, schools, recreational settings, etc.) IHBS services are not permitted during the same hours of the same day as: day treatment, group therapy, or TBS.

The Mental Health Intensive Care Coordinator must review the coordinated plan at least every 90 days and document on a progress note. Please see your supervisor or manager regarding additional Katie A. screening tools and samples of progress notes for the two new procedure codes.

**Educationally Related Mental Health Services (ERMHS formally AB3632)**

According to Assembly Bill 114, dated September 13, 2011, significant changes were made regarding mental health services provided to students with disabilities. These changes resulted in the removal of California Code of Regulations (CCR) Title 9 “medication monitoring” for students with disabilities. Medication monitoring consists of prescribing, administering medications, and monitoring of psychiatric medications necessary to alleviate symptoms of mental illness.

Thus, the ERMHS RU cannot bill Medi-cal for the provision of Medication Monitoring. All medication support services must be provided from a separate RU. For example, a Central County child who is receiving case management services from an ERMHS (RU 07217) case manager, should also be open to Central County Children’s services (RU 07219) for medication services. Both RUs must have separate Partnership Plans since the ERMHS plan cannot include medication services.

See Section 5 for further information.
SERVICE
and
REIMBURSEMENT
OVERVIEW

SCOPE
of
PRACTICE

SECTION 1
SERVICE AND REIMBURSEMENT
OVERVIEW

GENERAL GUIDELINES

A Progress Note is required for each billed service by the exact number of minutes used by persons providing a reimbursable service. The reimbursable time for Mental Health Services, Medication Support, Crisis Intervention, and Case Management Brokerage is based on staff time. When a person provides a service to more than one beneficiary at the same time (i.e., group therapy, group rehab), the time utilized by all those providing the service shall be added together to yield the total claimable services. The total time claimed is divided equally by the number of clients receiving the service. (The Mental Health Database automatically does the math when the service is entered)

Day Treatment Services are reimbursed by half days or full days of services. Half-day services must be available a minimum of three hours each day the program is open. Full-day services must be available over four hours per day. Day Treatment Intensive Services require a brief daily note and a weekly summary. Day Rehabilitation Services require a weekly summary. Medication Support Services are reimbursed separately from the day program service. All of our programs except 1 are out of county and many are unbundled.

Adult Residential Services and Crisis Residential Services are reimbursed by the calendar day in which the individual receives face-to-face services and the individual has been admitted to the program. The day of admission may be billed but not the day of discharge. Medication Support Services are reimbursed separately. Adult Residential Services and Crisis Residential Services require a weekly summary.

Lockout rules apply: some services are not reimburseable on the same day as some other services. The Mental Health Billing Database does not filter these services.
Documentation Rules

✓ Time should include all time spent by staff on a given service, including travel and documentation. Travel time is reimbursable if the travel is necessary to the provision of a billable service.

✓ Services may be provided anywhere in the community or by phone. However, the initial assessment must be a face-to-face visit. When the child is the client, the initial assessment may be with the parent/guardian.

✓ All notes must be signed and license/title indicated.

✓ Notes must be legible. Notes that are not legible are not reimbursable.

✓ To bill for completing a discharge summary, the clinician must provide a service to the client. If no service is provided, completing the discharge summary is considered Administrative. The clinician must use a non-billable procedure code for administrative discharges.

✓ Transportation services alone are not reimbursable. If while transporting a client the clinician provides a mental health or case management service, it could be reimbursable.

✓ Supervision time is not reimbursable, nor is Intern case conferences.

✓ Writing reports that is not connected to a service (i.e. assessment, evaluation) is not reimbursable.

✓ Translation only is not a billable service.

✓ If two staff provides the same service in a single contact, a single note may be submitted as long as the documentation reflects both staff's participation in the delivery of the service.

✓ If two staff provides different type services in a single contact, two notes should be written with each staff submitting his/her own Progress Note/Billing Form, using the appropriate procedure codes.

✓ When an interpreter is used or the session is provided in a non-English language, the clinician should document such on the Progress Note/Billing Form.
✓ Substance abuse issues can be addressed as long as they are linked to stabilizing the mental health condition, i.e., in the description/reason for contact part of the progress note, describe how the substance use behavior is impacting the stability of the included diagnosis.

✓ The progress note form includes the billing information. The form must be given to the clerical staff for data entry and filing. **BILLING MAY NOT BE ENTERED INTO THE COMPUTER WITHOUT A COMPLETED PROGRESS NOTE.**

✓ All No Show (300), Client Cancel (400), and Staff Cancel (700) should be entered in the computer and noted in the chart.

✓ Services to collaterals of deceased clients are not reimbursable. Clinician must use non-billable procedure code.

✓ Preparation time for groups is not reimbursable.
Guidelines for Scope of Practice and Co-Signature Requirements

Licensed Staff: MD, NP (Nurse Practitioner), PhD, PsyD, LCSW, MFT

Nursing Staff:
- MSN – Registered Nurse with MS degree in psychiatric nursing (May Diagnose)
- BSN/ADN – Registered Nurses.
- LPT – Licensed Psychiatric Technicians

Registered Interns:
- Associate Social Workers and Marriage Family Therapist Interns must be registered with the Board of Behavioral Services.

- Post Doctoral Interns must be registered with the Board of Psychology, or enrolled in a formal internship placement with an agreement between the school and supervisor. In addition, the PhD intern must have a waiver granted by the Department of Health Care Services (DHCS) if employed as a psychologist by a local mental health program or its contract provider. This waiver may not exceed five years from the date of employment.

Trainees:
- Students currently enrolled in a Master's degree program or a Doctoral degree program. Progress notes must be co-signed by a licensed clinician.

Unlicensed Staff:
- Mental Health Rehab Specialist (MHRS) must have a Master's degree and two years of experience in a mental health setting, or a Baccalaureate degree and four years of experience in a mental health setting, or an Associate's degree and six years of experience in a mental health setting.

- Designated Mental Health Worker (DMHW) or Community Support Worker (CSW) is a line staff that does not meet MHRS education/experience requirements. Progress notes must be co-signed by a licensed clinician.
## CONTRA COSTA MENTAL HEALTH PLAN
### GUIDELINES FOR SCOPE OF PRACTICE
#### December 2013

<table>
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<th>SERVICE ACTIVITY</th>
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<th>NURSING STAFF</th>
<th>DOCTORAL INTERNS</th>
<th>MFT/ASW INTERNS</th>
<th>TRAINEES</th>
<th>MHRS</th>
<th>DMHW</th>
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*Requires co-signature by licensed staff

**Co-Facilitation only**
MEDICAL NECESSITY CRITERIA

Medical Necessity is a phrase used by certain third party payers that encompasses criteria they feel are essential for reimbursement of services. If all the criteria making up medical necessity are not met, a payer will refuse or deny payment. The primary diagnoses of an episode will be the diagnosis associated with a claim and to be Medi-Cal reimbursable must be an “included” diagnosis.

Every claimed service must meet the test of medical necessity. The service must be directed toward an included diagnosis, and the impairments that are a result of that diagnosis have interventions aided at maintaining, reducing, or minimizing the effect of the diagnostic symptoms or impairment on a consumer’s life. Each time a service is claimed to Medi-Cal, the clinician who delivered the service and submitted the billing is saying that he/she believes that the service met all medical necessity criteria.

The Medi-Cal Medical Necessity criteria have three components: diagnosis, impairment, and interventions. All three of the following listed criteria must be met to be eligible for reimbursement (§1830.205):

Included Diagnoses:

1. Pervasive Developmental Disorders, except Autistic Disorder
2. Attention Deficit and Disruptive Behavior Disorders
3. Feeding & Eating Disorders of Infancy or Early Childhood
4. Elimination Disorders
5. Other Disorders of Infancy, Childhood, or Adolescence
6. Schizophrenia & Other Psychotic Disorders
7. Mood Disorders
8. Anxiety Disorders
9. Somatoform Disorders
10. Factitious Disorders
11. Dissociative Disorders
12. Paraphilias
13. Gender Identity Disorders
14. Eating Disorders
15. Impulse-Control Disorders Not Elsewhere Classified
16. Adjustment Disorders
17. Personality Disorders, excluding Antisocial Personality Disorder
18. Medication-Induced Movement Disorders related to other included diagnoses

**Excluded Diagnoses:**

1. Mental Retardation
2. Dementia
3. Organic Brain Syndrome
4. Learning Disorders
5. Motor Skills Disorder
6. Communication Disorders
7. Autistic Disorder Other Pervasive Developmental Disorders are included.
8. Tic Disorders
9. Delirium, Dementia, and Amnestic and Other Cognitive Disorders
10. Mental Disorders Due to a General Medical Condition
11. Substance-Related Disorders
12. Sexual & Gender Identity Disorders, except Paraphilias and Gender Identity Disorders in Children which are included
13. Sleep Disorders
14. Antisocial Personality Disorder
15. Other Conditions That May Be a Focus of Clinical Attention, except Medication Induced Movement Disorders which are included.
Impairment Criteria

Must have at least one of the following impairments as a result of the mental disorder(s) identified in the diagnostic criteria above:

- A significant impairment in an important area of life functioning, or

- A probability of significant deterioration in an important area of functioning, or

- Children also qualify if there is a probability the child will not progress developmentally as individually appropriate.

Intervention Related Criteria

Must meet all conditions listed below:

- The focus of proposed intervention is to address the condition identified in impairment criteria above, and

- It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children it is probable the child will progress developmentally as individually appropriate, and

- The condition would not be responsive to physical healthcare-based treatment.
Sequence of documentation that supports the demonstration of ongoing medical necessity:

- The completion of the Assessment establishes the specific impairments of a consumer and the certainty of an included diagnosis.

- The demonstration of medical necessity is carried forward into the Partnership Plan for Wellness where the diagnosis and impairments are used to establish treatment goals and the planned interventions are expected to effect the consumer's impairments.

- Progress Notes document, and thus support, the presence of medical necessity. Each service delivered is an intervention service that is identified on the Plan. Progress Notes should note progress the consumer is making toward his/her goals and toward diminishing the impairment established in the Assessment.
CURRENT MEDICAL NECESSITY CRITERIA

(as of January 2014)

The state of California has not made changes to the Medical Necessity criteria to reflect the release of the DSM 5, in May of 2013. Until further notice, CCMHP will continue to follow the Medical Necessity criteria and diagnoses in the DSM IV-TR. (Title 9, Section 1830.205)
CHILDREN/ADOLESCENT MEDICAL NECESSITY CRITERIA

Children or adolescents will be provided Mental Health Services where such services are deemed medically necessary. Medical necessity will be defined as (1) having a 5-Axis diagnosis with a primary Axis I diagnosis from the current edition of the Diagnostic and Statistical Manual of Mental Diagnosis (2) evidence of impaired functioning in the community and must meet criteria under any of the six categories (I-VI) below, and (3) provide evidence that proposed interventions are focused on the impairment identified above.

I) Client must meet DSM IV 5-Axis Mental Health Diagnosis Criteria for Medical Necessity.
   - Must be diagnosed by the MHP with an included DSM IV 5-Axis Mental Health Diagnosis

II) Client must meet Impairment Criteria for Service Necessity Substantial functional impairment in at least one of the following area:

   A) Any child who is eligible for mental health service pursuant to Chapter 26.5 of the California Government Code [AB 3632].

   B) At least one of the following:
      - Referred for treatment in State Hospital or presently a patient in State Hospital or former patient in State Hospital transitioning to community living.
      - In acute care hospital or former patient in an acute care hospital transitioning to the community.
      - At risk of placement in an RCL Level 13 or 14 facility.
      - Presently in a RCL level 13 or 14 facility or recently discharged from such a facility and transitioning to a lower level of care.
      - Referred by Child and Family Services (CFS) for assessment only regarding out-of-home placement in the least restrictive setting, return from placement, or family reunification.

   C) A child 5 years old or younger either:
      - Displays severe delays in psychosocial and/or developmental milestones not the result of a developmental disability.
      - OR
      - Is at risk for major psychosocial delay and the result of Mental Health Evaluation indicates significant deficits in at least one of the following areas: emotional, interpersonal, and behavioral.
      - OR
      - Without Mental Health intervention, the child is at risk of being removed from their home

   D) Children, of any age displaying:
      - At least one of the following: (Level 5 – Child and Adolescent Problem Rating Scale)
      - Persistent danger of hurting self and others.
      - Serious suicidal act/nomination/plan with clear expectations of death.
      - Behavior considerably influenced by delusions or hallucinations,
      - Stressors: Catastrophic
      - GAF: 0-30

      III) OR

   E) At least 3 of the following: (Level 4 – Child and Adolescent Problem Rating Scale)
      - Behavior threatening or dangerous to self or others in past 3 months.
      - Significant impairment in family, school, self maintenance or interpersonal relationships.
      - Threat of or recent removal from home or placement.
      - Recent release from psychiatric inpatient care.
      - History of past hospitalization with risk of re-hospitalization.
      - Stressors: Extreme
      - GAF: 31-50

      OR

MHC18_7 (10-9-08)
F) At least 4 of the following: (Level 3 – Child and Adolescent Problem Rating Scale)
☐ History of dangerous behavior to self or others in past year.
☐ History of runaway, extended truancy.
☐ Acting out or avoidant, isolative behaviors at school and community.
☐ At risk for higher levels of care.
☐ History of past hospitalization with risk of re-hospitalization.
☐ Minimally adequate psychological support.
☐ Significant impairment in at least 2 of the following: family, school, self maintenance or interpersonal relationships.
☐ Clinically significant and persistent anxiety or mood symptoms.
☐ Stressors: Severe
☐ GAF: 51-65

OR

G) ☐ Children or adolescents who have previously met the above criteria and, who are presently in individual, group, and/or family therapy, and who no longer meet the above criteria may receive up to an additional 25 sessions of therapy if necessary for maintenance and continued stabilization.

IV) At least one of the following (Medication Support Services Only):
☐ Child: Children whose mental disorder is in full or partial remission may continue to receive medication support services in order to maintain the remission.
☐ Parent: If a child meets criteria under I, II, III, or IV above and the parent or primary caretaker requires medication support services to stabilize the home situation and to prevent out-of-home placement of the child, such services may be provided.

V) Any parent, guardian, or primary caregiver of a child 5 years old or younger who has a primary DSM AXIS I diagnosis of mental illness other than substance abuse or developmental disability which significantly disrupts or interferes with daily activity and either of the following (1 or 2) is present:
At least one of the following:
☐ Persistent danger of hurting self and others.
☐ Serious suicidal act/ruminating/plan with clear expectations of death.
☐ Behavior considerably influenced by delusions or hallucinations.
☐ Due to a mental illness, is receiving or in need of medication to stabilize and maintain level of functioning in the community.

OR

VI) At least two of the following are present:
☐ Behavior threatening or dangerous to self or others in past 3 months.
☐ Significant impairment in ability to meet basic physical needs or to utilize resources for food, clothing, or shelter for self and children.
☐ Significant impairment in ability to meet basic psychological needs for self and child(ren) displaying severe delays in developmental milestones or a significant impairment in child(ren)'s self maintenance or family/school functioning.
☐ Threat of or recent removal of child(ren) from their care.
☐ Inadequate psychological and or psychosocial support system.
☐ Recent release from psychiatric inpatient service.
☐ History of past hospitalization with risk of re-hospitalization.

III) Client must meet Intervention Criteria for Service Necessity. (Must have all 1, 2, and 3)
A) The focus of the proposed intervention is to address the condition identified in the Impairment Criteria.
☐ Primary Goal of Partnership Plan outlines proposed interventions which address the condition of impairment.

AND

B) The expectation is that the proposed intervention will:
☐ Benefit from the proposed interventions by diminishing the impairment or preventing significant deterioration
☐ It is probably that the child will progress developmentally as individually appropriate
☐ If covered by EPSDT can be corrected or ameliorated.

AND

☐ The condition would not be responsive to physical health care-based treatment

Signature/Title:

Date:

MH-C 18 (10-9-08) Medical Necessity Form Page 2
Medically Necessary Service

A medically necessary service is one which attempts to impact a functional impairment brought about by a symptom of an included diagnosis.
<table>
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<th>Code</th>
<th>Diagnosis</th>
<th>Code</th>
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<td>Schizophrenia, disorganized type</td>
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<td>Tranvestic Fetishism</td>
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<td>Schizophrenia, catatonic type</td>
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<td>Exhibitionism</td>
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<td>296.20-26</td>
<td>Major depressive disorders, single episode</td>
<td>302.9</td>
<td>Paraphilia/Sexual disorder NOS</td>
</tr>
<tr>
<td>296.30-36</td>
<td>Major depressive disorders, recurrent</td>
<td>307.1</td>
<td>Anorexia nervosa</td>
</tr>
<tr>
<td>296.40</td>
<td>Bipolar I disorder, most recent ep. hypomanic</td>
<td>307.3</td>
<td>Stereotypic movement disorder</td>
</tr>
<tr>
<td>296.40-46</td>
<td>Bipolar I disorder, most recent ep. manic</td>
<td>307.50</td>
<td>Eating disorder NOS</td>
</tr>
<tr>
<td>296.50-56</td>
<td>Bipolar I disorder, most recent ep. depressed</td>
<td>307.51</td>
<td>Bulimia nervosa</td>
</tr>
<tr>
<td>296.60-66</td>
<td>Bipolar I disorder, most recent ep. mixed</td>
<td>307.52</td>
<td>Pica</td>
</tr>
<tr>
<td>296.70</td>
<td>Bipolar I disorder, most recent ep. unspec</td>
<td>307.53</td>
<td>Rumination disorder</td>
</tr>
<tr>
<td>296.80</td>
<td>Bipolar disorder NOS</td>
<td>307.59</td>
<td>Feeding disorders of infancy or early childhood</td>
</tr>
<tr>
<td>296.89</td>
<td>Bipolar II disorder</td>
<td>307.6</td>
<td>Enuresis (not due to medical condition)</td>
</tr>
<tr>
<td>296.90</td>
<td>Mood disorder NOS</td>
<td>307.7</td>
<td>Encopresis without constipation/incontinence</td>
</tr>
<tr>
<td>297.1</td>
<td>Delusional disorder</td>
<td>307.80</td>
<td>Pain disorder assoc with psychological factors</td>
</tr>
<tr>
<td>297.3</td>
<td>Shared psychotic disorder</td>
<td>307.89</td>
<td>Pain disorder assoc with psych &amp; medical condition</td>
</tr>
<tr>
<td>298.8</td>
<td>Brief psychotic disorder</td>
<td>308.3</td>
<td>Acute stress disorder</td>
</tr>
<tr>
<td>298.9</td>
<td>Psychotic disorder NOS</td>
<td>309.0</td>
<td>Adjustment disorder with depressed mood</td>
</tr>
<tr>
<td>299.10</td>
<td>Childhood disintegrative disorder</td>
<td>309.21</td>
<td>Separation anxiety</td>
</tr>
<tr>
<td>299.80</td>
<td>Asperger’s disorder/Retts disorder</td>
<td>309.24</td>
<td>Adjustment disorder with anxiety</td>
</tr>
<tr>
<td>299.80</td>
<td>Pervasive developments disorder NOS</td>
<td>309.28</td>
<td>Adjustment disorder mixed mood</td>
</tr>
<tr>
<td>300.00</td>
<td>Anxiety disorder NOS</td>
<td>309.3</td>
<td>Adjustment disorder with conduct disturbance</td>
</tr>
<tr>
<td>300.01</td>
<td>Panic disorder without agoraphobia</td>
<td>309.4</td>
<td>Adjustment disorder mixed emotion &amp; conduct</td>
</tr>
<tr>
<td>300.02</td>
<td>Generalized anxiety disorder</td>
<td>309.81</td>
<td>Post traumatic stress disorder</td>
</tr>
<tr>
<td>300.11</td>
<td>Conversion disorder</td>
<td>309.9</td>
<td>Adjustment disorder unspecified</td>
</tr>
<tr>
<td>300.12-15</td>
<td>Dissociative disorders</td>
<td>311</td>
<td>Depressive disorder NOS</td>
</tr>
<tr>
<td>300.16</td>
<td>Factitious disorder, predom psychological</td>
<td>312.30</td>
<td>Impulse control disorder NOS</td>
</tr>
<tr>
<td>300.19</td>
<td>Factitious disorder, combined, physical, NOS</td>
<td>312.31</td>
<td>Pathological gambling</td>
</tr>
<tr>
<td>300.21</td>
<td>Panic disorder with agoraphobia</td>
<td>312.32</td>
<td>Kleptomania</td>
</tr>
<tr>
<td>300.22</td>
<td>Agoraphobia without history of panic disorder</td>
<td>312.33</td>
<td>Pyromania</td>
</tr>
<tr>
<td>300.23</td>
<td>Social phobia</td>
<td>312.34</td>
<td>Intermittent explosive disorder</td>
</tr>
<tr>
<td>300.29</td>
<td>Specific phobia</td>
<td>312.39</td>
<td>Trichotillomania</td>
</tr>
<tr>
<td>300.3</td>
<td>Obsessive compulsive disorder</td>
<td>312.8</td>
<td>Conduct disorder</td>
</tr>
<tr>
<td>300.4</td>
<td>Sythymic disorder</td>
<td>312.9</td>
<td>Disruptive disorder</td>
</tr>
<tr>
<td>300.6</td>
<td>Depersonalization disorder</td>
<td>313.23</td>
<td>Selective mutism</td>
</tr>
<tr>
<td>300.7</td>
<td>Body dysmorphic disorder/hypochondris</td>
<td>313.81</td>
<td>Oppositional defiant disorder</td>
</tr>
<tr>
<td>300.81</td>
<td>Somatization disorder/Somatofom disorder</td>
<td>313.82</td>
<td>Identity problem</td>
</tr>
<tr>
<td>301.0</td>
<td>Paranoid personality disorder</td>
<td>313.89</td>
<td>Reactive attachment disorder</td>
</tr>
<tr>
<td>301.13</td>
<td>Cyclothymic disorder</td>
<td>313.9</td>
<td>Disorder of infancy, child/NOS</td>
</tr>
<tr>
<td>301.20</td>
<td>Schizoid personality disorder</td>
<td>314.00</td>
<td>Attention deficit/hyperactive disorder, inattentive</td>
</tr>
<tr>
<td>301.21</td>
<td>Schizotypal personality disorder</td>
<td>314.01</td>
<td>Attention deficit/hyperdis, hyper, impulse, combined</td>
</tr>
<tr>
<td>301.4</td>
<td>Obsessive compulsive personality disorder</td>
<td>314.9</td>
<td>Attention Deficit/hyperactivity disorder, NOS</td>
</tr>
<tr>
<td>301.50</td>
<td>Histrionic personality disorder</td>
<td>322.1</td>
<td>Neuroleptic induced Parkinsonism</td>
</tr>
<tr>
<td>301.6</td>
<td>Dependent personality disorder</td>
<td>333.1</td>
<td>Medication induced postural tremor</td>
</tr>
<tr>
<td>301.81</td>
<td>Narcissistic personality disorder</td>
<td>333.7</td>
<td>Neuroleptic induced acute dystonia</td>
</tr>
<tr>
<td>301.82</td>
<td>Avoidant personality disorder</td>
<td>333.82</td>
<td>Neuroleptic induced tardive dystinesia</td>
</tr>
<tr>
<td>301.83</td>
<td>Borderline personality disorder</td>
<td>333.90</td>
<td>Medication induced movement disorder NOS</td>
</tr>
<tr>
<td>301.9</td>
<td>Personality disorder NOS</td>
<td>333.92</td>
<td>Neuroleptic Malignant syndrome</td>
</tr>
<tr>
<td>302.2</td>
<td>Pedophilia</td>
<td>333.99</td>
<td>Neuroleptic induced acute akathisia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>787.6</td>
<td>Encopresis with constipation/incontinence</td>
</tr>
</tbody>
</table>
EXCLUDED DIAGNOSIS (as primary)

Mental Retardation

Dementia

Organic Brain Syndrome

Learning Disorders

Motor Skills Disorders

Communication Disorders

Autistic Disorder (Other Pervasive Developmental Disorders are included)

Tic Disorders

Delirium, Dementia, and Amnestic & Other Cognitive Disorders.

Mental Disorders Due to a General Medical Condition.

Substance-Related Disorder

Sleep Disorders

Antisocial Personality Disorder

Other Conditions that may be a Focus of Clinical Attention, (except Medication Induced Movement Disorders which are included.)
REGISTRATION
FINANCIAL
INFORMATION
EPISODE
OPENING/CLOSING
CSI
CHANGE OF
THERAPIST/CHANGE
OF DIAGNOSIS

SECTION 3
REGISTRATION FORM

The Registration Form must be completed at the initial episode opening for new clients. For on-going clients, the Registration Form should be updated annually, only if relevant changes occurred.

DOCUMENTATION

Responsible Staff: Initially, it is the responsibility of the registration clerk or the clinician to ensure the form is completed at the time of the intake assessment or a crisis intervention service. This form has been designed so the client or the family/guardian can complete the majority of the form. In some programs the registration clerk or the clinician will complete this form.

NOTE: If the client or the family/guardian completes the Registration Form, the clerical staff must review the form to ensure each section is complete.

Billing Procedure Code Options: Time spent by the clinician to complete this form can be incorporated into the service being provided as Assessment 331, Evaluation 313, or Crisis Intervention 371. DO NOT BILL AS A STAND ALONE SERVICE.

Time Frame:
• Complete Registration Form at client’s initial visit.
• For those clients already receiving services, on a one-time basis the Registration Form needs to be completed in order to capture CSI requirements.
• All pertinent changes should be updated annually as needed.

INSTRUCTIONS FOR COMPLETING THE REGISTRATION FORM

For Office Use Only Section

☐ Consumer Guide Given: Check box that a Consumer Services Handbook was given to the client. It is mandatory that all clients receive this booklet.

☐ New: Should be checked for all clients new to the system or returning clients regardless of the length of time the episode was closed.
☐ Update: Should be checked for annual updates.
RU: Reporting Unit of program completing form.

MRN: Client’s Medical Record Number.

Staff ID: Staff number of clinician responsible for Assessment, Evaluation, or Crisis Intervention.

Please Complete All Sections Below For The Person Receiving Services

If the Client/Family/Guardian completes this section, the registration clerk or clinician must ensure all sections are completed.

**Today's Date:** The date the form is being completed and the episode is opened or date of annual update.

**Last Name:** The client’s last name.

**First Name:** The client’s first name.

**Middle Name:** The client’s middle name.

**Gen:** Generation means any title that is part of the client’s name. The possibilities are Jr., Sr., Esq., and Roman Numerals (I, II, III, etc.).

**Date of Birth:** Client’s birth date including month-day-year.

**Gender:** Check "M" for Male, "F" for Female.

**SS#:** The client’s nine-digit Social Security Number. This number is used as a key identifier in the system. It is recommended that the information be taken or checked directly from the client’s Social Security Card, if possible.

**Highest Grade Completed:** The number indicating the highest school grade completed.

**Primary Language:** Check the primary language the client speaks.

**Preferred Language For Receiving Mental Health Services:** Check the language the client prefers to receive services.

**Racial Background/Ethnicity (Please Select Up To Five):** This is the Race Field in the mental health database. The client may select up to five.
**Latino/Hispanic Origin**: Identifies whether or not the client is of Hispanic or Latino ethnicity. Check Yes, No, or Unknown.

**Martial Status**: Check current martial status from the following choices: Never Married, Married, Widowed, Divorced, Separated.

**How Many Dependents Cared For At Least 50% Of The Time Are Under 18?**: Number of dependents less than 18 years of age the client cares for/is responsible for at least 50% of the time.

PSP requires a 2-digit number in this field (i.e. 01, 02, 03, etc.) Use 00 for None and 99 for Not Reported.

**How Many Dependents Cared For At Least 50% Of The Time Are 18 And Over?**: Number of dependent adults 18 years of age and above the client cares for/is responsible for at least 50% of the time.

PSP requires a 2-digit number in this field (i.e. 01, 02, 03, etc.) Use 00 for None and 99 for Not Reported.

**Birth Last Name**: Client's last name at birth.

**Birth First Name**: Client's first name given at birth.

**Birth Middle Name**: Client's middle name given at birth.

**Gen**: Generation means any title that is part of the client's name. The possibilities are Jr., Sr., Esq., and Roman Numerals (I, II, III, etc.).

**Alias(es)**: Any other names the client has used including maiden name.

**Birthplace County**: County where client was born. (See County Codes for data entry)

**Birthplace State**: State where client was born. (See State Codes for data entry)

**Birthplace Country**: Country where client was born. (See Country Codes for data entry)

**Birth Mother's First Name**: The client's mother's first name.
Birth Mother’s Maiden Name: The client’s mother’s maiden name.

Current Address Street/City/State/Zip: Where the client currently resides.

Phone: The client’s phone number.

Emergency Contact/Significant Other: Person the client would want to be contacted in case of an emergency.

PSP labels this field Significant Other.

Relationship: Relationship of the Emergency Contact/Significant Other.

Emergency Contact Address (Street, City, State, Zip): Address of the Emergency Contact/Significant Other.

Emergency Contact Phone: Phone Number of the Emergency Contact/Significant Other.

Completed By: The name of the person completing the Form. If the clinician completes the form, license or title should be included.

Date: Date the form was completed.

Reviewed By: If the client or legal guardian fills out the form, it is the responsibility of the Registration Clerk to review the form to ensure it is complete before data entry.

Date: Date the form was reviewed.

Computer Entry Clerk Initials: The initials of the data entry clerk.

CLIENT FINANCIAL INFORMATION FORM

The Client Financial Information Form must be completed at the initial episode opening for new clients and updated annually. The form should also be completed if relevant changes occur. The UMDAP must not change unless the client's income increases $400 or more.

Name/MRN/Program/ RU: Client name, Medical Record Number, Program Name, and Reporting Unit.

Number of Dependents: Write in the number of the client’s dependents. For foster care or other placements, the number of dependents is only the child or children from the same family.

Gross Monthly Income (Except Foster Care Children): Gross household income for a family except for foster care or other placements. If the child/children is in foster care or other placement, the income is the monthly allocation for the child.

Total Assets: Liquid assets belonging to the family that can easily be converted into cash. (Current savings, bank balances, current market value of stocks, bonds, and mutual funds.)

Court Ordered Expenses: Court ordered obligations, which a court has made and a written order of liability has been issued. Such liabilities paid on a monthly basis can be allowed as a deduction from monthly gross income as long as the amount is currently being paid. Examples of court ordered expenses are alimony and child support.

Responsible Party/Legal Guardian Information:

Name: The responsible party is always an adult (the parents of a minor, or guardian or conservator of the client's estate. If in foster care, the responsible party is the Social Worker.

Relationship to Client: The responsible party’s relationship to the client.

Address (street, city, state, zip): The address of the responsible party.

Phone: Phone number of the responsible party.
Signature: The responsible party must sign to verify financial information.

NOTE: Child and Family Services is the responsible party for children in foster care. The Social Worker must sign the Responsible Party Section as the representative.

Insurance (Check all that apply): The choices are: None, Medi-Cal, Medi-Care, CCHP, Private Insurance (i.e. Kaiser, Blue Cross, etc.). For Private Insurance, write in Group Number and Subscriber ID; write in the birth date of the subscriber, write in the phone number and address of the insurance company.

*In order for private insurance to be billed for services, parents must give written permission by filling out and signing the AR1 form.

*If available, make a copy of the insurance card and send all private insurance information (AR1) to patient accounting.

Completed By: The name of the person completing the form. If the clinician completes the form, license or title should be included.

Date: Date the form was completed.

Office Use Only: This section is for the program staff to complete.

UMDAP Expiration Date: Write in the date the UMDAP expires.

UMDAP Liability: Write in the dollar amount of the UMDAP liability.

Account #: This number is automatically generated by PSP.

Financial Code: Code is used for the client’s clinic card. The most common codes are: IS- Private Insurance/Short-Doyle, IL- Private Insurance/Medi-Cal/Short-Doyle, SO- Short Doyle, LO- Medi-Cal.

Reviewed By: If the client or legal guardian fills out the form, it is the responsibility of the program clerical staff or clinician to review the form to ensure it is complete before data entry.

Date: Date Completed

Computer Entry Clerk Initials: The initials of the data entry clerk.
CLIENT FINANCIAL INFORMATION

Number of Dependents: _______  Gross Monthly Income (Except foster care children): $______

Total Assets (Checking, savings, stocks, bonds, etc.): $__________________________

Court Ordered Expenses (Alimony, child support): $__________________________

Responsible Party/Legal Guardian Information*:

Name: __________________________  Relationship to client: __________________________

Address (Street, City, State, ZIP): __________________________  Phone: __________________________

Signature: __________________________

* Child and Family Services is the responsible party for children in Foster Care. The social worker must sign in the Responsible Party section as the representative.

Insurance: (check all that apply)

☐ None  ☐ Medi-Cal  ☐ Medicare  ☐ CCHP

☐ Private

Insurance Name: __________________________  Group #: __________________________  Subscriber ID: __________________________

Subscriber Name: __________________________

Subscriber Birth Date: __________________________  Subscriber Phone #: __________________________

Subscriber Address: __________________________

Initial:  

I hereby assign any benefits payable by the above to Contra Costa County Health Services. This amount is not to exceed the regular charges for this period of services.

I authorize the county to bill on my behalf any and all identified commercial insurance coverage.

[For Educationally Related Mental Health Services Only] I give my permission for private insurance to be billed. This is a necessary step prior to billing other health coverage such as Medi-Cal for reimbursement. The school district will be billed for any charges denied reimbursed by private insurance or Medi-Cal.

Authorized Signature __________________________  Date __________________________

Staff Signature __________________________  Date __________________________

Office Use Only
If available, make copy of insurance card and fax with Client Financial Information form to Patient Accounting (925) 372-5115

UMDAP Expiration Date: __________________________  UMDAP Liability: __________________________

Account #: __________________________  Financial Code: __________________________

Reviewed By: __________________________  Date: __________________________  Computer Entry Clerk Initials: __________________________
EPISODE OPENING

An episode defines a period of treatment for a specific client at a specific program. The episode is bounded by an episode opening date (admission date) and an episode closing date (discharge date). Before services for a client can be entered into the mental health computer system, an episode for the client must be opened in the program providing the service.

DOCUMENTATION

Responsible Staff: It is the responsibility of the clinician providing the initial assessment, evaluation, or crisis intervention service to complete the episode opening section.

Billing Procedure Code Options and Time Frames:

For the episode opening, time spent by the clinician to complete this form can be incorporated into the service being provided as Assessment 331, Evaluation 313, or Crisis Intervention 371.

Instructions for Completing the Episode Opening

Name: The client’s first and last name.

MRN: Client’s Medical Record Number.

RU: Reporting Unit of the program.

Opening Date: Date of the client’s first service. The episode opening date is a critical date. It can affect client accounts and authorizations. No services can be entered into the mental health computer system before the episode is opened.

Referral From Code: It is important to know who or how clients are being referred to mental health programs. If the referral is from another provider use that county, contract, or other agency code. Referrals codes are listed on the Referral Code Form.

Trauma: Identifies clients that have experienced traumatic events including experiences such as having witnessed violence, having been a victim of
crime or violence, having lived through a natural disaster, having been a combatant or civilian in a war zone, having witnessed or having been a victim of a severe accident, or having been a victim of physical, emotional, or sexual abuse. The trauma should be related to the diagnosis. Check yes, no, or unknown, as appropriate.

Legal Status: Check the legal status under which the client is admitted to the program.

Diagnosis: Until further notification CCMHP will continue to utilize the Axis 5 diagnostic criteria in the DSM IV-TR.

Axis I Diagnosis: Identifies the Axis I diagnosis. This must be a valid diagnostic code for Axis I. It may or may not be the primary or secondary focus of treatment. In some instances this may be Deferred (799.9) or No Diagnosis (V71.09), but in these cases this would not be primary.

Alternative AXIS I: Identifies an additional Axis I diagnosis. (Optional)

Axis II Diagnosis: Identifies the Axis II diagnosis, which may be the primary or secondary focus of attention or treatment for mental health services.

Alternative AXIS II: Identifies an additional Axis II diagnosis. (Optional)

NOTE: There can only be one primary diagnosis. The primary diagnosis may either be an Axis I diagnosis or an Axis II diagnosis.

Axis III: An ICD-9 diagnosis that identifies the client's medical condition(s), if any. Should be entered if obtained from an MD. May report up to three.

OR

General Medical Condition Summary Code (GMC): May list general medical conditions from list below.

01 = Arterial Sclerotic Disease  
02 = Heart Disease  
21 = Osteoporosis  
22 = Cancer
03 = Hypercholesterolemia Impaired
04 = Hyperlipidemia
05 = Hypertension
06 = Birth Defects
07 = Cystic Fibrosis
08 = Psoriasis
09 = Digestive Disorders (Reflux, Irritable Bowel Syndrome)
10 = Ulcers
11 = Cirrhosis
12 = Diabetes
13 = Infertility
14 = Hyperthyroid
15 = Obesity
16 = Anemia
17 = Allergies
18 = Hepatitis
19 = Arthritis
20 = Carpal Tunnel Syndrome
23 = Blind/Visually Impaired
24 = Chronic Pain
25 = Deaf/Hearing Impaired
26 = Epilepsy/Seizures
27 = Migraines
28 = Multiple Sclerosis
29 = Muscular Dystrophy
30 = Parkinson's Disease
31 = Physical Disability
32 = Stroke
33 = Tinnitus
34 = Ear Infections
35 = Asthma
36 = Sexually Transmitted Disease (STD)
37 = Other
99 = Unknown/Not Reported
00 = No General Medical Condition

NOTE: IN THE AXIS III/GMC FIELDS, REPORT ONLY ICD-9 DIAGNOSES CODES OR THE GENERAL MEDICAL CONDITIONS SUMMARY CODES. UP TO 3 MAY BE USED, WITH NO MIXING OF ICD-9 AND GMC SUMMARY CODES.

AXIS IV: Check one of the following: A=Primary Support Group, B=Social Environment, C=Education, D=Work, E=Housing, F=Economic, G=Access Health Care, H=Legal, I=Other, J=Unknown.

AXIS V: Identifies the Global Assessment of Functioning rating of the consumer.

PSP requires a three-digit number for Axis V. The first number must be 0.
**AXIS V Past Year:** Identifies the Global Assessment of Functioning rating of the client for the past year. Unknown on Axis V is “00”, which can be used if current status is unknown.

PSP requires a three-digit number for Axis V. The first number must be 0.

**Substance Abuse or Dependence Issues:** Identifies whether or not the client has a substance abuse or dependence issue. The codes are Y=Yes, N=No, U=Unknown or Not Reported.

**Substance Abuse DX:** Identifies the client’s substance related disorder, if any.

**NOTE:** A CLIENT MAY HAVE A SUBSTANCE ABUSE/DEPENDENCE ISSUE WITHOUT HAVING A SUBSTANCE RELATED DIAGNOSIS, BUT IF S/HE HAS A SUBSTANCE RELATED DIAGNOSIS, S/HE MUST HAVE “Y” IN THE SUBSTANCE ISSUE FIELD.

**Clinician ID:** This is the clinician assigned (not MD unless only an MD is assigned) to treat the client.

**Physician ID:** This is the MD assigned to provide medication treatment/monitoring, if applicable.

**NOTE:** AFTER THE EPISODE IS OPENED, IF THE CASE IS ASSIGNED TO ANOTHER CLINICIAN OR MD, THE ASSIGNMENT/CHANGE OF THERAPIST/MD/RN, CHANGE OF DIAGNOSIS REQUEST FORM MUST BE COMPLETED AND GIVEN TO THE CLERICAL STAFF FOR DATA ENTRY.

**Source of Income:** Check the correct code. The source of income is used to record the primary or largest single source of family income for the client.

**Living Situation:** Check the correct code.

**Employment Status:** Check the correct code.

**Type of Employment:** Check the correct code.
Legal Consent: Check the correct code. The Legal Consent is used to indicate by what authority we are able to treat minors. It is also used in some cases for adults.

**Educationally Related Mental Health Services (ERMHS) formally AB3632 Reporting Units Only:**

*NOTE Data gathering procedures may change.*

**School District:** Enter the district county code and the district code (See School District Codes)

**Eff Date:** Enter the date the client began services in this school district.

**Special Population:** Mark only “N” for No Special Population Services or “C” for IEP Required Services.

- □ N = No Special Population Services
- □ C = Individualized Education Plan (IEP) Required Services (ERMHS)

**Eff Date:** Enter effective date of IEP.

**Signature/Title:** Signature and License/Title of clinical staff.

**Date:** The date the form was completed.

**Co-Signature/Title:** The co-signature of licensed clinician if applicable.

**Computer Entry Clerk Initials:** The initials of the clerical staff that enters the information into the mental health database.
**Episode Opening**

**Opening Date:**

**Referral From Code:**

**Trauma:** (Check one)

- Yes
- No
- Unknown

**Legal Status:** (Check one)

- W60000 Voluntary
- W51560 72-hr Hold (Adult)
- P10260 Not Guilty: Reas of Insanity
- P13680 Incompetent to Stand Trial
- P13700 Incompetent to Stand Trial
- P26840 Transfer to Correction Facility
- P99998 Other Involuntary Criminal

**WS2500 First 14-day Hold**

**WS2600 Second 14-day Hold**

**WS3000 180 Post-certification**

**WS3500 Temp Conservatorship**

**WS3520 Temp Conservatorship**

**WS3521 Temp Conservatorship Ext**

**WS3550 Perm Conservatorship**

**WS3551 Perm Conservatorship Ext**

**WS5850 72-hr Hold (Minor)**

**W65000 Judicial Commitment DD**

**W65500 Commitment: Minor DD Eval**

**W99998 Other Involuntary Civil**

**U99999 Unknown**

**Axis I:**

- P
- S

**Axis II:**

- S

- S

**Axis III/GMC:**

**Axis IV:** (Check one)

- A Primary Support Group
- B Social Environment
- C Education
- D Work
- E Housing
- F Economic
- G Access Health Care
- H Legal
- I Other
- J Unknown

**Substance Abuse or Dependence Issue:**

- Yes
- No
- Unknown

**Sub Abuse DX:**

**Axis III/GMC:**

**Axis V:**

**Source of Income:** (Check one)

- 0. Not Collected
- 1. None
- 2. Earned thru Employment
- 3. Unknown
- 4. Retirement
- 5. General or Public Assistance
- 6. Other

**Clinician ID:**

**Physician ID:**

**Living Situation:** (Check one)

- 01 Lives alone in house/apartment
- 02 Lives with immediate family
- 03 Lives with extended family (relatives)
- 04 Lives w non-related persons, except foster care
- 05 Foster Family
- 06 Single Room
- 07 Group Quarters
- 08 Group Home
- 09 CRTS — Long Term or Temporary
- 10 Satellite Housing
- 11 House or Apt
- 12 House or Apt w/ Support

**Employment Status:** (Check one)

- 01 Comp: 35 Hrs/More
- 02 Comp: 20 Hrs/Less
- 03 Comp: 20-35 Hrs
- 04 Homemaking: F/T
- 05 Rehab: 35 Hrs/More
- 06 Rehab: 20 Hrs/Less
- 07 Rehab: 20-35 Hrs
- 08 School: F/T
- 09 Training: F/T
- 10 Training: P/T
- 11 Volunteer
- 12 Seeking Work
- 13 Not Seeking Work
- 14 Retired
- 15 Not in Labor Force
- 16 Unknown
- 17 Resident / Inmate

**Type of Employment:** (Check one)

- 0 Not Collected
- 1 Exec/Admin/Managerial
- 2 Production, Inspection, Repair, Craft, Handle
- 3 Sales, Service
- 4 Farming/Forestry/Fishing
- 5 Unemployed

**Legal Consent:** (Check one)

- 0 Unknown
- 1 Not Applicable
- 2 Temporary Conservatorship
- 3 LPS Conservatorship
- 4 Murphy Conservatorship
- 5 Probate Conservatorship
- 6 PC 2974
- 7 Rep. Payee w/o Conservatorship
- 8 Juv Court — Dependent of Court
- 9 Juv Court — Ward Juv Offender

**AB3632 Reporting Units Only**

**School District:**

**Eff Date:**

**Special Population:**

- No Special Pop
- C IEP: AB 3632

**Eff Date:**

**Signature/Title**

**Date**

**Co-Signature/Title**

**Date**

**Computer Entry Clerk Initials**

MHC 099 (10-10-08)
EPISODE CLOSING

For an episode closing service providers complete the required closing documents for the medical record and appropriately bill this activity if (1) a decision has been made to discontinue services, (2) the client has not received services within the last 6 months, or (3) the client is deceased.

Under some circumstances, the medical record may not be closed in order to maintain the UR track, i.e. if the client is only receiving services from a contract agency.

DOCUMENTATION

Responsible Staff: At discharge, the primary clinician that provided services to the client must complete the episode closing.

Billing Procedure Code Options and Time Frames:

If the last service is provided directly to the client or on behalf of the client, all time spent by the clinician to complete this form in conjunction with the Discharge Summary or Progress Notes is billable. If the form is completed more than 5 days after the date of last service, it is considered an administrative closing which is not a billable service. Clinicians should use the Non-Billable Mental Health Service Code 540 for all administrative closings.

Instructions for Completing Episode Closing

Name: The client's first and last name.

MRN: Client's Medical Record Number.

RU: Reporting Unit of the program.

Closing Date: In most cases, the Closing Date will be the same as the date of last service.
Trauma: Identifies clients that have experienced traumatic events including experiences such as having witnessed violence, having been a victim of crime or violence, having lived through a natural disaster, having been a combatant or civilian in a war zone, having witnessed or having been a victim of a severe accident, or having been a victim of physical, emotional, or sexual abuse. The trauma should be related to the diagnosis. Circle yes, no, or unknown as appropriate.

Legal Status: Use the legal status at discharge.

Diagnosis: Use closing diagnoses (Axis I, Axis II, Axis III, IV, V, as appropriate).

PSP requires a three-digit number for Axis V. The first number must be 0.

Substance Abuse or Dependence Issues: Identifies whether or not the client has a substance abuse or dependence issue at discharge. The codes are Y=Yes, N=No, U=Unknown or Not Reported.

Substance Abuse DX: Identifies the client’s substance related diagnosis at discharge, if any.

Clinician ID: This should be the last clinician assigned to the client.

Physician ID: This should be the last MD assigned, if applicable.

Living Situation: Client’s living situation at discharge. Check correct code.

Employment Status: Client’s employment status at discharge. Check correct code.

Referral To Code: It is important to know where the client is being referred. A referral can be made to another provider (county or contract) or another agency. Up to three referrals codes can be entered into the mental health database. Referrals codes are listed on the Referral Code Form.

Reason For Discharge: Check the reason for discharge.
ERMHS “AB3632” Reporting Units Only:

*NOTE Educationally Related Mental Health Services (ERMHS) formally known as AB3632. Data gathering procedures may change.

School District: Enter the district county code and the district code (See School District Codes)

Eff Date: Enter the date the client ended services in this school district.

Special Population: Mark only “N” for No Special Population Services or “C” for IEP Required Services.

☐ N = No Special Population Services

☐ C = Individualized Education Plan (IEP) Required Services (ERMHS)

Eff Date: Enter expiration date of IEP.

Signature/Title: Signature and license or title of clinician completing the episode closing.

Date: The date the form was completed.

NOTE: Administrative closings are not reimbursable and non-billable codes must be used.

Co-Signature/Title: The co-signature of licensed clinician, if applicable.

Computer Entry Clerk Initials: The initials of the clerical staff that enters the information into the mental health database.
## Episode Closing

**Legal Status:** (Check one)
- [ ] 060000 Voluntary
- [ ] 515000 72-hr Hold (Adult)
- [ ] 10260 Not Guilty: Reas of Insanity
- [ ] 13680 Incompetent to Stand Trial
- [ ] 13700 Incompetent to Stand Trial
- [ ] 9840 Transfer to Correction Facility
- [ ] 99999 Other Involuntary Criminal

### Axis I: P S
- [ ] 23500 First 14-day Hold
- [ ] 26000 Second 14-day Hold
- [ ] 35000 30 Day Intensive Tx Hold
- [ ] 35500 Temp Conservatorship
- [ ] 35200 Temp Conservatorship
- [ ] 35250 Perm Conservatorship

### Substance Abuse or Dependence Issue:
- [ ] Yes
- [ ] No
- [ ] Unknown

### Substance Abuse DX:
- [ ] 15 House or Apt w/ Supervision
- [ ] 16 Supported Housing
- [ ] 20 Small Board & Care
- [ ] 21 Large Board & Care
- [ ] 22 Res Treatment Center
- [ ] 23 Community Treatment Facility
- [ ] 24 Adult Residential / Social Rehab
- [ ] 31 State Hospital
- [ ] 32 VA Hospital
- [ ] 33 SNF/ICF - Psych Reasons
- [ ] 34 SNF/ICF - Nursing Home
- [ ] 35 General Hospital

### Employment Status: (Check one)
- [ ] Comp: 35 Hrs/Less
- [ ] Training: P/T
- [ ] 10 Training: P/T
- [ ] 11 Volunteer
- [ ] 12 Seeking Work
- [ ] 13 Not Seeking Work
- [ ] 14 Retired
- [ ] 15 Not in Labor Force
- [ ] 16 Unknown
- [ ] 17 Resident / Inmate

### Referral To Code:
1.
2.
3.

### Reason for Discharge: (Check one)
- [ ] 1 Mutual Agreement: Treatment goals Reached
- [ ] 2 Mutual Agreement: Treatment Goals Partially Reached
- [ ] 3 Mutual Agreement: Treatment Goals Not Reached
- [ ] 4 Client Withdraw, AWOL, AMA, No Improvement
- [ ] 5 Client Withdraw, AWOL, AMA, No Improvement
- [ ] 6 Client Deceased
- [ ] 7 Client Moved Out of Area
- [ ] 8 Client Discharged, Program Unilateral Decision
- [ ] 9 Client Incarcerated
- [ ] 10 Client Discharged, Administrative Reasons
- [ ] 11 Other

### School District: __________________________ Exp Date: / / 

**Special Population:** [ ] No Special Pop [ ] C IEP: AB 3632 Exp Date: / / 

**Signature/Title ___________________________ Date ___________________________**

**Co-Signature/Title ___________________________ Date ___________________________**

MHC 099 (10-10-08)
CSI PERIODIC DATA FORM

The State of California Client and Service Information (CSI) data system require initial information and annual updates about clients receiving services. The purpose of collecting data in periodic records is to measure the effectiveness of services delivered to a client. Annual requirements allow the County and State Mental Health departments to collect information on service effectiveness over time.

Periodic data is reported to the state in three instances: When a client is admitted to County Mental Health; annually, while in the County Mental Health system; when the client is formally discharged from County Mental Health. When a new client is opened to a program, the CSI information is collected on the Registration and Episode Forms.

Completing the CSI Periodic Data Form is not a reimbursable activity.

DOCUMENTATION

Responsible Staff: It is the responsibility of the primary clinician to complete the CSI Periodic Data Form.

Billing Procedure Code Options: If done as a discrete activity, use non-billing codes. If done in conjunction with a billable direct service, include in the documentation time for that service.

INSTRUCTIONS FOR COMPLETING THE CSI PERIODIC DATA FORM

Name: Name of Client

MRN: Client’s Medical Record Number.

Clinician: Name of clinician completing form.

Agency/Clinic: Name of program where services are provided.
RU: Reporting Unit of program completing form.

Date Completed: The date the form was completed.

Education (# of Years Completed): The number indicating the highest school grade completed.

Employment Status: Check the correct code.

Legal Consent: Check the correct code. The Legal Consent is used to indicate by what authority we are able to treat minors. It is also used in some cases for adults.

Living Situation: Check the correct code.

Care Giver Under 18: Number of dependents less than 18 years of age the client cares for/is responsible for at least 50% of the time.

PSP requires a 2-digit number in this field (i.e. 01, 02, 03, etc.)
Use 00 for None and 99 for Unknown/Not Reported.

Care Giver Over 18: Number of dependent adults 18 years of age and above the client cares for/is responsible for at least 50% of the time.

PSP requires a 2-digit number in this field (i.e. 01, 02, 03, etc.)
Use 00 for None and 99 for Unknown/Not Reported.

ERMHS (formally AB3632) Reporting Units Only:

School District: Enter the district county code and the district code if client is ERMHS. (See School District Codes)

Eff Date: Enter the date the client began ERMHS services in this school district.

Exp Date: Enter the expiration date for ERMHS services in this school district, if applicable.
**Special Population:** Identifies any services being provided to ERMHS clients. Mark either "N" for No Special Population Services or "C" for IEP Required Services ERMHS.

**Eff Date:** Enter effective date of IEP for ERMHS.

**Exp Date:** Enter end date of IEP for ERMHS, if applicable.

**Signature/Title:** Signature and Title of clinician completing form.

**Date:** The date the form was completed.

**Computer Entry Clerk Initials:** The initials of the clerical staff that enters the information into the mental health database.
# CSI Periodic Data

<table>
<thead>
<tr>
<th>Clinician:</th>
<th>Agency/Clinic:</th>
</tr>
</thead>
<tbody>
<tr>
<td>RU:</td>
<td>Date Completed:</td>
</tr>
</tbody>
</table>

## Employment Status: (Check one)

- □ 1 Comp: 35 Hrs or More
- □ 2 Comp: 20 Hrs or Less
- □ 3 Comp: 20-35 Hrs
- □ 4 Homemaking: F/T
- □ 5 Rehab: 35 Hrs or More
- □ 6 Rehab: 20 Hrs or Less
- □ 7 Rehab: 20-35 Hrs
- □ 8 School: F/T
- □ 9 Training: F/T

## Legal Consent: (Check one)

- □ 0 Unknown
- □ 9 Not Applicable
- □ A Temporary Conservatorship
- □ B LPS Conservatorship
- □ C Murphy
- □ D Probate
- □ E PC 2974
- □ F Rep, Payee w/o Conservatorship
- □ G Juvenile Court – Dependent of Court
- □ H Juvenile Court – Ward Status Offender
- □ I Juvenile Court – Ward Juvenile Offender

## Living Situation: (Check one)

- □ 01 Lives alone in house/apartment
- □ 02 Lives with immediate family
- □ 03 Lives with extended family (relatives)
- □ 04 Lives w/ non-related persons, except foster care
- □ 05 Foster Family
- □ 06 Single Room
- □ 07 Group Quarters
- □ 08 Group Home
- □ 09 CRTS – Long Term or Temporary
- □ 10 Satellite Housing
- □ 13 House or Apartment
- □ 14 House or Apt w/ Support
- □ 15 House or Apt w/ Supervision
- □ 16 Supported Housing
- □ 20 Small Board & Care
- □ 21 Large Board & Care
- □ 22 Residential Treatment Center
- □ 23 Community Treatment Facility
- □ 24 Adult Residential / Social Rehab
- □ 31 State Hospital
- □ 32 VA Hospital
- □ 33 SNF/ICF - Psych Reasons
- □ 34 SNF/ICF - Nursing Home
- □ 35 General Hospital
- □ 36 MH Rehabilitative Center
- □ 37 PHF - In-Patient Psychiatric
- □ 40 Drug Abuse Facility
- □ 41 Alcohol Abuse Facility
- □ 42 Justice-related
- □ 50 Temporary Arrangement
- □ 51 Homeless - No Residence
- □ 52 Homeless - In Transit
- □ 98 Other
- □ 99 Unknown

**Caregiver (under 18 years)**  
How many dependents does consumer care for at least 50% of the time who are under 18 years of age?

**Caregiver (18 years and over)**  
How many dependents does consumer care for at least 50% of the time who are 18 years of age and over?

<table>
<thead>
<tr>
<th>AB3632 Reporting Units Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>School District:</td>
</tr>
<tr>
<td>Special Population:</td>
</tr>
</tbody>
</table>

Signature/Title

Date

Computer Entry Clerk
Initials

MHC 28-4 (Rev. 10-10-08)
ASSIGNMENT/CHANGE OF THERAPIST/M.D./R.N.
CHANGE OF DIAGNOSIS REQUEST

This form documents a change of therapist, MD, RN, or a change of diagnosis for the medical record and the mental health database. The appropriate section of the form is completed by the clinical staff and given to the clerical staff to enter the change into the mental health database.

NOTE: The change of therapist form does not indicate a change in “program or Reporting Unit (RU)” therefore, this does not change the UR track or anniversary date. All UR paperwork will continue to be due at the end of the established UR track and will not change when a change of therapist occurs.

Example: A client’s UR track is February 2013-January 2014, a change of therapist occurs on January 5, 2014 and the previous therapist did not complete the assessment or Partnership Plan. The newly assigned therapist must complete the Assessment and Partnership Plan by January 31, 2014, in order to ensure that there is not a lapse in the service authorization.
ASSIGNMENT/CHANGE OF THERAPIST/M.D.
CHANGE OF DIAGNOSIS REQUEST FORM

TO: CLERICAL SUPPORT STAFF

FROM: ___________________________ DATE: __________________________

For the client named below, please make additions/changes indicated, date and initial verifying action completed and file in the client’s record.

Client Name (last/first): ___________________________ Medical Record Number: _________________ Client DOB: _________________

Program Name: ___________________________

I. ASSIGNMENT OR CHANGE OF THERAPIST

Please assign or change the primary therapist (point person):

FROM: ___________________________ TO: ___________________________ STAFF#: ___________________________

Date Assignment/Change of therapist took place: ___________________________

Data Entry Date: ___________________________ Data Entry Initials: ___________________________

II. ASSIGNMENT OR CHANGE OF M.D.

Please assign or change M.D.:

FROM: ___________________________ TO: ___________________________ STAFF#: ___________________________

Date Assignment/Change of therapist took place: ___________________________

Data Entry Date: ___________________________ Data Entry Initials: ___________________________

III. CHANGE OF DIAGNOSIS

Please change the diagnosis on the above named client to:

Axis I ___________________________ (Primary) ___________________________ (Secondary)

Axis II ___________________________

Axis III ___________________________

Axis IV ___________________________

Axis V ___________________________

Enter both the number and name of the disorder on Axis I and II.

Data Entry Date: ___________________________ Data Entry Initials: ___________________________

MH-A 2
8/01
ASSESSMENT
CHILDREN & ADULT
INITIAL & ANNUAL UPDATE

SECTION 4
ASSESSMENT

The assessment is more than an information gathering process. It should begin the building of a trusting, helping, and therapeutic relationship. The initial assessment is to develop a clear picture account of the current issues and past history that are affecting a client. Understanding of cultural, family, and social issues is critical in assessing mental health symptoms, presentation, coping styles, and willingness to accept help.

The Assessment Form is also a billing form. The first three sections of the form have all the information necessary to enter the service into the mental health database. Remember, the assessment form must be complete before the service can be entered into the mental health database.

INITIAL ASSESSMENT

The initial assessment must be completed within 60 days of the client’s first contact with the county system. If a client transfers to a new program or is added to a new program, the clinician can use a prior assessment if the assessment was completed within the last year. When using an existing assessment, document in a progress note that the previous assessment was reviewed and no changes were necessary.

ANNUAL UPDATE

The Annual Update must include mental status and must be utilized to document medical and service necessity. The Family/Social section of the Adult Annual Update should specify all current situations such as where the client is living, what is the client’s income, still getting SSI, etc. The annual clinical update must be completed at the end of the UR track.

➢ For example, the UR track is January 1, 2013-December 31, 2013. The Annual Update needs to be completed by December 31, 2013.

DOCUMENTATION

Responsible Staff: Clinical staff, commensurate with scope of practice. (Licensed clinical staff and registered interns can diagnose and formulate mental
status exams.) Registered intern notes must be co-signed by a licensed clinician.

**Billing Procedure Code Options:** All time spent by the clinician providing and documenting the assessment is billable. The following services can be documented on the Assessment Form:

**331 Assessment:** A clinical analysis of the history and current status of the client's mental, emotional, or behavioral disorder. Relevant cultural issues and history may be included where appropriate. Assessment may include diagnosis and the use of testing procedures.

**371 Crisis Intervention:** A service activity that documents acuity of client or situation that jeopardizes his/her ability to maintain community functioning.

**580 Lockout:** A procedure code used when the client is in the hospital, jail, juvenile hall, IMD, etc.

**Diagnosis:** Both the numerical code and full clinical name of the diagnoses, based on the DSM IV-TR should be documented on the assessment.

➢ For example, “Axis I: 313.81, Oppositional Defiant Disorder”
INSTRUCTIONS FOR COMPLETING THE ADULT CLINICAL ASSESSMENT FORM

Name: Name of the client.

MRN: Client’s Medical Record Number.

Billing Information

Program Name: Name of the program providing the assessment.

RU: Reporting Unit of the program completing the form.

Date: The date the service was provided.

Staff #: Staff number of the clinician providing the service.

Hours/Mins: Time the clinician spent providing the service including time and travel time.

Code Activity: Check assessment or lockout.

Travel Time To/From: The amount of time spent traveling to provide a reimbursable service.

Location of Services (Please check one): Identifies the location where the service was rendered. New CSI requirements have expanded the place of service. Circle the appropriate place of service. The choices are:

1 Office – Services provided in the office where the mental health professional routinely provides services.

2 Field – When location is away from the clinician’s usual place of business. Use only when no other specific non-office location is applicable.

3 Phone – Services provided by telephone contact with the consumer.

4 Home – Services provided at a location, other than a hospital or other facility, where the consumer lives.

5 School – Services provided in any facility that has the primary purpose of education.

8 Correctional Facility – Services provided in a correctional facility (e.g. Jail, Prison, Camp/Ranch, etc.) including adult or juvenile detention facilities.

9 Inpatient – Services are provided in a Hospitals, Psychiatric Health Facilities (PHFs), Skilled Nursing Facilities (SNFs), Institutes for Mental Disease (IMDs), Mental Health Rehabilitation Centers (MHRCs).

10 Homeless/Emergency Shelter – Services provided in a facility specifically designed to provide shelter to the general homeless population.

11 Faith-based – Services provided in a location owned or leased by a faith group, with partial or full involvement of the faith group (e.g. church, temple, etc.).
12 Health Care/Primary Care — Services provided in the clinic or facility of the health care provider, including emergency rooms and public health clinics.

13 Age-Specific Community Center — Services provided in a location owned or leased by an age-specific community center, such as a senior's center, a teen drop in center, etc.

14 Client's Job Site — Services provided at the consumer's site of employment.

15 Licensed Community Care Facility — Adults — Services provided in a location supplying 24 hour non-medical care for adults

16 Mobile Services — This definition is consistent with the concept of a Mobile Clinic. Mobile clinics provide services to individuals in rural or outlying areas where services are otherwise inaccessible. The concept of mobile services is in contrast to services provided at other community locations that are reached by vehicle.

17 Non-Traditional Service Location — Services provided in the community, but not in a community center, school, faith-based location, homeless/emergency shelter, health-care center, or the consumer's job site. Examples include park bench, on the street under a bridge, in an abandoned building, etc.

18 Other Community Location — Services provided in the community, but not listed above.

19 Residential Treatment Center — Children — Services provided in a location supplying 24-hour non-medical care for children, other than inpatient hospital, or Psychiatric Health Facilities (PHFs). Includes Community Treatment Facilities (CTFs) and family foster homes.

20 Telehealth — Also known as "Telemedicine." Services are provided so that the clinician and consumer are in two different locations but can see each other via visual equipment (e.g., video, camera, web camera).

21 Unknown — Not Reported.

Service Strategies: Circle up to three service strategies, if applicable. The following are definitions for Service Strategies:

50 Peer and/or Family Delivered Services — Services and supports provided by consumers and family members who have been hired as treatment program staff, or who provide adjunct supportive or administrative services, such as training, information dissemination and referral, support groups and self-help support and empowerment. Please note that if the service/support is to be reimbursed by Medi-Cal, consumer and staff duties must meet Medi-Cal reimbursement requirements.

51 Psycho-education — Services that provide education about mental health diagnosis and assessment, medications, services and support planning, treatment modalities, other information related to mental health services and needs.

52 Family Support — Services provided to a consumer's family member(s) in order to help support the consumer.

53 Supportive Education — Services that support the consumer toward achieving educational goals with the ultimate aim of productive work and self-support.

54 Delivered in Partnership with Law Enforcement — Services that are integrated, interdisciplinary and/or coordinated with law enforcement, probation or courts (e.g., mental health courts, jail diversion programs, etc.) for the purpose of providing
alternatives to incarceration/detention for those with mental illness/emotional disturbance and criminal justice system involvement.

55 Delivered in Partnership with Health Care – Integrated, interdisciplinary and/or coordinated physical and mental health services, including co-location and/or collaboration between mental health and primary care providers, and/or other health care sites.

56 Delivered in Partnership with Social Services – Integrated, interdisciplinary and/or coordinated social services and mental health services, including co-location and/or collaboration between mental health and social services providers.

57 Delivered in Partnership with Substance Abuse Services – Integrated, interdisciplinary and/or coordinated substance use services and mental health services, including co-location and/or collaboration between mental health providers and agencies/providers of substance use services.

58 Integrated Services for Mental Health and Aging – Integrated, interdisciplinary and/or coordinated services for mental health and issues related to aging, including co-location and/or collaboration between mental health providers and agencies/providers of services specific to the aging (e.g., health, social, community service providers, etc.).

59 Integrated Services for Mental Health and Developmental Disability – Integrated, interdisciplinary and/or coordinated mental health services and services for developmental disabilities, including co-location and/or collaboration between mental health providers and agencies/providers of services specific to developmental disabilities.

60 Ethnic-Specific Service Strategy – Culturally appropriate services that reach and are tailored to persons of diverse cultures in order to eliminate disparities. Includes ethnic-specific strategies and community cultural practices such as traditional practitioners, natural healing practices, and ceremonies recognized by communities in place of, or in addition to, mainstream services.

61 Age-Specific Service Strategy – Age appropriate services that reach and are tailored to specific age groups in order to eliminate disparities. Age-specific strategies should promote a wellness philosophy including the concepts of both recovery and resiliency.

99 Unknown – Not known.

Referred by: Referring agency/or person.

Client Information:

Name: Client’s legal name.

Age/DOB: Write in the age of the client and their date of birth including month-day-year.

Preferred Name: Name client prefers to be addressed by.

Gender: Check appropriate gender.

Marital Status: Check current marital status from the following choices: Single, Married, Divorced, Partnered, or widowed.
Address: Where the client currently resides.

Phone: The client's phone number.

Emergency Contact/Name & Phone: Person the client would want to be contacted in case of an emergency and phone number.

Primary Language: The language the client speaks.

Other Languages spoken in the home: Any other languages that are used at the client's home.

Interpreter: Check if an interpreter was used.

Name of Interpreter: Name of person who provided interpreter services.

Language service provided in other than English: Indicate which language interpreter services were provided.

Entitlements: Check appropriate boxes regarding client's benefits.

Living Situation: Check appropriate boxes for the client's current living situation.

Support System Contacts: Name(s) of system of support persons who assist client.

Other Agencies Involved: Check boxes of other agencies who support the client.

MH Provider: Name of another provider(s) that the client is receiving services.

Presenting Problem: The current situation that prompts the person to seek help. Describe the current precipitating event, stressors, symptoms, current functional impairment, and other relevant information. May include recent history such as suicide attempts in the last year. This section should also include the referral source.

Family/Social History: Family history is crucially important since many mental health illnesses can be inherited genetically. Additionally, family interactions may affect the client's symptoms and illness. Include family of origin, education, work history, military history, history of trauma, marital or significant relationships, current family and children, current support system, income and living situation, health insurance.

Treatment History: Check boxes that apply. Previous outpatient mental health services, previous crisis contact without hospitalization within the past 6 months, previous psychiatric hospitalizations, previous Residential Treatment, previous Day Treatment/partial hospitalization program, or use of non-traditional or alternative healing practices.
Risk Assessment: Assessing danger to self, danger to others, or grave disability. Please ask about specified additional risk factors as listed on form.

Medical History: Because medical problems – including thyroid disease, head trauma, and brain infections – can cause psychological symptoms, a thorough medical history should be taken. Medical history should include current primary care provider, psychiatrist, last physical and dental exam, allergies, drug reactions, and pertinent childhood disease/injuries. Include severe injuries and chronic and acute illness. Current medications including current psych medications, over the counter, dosages, and who prescribed the medication should be recorded. Also note if the client is compliant with medications or if a referral for a health care provider for further evaluation is needed.

Criminal Justice History: Criminal Justice History may include incarceration, probation, parole, offenses, DUI, etc. Please list probation/parole officer contact information.

Substance Abuse History: This portion of the assessment details information on the client’s use of illicit drugs and nicotine and/or caffeine. The focus is usage (within the last 6 months or past), onset, amount and frequency of use, periods of abstinence and substance abuse treatment.

Mental Status: Begin by evaluating the person's:

General (appearance, attitude, behavior, speech): Well-groomed, adequately groomed, casually dressed, unkempt, disheveled, malodorous, emaciated, thin, average weight, overweight, obese. Speech: clear, coherent, incoherent, soft, loud, slow, rapid, monotone, pressured, slurred, difficult to understand, halting, mute. Alert, relaxed, cooperative, compliant, resistant, aggressive, belligerent, hostile, guarded, evasive, passive, inattentive, distracted, fearful, suspicious, hyper-vigilant, grandiose, entitled, impulsive, limit testing, combative, intoxicated.

Orientation: Person, day and date, place, purpose.

Mood (reported or observed)/Affect (visible emotions): Mood: Appropriate, euthymic, happy, elated, expansive, euphoric, dysphoric, sad, hopeless, despondent, irritable, angry, anxious, fearful. Affect: Appropriate, good or normal range, calm, stable, restricted, flat, blunted, animated, labile, tearful, agitated, incongruent, inappropriate.

Thought Process: Organized, concrete, linear, distorted, confused, disorganized, looseness of associations (LOA), circumstantial, rambling, tangential, word salad, internal preoccupation, thought blocking, racing thoughts, flight of ideas, obsessive rumination, thought broadcasting.

Memory/Thought Content: Memory: WNL, impaired, poor, excellent, poor short-term/long-term. Thought Content: normal/appropriate, no (overt) evidence of psychosis, paucity of content (impoverished), odd/idosyncratic/bizarre, paranoia, delusions (specify type), suicidal ideation (S/I) (Specify plan/intent), homicidal ideation (H/I) (Specify plan/intent), auditory hallucinations (A/H) (specify type), visual hallucination (V/H), ideas
of reference (IOR), somatic hallucinations, olfactory hallucinations, gustatory hallucinations, tactile hallucinations, flashbacks, dissociative episodes, derealization, depersonalization.

**Insight/Judgment:** Good, fair, poor, grossly impaired, impulsive, endangers self.

**Diagnostic Impression DSM IV:** All diagnoses must be made using the DSM IV-TR according to scope of practice. The person making the diagnosis must be documented in this section under "Diagnosis By."

**Functional Impairment:** Check degrees of functional impairment in all-important areas of life.

**Strengths:** Identify the person’s strengths which may include: abilities, talents, accomplishments, values, traditions, interests, hopes, aspirations, motivation, sense of humor, circumstances at home, school, work, etc.

**Treatment Plan:** Identify one or two goals and/or referrals made.

**Clinical Summary/Additional Comments:** Record any additional comments or additions from other sections of the assessment.

**Signature/License/Date:** The signature of the clinician providing the service with license or job title and date.

**Targeted Case Management (TCM):** Mark if client will receive TCM services, and fill in initial treatment goals and/or preliminary discharge plan.

**Co-Signature/License/Date:** Signature and date of licensed clinician, if applicable.

**Data Entry Clerk Initials:** The initials of the data entry clerk when service has been entered into the mental health database.
Initial Clinical Assessment for Adults

Billing Information

Program Name: ___________________________ RU: ___________ Date: ___________
Staff #: ___________________ Hours: _______ Mins: _______ Code Activity: [331 Assess] [580 Lockout]

Travel Time To/From included in above (if applicable) Hrs Mins

Location of Services: (Please check one)

☐ 1 Office ☐ 5 School ☐ 11 Faith-based ☐ 15 LicCommCareFac (Adult) ☐ 19 Res Tx Ctr (Child)
☐ 2 Field ☐ 8 Corr Fac ☐ 12 Healthcare ☐ 16 Mobile Service ☐ 20 TeleHealth
☐ 3 Phone ☐ 9 Inpatient ☐ 13 Age-spec Comm Ctr ☐ 17 NonTradSvcLoc ☐ 21 Unknown
☐ 4 Home ☐ 10 Homeless/Shelter ☐ 14 Client's Job-site ☐ 18 Other

Service Strategies: (Please check up to three, if applicable)

☐ 51 Psych Education ☐ 54 Ptnrshp: Law Enforc ☐ 57 Ptnrshp: Subs Abuse ☐ 60 Ethnic-Specific Service Strategy

Referred By: ____________________________

Identifying Information:

Legal Name: ___________________________ Age: _______ DOB: ____________
Preferred Name: _______________________

Gender: ☐ Male ☐ Female ☐ Transgender F-M ☐ Transgender M-F ☐ Intersex ☐ Other _______
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Widowed

Address: ____________________________________________________________

Phone #: ________________________________ Emergency Contact: ___________________________


Language:

Primary Language: ________________________ Other Languages spoken in home: ____________________________

☐ Interpreter Name of interpreter ____________________________

Language service provided in other than English. ☐ Spanish ☐ Other _______

Client Information:

Entitlements: ☐ M/C ☐ Medicare ☐ BHC ☐ Other Health Care Info _______________________
☐ No Health Insurance Coverage ☐ SSI ☐ SSDI Payee: ____________________________

Monthly Income: __________________________ Refer to a Financial Counselor? ☐ Yes ☐ No
Living Situation: ☐ Independent Living ☐ Immediate Family ☐ Extended Family ☐ Shared Housing
☐ Board & Care ☐ Residential Care Facility ☐ Homeless ☐ Other

Support System Contacts: ____________________________________________

Other Agencies Involved: ☐ CC Provider Network ☐ CFS/APS ☐ Voc Rehab ☐ Regional Center
☐ MHCC ☐ AOD ☐ Anka BHI ☐ Homeless Services
☐ Other ____________________________
Presenting Problem: (What is the primary reason for current referral? Describe current precipitating event, primary stressors, primary symptoms and functional impairment.)

Relevant Family/Social History: (Summarize relevant data regarding significant interpersonal relationships, including parents and marital status, children, siblings, living situations, education, work, history, military history, current support system, family history of mental illness or substance abuse and major traumatic events/losses, adverse childhood experiences.)
Medical History: □ Not available
Current Primary Medical Care Provider: ____________________________ □ None □ Unknown
Last Physical Exam: □ Within Past 12 months □ NOT Within Past 12 months □ Unknown
Last Dental Exam: □ Within Past 12 months □ NOT Within Past 12 months □ Unknown

Are there any health concerns (medical illness, medical symptoms)? □ No □ Yes (If so, please describe)

Has client had ANY allergic/serious reactions to medication(s)? □ No □ Yes (If yes, which medication(s)?)

Does client have any NON medication allergies (Food, pollen, bee strings, etc.)? □ No □ Yes (If so, please describe)

List name of any medication(s) client is taking at this time. (List all current medications including Psychiatric, OTC, herbal and homeopathic. Include Start date/Dose/Frequency.)

Compliance issues? □ No □ Yes (If so, please describe)

☐ Referral to Health Care Provider for Further Evaluation/Assessment
Treatment History: (Check all appropriate and comment below.)

☐ Yes  ☐ No  Previous outpatient mental health services? Where/When?  ☐ Transfer

☐ Obtain Release of Information for records from above (as needed)

☐ Yes  ☐ No  Previous crisis contact? Number of crisis unit visits without hospitalization in past 6 months  ☐ 0  ☐ 1  ☐ 2 or more  Most recent date:

☐ Yes  ☐ No  Previous psychiatric hospitalization(s)? #  Most recent date:

☐ Yes  ☐ No  Previous residential treatment?  Name of program:  Length of stay:

☐ Yes  ☐ No  Previous day treatment/partial hospitalization program?  Name of program:  Length of stay:

☐ Yes  ☐ No  Use of non-traditional or alternative healing practices (if yes, list):

Risk Assessment:
Danger to self (Intent, Plan Means):
Past:

Danger to others (Intent, Plan Means):
Past:

Grave Disability (Unable to make use of available Resources):

☐ 5150 Initiated  ☐ CPS Referral/Involvement  ☐ APS Referral  ☐ Tarasoff

Additional Risk Factors: (Check all that apply) Document details
☐ Family History of Suicide  ☐ Animal Cruelty
☐ History of Domestic Violence  ☐ Fire Setting
☐ Sexual Abuse  ☐ Emotional/Physical Neglect
☐ Adverse Childhood  ☐ Substance Abuse
☐ Trauma or Loss in Family  ☐ Self-Injurious Behavior
☐ Physical Abuse/Emotional Abuse  ☐ Access to Firearms (family, friends)
☐ Inappropriate Sexualized Behavior  ☐ Behavior Influences by Delusions or Hallucinations
☐ Impulsivity/Threatening Behavior  ☐ Severe Hopelessness
☐ Other

Comments:
Criminal Justice History:

☐ Probation  ☐ Parole

Probation/Parole Officer Contact: ________________________________ ☐ Obtain Release (ROI)

Offense History (include jail/prison facility): ________________________________

Substance Use:

During the past 6 months:
1. Have you ever used alcohol or drugs (such as wine, beer, hard liquor, pot, coke, heroin, or other opioids, uppers, downers, hallucinogens or inhalants)? ☐ Yes ☐ No

Check all substances that apply in the last 6 months:

<table>
<thead>
<tr>
<th>Substance</th>
<th>Frequency</th>
<th>Substance</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALCOHOL</td>
<td></td>
<td>DESIGNER DRUGS (GHB, PCP, Ecstasy)</td>
<td></td>
</tr>
<tr>
<td>AMPHETAMINE</td>
<td></td>
<td>INHALANTS (Paint, Gas, Aerosols)</td>
<td></td>
</tr>
<tr>
<td>COCAINE/CRACK</td>
<td></td>
<td>MARIJUANA</td>
<td></td>
</tr>
<tr>
<td>OPIATES (Heroin, Opium, Methadone)</td>
<td></td>
<td>TOBACCO</td>
<td></td>
</tr>
<tr>
<td>HALLUCINOGENS (LSD, Mushrooms, Peyote)</td>
<td></td>
<td>CAFFEINE (Energy Drinks, Sodas, Coffee, etc.)</td>
<td></td>
</tr>
<tr>
<td>PAIN KILLERS (Oxyc, Norco, Vicodin)</td>
<td></td>
<td>OVER THE COUNTER</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Has alcohol or drugs ever been a problem in your life? ☐ Yes ☐ No (If no, skip questions 2 – 9)

Frequency of use ________________________________

2. Have you felt that you use too much alcohol or drugs? ☐ Yes ☐ No

3. Have you tried to cut down or quit drinking or using alcohol or drugs? ☐ Yes ☐ No

4. Have you gone to anyone for help because of your drinking or drug use (such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program)? ☐ Yes ☐ No

5. Have you had any of the following due to substance use?

☐ Had blackouts or other periods or memory loss? ☐ Felt sick, shaky, or depressed?

☐ Injured your head after drinking or using drugs? ☐ Felt "coke bugs" or a crawling feeling under the skin?

☐ Had convulsions or delirium tremens ("DTs")? ☐ Been injured after drinking or using drugs?

☐ Had Hepatitis or other liver problems? ☐ Used needles to shoot drugs?

6. Has drinking or drug use caused problems between you and your family or friends? ☐ Yes ☐ No

7. Has your drinking or drug use caused problems at school or at work? ☐ Yes ☐ No

8. Have you been arrested or had other legal problems due to substance use (such as bouncing bad checks, driving while intoxicated, theft, or drug possession)? ☐ Yes ☐ No

Describe:
9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs?  □ Yes □ No

10. Are you needing to drink more and more to get the effect you want?  □ Yes □ No

11. Do you spend a lot of time thinking or trying to get the effect you want?  □ Yes □ No

12. When drinking or using drugs, are you more likely to do something you wouldn’t normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?  □ Yes □ No

13. Do you feel bad or guilty about your drinking or drug use?  □ Yes □ No

14. Have any of your family members ever had a drinking or drug problem?  □ Yes □ No

15. Do you feel that you have a drinking or drug problem now?  □ Yes □ No

16. What contributing factors/triggers do you have to drug/alcohol abuse?

17. Clean & Sober  ____ Month(s)  ____ Year(s)
   What has been most helpful to you in maintaining sobriety?

18. Are you currently or ever been in recovery?

19. What recovery models have you used?

Comments:
Mental Status:

General (Appearance, attitude, behavior, speech):

Orientation:

Mood/Affect:

Thought Process:

Memory/Thought Content:

Insight/Judgment/Impulsivity:

Additional Observation:

Diagnostic Impression: DSM Code and Narrative – Designate diagnosis which is primary focus of treatment with a “P”

Axis I _______ P

Axis I _______ S

Axis I _______

Axis II _______ P/S

Axis III _______________________________ By History, check if None □

Axis IV CONTRIBUTING STRESSORS – Problems related to:

☐ A – Primary Support ☐ B – Social Environment ☐ C – Education ☐ D – Occupation

☐ E – Housing ☐ F – Economic ☐ G – Access to Health Care ☐ H – Legal System

☐ I – Other

Axis V CURRENT GAF: ________________ HIGHEST GAF PAST YEAR: ________________

DSM Diagnosis by: ________________________________ Name of Licensed Clinician

FUNCTIONAL IMPAIRMENT: (IF MODERATE OR ABOVE, MAY WARRANT TARGETED CASE MANAGEMENT)

<table>
<thead>
<tr>
<th>None</th>
<th>Mild</th>
<th>Mod</th>
<th>Severe</th>
<th>None</th>
<th>Mild</th>
<th>Mod</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Relations</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Social Relations</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Employment/School Performance</td>
<td>☐</td>
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<td>☐</td>
<td>☐</td>
<td>Physical Health</td>
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<tr>
<td>Recreational/Leisure Activities</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Substance Abuse</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Food/Shelter</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Activities of Daily Living</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Initial Treatment Plan (e.g. MHS, Medication Support, Day Treatment, etc.):

Clinical Summary / Additional Comments:

TARGETED CASE MANAGEMENT (TCM):
Does client warrant the consideration for TCM? (May include moderate or above Functional Impairment and/or risk of losing placement/housing, needed for financial support, social support, prevocational/employment assistance, rehabilitation, or other programs or services considered as necessary.)  ☐ No  ☐ Yes

TCM Initial Treatment Plan (e.g. Referrals to medical services, AOD, Voc, Social Security, community agencies, etc.):

Preliminary Discharge Plan:

Staff Signature/License  Printed Name  Date

Co-Signature of Licensed Clinician  Date

Data Entry Clerk Initials
ASSESSMENT OF STRENGTHS

Check all that apply:

☐ Optimism / Hope
☐ Sense of Meaning
☐ Faith / Spirituality
☐ Empathy
☐ Compassion
☐ Resourcefulness
☐ Academic Accomplishments
☐ Daily Living Skills
☐ Flexibility
☐ Sense of Humor
☐ Support Relationship
☐ Friendships
☐ Open to Change
☐ Exercises Regularly
☐ Nutritional Awareness
☐ Understands Mental Illness / Needs
☐ Participates in 12 Step Program

☐ Participates in Self-Help Groups
☐ Able to voice Mental Health / Life needs
☐ Wellness Recovery Action Plan
☐ Able to Recognize Mental Health / Life Choices
☐ Hobbies / Special Interests
☐ Goal-Directed / Motivated
☐ Stable Family Life
☐ Communication
☐ Sense of Empowerment
☐ Work History
☐ Employment Skills
☐ Living Environment
☐ Positive Self Identity
☐ Cultural Identity / Integration
☐ Resilience
☐ Planning
☐ Other ____________________

Completed by: ☐ Therapist ☐ Consumer
**Adult Annual Clinical Update**

**Billing Information**

**Program Name:**

**RU:**

**Date:**

**Staff #:**

**Hours:**

**Mins:**

**Code Activity:**

- [ ] 331 Assessment
- [ ] 580 Lockout

**Travel Time To/From included in above (if applicable) Hrs _____ Mins _____

**Location of Services:** (Please check one)

- [ ] 1 Office
- [ ] 2 Field
- [ ] 3 Phone
- [ ] 4 Home
- [ ] 5 School
- [ ] 6 Cor Fac
- [ ] 9 Inpatient
- [ ] 10 Homeless/Shelter
- [ ] 11 Faith-based
- [ ] 12 Healthcare
- [ ] 13 Age-spec Comm Ctr
- [ ] 14 Client’s Job-site
- [ ] 15 LicCommCareFac (Adult)
- [ ] 16 Mobile Service
- [ ] 17 NonTradSvcLoc
- [ ] 18 Other
- [ ] 19 Flex Tx Ctr (Child)
- [ ] 20 TeleHealth
- [ ] 21 Unknown

**Service Strategies:** (Please check up to three, if applicable)

- [ ] 50 Peer/Fam Deliv Svcs
- [ ] 51 Psych Education
- [ ] 52 Family Support
- [ ] 53 Supportive Education
- [ ] 54 Prtnship: Law Enfrcmt
- [ ] 55 Prtnship: Health Care
- [ ] 56 Prtnship: Soc Svcs
- [ ] 57 Prtnship: Subs Abuse
- [ ] 58 IntSvcs: MH / Aging
- [ ] 59 Integrated Svcs: MH-Dvlp Disabled
- [ ] 60 Ethnic-Specific Service Strategy
- [ ] 61 Age-Spec Svc Strategy
- [ ] 99 Unknown

**Interpreter Name of Interpreter:**

**Language service provided in other than English:**

- [ ] Spanish
- [ ] Other

**Identifying Information:**

**Name:**

**Age:**

**DOB:**

**Address:**

**Phone:**

**Mental Status:**

- [ ] S
- [ ] M
- [ ] D
- [ ] P

**Emergency Contact/Name & Phone:**

**MH Provider:**

**Current Mental Health Functioning:** (Include current symptoms, improvements in functioning, on-going functional impairments, hospitalizations and other pertinent changes in past year.)

**Strengths:**

---

MHC102 (Revised 9/13) Adult Annual Clinical Update   Page 1 of 4
**Family/Social/Economic Update:** (Include living situation, income, socialization, work or educational activity, judicial involvement, support system and any changes in life circumstances.)

---

**Functional Impairment:** (IF MODERATE OR ABOVE, MAY WARRANT TARGETED CASE MANAGEMENT)

<table>
<thead>
<tr>
<th>Family Relations</th>
<th>None</th>
<th>Mild</th>
<th>Mod</th>
<th>Severe</th>
<th>Social Relations</th>
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<td></td>
<td></td>
<td>Activities of Daily Living</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Medical History:**

- **Primary Care Provider:** ____________________________  **Last Physical Exam:** ____________________________  **Last Dental Exam:** ____________________________
- **Psychiatrist:** ____________________________  **Location:** ____________________________
- **List all Medical Conditions:** ____________________________

---

- **Allergies/Drug Reactions:** ____________________________
- **Med Compliant?**  ☐ Yes  ☐ No  ☐ Unknown
  
  List name of medication(s) client is taking at this time.
  (List all current meds including OTC, herbal, and homeopathic. Include start date/dose/frequency.)

---

**Substance Use:**

- ☐ No Past Substance Abuse  ☐ Actively Using Substances  ☐ Currently Clean & Sober for: ____________________________

Please list all substance being used or list current treatment interventions.

---

MHC102 (Revised 9/13) Adult Annual Clinical Update  Page 2 of 4
Risk Assessment:

Danger to Self (Intent, Plan, Means):

Past:

Danger to others: (Intent, Plan, Means):

Past:

Grave Disability (unable to make use of available resources):

☐ 5150 Initiated  ☐ CPS Referral  ☐ APS Referral  ☐ Tarasoff  ☐ Arrests/Incarcerations in last 12 months

Additional Risk Factors: (Check all that apply.) Document details.

☐ Physical Abuse/Emotional Abuse  ☐ Sexual Abuse  ☐ Self-Injurious Behavior
☐ Family History of Suicide  ☐ Animal Cruelty  ☐ Trauma or Loss in Family
☐ Assaultive Behavior  ☐ Fire Setting  ☐ Access to Firearms (family, friends)
☐ Inappropriate Sexualized Behavior  ☐ Emotional/Physical Neglect  ☐ Behavior Influenced by Delusions or Hallucinations
☐ History of Domestic Violence  ☐ Adverse Childhood Experience  ☐ Severe Hopelessness
☐ Impulsivity/Threatening Behavior  ☐ Substance Abuse  ☐ Other

Comments:

Mental Status:

General (Appearance, attitude, behavior, speech) :

Orientation :

Mood/Affect :

Thought Process :

Memory/Thought Content :

Insight/ Judgment/ Impulsivity :

Additional Observation :

Diagnostic Impression: DSM Code and Narrative – Designate diagnosis which is primary focus of treatment with a “P”

Axis I

Axis I

Axis I

Axis II P/S

Axis III

By History, check if None ☐

Axis IV CONTRIBUTING STRESSORS – Problems related to:

☐ A – Primary Support  ☐ B - Social Environment  ☐ C - Education  ☐ D - Occupation
☐ E – Housing  ☐ F - Economic  ☐ G – Access to Health Care  ☐ H - Occupation
☐ I - Other

Axis V Current GAF: HIGHEST GAF PAST YEAR:

DSM Diagnosis by: Name of Licensed Clinician
Targeted Case Management (TCM):

Does client warrant the consideration for TCM? (May include moderate or above Functional Impairment and/or risk of losing placement/housing, needed for financial support, social support, prevocational/employment assistance, rehabilitation, or other programs or services considered as necessary.) □ Yes □ No

Clinical Summary / TCM (Linkage/Referrals) / Justification for Continued Care Services

Discharge Plan Update: (Clinical Presentation)

Staff Signature/License

Printed Name

Date

Co-Signature of Licensed Clinician

Date

Data Entry Clerk Initials

MHC 102 (9/13) Adult Annual Clinical Update
Page 4 of 4
CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) ASSESSMENT

In 2013, CCMHP provided initial training for the CANS to clinicians who work with children and youth. Following that training, CCMHP is in the process of including the CANS within the Children and Adolescent assessment and annual update forms. These are not ready for release, however, will be sent out to all staff upon its completion. Additional training and introductions will also be provided at each region’s children’s clinic’s.
INSTRUCTIONS FOR COMPLETING THE INITIAL CLINICAL ASSESSMENT FOR CHILDREN FORM

Name: Name of the client.

MRN: Client’s Medical Record Number.

Program Name: Name of the program providing the assessment.

RU: Reporting Unit of the program completing the form.

Date: The date the service was provided.

Staff #: Staff number of the clinician providing the service.

Hours/Mins: Time the clinician spent providing the service including time and travel time.

Code Activity: Check evaluation, assessment, or lockout.

Travel Time To/From: The amount of time spent traveling to provide a reimbursable service.

Location of Services (Please check one): Identifies the location where the service was rendered. New CSI requirements have expanded the place of service. Circle the appropriate place of service. The choices are:

1 Office – Services provided in the office where the mental health professional routinely provides services.

2 Field – When location is away from the clinician’s usual place of business. Use only when no other specific non-office location is applicable.

3 Phone – Services provided by telephone contact with the consumer.

4 Home – Services provided at a location, other than a hospital or other facility, where the consumer lives.

5 School – Services provided in any facility that has the primary purpose of education.

8 Correctional Facility – Services provided in a correctional facility (e.g. Jail, Prison, Camp/Ranch, etc.) including adult or juvenile detention facilities.

9 Inpatient – Services are provided in a Hospitals, Psychiatric Health Facilities (PHFs), Skilled Nursing Facilities (SNFs), Institutes for Mental Disease (IMDs), Mental Health Rehabilitation Centers (MHRCs),

10 Homeless/Emergency Shelter – Services provided in a facility specifically designed to provide shelter to the general homeless population.
11 Faith-based – Services provided in a location owned or leased by a faith group, with partial or full involvement of the faith group (e.g. church, temple, etc.).

12 Health Care/Primary Care – Services provided in the clinic or facility of the health care provider, including emergency rooms and public health clinics.

13 Age-Specific Community Center – Services provided in a location owned or leased by an age-specific community center, such as a senior’s center, a teen drop in center, etc.

14 Client’s Job Site – Services provided at the consumer’s site of employment.

15 Licensed Community Care Facility – Adults – Services provided in a location supplying 24 hour non-medical care for adults

16 Mobile Services – This definition is consistent with the concept of a Mobile Clinic. Mobile clinics provide services to individuals in rural or outlying areas where services are otherwise inaccessible. The concept of mobile services is in contrast to services provided at other community locations that are reached by vehicle.

17 Non-Traditional Service Location – Services provided in the community, but not in a community center, school, faith-based location, homeless/emergency shelter, health-care center, or the consumer’s job site. Examples include park bench, on the street under a bridge, in an abandoned building, etc.

18 Other Community Location – Services provided in the community, but not listed above.

19 Residential Treatment Center – Children – Services provided in a location supplying 24-hour non-medical care for children, other than inpatient hospital, or Psychiatric Health Facilities (PHFs). Includes Community Treatment Facilities (CTFs) and family foster homes.

20 Telehealth – Also known as “Telemedicine.” Services are provided so that the clinician and consumer are in two different locations but can see each other via visual equipment (e.g., video, camera, web camera).

21 Unknown – Not Reported.

Service Strategies: Circle up to three service strategies, if applicable. The following are definitions for Service Strategies:

50 Peer and/or Family Delivered Services – Services and supports provided by consumers and family members who have been hired as treatment program staff, or who provide adjunct supportive or administrative services, such as training, information dissemination and referral, support groups and self-help support and empowerment. Please note that if the service/support is to be reimbursed by Medi-Cal, consumer and staff duties must meet Medi-Cal reimbursement requirements.

51 Psycho-education – Services that provide education about mental health diagnosis and assessment, medications, services and support planning,
treatment modalities, other information related to mental health services and needs.

52 Family Support – Services provided to a consumer's family member(s) in order to help support the consumer.

53 Supportive Education – Services that support the consumer toward achieving educational goals with the ultimate aim of productive work and self-support.

54 Delivered in Partnership with Law Enforcement – Services that are integrated, interdisciplinary and/or coordinated with law enforcement, probation or courts (e.g., mental health courts, jail diversion programs, etc.) for the purpose of providing alternatives to incarceration/detention for those with mental illness/emotional disturbance and criminal justice system involvement.

55 Delivered in Partnership with Health Care – Integrated, interdisciplinary and/or coordinated physical and mental health services, including co-location and/or collaboration between mental health and primary care providers, and/or other health care sites.

56 Delivered in Partnership with Social Services – Integrated, interdisciplinary and/or coordinated social services and mental health services, including co-location and/or collaboration between mental health and social services providers.

57 Delivered in Partnership with Substance Abuse Services – Integrated, interdisciplinary and/or coordinated substance use services and mental health services, including co-location and/or collaboration between mental health providers and agencies/providers of substance use services.

58 Integrated Services for Mental Health and Aging – Integrated, interdisciplinary and/or coordinated services for mental health and issues related to aging, including co-location and/or collaboration between mental health providers and agencies/providers of services specific to the aging (e.g., health, social, community service providers, etc.).

59 Integrated Services for Mental Health and Developmental Disability – Integrated, interdisciplinary and/or coordinated mental health services and services for developmental disabilities, including co-location and/or collaboration between mental health providers and agencies/providers of services specific to developmental disabilities.

60 Ethnic-Specific Service Strategy – Culturally appropriate services that reach and are tailored to persons of diverse cultures in order to eliminate disparities. Includes ethnic-specific strategies and community cultural practices such as traditional practitioners, natural healing practices, and ceremonies recognized by communities in place of, or in addition to, mainstream services.

61 Age-Specific Service Strategy – Age appropriate services that reach and are tailored to specific age groups in order to eliminate disparities. Age-specific strategies should promote a wellness philosophy including the concepts of both recovery and resiliency.

99 Unknown – Not known.
Identifying Information:

Name: Name of client.

Male/Female: Check appropriate gender.

Age/DOB: Write in the age of the client and their date of birth including month-day-year.

Address: Where the client currently resides.

Phone: The client’s phone number.

Referred By: Describe who or how client was referred to mental health program.

Language:

Child’s Primary Language: The language the client speaks.

Parent’s Primary Language: The language the parent’s speak.

Other Languages Spoken in Home: Write any other languages spoken in the home.

Interpreter/Name of Interpreter: Check if an interpreter was used for this visit and write in the name of the interpreter.

Language service provided in other than English: Check “Spanish” box if the service was provided in Spanish. Check “Other” if the service was provided in a language other than English or Spanish and write in the language.

Presenting Problem: The current situation that prompts the person to seek help. Include description and timelines of current emotional and behavioral symptoms and current functional impairment. Describe relevant stressors.

Client Information:

Lives With: Check the current living situation. If “Other”, explain.

Residential Contact: Name and phone number.

Others in Home/Ages/Relationship to Child: List all in residence, their ages, and relationship to the client.

Composition of Family of Origin: If different from above describe.
Current Legal Status: Check appropriate.

Agencies/Other MH Providers Involved: Check all that apply and include names and phone numbers.

Developmental History: If birth and developmental history not available, check box. Otherwise continue. Answer all questions. If an answer is yes, describe. For Developmental Milestones, if “Delayed”, describe.

Family/Social History: Family history is crucially important since many mental health illnesses can be inherited genetically. Additionally, family interactions may affect the client’s symptoms and illness. Summarize relevant data regarding significant interpersonal relationships, including parents and siblings, living situations, family history of mental illness or substance abuse; and major traumatic events or losses.

Medical History: A thorough medical history should be taken. However, if information regarding a medical history is not available, check the box. Medical history includes current primary care provider, last physical and dental exam, health concerns, allergies, drug reactions, and pertinent childhood disease/injuries. Current medications including current psych medications, over the counter, dosages, and who prescribed the medication should be recorded. Also note if the client is compliant with medications.

Substance Abuse History: This portion of the assessment details information on the client’s use of illicit drugs, alcohol, nicotine and/or caffeine. The focus is usage (current or past), onset, amount and frequency of use.

Treatment History: Check all appropriate boxes and make comments if fitting.

Risk History: Elaborate on risk history, as appropriate. Check all that apply and answer questions.

Child’s Education History: Write in current school, grade and contact. List strengths, challenges, previous schools, and answer all questions.

Behavior and Social Relationships: Describe problems with peers, teachers, and authorities, if applicable. Describe extracurricular interests and activities.

Child & Family Strengths: List the client and family strengths which may include skills, positive experiences, attributes, talents, accomplishments, values, traditions, interests, hopes, aspirations, motivation, sense of humor, circumstances at home, school, work, etc.

Mental Status: Check and/or describe if abnormal or impaired. All sections must be filled out. Assessment is not complete until a face-to-face meeting with the child or adolescent occurs.
Risk Assessment/Report Filed: Check as appropriate.

Diagnostic Impression: All diagnoses must be made using the DSM IV-TR according to scope of practice. The person making the diagnosis must be documented in this section under “Diagnosis By”, and must be a licensed professional.

Functional Impairment: Check degrees of functional impairment in listed areas of life. All areas must be filled out.

Targeted Symptoms: Check degrees of targeted symptoms.

Initial Treatment Plan: Identify one or two goals and/or referrals made. If Partnership Plan is done on the same day as assessment, plan may be referenced in this section, eg. “See Plan dated ...”.

Additional Comments: Record any additional comments or additions from other sections of the assessment.

Signature/License/Date: The signature of the clinician providing the service with license or job title and date.

Co-Signature/License/Date: Signature and date of licensed clinician, if applicable.

Data Entry Clerk Initials: The initials of the data entry clerk when service has been entered into the mental health database.
Initial Clinical Assessment for Children

NAME / MRN

Program Name: ___________________________ RU: _____________ Date _____________

Staff #: ___________________ Hours: ________ Mins: ________ Code Activity: □ 313 Eval □ 331 Assess □ 580 Lockout

Travel Time To/From included in above (if applicable) Hrs ______ Mins ______

Location of Services: (Please check one)
[ ] 1 Office  [ ] 4 Home  [ ] 8 Inpatient  [ ] 12 Healthcare  [ ] 15 LicCommCareFac (Adult)  [ ] 18 Other
[ ] 2 Field  [ ] 6 School  [ ] 10 Homeless/Shelter  [ ] 13 AgeSpcCommCtr  [ ] 16 Mobile Service  [ ] 19 Res Tx Ctr (Child)
[ ] 3 Phone  [ ] 8 CorFac  [ ] 11 Faith-based  [ ] 14 Client Job-site  [ ] 17 NonTradSvcLoc  [ ] 20 Telehealth  [ ] 21 Unknown

Service Strategies: (Please check up to three, if applicable)
[ ] 50 Peer/Fam Delv Svcs  [ ] 53 Supportive Education  [ ] 56 Ptnrsp: Soc Svcs  [ ] 59 Integrated Svcs: Mhl-Dvlp Disabled
[ ] 51 Psych Education  [ ] 54 Ptnrsp: Law Enfrcmt  [ ] 57 Ptnrsp: Subs Abuse  [ ] 60 Ethnic-Specific Service Strategy
[ ] 52 Family Support  [ ] 55 Ptnrsp: Health Care  [ ] 58 IntSvcs: Mhl/Aging  [ ] 61 AgeSpcSvcStrgy  [ ] 99 Unknown

Identifying Information:

Name: ________________________________________  [ ] Male  [ ] Female  Age/DOB: _____________

Address: ____________________________________________

Phone: ____________________________________________

Referred By: ____________________________________________

Language:

Child's Primary Language: ___________________________  Parent's Primary Language: ___________________________

Other Languages: ____________________________________________

[ ] Interpreter  Name of Interpreter

Language service provided in other than English:  [ ] Spanish  [ ] Other: ___________________________

Presenting Problem: (What is the primary reason for current referral. Include description and timelines of current emotional and behavioral symptoms & current functional impairment. Describe relevant stressors.)

______________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
Client Information:

□ Acute Hospital □ Group Homes □ Emergency Foster Care □ Residential □ Other

Residential Contact (Name & Phone):

Others in Home/Ages/Relationship to Child:

Composition of Family of Origin: (If different from above)

Current Legal Status:
□ Independent Adult or Child in custody of Biological Parent(s), Adoptive Parent(s), or Legal Guardian(s)
□ Emancipated Minor □ Juv Dependent of Court (DCFS 300) □ Juvenile Ward (Probation 602)
□ Other

Agencies/Other MH Providers Involved: (Check all that apply. Include contact names & phone numbers as appropriate.)
□ CC Mental Health/AB3632 □ CFS □ Aid to Adoptive Parents □ SSI/SSDI
□ Outside Therapists □ Special Ed □ Regional Center □ Probation □ Other

Developmental History:
□ Birth and Developmental History is not available. Birth was: □ On-Time □ Early (<36 weeks) □ Late

While pregnant, did mother have any injuries, illnesses, physical traumas or use alcohol or drugs? □ No □ Yes

Were there any complications at time of birth? □ No □ Yes

Did the child experience any traumas during first 5 years □ No □ Yes

Did the child have any sleep, eating or social problems the first 5 years? □ No □ Yes

If "Yes" to any of the above, please describe:

Developmental Milestones: □ Early □ On Time □ Delayed (if Delayed, please describe):

Family/Social History: (Summarize relevant data regarding significant interpersonal relationships, including parents and siblings; living situations; family history of mental illness or substance abuse; and major traumatic events/losses):

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________
Medical History: ☐ Not Available

Current Primary Medical Care Provider: _______________________________ ☐ None   ☐ Unknown

Last Physical Exam: ☐ Within Past 12 months ☐ NOT Within Past 12 months ☐ Unknown
Last Dental Exam: ☐ Within Past 12 months ☐ NOT Within Past 12 months ☐ Unknown

Are there any health concerns (medical illness, medical symptoms) regarding this child? ☐ No   ☐ Yes (If so, please describe):

Has child had ANY allergic/serious reactions to medication(s)? ☐ No   ☐ Yes (Which medication(s)?

Please describe reaction(s):

Does child have any NON medication allergies (Food, pollen, bee stings, etc)? ☐ No   ☐ Yes (If so, please describe):

List name of any medication(s) child is taking at this time: (List all current medications including OTC, herbal and homeopathic):

Compliance Issues? ☐ No   ☐ Yes (If so, please describe):

Has child had any of the following problems/experiences? (Check all that apply):

☐ Asthma   ☐ Hearing or Vision Problem   ☐ Sexually Transmitted Disease (STD)
☐ Broken Bone(s)   ☐ Heart Problem   ☐ Sleep Problem
☐ Concentration Problem   ☐ High or Low Blood Pressure   ☐ Speech or Language Problem
☐ Convulsion or Seizure   ☐ Immune System Problem   ☐ Surgery of any kind
☐ Diabetes   ☐ Liver Problems or Hepatitis   ☐ Thyroid Problem
☐ Eating or Appetite Problem   ☐ Memory or Thought Problem   ☐ Tuberculosis (TB)
☐ Energy or Motivation Problem   ☐ Motor or Movement Problem   ☐ Urinary Tract or Kidney Problem
☐ Exposure to Toxic Lead Levels   ☐ Pregnancy   ☐ Weight Gain or Loss
☐ Head Injury, Significant   ☐ Serious Rash or Other Skin Problem   ☐ Other Medical Problem:

Please describe any checked items:

<table>
<thead>
<tr>
<th>Substance Use History: (Check all appropriate)</th>
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<tbody>
<tr>
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<tr>
<td>Alcohol</td>
</tr>
<tr>
<td>Cocaine</td>
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<tr>
<td>Opiates</td>
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<tr>
<td>Sedatives</td>
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<tr>
<td>Other:</td>
</tr>
</tbody>
</table>

MHC033(Rev. 1/08)   Page 3 of 6   Initial Clinical Assessment for Children
Treatment History: (Check all appropriate and comment below)

☐ Psych Hospitalization  ☐ Psych Medication  ☐ Residential Treatment  ☐ Day Treatment
☐ Substance Abuse Program  ☐ Psychotherapy  ☐ Testing- Psychological/Neurological/Educational

Comments on above History:


Risk History: (Check all that apply)

☐ Physical Abuse  ☐ Suicide Ideation
☐ Suicide Attempt  ☐ Self-injurious Behavior
☐ Assaultive Behavior  ☐ Trauma or Loss in Family
☐ Inappropriate Sexualized Behavior  ☐ Witness to Community Violence
☐ Witness to Domestic Violence  ☐ Behavior influenced by Delusions or Hallucinations
☐ Extended Truancy or Runaway  ☐ Threat of, or Recent Removal from, Home Placement
☐ Sexual Abuse  ☐ Other


How are arguments handled in the family?

Is there any pushing/shoving/hitting/name calling/threats?

Child’s Education History

Current School: ____________________________ Grade: __________ Contact: ____________________________

School Performance – In and Out of Classroom

Usual Grades: ☐ Exceptional  ☐ Above Average  ☐ Average  ☐ Below Average  ☐ Failing

Academic Strengths:

Academic Challenges:

Names of previous schools:

Has child been held back a grade? ☐ No  ☐ Yes  If Yes, Year(s)____________________

Has child ever been expelled from school? ☐ No  ☐ Yes  If Yes, Year(s)____________________

If child was ever held back or expelled, please explain: ______________________________________

Has child ever been considered for Special Education? ☐ No  ☐ Yes

Has child ever qualified for Special Education? ☐ No  ☐ Yes  If Yes, Grade ______

Is child receiving Special Education services now? ☐ No  ☐ Yes  If Yes, please describe ______________

School Attendance: Current (or Most Recent) School Year:

Absent due to Illness: ☐ Never  ☐ Seldom  ☐ Frequently

Absent due to Truancy: ☐ Never  ☐ Seldom  ☐ Frequently

Absent due to Suspension: ☐ Never  ☐ Seldom  ☐ Frequently

Has child been referred to SARB? ☐ No  ☐ Yes

MHC033(Rev. 1/08)  Page 4 of 6  Initial Clinical Assessment for Children
**Behavior and Social Relationships:**

Has child had problems with peers?  □ No  □ Yes
Has child had problems with teachers/authorities?  □ No  □ Yes
If yes, please describe: ____________________________________________________________

Extracurricular Interests/Activities: (e.g. Work, clubs, church groups, arts, music, sports, exercise) ____________________________________________________________

**Child & Family Strengths**

________________________________________________________________________

**Mental Status:** (Check and/or describe if abnormal or impaired)

<table>
<thead>
<tr>
<th>Category</th>
<th>Unremarkable</th>
<th>Remarkable for:</th>
<th>Inattentive</th>
<th>Avoidant</th>
<th>Hostile</th>
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<td>Appearance/Grooming</td>
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<td>Mood/Affect</td>
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<td>Thought Processes</td>
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<tr>
<td>Insight/Judgment</td>
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</table>

Additional Observations: ____________________________________________________________

**Risk Assessment:**

□ None Identified  □ Danger to Self  □ Danger to Others  □ Inability to Care for Self

**Report Filed:**

□ CPS  □ APS  □ DUTY TO WARN  □ Weapons Confiscated
Diagnostic Impression: DSM Code and Narrative - Designate primary diagnosis with a “P”

Axis I

Axis II

Axis III

Axis IV  CONTRIBUTING STRESSORS - Problems related to:
- A - Primary Support
- B - Social Environment
- C - Education (O-Occupation)
- D - Housing
- F - Economic
- G - Access to Health Care
- H - Legal System
- I - Other

Axis V  CURRENT GAF:_________  HIGHEST GAF PAST YEAR:_________

DSM Diagnosis by: ____________________________  
(Name of Licensed Clinician)

FUNCTIONAL IMPAIRMENT:

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<tr>
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<th>Mod</th>
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<tr>
<td>Family Relations</td>
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<tr>
<td>Substance Abuse</td>
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TARGETED SYMPTOMS:

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<tr>
<td>Other</td>
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Initial Treatment Plan:

________________________________________________________________________
________________________________________________________________________

Additional Comments:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Staff Signature/License Date

Co-Signature of Licensed Clinician Date

Data Entry Clerk Initials
Annual Clinical Update for Children

NAME / MRN

Program Name: ___________________________ RU: ___________ Date ___________

Staff #: ___________ Hours: _______ Mins: _______ Code Activity: □ 313 Eval □ 331 Assess □ 580 Lockout

Travel Time To/From included in above (if applicable) Hrs _______ Mins _______

Location of Services: (Please check one)

□ 1 Office □ 4 Home □ 9 Inpatient □ 12 Healthcare □ 15 LicCommCareFac (Adult) □ 18 Other
□ 2 Field □ 5 School □ 10 Homeless/Shelter □ 13 AgeSpcCommCtr □ 16 Mobile Service □ 19 Res Tx Ctr (Child)
□ 3 Phone □ 8 CorrFac □ 11 Faith-based □ 14 Client Job-site □ 17 NonTradSvcsLoc □ 20 Telehealth □ 21 Unknown

Service Strategies: (Please check up to three, if applicable)

□ 50 Peer/Fam Deliv Svcs □ 53 Supportive Education □ 56 Ptnrshp: Soc Svcs □ 59 Integrated Svcs: MHL-Dvlp Disabled
□ 51 Psych Education □ 54 Ptnrshp: Law Enfctm □ 57 Ptnrshp: Subs Abuse □ 60 Ethnic-Specific Service Strategy
□ 52 Family Support □ 55 Ptnrshp: Health Care □ 58 IntSvcs: MHL/Aging □ 61 AgeSpcSvcStrtgy □ 99 Unknown

Synopsis of Interim History: (Describe consumer/family accomplishments, improvements and strengths. Describe continuing needs and challenges in the areas of clinical symptoms, functional status and life circumstances.)

Educational and Medical Update:

Highest grade completed: ___________ Current School: ___________

Last Physical Exam: □ Within past 12 months □ NOT Within past 12 months □ Unknown
Last Dental Exam: □ Within past 12 months □ NOT Within past 12 months □ Unknown

Allergy Assessment: (Allergen:Reaction) □ NKA

Current Medications: (Include psychotropic, non-psychiatric, OTC, herbal and homeopathic remedies)
Update of Assessment Data:

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<td>Educational History</td>
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(See current Episode Opening Form)

[Change detailed below]

Diagnostic Impression: DSM Code and Narrative (Primary diagnosis must be congruent with diagnosis on face sheet. Please make changes as needed. Designate Primary diagnosis with a "P").

Axis I

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Axis II

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Axis III

Check if None □

Axis IV CONTRIBUTING STRESSORS – Problems related to:

- [ ] A – Primary Support
- [ ] B – Social Environment
- [ ] C – Education (O-Occupation)
- [ ] E – Housing
- [ ] F – Economic
- [ ] G – Access to Health Care
- [ ] H – Legal System
- [ ] I – Other

Axis V CURRENT GAF: ____________ HIGHEST GAF PAST YEAR: ____________

DSM Diagnosis by: ________________________ (Name of Licensed Clinician)

FUNCTIONAL IMPAIRMENT:

<table>
<thead>
<tr>
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</table>

Perceptual Disturbance
Oppositional/Conduct
Destructive/Assaultive
Mania/Agitation/Lability
Somatic Disturbance
Other

ADDitionAL COMMENTS:

Staff Signature/License Date Co-Signature of Licensed Clinician Date

Print Name

Data Entry Clerk Initials (Verify Primary diagnosis & enter into PSP if changed)
Psychiatric Assessment
(Physicians and RNs)
Adult & Children's Services

The Psychiatric Assessment completed by Physicians and RNs was developed for clients that are receiving medication support services.

NOTE: Please refer to Policy 706, Quality Management/Utilization Review: Documentation Standards regarding this exception below.

Each client receiving medication only support services, where there is no case manager involved must have an Initial Psychiatric Assessment completed within 60 days of the episode opening. For clients receiving medication support services only, the requirement for an annual reassessment using the Psychiatric Assessment Update is waived, but should be done in keeping with best practice under the guidance of the Medical Director. Documentation of medical necessity for ongoing medication services needs to be maintained in the progress notes. All physicians must continue to complete an annual Partnership Plan (see Section 5, Partnership Plan for Wellness – MDs and RNs).

Both the Initial Psychiatric Assessment and Psychiatric Assessment Update are under the 3rd round of revisions as of 3/2014.
**INITIAL PSYCHIATRIC ASSESSMENT**

**DATE OF SERVICE** ___________________________  **RU#** ___________________________

**STAFF #** ___________________________  **HOURS** ___________________________  **MINUTES** ___________________________

**Code Activity:** [361 EVAL/RX]  **Location:** □ 1 Office  □ 2 Field  □ 4 Home  □ 5 School Satellite  □ 18 Other

**Service Strategies:** (Please check up to three, if applicable)

- [ ] 60 Peer/Fam Deliv Svcs
- [ ] 53 Supportive Education
- [ ] 56 Ptnrshp:Soc Svcs
- [ ] 59 Integrated Svcs:MH-Dvlp Disabled
- [ ] 51 Psych Education
- [ ] 54 Ptnrshp:LawEnforcmt
- [ ] 57 Ptnrshp:Subs Abuse
- [ ] 60 Ethnic-Specific Service Strategy
- [ ] 52 Family Support
- [ ] 55 Ptnrshp:Health Care
- [ ] 58 IntSvcs:MH/Aging
- [ ] 61 Age-Spec Svc Strategy
- [ ] Unknown

Assessment in language other than English: □ Spanish  □ Other ___________________________

[ ] Interpreter  Name of Interpreter: ___________________________

**Identifying Information:**

Legal Name: ___________________________  **DOB/Age:** ___________________________

Preferred Name: ___________________________

Gender: □ Male  □ Female  □ Transgender F-M  □ Transgender M-F  □ Intersex  □ Other ______

Marital Status: □ Single  □ Married  □ Significant Other  □ Separated  □ Divorced

Address: ___________________________  **Phone #:** ___________________________

Emergency Contact / Significant Other: ___________________________  Name ___________________________  Phone: ___________________________

**Primary concerns per consumer:** ________________________________________________

**Presenting Problem/ Recent Course of Illness:** ____________________________________

____________________________________

____________________________________

____________________________________

____________________________________

**Consumer and Family Strengths (Positive factors to facilitate treatment e.g. faith, resiliency, etc.):**

____________________________________

____________________________________

____________________________________

____________________________________
Psychiatric History (include hospitalizations and dates, suicide attempts, history of intervention):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Psychiatric Medication History (Current and Past, side effects, adherence & outcomes) Current: [ ] None  Past: [ ] None

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Alcohol/ Drug Use History: (Check all appropriate and provide details.)

<table>
<thead>
<tr>
<th>Substance</th>
<th>Past</th>
<th>Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
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<tr>
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<td>Opiates</td>
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<td>Sedatives</td>
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<td>Other</td>
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<tr>
<td>Nicotine</td>
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<td>Marijuana</td>
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<td>Ecstasy</td>
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<td>Inhalants</td>
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<tr>
<td>Specify</td>
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<td>Caffeine</td>
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<td>Hallucinogens</td>
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<td></td>
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<tr>
<td>Energy Drinks</td>
<td></td>
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</table>

Current: [ ] 3 Mos.  [ ] 1 Yr

Medical History (include illnesses, surgeries, CNS, head injuries):

Date of Last Physical: __________________  Physician(s)/clinic: __________________  Phone #: __________________

Weight: __________  Height: __________  BMI: __________

Allergies (Meds & Other) / Adverse Reaction: __________________

Active Medical Concerns, History of Hospitalizations/Surgeries: __________________

Non-Psych Med/OTC __________________

Review of Systems: [ ] No Significant issues revealed

[ ] CV  [ ] Renal  [ ] GI  [ ] Hepatic  [ ] CNS  [ ] GU  [ ] Metabolic  [ ] CA  [ ] PULM  [ ] Gyn  [ ] ID/HIV

[ ] Sexually Active  Contraceptive Method ____________  [ ] Risk of Pregnancy  [ ] Pregnant

[ ] Breast-Feeding  LMP: __________

Pregnancy and Birth History (<18): __________________

Developmental History (<18): __________________

MHC113 Initial Psychiatric Assessment (9/13)
Family Psychiatric History:

_________________________________________________________________________

Psychosocial History (e.g. education, family, vocational, military, legal):

_________________________________________________________________________

_________________________________________________________________________

Psychosocial Risk Factors: (Check all that apply) Document details.

☐ Victim of Physical Abuse  ☐ History of Self-injurious Behavior
☐ Victim of Sexual Abuse  ☐ History of Suicidal Behavior
☐ Trauma or Loss in the Family  ☐ Family History of Suicide
☐ Domestic Violence:  ☐ Access to Firearms (family, friends, self)
   Victim ☐ Perpetrator
☐ History of Substance Abuse  ☐ Access to Other Means of Suicide
☐ History of Assaultive Behavior  ☐ Lack of Social Support
☐ History of Threatening Behavior  ☐ History of Foster Care
☐ History of Inappropriate Sexual Behavior  ☐ Homelessness
☐ Behavior Influences by Delusions or Hallucinations  ☐ Other

Comments:

MENTAL STATUS EXAMINATION

<table>
<thead>
<tr>
<th>APPEARANCE/GROOMING</th>
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<th>Remarkable for:</th>
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<tr>
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<td>ATTITUDE/RELATEDNESS</td>
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<td>MOOD</td>
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<td>Remarkable for:</td>
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<tr>
<td>AFFECT</td>
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<td>THOUGHT PROCESS</td>
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<td>THOUGHT CONTENT</td>
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</tr>
<tr>
<td>PERCEPTUAL DISTURBANCE</td>
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<td>ORIENTATION</td>
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<td>Remarkable for:</td>
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<tr>
<td>MEMORY/CONCENTRATION</td>
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<td>Remarkable for:</td>
</tr>
<tr>
<td>FUND OF KNOWLEDGE</td>
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</tr>
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<td>INTELLECT/ABSTRACT THINKING</td>
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<td>INSIGHT/ JUDGEMENT</td>
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</tr>
<tr>
<td>IMPULSE CONTROL</td>
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<td>Remarkable for:</td>
</tr>
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</table>

Additional Observations: ________________________________________________________

MHC113 Initial Psychiatric Assessment (9/13)
Current Risk Assessment:

Danger to SELF (Intent, Plan Means):

Danger to OTHER (Intent, Plan Means):

Grave Disability:

Clinical Summary (Optional):


Diagnostic Impression: DSM Code and Narrative – Designate diagnosis which is primary focus of treatment with a “P”

<table>
<thead>
<tr>
<th>Axis I</th>
<th>p/s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis I</td>
<td>p/s</td>
</tr>
<tr>
<td>Axis I</td>
<td>p/s</td>
</tr>
<tr>
<td>Axis II</td>
<td>p/s</td>
</tr>
<tr>
<td>Axis III</td>
<td>Check if None</td>
</tr>
</tbody>
</table>

Axis IV CONTRIBUTING STRESSORS – Problems related to:

- A – Primary Support
- B – Social Environment
- C – Education
- D – Occupation
- E – Housing
- F – Economic
- G – Access to Health Care
- H – Legal System
- I – Other/ System/ War

Axis V CURRENT GAF: __________ HIGHEST GAF PAST YEAR: __________

**FUNCTIONAL IMPAIRMENT: (IF MODERATE OR ABOVE, MAY WARRANTS TARGETED CASE MANAGEMENT)**

<table>
<thead>
<tr>
<th>Family Relations</th>
<th>None</th>
<th>Mild</th>
<th>Mod</th>
<th>Severe</th>
<th>Peer Relations</th>
<th>None</th>
<th>Mild</th>
<th>Mod</th>
<th>Severe</th>
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</thead>
<tbody>
<tr>
<td>Academic/Vocational Performance</td>
<td>None</td>
<td>Mild</td>
<td>Mod</td>
<td>Severe</td>
<td>Physical Health</td>
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<td>Mod</td>
<td>Severe</td>
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<tr>
<td>Self Care</td>
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<td>Mod</td>
<td>Severe</td>
<td>Substance Abuse</td>
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<td>Mild</td>
<td>Mod</td>
<td>Severe</td>
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</table>

**TARGETED SYMPTOMS:**

<table>
<thead>
<tr>
<th>Cognition/Memory/Thought</th>
<th>None</th>
<th>Mild</th>
<th>Mod</th>
<th>Severe</th>
<th>Perceptual Disturbance</th>
<th>None</th>
<th>Mild</th>
<th>Mod</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention/Impulsivity</td>
<td>None</td>
<td>Mild</td>
<td>Mod</td>
<td>Severe</td>
<td>Antisocial Behavior</td>
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<td>Mild</td>
<td>Mod</td>
<td>Severe</td>
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<tr>
<td>Socialization/Communication</td>
<td>None</td>
<td>Mild</td>
<td>Mod</td>
<td>Severe</td>
<td>Destructive/Assaultive</td>
<td>None</td>
<td>Mild</td>
<td>Mod</td>
<td>Severe</td>
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<tr>
<td>Depressive Symptoms</td>
<td>None</td>
<td>Mild</td>
<td>Mod</td>
<td>Severe</td>
<td>Mania/Agitation/Lability</td>
<td>None</td>
<td>Mild</td>
<td>Mod</td>
<td>Severe</td>
</tr>
<tr>
<td>Anxiety/Phobia/Panic Attack</td>
<td>None</td>
<td>Mild</td>
<td>Mod</td>
<td>Severe</td>
<td>Somatic Disturbance</td>
<td>None</td>
<td>Mild</td>
<td>Mod</td>
<td>Severe</td>
</tr>
<tr>
<td>Affect Regulation</td>
<td>None</td>
<td>Mild</td>
<td>Mod</td>
<td>Severe</td>
<td>Other</td>
<td>None</td>
<td>Mild</td>
<td>Mod</td>
<td>Severe</td>
</tr>
</tbody>
</table>
Initial Treatment Plan/Targeted Case Management:

Does consumer meet the criteria for TCM? (May include moderate or above Functional Impairment and/or risk of losing placement/housing, need for financial support, social support, prevocational/employment assistance, rehabilitation, ACD services, or other programs or services considered necessary.)  □ No  □ Yes

Explain:

________________________________________________________________________________________________________________________________________________________

Referral to Coordination of Care with:

□ PCP  □ Case Management  □ Therapist  □ Family/ Other Support  □ Substance Abuse Tx  □ Housing

□ Community Agencies  □ Vocational Rehab  □ Social Security

Details:

________________________________________________________________________________________________________________________________________________________

Labs Ordered:

________________________________________________________________________________________________________________________________________________________

Medications Prescribed / Dosage / Frequency:

________________________________________________________________________________________________________________________________________________________

□ Drug Information Sheet for each medication was given to consumer and family.
□ Benefits/Risks/Possible adverse effects of medication and Alternatives to medication have been discussed.
□ An opportunity was given to ask questions.
□ The consumer and/or family appear to understand the information on the form.
□ If appropriate, discuss the interaction of psychiatric medication with the following: Pregnancy, Lactation, Alcohol, Nutrition, and Non-Psychiatric Medications
□ An Informed Consent was signed within the past two years.

Consumer (Family) is able to manage own medication:  □ Yes  □ No

If not, explain:

________________________________________________________________________________________________________________________________________________________

Additional Information:

________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________

MD/DO/NP Signature: ____________________________ Date: ____________

PRINT FULL NAME AND TITLE ____________________________

MHC113Initial Psychiatric Assessment (9/13)
CONTRA COSTA
HEALTH SERVICES
MENTAL HEALTH DIVISION

PSYCHIATRIC ASSESSMENT ANNUAL UPDATE

DATE OF SERVICE: _________________________ RU#: _________________________

STAFF #: _________________________ HOURS: _________________________ MINUTES: _________________________

Code: ☑ 361EVAL/RX Location: ☐ 1 Office ☐ 2 Field ☐ 4 Home ☐ 5 School ☐ 10 Shelter

Service Strategies: (Please mark up to three, if applicable)

☐ 60 Peer/Fam Deliv Svcs ☐ 61 Psych Education ☐ 62 Family Support
☐ 63 Supportive Education ☐ 54 Pttnsp:LawEnfcmnt ☐ 64 Pttnsp:Health Care
☐ 66 Ptnsp:Occ Svcs ☐ 56 Ptnsp:Soc Svcs ☐ 58 IntSvcs/MH/Aging
☐ 69 Integrated Svcs:MH-Dvlp Disabled ☐ 67 Ptnsp:Subs Abuse ☐ 61 Age-Spec Svc Strategy
☐ 60 Ethnic-Specific Service Strategy ☐ 99 Unknown

Description and Interim Psychiatric Treatment History (since last assessment):

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

MENTAL STATUS EXAMINATION

General (e.g., appearance, behavior)

Mood/Affect _______________________________________________________________________

Perception _______________________________________________________________________

Thinking _______________________________________________________________________

Insight/Judgment ___________________________________________________________________

Cognitive ☐ WNL ___________________________________________________________________

Allergies or Adverse Reactions/Drug Intolerances: ☐ NKA ___________________________________________________________________

Reviewed and Discussed: ☐ Pregnancy Risk ☐ Current Substance ☐ Current Suicide Risk

Details: _______________________________________________________________________

MHC114 Psychiatric Assessment Update (9/13)

1
DIAGNOSIS: (Circle primary/secondary, p / s). Include substance related.

Axis I

Axis I

Axis I

Axis II p / s

Axis III

Check if None

Axis IV Contributing Stressors, problems related to:
[ ] A-Primary Support [ ] B-Social Environment [ ] C-Education [ ] D-Occupation [ ] E-Housing
[ ] F-Economic [ ] G-Access to Health Care [ ] H-Legal System [ ] I-Other/ System/ War

Axis V GAF:

Active Medical Problems:

PCP Date of last visit

Current Psychiatric Medications: Current Non-Psychiatric Drugs (incl OTC & herbal):

Changes in Treatment/ Recovery Plan:

[ ] Treatment Plan/Partnership Plan signed by consumer.
[ ] Drug information was provided and informed consent is current for each medication prescribed.
[ ] The consumer appears to understand the information provided and was given opportunity to ask questions.

Consumer is able to manage own medication: [ ] YES [ ] NO Explain

Does client warrant the consideration for TCM? (May include moderate or above Functional Impairment and/or risk of losing placement/housing, needed for financial support, social support, prevocational/employment assistance, rehabilitation, or other programs or services considered as necessary.) [ ] Yes [ ] No

Assessment in language other than English: [ ] Spanish [ ] Other

[ ] Interpreter Name of Interpreter:

MD Signature: ____________________________ Date: ____________

MHC114 Psychiatric Assessment Update (9/13)
PARTNERSHIP PLAN FOR WELLNESS

AND

PARTNERSHIP PLAN FOR WELLNESS (MDs and RNs)

SECTION 5
PARTNERSHIP PLAN FOR WELLNESS

The Partnership Plan For Wellness has been developed to encourage individual clinicians to use their own conversational and problem solving style supporting the principles of client empowerment and choice. The Plan should be person centered and focused on the person’s recovery and wellness issues. The Plan should be a realistic and understandable tool that the client and the clinician can utilize together to guide the journey of recovery. In order to be meaningful and effective, clients are encouraged and assisted in identifying their own life goals. Plans must be individualized, strengths-based, and address cultural and linguistic needs.

Each client will have a Partnership Plan for Wellness outlining Mental Health Services, Case Management, Day Treatment Intensive, Day Rehabilitation, and Residential Services that he/she is receiving.

Contra Costa Mental Health supports clients in choosing their own lifestyle changes. The clinician is expected to ask basic questions during the Planning meeting that will give the client the opportunity to explore possible changes in the following areas:

- Physical living situation
- Health (physical and emotional)
- Community contributions (employment and volunteer work)
- Connection to agency/government supports (Employment and Human Services, financial assistance, etc.)
- Financial
- Relationships with others (quality and quantity)
- Learning opportunities (school, job training)
- Special education

Revisions or additional goals may be added to the Plan at any time. Documentation of revisions or additional goals, including client’s participation, should be in a “Plan Development” progress note.

DOCUMENTATION

Responsible Staff: Clinical staff from each service provider with input from the client and identified significant persons.


Time Frame:

- The initial Partnership Plan for Wellness must be completed within 60 days from the time the episode is first opened to the Adult or Children’s System, or within one month from the time any additional service provider begins providing services.
For example, a client opens on January 1, 2013 at Concord Adult Mental Health and is not receiving services anywhere else in the county. In order for there not to be a lapse in authorization the Partnership Plan must be completed by February 28, 2013.

For example, a client opens on January 1, 2013 at Youth Services Bureau and the client is also being seen at West County Children’s Mental Health. In order for there not to be a lapse in authorization the Partnership Plan must be completed by January 31, 2013.

- Additional goals may be added to the Plan whenever it is clinically appropriate without re-approval from the Planned Services Authorization Committee.
- The Plan must be re-written annually. In general, the annual requirement is determined by the established UR track.
  - For example, a client who has a UR track of March 1, 2013-February 28, 2014, the Partnership Plan must be completed by the end of track, which is February 28, 2014 in order for there not to be a lapse in authorization.
- Late Renewals: If the annual review lapses or expires and the Partnership Plan is completed late then there will likely be uncovered/unauthorized days. This means service is not billable during that lapse in authorization. It is best for clinicians to check and make sure they know the UR track ending date to avoid lapses in service authorization.
  - For example, a client who has a UR track of March 1, 2013-February 28, 2014, and the annual Partnership Plan is completed on March 15, 2014, then services provided March 1, 2014-March 14, 2014 would be considered unauthorized. If the Partnership Plan was completed by February 28, 2014 there would not have been a lapse in authorization.
- A Partnership Plan for each Reporting Unit (RU) should be submitted for review. Details should be provided that outline what services are being provided and how it benefits the client.

NOTE: The Partnership Plan for Wellness can be approved for a maximum of 12 months and the effective date of the plan is based on the provider/clinician signature date.

INSTRUCTIONS FOR COMPLETING THE PARTNERSHIP PLAN FOR WELLNESS

Consumer’s Name: The client’s first and last name.

MRN: Client’s Medical Record Number.

Provider’s Name: The name of the clinician.

Program: The name of the program.

Strengths: List the client’s strengths, which may include desires, positive experiences, skills, attributes, talents, etc.

List Other Services/Agencies Involved: May include Employment and Human Services, Child and Family Services, Probation, Public Health, Community
Substance Abuse, Psychiatry Services, Mental Health Contractors such as Rubicon, Early Childhood, etc.

Life Goals: The Goal identifies what the client or child and family hope to achieve or work toward. Should use the person's own words. May include the person's hopes and dreams, as appropriate. The focus could be on a short-term goal (within one year) or a long-term goal (over 1 year). The clinician can discuss the goals with the client to break them down into more realistic steps.

Treatment Goals: The treatment goal is to assist the client or child and family to identify areas of his/her life in which an improvement in functioning is desired.

These are clinical or behavioral goals, which the case manager or clinician has determined must be accomplished in order to help the client achieve his/her Life Goals. The Treatment Goals may or may not be directly related to the Life Goals, but they should lead to an improved ability to pursue the Life Goals or to decrease the functional impairment or symptoms which impact functioning and interfere with achieving the goals.

Goals must be specific, observable or quantifiable, but the clinician does not have to measure them. For example: the treatment goals may specify a decrease in voices, but the clinician does not have to specify amount of decrease. The documentation on the progress note may refer to voices occurring once a week approximately instead of every day.

➢ TIP: There needs to be consistency between mental health diagnosis/functional impairments identified in the assessment and the treatment goal and strategies to achieve goals.

Examples of Treatment Goals

- "Decrease psychotic symptoms of paranoia, auditory hallucinations, delusions, disorganized behavior, isolation"
  "that interfere with functioning by ..." 
  "Preventing client from doing basic household tasks, maintaining adequate hygiene, interacting in appropriate manner, caring for children, maintaining social relationships, budgeting money, providing for basic needs, working, attending school, being able to maintain housing, etc."

- "Decrease depressive symptoms of tearfulness, lack of motivation, lethargy, insomnia, poor concentration, social isolation, suicide ideation, etc."
  "that interfere with ..."

- Renew typical interest in academic achievement and social involvement.
- "Decrease anxiety and/or panic disorder symptoms"
  "that interfere with ..."
- "Decrease mood swings"
  "that interfere with ..."
• "Decrease any or explosive outbursts"
  "which interferes …"
• "Reduce substance abuse"
  "that interfere …"
  "Stay clean and sober, to prevent reoccurrence of psychotic/anger/depressive symptoms."
• "Decrease impulsive behavior"
  "that interfere …"
• "Decrease financial instability"
• "Improve interpersonal relationship"
• "Express anger in a controlled, respective manner on a consistent basis"
• "Comply with rules and expectations in home and school settings"
• "Attend school on a consistent, full-time basis"
• Case Management treatment plan goal: to "stabilize or maintain symptoms, behaviors, daily activities, in order to maintain current housing for the next 12 months”
• "Reduce auditory hallucinations from 7 times to 1 time per day for the next 12 months”

TIP: Example of a non-compliant goal "Decrease depressive symptoms". This goal lacks specific symptoms and is too vague to measure or observe.

**Targeted Case Management Goals:** Describe treatment goals necessary for placement/housing, financial support, social support, vocational/employment, rehabilitation, AOD, or other programs necessary to assist/link client.

**Strategies To Achieve Goals:** The clinician must identify steps to promote recovery and wellness and partner with the client and significant persons who are responsible for supporting those tasks. Specific techniques, approaches, interventions, or actions that the clinician plans to take to help achieve treatment and/or life goals. Also include actions client agrees to take in support of these goals, such as attending groups, seeing MD, etc. It is important to focus on skill development, when appropriate, such as developing interpersonal skills, controlling anger outbursts, improve socialization. The progress notes should document to the Strategies/Goals. If clinician finds that he/she is addressing other issues much of the time, he/she should consider updating the goals and strategies. At the same time, the documentation should be based on actual interactions with the client.

**Example of Strategies**

**Depression**

• Provide opportunity for client to ... discuss feelings of depression/anxiety/anger/guilt and to help gain insight into causes of feelings. Develop ways to decrease impact of these triggers, such as increasing appropriate socialization and support system.
• Educate client about symptoms, causes and impact of depression and help client to develop coping skills.
• Help client to develop a plan to increase social and recreational activities and explore resistances and fears that might interfere with this plan.
• Educate client about importance and impact of medication in treating depression.
• Teach relaxation exercises, such as deep breathing and positive imagery.
• Client agrees to exercise and improve diet.
• Develop positive and accomplish short-term positive goals to experience sense of accomplishment; explore fears and other factors that prevent client from completing goals.
• For children, involve family in the treatment of the client, teaching them developmentally appropriate treatment goals, how to give support as the client faces his/her fears, and how to prevent reinforcing the client's fear and avoidance, offer encouragement and redirection as required.

Psychosis

• Monitor psychotropic medication compliance, effectiveness and potential side effects. Work with appropriate support system to deal with non-compliance, as needed.
• Monitor behavior in living situation and community, especially with regards to potential violence, inappropriate behavior, activities of daily living and hygiene.
• Provide reality testing and appropriate feedback regarding delusions.
• Teach possible ways of decreasing voices, such as listening to music, taking medication, eliminating any substance abuse.
• Encourage client to interact with others in an appropriate way and provide feedback to increase socialization and decrease isolative behavior.

Anxiety/Post-traumatic Stress Disorder

• Identify triggers of anxiety and explore ways of coping with triggers, especially by developing more reality-based perceptions and overcoming fears by taking small risks.
• Teach desensitization and relaxation exercises.
• Practice cognitive restructuring aimed at self-soothing and developing positive self-messaging.
• Practice assertiveness techniques to set appropriate limits with others.
• Help client see how past history of trauma may influence current reactions.

Money Management/Housing

• Help client improve decision making by discussing reasonable choices regarding money spending and learning to prioritize so he/she can maintain self in the community.
• Help client decrease impulsive behavior, especially regarding spending money by establishing budgets and learning ways to exercise limits.
• Help client maintain stable housing by setting up rent payment schedules and monitoring interactions with housemates. Provide appropriate feedback.
• Address issues interfering with client’s ability to maintain stable housing and help client develop ways to change these problems.
• Explore emotional reactions, such as anxiety, which prevent reasonable budgeting, or appropriate interactions with housemates.
• Increase independent skills related to keeping appointments, managing money, etc.

**Bi-Polar Behavior**

• Help client identify mood swings and behaviors associated with moods.
• Help client learn to identify triggers associated with mood swings and to develop ways to cope with triggers by reducing stress through relaxation techniques and cognitive restructuring.
• Help client anticipate possible mood swings by specific behaviors and to establish an external support system that can help identify the need for a medication shift or hospitalization (due to mania or depression).
• Learn to identify normal mood swings from extreme ones related to disorder and accept normal shifts.

**Impulsive Behavior**

• Learn to identify stressors and decrease anger outbursts.
• Help client learn coping skills to deal with frustration, such as positive self-messaging, taking time outs, identifying and discussing factors leading to frustration/anger and developing alternative reactions.
• Increase ability to tolerate conflict.
• Refer to anger management classes, as appropriate.

**Anger Management**

• Confront the client’s oppositional behavior and attitude, pointing out consequences for himself/herself and others.
• Confront statement in which the client lies and/or blames others for his/her misbehaviors and fails to accept responsibility for actions.
• Assist client in identifying the positive consequences of management of frustration and anger.
• Teach the client calming techniques (e.g. muscle relaxation, paced breathing, calming imagery) as part of a tailored strategy for responding appropriately to angry feelings when they occur.
• Teach the client conflict resolution skills.
• For parents, learn to specifically define and identify problem behaviors, identify their reactions to the behavior, determine whether the reaction encourages or discourages the behavior, and generate alternatives to the problem behavior.
Attention-Deficit/Hyperactivity Disorder

- Assign the client readings to increase his/her knowledge about ADHD and ways to manage symptoms.
- Assist the parents in developing and implementing an organizational system to increase the client's on-task behaviors and completion of school assignments, chores, or household responsibilities (e.g., using calendars, charts, notebooks, and class syllabi).
- Encourage the parents and teachers to maintain regular communication about the client's academic, behavioral, emotional, and social progress.
- Encourage the parents and teachers to use a behavioral classroom intervention (e.g., a school contract and reward system) to reinforce appropriate behavior and completion of his/her assignments.
- Teach the client mediational and self-control strategies to delay the need for instant gratification and inhibit impulses to achieve more meaningful, longer-term goals.
- Explore possible stressors or hurdles that might cause impulsive and acting out behaviors to increase in the future.

Group Strategies

- Attend group on weekly basis.
- Interact with others in an appropriate manner, discuss issues related to family, job, friends, relationships, etc. Receive feedback and support from group.
- Verbalize thoughts and feelings; practice listening skills.
- Practice cognitive restructuring as reinforced by group and group leader.
- Discuss effective coping skills, practice skills, relate effectiveness to group.
- Use group as source of reality testing, support and understanding of the commonality (normalcy) of issues and problems.

General Strategies

- Help client keep appointments (psychiatrist, M.D., Case Manager, school, etc.) or “client agrees to see psychiatrist on regular basis and take meds as prescribed, report symptoms and side-effects to case manager and psychiatrist.”
- Help client to understand impact of substance abuse on mental health. Client to stay clean and sober. Attend substance abuse programs as needed.
- Help client improve hygiene, nutrition, sleep patterns, appropriate friendships, etc.
- Provide encouragement and positive reinforcement.
- Help client increase their acceptance and understanding of their problem, i.e., depression, anxiety, substance abuse, psychosis.
- Help client develop a realistic understanding of their strengths and weaknesses.
- Help client improve communication skills and ability to be assertive and set limits, as needed.
- Address issues that can trigger decompensation or relapse.
• Explore factors that can help motivate client to take action, such as go to M.D., group, school, etc.

**Modality:** Check all that are appropriate to achieve goal(s):

- Individual Therapy  
- Medication Support  
- Self-Help/Wrap  
- Group  
- Child Wraparound  
- Other (Specify)  
- Family/Collateral  
- Case Management  
- Day Treatment  
- Rehab Services  
- Consultation with Other Agencies

**Proposed Duration _____ Months:** The amount of estimated time spent to achieve goal(s). The maximum time is 12 months.

**Consumer Signature/Date:** The client must sign and date the Plan to show participation and agreement. If the client refuses to sign or the clinician is unable to obtain a signature, the clinician must document the reason on the back of the form, as well as, subsequent attempts to obtain a signature.

**Legal Party Responsible Signature/Date:** If the child is a minor under 12 years of age the child’s parent/guardian/other responsible adult must also sign the plan.

**Provider’s Signature/Date:** This signature of the clinician completing the plan and the date the plan was written. All licensed staff: interns and waivered psychologists, can complete the partnership plan.

**Licensed Signature (If Required):** Signature of licensed supervisor if the provider is unlicensed. i.e. Trainees, BSN/AND, MHRS, and Pre-Doctoral Interns.

**Authorization Committee Signature:** Signature of clinician authorizing services.

**Consumer/Legal Responsible Party Was Offered A Copy Of Partnership Plan For Wellness:** Document that a copy of the plan was given to the client or responsible party of if the plan was declined.

**NOTE:** DOCUMENT REASON FOR NO CLIENT SIGNATURE ON THIS PLAN. INCLUDE DATE, AS WELL AS, DATES OF SUBSEQUENT ATTEMPTS TO GET CLIENT SIGNATURE. MONTHLY ATTEMPTS SHOULD BE DOCUMENTED TO OBTAIN SIGNATURE.
Educationally Related Mental Health Services (ERMHS) formally AB3632 Reporting Units Only:

According to Assembly Bill 114, dated September 13, 2011, significant changes were made regarding mental health services provided to students with disabilities. These changes resulted in the removal of California Code of Regulations (CCR) Title 9 "medication monitoring" for students with disabilities. Medication monitoring consists of prescribing, administering medications, and monitoring of psychiatric medications necessary to alleviate symptoms of mental illness.

Thus, the ERMHS RU cannot bill Medi-cal for the provision of Medication Monitoring. All medication support services must be provided from a separate RU. For example, a Central County child who is receiving case management services from an ERMHS (RU 07217) case manager, should also be open to Central County Children’s services (RU 07219) for medication services. Both RUs must have separate Partnership Plans since the ERMHS plan cannot include medication services.
Medication Monitoring

September 13, 2011

Dear County and District Superintendents, Special Education Local Plan Area Directors, Special Education Administrators at County Offices of Education, Charter School Administrators, Principals, and Nonpublic School Directors:

ASSEMBLY BILL 114: MEDICATION MONITORING

Assembly Bill 114 made significant changes to Chapter 26.5 of the California Government Code (GC) regarding the provision of mental health services to students with disabilities. As a result of AB 114, local educational agencies (LEAs) are responsible for ensuring the provision of related services, including some services previously provided by county mental health agencies (CMHAs) under Chapter 26.5 of the GC. As LEAs implement this transition, and as a result of changes in state statute stemming from AB 114, the Individuals with Disabilities Education Act (IDEA) serves as the statutory framework for the provision of related services.

This document is intended to assist LEAs in facilitating the transition of certain services formerly provided by CMHAs under state law prior to AB 114, to the LEAs providing services authorized by the IDEA and complying with the requirements therein. To the extent that service provision requirements under the IDEA differ from those formerly specified in Chapter 26.5 of the GC prior to AB 114, this document is meant to assist in making that distinction. However, it must be emphasized that a blanket restriction on any particular service would be contradictory to the IDEA. The individualized education program (IEP) team should develop the IEP based on the child’s unique needs and include supportive services that are necessary to assist the child in benefitting from special education. Therefore, the IEP team decision about a specific child’s eligibility for services under the IDEA must remain the most critical factor.

The changes to Chapter 26.5 of the GC, as outlined in AB 114, resulted in the removal of statutory authority for many of the implementing regulations found in Division 9 of Title 2 of the California Code of Regulations (CCR). "Medication Monitoring" was a
service previously provided by CMHAs and authorized by Section 60020(f) of Division 9 of Title 2 of the CCR, prior to AB 114:

2 CCR §60020(f):

(f) "Medication monitoring" includes all medication support services with the exception of the medications or biologicals themselves and laboratory work. Medication support services include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals necessary to alleviate the symptoms of mental illness.

As LEAs assume responsibility for the provision of related services, many questions have been raised about how and if 'medication monitoring', as previously defined in 2 CCR §60020(f), fits into the IDEA statutory requirements for related service provision.

Medical Services Under IDEA

The definition of "related services" found in Section 300.34(a) of Title 34 of the Code of Federal Regulations (CFR) includes medical services for diagnostic or evaluation purposes. "Medical services" is defined in Section 300.34(c)(5) of Title 34 of the CFR:

"Medical services means services provided by a licensed physician to determine a child's medically related disability that results in the child's need for special education and related services."

Thus, in general, medical services are required under the IDEA if they are necessary for the purpose of diagnosis or evaluation. However, medical services provided by a licensed physician for other purposes, such as treatment, may not be a related service required by the IDEA. Furthermore, services exclusively provided by a licensed physician may be subject to what is widely known as the medical exclusion of the IDEA. Irving Independent School District v. Tatro, 468 U.S. 883 (1984) developed a "bright line" rule that established that services provided by a physician, other than for diagnostic or evaluation purposes, are subject to the medical exclusion of the IDEA. This "bright line" rule was further supported by Cedar Rapids Community School District v. Garret F., 526 U.S. 66 (1999). However, services that can be provided in the school setting by a nurse or qualified layperson are not subject to the medical exclusion.

The definition of "related services" in the IDEA includes school health services and school nurse services. Section 300.34(c)(13) of Title 34 of the CFR defines these services as follows:

School health services and school nurse services means health services that are designed to enable a child with a disability to receive a free appropriate public education (FAPE) as described in the child's IEP. School nurse
services are services provided by a qualified school nurse. School health services are services that may be provided by either a qualified school nurse or other qualified person.

Therefore, as LEAs consider “medication monitoring” as defined in 2 CCR §60020(f), it is recommended they consider the various components of that service definition to establish whether or not a particular service activity may be required under the IDEA. In addition, LEAs should consider which personnel are qualified to perform that activity, along with the child’s established need for the service, pursuant to his/her IEP. For example, prescribing psychiatric medications is a component of ‘medication monitoring’ under 2 CCR §60020(f). To the extent that only a physician or psychiatrist can perform that service activity, it appears that component would fall under the medical exclusion of the IDEA, which would relieve a school district of the responsibility to provide that particular service. However, when considering a supportive service such as the administration of medication (also included in the former definition of “medication monitoring” under 2 CCR §60020(f)), that service activity may fall under the IDEA definition of “school health services and school nurse services,” depending on the child’s individualized need for the service and the ability of school personnel to provide the service (meaning within their respective scope of practice). For more information and further guidance on medication administration, please visit the CDE Medication Administration Web page at: http://www.cde.ca.gov/ls/he/hn/medication.asp.

If you have any questions regarding this subject, please contact the Policy and Program Services Unit of the Special Education Division by phone at 916-323-2409.

Sincerely,

Original signed by Fred Balcom. Hard copy of the signed document is available by contacting the Special Education Division’s Director’s Office at 916-445-4602.

Fred Balcom, Director
Special Education Division

FB:sw

Last Reviewed: Friday, February 28, 2014
Partnership Plan for Wellness

Consumer’s Name

Provider’s Name
Strengths:

MRN

Program
List other services/agencies involved:

Life Goals: What does the consumer or child and family hope to achieve or work toward? Please use their own words. Include hopes and dreams.

Clinical Treatment Goals: Must be specific, observable or quantifiable and improve ability to pursue goals and/or decrease impairment or symptoms related to diagnosis (once mental health goals are identified, you may also include case management, targeted case management goals).

Strategies to Achieve Goals: Specify what Consumer/Family/Provider are to do, as appropriate. (For example, How do these actions help decrease symptoms, increase functionality?)

Please select all appropriate treatment options:

- Individual
- Fam/Collateral
- Medication
- CM/TCM Case Mgmt
- Group
- Rehab Svcs
- Day Tx
- TBS
- Self-Help/WRAP
- Child Wraparound
- Other

MHC021-7 (Rev_3-14) Partnership Plan for Wellness
Revisions or additions:

Life Goals: What does the consumer or child and family hope to achieve or work toward? Please use their own words. May include hopes and dreams, as appropriate.

Treatment Goals: Must be specific, observable or quantifiable and improve ability to pursue goals and/or decrease impairment or symptoms.

Strategies to Achieve Goals: Specify what Consumer/Family/Provider are to do, as appropriate.

Proposed Duration _____ months.

Please select all appropriate treatment options:

- Individual
- Fam/Collateral
- Medication
- CM/TCM Case Mgmt
- Group
- Rehab Svcs
- Day Tx
- TBS
- Self-Help/WRAP
- Child Wraparound
- Other

I have participated in the development of this plan:

Consumer’s Signature*

Date

Provider’s Signature

Date

Auth. Committee Signature

Date

MD Signature

Date

If consumer is a minor under age 12:

Legal Party Responsible Signature

Date

Licensed Signature (If Req’d)

Date

Consumer/Legal Responsible Party was offered a copy of Partner

- A copy was given
- A copy was declined (date __________)

*Document reason for no consumer signature on this Plan.
Partnership Plan For Wellness
Children’s Services
(Physicians and RNs)

This plan is to describe my treatment goals and responsibilities.
My (foster) child’s psychiatrist, my (foster) child, and I will work on this plan together and review these goals at least every 6 – 12 months.

My Child’s Strengths:

__________________________

Our Goal #1:
We will collaborate with our psychiatrist to minimize or eliminate symptoms and to prevent or minimize medication side effects so that my child may better live like others the same age.

Other goals for your child’s treatment may include (✓ all appropriate boxes):

☐ To feel well
☐ To find meaningful and satisfying work
☐ To become more self-reliant and/or live independently
☐ To enjoy a better social life
☐ To go to school or get training
☐ To avoid hospitalization

Strategies we will use to achieve Goals -

☐ We will understand and be able to describe @ each visit, the potential benefits, risks, and side effects of my medications.
☐ We will understand treatment options, including other medications and alternatives to medications and discuss them with the psychiatrist @ each visit.
☐ We will identify and discuss different steps to improve my child’s health @ each visit so that my child’s treatment is safe, specific, and effective.
☐ We will recognize and discuss @ each visit, side effects of my medications or other concerns my child or I might have regarding my treatment.
☐ My child will take any medication as prescribed and report to the psychiatrist @ each visit any difficulty in doing so.
☐ We both will attend all of our appointments with the psychiatrist.
☐ My child and/or I will attend monthly medication support group.
☐ My child and I will discuss with the psychiatrist whenever my child engages in self-harmful activities and discuss strategies to prevent such activities.
☐ My child and I will identify 3 stressors or events that trigger a crisis and discuss with the psychiatrist @ each visit, stressors as they come up.

Page 1 of 2

MHCl10 (3/10) Coordinated Service Tab
Additional goals for my treatment:

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I can help my child’s treatment by developing a trusting relationship with the psychiatrist. It is important for both my child and me to feel comfortable talking with my doctor about changes in symptoms, concerns about medications, and any side effects that my child experience.

My signature and my child’s signature on this plan indicate our participation in discussion about its contents.

Parent/Foster parent’s Signature* Date Psychiatrist Signature Date

Child/Adolescent’s Signature Date

On_______, the parent was offered and: □ received □ declined a copy of Treatment Plan.

*If no signature, see progress note dated: __________________________

Goals for this treatment added or changed after signature above: (Please date additions or changes):

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-------------------------------------------------------------

My signature and my child’s signature on this plan indicate our participation in discussion about these additions or changes.

Parent/Foster parent’s Signature* Date Psychiatrist Signature Date

Child/Adolescent’s Signature Date

On_______, the parent was offered and: □ received □ declined a copy of Treatment Plan.

*If no signature, see progress note dated: __________________________
PARTNERSHIP PLAN FOR WELLNESS  
(Physicians and RNs)  
Adult & Children’s Services

The Partnership Plan For Wellness completed by Physicians and RNs was developed for clients that are only receiving medication support services or when a client is receiving medication treatment that is complicated and out of scope for a clinician to include in a clinical Partnership Plan. The Plan is a practical tool to address what the client wants to achieve from treatment. Clients are encouraged and assisted in identifying their own goals. One of the goals of medication management is to minimize symptoms in order for the client to feel better and have a better quality of life. The form also lists other possible goals that the client may choose. Additional goal(s) may be added to the Plan, as appropriate.

Each client receiving only medication support services will have a Partnership Plan For Wellness completed by a Physician or RN developed during the 60-day period from the time the initial services begin, or 30 days if the client is already receiving mental health services. The Plan is effective for a maximum of 12 months, and is rewritten annually within 30 days of the anniversary date or end of UR track. For clients receiving medication only services, that are not scheduled to return for services until after their anniversary date/end of UR track, can complete the treatment plan at the next scheduled visit and submit for continued authorization. A written explanation as to why the annual treatment plan is late must be documented in a corresponding progress note.

Title 9 Regulations and Department of Health Care Services (DHCS) require a treatment plan annually.
Partnership Plan For Wellness  
Adult Services  
(Physicians and RNs)

This plan is to describe my treatment goals and responsibilities. My psychiatrist and I will work on this plan together and review these goals at least every 6 – 12 months.

My Strengths:

________________________________________________________________________

________________________________________________________________________

I will collaborate with my psychiatrist to minimize or eliminate my symptoms and to prevent or minimize medication side effects so that I may better live a life of my own choosing.

Specify goals for my treatment may include (✓ all appropriate boxes):

☐ To feel well  ☐ To enjoy a better social life
☐ To find meaningful and satisfying work  ☐ To go to school or get training
☐ To become more self-reliant and/or live independently  ☐ To avoid the need for hospitalization

Additional goals for my treatment:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Strategies I will use to achieve Goals -

☐ I will understand and be able to describe at each visit, the potential benefits, risks, and side effects of my medications

☐ I will understand my treatment options, including other medications and alternatives to medications and discuss them with my psychiatrist at each visit.

☐ I will identify and discuss different steps to improve my health at each visit so that my treatment is safe, specific, and effective.

☐ I will recognize and discuss at each visit, side effects of my medications or other concerns I might have regarding my treatment.

Page 1 of 2  
(Continued on page 2)
☐ I will take my medication as prescribed and report to my psychiatrist at each visit the difficulty I have doing so.
☐ I will attend all of my appointments with my psychiatrist.
☐ I will attend monthly medication support group.
☐ I will discuss with my psychiatrist whenever I engage in self-harmful activities and discuss strategies to prevent such activities.
☐ I will identify stressors or events that trigger a crisis and discuss with my psychiatrist at each visit, stressors as they come up.
☐ I will discuss with my psychiatrist any and all behavioral health conditions, challenges and my recovery process.

I can help my own treatment by learning about self-care recovery strategies and developing a trusting relationship with my doctor. It is important for me to feel comfortable talking with my doctor about changes in symptoms, concerns about my medications, and any side effects that I experience.

My signature on this plan indicates my participation in discussion about its contents.

Consumer/Representative’s Signature* Date Psychiatrist/RN Signature Date

On_______, Consumer was offered and: ☐ received ☐ declined a copy of Partnership Plan.

*If no signature, see progress note dated: ____________________________

Goals for my treatment added or changed after signature above: (Please date additions or changes.)
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

My signature indicates my participation in discussion about these additions or changes to this plan.

Consumer/Representative’s Signature* Date Psychiatrist/RN Signature Date

On_______, Consumer was offered and: ☐ received ☐ declined a copy of amended Partnership Plan.

*If no signature, see progress note dated: ____________________________
PROGRESS NOTE/BILLING FORM

Billing for Mental Health Services, Crisis Intervention, Case Management, and Medication Support is based on staff time. Time should include all time spent by staff on a given service including travel and charting. Services may be provided anywhere in the community or by phone. All progress notes should stand alone as support for the service provided.

A Progress Note is required for each service. A service may not be entered into the mental health database without a fully completed Progress Note/Billing Form.

All No Show (300), Client Cancellations (400), and Staff Cancellations (700) should be entered in the computer and noted on the progress note form. It is not necessary to complete all sections of the form for No Shows and Cancellations. If the service is not a Medi-Cal reimbursable service, the clinician should document the encounter and use one of the non-billable codes.

DOCUMENTATION

Responsible Staff: Clinical staff, commensurate with scope of practice, provides a reimbursable service to a client.

Billing Procedure Code Options: All time spent by the clinician providing and documenting a service is billable. The following services can be documented on the Progress Note/Billing Form:

- No Show (300)
- Client Cancel (400)
- Staff Cancel (700)
- Collateral (311)

A Collateral service is contact with one or more significant support persons in the life of the client, which may include consultation and training to assist in better utilization of services and understanding of mental illness. Collateral services include, but are not limited to helping significant support person(s) to understand and accept the client's condition and involving them in service planning and
implementation of treatment plan(s). Collateral services also include family counseling or therapy, which is provided on behalf of the individual.

- Significant support persons may include parents or legal guardians, persons living in the same household, relatives, etc.

- **Evaluation (313)**
  Evaluation is an appraisal of the client's community functioning in several areas including living situation, daily activities, social support systems and health status. Cultural issues must be addressed where appropriate.

- **Plan Development (315)**
  Plan Development is a service activity that refers to a written treatment plan and may include any or all of the following:
  - Development of Treatment Plans
  - Verification of medical or service necessity
  - Monitoring of client's progress towards treatment goals

- **Rehab Support (317)**
  Rehab Support is a service activity, which includes assistance in improving, maintaining, or restoring a client's or group of client's functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources, and/or medication education.

- **Assessment (331)**
  Assessment is a clinical analysis of the history and current status of the client's mental, emotional, or behavioral disorder. Relevant cultural issues and history may be included where appropriate. Assessment may include diagnosis and the use of testing procedures.

- **Individual Therapy (341)**
  Individual Therapy is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Individual Therapy should be consistent with client's stated goals.
• **Group Therapy (351)**
  Group Therapy is a therapeutic intervention with two or more clients in a group with a primary focus of symptom reduction as a means to improve social functioning and reduce interpersonal conflicts.

• **Group Rehab (355)**
  Group Rehab is a service activity with two or more individuals directed at improving, restoring, or maintaining functional skills.

• **Group Collateral (357)**
  Group Collateral is a medically necessary service that is provided to significant support persons in a group setting. Support persons must play an integral part in assisting the client in achieving the goals on their Partnership Plan. This service may include, but are not limited to, consultation and training of the significant support persons to assist in better utilization of mental health services, to promote a better understanding of the client's mental illness, and to assist the client in meeting their goals.

  **NOTE:** The client is not required to be present when this collateral group contact occurs.

• **Crisis Intervention (371)**
  Crisis Intervention is a quick response service enabling the client to cope with a crisis, while maintaining his/her status as a functioning community member to the greatest extent possible. A crisis is an unplanned event that results in the client’s need for immediate service intervention.

**Katie-A Subcodes**

• **Intensive Care Coordination (ICC)**
  ICC is case management services that develop and guide care planning and coordination of services. This includes assessment and urgent services in coordination with the Child Family Team (CFT).

• **Intensive Home Based Services (IHBS)**
  Intensive home and community based individualized intervention activities. These activities focus on child/youth skill development and/or caregiver support to meet treatment plan goals.
Case Management Brokerage

- **Linkage and Advocacy (561)**
  Identification and pursuit of resources including:
  - Interagency and intra-agency consultation, communication, coordination, and referral.
  - Monitoring service delivery to ensure a client's access to service and the service delivery system.
  - Monitoring of the client's progress.

- **Placement Services (541)**
  Supportive assistance to the client in the assessment, determination of need and securing of adequate and appropriate living arrangements, including:
  - Monitoring of the client's progress.
  - Locating and securing an appropriate living environment.
  - Locating and securing funding.
  - Pre-placement visit(s)
  - Negotiation of housing or placement contracts
  - Placement and placement follow-up.
  - Accessing services necessary to secure placement

- **Plan Development (571)**
  Development of Treatment Plans, verification of medical or service necessity, and monitoring of progress towards treatment goals.

- **Non-Billable – Mental Health Services (540)**
  This service code should be used for any mental health service that cannot be billed to Medi-Cal. This may include services such as work training, recreational activities, preparing meals, teaching a class, etc.

- **Non-Billable – Lockout (580)**
  This service code should be used for any mental health service that cannot be billed to Medi-Cal because the client is in an IMD, MHRC, hospital, jail, juvenile, etc.

Progress Notes are to be documented for each service contact for Mental Health Services, Crisis Intervention, Case Management, and Medication Support.
INSTRUCTIONS FOR COMPLETING THE PROGRESS/NOTE BILLING FORM

NAME: The client's first and last name.

MRN: Client's Medical Record Number.

SERVICE DATE: The date the service was provided.

RU: Reporting Unit of program completing form.

STAFF #: Staff number of clinician providing the service.

HOURS/MINS: Time the clinician spent providing the service including documentation time and travel time.

# IN GROUP: If the service provided was Group Therapy or Group Rehab, the total number of clients with open episodes in the group.

Note: There must be at least two clients present to bill for a group.

Co-Staff #: Staff number of other staff providing the same service, if applicable.

HOURS/MINS: Time spent by the co-staff providing the service, if applicable.

TRAVEL TIME: The amount of time spent traveling to provide a reimbursable service. If a service was provided that included travel time but cannot be billed to Medi-Cal, document and use non-billable code. If the clinician travels to attempt to provide a service but is unable to provide the service, i.e. the client/family is not home or cannot find the client; s/he should use a non-billable code to document the attempt and the travel time.

If the client is not present, but a billable collateral or linkage service is provided, the travel time should be included in the billing time.

SERVICES: Check the type of service that was provided. Document all No Shows and Cancellations. Use the Non-Billable code for services that are not Medi-Cal reimbursable.
LOCATION OF SERVICE: Identifies the location where the service was rendered. CSI requirements have expanded the place of service. Circle the appropriate place of service. The choices are:

1 **Office** – Services provided in the office where the mental health professional routinely provides services.
2 **Field** – When location is away from the clinician’s usual place of business. Use only when no other specific non-office location is applicable.
3 **Phone** – Services provided by telephone contact with the consumer.
4 **Home** – Services provided at a location, other than a hospital or other facility, where the consumer lives.
5 **School** – Services provided in any facility that has the primary purpose of education.
6 **Correctional Facility** – Services provided in a correctional facility (e.g. Jail, Prison, Camp/Ranch, etc.) including adult or juvenile detention facilities.
7 **Inpatient** – Services are provided in a Hospitals, Psychiatric Health Facilities (PHFs), Skilled Nursing Facilities (SNFs), Institutes for Mental Disease (IMDs), Mental Health Rehabilitation Centers (MHRCs),
8 **Homeless/Emergency Shelter** – Services provided in a facility specifically designed to provide shelter to the general homeless population.
9 **Faith-based** – Services provided in a location owned or leased by a faith group, with partial or full involvement of the faith group (e.g. church, temple, etc.).
10 **Health Care/Primary Care** – Services provided in the clinic or facility of the health care provider, including emergency rooms and public health clinics.
11 **Age-Specific Community Center** – Services provided in a location owned or leased by an age-specific community center, such as a senior’s center, a teen drop in center, etc.
12 **Client’s Job Site** – Services provided at the consumer’s site of employment.
13 **Licensed Community Care Facility – Adults** – Services provided in a location supplying 24 hour non-medical care for adults
14 **Mobile Services** – This definition is consistent with the concept of a Mobile Clinic. Mobile clinics provide services to individuals in rural or outlying areas where services are otherwise inaccessible. The concept of mobile services is in contrast to
services provided at other community locations that are reached by vehicle.

17 Non-Traditional Service Location – Services provided in the community, but not in a community center, school, faith-based location, homeless/emergency shelter, health-care center, or the consumer’s job site. Examples include park bench, on the street under a bridge, in an abandoned building, etc.

18 Other Community Location – Services provided in the community, but not listed above.

19 Residential Treatment Center – Children – Services provided in a location supplying 24-hour non-medical care for children, other than inpatient hospital, or Psychiatric Health Facilities (PHFs). Includes Community Treatment Facilities (CTFs) and family foster homes.

20 Telehealth – Also known as “Teledmedicine.” Services are provided so that the clinician and consumer are in two different locations but can see each other via visual equipment (e.g., video, camera, web camera).

21 Unknown – Not Reported.

PLACE OF SERVICE TERMS:

Community Treatment Facility (CTF): Any residential facility that provides mental health treatment services to children in a group setting which has the capacity to provide secure containment.

Mental Health Rehabilitation Center (MHRC): This is a 24-hour program, licensed by the State Department of Healthcare Services (DHCS), which provides intensive support and rehabilitation services designed to assist persons 18 years or older, with mental disorders who would have been placed in a state hospital or another mental health facility to develop skills to become self-sufficient and capable of increasing levels of independent functioning.

Institute for Mental Disease (IMD): A term used by the Federal Government in California to distinguish skilled nursing facilities (SNF) that primarily care for people with psychiatric diagnoses, from those that provide care for people with primarily medical illnesses. Any SNF with greater than 16 beds and with 51% or more of its population with a psychiatric diagnosis is considered to be an IMD.

Psychiatric Health Facility (PHF): A non-hospital 24-hour acute care facility licensed by the DHCS.

Skilled Nursing Facility (SNF): A health facility, which provides the following basic medical services: skilled nursing care and supportive care to consumers whose primary need is for availability of skilled nursing care on an extended basis.

State Hospital: A psychiatric facility owned and operated by the State of California.
SERVICE STRATEGIES: This is a requirement for CSI reporting. Circle up to three service strategies, if applicable. The following are definitions for Service Strategies:

50 Peer and/or Family Delivered Services – Services and supports provided by consumers and family members who have been hired as treatment program staff, or who provide adjunct supportive or administrative services, such as training, information dissemination and referral, support groups and self-help support and empowerment. Please note that if the service/support is to be reimbursed by Medi-Cal, consumer and staff duties must meet Medi-Cal reimbursement requirements.

51 Psycho-education – Services that provide education about mental health diagnosis and assessment, medications, services and support planning, treatment modalities, other information related to mental health services and needs.

52 Family Support – Services provided to a consumer’s family member(s) in order to help support the consumer.

53 Supportive Education – Services that support the consumer toward achieving educational goals with the ultimate aim of productive work and self-support.

54 Delivered in Partnership with Law Enforcement – Services that are integrated, interdisciplinary and/or coordinated with law enforcement, probation or courts (e.g., mental health courts, jail diversion programs, etc.) for the purpose of providing alternatives to incarceration/detention for those with mental illness/emotional disturbance and criminal justice system involvement.

55 Delivered in Partnership with Health Care – Integrated, interdisciplinary and/or coordinated physical and mental health services, including co-location and/or collaboration between mental health and primary care providers, and/or other health care sites.

56 Delivered in Partnership with Social Services – Integrated, interdisciplinary and/or coordinated social services and mental health services, including co-location and/or collaboration between mental health and social services providers.

57 Delivered in Partnership with Substance Abuse Services – Integrated, interdisciplinary and/or coordinated substance use services and mental health services, including co-location and/or collaboration between mental health providers and agencies/providers of substance use services.
58 Integrated Services for Mental Health and Aging – Integrated, interdisciplinary and/or coordinated services for mental health and issues related to aging, including co-location and/or collaboration between mental health providers and agencies/providers of services specific to the aging (e.g., health, social, community service providers, etc.).

59 Integrated Services for Mental Health and Developmental Disability – Integrated, interdisciplinary and/or coordinated mental health services and services for developmental disabilities, including co-location and/or collaboration between mental health providers and agencies/providers of services specific to developmental disabilities.

60 Ethnic-Specific Service Strategy – Culturally appropriate services that reach and are tailored to persons of diverse cultures in order to eliminate disparities. Includes ethnic-specific strategies and community cultural practices such as traditional practitioners, natural healing practices, and ceremonies recognized by communities in place of, or in addition to, mainstream services.

61 Age-Specific Service Strategy – Age appropriate services that reach and are tailored to specific age groups in order to eliminate disparities. Age-specific strategies should promote a wellness philosophy including the concepts of both recovery and resiliency.

99 Unknown – Not known.

☐ Interpreter: Check if an interpreter was utilized in the service.

Name of Interpreter: If an interpreter was utilized, write his/her name.

Language service provided in other than English: ☐ Spanish ☐ Other: Check if service was provided by the clinician in Spanish, or check other and write in the language the service was provided in.

CLINICAL DOCUMENTATION

Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

Treatment Goal(s) addressed, if appropriate: Chart appropriate treatment goals addressed during clinical service.
Description of Current Situation: Chart as appropriate to the reason for contact; clients concern(s); status update since last contact; clinical behavioral acuity; current stressors; needs; progress/lack of progress toward specific goal (not a restatement of goal).

Note: do not bill for a progress note that states, “completed ur paperwork/level 1 paperwork.” In an audit, this note would be disallowed because it does not document a service. The clinician can document the completion of an assessment or treatment plan, which would be acceptable in an audit.

Current DSM Diagnosis: Document the client’s diagnosis. The state of California has not made changes to the Medical Necessity criteria to reflect the release of the DSM 5, in May of 2013. Until further notice, CCMHP will continue to follow the Medical Necessity criteria and diagnoses in the DSM IV-TR. (Title 9, Section 1830.205)

Focus of Activity: Intervention (What did you do?) What was the client’s response to the intervention.

The clinician’s intervention should include an interactive verb. Examples can include:

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<tr>
<th>Actively Listened</th>
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<td>Supported</td>
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Plan: As applicable chart to: the coordination of care, referrals to community resources and agencies; follow up care, and/or return for next appointment. Include Person’s Planned Action and Staff’s Planned Action, as agreed upon.

Signature/License/Job Title: This is the clinician providing the service.
Printed Name: Print the name of the clinician providing service and include License, Title, or Designation.

Documentation Date: The date the note was written. In situations where documentation of services does not occur on the day the service was provided, the correct date should be noted, followed by “Late Entry for insert date of service”.

Co-Signature/License: Signature of licensed clinician, if applicable. CSW, Parent Partner, and Trainee require a Co-Signature.

Date: Date of co-signature by licensed clinician, if applicable.

Computer Entry Clerk Initials: The initials of the data entry clerk.
SERVICE DEFINITIONS

MENTAL HEALTH SERVICES

Title 9 Definition (§1810.227):

"Mental Health Services" mean those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of Adult Residential Services, Crisis Residential Treatment Services, Crisis Intervention, Crisis Stabilization, Day Rehabilitation, or Day Treatment Intensive Services. Mental Health Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

NOTE: For seriously emotionally disturbed children and adolescents, Mental Health Services provides a range of services to assist the child/adolescent to gain the social and functional skills necessary for appropriate development and social integration.

Types of Service Activities:

- **Assessment** (331) (if within your scope of practice, see scope of practice chart in Section 1)

  Assessment is a clinical analysis of the history and current status of the client's mental, emotional, or behavioral disorder. Relevant cultural issues and history may be included where appropriate. Assessment may include diagnosis and the use of testing procedures.

Examples:
  - Interviewing the client and/or significant support person
  - Administering, scoring, and analyzing psychological tests
  - In some instances, gathering information from other professionals (e.g. teachers, school counselor, etc) and
reviewing/analyzing clinical documents/other relevant documents may be justified as contributing towards an assessment.

- Observing the client in a setting such as milieu, school, etc. may be indicated for clinical purposes.
- Formulate a diagnosis

- **Evaluation (313)**
  Evaluation is an appraisal of the client's community functioning in several areas including living situation, daily activities, social support systems and health status. Cultural issues must be addressed where appropriate.

Examples:

- In some instances, gathering information from other professionals (e.g. teachers, school counselor, etc) and reviewing/analyzing clinical documents/other relevant documents may be justified as contributing towards an assessment.
- Observing the client in a setting such as milieu, school, etc. may be indicated for clinical purposes.

- **Collateral (311)**
  A Collateral service is contact with one or more significant support persons in the life of the client, which may include consultation and training to assist in better utilization of services and understanding of mental illness. Collateral services include, but are not limited to helping significant support person(s) to understand and accept the client's condition and involving them in service planning and implementation of treatment plan(s). Collateral services also include family counseling or therapy, which is provided on behalf of the individual.

- Significant support persons may include parents or legal guardians, persons living in the same household, relatives, etc.
- The client may or may not be present for the collateral activity.

Examples:

- Educating the support person about the client's mental illness.
- Training the support person to better support or work with the client.
• **Individual Therapy (341)**
  Individual Therapy is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Individual Therapy should be consistent with client’s stated goals.
  - Progress notes need to adequately document the therapeutic intervention(s) or therapy activity that was provided.

• **Rehab Support (317)**
  Rehab Support is a service activity, which includes assistance in improving, maintaining, or restoring a client’s or group of client’s functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources, and/or medication education.

  Examples:
  - Maintaining current housing situation
  - Social skills, developing and maintaining a support system

• **Plan Development (315)**
  Plan Development is a service activity that refers to a written treatment plan and may include any or all of the following:
  - Development of Treatment Plans
  - Verification of medical or service necessity
  - Monitoring of client’s progress towards treatment goals

• **Group Therapy (351)**
  Group Therapy is a therapeutic intervention with two or more clients in a group with a primary focus of symptom reduction as a means to improve social functioning and reduce interpersonal conflicts.

• **Group Rehab (355)**
  Group Rehab is a service activity with two or more individuals directed at improving, restoring, or maintaining functional skills.
• **Group Collateral (357)**
  Group Collateral is a medically necessary service that is provided to significant support persons of multiple consumers in a group setting. Support persons must play an integral part in assisting the client in achieving the goals on their Partnership Plan. This service may include, but are not limited to, consultation and training of the significant support persons to assist in better utilization of mental health services, to promote a better understanding of the client’s mental illness, and to assist the client in meeting their goals. The client is not required to be present when this collateral group contact occurs.

• **Non-Billable – Mental Health Services (540)**
  This service code should be used for any mental health service that cannot be billed to Medi-Cal. This may include services such as work training, recreational activities, preparing meals, transporting clients, money management, etc.

• **Non-Billable – Lockout (580)**
  This service code should be used for any mental health service that cannot be billed to Medi-Cal because the client is in an IMD, MHRC, hospital, jail, juvenile, etc.

**Katie-A Subclass Services**

New procedure codes have been developed by the State Department of Health Care Services (DHCS). A Katie-A progress note was developed to include the new procedure codes. All services provided for Subclass members are to be documented on the Katie-A progress note. This includes all mental health services such as Individual Therapy or Collateral services with the exception of TBS, medication notes, and Wraparound notes and plans.

• **Intensive Care Coordination (ICC)**
  This service code should be used for case management services that facilitates assessment of, care planning for, and coordination of services including urgent services. ICC services ensures that plans from any of the system partners (i.e. child welfare, education, juvenile probation, community partners, etc.) are integrated.
• **Intensive Home Based Services (IHBS)**
  This service code should be used for services aimed at helping the client build skills necessary for successful functioning in the home and community and improving the youth's family ability to help the youth successfully function in those settings.

**Documentation:** Each progress must stand alone. This means, that each note needs to include the treatment goal(s) addressed (if appropriate), description of current situation/reason for contact (status update, clinical impression, current stressors, clinical/behavioral acuity, needs, or concerns), intervention (what did you do) and response to intervention, and plan (coordination of care, referrals, follow up).

**TIP:** Progress notes should clearly document the reason for the service as it relates to the treatment plan and how it benefits the client.

- **Example:** Depressed client who needs encouragement to socialize in order to improve his support system. The documented progress note... “spoke with client about ways to meet people in their self-help group and re-engage contact with his sister, with the intent of decreasing his isolation.”

- **Example:** Disruptive child who lives in foster home, not following directions, and needs structure to maintain placement. The documented progress note... “talked with client about positive ways to interact with adults and role played with client how to have respectful adult interactions which will assist him in maintaining his foster placement.”

**Lockouts For Mental Health Services**

IMDs, MHRCs, Jail, and Juvenile Hall: No Medi-Cal claimable services. Use only non-billable codes, i.e. 580. Applies to all staff.

Day Treatment, Day Rehab: Mental Health Services are not reimbursable when provided by Day Rehab or Day Treatment Intensive staff during the same time period that Day Rehab or Day Treatment intensive services are provided. Therapeutic Behavioral Services (TBS) may be claimed during Day Rehab or Day Treatment Intensive if TBS services were pre-authorized and delivered by staff other than the Day Rehab or Day Treatment Intensive staff.
Crisis Residential: (Nierika) No Mental Health claimable services except Case Management. Use Case Management procedure codes or Non-Billable procedure codes.

Acute Psychiatric Inpatient: No Medi-Cal Mental Health Services except day of admission and day of discharge. Case Management-Placement allowed

Katie-A: Certain restrictions apply to the ICC & IHBS codes.

- ICC services are locked out for youth in hospitals, group homes, psychiatric health facilities, or psychiatric nursing facilities except for the purposes of coordinating placement of the youth transitioning from those facilities for a maximum of 30 days -for no more than 3 non-consecutive 30 day periods.

- IHBS may not be provided to youth in the group home facility; however, they can be provided to youth outside the group home to facilitate transition. IHBS can be provided in the community (homes, schools, recreational settings, etc.) IHBS services are not permitted during the same hours of the same day as: day treatment, group therapy, or TBS.

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Case Management

Title 9 Definition (§1810.249)

Case Management is services that assist a client to access needed medical, educational, social, pre-vocational, vocational, rehabilitative, or other community services. Case Management service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure the client’s access to service and the service delivery system; monitoring of the client’s progress and plan development.

TIP: Case Management is also known as Targeted Case Management and Case Management Brokerage.
NOTE: Case Management is NOT skill development, assistance in daily living, or training a client to access services him/herself. These types of services are Mental Health Services (i.e., Rehab Support).

While more than one program may deliver Case Management services, there should be different clinical roles and documentation of why more than one program is involved.

TIP: A case management progress note includes the focus of the assistance/intervention provided to the client (i.e. accessing medical services, housing support, etc.) and justifies the need for this service based on mental health symptoms/issues; i.e. who was spoken to, what was discussed, what is the plan, is there a referral to an outside services, and what is the next step needed to assist the client.

Types of Service Activities:

- **Linkage and Advocacy (561)**
  Identification and pursuit of resources including:
  o Interagency and intra-agency consultation, communication, coordination, and referral.
  o Monitoring service delivery to ensure a client’s access to service and the service delivery system.
  o Monitoring of the client’s progress.

- **Placement Services (541)**
  Supportive assistance to the client in the assessment, determination of need and securing of adequate and appropriate living arrangements, including:
  o Monitoring of the client’s progress.
  o Locating and securing an appropriate living environment.
  o Locating and securing funding.
  o Pre-placement visit(s)
  o Negotiation of housing or placement contracts
  o Placement and placement follow-up.
  o Accessing services necessary to secure placement

- **Plan Development (571)**
  Discussing a treatment plan (i.e. IEP, Wraparound Plan, TBS), or monitoring a client’s progress towards treatment goals. Case
management plan development is similar to Plan Development but, has an emphasis on linking, coordinating, or placement. (i.e. focus on education, vocational, medical needs, or coordination of care).

Lockouts For Case Management Services

IMDs, MHRCs, Jail, and Juvenile Hall: No Medi-Cal claimable services. Use only non-billable codes, i.e. 580. Applies to all staff.

Acute Psychiatric Inpatient: May use 541 Placement if service activity is related to coordinating placement within 30 days of discharge for up to 3 nonconsecutive 30 day periods. All services provided on day of admission, but before admission are allowed. All services are allowed on day of discharge. Applies to all staff.

CRISIS INTERVENTION

Title 9 Definition (§1810.209):

Crisis Intervention means a service to or on behalf of a client for a condition that requires a more timely response than a regularly scheduled visit. The maximum amount billable for Crisis Intervention in a 24-hour period is 8 hours. Service activities may include but are not limited to assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by different service providers.

Types of Service Activities:

- Crisis Intervention (371)
  A service activity that may include but is not limited to assessment, collateral, and individual therapy.

NOTE: Crisis Intervention is an immediate emergency response that is intended to help the client cope with a crisis (potential danger to self or others, severe reaction that is above the client’s normal baseline).

  For Example: A child who does not want to go to school and is threatening to beat up his mother. All the work with this client to help
deescalate and prevent hospitalization and incarceration would be billable as Crisis Intervention. Once the client is no longer a danger to himself or others, and is stabilized then all subsequent visits or services should not be billed as Crisis Intervention, but can be billed as Rehab Services (317) or Individual Therapy (341).

Documentation Requirements:

Each note must include the following information:
- Acuity of client or situation that jeopardizes his/her ability to maintain community functioning.
- A description of what was attempted and/or accomplished by service staff at the time the service was being provided.
- Plan for subsequent service, if applicable.

Lockouts For Crisis Intervention (§1840.366):

IMDs, MHRCs, Jail, and Juvenile Hall: No Medi-Cal claimable services. Use only non-billable codes, i.e. 580. Applies to all staff.

Acute Psychiatric Inpatient: No Medi-Cal claimable services except on the day of admission, but before admission are allowed. Service allowed on day of discharge.

MEDICATION SUPPORT

Title 9 Definition (§1810.225):

Medication support services, which include prescribing, administration, or dispensing and monitoring of psychiatric medications or biologicals, which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, the obtaining of informed consent, instruction in the use, risks and benefits of and alternative for medication, and medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.
Types of Service Activities:

- **Evaluation/Rx (361)**
  Initial Assessment including medical and psychiatric history, current medication, chart review. Observation of need for medication due to acuity. Consultation with clinician, M.D., or nurse regarding medication. Prescribing, administering, and dispensing medication, lab work, vitals, observation for clinical effectiveness, side effects and compliance to medication. Obtaining informed consent for medications.

- **RN/Injection (362)**
  Specifically for the injection and all that an injection entails under guidelines of administration/evaluation of medication.

- **Education (363)**
  Medication education (including discussing risks, benefits, and alternative with the individual or significant support persons.)

- **Plan Development (364)**
  Plan development related to the delivery of this service and/or to the status of the client's community functioning.

- **Medication Group (369)**
  Therapeutic interventions with two or more clients with a primary focus on medications.

NOTE: The maximum amount claimable to Medi-cal for medication support services in a 24 hour period is 4 hours per client.

**Lockouts For Medication Support**

Acute Psychiatric Inpatient: No claimable services except on the day of admission, but before admission are allowed. Service allowed on day of discharge
Medication Informed Consent

A voluntary client shall be treated with psychotropic medications only after s/he has been informed by the physician of his/her right to accept or refuse such medications and that consent, once given, can be withdrawn at any time.

The information received by the client and documented by the physician shall include, but need not be limited to (Title 9, §851):

- Nature of the client’s mental condition.
- Reason(s) for taking the medication(s), including the likelihood of improving or not improving without the recommended medication.
- Type, range of frequency and amount, and method and duration of taking medication(s).
- Probable side effects which commonly occur and any possible additional side effects which are likely to occur if medication is taken beyond three (3) months; the client shall be advised in accord with the medication(s) prescribed that the symptoms of tardive dyskinesia are potentially irreversible and may continue or appear after medications have been discontinued.

The client, indicating the above has been discussed, must sign an informed consent form. A copy must be offered to the client. The original consent form must be filed in the client’s medical record. Consent forms should be updated every 2 years.

| DAY TREATMENT SERVICES |

Day Treatment Intensive and Day Rehab services must be authorized by the Day Treatment Authorization Committee prior to claiming services.

In the therapeutic milieu, specific activities are performed by identified staff and take place for the continuous scheduled hours of operation for the program. Staff teach, model, and reinforce constructive interactions. Therapeutic interaction includes peer and staff feedback to clients, strategies for reducing symptoms, and increasing adaptive behaviors. Clients learn self-management skills, which they can use to control their own lives, to deal effectively with future and present problems, and to function well with minimal or no additional therapeutic interventions.
The hours of operation that establish day treatment intensive and day rehabilitation programs are four hours or more per day for full-day programs and at least three hours but less than four hours per day for half-day programs.

Clients are expected to be present for all scheduled hours of operation for each day. When a client is unavoidably absent for some part of the hours of operation, Medi-Cal can only be claimed if the client is present for at least 50 percent of the scheduled hours of operation for that day.

Definitions

Both Day Treatment Intensive and Day Rehabilitation are programs with services available at least four hours per day or more for a full day program and at least three hours but less than four hours per day for a half-day program.

Lockouts For Day Treatment

IMDs, MHRCs, Crisis Residential Treatment Services, and Acute Psychiatric Inpatient are not reimbursable except for the day of admission and day of discharge.

Mental Health Services are not reimbursable when provided by Day Rehabilitation or Day Treatment Intensive staff during the same time period that Day Rehabilitation or Day Treatment Intensive Services are being provided. While Mental Health Services cannot be claimed separately by day treatment staff during the hours these program operate, Therapeutic Behavioral Services (TBS) may be claimed during Day Rehab and Day Treatment Intensive if TBS services are preauthorized.

NOTE: The Contra Costa Day Treatment Authorization Committee must authorize Supplemental Mental Health Services. Supplemental Mental Health Services are those services that are provided outside of the day treatment hours. The service provider must identify each type of service they wish to provide and the justification as to why the service is medically necessary.

See examples of the Request for Supplemental Services.
Day Treatment Intensive (§1810.213)

Day Treatment Intensive service is a structured multi-disciplinary treatment program as an alternative to hospitalization, to avoid placement in a more restrictive setting, or to maintain the client in a community setting. These services are provided to a distinct group of clients and occur in a therapeutic, organized and structured setting.

NOTE: For seriously emotionally disturbed children and adolescents, Day Treatment Intensive provides a range of services to assist the child/adolescent to gain the social and functional skills necessary for appropriate development and social integration. Interventions are intended to prevent hospitalization, placement in a more restrictive facility, or out of home placement. This service may be integrated with an education program. A key component of this service is contact with the families of these children/adolescents.

Service Activities

Service activities include but are not limited to Assessment, Evaluation, Plan Development, Individual Therapy, Rehab, and Collateral. The billing for Day Intensive is the day, not the service.

Medication Support Services that are provided within a Day Intensive program shall be billed separately.

Day Treatment Intensive programs are required to include the following service components and shall be available four hours or more per day for full-day programs and at least three hours but less than four hours per day for half-day programs. The service components must be developmentally and age appropriate.

- Community meetings that occur at a minimum of once a day, but may occur more frequently as necessary to address issues pertinent to the continuity and effectiveness of the therapeutic milieu, and actively involve staff and clients. The community meetings will address relevant items, including the schedule for the day, current events, individual issues clients or staff wish to discuss or elicit support of the group, conflict resolution within the milieu, planning for the day, the
week, or for special events, old business from previous meetings, or from previous day treatment experiences, and debriefing or wrap up. Community meetings are not counted as part of the day treatment hours.

- Skill building groups where staff help clients identify barriers related to their psychiatric and psychological experiences and through group interaction, become better able to identify skills that address symptoms and behaviors. Skill building will support learning and using adaptive behaviors.

Some examples of Skill Building Groups: Anger management group, independent living skills, relationship skills, symptom management skills, relapse prevention skills, stress/anxiety management, crisis management, nutrition group, dual diagnosis group.

- Adjunctive therapies are non-traditional therapies involving staff and clients where the therapeutic intervention utilizes self-expressive modalities, e.g. art, recreation, dance, music. The modality is directed towards developing and enhancing skills toward client plan goals.

Some examples of Adjunctive therapies: Art therapy, drama therapy, music therapy, recreation therapy, horticulture therapy.

- Psychotherapy is the use of psychosocial methods within a professional relationship to assist the client(s) to achieve a better psychosocial adaptation; to acquire greater human realization of psychosocial potential and adaptation; to modify internal and external conditions that affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to their intra-personal and interpersonal processes. **Psychotherapy shall be provide by licensed, registered, or waived staff practicing within their scope of practice.**

Some examples of Psychotherapy Groups: Mens/womens groups, communication group, self-esteem group, responsibility group, cognitive problem solving group, communications group, anger management group.
• Day Treatment Intensive programs may also include process groups (see Day Rehabilitation) in addition to the service activities listed above.

• Family/Caregiver Involvement of at least one contact per month is required for children in Intensive Day Treatment. Adult clients may identify a significant support person for this monthly contact. Also, adult clients may choose whether or not this service component is done for them. The contacts and involvement should focus on the role of the significant support person in supporting the client’s community reintegration. It is expected that this contact will occur outside the hours of operation of the day treatment program.

A detailed weekly schedule identifying where and when the service components identified above will be provided and by whom shall be made available to clients and, as appropriate, to their families, caregivers, or significant support persons. The written weekly schedule shall specify program staff.

**Staffing Requirements**

At a minimum there must be an average ratio of at least one staff to eight clients in attendance during the period the program is open. Other staff may be utilized according to program need, but shall not be included as part of the ratio formula.

At least one staff person must be present and available to the group in the therapeutic milieu for all scheduled hours of operation, and for day treatment intensive staffing must include at least one person whose scope of practice includes psychotherapy. This person can be a physician, Registered Nurse, or licensed/waivered/registered psychologist, social worker, MFT.

**Documentation Requirements**

• Daily Notes describing the service provided and the daily activities.

• Weekly Clinical Summary describing what was attempted and/or accomplished toward the client goal(s) by the client and service staff.
  o Weekly clinical summaries may be written by any clinical staff, but must be reviewed and signed by a licensed clinician of the
Healing Arts (LPHA): physician, a licensed psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service.

DAY REHABILITATION (§1810.213)

Day Rehabilitation is a structured program of rehabilitation and therapy to improve, maintain, or restore personal independence and functioning, consistent with the requirements for learning and development, which provides services to a distinct group of clients.

Service Activities

Service activities include but are not limited to Assessment, Evaluation, Plan Development, Individual Therapy, Rehab, and Collateral. The billing for Day Intensive is the day, not the service.

Medication Support Services that are provided within a Day Rehabilitation program shall be billed separately.

Day Rehabilitation programs are required to include the following service components and shall be available four hours or more per day for full-day programs and at least three hours but less than four hours per day for half-day programs. The service components must be developmentally and age appropriate.

- Community meetings that occur at a minimum of once a day, but may occur more frequently as necessary to address issues pertinent to the continuity and effectiveness of the therapeutic milieu, and actively involve staff and clients. The community meetings will address relevant items, including the schedule for the day, current events, individual issues clients or staff wish to discuss to elicit support of the group, conflict resolution within the milieu, planning for the day, the week, or for special events, old business from previous meetings, or from previous day treatment experiences, and debriefing or wrap up. Community meetings are not counted as part of the day treatment hours.
- Skill building groups where staff help clients identify barriers related to their psychiatric and psychological experiences and through group interaction, become better able to identify skills that address symptoms and behaviors. Skill building will support learning and using adaptive behaviors.

Some examples of Skill Building Groups: Anger management group, independent living skills, relationship skills, symptom management skills, relapse prevention skills, stress/anxiety management, crisis management, nutrition group, dual diagnosis group.

- Adjunctive therapies are non-traditional therapies involving staff and clients where the therapeutic intervention utilizes self-expressive modalities, e.g. art, recreation, dance, music. The modality is directed towards developing and enhancing skills toward client plan goals.

Some examples of Adjunctive Therapies (Alternative non-verbal self expression groups): Art therapy, drama therapy, music therapy recreation therapy, horticulture therapy.

- Process Groups facilitated by staff to help clients develop the skills necessary to deal with their individual problems and issues by using the group process to provide peer interaction and feedback in developing problem-solving strategies and to assist one another in resolving behavioral and emotional problems.

Some examples of Process Groups: Mens/womens groups, communication group, self-esteem group, responsibility group, cognitive problem solving group, communications group, anger management group.

- Day Rehabilitation programs may also include psychotherapy groups (See Day Intensive) instead of process groups or in addition to process groups.

- Family/Caregiver Involvement of at least one contact per month is required for children in Rehabilitation Day Treatment. Adult clients may identify a significant support person for this monthly contact. Also, adult clients may choose whether or not this service component is done for them. The contacts and involvement should focus on the role of the significant support person in supporting the client’s
community reintegration. It is expected that this contact will occur outside the hours of operation of the day treatment program.

A detailed weekly schedule identifying where and when the service components identified above will be provided and by whom shall be made available to clients and, as appropriate, to their families, caregivers, or significant support persons. The written weekly schedule shall specify program staff.

**Staffing Requirements**

At a minimum there must be an average ratio of at least one staff to ten clients in attendance during the period the program is open. Programs serving more than twelve clients must include two staff as part of the staff ratio. Other staff may be utilized according to program need, but shall not be included as part of the ratio formula. At least one staff person must be present and available to the group in the therapeutic milieu for all scheduled hours of operation.

**Documentation Requirements**

Weekly summary including a description of what was attempted and/or accomplished toward the client goal(s) by the client and service staff. Daily activities in which the client participated must be reflected in the documentation.

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<th>THERAPEUTIC BEHAVIORAL SERVICES</th>
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**Title 9 Definition (§1810.215)**

Therapeutic Behavioral Services (TBS) is an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental specialty mental health service for children and youth. TBS allows for the provision of intensive one-to-one services for children/youth who have serious emotional problems and are experiencing stressful transitions or life crises. Since TBS is an EPSDT service, it may be provided to children/youth up to the age of 21. TBS may be provided to support other specialty mental health services when additional short-term support is needed to prevent
placement in high level group homes (RCL 12 through 14) or a locked facility for the treatment of mental health needs. TBS may also be provided to enable a transition from any of those levels to a lower level or residential care.

TBS eligibility requires Full-Scope Medi-Cal and the client to be under the age of 21 years who meet medical necessity criteria.

**TYPES OF SERVICE ACTIVITIES**

TBS is an intensive one-to-one short-term outpatient treatment intervention. TBS is not a “stand alone” service but is intended to supplement other specialty mental health services.

- **TBS INTERVENTION: [391, 392]**
  an individualized one-to-one behavioral assistance intervention to accomplish outcomes specifically outlined in the written TBS treatment plan. A TBS intervention can be provided either through face-to-face interaction or by telephone

- **TBS COLLATERAL: [393]**
  A TBS collateral service activity is an activity provided to significant support persons in the child/youth’s life, rather than to the child/youth. The documentation of collateral service activities must indicate clearly that the overall goal of collateral service activities is to help improve, maintain, and restore the child/youth’s mental health status through interaction with the significant support person.

*NOTE: Not all contacts with a significant support person will qualify as a TBS Collateral contact; it is important to distinguish TBS Collateral contacts from Case Management service contacts.

- **TBS ASSESSMENT: [397]**
  A TBS assessment service activity is an activity conducted by a provider to assess a child/youth’s current problem presentation, maladaptive at risk behaviors that require TBS, member class inclusion criteria, and clinical need for TBS services. Periodic re-assessments for continued medical necessity and clinical need for TBS should also be recorded under this service function.
• **TBS PLANS: [395, 396]**

TBS Plans of Care/Client Plan service activities include the preparation and development of a TBS care plan. Activities that would qualify under this service function code include, but are not limited to:

- Preparing Client Plans
- Reviewing Client Plan (Reimbursable only if review results in documented modifications to the Client Plan)
- Updating Client Plan
- Discussion with others to coordinate development of a child/youth’s Client Plan (excludes supervision). (Reimbursable only if discussion results in documented modifications to the Client Plan.)

**Lockouts For TBS**

IMDs, MHRCs, Crisis Residential: No TBS services are reimbursable.

Juvenile Hall: No TBS services are reimbursable unless there is evidence that the court has ordered placement.

Acute Psychiatric Inpatient: No TBS services except for the day of admission and the day of discharge.

Crisis Stabilization: TBS Services are not reimbursable when provided during the same time period that Crisis Stabilization services are provided.

---

**ADULT RESIDENTIAL TREATMENT SERVICES**

**Definition (§1810.203)**

Adult Residential Treatment Services are rehabilitation services provided in a non-institutional, residential setting, other than crisis residential, which provide a therapeutic community including a range of activities and services for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service is available 24 hours a day, seven days a week.
TYPES OF SERVICE ACTIVITIES

Service activities may include assessment, plan development, therapy, rehabilitation, and collateral.

Medication Support Services are billed separately.

FREQUENCY OF DOCUMENTATION

At least a weekly summary and a separate note whenever a scheduled session takes place with the client.

Lockouts For Adult Residential

Crisis Residential, IMDs, MHRCs: No Adult Residential services are reimbursable except for the day of admission.

Acute Psychiatric Inpatient: No Adult Residential services are reimbursable except for the day of admission and the day of discharge.

STAFFING REQUIREMENTS

Greater numbers of staff shall be present during times when there are greater numbers of clients in programmed activities. Staff schedules shall be determined by the program based on the number of clients in the program during specific hours of the day, level of care provided by the program, and the range of services provided within the facility.

At least one staff shall be present at any time there are clients at the facility. There shall be a staffing ratio of at least one (1) full-time equivalent direct service staff for each 2.5 clients serviced. All scheduled hours in the facility shall be considered part of this required full-time equivalent staffing ratio.

Providers may not allocate the same staff's time under the two cost centers of Adult Residential and Mental Health Services for the same period of time.

Nevin House and Crestwood Healing Center: Pathways are the adult residential programs in contra costa county.
CRISIS RESIDENTIAL TREATMENT SERVICES

Definition (§1810.208)

Crisis Residential Treatment Services mean therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program for clients as an alternative to hospitalization for clients experiencing an acute psychiatric episode or crisis who do not present medical complications requiring nursing care. The service support clients in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include assessment; plan development, therapy, rehabilitation, collateral, and crisis intervention.

TYPES OF SERVICE ACTIVITIES

Clients admitted to Crisis Residential Services must receive a mental health and medical assessment, including a screening for medical complications, which may contribute to his/her disability, within three days prior to or after admission.

Service activities include Assessment, Evaluation, Plan Development, Individual Therapy, Rehabilitation, Collateral, and Crisis Intervention. Not all of the activities need to be provided for the service to be billable. Billing for Crisis Residential is the day, not the service.

Medication support services that are provided within a Crisis Residential program shall be billed separately.

When a client is in a Crisis Residential program, other service providers can bill Case Management services.

FREQUENCY OF DOCUMENTATION

A daily note must include what was attempted and/or accomplished toward the goals, by the client and service provider or what was necessary at the time the service was delivered.
Lockouts For Crisis Residential

Except for the day of admission to Crisis Residential, the following services may not be billed on the same day as a Crisis Residential service:

Mental Health Services
Crisis Intervention
Crisis Stabilization
Day Treatment Intensive
Day Rehab, Adult Residential
IMDs
MHRCs

Acute Psychiatric Inpatient: No Crisis Residential services are reimbursable except for the day of admission and the day of discharge from the hospital.

Case Management services are allowed

Nierika House is the only adult crisis residential program in Contra Costa county.
**Progress Note/Billing Form**

**NAME / MRN**

**Service Date:**

**RU:**

**Staff #:**

**Hours**   **Mins**   **# in Group:**

**Co-Staff #:**

**Hours**   **Mins**   **Total Travel Time: Hours**   **Mins**

*Service duration must include travel time, if applicable*

**Services:** (Check one)

- [ ] 300 No Show
- [ ] 400 Client Cancel
- [ ] 700 Staff Cancel
- [ ] 371 Crisis Int.
- [ ] 311 Collateral

  - [ ] 313 Evaluation
  - [ ] 315 Plan Develpmnt
  - [ ] 317 Rehab
  - [ ] 331 Assessment
  - [ ] 341 Indiv Therapy

  - [ ] 351 Group Therapy
  - [ ] 355 Group Rehab
  - [ ] 357 Group Collateral
  - [ ] 541 Case Mgmt - Placement
  - [ ] 561 Case Mgmt - Linkage

  - [ ] 571 Case Mgmt - Plan Develpmnt
  - [ ] 540 Non-Billable Services
  - [ ] 580 Non-Billable - Lock-outs

**Location of Services:** (Check one)

- [ ] 1 Office
- [ ] 2 Field
- [ ] 3 Phone
- [ ] 4 Home

  - [ ] 5 School
  - [ ] 8 Correctional Facility
  - [ ] 9 Inpatient
  - [ ] 10 Homeless/Shelter

  - [ ] 11 Faith-based
  - [ ] 12 Healthcare
  - [ ] 13 Age-Specific Center
  - [ ] 14 Client's Job-site

  - [ ] 15 Licensed Care Fac. (Adult)
  - [ ] 16 Mobile Service
  - [ ] 17 Non-Traditional Location
  - [ ] 18 Other

  - [ ] 19 Residential Tx Center (Child)
  - [ ] 20 Telehealth
  - [ ] 21 Unknown

**Service Strategies:** (Check up to three, if applicable)

- [ ] 50 Peer/Family Services
- [ ] 51 Psycho-Education
- [ ] 52 Family Support

  - [ ] 53 Supportive Education
  - [ ] 54 With Law Enforcement
  - [ ] 55 With Health Care

  - [ ] 56 With Social Services
  - [ ] 57 With Substance Abuse
  - [ ] 58 With Aging Providers

  - [ ] 59 With Develpmnt Disabled
  - [ ] 60 Ethnic-specific Services
  - [ ] 61 Age-specific Services

  - [ ] 99 Unknown

- [ ] Interpreter

**Language service provided in other than English:**

- [ ] Spanish
- [ ] Other

**Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.**

1a. Treatment goal(s) addressed, if appropriate.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

1b. Description of Current Situation/Reason for Contact:

(Status update, needs, clinical impressions)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Current DSM Diagnosis
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
2. Focus of Activity:
(Intervention and Response to Intervention, what did you do? What is the consumer's response?)

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.

Signature/License/Job Title

Printed Name

Date

Co-Signature/License (if applicable)

Date

Computer Entry Clerk Initials

MHCO17-9 (Rev 11-13) Progress Note/Billing Form Page 2 of 2
## Katie A Progress Note/Billing Form

**CONTRA COSTA HEALTH SERVICES**  
Behavioral Health Services Division

**NAME / MRN**

### Service Date: ____________  
**RU:** ____________  
**Hours** ____________  
**Mins** ____________  
**Staff #:** ____________  
**Co-Staff #:** ____________  
**Mins** ____________  
**# in Group:** ____________  
**Total Travel Time: Hours** ____________  
**Mins** ____________  

*Service duration must include travel time, if applicable*

### Services: (Check one)

<table>
<thead>
<tr>
<th>No Show</th>
<th>Evaluation</th>
<th>Group Therapy</th>
<th>Case Mgmt - Plan Develpmt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Cancel</td>
<td>Plan Develpmt</td>
<td>Group Rehab</td>
<td>Non-Billable Services</td>
</tr>
<tr>
<td>Staff Cancel</td>
<td>Rehab</td>
<td>Group Collateral</td>
<td>Non-Billable - Lock-outs</td>
</tr>
<tr>
<td>Crisis Int.</td>
<td>Assessment</td>
<td>Case Mgmt - Placement</td>
<td>Katie A Sub-Class</td>
</tr>
<tr>
<td>Collateral</td>
<td>Indiv Therapy</td>
<td>Case Mgmt - Linkage</td>
<td></td>
</tr>
</tbody>
</table>

### Location of Services: (Check one)

<table>
<thead>
<tr>
<th>Office</th>
<th>School</th>
<th>Faith-based</th>
<th>Licensed Care Fac. (Adult)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field</td>
<td>Correctional Facility</td>
<td>Healthcare</td>
<td>Mobile Service</td>
</tr>
<tr>
<td>Phone</td>
<td>Inpatient</td>
<td>Age-Specific Center</td>
<td>Non-Traditional Location</td>
</tr>
<tr>
<td>Home</td>
<td>Homeless/Shelter</td>
<td>Client's Job-site</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>21 Unknown</td>
</tr>
</tbody>
</table>

### Service Strategies: (Check up to three, if applicable)

<table>
<thead>
<tr>
<th>Peer/Family Services</th>
<th>Supportive Education</th>
<th>With Social Services</th>
<th>With Developmt Disabled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psycho-Education</td>
<td>With Law Enforcement</td>
<td>With Substance Abuse</td>
<td>Ethnic-specific Services</td>
</tr>
<tr>
<td>Family Support</td>
<td>With Health Care</td>
<td>With Aging Providers</td>
<td>Age-specific Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>99 Unknown</td>
</tr>
</tbody>
</table>

### Interpreter  
**Name of Interpreter:** ____________________________

Language service provided in other than English:  
☐ Spanish  
☐ Other

**Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.**

1a. **Treatment goal(s) addressed, if appropriate.**

________________________________________________________________________

________________________________________________________________________

1b. **Description of Current Situation/Reason for Contact:**  
(Status update, needs, clinical impressions)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**Current DSM Diagnosis** ____________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

MHC112 (12/13) Katie A Progress Note/Billing Form  
Page 1 of 2
2. Focus of Activity:
(Intervention and Response to Intervention, what did you do? What is the consumer’s response?)


3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.


Signature/License/Job Title

Printed Name

Date

Co-Signature/License (If applicable)  

Date

Computer Entry Clerk Initials
CONTRA COSTA
HEALTH SERVICES
MENTAL HEALTH DIVISION

PSYCHIATRIC SERVICES PROGRESS NOTE/BILLING FORM

DATE OF SERVICE __________________________ RU# _______________ # IN GROUP _______________
STAFF # ___________________________ HOURS _______________ MINUTES _______________
CO-STAFF# ___________________________ HOURS _______________ MINUTES _______________

TRAVEL TIME: Hrs ______ Minutes ______

<table>
<thead>
<tr>
<th>Med Svcs</th>
<th>MH Services</th>
<th>CM and Non-Billable Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>300 No Show</td>
<td>362 RN/INU</td>
<td>311 Collateral</td>
</tr>
<tr>
<td>400 Client Cancel</td>
<td>363 EDUC</td>
<td>341 Indiv. Therapy</td>
</tr>
<tr>
<td>700 Staff Cancel</td>
<td>364 PLAN/DEV</td>
<td>351 Group Therapy</td>
</tr>
<tr>
<td>361 EVAL/RX</td>
<td>369 MED GROUP</td>
<td>371 Crisis Intervention</td>
</tr>
<tr>
<td>1 Office</td>
<td>3 Phone</td>
<td>6 School</td>
</tr>
<tr>
<td>2 Field</td>
<td>4 Home</td>
<td>8 Correctional Facility</td>
</tr>
<tr>
<td>50 Peer/Family Services</td>
<td>59 Supportive Education</td>
<td>59 With Social Services</td>
</tr>
<tr>
<td>51 Psycho-Education</td>
<td>54 With Law Enforcement</td>
<td>57 With Substance Abuse</td>
</tr>
<tr>
<td>52 Family Support</td>
<td>56 With Health Care</td>
<td>58 With Aging Providers</td>
</tr>
</tbody>
</table>

BRIEF DESCRIPTION OF CLIENT (Age, Gender, Current Presentation, Date of Last Visit):
________________________________________________________________________________________
________________________________________________________________________________________

☐ Interpreter Name of Interpreter:
Language service provided in other than English: ☐ Spanish ☐ Other __________________________

INTERIM HISTORY AND OBSERVATIONS
(Progress and Improvement, Current and/or Persistent and/or Symptoms/Problems/Issues):
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

TARGETED MENTAL STATUS EXAM (Orientation, grooming, mood, affect, thought/perceptual content, insight):
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

MHC055-9 (Rev_9-13) Psychiatric Progress Note/Billing Form PAGE 1 OF 2
CURRENT MEDICATIONS: Please list all Psychiatric and non-Psychiatric medications at each visit.

☐ Medication Consents are current  ☐ Adherence / Side Effects / Adverse Effects Discussed

OBJECTIVE DATA: Lab or other Studies Reviewed: ☐ AIMS Performed: ☐ Ht   Wt   BMI   Waist   BP/P

Results:

CURRENT DIAGNOSTIC IMPRESSION (DSM DXS plus status):

DESCRIPTION OF PSYCHOTHERAPEUTIC INTERVENTION, IF ANY:

PLAN FOR CONTINUED SERVICE: (INCLUDING LAB ORDERS, EDUCATION, COORDINATION OF CARE).

LABS/ Other Studies ordered: ☐ REFERRAL to PCP ☐ REFERRAL for Psychotherapy ☐ Coordination with PCP ☐

R: ☐ No R Changes. ☐ Refills Authorized ☐ Medication Record Updated
☐ Medication Changes and Rationale ☐ Justification of Continued Use of Benzodiazepines

SPECIFIC CHANGES:

Next Appt: w/ MD/DO w/ RN w/ Case Manager/Other

MD/DO/NP Signature: ___________________________ DATE: ________________

MD/DO/NP NAME: ___________________________________________

MHC055-9 (Rev_9-13) Psychiatric Progress Note/Billing Form PAGE 2 OF 2
MENTAL HEALTH DISCHARGE SUMMARY/ BILLING FORM

DOCUMENTATION

Service providers complete the required closing documents for the medical record and appropriately bill this activity if (1) a decision has been made to discontinue services, (2) the client has not received services within the last 6 months, or (3) the client is deceased.

Under some circumstances, the medical record may not be closed in order to maintain the UR track, i.e. if the client is only receiving services from a contract agency or a medication only patient who has not been seen due to extenuating circumstances.

Responsible Staff: At discharge, the primary clinician that provided services to the client must complete the Mental Health Discharge Summary Form.

Billing Procedure Code Options:
To be a billable service the Mental Health Discharge Summary Form must be completed within five (5) days of last contact or notification of planned discontinuance of services. If submitted after 5 days, it must be billed as 540. The Mental Health Discharge Summary Billing form is used for the purpose of documenting decision making regarding medical necessity, or documentation should be such that consumer will benefit, i.e., to ensure continuity of care, or to facilitate the communication of pertinent information to another provider. Administrative discharges after period of no contact should always be coded 540.

INSTRUCTIONS FOR COMPLETING THE MENTAL HEALTH DISCHARGE SUMMARY/BILLING FORM

NAME: The client’s first and last name.

MRN: Client’s Medical Record Number.

SERVICE DATE: The date the service was provided.

RU: Reporting Unit of program completing form.
STAFF #: Staff number of clinician providing the service.

HOURS/MINS: Time the clinician spent providing the service including documentation time and travel time.

SERVICES: Check the type of service that was provided. Use the Billable code for services that are direct billable services. Use the Non-Billable code for services that are not Medi-Cal reimbursable.

315 Plan Development
571 Case Management Plan Development
364 Medication Support: Plan Development
540 Non-Medi-Cal billable MHS

LOCATION OF SERVICE:

1 Office – Services provided in the office where the mental health professional routinely provides services.
2 Field – When location is away from the clinician's usual place of business. Use only when no other specific non-office location is applicable.
3 Phone – Services provided by telephone contact with the consumer.
4 Home – Services provided at a location, other than a hospital or other facility, where the consumer lives.
5 School – Services provided in any facility that has the primary purpose of education.

Signature/License/Job Title: This is the clinician providing the service.

Documentation Date: The date the Mental Health Discharge Summary Form was written.

Co-Signature/License: Signature of licensed clinician, if applicable.

Date: Date of co-signature by licensed clinician, if applicable.

Computer Entry Clerk Initials: The initials of the data entry clerk.
MENTAL HEALTH DISCHARGE SUMMARY/BILLING FORM

DATE: ___________  RU#: ___________  CODE ACTIVITY: □ 315  □ 571  □ 364  □ 540
      PD   CMPD   MD PD  NonBill M/L S
STAFF #: ______________________  HOURS: _______  MINUTES: ___________
LOCATION: (please ☐)  ☐ 1 Office  ☐ 2 Field  ☐ 3 Phone  ☐ 4 Home  ☐ 5 School

1. DISCHARGE DIAGNOSIS: __________________________________________________________

2. COURSE OF TREATMENT:
   a. Opening and Closing Date: ______________________________________________________
   b. Referral Source (reason for admission): __________________________________________
        ____________________________________________________________
   c. Discharge Medications (include dosage and schedule, response, compliance, side effects, adverse labs, and other medication issues): ____________________________________________________________
        ____________________________________________________________
        ____________________________________________________________
   d. Allergies: ___________________________________________________________________
   e. Outcome (treatment highlights, modalities of treatment, goals obtained): ________________
        ____________________________________________________________

3. DISCHARGE PLANS:
   a. Recommendations: ______________________________________________________________
        ____________________________________________________________
        ____________________________________________________________
   b. Possible Future Problems: ______________________________________________________
        ____________________________________________________________
        ____________________________________________________________
   c. Referrals Out: __________________________________________________________________
        ____________________________________________________________

Date: ___________  Signature: ______________________________  License/Title: _______________________
Co-Signature: ____________________________________________  License/Title: _______________________
Date: ___________  (if applicable)  License/Title: _______________________

USE REVERSE SIDE FOR ADDITIONAL INFORMATION

MHC022 (Rev. 7-13) Discharge Summary/Billing Form

__________________________  Computer Entry Clerical Initials
MENTAL HEALTH ADMINISTRATIVE DISCHARGE SUMMARY FORM

The Mental Health Administrative Discharge Summary Form is an optional form. Clinical staff can utilize this form when preparing an episode closing in order to document a client who has not received services (inactive) for more than 6 months. If appropriate the clinician can document attempts or any responses made to contact the client or the reason for discharge.

INSTRUCTIONS FOR COMPLETING THE MENTAL HEALTH DISCHARGE SUMMARY/BILLING FORM

NAME: The client’s first and last name.

MRN: Client’s Medical Record Number.

DATE FORM COMPLETED: The date the form was completed.

RU: Reporting Unit of program completing form.

DISCHARGE DIAGNOSIS: Diagnosis at time of closing

CONSUMER LAST SEEN: Date the clinician last saw the client.

REASON FOR DISCHARGE: If appropriate check the reason for discharge. (i.e. failed follow-up appointment, declined follow up appointment, or missed scheduled appointment)

ATTEMPTS TO CONTACT CONSUMER UNSUCCESSFUL: If appropriate document attempts to reach client. (i.e. phone disconnected, letter sent, left messages with no return call, or declined appointment).

COMMENTS: Include any relative comments regarding the discharge of the client.

Signature/License/Job Title: This is the clinician providing the service.

Date: The date the Mental Health Administrative Discharge Summary Form was written.

Co-Signature/License: Signature of licensed clinician, if applicable.
Date: Date of co-signature by licensed clinician, if applicable.
MENTAL HEALTH ADMINISTRATIVE DISCHARGE SUMMARY FORM

For use only for closing episodes inactive for more than 6 months, at the discretion of the physician/clinician or program manager/supervisor.

Date Form Completed: ________________  RU#: ________________

1. Discharge Diagnosis: __________________________

2. Consumer Last Seen: __________________________

3. Reason for Discharge
   - [ ] Consumer Failed follow-up appointment(s)
   - [ ] Consumer declined follow-up appointment(s)
   - [ ] Consumer missed scheduled appointment on ________________

4. Attempts to contact consumer unsuccessful:
   - [ ] Phone disconnected or no phone
   - [ ] Letter sent on ________________
   - [ ] Left Messages – calls not returned.
     Messages left on ________________,

                      ________________

   - [ ] Reached but declined appointment.
     Date ________________

5. Comments:

Signature 
License/Title: __________________________  Date: ________________
Co-Signature: __________________________
(if applicable)  Date: ________________
SERVICE
AUTHORIZATION

LOCKOUTS & LIMITATIONS

SECTION 7
SERVICE AUTHORIZATION FORM

The Service Authorization Form must be completed for each client receiving Mental Health Services, Case Management, Day Treatment Intensive, Day Treatment Rehabilitation, TBS, and/or Adult Residential services within 60 days from the time the initial service(s) begin and the episode is opened. Clients receiving Medication Support in conjunction with one or more of the above services must also be specified on the Service Authorization Form. Service by an additional provider must be authorized within 30 days of the episode opening. The UR track (the 12 month service authorization period) is established by the opening month and goes through the last day of the 12th month. In Contra Costa County the anniversary date refers to the end of the UR track date.

DOCUMENTATION

Responsible Staff: Primary clinician in conjunction with additional service providers.

Time Frame:

- Service authorization for ongoing Mental Health Services, Case Management, and Adult Residential Services is required within 60 days from the time the initial services begin and the episode is opened, or within one month from the time any additional Service Provider begins providing services.
- Service authorization is required initially for Day Treatment Intensive and Day Rehabilitation 14 days from the day the episode was opened.
- Medication Support must be included when one of the above-mentioned services is provided.
- The Service Authorization Form must be re-written annually according to the client's anniversary date or end of the UR track. All annual assessments and Partnership Plans with all required signatures must be completed during the last month of the established UR track.
- Day Treatment Intensive services are authorized a maximum of 3 months.
- Day Treatment Rehabilitation services are authorized a maximum of 6 months.
- TBS Agency will receive Referral and authorization for 10 hours of Plan Development. Once Final Treatment Plan is submitted, up to 120 hours of direct service per month may be authorized.

NOTE: The Service Authorization Form can be approved for a maximum of 12 months. No services can be approved beyond the UR track. However, when Day Treatment is authorized all ancillary services must have the same authorization period and maximum amount of months, i.e., 3 months for Day Treatment Intensive, 6 months for Day Rehabilitation. See also example request for Supplemental Mental Health Services.
Extensions

If a service is authorized for a period that ends prior to the end of the UR track, the clinician or the case manager can request an extension of services, but not beyond the end of the UR track. This request should be documented on a blue progress note, specifying the progress made and the current symptoms and impairments, which necessitate on-going services. This can be billed as Evaluation (Procedure Code 313), or, when an update to the partnership plan is made, Plan Development (either Procedure Code 315). See also Plan Development Note example. The new authorization will then be added to the original authorization form. If a new goal is needed, this is a good time to add to the existing Partnership Plan. Please note that if the original duration of the Partnership Plan for Wellness has expired, a new Plan and goals are required.

Add-Ons

Sometimes different Reporting Units or outside agencies may be providing services to a client. The “holder of the track” (i.e., the primary provider) will be responsible for the initial Assessment or the Annual Update, the CSI (if needed) and their own Partnership Plan for Wellness. The original service authorization form will be located at the site of the primary provider. The clinic or the agency that is adding a service will present their own Partnership Plan at the appropriate Authorization Committee Meeting. If this is the same location as the “holder of the track”, the approval of services will be added directly to the original Service Authorization Form. If the service to be added is at another location, the following procedure applies:

1. If there is sufficient time, the UR clerk will obtain the Service Authorization Form from the original site (holder of the track). The Authorization will be updated with the new added services and returned to the original site. A copy of the Service Authorization Form will be kept at the add-on site.

2. If there is no time to obtain the original Service Authorization Form, the UR clerk will request a copy (via FAX). The add-on site will fill out a new Service Authorization Form with the new approval. A copy of this new approval as well as a copy of the original will be kept in the chart. The second "original" will be returned to the initiating site and attached to the first original.

NOTE: The initial assessment or the annual update should be sent to other service providers.

INSTRUCTIONS FOR COMPLETING THE SERVICE AUTHORIZATION FORM

CONSUMER’S NAME: The client’s first and last name.

MRN: Client’s Medical Record Number.

UR TRACK: The annual track based upon the client’s anniversary date. The UR Clerks will write in this time period.
STATE DATE: Initially, the month/day/year of episode opening. The annual anniversary date begins with the first day of the month the track begins.

END DATE: One year from the client’s anniversary date.

TYPE OF SERVICE: The type of services requested and/or authorized. The choices are MHS – Mental Health Services, CM – Case Management, AR – Adult Residential, DTI – Day Treatment Intensive, MS – Medication Support, TBS – Therapeutic Behavioral Services, DTR – Day Treatment Rehabilitative.

NAME OF PROVIDER AGENCY: The name of the program providing services.

UP TO # OF MONTHS APPROVED: The number of months appropriate for a client to receive services based on medical and service necessity. The maximum number of months that can be requested is 12. If a new service provider is added to the Service Authorization Form during the 12-month track, the end date remains the same.

Day Treatment Intensive services can be authorized a maximum of 3 months. Day Treatment Rehab services can be authorized a maximum of 6 months. When day treatment is authorized all ancillary services must have the same authorization period and maximum amount of months.

SERVICES CHANGED: If the Authorization Committee approves less time than the provider has requested, this box must be checked.

SERVICES DENIED: If the Authorization Committee denies services, this box must be checked.

NOA DISCUSSED WITH CLIENT/PROVIDER: If the Authorization Committee changes or denies services, a Notice of Action (NOA) form must be completed and mailed/delivered to the client and the service provider. Only Medi-Cal beneficiaries should receive a NOA.

AUTHORIZATION DATE/INITIALS: The date and initial of the Authorization Committee member. All new services added during the 12-month track need authorization. The Authorization Committee will need to date and initial authorization for additional services.

ORIGINAL/COORDINATOR LOCATED: The name and location of the primary clinician and program responsible for the case. The UR Clerk completes this section.

STAFF SIGNATURE/LICENSE, DATE: The signature of the clinician completing the plan, license or scope of practice designee, and the date.

AUTHORIZING COMMITTEE, DATE: Signature of clinician authorizing services and the date.
# SERVICE AUTHORIZATION FORM

**Type of Service Codes:**
- MHS - Mental Health Services
- CM - Case Management
- AR - Adult Residential
- DTI - Day Treatment Intensive
- MS - Medication Support
- TBS - Therapeutic Behavioral Services
- DTR - Day Treatment Rehabilitative

<table>
<thead>
<tr>
<th>Start Date</th>
<th>End Date</th>
<th>Type of Service</th>
<th>Name of Provider Agency</th>
<th>UP TO # of Months Approved</th>
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* If services changed or denied, a Notice of Action (NOA) must be sent to the client and/or service provider.

**All Services must be documented on one service authorization form.**

THE ORIGINAL SHOULD RESIDE IN THE COORDINATOR'S CHART.

Original/Coordinator
Located:

---

**Service Provider/License and/or Job Title/Class** Date

Authorizing Committee Date

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MHC036_5 Rev 1/04 (Coordinated Services Tab)
# SERVICE AUTHORIZATION FORM - CONTINUATION

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Lockouts and Limitations

IMDs, MHRCs, Jail and Juvenile Hall: No Medi-Cal Claimable services. Use only non billable codes, i.e. 580. Applies to all staff types. See below for specific facilities.

Acute psychiatric inpatient: May use 541 Placement if service activity is relating to placement within 30 days of discharge, up to 3 non-consecutive 30 day periods. If other services, including medication services, are provided while consumer is hospitalized, use lockout non-claiming code, 580. Other services provided on day of admission, but before admission are allowed. Ali services allowed on day of discharge. Applies to all staff types.

Crisis Residential - Nierika: Case Management codes, i.e., 541 Placement, 561 Linkage, 571 Plan Development are allowed. Medication services are allowed if within scope of practice. Mental Health Services, i.e., Individual, Group, Rehab, Collateral, Crisis Intervention, and Assessment are not allowed. May use non-billable codes.

Other residential treatment - Residential treatment other than Crisis Residential has no Medi-Cal lockout. These facilities include Nevin house and Pathways (on the Crestwood Pleasant Hill campus)

Other Acute Inpatient – Medical (non-psychiatric) Inpatient services to not have a Medi-Cal lockout.

Limits for Medication Support Services.

The maximum amount claimable for Medication Support Services in a 24-hour period is 4 hours. Is based on staff time, i.e., staff and co-staff providing a 2 hour service would equal 4 hours.

Lockouts and Limits for Crisis Intervention.

(a) Crisis Intervention is not reimbursable on days when Crisis Residential Treatment Services, Psychiatric Health Facility Services, Psychiatric Nursing Facility Services or Psychiatric Inpatient Hospital Services are reimbursed, except for the day of admission to those services.

(b) The maximum amount claimable for Crisis Intervention in a 24-hour period is 8 hours. Is based on staff time like medication support services.
Day Rehab or Day Treatment Intensive Lockouts

Mental Health Services are not reimbursable when provided by Day Rehab or Day Treatment Intensive staff during the same time period that Day Rehab or Day Treatment intensive services are provided. While Mental Health Services cannot be claimed separately by day treatment staff during the hours these programs operate, Therapeutic Behavioral Services (TBS) may be claimed during Day Rehab or Day Treatment intensive if TBS services were pre-authorized and delivered by staff other than the Day Rehab or Day Treatment Intensive staff.

Long Term Care Facilities.

Facilities vary as to whether they are technically an IMD/MHRC, and subject to IMD/MHRC lockouts.

**IMD/MHRC facilities:** Crestwoods Sacramento, Angwin, San Jose; Canyon Manor; California Psychiatric Transitions (CPT), Villa Fairmont are all IMD/MHRC. **All Medi-Cal Claimable services are locked out.**

**SNF – with STP:** Crestwood Fremont, Crestwood Idlewood, Crestwood Stockton, Creekside. All are considered medical SNF, so Medi-Cal services are not locked out.

**Crestwood Vallejo** Only RU 00461 is an MHRC - an IMD lockout. Their other facilities, Our House and Hope Center are B&C and have no Medi-Cal lockout.

**Crestwood Pleasant Hill** is no longer an IMD/MHRC has no Medi-Cal lockouts.

Katie-A Billing Codes

**ICC services:** ICC services are locked out for youth in hospitals, group homes, psychiatric health facilities, or psychiatric nursing facilities except for the purposes of coordinating placement of the youth transitioning from those facilities for a maximum of 30 days -for no more than 3 non-consecutive 30 day periods.

**IHBS:** IHBS may not be provided to youth in the group home facility; however, they can be provided to youth outside the group home to facilitate transition. IHBS can be provided in the community (homes, schools, recreational settings, etc.) IHBS services are not permitted during the same hours of the same day as: day treatment, group therapy, TBS or Targeted Case Management (TCM).
FREQUENTLY ASKED QUESTIONS

SECTION 8
Memorandum

Date: May 4, 2012

To: Adult Program Managers & Supervisors
    Adult UR Staff and Clerks

From: David Cassell

Re: Documentation requirements for Psychiatrist Only clients that attend groups

Effective immediately, those clients whose primary staff is the psychiatrist, i.e. are not assigned to a therapist/case manager, but are receiving group services not limited to medication groups will not have to have an annual clinical assessment (MHC 102), as long as there is a current initial psychiatric assessment (MHC 103) or psychiatric assessment update (MHC 104). It is assumed that there will have been an initial clinical assessment (MHC 100) or equivalent done at the initiation of services.

Those individuals that are receiving group services other than medication services must have a regular Partnership Plan (MHC 021-7), that includes a goal that is to be addressed by the group service. The MHC105 Partnership Plan for MDs and RNs is not adequate for this purpose.

This applies to groups only - the documentation requirements for individual non-medications services are unchanged, regardless of whether the consumer is assigned to a case manager/therapist.

CC: V. Montoya
    G. Marlar
    D. Renton
QUESTIONS AND ANSWERS

Clinical Questions:

In the first session, does there need to be a face-to-face meeting with the client or can the clinician meet with the parents first? If yes, how would they bill the session?
   The clinician can and often does meet with the parents first to begin gathering information i.e. history, presenting problem, etc. The service can be billed an as Assessment or Evaluation depending on the clinician’s scope of practice. (See distinction in Service and Reimbursement Overview - Scope of Practice)

How long can a person stay in a group?
   As long as it’s medically necessary. This includes that the person continues to benefit from the service.

Does the primary diagnosis need to be an included diagnosis?
   Yes

Can the therapist mention an excluded diagnosis while providing treatment for an included diagnosis?
   Yes, the presence of an excluded diagnosis does not preclude a person from getting services to ameliorate impairments brought about by symptoms of an included diagnosis.

Group Questions:

How do you bill for a group when the group is composed of both Medi-Cal and non Medi-Cal client?
   The provider does not prorate the time, the computer billing system will complete the correct prorated time.

When documenting a group, how much of the group note can be the same for all participants in the group, and what needs to be individualized?
   The parts of the group that applies to the group as a whole can be the same for all participants, while the individual's level of participation or response, or any specific noteworthy behavior during the group would be specific to each participant's chart.
For example: Description of Current Situation
Client attended pro-social skill group to address goal of managing aggressive behaviors in school and at home. [in notes for all participants] Report from classroom is that client has been disruptive, but not overtly aggressive. [client specific]
Focus of activity
Facilitated pro-social skills group for the purpose of improving social skill development, learning how to modulate moods, and management of anger outbursts. [in notes for all participants] Client participated well but appeared to have difficulty staying focused and listening to others. [client specific]

How do staff and co-staff bill a group, including documentation time, if they split charting responsibility?
Each staff would only add the documentation time for the consumers s/he is charting on.

For example: There are 6 clients in the group. Group lasts an hour. There are two staff, Staff A and Staff B, that are co-facilitating the group. Documentation time is 5 minutes per client.

So staff A writes notes on 3 clients, listing Staff B as co-staff
Staff B writes notes on the other 3, listing Staff A as co-staff
Both list 6 clients for the “# in group”.

On the notes that Staff A writes, the documentation time for all 3 that they are documenting on is added to staff A’s time, but not B’s time
On the notes that Staff B writes, the documentation time for all 3 that they are documenting on is added to staff B’s time, but not A’s time

So, for the clients that Staff A charts on, Staff A bills 1 hr 15 min (60 + (5 x 3)), with Staff B as co-staff for 60 minutes, and 6 clients in the group.
For the client that Staff B charts on, Staff B bills 1 hr 15 min, with Staff A as co-staff for 60 minutes, and 6 clients in the group.

Sometimes we have 3 staff co-facilitating groups, particularly with larger groups. How do we bill and document these services?
First, make sure that having a third staff involved is necessary and justified. This may be due to the size of the group, or due to the nature of the group, such as with DBT groups.
For large groups, divide the group into three equal (if possible) smaller groups for billing and documentation purposes, assigning each sub-group to a staff person. Each staff person claims as if they were the only staff providing the service to their sub-group and uses the count of the sub-group as the "# in group". IMPORTANT: None of the staff should make any entry in the co-staff field. Documentation time should be included.

So, for example, for a 90 minute group of 15 consumers with 3 staff, each staff would write on and bill for 5 consumers (# in group = 5) for 1 hr 55 min (90 minutes + 25 minutes documentation time: [5 minutes x 5 charts]), with no co-staff.

For smaller groups, i.e. less than 9, where it is appropriate for three staff to be present, each staff should write a note for each consumer and include the documentation time for each, with no co-staff.

For example, for a 2 hour DBT group of 5 consumers and three staff, each staff should write a note for each of the 5 consumers, entering 2 hr 25 minutes (2 hours for the group + 25 minutes documentation time: [5 minutes x 5 charts]), with no co-staff.

**Procedure Code Questions:**

**How do I choose the right procedure code?**

The following common service activities are matched with the best procedure code.

To document:
- Coordinating
- Linking
- Placing
- Making sure s/he gets to...
- Checking on whether s/he has been hooked up with...
- Relaying information from consumer/therapist/case manager/psychiatrist to another clinician

Use Case Management [541, 561].
To document:
- Assisting with a specific problem area
- Showing consumer how some obstacle might be overcome
- Helping strategize with consumer about how they can accomplish....
- Figuring out what obstacles are
- Educating regarding how symptoms/problem behaviors are getting in the way
- Educating about how symptoms/problem behaviors might be managed

And the focus is functioning skills (improving, maintaining, restoring)

Use rehab/group rehab [317, 355].

To document:
- Assisting with a specific problem area
- Showing consumer how some obstacle might be overcome
- Helping strategize with consumer about how they can accomplish....
- Figuring out what obstacles are
- Educating regarding how symptoms/problem behaviors are getting in the way
- Educating about how symptoms/problem behaviors might be managed

And the focus is on symptom reduction, with the goal of improving functioning

Use individual/group [341, 351]. (If within scope of practice.)

To document:
- Getting information from an important person in consumers life
- Discussing (assuming with permission) with an important person in consumer’s life how to collaborate in overcoming obstacles, or how they might support (and not hinder) some area of improvement in functioning.

Use collateral/group collateral [311, 357].

- Note: Do not use collateral for coordinating/collaborating with other providers - may be linkage, or plan development, depending on service.
To document:
- Gathering information from the consumer
- Gathering information about the consumer from another source
- Analyzing information from sources to make a complete (and documented) picture of how the consumer is functioning, what are obstacles, etc.

Use Evaluation [313].

To document:
- Gathering information from the consumer
- Gathering information about the consumer from another source
- Analyzing information from sources to make a complete picture of how the consumer is functioning, what are obstacles, etc.
- Do a Mental Status Exam
- Formulate a diagnosis

Use Assessment [331] (If within scope of practice).

To document:
- Taking information from evaluation/assessment and developing a written plan.
- Discussing, negotiating, getting approval of a written plan.
- Checking on progress toward a previously planned goal.

Use Plan Development [315]

If doing the above, but the goals are limited to linking, placement, and coordination,

Use Case Management Plan development [571].

To document:
- An immediate response to an acute situation
- An intervention to prevent an escalation that may include violence or self-destructive behavior or would cause loss of housing
- Facilitating a 5150

Use Crisis Intervention [371].
Billing & Documentation Questions:

Can a court related assessment be billed?
Yes, when the assessment is completed for clinical, treatment-related purposes. For example, if the purpose of a court-ordered assessment is to determine medical necessity.

No, if the assessment is completed per request of the court for a purpose other than determining medical necessity. For example, if a court related entity (i.e., CFS) is paying for the service.

Does each progress note need to document when an interpreter is used or when a session is provided in a language other than English?
Yes each time. If the clinician is bilingual, s/he should note that sessions are conducted in the non-English language. The Progress Note/Billing Form has a section to document if an interpreter is used and the name of the interpreter, or if the session was delivered in a language other than English, i.e. by a bilingual staff.

Can the clinician bill for filling out a TBS referral form?
Making a referral is a billable linkage service. The clinician must phrase the note so that it is clear that the writer is making a referral, not just filling out a form.

Whose progress notes require a co-signed by a licensed clinician?
Progress Notes that require co-signatures are for Doctoral Interns (unless waived), Practicum Students, and unlicensed staff that do not meet the MHRS education/experience requirements. See the scope of practice grid.

Can staff bill for the time it takes to make acceptable corrections to the chart as identified by the Audit Team?
No. Documentation time has already been billed. In order to bill, the clinician must be providing a service to the client.

Can staff bill for emailing other service providers?
No, the state considers use of email as a clerical function.

Can staff bill for photocopying or faxing?
No, this is considered a clerical type activity.
What is the difference between a Collateral Service and a Case Management Linkage?

A Collateral service is a contact with a significant support person in the life of the client, such as a family member or caretaker. Case Management Linkage service includes contact with another provider in order to coordinate services. Case Management Linkage also is assisting a client to access needed medical, educational, social, prevocational, vocational rehabilitative or other community services.

What is the difference between Plan Development and Case Management Plan Development?

Plan development focuses taking information from evaluation/assessment and developing or modifying a written plan, discussing a treatment plan, or monitoring a client’s progress towards treatment goals. Case management plan development focuses on discussing a treatment plan (i.e. IEP, Wraparound Plan, TBS), or monitoring a client’s progress towards treatment goals. However, has an emphasis on linking, coordinating, or placement. (i.e. focus on education, vocational, medical needs, or coordination of care).

If a clinician is providing different services on the same day to a client (i.e., talk with client, talk with client’s family, talk to psychiatrist). How should the services be documented?

It depends. If the clinician is providing three separate services at three distinct times, s/he should write three different progress notes and bill each according to what the service is.

For example if the clinician were talking to the client about improving their social skills, the service could be billed as Rehab. Later, when the clinician is talking to the family about the client’s mental illness, the service would be billed as Collateral. Then at another time the clinician talks to the psychiatrist to relay the information and coordinate the services or update the plan, the service could be billed as Linkage or Plan Development.

However, if the clinician mixes some services together in one session, the ‘preponderance rule’ applies – the service with the most documented activity determines the procedure code.

Example: Clinician spends time with client, talks to family, talks to psychiatrist. Most of the time is spent talking with client about improving skills in social situations, how to deal with stressful
situations, and how to communicate effectively with family and psychiatrist. Also spoke with family and psychiatrist to relay information.

Because the majority of the time was spent in skill development with the client, the best code would be rehab. The contact with family (which if alone would be a collateral) and the coordination with the psychiatrist (which alone would be linkage) can be lumped in with the rehab.

**Can staff bill for time transporting a client to a mental health appointment?**
No, simply transporting is not reimbursable. However...

**When assisting a client to get to an appointment. How should the service be billed and documented?**
Accompanying a client to an appointment may be a CM Linkage service, a Rehab service or may be unbillable. If CM Linkage, the documentation must support and substantiate a reimbursable service activity. Transportation by itself is not a reimbursable service.

So if while accompanying a client to an appointment with their doctor, you ask how they are doing and help them review what all they are going to say to her, that could be CM Linkage. If you help them to become more organized about how they use their time with the doctor, like maybe between appointments they write down things they want to let their doctor know about their symptoms, etc., that could be Rehab.

If you pick them up and take them to their appointment, but not much else, that’s not claimable, so use a non-billable code.

See Examples of Rehab, CM-linkage and Non-Billable Transportation

**Can travel time be billed traveling from one provider site to another provider site?**
No, if a provider is traveling from one site to another it is not billable (i.e. Concord Clinic to Pittsburg Clinic). Travel time can only be claimed if the provider is going from a provider site to a field location where a service is actually delivered.
Can travel time be billed from a staff person’s residence to a provider site or from a staff’s home to a client’s home?
No

When traveling to a community site to provide services to more than one client, how should the travel time be billed?
The travel time should be prorated to each client.

When talking to a co-worker about a client, how would each person bill?
In order for co-workers to bill, they each must be providing services that will benefit the client. One option is Plan Development if the result of the conversation is an update to the Partnership or Service plan or a specific statement about the status of a goal on the plan. Another option is Linkage if the clinicians that are both involved with the client either (inter or intra clinic) are discussing how to best coordinate services.

When two clinicians are working in the field, how would they document?
When more than one clinician is providing a service to a client, the progress note must document the intervention of each clinician. There can be one note that documents each clinician’s activity or each clinician can write a separate note.

How do you bill for an IEP?
In many instances there is more than one way to document a service. It is important to bill for the service provided. If the service is a development of a written plan, bill Plan Development. If the service is linking the family to a needed service, bill Case Management Linkage.

When traveling to a school and the traffic is stopped, can all travel time be billed?
Yes, travel time is based on staff time.

Can a clinician bill for reviewing records/history?
Yes, if it is part of an overall service that benefits the consumer, i.e., it is part of the evaluation process and/or treatment planning and delivery process.
How should the clinician bill for services if a client is in juvenile hall?

Juvenile hall is a total lockout, meaning there are no Medi-Cal reimbursable services allowed. The clinician should use 580 Non-Billable Lockout for any service provided to the client or the family/significant support persons when a client is in juvenile hall.

THE EXCEPTION IS: If there is a placement order by the judge and the clinician obtains a copy of the order (usually from the Probation Officer), services are reimbursable. A copy of the placement order must be in the medical record and the clinician must refer to the order in the body of the progress note.

See Sample Placement Order

How should the clinician bill for services if a client is in jail?

Jail is also a total lockout, meaning there are no Medi-Cal reimbursable services allowed. The clinician should use 580 Non-Billable Lockout for any service provided to the client or the family/significant support persons when a client is in jail. Once they are released, the lockout is lifted.

A client is in the hospital and the clinician goes to meet with the client or does a collateral service with the family. How can these services be billed?

Except for the day of admission or discharge, when a client is in an acute psychiatric hospital, the only claimable service is Case Management – Placement (541). So if meeting with the client includes a discussion related to placement, or if the discussion with the family is about placement, then Case Management – Placement. Other services besides placement related services must be coded as non-billable – Lockout (580). These would include Collateral Services provided to the family or significant others, along with other mental health or medication support services as they are not reimbursable when the client is in an acute psychiatric hospital.
Day Treatment Questions:

Is the staff ratio requirement met if the staff is in the milieu room but working individually with a consumer? On site (in another room) but working with a consumer or awaiting a need for their intervention?

Day treatment staff must be available where and when day treatment therapeutic milieu is being provided and available to respond to the needs of the group. At least one staff person must be available to the group in the therapeutic milieu. Staff in the room working with an individual would be considered staff available to the milieu. Staff on site, but in another room working with one client would not be considered staff available to the milieu. Staffing ratios must be maintained.

Continuous hours of operation: If staff is fully integrated into a classroom during academic instruction, may the school day hours be counted as part of the continuous hours? If so, must staff be present in the classroom to be counted as fully integrated?

The hours of the day treatment milieu must be continuous and are not tied to the hours of the setting in which they are provided (e.g. school). The day treatment milieu may operate for a continuous period of time during the school day, but may not be provided in discontinuous “blocks” of time (e.g. two hours in the morning, two hours in the afternoon, and one hour after school). The day treatment milieu establishes the hours of operation and must exceed four hours per day for full day programs and be at least three hours per day for half-day programs.

In addition to required hours of operation, full-day program require an average of three treatment hours and half-day program require an average of two treatment hours per day in the day treatment milieu. The community meeting time is not counted in the required treatment hours, but may be a part of the continuous hours of operation/therapeutic milieu or may be separate. If day treatment is taking place in a school setting, day treatment staff must be present during day treatment time.

Minimum attendance: Must a child be in the milieu for over 50% of the day for billing to be allowed? Or could some of the time be spent in individual services apart from the milieu but not separately billed, or in transitioning to a mainstream classroom?

Children are expected to be present in the day treatment program for all scheduled hours of operation of the day treatment program. When
a child is unavoidably absent for some part of the hours of operation, day treatment for an individual will be reimbursed if the child is present for at least 50% of the hours of the scheduled hours of that day. Individual services may be part of the day treatment program, provided the minimum day treatment requirements are met for the child. There are no exceptions to these requirements for children being transitioned to a mainstream classroom.

Activities outside program hours: How can required contact with caregivers, documentation, etc. be distinguished from non-day treatment activities such as collateral contacts?

The caregiver contact requirement specific to day treatment is focused on the contact being related to the beneficiary's progress in day treatment and to support the role of the caregiver in supporting the beneficiary's treatment goals. Documentation of the contact should be included in the day treatment documentation.

Under what conditions can classroom time be counted towards day treatment time?

Academic educational activities cannot be counted towards day treatment time. There is no prohibition to providing day treatment intensive or day rehabilitation to address the beneficiaries mental health needs in conjunction with classroom time.

There are two basic types of school-based day treatment programs. An example of a “sequential program” has the academic school time scheduled for one time period and the day treatment program for another time period often at the same site. The “integrated program” has a set number of hours at school, e.g., four hours, in which day treatment and academics are fully integrated.

Integrated programs must be carefully planned and executed to meet all requirements of a day treatment intensive or day rehabilitation program. The academic and special education goal is to maximize the educational benefit of academic instruction. The mental health program goals is to provide day treatment mental health treatment services that help the children in the program achieve their mental health treatment goals, including decreasing symptoms and maladaptive behaviors that interfere with achieving theses goals. Close teamwork between the day treatment program staff and the teacher is required to ensure that the therapeutic milieu is maintained. A program that consists solely of children being pulled out of the classroom to receive their mental health services does not
qualify as a day treatment program. The therapeutic milieu must exist in the classroom for classroom time to count toward day treatment hours of operation.

**General Questions:**

**What is EPSDT?**
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. The EPSDT program consists of two mutually supportive, operational components: (1) assuring availability and accessibility of required health care resources, and (2) helping eligible children and their parents or guardians to effectively use these resources.

**What is TBS?**
Therapeutic Behavioral Services (TBS) are supplemental specialty mental health services under the EPSDT benefit. TBS is an intensive, individualized, one-to-one, short-term, outpatient treatment intervention for beneficiaries under age 21 with serious emotional disturbances (SED) who are experiencing a stressful transition or life crisis and need additional short-term specific support services. TBS eligibility requires clients to have full-scope Medi-Cal and meet criteria for certified class membership.

**What are Level 1 and Level 2?**
Level 1 and Level 2 are terms we have used in Contra Costa since the implementation of Specialty Mental Health Services. Level 1 is utilization review and service authorization. Each county-owned and operated program authorizes services for clients at county and contract programs. Level 2 is a compliance review. There is also a Centralized Utilization Review Committee that meets monthly to review both medical records from county and contract programs.

**What is Katie-A?**
On July 18, 2002, a lawsuit, Katie A. et al. v. Bonta et al. was filed. This lawsuit sought relief on behalf of a class of children/youth in California who (1) are in foster care or at risk of foster care placement, (2) have a mental illness, and (3) need individualized mental health services to treat their illness or condition.
In December 2011, a settlement was reached and DHCS agreed to provide the identified subclass members who have the most intensive and complex needs an intensive array of mental health services delivered in a coordinated, comprehensive, community-based approach. These children with significant needs may receive Intensive Care Coordination (ICC) and/or Intensive Home Based Services (IHBS) in their own family setting, will most likely improve their safety, self-sufficiency, well-being, and reduce timelines to permanency.

**What is Targeted Case Management (TCM)**
Members of the target group are clients who are transitioning to a community setting from a hospitalization or inpatient stay. Contacts with significant support persons may include helping the eligible client access needed medical, alcohol and drug treatment, prevocational, vocational, rehabilitative, or other community services. TCM may include case coordination, monitoring service delivery, monitoring of progress, placement services, and plan development. Services may only be provided for up to 30 days for no more than 3 non-consecutive periods of 30 days or less per hospitalization or inpatient stay.

**What is a NOA and what is its purpose?**
A Notice of Action is a form given to a Medi-Cal beneficiary whenever:

- The beneficiary does not meet medical necessity
- When the Mental Health Plan denies or modifies payment authorization of a requested service

The purpose of the NOA is to advise the beneficiary of the action and to provide information on the beneficiary’s right to appeal the decision.

Please see attached NOAs FAQ and sample NOA forms.
Notice of Action (NOAs) FAQs

(Updated 09/09)

Q1. What is a Notice of Action (NOA), and what is its purpose?

A1. A Notice of Action is a form given to a beneficiary whenever any of the following occur:

An NOA-A is used when the MHP or its providers assess a Medi-Cal beneficiary and decide the beneficiary does not meet medical necessity and no specialty mental health services will be provided. Not meeting medical necessity means any of the following:

That the beneficiary doesn't have a diagnosis covered by the MHP (an included diagnosis);
That a beneficiary who is 21 or over has an included diagnosis, but doesn't have a significant impairment;
That a beneficiary who is under 21 years of age has an included diagnosis, but there is no covered intervention that will correct or ameliorate the condition;
That the beneficiary has an included diagnosis, but the condition would be responsive to physical health care based treatment.

An NOA-B is used when the MHP denies or modifies MHP payment authorization of a requested service, including the type or level of service; reduces, suspends, or terminates a previously authorized service; or denies, in whole or in part, payment for a service prior to the delivery of the service.

An NOA-C is used when the MHP denies, in whole or in part, payment for a service, post-service delivery, but pre-payment based on a determination that the service was not medically necessary, or otherwise not a covered service.

An NOA-D is used when the MHP fails to act within the time frames for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

An NOA-E is used when the MHP or its providers fail to provide services in a timely manner, as determined by the MHP.

The purpose of the Notice of Action is to advise the beneficiary of the action and to provide information on the beneficiary's right to appeal the decision. An NOA-BACK must be issued in conjunction with all the NOA forms. The NOA-BACK contains important information about the beneficiary's appeal and state Fair Hearing rights. NOTE: The beneficiaries right to an NOA is independent of the beneficiary's right to request a fair hearing, to utilize the appeal process, and, when applicable, to the right of a second opinion.
Medi-Cal Specialty Mental Health Program
NOTICE OF ACTION
(Assessment)

Date: ____________________

To: ____________________________________________, Medi-Cal Number ______________________

The mental health plan for Contra Costa County has decided, after reviewing the results of an assessment of your mental health condition, that your mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services through the plan.

In the mental health plan's opinion, your mental health condition did not meet the medical necessity criteria, which are covered in the state regulations at Title 9, California Code of Regulations (CCR), Section 1830.205, for the reason checked below:

☐ Your mental health diagnosis as identified by the assessment is not covered by the mental health plan (Title 9, CCR, Section 1830.205(b)(1)).

☐ Your mental health condition does not cause problems for you in your daily life that are serious enough to make you eligible for specialty mental health services from the mental health plan (Title 9, CCR, Section 1830.205(b)(2)).

☐ The specialty mental health services available from the mental health plan are not likely to help you maintain or improve your mental health condition (Title 9, CCR, Section 1830.205(b)(3)(A) and (B)).

☐ Your mental health condition would be responsive to treatment by a physical health care provider (Title 9, CCR, 1830.205(b)(3)(C)).

If you agree with the plan's decision, and would like information about how to find a provider outside the plan to treat you, you may call and talk to a representative of your mental health plan at (925) 957-5160 or write to:

Office of Quality Improvement 1340 Arnold Drive, Suite 200 Martinez, CA 94553

If you don't agree with the plan's decision, you may do one or more of the following:

You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan at (925) 957-5160 or write to: Office of Quality Improvement 1340 Arnold Drive, Suite 200 Martinez, CA 94553

You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at (925) 957-5160 or write to: Office of Quality Improvement 1340 Arnold Drive, Suite 200 Martinez, CA 94553, or follow the directions in the information pamphlet the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions.

If you have questions about this notice, you may call and talk to a representative of your mental health plan at ______________________ or write to:

If you are dissatisfied with the outcome of your appeal, you may request a state hearing. The other side of this form will explain how to request a hearing.

NOA-A (revised 6-1-05)
YOUR HEARING RIGHTS

You only have 90 days to ask for a hearing. The 90 days start either:

1. The day after we personally gave you this the mental health plan's appeal decision notice, OR

2. The day after the postmark date of this mental health plan's appeal decision notice.

Expedited State Hearings

It usually takes about 90 days from the date of your request to make a hearing decision. If you think this timing will cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions, you may request an expedited state hearing. To request an expedited hearing, please check the 1st box in the right hand column of this page under HEARING REQUEST and include the reason why you are requesting an expedited hearing. If your expedited hearing request is approved, a hearing decision will be issued within three working days of the date your request is received by the State Hearings Division.

To Keep Your Same Services While You Wait for A Hearing

- You must ask for a hearing within 10 days from the date the mental health plan's appeal decision notice was mailed or personally given to you or before the effective date of the change in services, whichever is later.
- Your Medi-Cal mental health services will stay the same until a final hearing decision is made which is adverse to you, you withdraw your request for a hearing, or the time period or service limits for your current services expire, whichever happens first.

State Regulations Available

State regulations, including those covering state hearings, are available at your local county welfare office.

To Get Help

You may get free legal help at your local legal aid office or other groups. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:

Call toll free: 1-800-952-5253

If you are deaf and use TDD, call: 1-800-952-8349

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, an attorney or anyone else you choose. You must arrange for this representative yourself.

Information Practices Act Notice (California Civil Code Section 1798, et. seq.) The information you are asked to write in on this form is needed to process your hearing request. Processing may be delayed if the information is not complete. A case file will be set up by the State Hearings Division of the Department of Social Services. You have the right to examine the materials that make up the record for decision and may locate this record by contacting the Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with the mental health plan, the State Departments of Health Services and Mental Health and with the U.S. Department of Health and Human Services (Authority: Welfare and Institutions Code, Section 14100.2)

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then send this page to:

State Hearings Division
California Department of Social Services
P.O. Box 942423, Mail Station 19-37
Sacramento, CA 94244-2430

Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call 1-800-952-8349.

HEARING REQUEST

I want a hearing because of a Medi-Cal related action by the Mental Health Plan of Contra Costa County.

Check here if you want an expedited state hearing and include the reason below.

Here's why:

My name: (print)

My Social Security Number:

My Address: (print)

My phone number: (______)

My signature:

Date:

I need an interpreter at no cost to me. My language or dialect is:

I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name

Address

Phone number:
Medi-Cal Specialty Mental Health Services Program

NOTICE OF ACTION

To: __________________________________ Med-Cal Number __________________________

One mental health plan for Contra Costa County has □ denied □ changed your provider’s request for payment of the following service(s):

_________________________________________________________________________

The request was made by: (provider name) ______________________________________

The original request from your provider was dated ________________________________

The mental health plan took this action based on information from your provider for the reason checked below:

□ Your mental health condition does not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (Title 9, California Code of Regulations (CCR), Section 1820.205).

□ Your mental health condition does not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services for the following reason (Title 9, CCR, Section 1830.205): ____________________________

_________________________________________________________________________

□ The service requested is not covered by the mental health plan (Title 9, CCR, Section 1810.345).

□ The mental health plan requested additional information from your provider that the plan needs to approve payment of the proposed service. To date, the information has not been received.

□ The mental health plan will pay for the following service(s) instead of the service requested by your provider, based on the available information on your mental health condition and service needs: ____________________________

_________________________________________________________________________

□ Other ____________________________

If you don’t agree with the plan’s decision, you may:

1. You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at (925) 957-5160 or write to: Office of Quality Improvement 1340 Arnold Drive, Suite 200, Martinez, CA 94553, or follow the directions in the information brochure the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions. You can request that your services stay the same until an appeal decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period ____________________________. The effective date for the change in these services is ____________________________.

2. If you are dissatisfied with the outcome of your appeal, you may request a state hearing which may allow services to continue while you wait for the hearing. The other side of this notice explains how to request a hearing. You can request that your services stay the same until a hearing decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period ____________________________. The effective date for the change in these services is ____________________________. The services may continue while you wait for a resolution of your hearing.

3. You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan at (925) 957-5160 or write to: Office of Quality Improvement, 1340 Arnold Drive, Suite 200, Martinez, CA 94553

NOA-B (revised 6-1-05)
YOUR HEARING RIGHTS
You only have 90 days to ask for a hearing. The 90 days start either:

1. The day after we personally gave you this the mental health plan’s appeal decision notice, OR

2. The day after the postmark date of this mental health plan’s appeal decision notice.

Expedited State Hearings
It usually takes about 90 days from the date of your request to make a hearing decision. If you think this timing will cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions, you may request an expedited state hearing. To request an expedited hearing, please check the 1st box in the right hand column of this page under HEARING REQUEST and include the reason why you are requesting an expedited hearing. If your expedited hearing request is approved, a hearing decision will be issued within three working days of the date your request is received by the State Hearings Division.

To Keep Your Same Services While You Wait for a Hearing
• You must ask for a hearing within 10 days from the date the mental health plan’s appeal decision notice was mailed or personally given to you or before the effective date of the change in services, whichever is later.
• Your Medi-Cal mental health services will stay the same until a final hearing decision is made which is adverse to you, you withdraw your request for a hearing, or the time period or service limits for your current services expire, whichever happens first.

State Regulations Available
State regulations, including those covering state hearings, are available at your local county welfare office.

To Get Help
You may get free legal help at your local legal aid office or other groups. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:
• Call toll free: 1-800-952-5253
• If you are deaf and use TDD, call: 1-800-952-8349

Authorized Representative
You can represent yourself at the state hearing. You can also be represented by a friend, an attorney or anyone else you choose. You must arrange for this representative yourself.

Information Practices Act Notice (California Civil Code Section 1798, et. seq.) The information you are asked to write in on this form is needed to process your hearing request. Processing may be delayed if the information is not complete. A case file will be set up by the State Hearings Division of the Department of Social Services. You have the right to examine the materials that make up the record for decision and may locate this record by contacting the Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with the mental health plan, the State Departments of Health Services and Mental Health and with the U.S. Department of Health and Human Services (Authority: Welfare and Institutions Code, Section 14100.2)

HOW TO ASK FOR A STATE HEARING
The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then send this page to:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mall Station 19-37
Sacramento, CA 94244-2438

Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call 1-800-952-8349.

HEARING REQUEST
I want a hearing because of a Medi-Cal related action by the Mental Health Plan of _______ County.

• Check here if you want an expedited state hearing and include the reason below.

Here’s why:

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

• Check here and add a page if you need more space.

My name: (print)

My Social Security Number:

My Address: (print)

My phone number: (______)

My signature:

Date: ______________

I need an interpreter at no cost to me. My language or dialect is:

______________________________________________________________

I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name ______________

Address ______________

Phone number: ______________
Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION
(Post-Service Denial of Payment)

Date: __________

To: ____________________________, Medi-Cal Number ____________

The mental health plan for _________________ County has □ denied □ changed your provider's request for payment of the following service(s):

________________________________________________________

The request was made by: (provider name) _____________________________________

The original request from your provider was dated _________________ and your provider says that you received the service on the following date or dates:

________________________________________________________

THIS IS NOT A BILL. YOU WILL NOT HAVE TO PAY FOR THE SERVICE OR SERVICES DESCRIBED ON THIS FORM.

The mental health plan took this action based on information from your provider for the reason checked below:

☐ Your mental health condition as described to us by your provider did not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (Title 9, California Code of Regulations (CCR), Section 1820.205).

☐ Your mental health condition as described to us by your provider did not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services for the following reason (Title 9, CCR, Section 1830.205):

________________________________________________________

☐ The service provided is not covered by the mental health plan (Title 9, CCR, Section 1810.345).

☐ The mental health plan requested additional information from your provider that the plan needs to approve payment of the service you received. To date, the information has not been received.

☐ Other ______________________________________________________

If you don't agree with the plan's decision, you may:
You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at ____________________________ or write to: ____________________________

or follow the directions in the information brochure the mental health plan has given you. You must file an appeal within 90 days of the date of this notice.

If you are unhappy with the outcome of your appeal, you may request a state hearing. The other side of this notice explains how to request a hearing. The state hearing will decide if the plan should pay your provider for the service that you already received. Whatever the appeal or state hearing decision, you will not have to pay for the service.

NOA-C Post-Service (revised 6-1-05)
YOUR HEARING RIGHTS
You only have 90 days to ask for a hearing. The 90 days start either:

1. The day after we personally gave you this the mental health plan's appeal decision notice, OR

2. The day after the postmark date of this mental health plan's appeal decision notice.

Expedited State Hearings
It usually takes about 90 days from the date of your request to make a hearing decision. If you think this timing will cause serious problems with your mental health, including problems with your ability to get, maintain or regain important life functions, you may request an expedited state hearing. To request an expedited hearing, please check the 1st box in the right hand column of this page under HEARING REQUEST and include the reason why you are requesting an expedited hearing. If your expedited hearing request is approved, a hearing decision will be issued within three working days of the date your request is received by the State Hearings Division.

To Keep Your Same Services While You Wait for A Hearing
• You must ask for a hearing within 10 days from the date the mental health plan's appeal decision notice was mailed or personally given to you or before the effective date of the change in services, whichever is later.
• Your Medi-Cal mental health services will stay the same until a final hearing decision is made which is adverse to you, you withdraw your request for a hearing, or the time period or service limits for your current services expire, whichever happens first.

State Regulations Available
State regulations, including those covering state hearings, are available at your local county welfare office.

To Get Help
You may get free legal help at your local legal aid office or other groups. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:
Call toll free: 1-800-952-5253
If you are deaf and use TDD, call: 1-800-952-8349

Authorized Representative
You can present yourself at the state hearing. You can also be represented by a friend, an attorney or anyone else you choose. You must arrange for this representative yourself.

Information Practices Act Notice (California Civil Code Section 1798, et. seq.) The information you are asked to write in on this form is needed to process your hearing request. Processing may be delayed if the information is not complete. A case file will be set up by the State Hearings Division of the Department of Social Services. You have the right to examine the materials that make up the record for decision and may locate this record by contacting the Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with the mental health plan, the State Departments of Health Services and Mental Health and with the U.S. Department of Health and Human Services (Authority: Welfare and Institutions Code, Section 14100.2)

HOW TO ASK FOR A STATE HEARING
The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then send this page to:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call 1-800-952-8349.

HEARING REQUEST
I want a hearing because of a Medi-Cal related action by the Mental Health Plan of ________ County.

" Check here if you want an expedited state hearing and include the reason below,

Here's why:


" Check here and add a page if you need more space.

My name: (print)

My Social Security Number:

My Address:(print)

My phone number: (_______)

My signature:

Date:

I need an interpreter at no cost to me. My language or dialect is:

I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name ____________________________

Address ____________________________

Phone number: ________________________
Medi-Cal Specialty Mental Health Services Program

NOTICE OF ACTION
(Delays in Grievance/Appeal Processing)

Date: ____________

To: _____________________________________, Medi-Cal Number ____________

The mental health plan for __________________________ County has not processed your
☐ grievance ☐ appeal ☐ expedited appeal on time.

Our records show you made your request on
________________________________________

You requested that ____________________________________________
________________________________________
________________________________________

We are sorry for the delay in answering your request. We will continue to work on your request
and hope to provide you with a decision soon.

If your request was about the denial of or a change in the mental health services you
receive from the mental health plan and you do not want to wait for our decision, you may
request a state hearing to consider the denial or change. You may also ask that the state
hearing consider the reason for the delay.

If your request was about another issue, you may request a state hearing to consider the reason
for the delay. The other side of this form explains how to request a state hearing.

This notice is required pursuant to Title 42, Code of Federal Regulations, Part 438, Subpart F.
YOUR HEARING RIGHTS
You only have 90 days to ask for a hearing. The 90 days start either:

1. The day after we personally gave you this the mental health plan's appeal decision notice, OR

2. The day after the postmark date of this mental health plan's appeal decision notice.

Expedited State Hearings
It usually takes about 90 days from the date of your request to make a hearing decision. If you think this timing will cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions, you may request an expedited state hearing. To request an expedited hearing, please check the 1st box in the right hand column of this page under HEARING REQUEST and include the reason why you are requesting an expedited hearing. If your expedited hearing request is approved, a hearing decision will be issued within three working days of the date your request is received by the State Hearings Division.

To Keep Your Same Services While You Wait for a Hearing
• You must ask for a hearing within 10 days from the date the mental health plan's appeal decision notice was mailed or personally given to you or before the effective date of the change in services, whichever is later.
• Your Medi-Cal mental health services will stay the same until a final hearing decision is made which is adverse to you, you withdraw your request for a hearing, or the time period or service limits for your current services expire, whichever happens first.

State Regulations Available
State regulations, including those covering state hearings, are available at your local county welfare office.

To Get Help
You may get free legal help at your local legal aid office or other groups. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:
Call toll free: 1-800-952-5253
If you are deaf and use TDD, call: 1-800-952-8349

Authorized Representative
You can represent yourself at the hearing. You can also be represented by a friend, an attorney or anyone else you choose. You must arrange for this representative yourself.

Information Practices Act Notice (California Civil Code Section 1798, et. seq.) The information you are asked to write in on this form is needed to process your hearing request. Processing may be delayed if the information is not complete. A case file will be set up by the State Hearings Division of the Department of Social Services. You have the right to examine the materials that make up the record for decision and may locate this record by contacting the Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with the mental health plan, the State Departments of Health Services and Mental Health, and with the U.S. Department of Health and Human Services (Authority: Welfare and Institutions Code, Section 14100.2)

HOW TO ASK FOR A STATE HEARING
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State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call 1-800-952-8349.

HEARING REQUEST
I want a hearing because of a Medi-Cal related action by the Mental Health Plan of ______ County.

Check here if you want an expedited state hearing and include the reason below.

Here's why:

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Check here and add a page if you need more space.

My name: (print)

My Social Security Number:

My Address:(print)

My phone number: (____)

My signature:

Date: __________

I need an interpreter at no cost to me. My language or dialect is:

______________________________________________________________

I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name ____________________________

Address __________________________

Phone number: _____________________

NOA-BACK (6-1-05)
Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION
(Lack of Timely Service)

Date: _____________

To: _______________________________, Medi-Cal Number _____________

The mental health plan for ____________________________ County has not provided services within _____ working days of the date of the initial service request.

Our records show that you requested services, or services were requested on your behalf on ____________________________

The following services were requested by you or on your behalf:

_________________________________________________________________
_________________________________________________________________

We are sorry for the delay in providing timely services. We are working on your request and hope to provide you with the requested service(s) soon.

You may request a state hearing to consider the reason for the delay.

The other side of this form explains how to request a state hearing.

This notice is required pursuant to Title 42, Code of Federal Regulations, Part 438, Subpart F.

NOA-E Timeliness (revised 6-1-05)
YOUR HEARING RIGHTS
You only have 90 days to ask for a hearing. The 90 days start either:

1. The day after we personally gave you this the mental health plan’s appeal decision notice, OR

2. The day after the postmark date of this mental health plan’s appeal decision notice.

Expedited State Hearings
It usually takes about 90 days from the date of your request to make a hearing decision. If you think this timing will cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions, you may request an expedited state hearing. To request an expedited hearing, please check the 1st box in the right hand column of this page under HEARING REQUEST and include the reason why you are requesting an expedited hearing. If your expedited hearing request is approved, a hearing decision will be issued within three working days of the date your request is received by the State Hearings Division.

To Keep Your Same Services While You Wait for a Hearing
• You must ask for a hearing within 10 days from the date the mental health plan’s appeal decision notice was mailed or personally given to you or before the effective date of the change in services, whichever is later.
• Your Medi-Cal mental health services will stay the same until a final hearing decision is made which is adverse to you, you withdraw your request for a hearing, or the time period or service limits for your current services expire, whichever happens first.

State Regulations Available
State regulations, including those covering state hearings, are available at your local county welfare office.

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P.O. Box 942423, Mail Station 19-37
Sacramento, CA 94244-2430

Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call 1-800-952-8349.

HEARING REQUEST
I want a hearing because of a Medi-Cal related action by the Mental Health Plan of Costra Costa County.

• Check here if you want an expedited state hearing and include the reason below.

Here’s why:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Check here and add a page if you need more space.

My name: (print)

My Social Security Number:

My Address: (print)

My phone number: (____)

My signature:

Date:

I need an interpreter at no cost to me. My language or dialect is:

__________________________________________

I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name

Address

Phone number:

NOA-BACK (6-1-05)
Partnership Plan for Wellness

Sample Client
Consumer's Name
Sample Case Manager
Provider's Name

MRN
El Portal RU 07051

Strengths:
Creative
Wants to get better

List other services/agencies involved:
Shelter, Inc.

Life Goals: What does the consumer or child and family hope to achieve or work toward? Please use their own words. Include hopes and dreams.

"I want to find a job and an apartment."

Clinical Treatment Goals: Must be specific, observable or quantifiable and improve ability to pursue goals and/or decrease impairment or symptoms related to diagnosis. (once mental health goals are identified, you may also include case management, targeted case management goals).

Client will work on decreasing the depressive symptom of isolation, by participating in social activities at least 1 time per week. The client will work on replacing her negative self talk (low self esteem & poor body image) with a more positive self image as reflected in her individual therapy progress.

Strategies to Achieve Goals: Specify what Consumer/Family/Provider are to do, as appropriate. (For example, How do these actions help decrease symptoms, increase functionality?)

1. Client will participate in individual therapy sessions weekly in order to decrease negative self talk and work on positive self image that will decrease depressive symptoms.
2. Client will take her medications as prescribed and attend all scheduled psychiatric appointments.
3. Case manager and clinician will work with client on increasing her social activities so that she can work on her isolation.

Please select all appropriate treatment options:

- Individual
- Fam/Collateral
- Medication
- CM/TCM Case Mgmt
- Group
- Rehab Svcs
- Day Tx
- TBS
- Self-Help/WRAP
- Child Wraparound
- Other

MHC021-7 (Rev_3-14) Partnership Plan for Wellness PAGE 1 of 2
Revisions or additions:

Life Goals: What does the consumer or child and family hope to achieve or work toward? Please use their own words. May include hopes and dreams, as appropriate.

Treatment Goals: Must be specific, observable or quantifiable and improve ability to pursue goals and/or decrease impairment or symptoms.

Strategies to Achieve Goals: Specify what Consumer/Family/Provider are to do, as appropriate.

Proposed Duration [12] months.

Please select all appropriate treatment options:

- Individual
- Fam/Collateral
- Medication
- CM/TCM Case Mgmt
- Group
- Rehab Svcs
- Day Tx
- TBS
- Self-Help/WRAP
- Child Wraparound
- Other

I have participated in the development of this plan:

Consumer’s Signature*  Date

Provider’s Signature  Date

Auth. Committee Signature  Date

MD Signature  Date

If consumer is a minor under age 12:

Legal Party Responsible Signature  Date

Licensed Signature (If Req’d)  Date

Consumer/Legal Responsible Party was offered a copy of Partner

☐ A copy was given
☐ A copy was declined (date )

*Document reason for no consumer signature on this Plan.

MHCO21-7 (Rev_3-14) Partnership Plan for Wellness  PAGE 2 of 2
**Partnership Plan for Wellness**

**Sample Client**

**Consumer’s Name**

**Sample**

**Provider’s Name**

**Strengths:**
- insightful
- caring
- resilient

**List other services/agencies involved:**
- ECCMH-Mental health services

**Life Goals:** What does the consumer or child and family hope to achieve or work toward? Please use their own words. Include hopes and dreams.

Parents: "We want her to graduate from High School, get a job, and live on her own."

Client: "I want my parents to let me live my life."

**Clinical Treatment Goals:** Must be specific, observable or quantifiable and improve ability to pursue goals and/or decrease impairment or symptoms related to diagnosis. (once mental health goals are identified, you may also include case management, targeted case management goals).

Decrease isolation, anxiety, depression, and harming behaviors by increasing access and connection to natural supports, coping skills, community connection, and supportive services. Work with the family to increase long term resiliency by empowering and supporting client with support resources, tools, and management skills as well as use their strengths to foster independent and connection.

**Strategies to Achieve Goals:** Specify what Consumer/Family/Provider are to do, as appropriate. (For example, How do these actions help decrease symptoms, increase functionality?)

Collaborate with the family to develop a team of professional and natural supports that will assist family in establishing and maintaining appropriate structure, boundaries, and support by identifying strengths. We will also work towards facilitating open and honest communication, crisis support, and access to needed resources to improve everyone's quality of life. The team will develop a Wraparound plan that identifies needs and goals, assigns action items to team members, and checks in with the family for regular updates. Plan includes the participation of a Family Partner to assist the family in identifying resources in the community, parenting strategies, social skills, and other supports. Facilitator and family partner will link family to support and mental health resources to aid in providing a stable and structured environment at home, link to activities and resources to aid in reducing stress at home such as skill building workshops, and/or community connections. The team will also assist the family with defining and implementing their specific needs, and strategies to accomplish their goals.

**Please select all appropriate treatment options:**

- [ ] Individual
- [ ] Fam/Collateral
- [ ] Medication
- [ ] CM/TCM Case Mgmt
- [ ] Group
- [ ] Rehab Svcs
- [ ] Day Tx
- [ ] TBS
- [ ] Self-Help/WRAP
- [ ] Child Wraparound
- [ ] Other:

MHC021-7 (Rev_3-14) Partnership Plan for Wellness   PAGE 1 of 2
Revisions or additions:

Updated Plan Date

Life Goals: What does the consumer or child and family hope to achieve or work toward? Please use their own words. May include hopes and dreams, as appropriate.

Treatment Goals: Must be specific, observable or quantifiable and improve ability to pursue goals and/or decrease impairment or symptoms.

Strategies to Achieve Goals: Specify what Consumer/Family/Provider are to do, as appropriate.

Proposed Duration __ months.

Please select all appropriate treatment options:

☐ Individual  ☐ Fam/Collateral  ☐ Medication  ☐ CM/TCM Case Mgmt  ☐ Group  ☐ Rehab Svcs
☐ Day Tx  ☐ TBS  ☐ Self-Help/WRAP  ☐ Child Wraparound  ☐ Other

I have participated in the development of this plan:

Consumer's Signature*  
Provider's Signature  
Auth. Committee Signature  
MD Signature

If consumer is a minor under age 12:
Legal Party Responsible Signature

Licensed Signature (If Req'd)

Consumer/Legal Responsible Party was offered a copy of Partner
☒ A copy was given
☐ A copy was declined (date )

*Document reason for no consumer signature on this Plan.

MHC021-7 (Rev. 3-14) Partnership Plan for Wellness  PAGE 2 of 2
**Partnership Plan for Wellness**

**Sample Client**

**Consumer’s Name**

**Sample Case Manager**

**Provider’s Name**

**MRN**

**EFC RU 07162**

**Program**

**Strengths:**

- athletic
- well liked

**List other services/agencies involved:**

**Life Goals:** What does the consumer or child and family hope to achieve or work toward? Please use their own words. Include hopes and dreams.

Client: "Live with my mom".
Foster Mom: "I want him to settle down."

**Clinical Treatment Goals:** Must be specific, observable or quantifiable and improve ability to pursue goals and/or decrease impairment or symptoms related to diagnosis. (Once mental health goals are identified, you may also include case management, targeted case management goals).

Case manager will assist client in decreasing emotional outbursts from 5 times per week to 1 time per week, which consist of yelling and punching walls, as evidenced by foster mother’s report.

**Strategies to Achieve Goals:** Specify what Consumer/Family/Provider are to do, as appropriate. (For example, How do these actions help decrease symptoms, increase functionality?)

1. Case manager will provide coordination of care with school staff, therapist, foster parent, and Child Protective Services (CPS) social worker to discuss client’s progress and possible reunification with biological mom.
2. Assist client in identifying triggers to anger outbursts and learning new coping skills.
3. Will explore possible referral to Therapeutic Behavioral Services (TBS).

**Please select all appropriate treatment options:**

- Individual
- Fam/Collateral
- Medication
- CM/TCM Case Mgmt
- Group
- Rehab Svcs
- Day Tx
- TBS
- Self-Help/WRAP
- Child Wraparound
- Other

MHC021-7 (Rev_3-14) Partnership Plan for Wellness

Page 1 of 2
Revisions or additions:  

Life Goals: What does the consumer or child and family hope to achieve or work toward? Please use their own words. May include hopes and dreams, as appropriate.

Treatment Goals: Must be specific, observable or quantifiable and improve ability to pursue goals and/or decrease impairment or symptoms.

Strategies to Achieve Goals: Specify what Consumer/Family/Provider are to do, as appropriate.

Proposed Duration: [12] months.

Please select all appropriate treatment options:
- [ ] Individual
- [ ] Fam/Collateral
- [ ] Medication
- [ ] CM/TCM Case Mgmt
- [ ] Group
- [ ] Rehab Svcs
- [ ] Day Tx
- [ ] TBS
- [ ] Self-Help/WRAP
- [ ] Child Wraparound
- [ ] Other

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Provider's Signature

Auth. Committee Signature

MD Signature

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Licensed Signature (If Req'd)

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**Partnership Plan for Wellness**

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<tr>
<td>Sample Clinician</td>
<td>W. County Children’s RU 07688</td>
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<tr>
<td><strong>Provider’s Name</strong></td>
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**Strengths:**
- friendly
- enjoys arts and crafts
- communicates needs

**List other services/agencies involved:**

**Life Goals:** What does the consumer or child and family hope to achieve or work toward? Please use their own words. Include hopes and dreams.

Client: "I want to finish kindergarten."
Parent: "I want to see my child excel in school and do well."

**Clinical Treatment Goals:** Must be specific, observable or quantifiable and improve ability to pursue goals and/or decrease impairment or symptoms related to diagnosis. (once mental health goals are identified, you may also include case management, targeted case management goals).

1. Client will decrease symptoms of hyperactivity and aggression at school from 5 times per week to 2 times per week. This will be reported by family and teacher.
2. Client will learn new coping skills to replace negative symptomatology of hitting, pushing, kicking other peers or disrespectful language with parents. Parents will report when client is able to replace behaviors 2 times per week.

**Strategies to Achieve Goals:** Specify what Consumer/Family/Provider are to do, as appropriate. (For example, How do these actions help decrease symptoms, increase functionality?)

Client and family will participate in family Wraparound meetings in order to learn new coping skills and work on increasing the parent’s ability to effectively parent their child. The parents will work on parenting skills and behavior modification in order to assist the client when she is having an emotional outburst (hitting, kicking, or pushing others). The client will participate in therapy one time per week with therapist in order to role play or play act her behaviors so that the client can work on relaxation techniques and replacement behaviors. The parents will work with case manager on referral to psychiatrist in order to determine if medication therapy would be effective in managing some of the Attention Deficit Hyperactivity Disorder (ADHD) symptoms of inability to focus, compulsive behaviors, and aggressive behaviors.

**Please select all appropriate treatment options:**
- Individual
- Fam/Collateral
- Medication
- CM/TCM Case Mgmt
- Group
- Rehab Svcs
- Day Tx
- TBS
- Self-Help/WRAP
- Child Wraparound
- Other

MHC021-7 (Rev_3-14) Partnership Plan for Wellness

**PAGE 1 of 2**
Revisions or additions:  

Updated Plan Date

Life Goals: What does the consumer or child and family hope to achieve or work toward? Please use their own words. May include hopes and dreams, as appropriate.

Treatment Goals: Must be specific, observable or quantifiable and improve ability to pursue goals and/or decrease impairment or symptoms.

Strategies to Achieve Goals: Specify what Consumer/Family/Provider are to do, as appropriate.

Proposed Duration 12 months.

Please select all appropriate treatment options:

- Individual
- Fam/Collateral
- Medication
- CM/TCM Case Mgmt
- Group
- Rehab Svcs
- Day Tx
- TBS
- Self-Help/WRAP
- Child Wraparound
- Other

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Provider's Signature  

Auth. Committee Signature  

MD Signature

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Licensed Signature (If Req'd)

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*Document reason for no consumer signature on this Plan.
Sample Client

**Consumer’s Name**

123456

**MRN**

Sample Case Manager

W. County Adult RU 07051

**Program**

---

**Strengths:**

- friendly
- intelligent
- motivated

**List other services/agencies involved:**

---

**Life Goals:** What does the consumer or child and family hope to achieve or work toward? Please use their own words. Include hopes and dreams.

"Find a place to live so that I can get my kids back."

---

**Clinical Treatment Goals:** Must be specific, observable or quantifiable and improve ability to pursue goals and/or decrease impairment or symptoms related to diagnosis. (Once mental health goals are identified, you may also include case management, targeted case management goals).

Case manager will assist client in identifying techniques to decrease impulsive behaviors so that client can maintain stable housing. Develop and maintain linkages with family, housing support, and other services.

---

**Strategies to Achieve Goals:** Specify what Consumer/Family/Provider are to do, as appropriate. (For example, How do these actions help decrease symptoms, increase functionality?)

1. Case manager will assist client in addressing issues that interfere with client’s ability to maintain stable housing and help client develop new ways to cope with anxiety.
2. Increase independent skills related to finding and maintaining stable housing.
3. Case manager will assist client in accessing psychiatric services.
4. Provide assistance with linkages to housing support and other services.

---

**Please select all appropriate treatment options:**

- [ ] Individual
- [ ] Fam/Collateral
- [ ] Medication
- [ ] CM/TCM Case Mgmt
- [ ] Group
- [ ] Rehab Svcs
- [ ] Day Tx
- [ ] TBS
- [ ] Self-Help/WRAP
- [ ] Child Wraparound
- [ ] Other

---

MHC021-7 (Rev_3-14) Partnership Plan for Wellness  PAGE 1 of 2
Revisions or additions:

Life Goals: What does the consumer or child and family hope to achieve or work toward? Please use their own words. May include hopes and dreams, as appropriate.

Treatment Goals: Must be specific, observable or quantifiable and improve ability to pursue goals and/or decrease impairment or symptoms.

Strategies to Achieve Goals: Specify what Consumer/Family/Provider are to do, as appropriate.

Proposed Duration 12 months.

Please select all appropriate treatment options:

- Individual
- Fam/Collateral
- Medication
- CM/TCM Case Mgmt
- Group
- Rehab Svcs
- Day Tx
- TBS
- Self-Help/WRAP
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- Other

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Provider’s Signature Date

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Partnership Plan for Wellness

Sample Client

Consumer's Name

Sample Case Manager

Provider's Name

Strengths:
creative
happy
likes dogs

List other services/agencies involved:

Life Goals: What does the consumer or child and family hope to achieve or work toward? Please use their own words. Include hopes and dreams.

"I want to graduate high school so I can make money."

Clinical Treatment Goals: Must be specific, observable or quantifiable and improve ability to pursue goals and/or decrease impairment or symptoms related to diagnosis. (Once mental health goals are identified, you may also include case management, targeted case management goals).

Case manager will help identify triggers so that aggressive and defiant behaviors (name calling towards authority figures) decrease so that client can successfully graduate high school.

Strategies to Achieve Goals: Specify what Consumer/Family/Provider are to do, as appropriate. (For example, How do these actions help decrease symptoms, increase functionality?)

1. Case manager will assist Client in addressing issues that interfere with client's ability to stay on track with educational goals and graduate
2. Consult with school staff and parent as needed.
3. Link to additional supportive services to help client maintain school placement.
4. Explore possible referral to Transitional Age Youth (TAY) program

Please select all appropriate treatment options:

☐ Individual ☐ Fam/Collateral ☐ Medication ☐ CM/TCM Case Mgmt ☐ Group ☐ Rehab Svcs
☐ Day Tx ☐ TBS ☐ Self-Help/WRAP ☐ Child Wraparound ☐ Other

MHC021-7 (Rev. 3-14) Partnership Plan for Wellness PAGE 1 of 2
Revisions or additions:

Updated Plan Date

Life Goals: What does the consumer or child and family hope to achieve or work toward? Please use their own words. May include hopes and dreams, as appropriate.

Treatment Goals: Must be specific, observable or quantifiable and improve ability to pursue goals and/or decrease impairment or symptoms.

Strategies to Achieve Goals: Specify what Consumer/Family/Provider are to do, as appropriate.

Proposed Duration 12 months.

Please select all appropriate treatment options:

- Individual
- Fam/Collateral
- Medication
- CM/TCM Case Mgmt
- Group
- Rehab Svcs
- Day Tx
- TBS
- Self-Help/WRAP
- Child Wraparound
- Other

I have participated in the development of this plan:

Consumer's Signature* Date
Provider's Signature Date
Auth. Committee Signature Date
MD Signature Date

If consumer is a minor under age 12: Legal Party Responsible Signature Date
Licensed Signature (If Req'd) Date

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- A copy was declined (date)

*Document reason for no consumer signature on this Plan.

MHIC021-7 (Rev_3-14) Partnership Plan for Wellness PAGE 2 of 2
Progress Note/
Billing Form

Sample Crisis Intervention
123456
NAME / MRN

Service Date: 11/06/13  RU: 2222

Staff #: 1234  Hours* 1 Mins
Co-Staff #:  Hours* Mins

Total Travel Time: Hours Mins

* Service duration must include travel time, if applicable

Services: (Check one)

☐ 300 No Show  ☐ 313 Evaluation  ☐ 351 Group Therapy  ☐ 571 Case Mgmt - Plan Develpmt
☐ 400 Client Cancel  ☐ 315 Plan Develpmt  ☐ 355 Group Rehab  ☐ 540 Non-Billable Services
☐ 700 Staff Cancel  ☐ 317 Rehab  ☐ 357 Group Collateral  ☐ 580 Non-Billable - Lock-outs
☒ 371 Crisis Int.  ☐ 331 Assessment  ☐ 541 Case Mgmt - Placement
☐ 311 Collateral  ☐ 341 Indiv Therapy  ☐ 561 Case Mgmt - Linkage

Location of Services: (Check one)

☐ 1 Office  ☐ 5 School  ☐ 11 Faith-based  ☐ 15 Licensed Care Fac. (Adult)
☐ 2 Field  ☐ 8 Correctional Facility  ☐ 12 Healthcare  ☐ 16 Mobile Service
☐ 3 Phone  ☐ 9 Inpatient  ☐ 13 Age-Specific Center  ☐ 17 Non-Traditional Location
☒ 4 Home  ☐ 10 Homeless/Shelter  ☐ 14 Client’s Job-site  ☐ 18 Other
☐ 19 Residential Tx Center (Child)
☐ 20 Telehealth

Service Strategies: (Check up to three, if applicable)

☐ 50 Peer/Family Services  ☐ 53 Supportive Education  ☐ 56 With Social Services  ☐ 59 With Develpmt Disabled
☐ 51 Psycho-Education  ☐ 54 With Law Enforcement  ☐ 57 With Substance Abuse  ☐ 60 Ethnic-specific Services
☒ 52 Family Support  ☐ 55 With Health Care  ☐ 58 With Aging Providers  ☒ 61 Age-specific Services
☐ 99 Unknown

Interpreter  Name of Interpreter: 

Language service provided in other than English: ☐ Spanish ☐ Other

Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

1a. Treatment goal(s) addressed, if appropriate.

Client will express her anger in a controlled respectful manner and continue to utilize her safety plan. Client will decrease self harm incidents which consist of cutting to 0 times per month as evidenced by foster mother’s report.

1b. Description of Current Situation/Reason for Contact:
(Status update, needs, clinical impressions)  Current DSM Diagnosis 309.28

Client is a 12 year old girl that has been residing in foster care for 3 months. Client has had difficulty maintaining her foster care placements and has moved from 2 foster families. Client moved in with current foster family 2 weeks ago. Caseworker was notified that client was currently in the bathroom with a knife threatening to cut herself. The foster parents report that she is very upset that she wasn't visited by her mom over the weekend.
2. Focus of Activity:
(What is the intervention? What was the result?)

Caseworker listened as client expressed her feelings. Client stated that she wanted to cut herself because that was the only way she knew how to deal with her anger. Caseworker attempted to de-escalate her and reminded client of other ways to express her feelings. Client agreed to try deep breathing exercises during the session. Client said that she hated her mom for everything that she had put her through. She eventually released the knife and said that she could talk to the caseworker because she wanted to stay with this foster family because they treated her well. Caseworker and client created a safety plan she could use next time she becomes very angry.

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.

Caseworker will check in with client later this week to see how she is feeling and follow up on her use of relaxation techniques between sessions. Caseworker will continue to collaborate with CFS social worker in order to discuss the reunification plan.
Progress Note/ Billing Form

Sample Collateral

123456
NAME / MRN

Service Date: 11/06/13  RU: 2222  Hours* Mins 30  # In Group: 

Co-Staff #:  

Hours* Mins  
Total Travel Time: Hours Mins 
* Service duration must include travel time, if applicable

Services: (Check one)

☐ 300 No Show  ☐ 313 Evaluation  ☐ 351 Group Therapy  ☐ 571 Case Mgmt - Plan Develpmnt
☐ 400 Client Cancel  ☐ 315 Plan Develpmnt  ☐ 355 Group Rehab  ☐ 540 Non-Billable Services
☐ 700 Staff Cancel  ☐ 317 Rehab  ☐ 357 Group Collateral  ☐ 580 Non-Billable - Lock-outs
☐ 371 Crisis Int.  ☐ 331 Assessment  ☐ 541 Case Mgmt - Placement
☑ 311 Collateral  ☐ 341 Indiv Therapy  ☐ 561 Case Mgmt - Linkage

Location of Services: (Check one)

☐ 1 Office  ☐ 5 School  ☐ 11 Faith-based  ☐ 15 Licensed Care Fac. (Adult)
☐ 2 Field  ☐ 8 Correctional Facility  ☐ 12 Healthcare  ☐ 16 Mobile Service
☑ 3 Phone  ☐ 9 Inpatient  ☐ 13 Age-Specific Center  ☐ 17 Non-Traditional Location
☐ 4 Home  ☐ 10 Homeless/Shelter  ☐ 14 Client’s Job-site  ☐ 18 Other
☐ 19 Residential Tx Center (Child)
☐ 20 Telehealth
☐ 21 Unknown

Service Strategies: (Check up to three, if applicable)

☐ 50 Peer/Family Services  ☐ 53 Supportive Education  ☐ 56 With Social Services  ☐ 59 With Develpmnt Disabled
☐ 51 Psycho-Education  ☐ 54 With Law Enforcement  ☐ 57 With Substance Abuse  ☐ 60 Ethnic-specific Services
☑ 52 Family Support  ☐ 55 With Health Care  ☐ 58 With Aging Providers  ☑ 61 Age-specific Services
☐ 99 Unknown

 Interpreter Name of Interpreter: 

Language service provided in other than English: ☐ Spanish ☐ Other 

Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

1a. Treatment goal(s) addressed, if appropriate.

Decrease outbursts of cursing, hitting, slamming doors, and punching walls to less than 2 times per week. Client will learn new coping skills to deal with his anger in a manner that does not include harming others or destroying property. Comply with rules and reasonable expectations at home and at school.

1b. Description of Current Situation/Reason for Contact: (Status update, needs, clinical impressions) Current DSM Diagnosis 313.81

Client’s mother called because she does not know what to do with him anymore, she wants help in dealing with his angry outbursts and such as cursing, hitting, slamming doors, and punching the walls. Client continues to act out his anger in inappropriate ways at home. These angry outbursts include hitting his parent, slamming doors, throwing items, or hitting/kicking the walls.
2. Focus of Activity:
(Intervention and Response to intervention, what did you do? What is the consumer’s response?)
Clinician listened and provided emotional support. Discussed strategies for handling situations when client is angry. Introduced de-escalation techniques that will assist mother in controlling client's behavior. Mother agreed to try the strategies.

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.
Will meet with client at school this week for weekly therapy session. Clinician will also follow up with mother to see if she was able to use the de-escalation techniques and if they were successful in decreasing the client's maladaptive behaviors.

Name: Sample Collateral
MRN: 123456

Signature/License/Job Title
Sample ASW
Printed Name
11/6/13
Date

Co-Signature/License (If applicable)
Date

Computer Entry Clerk Initials

MHC017-9 (Rev 11-13) Progress Note/Billing Form Page 2 of 2
**Progress Note/Billing Form**

**Sample Evaluation**

123456  
NAME / MRN  

**Service Date:** 11/7/13  
**RU:** 1234  
**Hours* **1 Mins 30  
**Total Travel Time:** Hours ____ Mins ____  

**Services:** (Check one)  
- □ 300 No Show  
- □ 400 Client Cancel  
- □ 700 Staff Cancel  
- □ 371 Crisis Int.  
- □ 311 Collateral  
- □ 313 Evaluation  
- □ 315 Plan Develpmnt  
- □ 317 Rehab  
- □ 331 Assessment  
- □ 341 Indiv Therapy  
- □ 351 Group Therapy  
- □ 355 Group Rehab  
- □ 357 Group Collateral  
- □ 541 Case Mgmt - Placement  
- □ 561 Case Mgmt - Linkage  
- □ 571 Case Mgmt - Plan Develpmnt  
- □ 540 Non-Billable Services  
- □ 580 Non-Billable - Lock-outs  

**Location of Services:** (Check one)  
- □ 1 Office  
- □ 2 Field  
- □ 3 Phone  
- □ 4 Home  
- □ 5 School  
- □ 8 Correctional Facility  
- □ 9 Inpatient  
- □ 10 Homeless/Shelter  
- □ 11 Faith-based  
- □ 12 Healthcare  
- □ 13 Age-Specific Center  
- □ 14 Client's Job-site  
- □ 15 Licensed Care Fac. (Adult)  
- □ 16 Mobile Service  
- □ 17 Non-Traditional Location  
- □ 18 Other  
- □ 19 Residential Tx Center (Child)  
- □ 20 Telehealth  
- □ 21 Unknown

**Service Strategies:** (Check up to three, if applicable)  
- □ 50 Peer/Family Services  
- □ 51 Psycho-Education  
- □ 52 Family Support  
- □ 53 Supportive Education  
- □ 54 With Law Enforcement  
- □ 55 With Health Care  
- □ 56 With Social Services  
- □ 57 With Substance Abuse  
- □ 58 With Aging Providers  
- □ 59 With Develpmnt Disabled  
- □ 60 Ethnic-specific Services  
- □ 61 Age-specific Services  
- □ 99 Unknown

☐ Interpreter  
**Name of Interpreter:**  

Language service provided in other than English:  
□ Spanish  
□ Other  

Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

1a. Treatment goal(s) addressed, if appropriate.

To be determined, partnership plan has not been developed yet. Diagnosis is by history.

1b. Description of Current Situation/Reason for Contact:  
(Status update, needs, clinical impressions)  

Client is a 5 year female enrolled in a regular kindergarten class. Her mom initiated therapeutic services because she is concerned that her daughter does not socially interact with her peers and does not have any friends.
2. Focus of Activity:
(Intervention and Response to Intervention, what did you do? What is the consumer's response?)

Met with client's mom to discuss the concerns that she has surrounding her daughter. Gathered information from mom regarding her behavior at home and at school. Mom reports that the client is an only child and does not have the same issues at home because she interacts with adult figures well. Mom provided insight that the client has had difficulty making friends and will isolate herself at home and at school because she doesn't like to talk/play with others. Clinician made initial contact with client, and introduced myself and explained my role to the client. Client seemed interested in my presence at her home and asked me to join her in coloring. Client was quiet and did not verbally interact while she colored.

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.

Clinician will plan to meet with mom and client next week to develop a partnership plan and complete the assessment.

Signature/License/Job Title

Sample, MFTI

11/7/13

Printed Name

Date

Co-Signature/License (If applicable)

Date

Computer Entry Clerk Initials
Progress Note/ Billing Form

Sample Plan Development

123456

NAME / MRN

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* Service duration must include travel time, if applicable

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<td>☐ 3 Phone</td>
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<td>☐ 8 Correctional Facility</td>
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<td>☐ 11 Faith-based</td>
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<td>☐ 12 Healthcare</td>
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<tr>
<td>☐ 13 Age-Specific Center</td>
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<td>☐ 14 Client's Job-site</td>
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<td>☐ 15 Licensed Care Fac. (Adult)</td>
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<td>☐ 16 Mobile Service</td>
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<td>☐ 17 Non-Traditional Location</td>
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Language service provided in other than English: ☐ Spanish ☐ Other

Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

1a. Treatment goal(s) addressed, if appropriate.

Client will decrease episodes of anxiety from 3 times per day to 1 time per day, which prevent him from completing his daily functions such as bathing and working.

1b. Description of Current Situation/Reason for Contact:
(Status update, needs, clinical impressions) Current DSM Diagnosis 300.0

Met with client to discuss treatment plan and goals. Client presents as anxious and guarded. He seems to be internally occupied, but denies auditory hallucinations. The client's anxiety prevents him from performing daily functions such as hygiene, working, and positive social interactions.
2. Focus of Activity:
(Intervention and Response to Intervention, what did you do? What is the consumer's response?)

Discussed with client his symptoms and current level of functional impairment. We developed goals and strategies to reduce symptoms of anxiety and his impairments in his hygiene skills, lack of regular work, and little to no positive social interactions. Completed Partnership Plan. Client was willing to engage in process. Client agreed to and signed the Partnership Plan. A copy of the plan was given to the client.

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.

Clinician and client agreed to meet for weekly therapy sessions in order to begin addressing treatment goals.

Signature/License/Job Title

Sample, LCSW

Printed Name

10/7/13

Date

Co-Signature/License (if applicable)

Date

Computer Entry Clerk Initials
### Progress Note/ Billing Form

**Service Date:** 11/07/13  
**RU:** 1212  
**Staff #:** 1111  
**Co-Staff #:**  
**Hours:** 1  
**Mins:** 45  
**# in Group:**  
**Total Travel Time:** Hours __ Mins __  

*Service duration must include travel time, if applicable*

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| ☐ 400 Client Cancel | ☐ 351 Group Therapy  
| ☐ 700 Staff Cancel | ☐ 355 Group Rehab  
| ☐ 371 Crisis Int. | ☐ 357 Group Collateral  
| ☐ 311 Collateral | ☐ 331 Assessment  
| ☐ 341 Indiv Therapy | ☐ 541 Case Mgmt - Placement  
| | ☐ 561 Case Mgmt - Linkage  

#### Location of Services: (Check one)

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</table>
| ☐ 2 Field | ☐ 15 Licensed Care Fac. (Adult)  
| ☐ 3 Phone | ☐ 12 Healthcare  
| ☐ 4 Home | ☐ 16 Mobile Service  
| ☐ 5 School | ☐ 13 Age-Specific Center  
| ☐ 8 Correctional Facility | ☐ 17 Non-Traditional Location  
| ☐ 9 Inpatient | ☐ 20 Telehealth  
| ☐ 10 Homeless/Shelter | ☐ 18 Other  
| ☐ 14 Client's Job-site | ☐ 21 Unknown |

#### Service Strategies: (Check up to three, if applicable)

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| ☐ 51 Psycho-Education | ☐ 56 With Social Services  
| ☐ 52 Family Support | ☐ 57 With Substance Abuse  
| | ☐ 58 With Aging Providers  
| | ☐ 59 With Developmt Disabled  
| | ☐ 60 Ethnic-specific Services  
| | ☐ 61 Age-specific Services  
| | ☐ 99 Unknown |

#### Interpreter

Name of Interpreter: ____________________________

Language service provided in other than English: ☐ Spanish ☐ Other ____________________________

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**Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.**

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**1a. Treatment goal(s) addressed, if appropriate,**

Decrease impulsive behaviors evidenced by an increase in ability to regulate anxiety around money as self reported by client.

---

**1b. Description of Current Situation/Reason for Contact:**

(Status update, needs, clinical impressions)  

<table>
<thead>
<tr>
<th>Current DSM Diagnosis</th>
<th>300.02</th>
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Met with client to explore how to manage finances better. Also discussed other issues related to poor impulse control. She has been anxious about her money.
2. Focus of Activity:
(Intervention and Response to Intervention, what did you do? What is the consumer’s response?)

Discussed need to be able to manage money better. Client stated she needs more money. Informed her that unfortunately this was not something we could change, but suggested ways to make money last longer. Discussed how impulsive spending makes it difficult to make money last and interferes with ability to cover basic necessities. Developed strategies with client to put money in daily envelopes instead of carrying it with her. Practiced skill of waiting and thinking of consequences before making purchases. Pointed out that impulsive behaviors have caused problems in the past. Discussed how practicing thinking of consequences before acting on impulse could help with this. Client agreed to try strategies before next visit.

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.

Will continue to meet with client weekly to explore strategies to reduce impulsive behavior and check in on homework assignments.

______________________________  ____________________________  __________/____/____
Signature/License/Job Title  Sample, MFT Trainee  Date

______________________________
Co-Signature/License (If applicable)  Date

______________________________  ____________________________  ___________________
Computer Entry Clerk Initials  Printed Name  Date
### Progress Note/Billing Form

**Sample Assessment**

**123456**

**NAME/MRN**

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**Service Date:** 11/07/13  
**RU:** 1212  
**Staff #:** 1111  
**Co-Staff #:**

**Hours**: 1  
**Mins**: 10  
**# In Group:**

**Total Travel Time:**

*Service duration must include travel time, if applicable*

### Services: (Check one)

- [ ] 300 No Show  
- [ ] 400 Client Cancel  
- [ ] 700 Staff Cancel  
- [X] 371 Crisis Int.  
- [ ] 311 Collateral  
- [ ] 313 Evaluation  
- [ ] 315 Plan Developmt  
- [ ] 317 Rehab  
- [ ] 331 Assessment  
- [X] 341 Indiv Therapy  
- [ ] 351 Group Therapy  
- [ ] 355 Group Rehab  
- [ ] 357 Group Collateral  
- [ ] 541 Case Mgmt - Placement  
- [ ] 561 Case Mgmt - Linkage

### Location of Services: (Check one)

- [X] Office  
- [ ] 5 School  
- [ ] 11 Faith-based  
- [ ] 15 Licensed Care Fac. (Adult)  
- [ ] 19 Residential Tx Center (Child)  
- [ ] 2 Field  
- [ ] 8 Correctional Facility  
- [ ] 12 Healthcare  
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- [ ] 59 With Developmt Disabled  
- [ ] 60 Ethnic-specific Services  
- [ ] 61 Age-specific Services  
- [ ] 99 Unknown

### Service Strategies: (Check up to three, if applicable)

- [ ] Interpreter  
- [ ] Name of Interpreter:

**Language service provided in other than English:**  
[ ] Spanish  
[ ] Other

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**Chart to:** Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

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1a. **Treatment goal(s) addressed, if appropriate.**

Will develop treatment goals at next session.

---

1b. **Description of Current Situation/Reason for Contact:**  
(Status update, needs, clinical impressions)

<table>
<thead>
<tr>
<th>Current DSM Diagnosis</th>
<th>300.02</th>
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Met with client for the first time to complete initial assessment.
2. Focus of Activity:
(Intervention and Response to Intervention, what did you do? What is the consumer's response?)

Client came into the office requesting services because she has had several panic attacks this past month. She mentioned that these panic attacks happen when she becomes overwhelmed. Client stated that these panic episodes started after her baby was born and has been feeling hopeless that she cannot stop them. She is not suicidal or homicidal and is agreeable to weekly individual therapy. Reviewed client's history, presenting issues, and mental health concerns. Completed initial Assessment.

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.

Clinician will meet with client next week to discuss treatment goals and complete Partnership Plan.

______________________________
Signature/License/Job Title

______________________________
Co-Signature/License (If applicable)

______________________________
Sample ASW

______________________________
Printed Name

______________________________
Date

______________________________
11/7/13

______________________________
Date

______________________________
Computer Entry Clerk Initials
### Progress Note/ Billing Form

**Sample Individual Therapy**

123456

**NAME / MRN**

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<td>Co-Staff #:</td>
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<td>Hours*</td>
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#### Services: (Check one)

- [ ] 300 No Show
- [ ] 400 Client Cancel
- [ ] 700 Staff Cancel
- [ ] 371 Crisis Int.
- [ ] 311 Collateral
- [ ] 313 Evaluation
- [ ] 315 Plan Developmt
- [ ] 317 Rehab
- [ ] 331 Assessment
- [ ] 341 Indiv Therapy
- [x] 351 Group Therapy
- [ ] 355 Group Rehab
- [ ] 357 Group Collateral
- [ ] 541 Case Mgmt - Placement
- [ ] 561 Case Mgmt - Linkage
- [ ] 571 Case Mgmt - Plan Developmt
- [ ] 540 Non-Billable Services
- [ ] 580 Non-Billable - Lock-outs

#### Location of Services: (Check one)

- [ ] 1 Office
- [ ] 4 Home
- [ ] 5 School
- [ ] 6 Field
- [ ] 8 Correctional Facility
- [ ] 9 Inpatient
- [x] 10 Homeless/Shelter
- [ ] 11 Faith-based
- [ ] 12 Healthcare
- [ ] 13 Age-Specific Center
- [ ] 14 Client's Job-site
- [ ] 15 Licensed Care Fac. (Adult)
- [ ] 16 Mobile Service
- [ ] 17 Non-Traditional Location
- [ ] 18 Other
- [ ] 19 Residential Tx Center (Child)
- [ ] 20 Telehealth
- [ ] 21 Unknown

#### Service Strategies: (Check up to three, if applicable)

- [ ] 50 Peer/Family Services
- [ ] 51 Psycho-Education
- [ ] 52 Family Support
- [ ] 53 Supportive Education
- [ ] 54 With Law Enforcement
- [ ] 55 With Health Care
- [x] 56 With Social Services
- [ ] 57 With Substance Abuse
- [ ] 58 With Aging Providers
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- [ ] 60 Ethnic-specific Services
- [ ] 61 Age-specific Services
- [ ] 99 Unknown

#### Interpreter

Name of Interpreter:

Language service provided in other than English: [ ] Spanish

#### Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

1a. Treatment goal(s) addressed, if appropriate.

Client will work on replacing her negative self talk (low self esteem) with a more positive self image as reflected in her individual therapy progress.

1b. Description of Current Situation/Reason for Contact:

(Status update, needs, clinical impressions)

Current DSM Diagnosis 296.89

Therapy session with client. She presented in a cheerful mood. Client states concern about being unable to visit with father because he has injured himself at work. Client is also anxious and worried about father's well being.
2. Focus of Activity:
(Intervention and Response to Intervention, what did you do? What is the consumer's response?)

Facilitated expression of anxious feelings regarding situation with father. Supported client's continued efforts to achieve age appropriate autonomy. Engaged in problem solving discussion regarding client's tendency to abandon new ideas before she tries them. She would like to continue to work on creating new friendships and maintaining the friendships that she currently has. Provided an assignment for client to create a list of how she would like to help her father and what she can realistically do to help him. Client agreed to homework assignment given for next session. Client left in an upbeat mood.

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.

Clinician will meet with client next week to discuss her homework assignment. Will continue to work on goals of decreasing anxiety and increasing positive social interactions with peers.

_________________________________________  Sample, MFTI  11/7/13
Signature/License/Job Title  Printed Name  Date

_________________________________________  Co-Signature/License (If applicable)  Date

Computer Entry Clerk Initials
**Progress Note/Billing Form**

**CONTRA COSTA HEALTH SERVICES**
Behavioral Health Division

**Sample Group Therapy**

**123456**

**NAME / MRN**

**Service Date:** 11/7/13  
**RU:** 1234  
**Staff #:** 2222  
**Co-Staff #:**

**Hours** 2 Mins 30  
**# in Group:** 5  
**Total Travel Time:** Hours _ Mins ___

**Services:** (Check one)

- [ ] 300 No Show
- [ ] 400 Client Cancel
- [ ] 700 Staff Cancel
- [ ] 311 Crisis Int.
- [ ] 341 Indiv Therapy
- [ ] 313 Evaluation
- [ ] 315 Plan Devlpmnt
- [ ] 317 Rehab
- [ ] 331 Assessment
- [ ] 341 Indiv Therapy
- [ ] 351 Group Therapy
- [ ] 355 Group Rehab
- [ ] 357 Group Collateral
- [ ] 541 Case Mgmt - Placement
- [ ] 561 Case Mgmt - Linkage
- [ ] 571 Case Mgmt - Plan Devlpmnt
- [ ] 540 Non-Billable Services
- [ ] 580 Non-Billable - Lock-outs

**Location of Services:** (Check one)

- [ ] 1 Office
- [ ] 2 Field
- [ ] 3 Phone
- [ ] 4 Home
- [ ] 5 School
- [ ] 8 Correctional Facility
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- [ ] 10 Homeless/Shelter
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**Service Strategies:** (Check up to three, if applicable)

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- [ ] 51 Psycho-Education
- [ ] 52 Family Support
- [ ] 53 Supportive Education
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**Interpreter**

**Name of Interpreter:**

Language service provided in other than English:  
[ ] Spanish  
[ ] Other ______________

**Chart to:** Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

1a. **Treatment goal(s) addressed, if appropriate.**

Client will work on identifying triggers of depression which interferes with the client's ability to maintain stable housing.

1b. **Description of Current Situation/Reason for Contact:**

(Status update, needs, clinical impressions)  

| Current DSM Diagnosis | 298.89 |

Client attends/participates in Women's Depression/Bi-Polar group. Group covered the impact of poverty on depression.

Client reports having a very bad week. She states that her housing situation is unstable and she fears that she may be homeless. She reports that she is experiencing severe insomnia and depression.
2. Focus of Activity:
(Intervention and Response to Intervention, what did you do? What is the consumer’s response?)

Therapist facilitated group which was interactive and dynamic. Therapist encouraged all members to discuss feelings openly with the group. We talked about reasonable vs. unreasonable expectations and ways to act on these feelings. Client was sullen and quiet for the first half of the group. She appeared to be listening to her peers and was interested in how others were feeling. She was able to discuss her fears surrounding her possible future homelessness and responded well to group feedback. Client shared that she was not suicidal and felt that she had made progress over the past 2 months. She stated that 2 months ago if she thought she was going to be evicted she would have considered suicide. The group discussed suicide and safety plans. Other members of the group were able to help her think of natural supports for her if she were to lose her apartment. Client was receptive to positive group feedback and expressed feeling supported.

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.

Clinician will meet with client next week to for individual therapy. Client will continue to attend listening skills group as he has had marked progress and is actively participating in group.

Sample, LCSW 11/7/13

Signature/License/Job Title Printed Name Date

Co-Signature/License (if applicable) Date

Computer Entry Clerk Initials

MHC017-9 (Rev 11-13) Progress Note/Billing Form Page 2 of 2
### Progress Note/Billing Form

**Sample Group Rehab**

**RU:** 1234

**123456**

**NAME / MRN**

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* Service duration must include travel time, if applicable.

**Services:** (Check one)

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**Location of Services:** (Check one)

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**Service Strategies:** (Check up to three, if applicable)

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**Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.**

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**1a. Treatment goal(s) addressed, if appropriate.**

Decrease episodes of aggression and learn to express anger in an appropriate manner as evidenced by foster parent's report.

**1b. Description of Current Situation/Reason for Contact:**

( Status update, needs, clinical impressions)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Current DSM Diagnosis 309.4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Client continues to attend weekly group therapy session at school. He continues to have difficulty interacting appropriately with his peers and tends to act out aggressively towards others.
2. Focus of Activity:
(Intervention and Response to Intervention, what did you do? What is the consumer’s response?)

Therapist facilitated group where clients practiced listening skills. Members of the group would take turns listening to what others said about a recent experience, then repeating back what they heard, and then asking questions about a detail of the speaker’s experience. Client was able to share that he recently had an argument with his friend. He was feeling very upset with his friend and was so angry that he pushed his friend on the playground. When other members of the group retold his experience client reported that he was liked that other people were listening to his story. Clinician asked client what he could have done instead of pushing his friend. Client explained that he could have walked away and found something else to do on the playground. Clinician stated that this is a good option to try next time he wants to push someone on the playground. Client was receptive to this intervention. He also seemed to enjoy the conversations during group and actively participated during the listening skills activity.

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.

Clinician will meet with client next week to discuss goals of decreasing aggression and increasing social interactions with his friends. Client will continue to attend listening skills group as he has had marked progress and is actively participating in group.

_________________________  _________________  ____________
Sample, MFT       Printed Name      Date      

_________________________  ____________
Co-Signature/License (if applicable)  Date

_________________________  
Computer Entry Clerk Initials

MHC017-9 (Rev 11-13) Progress Note/Billing Form
## Progress Note/Billing Form

**Sample Group Collateral**

123456

**NAME / MRN**

<table>
<thead>
<tr>
<th>Service Date: 11/7/13</th>
<th>RU: 1234</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff #: 2222</td>
<td></td>
</tr>
<tr>
<td>Co-Staff #:</td>
<td></td>
</tr>
<tr>
<td>Hours*</td>
<td>Mins 30</td>
</tr>
<tr>
<td></td>
<td># in Group: 5</td>
</tr>
<tr>
<td></td>
<td>Total Travel Time: Hours __ Mins ___</td>
</tr>
</tbody>
</table>

**Services:** (Check one)

- [x] 300 No Show
- [x] 313 Evaluation
- [ ] 351 Group Therapy
- [ ] 571 Case Mgmt - Plan Develpmnt
- [ ] 400 Client Cancel
- [x] 315 Plan Develpmnt
- [ ] 355 Group Rehab
- [ ] 540 Non-Billable Services
- [ ] 700 Staff Cancel
- [x] 317 Rehab
- [x] 357 Group Collateral
- [ ] 580 Non-Billable - Lock-outs
- [ ] 371 Crisis Int.
- [x] 331 Assessment
- [ ] 541 Case Mgmt - Placement
- [ ] 311 Collateral
- [ ] 341 Indiv Therapy
- [ ] 561 Case Mgmt - Linkage

**Location of Services:** (Check one)

- [x] 1 Office
- [x] 5 School
- [ ] 11 Faith-based
- [ ] 15 Licensed Care Fac. (Adult)
- [ ] 19 Residential Tx Center (Child)
- [ ] 2 Field
- [ ] 8 Correctional Facility
- [x] 12 Healthcare
- [ ] 16 Mobile Service
- [ ] 20 Telehealth
- [ ] 3 Phone
- [x] 9 Inpatient
- [ ] 13 Age-Specific Center
- [ ] 17 Non-Traditional Location
- [ ] 21 Unknown
- [ ] 4 Home
- [ ] 10 Homeless/Shelter
- [ ] 14 Client's Job-site
- [ ] 18 Other
- [ ] 99 Unknown

**Service Strategies:** (Check up to three, if applicable)

- [x] 50 Peer/Family Services
- [ ] 53 Supportive Education
- [x] 56 With Social Services
- [x] 59 With Develpmnt Disabled
- [ ] 51 Psycho-Education
- [ ] 54 With Law Enforcement
- [x] 57 With Substance Abuse
- [x] 60 Ethnic-specific Services
- [x] 52 Family Support
- [ ] 55 With Health Care
- [x] 58 With Aging Providers
- [x] 61 Age-specific Services
- [ ] 99 Unknown

**Interpreter**

Name of Interpreter: ________________

**Language service provided in other than English:** [x] Spanish [ ] Other

**Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.**

### 1a. Treatment goal(s) addressed, if appropriate.

Decrease client's impulsive behavior (agression and hyperactivity), from 3 times per week to 1 time per week, that interferes with mom's ability to provide structure and rules at home.

### 1b. Description of Current Situation/Reason for Contact: (Status update, needs, clinical impressions)

Client is currently attending Kindergarten and receives support for his aggression and hyperactivity at home and at school. His mom is unable to support her son at home and does not know what to do when he is threatening to hit her or his siblings. Mom would like to receive parent education classes in order to increase her parenting skills and learn new ways to positively interact with her son.

**Current DSM Diagnosis:** 314.01
2. Focus of Activity:
(Intervention and Response to Intervention, what did you do? What is the consumer's response?)

Clinician facilitated a parenting skills group. The parents who attended the group all have children who are diagnosed with ADHD. The topic of the group was to discuss one area of need and one area of parenting that they do well. Client's mother was very attentive to others in the group. She was able to share that she lacks the skills to discipline her child effectively, and usually ends up yelling at her son. Mom shared she feels defeated. Mom stated she is able to get her son to school everyday on time. Mom responded well to the other parents in the group. The members of the group were able to share what they have done to discipline their child/ren and what worked and what didn't. Mom felt validated and stated she was glad that she was not the only one who didn't know how to discipline. Mom learned new ways to interact with her son when he is yelling, screaming, or attempting to hit his siblings. Mom's ability to effectively parent her son and create healthy boundaries will hopefully allow her to be consistent when disciplining her son.

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.

Continue to have mom attend parenting classes in order to effectively parent her son. Clinician will continue to meet with son and mom for family therapy sessions to address concerns surrounding his behaviors at home and at school. Will continue to address needs of the family and also treatment goals of decreasing the client's tantruming and abusive behaviors at home and school.

Signature/License/Job Title

Sample ASW

Printed Name

11/7/13

Date

Co-Signature/License (if applicable)

Date

Computer Entry Clerk Initials
Progress Note/Billing Form

Sample CM Placement
123456
NAME / MRN

Service Date: 11/12/13
RU: 1212

Staff #: 1111
Hours* Mins 20
Co-Staff #: _______
Hours* Mins ______ Total Travel Time: Hours Mins ______

Services: (Check one)

☐ 300 No Show ☐ 313 Evaluation ☐ 351 Group Therapy ☐ 571 Case Mgmt - Plan Develpmnt
☐ 400 Client Cancel ☐ 315 Plan Develpmnt ☐ 355 Group Rehab ☐ 540 Non-Billable Services
☐ 700 Staff Cancel ☐ 317 Rehab ☐ 357 Group Collateral ☐ 580 Non-Billable - Lock-outs
☐ 371 Crisis Int. ☐ 331 Assessment ☐ 541 Case Mgmt - Placement
☐ 311 Collateral ☐ 341 Indiv Therapy ☐ 561 Case Mgmt - Linkage

Location of Services: (Check one)

☐ 1 Office ☐ 5 School ☐ 11 Faith-based ☐ 15 Licensed Care Fac. (Adult) ☐ 19 Residential Tx Center (Child)
☐ 2 Field ☐ 8 Correctional Facility ☐ 12 Healthcare ☐ 16 Mobile Service
☐ 3 Phone ☐ 9 Inpatient ☐ 13 Age-Specific Center ☐ 17 Non-Traditional Location ☐ 20 Telehealth
☐ 4 Home ☐ 10 Homeless/Shelter ☐ 14 Client's Job-site ☐ 18 Other ☐ 21 Unknown

Service Strategies: (Check up to three, if applicable)

☐ 50 Peer/Family Services ☐ 53 Supportive Education ☐ 56 With Social Services ☐ 59 With Developmnt Disabled
☐ 51 Psycho-Education ☐ 54 With Law Enforcement ☐ 57 With Substance Abuse ☐ 60 Ethnic-specific Services
☐ 52 Family Support ☐ 55 With Health Care ☐ 58 With Aging Providers ☐ 61 Age-specific Services
☐ 99 Unknown

Interpreter Name of Interpreter: ____________________________

Language service provided in other than English: ☐ Spanish ☐ Other

Chart to: Goals/Strategies on plan; Impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

1a. Treatment goal(s) addressed, if appropriate.

Client will have zero incidents of harm to self or suicide attempts. Client will create and follow his safety plan.

1b. Description of Current Situation/Reason for Contact:
(Status update, needs, clinical impressions) Current DSM Diagnosis 296.31

Client was admitted to hospital last week on a 5150. Working on discharge plan with psychiatrist focusing on appropriate placement and medication compliance. Client is a high risk for suicidality.
2. Focus of Activity:
(Intervention and Response to Intervention, what did you do? What is the consumer's response?)
Placed a phone call to Nierika House when Client is released from CCRMC 4C. Consulted with Nierika staff about securing a bed for possible release of client tomorrow. Discussed client's current functioning and high risk for suicide.

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.
Clinician will monitor placement at Nierika and will continue to collaborate with staff when client is discharged. Will also continue to closely monitor client's high risk behaviors and suicidality. Clinician will schedule weekly therapy sessions with client upon discharge.
Progress Note/Billing Form

Service Date: 11/12/13  
RU: 1212  
Staff #: 1111  
Hours* 2 Mins 20  
Co-Staff #:  
Hours* _____ Mins _____  
# In Group:  
Total Travel Time: Hours _____ Mins 40  
Service duration must include travel time, if applicable

Services: (Check one)
- 300 No Show
- 400 Client Cancel
- 700 Staff Cancel
- 371 Crisis Int.
- 311 Collateral
- 313 Evaluation
- 315 Plan Developmt
- 317 Rehab
- 331 Assessment
- 341 Indiv Therapy
- 351 Group Therapy
- 355 Group Rehab
- 357 Group Collateral
- 541 Case Mgmt - Placement
- 561 Case Mgmt - Linkage
- 571 Case Mgmt - Plan Developmt
- 540 Non-Billable Services
- 580 Non-Billable - Lock-outs

Location of Services: (Check one)
- 1 Office
- 2 Field
- 3 Phone
- 4 Home
- 5 School
- 8 Correctional Facility
- 9 Inpatient
- 10 Homeless/Shelter
- 11 Faith-based
- 12 Healthcare
- 13 Age-Specific Center
- 14 Client's Job-site
- 15 Licensed Care Fac. (Adult)
- 16 Mobile Service
- 17 Non-Traditional Location
- 18 Other
- 19 Residential Tx Center (Child)
- 20 Telehealth
- 21 Unknown

Service Strategies: (Check up to three, if applicable)
- 50 Peer/Family Services
- 51 Psycho-Education
- 52 Family Support
- 53 Supportive Education
- 54 With Law Enforcement
- 55 With Health Care
- 56 With Social Services
- 57 With Substance Abuse
- 58 With Aging Providers
- 59 With Developmt Disabled
- 60 Ethnic-specific Services
- 61 Age-specific Services
- 99 Unknown

Interpreter:  
Name of Interpreter:

Language service provided in other than English:  
- Spanish
- Other

Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

1a. Treatment goal(s) addressed, if appropriate.
Client will increase the use of relaxation techniques when feeling overwhelmed or anxious based on her progress in individual therapy.

1b. Description of Current Situation/Reason for Contact:  
(Status update, needs, clinical impressions)  
Current DSM Diagnosis 296.31

Met with client to assist in completing application for refurbished low cost apartment to open in 2 months. Client was unable to do this on her own due to depression, feeling anxious, and being overwhelmed.
2. Focus of Activity:
(Intervention and Response to Intervention, what did you do? What is the consumer's response?)
Accompanied client to apartment complex to fill out and submit application. During the application process client complained of dizziness and nausea. She took frequent breaks while filling out the paperwork. Encouraged client to finish the application so that she could secure housing. Reminded client that she may be evicted from her apartment and needed to secure permanent housing so that she would not be homeless. Client responded to encouragement and said that she would really like to obtain this apartment. Client stated that she felt overwhelmed with everything that was going on in her life. Discussed relaxation techniques and handling one stressful situation at a time to decrease her anxiety. Client was grateful that she had support and assistance while applying for the apartment.

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.
Caseworker will continue to assist client with securing housing and possibly refer her to Shelter Inc. Will follow up with client next week to assist her in calling the apartments to see if she qualified for housing. Continue to remind client of relaxation techniques to assist with decreasing her anxiety when she becomes overwhelmed.
**Progress Note/Billing Form**

**CONTRA COSTA HEALTH SERVICES**
Behavioral Health Division

**Service Date:** 10/7/13  
**RU:** 1234

** Staff #: 2222**  
**Co-Staff #:**

**Hours** ____ **Mins**  ____  # in Group: ______

**Total Travel Time:** Hours ____ **Mins** ______  
*Service duration must include travel time, if applicable*

**Services:** (Check one)

- [ ] 300 No Show
- [ ] 400 Client Cancel
- [ ] 700 Staff Cancel
- [ ] 371 Crisis Int.
- [ ] 311 Collateral
- [ ] 313 Evaluation
- [ ] 315 Plan Develpmnt
- [ ] 317 Rehab
- [ ] 331 Assessment
- [ ] 341 Indly Therapy
- [ ] 351 Group Therapy
- [ ] 355 Group Rehab
- [ ] 357 Group Collateral
- [ ] 341 Case Mgmt - Placement
- [ ] 541 Case Mgmt - Linkage
- [ ] 571 Case Mgmt - Plan Develpmnt
- [ ] 540 Non-Billable Services
- [ ] 580 Non-Billable - Lock-outs

**Location of Services:** (Check one)

- [ ] Office  
- [ ] Field  
- [ ] Phone  
- [ ] Home  
- [ ] School  
- [ ] Correctional Facility  
- [ ] Inpatient  
- [ ] Homeless/Shelter  
- [ ] Faith-based  
- [ ] Healthcare  
- [ ] Age-Specific Center  
- [ ] Client's Job-site  
- [ ] Licensed Care Fac. (Adult)  
- [ ] Mobile Service  
- [ ] Non-Traditional Location  
- [ ] Other  
- [ ] Residential Tx Center (Child)  
- [ ] Telehealth  
- [ ] Unknown

**Service Strategies:** (Check up to three, if applicable)

- [ ] 50 Peer/Family Services  
- [ ] 51 Psycho-Education  
- [ ] 52 Family Support  
- [ ] 53 Supportive Education  
- [ ] 54 With Law Enforcement  
- [ ] 55 With Health Care  
- [ ] 56 With Social Services  
- [ ] 57 With Substance Abuse  
- [ ] 58 With Aging Providers  
- [ ] 59 With Devolpmnt Disabled  
- [ ] 60 Ethnic-specific Services  
- [ ] 61 Age-specific Services  
- [ ] 99 Unknown

**Interpreter**

**Name of Interpreter:**

**Language service provided in other than English:** [ ] Spanish  [ ] Other

**Chart to:** Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

**1a. Treatment goal(s) addressed, if appropriate.**

Case Manager will work with client to identify triggers of anxiety which interferes with the client's ability to maintain stable housing.

**1b. Description of Current Situation/Reason for Contact:**

(Status update, needs, clinical impressions)

<table>
<thead>
<tr>
<th>Current DSM Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>296.89</td>
</tr>
</tbody>
</table>

Client's lease is ending this month and needs to apply for a new apartment.
2. Focus of Activity:
(Intervention and Response to Intervention, what did you do? What is the consumer’s response?)

Faxed application to new apartment complex for client.

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.

Continue to provide case management services and to assist client in finding and securing housing.

Signature/License/Job Title

Sample, MHRS

Printed Name

10/7/13

Date

Co-Signature/License (if applicable)

Date

Computer Entry Clerk Initials
**Progress Note/Billing Form**

**CONTRA COSTA HEALTH SERVICES**
Behavioral Health Division

**Service Date:** 10/7/13  
**RU:** 1234  
**Staff #:** 2222  
**Co-Staff #:**  
**Hours:** _____  **Mins:** 30  
**Hours:** _____  **Mins:**  
**Total Travel Time:** Hours ____ Mins ____

**Services:** (Check one)

- □ 300 No Show
- □ 400 Client Cancel
- □ 700 Staff Cancel
- □ 371 Crisis Int.
- □ 311 Collateral
- □ 313 Evaluation
- □ 315 Plan Devlpmt
- □ 317 Rehab
- □ 331 Assessment
- □ 341 Indiv Therapy
- □ 351 Group Therapy
- □ 355 Group Rehab
- □ 357 Group Collateral
- □ 541 Case Mgmt - Placement
- □ 561 Case Mgmt - Linkage
- □ 571 Case Mgmt - Plan Devlpmt
- □ 540 Non-Billable Services
- □ 580 Non-Billable - Lock-outs

**Location of Services:** (Check one)

- □ 1 Office
- □ 2 Field
- □ 3 Phone
- □ 4 Home
- □ 5 School
- □ 8 Correctional Facility
- □ 9 Inpatient
- □ 10 Homeless/Shelter
- □ 11 Faith-based
- □ 12 Healthcare
- □ 13 Age-Specific Center
- □ 14 Client’s Job-site
- □ 15 Licensed Care Fac. (Adult)
- □ 16 Mobile Service
- □ 17 Non-Traditional Location
- □ 18 Other
- □ 19 Residential Tx Center (Child)
- □ 20 Telehealth
- □ 21 Unknown

**Service Strategies:** (Check up to three, if applicable)

- □ 50 Peer/Family Services
- □ 51 Psycho-Education
- □ 52 Family Support
- □ 53 Supportive Education
- □ 54 With Law Enforcement
- □ 55 With Health Care
- □ 56 With Social Services
- □ 57 With Substance Abuse
- □ 58 With Aging Providers
- □ 59 With Devlpmt Disabled
- □ 60 Ethnic-specific Services
- □ 61 Age-specific Services
- □ 99 Unknown

**Interpreter**  
**Name of Interpreter:**

**Language service provided in other than English:** □ Spanish  □ Other

**Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.**

**1a. Treatment goal(s) addressed, if appropriate.**

Client would like to maintain emotional stability in order to find stable housing and not be rearrested.

**1b. Description of Current Situation/Reason for Contact:**

(Status update, needs, clinical impressions)  
**Current DSM Diagnosis** 296.89

Client was charged with armed robbery and has been referred for mental health services in order to assist in his transition back into the community.
2. Focus of Activity:
(Intervention and Response to Intervention, what did you do? What is the consumer's response?)
Clinician completed assessment and partnership plan with client over the phone. He will be released from the detention facility next week.

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.
Will continue to coordinate with client and assigned parole officer upon release from the detention facility. Will obtain client signature on Partnership Plan upon his release.

Signature/License/Job Title ____________________________ Sample ASW ____________________________ 10/7/13
Printed Name ____________________________ Date ____________________________
Co-Signature/License (if applicable) ____________________________ Date ____________________________

Computer Entry Clerk Initials ____________________________
Progress Note/ Billing Form

Disallow- non billable

123456
NAME / MRN

Service Date: 10/7/13  RU: 1212
Staff #: 1111
Co-Staff #: 
Hours* 3 Mins 30 # in Group: 
Hours* Mins Total Travel Time: Hours Mins

* Service duration must include travel time, if applicable

Services: (Check one)
☐ 300 No Show  ☐ 313 Evaluation  ☐ 351 Group Therapy  ☐ 571 Case Mgmt - Plan Develpmnt
☐ 400 Client Cancel  ☐ 315 Plan Develpmnt  ☐ 355 Group Rehab  ☐ 540 Non-Billable Services
☐ 700 Staff Cancel  ☐ 317 Rehab  ☐ 357 Group Collateral  ☐ 580 Non-Billable - Lock-outs
☐ 371 Crisis Int.  ☐ 331 Assessment  ☐ 541 Case Mgmt - Placement
☐ 311 Collateral  ☐ 341 Indiv Therapy  ☐ 561 Case Mgmt - Linkage

Location of Services: (Check one)
☐ 1 Office  ☐ 5 School  ☐ 11 Faith-based  ☐ 15 Licensed Care Fac. (Adult)  ☐ 19 Residential Tx Center (Child)
☐ 2 Field  ☐ 8 Correctional Facility  ☐ 12 Healthcare  ☐ 16 Mobile Service
☐ 3 Phone  ☐ 9 Inpatient  ☐ 13 Age-Specific Center  ☐ 17 Non-Traditional Location
☐ 4 Home  ☐ 10 Homeless/Shelter  ☐ 14 Client’s Job-site  ☐ 18 Other
☐ 21 Unknown

Service Strategies: (Check up to three, if applicable)
☐ 50 Peer/Family Services  ☐ 53 Supportive Education  ☐ 56 With Social Services  ☐ 59 With Develpmnt Disabled
☐ 51 Psycho-Education  ☐ 54 With Law Enforcement  ☐ 57 With Substance Abuse  ☐ 60 Ethnic-specific Services
☐ 52 Family Support  ☐ 55 With Health Care  ☐ 58 With Aging Providers  ☐ 61 Age-specific Services
☐ 99 Unknown

☐ Interpreter Name of Interpreter:

Language service provided in other than English: ☐ Spanish ☐ Other

Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

1a. Treatment goal(s) addressed, if appropriate.

Client will decrease anxiety symptoms which prevent her from obtaining needed medical care.

1b. Description of Current Situation/Reason for Contact: (Status update, needs, clinical impressions)

Current DSM Diagnosis 309.28

Client is nervous and anxious about her upcoming medical procedure.
2. Focus of Activity:
(Intervention and Response to Intervention, what did you do? What is the consumer’s response?)

Drove client to her doctor appointment in Antioch. Client normally has her son take her to her appointments, but her son was not answering his phone.

*****This note is solely transportation, it does not document how this intervention will assist the client in decreasing an impairment or prevent deterioration in an important area of life functioning. If this note was in a chart and was billed, it would be disallowed.

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.

Will continue to coordinate with client so that she attends all necessary medical appointments. Will meet with client next week to explore her anxiety over her upcoming surgical procedure.

Signature/License/Job Title

Sample, MHRS

Printed Name

10/7/13

Date

Co-Signature/License (if applicable)

Date

Computer Entry Clerk Initials

MHC017-9 (Rev 11-13) Progress Note/Billing Form Page 2 of 2
Progress Note/Billing Form

Sample Disallowed Note

123456

NAME / MRN

Service Date: 10/7/13
RU: 1234
Staff #: 2222
Co-Staff #: 
Hours* ____ Mins 10 # in Group: 
Hours* ____ Mins ____ Total Travel Time: Hours ____ Mins ____

* Service duration must include travel time, if applicable

Services: (Check one)

☐ 300 No Show
☐ 400 Client Cancel
☐ 700 Staff Cancel
☐ 371 Crisis Int.
☐ 311 Collateral
☐ 313 Evaluation
☐ 315 Plan Developmt.
☐ 317 Rehab
☐ 341 Indiv Therapy
☐ 351 Group Therapy
☐ 355 Group Rehab
☐ 347 Group Collateral
☐ 341 Indiv Therapy
☐ 541 Case Mgmt - Placement
☐ 561 Case Mgmt - Linkage
☐ 571 Case Mgmt - Plan Developmt.
☐ 540 Non-Billable Services
☐ 580 Non-Billable - Lock-outs

Location of Services: (Check one)

☐ 1 Office
☐ 2 Field
☐ 3 Phone
☐ 4 Home
☐ 5 School
☐ 8 Correctional Facility
☐ 9 Inpatient
☐ 10 Homeless/Shelter
☐ 11 Faith-based
☐ 12 Healthcare
☐ 13 Age-Specific Center
☐ 14 Client's Job-site
☐ 15 Licensed Care Fac. (Adult)
☐ 16 Mobile Service
☐ 17 Non-Traditional Location
☐ 18 Other
☐ 19 Residential Tx Center (Child)
☐ 20 Telehealth
☐ 21 Unknown

Service Strategies: (Check up to three, if applicable)

☐ 50 Peer/Family Services
☐ 51 Psycho-Education
☐ 52 Family Support
☐ 53 Supportive Education
☐ 54 With Law Enforcement
☐ 55 With Health Care
☐ 56 With Social Services
☐ 57 With Substance Abuse
☐ 58 With Aging Providers
☐ 59 With Developmt Disabled
☐ 60 Ethnic-specific Services
☐ 61 Age-specific Services
☐ 99 Unknown

☐ Interpreter
Name of Interpreter:

Language service provided in other than English: ☐ Spanish ☐ Other

Chart to: Goals/Strategies on plan; Impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

1a. Treatment goal(s) addressed, if appropriate.

Client will identify triggers of anxiety which interferes with the client's ability to maintain stable housing.

1b. Description of Current Situation/Reason for Contact:
(Status update, needs, clinical Impressions) Current DSM Diagnosis 298.89

Called client to remind her of therapy session this afternoon.
2. **Focus of Activity:**
(Intervention and Response to Intervention, what did you do? What is the consumer's response?)

Left message for client to remind her of her appointment later today.

**This note is solely clerical. It does not document how this intervention will assist the client in decreasing an impairment or prevent deterioration in an important area of life functioning. If this note was in a chart and was billed, it would be disallowed.**

3. **Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.**

Continue to meet client for weekly therapy sessions.

<table>
<thead>
<tr>
<th>Signature/License/Job Title</th>
<th>Sample, MFT</th>
<th>10/7/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-Signature/License (if applicable)</td>
<td>Printed Name</td>
<td>Date</td>
</tr>
</tbody>
</table>

Computer Entry Clerk Initials
Progress Note/Billing Form

Service Date: 10/7/13  RU: 1212
Staff #: 1111  Hours*  Mins  30  # in Group: 
Co-Staff #: 
Hours*  Mins  Total Travel Time: Hours  Mins
* Service duration must include travel time, if applicable

Services: (Check one)
☐ 300 No Show  ☐ 313 Evaluation  ☐ 351 Group Therapy  ☑ 571 Case Mgmt - Plan Developmt
☐ 400 Client Cancel  ☐ 315 Plan Developmt  ☐ 355 Group Rehab  ☐ 540 Non-Billable Services
☐ 700 Staff Cancel  ☐ 317 Rehab  ☐ 357 Group Collateral  ☐ 580 Non-Billable - Lock-outs
☐ 371 Crisis Int.  ☐ 331 Assessment  ☐ 541 Case Mgmt - Placement
☐ 311 Collateral  ☐ 341 Indiv Therapy  ☐ 561 Case Mgmt - Linkage

Location of Services: (Check one)
☐ 1 Office  ☐ 5 School  ☑ 11 Faith-based  ☐ 15 Licensed Care Fac. (Adult)
☐ 2 Field  ☐ 8 Correctional Facility  ☐ 12 Healthcare  ☐ 16 Mobile Service
☐ 3 Phone  ☐ 9 Inpatient  ☐ 13 Age-Specific Center  ☐ 17 Non-Traditional Location
☐ 4 Home  ☐ 10 Homeless/Shelter  ☐ 14 Client's Job-site  ☐ 18 Other
☐ 21 Unknown

Service Strategies: (Check up to three, if applicable)
☐ 50 Peer/Family Services  ☐ 53 Supportive Education  ☐ 56 With Social Services
☐ 51 Psycho-Education  ☐ 54 With Law Enforcement  ☐ 57 With Substance Abuse
☐ 52 Family Support  ☐ 55 With Health Care  ☐ 58 With Aging Providers
☐ 99 Unknown

Interpreter  Name of Interpreter:

Language service provided in other than English: ☐ Spanish  ☐ Other

Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

1a. Treatment goal(s) addressed, if appropriate.
To be determined, partnership plan has not been developed yet.

1b. Description of Current Situation/Reason for Contact: (Status update, needs, clinical impressions)
Current DSM Diagnosis 314.9

Client is a 5 year old boy who has been referred for services due to his acting out at home and poor school attendance. Client has been yelling, screaming, and throwing items in class when he is asked to do something that he does not want to do. Teacher reports that client does not respond to redirection and is very defiant to adults.
2. Focus of Activity:
(Intervention and Response to Intervention, what did you do? What is the consumer's response?)

Clinician collaborated with supervisor to discuss what goals would be appropriate for the partnership plan. Supervisor suggested behavioral interventions and also possible parenting classes for the parents. Supervisor also advised clinician to collaborate with the teacher to discuss interventions that she has tried.

**********This note is for supervision and is not an allowable service, however, consultations between other colleagues (intra agency or interagency) to discuss service delivery and access to services or monitoring the client’s progress amongst the service delivery system would be linkage (561). If this note was in a chart and was billed, it would be disallowed.

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.

Clinician will observe child in the classroom tomorrow to obtain information to complete the partnership plan. Clinician will also call mom to schedule time to go over completed partnership plan.

Signature/License/Job Title  Sample, LCSW  10/7/13
Printed Name
Date

Co-Signature/License (if applicable)  Date

Computer Entry Clerk Initials
Progress Note/ Billing Form

Disallow- non billable

123456
NAME / MRN

Service Date: 10/7/13  RU: 1212

Staff #: 1111  Hours*  Mins  30  # In Group:

Co-Staff #:  Hours*  Mins  Total Travel Time: Hours  Mins

* Service duration must include travel time, if applicable

Services: (Check one)

☐ 300 No Show  ☐ 313 Evaluation  ☐ 351 Group Therapy  ☐ 571 Case Mgmt - Plan Developmt

☐ 400 Client Cancel  ☐ 315 Plan Developmt  ☐ 355 Group Rehab  ☐ 540 Non-Billable Services

☐ 700 Staff Cancel  ☐ 317 Rehab  ☐ 357 Group Collateral  ☐ 580 Non-Billable - Lock-outs

☐ 371 Crisis Int.  ☐ 331 Assessment  ☐ 541 Case Mgmt - Placement

☐ 311 Collateral  ☐ 341 Indiv Therapy  ☐ 561 Case Mgmt - Linkage

Location of Services: (Check one)

☐ 1 Office  ☐ 11 Faith-based  ☐ 15 Licensed Care Fac. (Adult)  ☐ 19 Residential Tx Center (Child)

☐ 2 Field  ☐ 12 Healthcare  ☐ 16 Mobile Service  ☐ 20 Telehealth

☑ 3 Phone  ☐ 9 Inpatient  ☐ 13 Age-Specific Center  ☐ 17 Non-Traditional Location

☐ 4 Home  ☐ 10 Homeless/Shelter  ☐ 14 Client's Job-site  ☐ 18 Other  ☐ 21 Unknown

Service Strategies: (Check up to three, if applicable)

☐ 50 Peer/Family Services  ☐ 53 Supportive Education  ☐ 56 With Social Services  ☐ 59 With Developmt Disabled

☐ 51 Psycho-Education  ☐ 54 With Law Enforcement  ☐ 57 With Substance Abuse  ☐ 60 Ethnic-specific Services

☐ 52 Family Support  ☐ 55 With Health Care  ☐ 58 With Aging Providers  ☐ 61 Age-specific Services

☐ 59 Unknown

☐ Interpreter  Name of Interpreter:

Language service provided in other than English: ☐ Spanish  ☐ Other

Chart to: Goals/Strategies on plan; Impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

1a. Treatment goal(s) addressed, if appropriate.

Client will decrease depressive symptoms which prevent her from managing her budget and maintaining stable housing.

1b. Description of Current Situation/Reason for Contact:
(Status update, needs, clinical impressions)  Current DSM Diagnosis 296.31

Call from client because she has been very upset that her SSI check has not arrived yet. Client is requesting a check for $50 for personal needs.
2. Focus of Activity:
(Intervention and Response to Intervention, what did you do? What is the consumer’s response?)

Case manager informed client that a request would be made and the check would be delivered when it was available.

*******This note is solely money management, it does not document how this intervention will assist the client in decreasing an impairment or prevent deterioration in an important area of life functioning. If this note was in a chart and was billed, it would be disallowed.

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.

Will continue to coordinate money management and budgeting with client.

Signature/License/Job Title

Sample, MHRSC
Printed Name

10/7/13
Date

Co-Signature/License (if applicable)

Date

Computer Entry Clerk Initials
Katie A  
**Progress Note/Billing Form**  
Sample ICC  
MRN: 1234567  
NAME / MRN

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**Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.**

**1a. Treatment goal(s) addressed, if appropriate.**

Case manager will assist client in decreasing emotional outbursts which consist of yelling, hitting, or threatening to harm others as evidenced by mother and Therapeutic Behavioral Services (TBS) worker.

**1b. Reason for contact**

Update on progress with family regarding services received through TBS and school based therapy for client.

**1c. Clinical Impression**

Mom reports that client has been attending school every day and has had an increase in incidents of aggression this past week.
2. **Intervention and Response to Intervention** *(What did you do? e.g., What is the consumer's response?)*

Met with client, client's mother, and parent partner. Parent partner informed this writer that the client has had an increase in his behaviors of hitting, kicking, throwing items, and/or threatening to harm peers. At this time school counselor has contacted parent to inform her of the 5 incidenis per day this past week. ICC coordinator will inform IHBS worker of this increase in behaviors and will suggest that the IHBS worker increase contact with family from 1 time per week to 2 times per week in order to address the increase in maladaptive behaviors. Mom and client were receptive to the increase in support. Mom would also like ICC coordinator to contact the school in order to facilitate a meeting with the school counselor and IHBS worker.

3. **Plan** *(e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.*

ICC coordinator will contact school counselor to facilitate a team meeting. Will also coordinate with IHBS worker to discuss an increase in contact and continue to work with client on anger management, replacement behaviors, and self regulation skills. ICC will check back in with family and providers in 2 weeks.

---

**Signature/License/Job Title**

**Sample, MFTI**

**Printed Name**

**11/14/13**

**Date**

**Co-Signature/License (If applicable)**

**Date**

Computer Entry Clerk Initials

MHC112 (09/13)

Page 2 of 2

Katie A Progress Note/Billing Form
**Katie A**

**Progress Note/Billing Form**

**CONTRA COSTA HEALTH SERVICES**

Behavioral Health Division

**Service Date:** 11/14/13  **RU:** 1234

**Staff #:** 5555  **Co-Staff #:**

**Hours:** ___  **Mins:** 30  **Total Travel Time:** Hours ___  **Mins**

**Services:** (Check one)

- [ ] 300 No Show
- [ ] 400 Client Cancel
- [ ] 700 Staff Cancel
- [ ] 371 Crisis Int.
- [ ] 311 Collaboral

- [ ] 313 Evaluation
- [ ] 315 Plan Developm
- [ ] 317 Rehab
- [ ] 331 Assessment
- [ ] 341 Indiv Therapy

- [ ] 351 Group Therapy
- [ ] 355 Group Rehab
- [ ] 357 Group Collateral
- [ ] 541 Case Mgmt - Placement
- [ ] 561 Case Mgmt - Linkage

- [ ] 571 Case Mgmt - Plan Developm
- [ ] 540 Non-Billable Services
- [ ] 580 Non-Billable - Lock-outs

**Katie A Sub-Class**

- [ ] 358 IHBS
- [ ] 564 ICC

**Location of Services:** (Check one)

- [ ] 1 Office
- [ ] 2 Field
- [ ] 3 Phone
- [ ] 4 Home

- [ ] 5 School
- [ ] 8 Correctional Facility
- [ ] 9 Inpatient
- [ ] 10 Homeless/Shelter

- [ ] 11 Faith-based
- [ ] 12 Healthcare
- [ ] 13 Age-Specific Center
- [ ] 14 Client's Job-site

- [ ] 15 Licensed Care Fac. (Adult)
- [ ] 16 Mobile Service
- [ ] 17 Non-Traditional Location
- [ ] 18 Other

- [ ] 19 Residential Tx Center (Child)
- [ ] 20 Telehealth
- [ ] 21 Unknown

**Service Strategies:** (Check up to three, if applicable)

- [ ] 50 Peer/Family Services
- [ ] 51 Psycho-Education
- [ ] 52 Family Support

- [ ] 53 Supportive Education
- [ ] 54 With Law Enforcement
- [ ] 55 With Health Care

- [ ] 56 With Social Services
- [ ] 57 With Substance Abuse
- [ ] 58 With Aging Providers

- [ ] 59 With Developm Disabled
- [ ] 60 Ethnic-specific Services
- [ ] 61 Age-specific Services
- [ ] 99 Unknown

**Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.**

**1a. Treatment goal(s) addressed, if appropriate.**

Client will decrease emotional outbursts which consist of yelling, tantrumming, and hitting peers as evidenced by foster mother's report.

**1b. Reason for contact**

Received a phone call from the client's school counselor due to serious concerns regarding increase in the client's acting out behaviors consisting of yelling, tantrumming, and hitting other students.

**1c. Clinical Impression**

N/A
2. Intervention and Response to Intervention (What did you do? e.g., What is the consumer’s response?)

Discussed with school counselor (SC) concerns for client's increase of acting out at school. ICC coordinator informed SC that IHBS worker has increased support at home to 3 times per week in order to assist client in self regulation skills, anger management, and replacement behaviors. ICC coordinator suggested a team meeting with client, mom, and parent partner to discuss the increase of aggression at school and upcoming IEP meeting.

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.

IHBS worker will continue to meet 3 times a week with client to continue to work on anger management, replacement behaviors, and self regulation skills. ICC will check in with family and discuss a meeting this week with parent partner and client regarding current progress towards treatment goals, upcoming IEP, and SC concerns regarding increase in behaviors at school.

Signature/License/Job Title

Sample, MFTI

Printed Name

11/14/13

Date

Co-Signature/License (If applicable)

Date

Computer Entry Clerk Initials
Katie A
Progress Note/Billing Form

Service Date: 11/14/13
RU: 1234
Staff #: 5555
Co-Staff #: 
Hours*: 1 Mins 30
Hours*: Mins
Total Travel Time: Hours Mins 30
# in Group: 

Services: (Check one)

☐ 300 No Show ☐ 313 Evaluation ☐ 351 Group Therapy
☐ 400 Client Cancel ☐ 315 Plan Develpmt ☐ 355 Group Rehab
☐ 700 Staff Cancel ☐ 317 Rehab ☐ 357 Group Collateral
☐ 371 Crisis Int. ☐ 331 Assessment ☐ 541 Case Mgmt - Placement
☐ 311 Collateral ☐ 341 Indiv Therapy ☐ 561 Case Mgmt - Linkage

Location of Services: (Check one)

☐ 1 Office ☐ 5 School ☐ 11 Faith-based ☐ 15 Licensed Care Fac. (Adult)
☐ 2 Field ☐ 8 Correctional Facility ☐ 12 Healthcare ☐ 16 Mobile Service
☐ 3 Phone ☐ 9 Inpatient ☐ 13 Age-Specific Center ☐ 17 Non-Traditional Location
☒ 4 Home ☐ 10 Homeless/Shelter ☐ 14 Client’s Job-site ☐ 18 Other
☐ 21 Unknown

Service Strategies: (Check up to three, if applicable)

☐ 50 Peer/Family Services ☐ 53 Supportive Education ☐ 56 With Social Services
☐ 51 Psycho-Education ☐ 54 With Law Enforcement ☐ 57 With Substance Abuse
☒ 52 Family Support ☐ 55 With Health Care ☐ 58 With Aging Providers
☐ 59 With Develpmt Disabled ☐ 60 Ethnic-specific Services
☐ 99 Unknown

☐ Interpreter Name of Interpreter: 

Language service provided in other than English: ☐ Spanish ☐ Other

Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

1a. Treatment goal(s) addressed, if appropriate.

Client and family will continue to receive mental health services in order to strengthen the parent/child relationship and decrease the client's hitting, biting, or kicking directed towards parents from 5 times per week to 1 time per week.

1b. Reason for contact

IHBS worker continues to meet with family 2 times per week in order to assist in modeling positive parent/child interactions and to assist the parents in positive reinforcement.

1c. Clinical Impression

Mom and dad report that client continues to get angry quickly and will attempt to hit or kick them. This typically occurs when the client is being disciplined or told "no".
2. Intervention and Response to Intervention (What did you do? e.g., What is the consumer’s response?)

IHBS worker discussed the triggers to client's emotional reactions (aggression or frustration). Parents disclosed that they are still learning how to be consistent with client and typically want to give into to her when she gets angry. Worker discussed alternative ways to intervene when they are trying to discipline her such as responding calmly, allowing her space to take a "time out" and being firm/consistent. Parents agreed to try these interventions. Worker also spoke with client and she agreed that when she gets angry she would like to take a 5 minute space in her room away from her parents. Client and parents would like to have worker continue to meet 2 times a week as treatment goals have not yet been met.

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.

IHBS worker will continue to meet with family 2 times a week. Worker will continue to assist client in decreasing incidents of aggression and also increasing parents ability to positively interact with client.
Katie A
Progress Note/Billing Form

Sample iHBS
MRN: 1234567

NAME / MRN

Service Date: 11/14/13  RU: 1234
Hours* 1  Mins 30  # in Group: _______

Staff #: 5555  Co-Staff: _______
Hours*  ______ Mins  ______ Total Travel Time: Hours 30 Mins 30

Services: (Check one)
☐ 300 No Show  ☐ 313 Evaluation  ☐ 351 Group Therapy
☐ 400 Client Cancel  ☐ 315 Plan Develpmt  ☐ 355 Group Rehab
☐ 700 Staff Cancel  ☐ 317 Rehab  ☐ 357 Group Collateral
☐ 371 Crisis Int.  ☐ 331 Assessment  ☐ 541 Case Mgmt - Placement
☐ 311 Collateral  ☐ 341 Indiv Therapy  ☐ 561 Case Mgmt - Linkage
☐ 571 Case Mgmt - Plan Develpmt
☐ 540 Non-Billable Services  ☐ 580 Non-Billable - Lock-outs

Katie A Sub-Class
☐ 358 IHSB  ☐ 564 ICC

Location of Services: (Check one)
☐ 1 Office  ☐ 5 School  ☐ 11 Faith-based  ☐ 15 Licensed Care Fac. (Adult)
☐ 2 Field  ☐ 8 Correctional Facility  ☐ 12 Healthcare  ☐ 16 Mobile Service
☐ 3 Phone  ☐ 9 Inpatient  ☐ 13 Age-Specific Center  ☐ 17 Non-Traditional Location
☐ 4 Home  ☐ 10 Homeless/Shelter  ☐ 14 Client's Job-site  ☐ 18 Other
☐ 20 Telehealth  ☐ 21 Unknown

Service Strategies: (Check up to three, if applicable)
☐ 50 Peer/Family Services  ☐ 53 Supportive Education  ☐ 56 With Social Services
☐ 51 Psycho-Education  ☐ 54 With Law Enforcement  ☐ 57 With Substance Abuse
☐ 52 Family Support  ☐ 55 With Health Care  ☐ 58 With Aging Providers
☐ 59 With Develpmt Disabled  ☐ 60 Ethnic-specific Services
☐ 61 Age-specific Services  ☐ 99 Unknown

Interpreter Name of Interpreter: ____________________________
Language service provided in other than English: ☐ Spanish  ☐ Other

Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

1a. Treatment goal(s) addressed, if appropriate.
Client will reduce aggressive behaviors related to her diagnosis such as hitting, kicking, and yelling at family members and peers and will increase pro-social replacement behaviors as evidenced by mother and grandfather.

1b. Reason for contact
Current DSM Diagnosis 3 1 4 0 1
IHBS worker met with mother and grandfather to identify situations and triggers at home that contribute to client's angry outbursts and inappropriate responses.

1c. Clinical Impression
IHBS worker assessed home situation and identified a couple areas to focus on.
2. Intervention and Response to Intervention (What did you do? e.g., What is the consumer's response?)

Worker and family discussed alternative ways to deal with client's anger and frustration such as talking with him firmly, but calmly. Role played how to carry this intervention out with client. Worker also assisted mother in gaining a better understanding of client's behavior. Encouraged the use of positive reinforcement and building on client's strengths. Client and worker talked and he agreed that he will go in the garage and practice deep breathing when he is feeling very upset and struggling to control emotions/actions. Client agrees to wait 10 minutes to cool down.

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) Specify what the consumer/family/providers are to do.

IHBS worker will continue to meet with family one time a week. Continue to work with mother to reinforce interventions at home to assist in decreasing client's emotional reactivity.
NAME: Wrap Sample  
MRN: 123456  

Service Date: 2/24/2014  
RU: 1234  
Hours: 2 Mins  
Co-Staff #:  

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Location of Services: (Check One)  

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Service Strategies: (Check up to Three, if applicable)  

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Interpreter: Name of Interpreter:  

Language service provided in other than English: ☐ Spanish ☐ Other  

Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery, or unplanned events.  

1. Description of Current Situation: (e.g. Reason for Contact; Consumer's Concern(s); Status Update Since Last Contact; Clinical/Behavioral Acuity; Current Stressors; Needs)  

Mother reports that the client has recently become more difficult to redirect when she is acting out. Mom tends to focus on the client's negative behaviors and has a hard time discussing the goals that the client has reached or any positive progress that has been made since the last meeting.
2. Focus of Activity: Intervention (What did you do?), Response to Intervention.

Facilitator conducted a field contact with the client's mother to check in with mom regarding the client's behavioral progress and implementation of strategies to help client achieve Partnership Plan goals as it relates to decreasing symptoms of Depressive Disorder which consist of lying and defiance directed at her parents.

Mom communicated concerns about the client's targeted behaviors. Mom stated that client has increased defiance and deceptive behaviors towards her and is very aggressive (hitting, pushing, or verbally abuse) towards her younger brother. Mom communicated that the client has been refusing to follow basic instructions. For example the mom instructed the client to wait to be picked up by her after school for safety reasons, and the client disobeyed her mom by leaving the school campus multiple times during the past two weeks. Mom stated that the neighborhood is very dangerous and fears for her daughter's safety when she walks home from school alone.

Facilitator inquired about the mom's implementation of previously suggested strategies such as lack of privileges, and communicating behaviors to the client's Therapeutic Behavioral Services (TBS) worker. Facilitator reminded Mom that the TBS worker is working in collaboration with staff at school to help the client decrease deceptive behaviors, increase honesty, and increase her communication of feelings. Mom presented in a negative depressive affect and was focused on the client's negative behaviors. Staff coordinated a meeting to assist Mom to communicate her feelings and concerns to the client. Staff also offered to accompany Mom to Familias Unidas in order to access individual and group therapy for the client.

Facilitator assisted Mom to identify positive ways to communicate her concerns to the client. This worker also helped Mom to learn the use of "I" messages through role play and instruction. Mom agreed to implement all suggested strategies to help client achieve her goals of decreasing her lying and defiance towards her mom, which will lead to a healthier Mother-Daughter relationship. Mom still continues to struggle with acknowledging the client's positive progress and tends to focus more on the negative behaviors.

3. Plan: (e.g. Coordination of Care, Referrals, Follow-up) Include Person's Planned Action and Staff's Planned Action, as appropriate.

- The team plans to continue working with client to help her reach her goals associated with symptom reduction
- Facilitator will work with the client and her family members by creating an appropriate Wraparound team to address their needs and future hopes.
- Facilitator plans to meet with the client and her mom next week.
- Facilitator will work on referral process to Familias Unidas.
WRAP Progress Note/
Billing Form

NAME: Wrap Sample
MRN: 123456

Service Date: 2/24/2014
RU: 1234

Staff #: 2222
Hours: 3 Mins

Co-Staff #:
Hours: Mins

# In Group:
Total Travel Time: Hours Mins 30

* Service duration must include travel time, if applicable

Services: (CHECK ONE)

☐ 300 No Show ☐ 311 Collateral ☐ 341 Indiv Therapy ☐ 561 Case Mgmt - Linkage
☐ 400 Client Cancel ☐ 313 Evaluation ☐ 351 Group Therapy ☐ 571 Case Mgmt - Plan Develpmnt
☐ 700 Staff Cancel ☐ 315 Plan Develpmnt ☐ 355 Group Rehab ☐ 540 Non-Billable -MH Services
☐ 371 Crisis Intervention ☐ 317 Rehab ☐ 357 Group Collateral ☐ 560 Non-Billable - CM Services
☐ 331 Assessment ☐ 541 Case Mgmt - Placement ☐ 580 Non-Billable - Lock-outs

Location of Services: (CHECK ONE)

☐ 1 Office ☐ 5 School ☐ 11 Faith-based ☐ 15 Licensed Care Fac. (Adult)
☐ 2 Field ☐ 8 Correctional Facility ☐ 12 Healthcare ☐ 16 Mobile Service
☐ 3 Phone ☐ 9 Inpatient ☐ 13 Age-Specific Center ☐ 17 Non-Traditional Location
☒ 4 Home ☐ 10 Homeless/Shelter ☐ 14 Client’s Job-site ☐ 18 Other
☐ 19 Residential Tx Center (Child)
☐ 20 Telehealth ☐ 21 Unknown

Service Strategies: (CHECK UP TO THREE, IF APPLICABLE)

☒ 50 Peer/Family Services ☐ 53 Supportive Education ☐ 56 With Social Services ☐ 59 With Develpmnt Disabled
☐ 51 Psycho-Education ☐ 54 With Law Enforcement ☐ 57 With Substance Abuse ☐ 60 Ethnic-specific Services
☒ 52 Family Support ☐ 55 With Health Care ☐ 58 With Aging Providers ☒ 61 Age-specific Services
☐ 99 Unknown

☑ Interpreter

Name of Interpreter:

Language service provided in other than English: ☐ Spanish ☐ Other

Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery, or unplanned events.

1. Description of Current Situation: (E.G. REASON FOR CONTACT; CONSUMER’S CONCERN(S); STATUS UPDATE SINCE LAST CONTACT; CLINICAL/BEHAVIORAL ACUITY; CURRENT STRESSORS; NEEDS)

Mother reports that her relationship with her daughter has recently been more hostile. The client continues to disobey her Mom’s requests and is verbally abusive to her younger brother. The Mom does have a tendency to focus on the negative and has a hard time observing and reporting the client’s positive progress.
Name Sample

MRN 123456

2. Focus of Activity: Intervention (What did you do?), Response to Intervention.

The facilitator conducted a home visit with the purpose of meeting with the client and her Mom for a family meeting. The goal of the meeting is to help the Mom establish herself as the authoritative figure in the family system and to help foster effective communication between Mom and the client.

The client's symptoms of being defiant towards authority figures, especially her Mom and teachers as well as aggressive towards her younger brother has a negative impact on the client's academic performance and social functioning. The client continues to work on increasing self confidence and self esteem as evidenced by engaging in supportive and creative activities to increase her socialization skills level, and the client will improve her relationship with teachers and peers at school and with family members at home as evidenced by reducing angry outbursts, impulsiveness, defiance, deceptive, and negative attention seeking behaviors.

During the home visit, the Facilitator warmly greeted the client and the client's Mom. The client presented with a happy mood and affect. The client welcomed Facilitator with a hug and a smile. The facilitator engaged the client and her Mom in a conversation related to the Parent-Child relationship and client's behavioral progress. While getting ready for the meeting, the Facilitator observed a pleasant conversation between the client and her Mom. However, as the session began, Mom's affect shifted as she began to describe a number of behaviors presented by the client over the past 2 weeks. Mom became loud and angry. Which then affected the client who began to become angry and defensive in response to Mom becoming angry and loud. Client seemed to struggle while attempting to explain her Mom's shift in the conversation.

Facilitator guided the meeting by helping cue Mom when listening to the client without interrupting. Facilitator interacted with Mom in a soft calm manner in order to move her into a more calm state. Facilitator also helped the client move from a defensive and angry position to a more calm state. Facilitator encouraged Mom and client to talk about when and how they enjoy time together. The client was able to acknowledge that her Mom can be caring and loving at time.

As Mom began to develop a more calm demeanor she was able to be more clear about her concerns. Mom was able to focus on one issue of importance. This issue involves the client leaving the school to go home instead of waiting for her Mom to pick her up as she was instructed to. Mom was able to talk to the client about this issue and how she is afraid of something tragic happening to the client. Facilitator was able to assist Mom to communicate her concerns in a calm manner, without verbally attacking the client. Facilitator was also able to assist Mom in setting clear limits and boundaries around client leaving the school campus after school.

3. Plan: (E.g. Coordination of Care, Referrals, Follow-up) Include Person's Planned Action and Staff's Planned Action, as appropriate.

- The team plans to continue working with client to help her reach her goals associated with symptom reduction
- Facilitator will work with the client and her family members by creating an appropriate Wraparound team to address their needs and future hopes.
- Facilitator will collaborate with school therapist and Therapeutic Behavioral Services (TBS) worker on an update on client's progress towards her behavioral goals.

Signature/License/Job Title

2/24/2014

Documentation Date

Co-Signature/License (if applicable)

Date

Computer Entry Clerk Initials

MHC062-4 (Revised 9/08)  Page 2 of 2

Progress Note/Billing Form
Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery, or unplanned events.

1. Description of Current Situation: (E.g. Reason for Contact; Consumer’s Concern(s); Status Update Since Last Contact; Clinical/Behavioral Acuity; Current Stressors; Needs)

The client's parents have reached out to family partner in order to assist in advocating for their son during the Individualized Education Plan (IEP) at the school. The parents would like more services, but feel that they have not been heard at the previous IEP meetings. The client is a 6 year old boy with a diagnosis of Attention Deficit Hyper Activity Disorder (ADHD) who is struggling in school because he is unable to sit for long periods, has a hard time focusing, as he is quick to anger and will lash out at teachers or other peers when he becomes upset.
2. Focus of Activity: Intervention (What did you do?), Response to Intervention.

This worker encouraged the parents to read the list of items that they would like to see provided to their son. The parents stated that they would like to have additional support at school so that their son is able to better manage his behaviors of hurting others or threatening to hurt others. They would also like to see that their son receive academic support, since his grades have suffered this school year. This worker supported the parents by paraphrasing the requests to the team and posing questions to see if there were other services that could be provided for the client. This worker updated the team that the client is doing well in individual play therapy with county mental health and seems to have decreased his defiant behaviors (hitting, pushing, or kicking others) at home, to only 4 times per week. He is now able to comply with the parent’s requests and rules at home more frequently. The parents have made adjustments to their reward system and have learned that their son responds more favorably to positive reinforcement (adding time outs) rather than negative reinforcements (taking away TV time or video games). The IEP team will look into additional supports for the client while at school in order to assist in decreasing his emotional outbursts at school, as it seems the WRAP meetings have helped decrease the emotional outbursts at home. Having the additional supports will help the client cope with his anger and learn new mechanisms in which to display his frustrations, which will hopefully help create a more constructive learning environment for him to focus on his academic assignments.

3. Plan: (E.g. Coordination of Care, Referrals, Follow-up) Include Person’s Planned Action and Staff's Planned Action, as appropriate.

WRAP meeting is scheduled for tomorrow. Family Partner will follow up the IEP meeting with a collateral contact with the parents on the phone to check in and see their perception of the IEP and possibly create a list of any issues that were not discussed or any areas that need further discussion. Family partner will coordinate with the individual therapist to update her on the supports that the school district will provide so that she is aware of the changes at school.

Signature/License/Job Title 2/24/2014

Co-Signature/License (if applicable) Documentation Date

Computer Entry Clerk Initials

MHC062-4 (Revised 9/08) Page 2 of 2 Progress Note/Billing Form
## WRAP Progress Note/Billing Form

**Name:** Wrap Sample  
**MRN:** 123456

### Service Information
- **Service Date:** 2/24/2014  
- **RU:** 1234  
- **Hours* 2 Mins**  
- **Co-Staff #:**  
- **Hours* Mins**  
- **# In Group:**  
- **Total Travel Time:** Hours  Mins 30

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<td>700 Staff Cancel</td>
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<td>School</td>
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<td>2 Field</td>
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<td>Correctional Facility</td>
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<td>3 Phone</td>
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<td>Inpatient</td>
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<td>4 Home</td>
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<tr>
<td></td>
<td>11</td>
<td>Faith-based</td>
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<td>14</td>
<td>Client’s Job-site</td>
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### Service Strategies: (Check Up to Three, If Applicable)

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### Interpreter
- Name of Interpreter:
- Language service provided in other than English:  
  - Spanish  
  - Other

---

**Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery, or unplanned events.**

1. **Description of Current Situation:** (E.g., Reason for Contact; Consumer’s Concern(s); Status Update Since Last Contact; Clinical/Behavioral Acuity; Current Stressors; Needs)

Wraparound meeting with client’s mother, peer mentor, and facilitator to talk about challenges and family needs. Client did not attend meeting, he refused to go to school, and stayed in his room. Mother stated client is refusing to go to school once and awhile. She stated the doctor changed his medication to a lower dosage. Mother feels client is trying to adjust to the medications.
2. **Focus of Activity**: Intervention (What did you do?), Response to Intervention.

Actively listened to each team member and encouraged them to remain positive throughout the meeting. Worked closely with team to obtain outcomes and reviewed needs.

Discussed the following:
- Client is meeting all his goals
- Client’s weekly progress/how to decrease his mood swings and stabilize mood
- Address problematic behaviors/arguing/family conflicts
- Setting limits and consequences for misbehavior
- Dealing with emotional behavior
- Never confront when you are angry, remain calm
- Active supervision and structure
- Parenting classes to learn new tools
- Improving school performance
- Family has agreed to transition from the wraparound process

Brainstormed ideas and heard from every team member talk about family strengths and how well client and family are doing. Discussed how well family is doing in the wraparound process and how great it feels to have accomplished all their goals.

Reviewed how important it is for client to attend therapy once a week. Reviewed client’s symptoms and addressed appropriate ways to handle his misbehaviors i.e. not wanting to get up in the morning and refusing to go to school.

Helped brainstorm consequences for client getting up late to go to school i.e. take away something for a short period of time such as spending time with friends. Family has met all wraparound goals.

---

3. **Plan**: (e.g. Coordination of Care, Referrals, Follow-up) Include Person’s Planned Action and Staff’s Planned Action, as appropriate.

- The team plans to begin transitioning family from the wraparound program.

---

**Signature/License/Job Title**  
2/24/2014  
**Documentation Date**

**Co-Signature/License (if applicable)**  
**Date**

**Computer Entry Clerk Initials**

---

MHC062-4 (Revised 9/08)  
Page 2 of 2  
Progress Note/Billing Form
**WRAP Progress Note/Billing Form**

**NAME:** Wrap Sample  
**MRN:** 123456

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<tr>
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<td>Hours* Mins 45</td>
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<tr>
<td>Co-Staff #:</td>
<td>Hours* Mins</td>
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<table>
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<tr>
<th># in Group:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Travel Time: Hours Mins</td>
</tr>
</tbody>
</table>

*Service duration must include travel time, if applicable*

**Services:** (Check One)

| 300 | No Show |
| 400 | Client Cancel |
| 700 | Staff Cancel |
| 371 | Crisis Intervention |

- **311** Collateral  
- **313** Evaluation  
- **315** Plan Develpmnt  
- **317** Rehab  
- **331** Assessment  
- **341** Indiv Therapy  
- **351** Group Therapy  
- **355** Group Rehab  
- **357** Group Collateral  
- **541** Case Mgmt - Placement  
- **561** Case Mgmt - Linkage  
- **571** Case Mgmt - Plan Develpmnt  
- **540** Non-Billable -MH Services  
- **560** Non-Billable - CM Services  
- **580** Non-Billable - Lock-outs

**Location of Services:** (Check One)

- **1** Office  
- **2** Field  
- **3** Phone  
- **4** Home  
- **5** School  
- **8** Correctional Facility  
- **9** Inpatient  
- **10** Homeless/Shelter  
- **11** Faith-based  
- **12** Healthcare  
- **13** Age-Specific Center  
- **14** Client's Job-site  
- **15** Licensed Care Fac. (Adult)  
- **16** Mobile Service  
- **17** Non-Traditional Location  
- **18** Other  
- **19** Residential Tx Center (Child)  
- **20** Telehealth  
- **21** Unknown

**Service Strategies:** (Check Up to Three, If Applicable)

- **50** Peer/Family Services  
- **51** Psycho-Education  
- **52** Family Support  
- **53** Supportive Education  
- **54** With Law Enforcement  
- **55** With Health Care  
- **56** With Social Services  
- **57** With Substance Abuse  
- **58** With Aging Providers  
- **59** With Develpmt Disabled  
- **60** Ethnic-specific Services  
- **61** Age-specific Services  
- **99** Unknown

**Interpreter**

Name of Interpreter:

Language service provided in other than English:  
- [ ] Spanish  
- [ ] Other

**Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery, or unplanned events.**

1. **Description of Current Situation:** (E.g. Reason for Contact; Consumer's Concern(s); Status Update Since Last Contact; Clinical/Behavioral Acuity; Current Stressors; Needs)

Received a call from client's mother. Mother stated client's aggressive behavior is increasing. She stated she called the police because client grabbed scissors and tried to cut her car tires. The police talked with client and he has been calm since the incident.
2. **Focus of Activity:** Intervention (What did you do?), Response to Intervention.

Listened to mother talk about concerns and challenges. We discussed the client's weekly behavior of being defiant and fighting with younger sibling. Mom stated that client's father is still unable to participate in our wraparound meetings because he is working. Discussed with mom coping skills and triggers. Also, discussed the family changing insurance to Blue Cross and finding a new psychiatrist that will listen to family's needs. Reviewed client's defiant behaviors which consist of defiant behavior, disrespectful language and screaming. Helped Mom identify client's triggers to his explosive outbursts. Explored activities for the client and younger sibling that can help build positive communication. Brainstormed ideas on how client's mom can assist the client when she returns from school such as assuring client completes her homework and follow up with the school staff on client's progress.

3. **Plan:** (e.g. coordination of care, referrals, follow-up) Include Person's Planned Action and Staff's Planned Action, as appropriate.

Plan is to check with family about needs and challenges. The next visit is scheduled for next week at the client's home. Parent Partner will call mom once a week to continue to check in. Will also follow up with Wraparound facilitator about mom's concerns about the client's escalating behaviors.
Partnership Plan for Wellness

Sample Client
Consumer’s Name
X 123456
MRN
Sample Case Manager
El Portal RU 07051
Program

Strengths:

Creative
Wants to get better

List other services/agencies involved:

Shelter, Inc.

Life Goals: What does the consumer or child and family hope to achieve or work toward? Please use their own words. Include hopes and dreams.

"I want to find a job and an apartment."

Clinical Treatment Goals: Must be specific, observable or quantifiable and improve ability to pursue goals and/or decrease impairment or symptoms related to diagnosis. (once mental health goals are identified, you may also include case management, targeted case management goals).

Client will work on decreasing the depressive symptom of isolation, by participating in social activities at least 1 time per week. The client will work on replacing her negative self talk (low self esteem & poor body image) with a more positive self image as reflected in her individual therapy progress.

Strategies to Achieve Goals: Specify what Consumer/Family/Provider are to do, as appropriate. (For example, How do these actions help decrease symptoms, increase functionality?)

1. Client will participate in individual therapy sessions weekly in order to decrease negative self talk and work on positive self image that will decrease depressive symptoms.
2. Client will take her medications as prescribed and attend all scheduled psychiatric appointments.
3. Case manager and clinician will work with client on increasing her social activities so that she can work on her isolation.

Please select all appropriate treatment options:

☐ Individual  ☐ Fam/Collateral  ☐ Medication  ☐ CM/TCM Case Mgmt  ☐ Group  ☐ Rehab Svcs
☐ Day Tx  ☐ TBS  ☐ Self-Help/WRAP  ☐ Child Wraparound  ☐ Other

MHC021-7 (Rev_3-14) Partnership Plan for Wellness  PAGE 1 of 2
Revisions or additions:

Life Goals: What does the consumer or child and family hope to achieve or work toward? Please use their own words. May include hopes and dreams, as appropriate.

Treatment Goals: Must be specific, observable or quantifiable and improve ability to pursue goals and/or decrease impairment or symptoms.

Strategies to Achieve Goals: Specify what Consumer/Family/Provider are to do, as appropriate.

Proposed Duration 12 months.

Please select all appropriate treatment options:

- Individual
- Fam/Collateral
- Medication
- CM/TCM Case Mgmt
- Group
- Rehab Svcs
- Day Tx
- TBS
- Self-Help/WRAP
- Child Wraparound
- Other

I have participated in the development of this plan:

Consumer's Signature* Date

Provider's Signature Date

Auth. Committee Signature Date

MD Signature Date

If consumer is a minor under age 12: Legal Party Responsible Signature Date

Licensed Signature (If Req’d) Date

Consumer/Legal Responsible Party was offered a copy of Partner

- A copy was given
- A copy was declined (date_)

*Document reason for no consumer signature on this Plan.

MHC021-7 (Rev_3-14) Partnership Plan for Wellness PAGE 2 of 2
Revisions or additions:

Updated Plan Date

Life Goals: What does the consumer or child and family hope to achieve or work toward? Please use their own words. May include hopes and dreams, as appropriate.

Treatment Goals: Must be specific, observable or quantifiable and improve ability to pursue goals and/or decrease impairment or symptoms.

Strategies to Achieve Goals: Specify what Consumer/Family/Provider are to do, as appropriate.

 Proposed Duration 12 months.

I have participated in the development of this plan:

Consumer’s Signature* ____________ Date ____________

Provider’s Signature ____________ Date ____________

Auth. Committee Signature ____________ Date ____________

MD Signature ____________ Date ____________

If consumer is a minor under age 12:

Legal Party Responsible Signature ____________ Date ____________

Licensed Signature (If Req’d) ____________ Date ____________

Consumer/Legal Responsible Party was offered a copy of Partner

☐ A copy was given

☐ A copy was declined (date ____________)

*Document reason for no consumer signature on this Plan.
REQUEST FOR SUPPLEMENTAL MENTAL HEALTH SERVICES

Name of Additional Service Provider: Out-Patient Program RU 12345
Name of Day Treatment Provider: Day Treatment Provider RU 23456
Service Provider Phone #: (925) 957-1111 FAX # (925) 957-2222

If Supplemental Mental Health Services are required, please identify each type of supplemental service(s) you wish to provide and the justification as to why this service is medically necessary. Supplemental Mental Health Services are those that are provided outside of the day treatment hours.

Day Treatment Providers: Supplemental Mental Health Services are those that: 1) are billed services provided outside of the day treatment hours or 2) participation in day treatment more than 5 days per week.

Client is in need of wraparound services due to dangerous behavior at home and in the community. This service will help to coordinate client’s care and to reduce fragmentation of care and sabotaging behavior. Wraparound services will also support his parents, and address his needs and behaviors at home.
REQUEST FOR SUPPLEMENTAL MENTAL HEALTH SERVICES

Name of Additional Service Provider: Out-Patient Program RU 34545
Name of Day Treatment Provider: Day Treatment Provider RU 65432
Service Provider Phone #: (925) 957-3333 FAX #: (925) 957-4444

If Supplemental Mental Health Services are required, please identify each type of supplemental service(s) you wish to provide and the justification as to why this service is medically necessary. Supplemental Mental Health Services are those that are provided outside of the day treatment hours.

Day Treatment Providers: Supplemental Mental Health Services are those that: 1) are billed services provided outside of the day treatment hours or 2) participation in day treatment more than 5 days per week.

Mental Health Services are required for this client who continues to have significant functional impairment and was recently discharged from the hospital. Case Manager will provide Rehab Support to maintain stability with the community, including coordinating housing and health services.
POLICIES & PROCEDURES

SECTION 10
POLICY: **DIAGNOSIS AND MEDICAL NECESSITY**

I. **PURPOSE:**

The purpose of this policy is to ensure that all services provided are medically necessary.

II. **REFERENCES:**

Contra Costa Mental Health Plan  
CCMHP Provider Manual  
CCR, Title 9, Chapter 11, Section 1830.205 (b) (1) (A-R), 1830.210, 1810.345 (c ) ,  
1840.112 (b) (1-4) , 1840.314 (d) and 51303 (a)

III. **POLICY:**

Diagnosis and medical necessity shall be established on initial assessment and reviewed annually. Medical necessity shall be based upon all of the following:

A. A complete five-axis diagnosis, which must have one of the following DSM-IV diagnosis:
   1. Pervasive Developmental Disorders, except Autistic Disorder excluded.
   2. Attention Deficit and Disruptive Behavior Disorders
   3. Feeding and Eating Disorders of Infancy or Early Childhood
   4. Elimination Disorders
   5. Other Disorders of Infancy, Childhood, or Adolescence
   6. Schizophrenia and Other Psychotic Disorders
   7. Mood Disorders
   8. Anxiety Disorders
   9. Somatoform Disorders
   10. Factitious Disorders
   11. Dissociative Disorders
   12. Paraphilias
   13. Gender Identity Disorders in Children
   14. Eating Disorders
   15. Impulse-Control Disorders Not Elsewhere Classified
   16. Adjustment Disorders
17. Personality Disorders, excluding Antisocial Personality Disorder
18. Medication-Induced Movement Disorders

B. Impairment Criteria: Must meet one of the following conditions as a result of the mental disorder(s) identified in the diagnostic criteria:
1. A significant impairment in an important area of life functioning, or
2. A probability of significant deterioration in an important area of functioning, or
3. A probability the child will not progress developmentally as individually appropriate.
4. For Full-scope Medi-Cal beneficiaries under age 21 a condition as a result of mental disorder that Mental Health Services can correct or a mediate.

C. Intervention Related Criteria: Must meet all conditions listed:
1. The focus of proposed intervention is to address the condition identified in impairment criteria “B” above, and
2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment.
3. Preventing significant deterioration in an important area of life functioning.
4. Allow the child to progress developmentally as individually appropriate.
5. The condition would not be responsive to physical healthcare-based treatment.
6. For full-scope Medi-Cal beneficiaries under age 21, correct or a mediate the condition.

IV. AUTHORITY/RESPONSIBILITY:

Licensed Practitioner
Authorization of Service Committee Members
Utilization Management Committee

V. PROCEDURE:

A. At Intake

As part of the assessment process, the person doing the assessment will initiate the Assessment Form on the first visit, describing current symptoms, behaviors and functional impairments that support the diagnosis and additional medical necessity criteria that are met. The licensed, registered or waivered practitioner’s signature and designation will be noted on the diagnosis section or in the signature section.
B. Annual Update

The Annual Update Form will be updated annually according to the beneficiary’s anniversary date, which will specify diagnosis, current symptoms and behavior that support the diagnosis and additional medical necessity criteria that are not met. Licensed staff will be involved as with the initial assessment process.
PERSHING ELEMENTARY SCHOOL DISTRICT

POLICY NO. 709

Review Date: February 2017

POLICY:
QUALITY MANAGEMENT/UTILIZATION REVIEW: DOCUMENTATION STANDARDS

Date Initially Approved: February 11, 2005
Date Revised: May 13, 2014

By:
Cynthia Belon, LCSW
Director of Behavioral Health

POLICY: QUALITY MANAGEMENT/UTILIZATION REVIEW: DOCUMENTATION STANDARDS

I. PURPOSE:

The purpose of this policy is to establish documentation standards for CCMHP Organizational Providers and to ensure that the Contra Costa Mental Health Plan (CCMHP) complies with current State and Federal Regulations.

II. REFERENCES:

Title, 9, California Code of Regulations, Chapter 11
Code of Federal Regulations, CFR 42
Contra Costa Mental Health Plan (CCMHP) for Consolidated Specialty Medi-Cal Mental Health Services
CCMHP Policy No. 509: Diagnosis and Medical Necessity

III. POLICY:

It is the policy of Contra Costa Mental Health Plan that interactions with our clients are documented in client records. In addition, it is CCMHP's policy to ensure all documentation is completed following established documentation standards, and such documentation is completed in a timely manner. Completed documentation provides evidence that a service was provided, is necessary for authorization and reimbursement, and decreases liability risk.

IV. AUTHORITY/RESPONSIBILITY:

Mental Health Plan Service Providers
Program Manager/Supervisors
Program Chiefs
Utilization Review Coordinator/Staff
Medical Records Technicians

QUALITY MANAGEMENT/UTILIZATION REVIEW: DOCUMENTATION STANDARDS
V. PROCEDURE:

Service Providers are required to produce timely, accurate and complete documentation of client’s history and current treatment. CCMHP Organizational Providers shall use county-approved forms for documentation unless otherwise approved by CCMHP.

Treatment services should be provided and documented in a culturally competent, age appropriate manner and be in accordance with Federal and State regulatory/statutory requirements.

Documentation is required, as follows:

A. ASSESSMENT

Clients seeking Mental Health Services (MHS) will be assessed by a licensed or waived/registered clinician to determine medical/service necessity. Protocol is as follows:

1. Assessing Clinician must complete the Initial Clinical Assessment for Children or Initial Adult Clinical Assessment. Psychiatrist must complete the initial psychiatric assessment.

2. The Initial Clinical Assessment and Initial psychiatric assessment must be completed within (sixty) 60 days. If psychiatric services are initiated at a later time the Psychiatric Initial Assessment must be completed by the psychiatrist upon initiation of services.

3. Initial Clinical Assessments and Psychiatric Initial Assessment should have the following elements:

   a. Diagnosis – full 5 Axis DSM IV Diagnosis (code and narrative).
      1. Primary Diagnosis shall fall into one of the included diagnosis categories as established in Title 9.

   b. Mental Status Examination.

   c. Physical health conditions.

   d. Presenting problems and relevant conditions affecting physical and mental health status.

   e. Client strengths in achieving client plan goals.

   f. Special status situations and risks to client or others.

   g. Medication, dosages, dates of initial prescription and refills.

   h. Allergies and adverse reactions, or lack of allergies/sensitivities.
i. Mental Health History, previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information, lab tests, and consultations reports. Cultural context should be taken into consideration when doing client assessments.

j. For children and adolescents, prenatal and perinatal events, and complete developmental history.

k. Past and present use of tobacco, alcohol and caffeine, as well as illicit, prescribed and over-the-counter drugs.

l. Plan for continued care.

m. If the assessment is conducted in a language other than English please note on the assessment.

B. ANNUAL RE-ASSESSMENT

Service Providers must perform a Mental Health re-assessment by completing the Annual Clinical Update for Children or the Annual Clinical Update for Adults. The re-assessment must be completed by the end of the established UR track. For clients receiving medications only, the requirement for an annual reassessment using the Psychiatric Assessment Update is waived, but should be done in keeping with best practice under the guidance of the Medical Director.

Documentation of medical necessity for ongoing medication services shall be maintained in the progress notes.

C. MEDICAL/SERVICE NECESSITY CRITERIA FOR CHILDREN

The Children Medical/Service Necessity Criteria Form shall be completed in conjunction with the Initial Clinical Assessment for Children within (sixty) 60 days of the initial service date by a CCMHP Provider, and annually thereafter. The Medical/Service Necessity Criteria Form demonstrates the continued evaluations of the assessing clinician.

D. TREATMENT PLAN

CCMHP calls its treatment plan a Partnership Plan for Wellness, or for clients receiving medication only, a Psychiatric Treatment Plan.

Once the assessing clinician makes the determination that the client requires specialty mental health services, the Service Provider must work with the client, and family to establish a Partnership Plan for Wellness.
1. The Partnership Plan for Wellness focuses on Life Goals that the client hopes to achieve or work toward, and focuses on Treatment Goals that are clinical and concentrate on alleviating symptoms or overcoming the client’s identified functional impairment(s). The primary purpose of the development of the Partnership Plan is to assist the consumer and family to clearly identify areas of his/her life in which an improvement in functioning is desired. The secondary purpose is to identify strategies to achieve the goals.
   a. Goals, while client driven, must be “specific, observable, or quantifiable.”
   b. Goals must be time specific and have a proposed duration for the interventions listed.
   c. Strategies should be identified to meet desired goal(s) on the plan.
   d. Specify the modalities that are needed to achieve the goal(s).

2. Partnership Plan should contain the following signatures:
   a. Client.
   b. Legal responsible party (should consumer be a minor age).
   c. Service Provider.
   d. Licensed Clinician if the Service Provider is unlicensed.
   e. Committee Reviewer

3. Should the signature of the client or legal responsible party be unobtainable, the Service Provider must document on the back of the form verbal agreement and detail the reason as to why the signature was not obtained.
   a. Continued efforts must be made by the Service Provider to obtain the client’s/legal responsible party’s signature. These efforts must be documented until the signature is obtained.
   b. A faxed copy of the client/legal responsible party’s signature is acceptable and should be attached to the original plan in the medical record.

4. Once completed and signed, a copy of the Partnership Plan for Wellness shall be offered to the client/legal responsible party and documented on the form that a copy was given or declined.
5. Completion of Partnership Plan for Wellness or the Psychiatric Treatment Plan shall be within the following time frames:
   a. Within 60 days if this is the client’s initial contact with CCMIIP.
   b. Within 30 days of admission to a second program, should the client already be receiving mental health services.
   c. Completed annually thereafter. In general, the annual requirement is set by the established UR track and reflected on the Service Authorization form. For clients receiving medications only, however, the annual requirement may be set by the completion date of the previous plan. This date should be listed on the service authorization form.

E. REGISTRATION FORM/CLIENT FINANCIAL INFORMATION FORM

At the initial service, the Registration Form and Client Financial Information form must be completed. It is the responsibility of the registration clerk or the clinician to ensure the forms are completed. The forms have been designed so the client or the family/guardian completes the Registration and Client Financial Information forms, the clerical staff shall review the form to ensure each section is complete.

1. The Registration Form is completed with the following required information:
   a. Informing Materials – A Consumer Services Guide must be given to the consumer during the first contact.
   b. Special Populations/Demographic/CSI Initial Information.
   c. Financial information.

2. The Financial Information form must be completed annually in order to update the UMDAP and other financial information. The Registration Form should be updated annually, if relevant changes occurred.

F. SERVICE AUTHORIZATION FORM, EPISODE OPENING/EPISODE CLOSING FORM

The Service Provider at the initial assessment must complete the Episode Opening Section of this form. At discharge, the Primary Clinician that provided services to the client must complete the Episode Closing section. The information is entered into PSP by clerical staff.

1. The Episode Opening Section is completed with the following information:
   a. Opening Date.
b. Referral From Code.

c. Trauma.

d. Primary Service Provider/MD.

e. Full DSM IV-R Diagnosis, including Substance Abuse

f. Legal Status, Source of Income, Living Situation, Employment Status, Type of Employment, Legal Status.

2. The Episode Closing Section is completed with the following information:

   a. Closing Date.

   b. Full DSM-IV-TR Diagnosis.

   c. Referral to Code.

   d. Reason for discharge.

G. SERVICE AUTHORIZATION

The Service Authorization Form must be completed for each client receiving Mental Health Services, Case Management Service, Medication Support Services, Adult Residential Services, Day Treatment Services and TBS.

1. The Service Authorization Form details the following:

   a. Authorized types of services to be provided to the client.

   b. The length of service authorization.

      i. Start and End Dates.

      ii. (Up to) the number of months approved.

         a. The maximum number of approved months is 12 for Outpatient Specialty Mental Health Service authorizations.

         b. Day Treatment Intensive Programs: Maximum number of approved months is three months/90 days.

         c. Day Treatment Rehabilitative Programs: Maximum number of approved months is six months/180 days

   iii. The Service Provider Agency.

   iv. Changes in Authorization, e.g., denial or reduction in services necessitate the completion of a NOA. Indication of NOA is marked on the Service Authorization Form, if applicable.

   v. Authorizing Committee member initials and signature.

   vi. Date Authorization was granted.
c. The Service Authorization Form must be completed within (sixty) 60 days of initial admission and annually thereafter.

d. In the event that any "additional Service Providers" are authorized by the Committee, the Service Provider will be added to the original Service Authorization Form and given a copy of the Service Authorization Form for their records after review of their Partnership Plan. Partnership Plan review must occur within (thirty) 30 days of initial visit with the additional Provider. Note: If adding Mental Health services to a medication only client the clinician has 30 days to complete the required UR documentation. However, when there is a change in therapist there is no thirty day period for the completion of UR documentation.

e. Completed annually thereafter. In general, the annual requirement is set by the established UR track and reflected on the Service Authorization form. For clients receiving medications only, however, the annual requirement may be set by the completion date of the previous plan. This date should be listed on the service authorization form.

H. CLIENT SERVICE INFORMATION (CSI) UPDATE

1. CSI data is mandated by the State and reported monthly. Periodic Record Fields include the following:
   a. Living Situation
   b. Employment Status
   c. Global Function (GAF)
   d. Level of Education
   e. Legal Consent

2. Completed form must be submitted prior to presenting case to Authorization Committee.

3. The CSI Update Form must be completed annually and at the time of discharge.

I. PROGRESS NOTES/BILLING

1. Frequency of Progress Notes:
   a. Progress notes are to be completed after each service contact for mental health services, medication support, crisis intervention, case management brokerage, and TBS.
b. Day Treatment Intensive programs are required to complete a daily note and a weekly summary.
   i. Weekly summaries must be signed or co-signed by a licensed clinician.

c. Day Treatment Habilitative programs are required to complete a weekly summary.
   i. Weekly summaries must be signed or co-signed by a licensed clinician.

2. Service Providers, commensurate with scope of practice, after rendering a direct service to a client shall complete a Progress Note/Billing Form. Direct services can be any mental health service, medication support service, crisis intervention, case management brokerage, and TBS.
   a. The purpose of the Progress Note/Billing Form is to provide written documentation of a service provided to our clients.
   b. Billing may not be entered into the PSP system without a completed progress note.
   c. If the documentation date differs from the service date, the Progress Note/Billing Form is considered a “late entry”.
   d. The Progress Note/Billing Forms should be completed within one (1) business day of service. However, in consideration of the varied work schedules and field assignments of many staff, billing and charting will not be considered “late for billing entry” if submitted by the first Friday immediately following the service.
      (1) Staff that is clinic/program-based Monday through Friday should have charting/billing through Friday submitted by Friday of that same workweek.
      (2) Staff that work in the field on Friday and do not return to their office that day, should submit charting/billing as soon as possible upon return to the office, but no later than the first following Friday.
      (3) Staff that work Saturday or Sunday should also submit charting and billing as soon as possible, but no later than the first following Friday.

3. The Progress Note/Billing Form should document all of the required elements as indicated below:
   a. Name of the client and Medical Record Number.
   b. Date of service, RU, staff number, duration of service, location of service, and service strategy (if applicable).
c. Name of interpreter or language service provided in other than English (if applicable).

d. Description of Current Situation (Reason for contact, consumer concerns, status update, behavioral acuity, current stressors, needs, etc.).

e. Focus of Activity (Intervention, response to intervention, etc.).

f. Plan (Coordination or care, referrals, follow-up, person’s planned action, staff’s planned action, etc.).

4. The Psychiatric Services Progress Note/Billing Form should document all of the required elements as indicated below:

a. Name of the client and Medical Record Number

b. Date of service, RU, staff number, duration of service, location of service, and service strategy (if applicable)

c. Brief Description of Client (Age, gender, diagnoses, date of last visit, etc.).

d. Interim History and Observations.

e. Targeted Mental Status Exam.

f. Medications Since Last Visit.

g. Other Objective Data (Recent labs, weight/BMI, vital signs, non-psychotropic medications, etc.).

h. Clinical Assessment.

i. Plan for Continued Service.

j. Medications.

5. All Clinical and Medication Support progress notes must have all of the following information:

a. Name and/or Medical Record Number (MRN) of the client.

b. Date of Service - Full Date (Month/Date/Year) must be documented.

c. Duration of Service (Hours/Minutes).

d. Location of Service.

e. Procedure Code (Type of Service Delivered).

f. Service Strategies.

g. If an interpreter is required for a monolingual client and is present during session, the Service Provider's documentation should contain the name of the interpreter.

h. If the translation service is provided in a language other than English, the Service Provider must indicate the language.

i. Signature of Service Provider (signature shall include full first name, full last name, licensure, and/or job title.

j. Co-signature of licensed clinician, when applicable.
k. Date documentation completed.

6. All “No Shows” and cancellations (300, 400, 700) must be entered in the PSP system and noted in the chart.

7. If documentation date differs from service date, progress notes are considered a “late entry”.

8. Travel time should be indicated on the progress note and included in the total time claimed.

9. If services will terminate at the end of service delivery, the service provider has the option of utilizing and documenting progress/billing note as discharge summary.

J. **DISCHARGE SUMMARY**

The discharge summary is the documentation source for the ultimate outcome of service provided by the program to the client.

The Discharge Summary is to be completed on the last day of a planned discharge in order to bill for completing the form.

In those cases when the consumer terminates in an unplanned manner, the discharge summary must be written at the time of the administrative discharge, which occurs two (2) months from the last date of contact and the episode closed. Administrative discharges are not reimbursable and the clinician must use a non-billable procedure code.

For consumers that receive only Medication Support services, if there has been no contact for six (6) months, the discharge summary should be completed and the episode closed.

K. **CCMHP DOCUMENTATION STANDARDS**

1. Documentation must be legible.

2. Signatures should include legible first and last names followed by license number or job title.

3. All forms shall be fully completed using black or blue indelible ink pens.
   a. The following is not allowed:
      i. Erasable ink pens.
      ii. Pencils.
      iii. Liquid Paper/erasable tape.
iv. Other colored ink pens.

4. All CCMHP forms must be completed fully.
   a. Service Provider shall fill in all lines and spaces on a form.
      i. If the statement does not fit a certain situation or an answer cannot be obtained, the Service Provider shall indicate with N/A, a “hyphen” or “UTO” (unable to obtain) or other similar phrase to indicate that the question was asked and not answered.
   b. Clients can only be asked to sign fully completed forms.

5. Once entered into the medical record, documentation becomes a legal document. Service Providers, therefore, cannot do the following once entered:
   a. Obliterate material in the medical record.
   b. Erase documentation from progress notes.
   c. Remove pages from documentation.
   d. Use liquid correctional fluid or tape.

6. If an error is made, the error must be corrected in the following manner:
   a. A single line is drawn through the error.
   b. The Service Provider shall write “error”, initial, and date.

EXAMPLE: ERROR error 9-1-07
POLICY: DOCUMENTATION REQUIREMENTS: LATE ENTRY

I. PURPOSE:

The purpose of this policy is to ensure that progress notes completed subsequent to the day the service was provided are accurately documented, labeled and billed.

II. REFERENCES:

Title 9, California Code of Regulations, Chapter 11
Contra Costa Mental Health Plan for Consolidated Specialty Medi-Cal Mental Health Services
CCMHP Policy Number 709. Documentation Requirements. Documentation Standards

III. POLICY:

It is the policy of Contra Costa Mental Health Plan that documentation of any Mental Health, Case Management Brokerage, Medications Support or Crisis Intervention services occurring subsequent to the day in which the service was delivered, be noted as a late entry on the Progress Note/Billing Form.

IV. AUTHORITY/RESPONSIBILITY:

CCMHP Service Provider
Program Supervisor/Manager
Mental Health Program Chiefs
Compliance Officer

V. PROCEDURE

When documentation of a service does not occur on the day the service is provided, staff will:

A. Note the date of service delivery in billing section of the Progress Note/Billing Form;

1. At the beginning of the note, write:
"This is a late entry for ______________." (insert service date)

B. Note the date documentation was written next to the Service Provider’s signature;

C. Claiming documentation time.

1. If the documentation is not completed on the same day the service was provided, documentation time cannot be included in the time billed for that service;
2. The Service Provider may either not bill for the documentation time or may complete a separate Progress Note/Billing Form stating “Documentation time for late entry”;
3. When billing for late documentation time, the “service date” on the form must be the date the documentation is completed, not the date the actual service was provided;

D. Late service documentation will only be submitted for claiming to Medi-Cal up to thirty (30) days from date of service.

1. After thirty (30) days, these services are considered non-claimable. These must be entered as a non-billable service.
2. Services submitted for billing after thirty (30) days will not count toward productivity.
POLICY: **COMPLIANCE WITH DOCUMENTATION STANDARDS**

I. **PURPOSE:**

The purpose of this policy is to describe the Behavioral Health Division’s policy that expectation that documentation standards are met, and to minimize liability when these standards are not adhered to.

II. **REFERENCES:**

- 42 CFR 456.180,
- CCR, Title 9, Chapter 11, § 1830.205, 1830.210, and 1840.314
- Contra Costa Mental Health Plan (CCMHP) for Consolidated Specialty Medi-Cal Mental Health Services Contract, Attachment C
- CCMHP Documentation Training Manual

III. **POLICY:**

It is the policy of Contra Costa Mental Health Plan policy that reimbursement for services shall be based upon complete and timely documentation, filed in the client’s record. Services that do not meet standards and requirements shall not be submitted for reimbursement.

In the event that service documentation does not meet Contra Costa Behavioral Health’s standards and requirements, evaluation for possible corrective action will be initiated (see Corrective Action, Page 3).

IV. **AUTHORITY/ RESPONSIBILITY:**

Compliance Officer
Mental Health Program Chiefs
Mental Health Program Managers/Supervisors
Mental Health Plan Service Providers
Utilization Review Coordinator/Staff
V. PROCEDURE:

A. All services provided shall be documented as described in Policy Number 709, Documentation Standards.

B. All services shall be documented as follows:

1. Services shall be documented on the same day service was provided;
2. Should extenuating circumstances occur, documentation must be completed within 72 hours and submitted for billing and filing.
3. Specific information concerning the documentation and claiming process for late entries may be found in Behavioral Health Policy 712, Documentation Requirements, Late Entry;
4. Late service documentation will only be submitted for claiming up to thirty (30) days from date of service. After thirty (30) days, these services are considered non-claimable and will be entered as a non-billable service.

C. Every service entry shall comply with documentation standards as found in Policy Number 709, Documentation Standards.

RESPONSIBILITIES:

Clinical Staff

1. For the purpose of this policy, clinical staff is defined as those personnel that directly provide a clinical service to a consumer, and that they document the provision of services in a mental health record.

2. Clinical staff shall ensure that all documentation is based on the clinical standards and documentation requirements included in the Documentation Manual and other distributed memos, training materials, and bulletins (see Policy Number 709, Documentation Standards).

3. Clinical staff shall attend documentation training upon employment and continued training as directed.

4. In the event that the Clinician discovers that inappropriate billing occurred, the Clinician shall inform the supervisor so that remedial action can be taken.
5. Progress Notes which require co-signature and which do not meet documentation standards, shall not be submitted for billing until they are review and corrected.

Program Manager/Supervisors

1. For purposes of this policy, Supervisory (Clinical) Staff are defined as those supervisory personnel responsible for the performance of subordinate clinical staff as defined above.

2. Supervisory staff shall ensure that subordinate clinical staff members are aware of all requirements for appropriate and accurate billing and that the staff is trained in this regard.

3. The supervisor is responsible for ongoing supervision, regular evaluations, staff meetings, and individual training to ensure that staff is appropriately documenting services.

4. Progress Notes, which require co-signatures and which do not meet documentation standards, shall not be submitted for billing until they are reviewed and corrected.

5. It is the supervisor’s responsibility to inform the appropriate Program Manager. The Program Manager shall inform the appropriate Program Chief and the Division’s designated Compliance Officer. The supervisor shall take immediate action to ensure that the inappropriate practice does not reoccur.

**CORRECTIVE ACTION:**

Non-Compliance

1. In the event of non-compliance with established documentation requirements, the appropriate supervisor/manager shall take corrective action to ensure compliance. This may include training, counseling, and formal disciplinary action. It is the responsibility of the supervisor/manager to ensure staff receives documentation training and to monitor documentation on an ongoing basis to ensure compliance.
2. The supervisor/manager may make a simultaneous referral to the Utilization Review Supervisor and appropriate Program Chief to conduct up to a 100% audit of the Clinician’s caseload. Closed cases may also be reviewed.

3. The Program Manager/Supervisor shall meet with the Clinician and review the audit findings and expectations concerning documentation.
POLICY: SERVICE AUTHORIZATION FOR ORGANIZATIONAL PROVIDERS

I. PURPOSE:

The purpose of this policy is to establish and outline the Service Authorization Process in regards to CCMHP Organizational Providers and to ensure that the Contra Costa Mental Health Plan (CCMHP) complies with current State and Federal Regulations.

II. REFERENCES:

Title 9, California Code of Regulations, Chapter 11
Contra Costa Mental Health Plan for Consolidated Specialty Medi-Cal Mental Health Services

III. POLICY:

It is the policy of Contra Costa Mental Health Plan that all CCMHP Organizational Providers obtain service authorization for specialty mental health services. Designated Service Authorization Committees will convene in order to review and authorize services for Adult/Children CCMHP Organizational Provider clinics and contract agencies based on acuity, medical/service necessity guidelines and eligibility criteria.

IV. AUTHORITY/RESPONSIBILITY:

Utilization Review Coordinators/UR Specialist Level Clerks
UR Program Supervisor
Program Chiefs
Mental Health Plan Service Providers
Medical Records Technicians
V. PROCEDURE:

A. Authorization Committee:

1. In order to obtain Service Authorization for Specialty Mental Health Services, the Service Provider must complete all required clinical documentation and present the case to the Authorization Committee.

2. Authorization Committee Meetings are held at each of the each of the Adult and Children’s Regional Clinics, as well as Contract Provider sites.

3. Authorization Committee is comprised of the following:
   a) Program Managers/Supervisors/Designated Licensed Clinicians/UR Coordinators are responsible for review and authorization of services.
   b) Utilization Review Clerk coordinates Authorization Meetings. UR Clerk is responsible for collecting and organizing documentation to be reviewed and must enter Service Authorization into the Mental Health Database.
   c) Meetings take place at a minimum of (one) 1 time per month

B. Initial Service Authorization

1. Service Authorization must be obtained within 60 days from the time the initial services begin and the episode is opened.

2. PSP 192 report notifies clinicians of cases requiring Service Plan Authorization.

3. Documents required to obtain initial service authorization are:
   a) Initial Clinical Assessment for Children, Adult Clinical Assessment or other assessments approved by CCMHP.
   b) Medical Necessity Criteria Form (Children’s Services Only).
   c) Partnership Plan for Wellness with all required signatures or documentation why signatures were not obtained on back of form.
   d) Service Authorization Form.

4. Documentation must be submitted to the Authorization Committee Meeting to be reviewed.

5. Committee Members will use the Service Authorization Committee Worksheet to ensure that all required documents are complete, client is receiving services at the appropriate level of care and all Medical/Service Necessity Criteria are met.

6. Coordination between Service Authorization Committee and Service Provider will occur should questions regarding documentation arise.
7. Service Providers may be required to present their cases in order to obtain service authorization.

8. Based on assessment, acuity, formulated partnership plan timelines and information gathered during Authorization Committee Meeting, the Committee Member may give up to 12 months of service authorization.

9. Types of services authorized and length of authorization will be listed on the green Service Authorization Form.

10. The Service Authorization Committee Member must initial and date once Authorization is approved.

11. Should required documents be completed and signed after the initial 60-day period, the date in which the Committee initials the Service Authorization Form would serve as the authorization date.

12. UR Clerks are responsible for entering any obtained service authorization into the Mental Health Database.

C. Initial Authorization of an Additional Provider

1. An additional provider is defined as “any Service Provider that provides mental health services in addition to another CCMHP Provider.”

2. Documents will be presented and authorization will be granted once the additional provider completes and submits to the Authorization Committee a copy of a signed Partnership Plan for Wellness detailing their planned course of treatment during the remainder of the authorization period.

3. PSP 192 report notifies clinicians of cases requiring Service Plan Authorization from the Authorization Committee.

4. Additional Service Provider must obtain service authorization within 30 days from the time the initial services began and the episode is opened.

5. Based on assessment, acuity, formulated Partnership Plan timelines and information gathered during Authorization Committee Meeting, the Committee Member may grant only up to what is remaining of the 12 months of service authorization granted to the initial Service Provider.

6. If presented documents are insufficient to grant service authorization, the Authorization Committee may consult with additional Service Provider(s) to obtain or secure further information.
7. Types of Services Authorized and length of authorization will be listed on the green Service Authorization Form.

8. The Authorization Committee Member must initial and date once Authorization is approved.

9. Should required documents be completed and signed after the initial 30-day mark, the Date in which the Authorization Committee Member initials the Service Authorization Form would serve as the authorization date.

10. UR Clerks are responsible for entering any obtained service authorization into the Mental Health Database.

D. Reauthorization of Services for Initial Provider and Additional Providers

1. Reauthorization of Services must be prior to the expiration of the initial authorization period listed on the Service Authorization Form.

2. PSP 192 report notifies clinicians of cases requiring Service Authorization from the Authorization Committee.

3. Documentation required to obtain continued Service Authorization are:
   a) Annual Clinical Update for Children, and Adult Annual Clinical Update.
   b) Partnership Plan for Wellness with all required signatures or documentation detailing why signatures were not obtained on back of form.
   c) Service Authorization Form
   d) CSI Update Form

4. Collaboration between Initial and any Additional Service Providers should occur to ensure that all required documentation is completed.

5. The Service Authorization Committee Worksheet will be used to ensure that all required documents are completed, continues to need on-going services and is receiving services at the appropriate level of care and all Medical/Service Necessity Criteria are met.

6. If presented documents are insufficient to grant service authorization, the Authorization Committee will consult with Service Provider to obtain or secure further information.

7. Based on assessment, acuity, formulated Partnership Plan for Wellness timelines and information gathered during Authorization Committee Meeting, the Committee Member may grant only up to 12 months of service authorization.
8. Types of Services Authorized and length of authorization will be listed on the green Service Authorization Form.

9. The Committee Members must initial and date once Authorization is approved.

10. Should the date of required documents occur after the initial authorization period has lapsed, the date in which the Authorization Committee Member initials the Service Authorization Form will serve as the authorization date.

11. UR Clerks are responsible for entering any obtained service authorization into the Mental Health Database.
POLICY: UTILIZATION REVIEW: DAY TREATMENT AUTHORIZATION PROCESS

I. PURPOSE:

The purpose of this policy is to establish and outline the Utilization Review Process in regard to Day Treatment Services Authorization and to ensure that the Contra Costa Mental Health Plan complies with current State and Federal Regulations.

II. REFERENCES:

- CCR Title 9 Chapter 11, Section 1810.405 (d), 1810.410
- CFR, Title 42, Section 438.10 (c) (4) (5)
- Title, 9 California Code of Regulations, Chapter 11 section 1840.314 (d) (E), 1840.318 Section 1810.212, 213
- Contra Costa Mental Health Plan for Consolidated Specialty Medi-Cal Mental Health Services
- DMH Information Notice Number 02-06
- DMH Informational Letter 03-03

A. It is the policy of the Contra Costa Mental Health Plan (hereinafter “CCMHP”) that all Day Treatment Providers obtain timely service authorization. The Day Treatment Authorization Committee will convene in order to review and authorize Day Treatment services for Adult/Children CCMHP Organization Provider clinics and contract agencies based on acuity, medical service necessity and established admission/reauthorization guidelines. Providers of other planned mental health services, which are being provided while a consumer is receiving Day Treatment Services must also get prior authorization from the Day Treatment Authorization Committee.
B. Supplemental Mental Health Service Providers are required to request service authorization for continuation of these services on the same cycle required for continuation of Day Treatment Intensive or Day Treatment Rehabilitative.

C. Day Treatment Service providers must submit request for service authorization within 30 days of initiation of service.

III. AUTHORITY/RESPONSIBILITY:

Utilization Review Coordinator/Staff
Mental Health Program Managers/Supervisors
Mental Health Program Chiefs
Medical Records Technicians

IV. PROCEDURE:

The following procedure should be utilized:

A. All Day Treatment providers must fax required authorization documents listed on the Request for Day Treatment Payment Authorization Form (initial, reauthorization, annual reauthorization) at the Day Treatment Office.

1. Initial Authorization Packet - completed for clients that are requesting Day Treatment authorization for the first time. Documents must include the following:
   b. Assessment: Most recent Initial or Annual Adult and Children’s Assessment.
   c. Medical/Service Necessity Form (Children’s Services Only).
   d. Problem Severity Rating Scale for all Day Treatment Service Providers.
   e. Partnership Plan for Wellness, if available, must indicate Day Treatment as a service modality.
   f. If no Partnership Plan is available, 30 days authorization will be granted during which a Partnership Plan should be submitted (See A4).
   g. If applicable, Request for Supplemental Mental Health Services.

2. Reauthorization Packet - completed for clients that are currently authorized and participating in a Day Treatment Program and authorization has or will be ending soon. Reauthorization Packet must include the following:
b. Problem Severity Rating Scale for all Day Treatment Service Providers.
d. If applicable, Request for Supplemental Mental Health Services.

3. Annual Reauthorization Packet - completed for clients who are currently in Day Treatment and whose annual documentation, e.g., Partnership Plan, Annual Assessment, update is due. Annual Reauthorization Packet includes the following:
   f. Assessment (Annual Clinical Assessment for Children and Adult Services).
   g. Medical/Service Necessity Form (Children’s Services only).
   h. Problem Severity Rating Scale for all Service Providers
   i. Justification or Quarterly Report.
   j. Partnership Plan for Wellness (must indicate Day Treatment as a service modality).
   k. CSI.
   l. If applicable, Request for Supplemental Mental Health Services.

4. Authorization Committee may require completion and resubmission of inadequate documentation. The Committee may also request a progress note supporting acuity.

5. Documentation must be received by 1 PM, Monday, on the given schedule for the program to obtain authorization. Packets received after this deadline will not be processed until the following program schedule meeting.

B. UR Clerical staff will process authorization packets prior to the authorization meeting. Processing includes:

1. Check each packet for completeness.

2. Check Medi-Cal Eligibility for each consumer.
   a. If Medi-Cal Eligible is confirmed as Contra Costa County, note and report to UR Coordinator if any other county is reported.
   b. If ineligible for example, “no recorded eligibility. “Notify the referring Day Treatment Program. Status will remain “pending” until the providers resubmits request.
3. Review PSP Face Sheet to note other open episodes.
   a. If other reporting units are opened at the same time as the Day Treatment Program, the authorization committee looks to ensure there is no duplication of services and coordination of care. If it appears to be duplicative a denial will be submitted and a NOA A will be issued.
   b. Notification of county clinics/contract agencies of missing documents/eligibility.
      a. UR Clerk will contact providing detailed information to referring provider at the contract agency/county clinic alerting them to the following:
      b. Missing documents (examples: incomplete assessment, supplemental mental health services request, CFARS).
      c. Notification of Medi-Cal ineligibility (e.g., out of county Medi-Cal, ERMHS, no Medi-Cal eligibility, private insurance).

5. Prepare a Day Treatment Authorization Committee (DTAC) form, Utilization Review Committee Worksheet and Day Treatment Worksheet for each packet. Complete as follows:
   a. Day Treatment Authorization Committee (DTAC) Form. Clerk must fill in the following:
      i. Client's Name (last name, first name)
      ii. Client's MRN (medical record number)
      iii. Name of Day Treatment Program
      iv. Name of Agency/Referring Person
      v. Agency/Clinic Phone Number
      vi. Agency/Clinic Fax Number
      vii. Other Service Providers
   b. Day Treatment Worksheet. The UR clerk will determine either Rehabilitative or Intensive Day Treatment as indicated on initial request form.
   c. Clerk checks to see whether there is an existing authorization file, and if none, initiate one.

6. Regional Medical Record Technicians are notified of required Medical Records
prior to 1:00 p.m. Wednesday afternoon.

C. Authorization Committee:

Authorization Committee Meetings are held at the Day Treatment Office. Meetings take place once a month.

1. Licensed Mental Health Program Managers/Supervisors and UR staff are responsible for review and authorization of services.

2. Utilization Clerk coordinates the Day Treatment Committee Meetings and is responsible for review and entering authorization of services after a Program Manager or Utilization Review Coordinator signs off on level 1 review.

3. Utilization Review Clerk is responsible for collecting and organizing documentation to be reviewed and for data entry of authorization decisions.

4. Utilization Review Clerk is responsible for data entry of authorization decisions.

5. Committee Members cannot authorize services for their own program.

D. Authorization Criteria:

Authorization is granted based on admission/re-authorization criteria.

1. Intensive Day Treatment Programs - Initial Authorization Criteria. Consumer must meet all of the criteria.

   a. Consumer is deemed unable to be maintained in the community with outpatient mental health services alone. DTI is a structured, multidisciplinary program of therapy that may be an alternative to hospitalization, avoid placement in a more restrictive setting or maintain the individual in a community setting;

   b. History of at least one of the following:

      i. Psychiatric Hospitalization
      ii. Extensive Use of Mobile Response Team (MRT)
      iii. Previous Day Treatment Participation
      iv. Previous or current Therapeutic Behavioral Services (TBS)
      v. Out of Home Placement
      vi. ERMHS Services

   c. Completed 5-Axis DSM Diagnosis

   d. DSM IV Diagnosis meets Medical Necessity Criteria
Contra Costa County
Health Services Department
Behavioral Health Division- Mental Health Plan

POLICY:

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<th>UTILIZATION REVIEW: DAY TREATMENT AUTHORIZATION PROCESS</th>
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- Current GAF (Axis 5) of 45 or below
- Functional Impairment rated as:
  - "Severe" in at least two areas
- Targeted Symptoms (Children’s services only, found at Initial and Annual Assessment) rated as:
  - "Severe" in at least two areas or
  - "Moderate" ratings in an additional two areas.
- Completed 16-item, (nine) 9-point Likert Scale from the Problem Severity Rating Scale for all Day Treatment Service Providers.
  - Consumer must have a rating of “6” or higher in at least four areas on the Problem Severity Rating Scale.

2. Intensive Day Treatment Programs Reauthorization Criteria must meet all of the following:
   - Consumer continues to be deemed unable to be maintained in the community with outpatient mental health services alone.
   - Must be documented on the Justification form or Quarterly Report as stated on DTT initial authorization criteria.
   - Completed CAN and CALOCUS for in County Service Providers.
   - Completed 16-item, (nine) 9-point Likert Scale from the Problem Severity Rating Scale for all Day Treatment Service Providers.
     - Consumer must have a rating of “6” or higher in at least (four) 4 areas on the Problem Severity Rating Scale.
     - Continued persistent severity with demonstrated progress in treatment.

3. Rehabilitative Day Treatment Programs - Initial Authorization Criteria. Must meet all of the following criteria:
   - Consumer is deemed unable to be maintained in the community with outpatient mental health services alone
   - Consumer previously received or currently receives service or interventions by one of the following:
     - Mental Health or
     - CCMHP Organization Provider Partner
       - Education
       - Probation
       - CFS
4. Public Health
5. AOD
   c. Completed 5-Axis DSM Diagnosis
   d. DSM IV Diagnosis that meets Medical Necessity Criteria
   e. Current GAF (Axis 5) of 55 or below
   f. Functional Impairment rated as:
      i. “Severe” in at least (one) 1 area or
      ii. “Moderate” ratings in (two) 2 areas
   g. Targeted Symptoms rated as (Children’s Services only, on Initial and/or
      Annual Assessment):
      i. “Severe” in at least (one) 1 area or
      ii. “Moderate” ratings in (two) 2 areas
   h. Completed 16-Item, (nine) 9-point Likert Scale from the Problem
      Severity Rating Scale for all providers.
      i. Consumer must have a rating of “6” or higher in at least (two) 2
         areas on the Problem Severity Rating Scale.

4. Rehabilitative Day Treatment Programs - Re-Authorization Criteria. Must meet all of the
   following criteria:
   a. Consumer continues to be deemed unable to be maintained in the community with
      outpatient mental health services alone.
   b. As stated on DTR Authorization Criteria to be documented on Justification for
      Reauthorization Form or Quarterly Report.
      i. Continued persistent severity with demonstrated progress in treatment.
   c. Completed 16-Item, (nine) 9-point Likert Scale from the Problem Severity Scale for
      all Day Treatment Service Providers.
      i. Consumer must have a rating of “6” or higher in at least (two) 2 areas on the
         Problem Severity Rating Scale.

5. If presented documents are insufficient to justify authorization, if appropriate, the
   Day Treatment Committee will consult with Day Treatment Provider on how they
   can submit adequate documentation. In this case, this authorization will be
   pended.
   a. Requested documentation for pended authorization will be reviewed on the
      next scheduled committee meeting.

6. If criteria are met and services are authorized, DTAC member will complete and
   sign “Day Treatment Committee Authorization Form”. The following should be
   completed:
Contra Costa County
Health Services Department
Behavioral Health Division- Mental Health Plan

POLICY NO.  707

POLICY:

Date Initially Approved: February 11, 2005
Date Revised: June 18, 2013

UTILIZATION REVIEW: DAY TREATMENT
AUTHORIZATION PROCESS

a. Initial/Reauthorization DT Authorization (should be checked ☑)
b. If applicable, authorization for Supplemental Mental Health
   Services (SMHS). Identifying each specific service will be identified.
c. Service Authorization Form (MHC36-5)
d. Period of Authorization (maximum of three months for intensive and six
   months for rehabilitative).
e. Number of Days/week
f. Type of Day Treatment (Rehabilitative or Intensive; indicate if half day or full day).

7. If criteria are not met and services are denied, DTAC member will complete and
   sign “Day Treatment Committee Authorization Form”. The following should be
   completed:
   a. Day Treatment: Denial Authorization/NOA “A” or “B” completed box should
      be checked ☑.
   b. Note requesting transitioning immediately out of program is indicated on the
      Day Treatment Denial of Authorization Form.
      i. Adequate time to transition will be authorized.
   
8. If criteria may be met, but documentation is inadequate, service authorization is
   “PENDED”; the DTAC member will complete and sign the “Day Treatment
   Committee Authorization Form”. The following should be completed:
   a. Pending Authorization box should be checked ☑.
   b. Requests for additional documentation and due date for submission.

9. Resubmission on a previously “PENDED” authorization.
   a. DTAC will review documentation for the previously PENDED authorization for
      completeness.
   b. DTAC will complete corresponding areas of the UR Committee Worksheet.

10. UR Coordinator or designee must review for completeness and will co-sign all DTC
    Authorization Sheets.

11. Day Treatment Authorization sheets will be forwarded to UR Clerk for data entry.

F. Distribution of Day Treatment Committee (DTC) Authorization Form and County
    Service Authorization form (MHC 36-5):
    1. Original to DTC file or if open to County is placed in County chart.
    2. Copy made for UR Clerk
    3. Copy faxed to Day Treatment Program
       a. If Day Treatment Program’s Medical Record is available, instead of faxing
          ATTACH TO FRONT of medical record, DO NOT FAX.
4. Fax the authorization form and copy of county service authorization to other supplemental mental health services authorized provider.
   a. If other supplemental health services provider’s medical record is available, ATTACH TO FRONT of medical record.

5. Original County Service Authorization form to track holder (can be a Day Treatment contract provider if no county provider, otherwise, original to county chart).

6. Copy of Service Authorization form to DTC file (MHC 36-5).

G. Utilization Review Committee Worksheet will be filed at DTC Authorization file.

H. Once processing has been completed, the County Medical Records shall be placed in designated suitcases and returned to regional clinics within one workday.
POLICY: UTILIZATION REVIEW: THERAPEUTIC BEHAVIORAL SERVICES (TBS)

I. PURPOSE:

The purpose of this policy is to establish and outline the Utilization Review process in regards to Therapeutic Behavioral Services (TBS) and to ensure that the Contra Costa Mental Health Plan (CCMHP) complies with current State and Federal Regulations.

II. REFERENCES:

- DMH Information Notice Number 08-38
- DMH Information Notice Number 09-10, Enclosure 1
- DMH Information Notice No 10-20, Enclosure 1 & 2
- Emily Q. versus Bonta
- Title 9, California Code of Regulations, Chapter 11
- Contra Costa Mental Health Plan for Consolidated Specialty Medi-Cal Mental Health Services

III. POLICY:

It is the policy of CCMHP that consumers (children/youth 18-20) who are identified to have a need and who meet class criteria as defined in DMH Information Notice Number 08-38, are offered the opportunity to receive TBS. CCMHP requires providers to request payment authorization for TBS in advance of the delivery of services and request payment after clinical authorization has been approved. Designated authorizing agents will convene in order to review and authorize TBS for children/youths based on acuity and Medical/Service Necessity.

IV. AUTHORITY/RESPONSIBILITY:

Utilization Review Coordinator/Staff
Mental Health Program Managers/Supervisors
Program Chiefs
V. PURPOSE OF THERAPEUTIC BEHAVIORAL SERVICES:

The purpose of providing TBS is to help the child/youth in his/her daily environment to learn and use new behaviors that are more conducive to maintaining placement and to avoid hospitalizations. These new behaviors are intended to replace old, inappropriate, destructive, or aggressive behaviors.

VI. EXPECTATION OF PROGRAM:

1. Therapeutic Behavioral Services (TBS) are a supplemental mental health service. TBS must be provided in conjunction with mental health services provided by a CCMHP organization provider clinic or contract provider. It cannot be provided on a stand-alone basis.
2. TBS is a short-term, time-limited service. It is intended to be strictly cognitive behavioral and provided in the child’s normal environment.
3. Contra Costa Mental Health Plan will contract with community-based organizations to provide this service.
4. The contract agency will provide intensive, one-to-one TBS services with identified consumers.
5. TBS services will be provided under the direction of a licensed practitioner of the healing arts (LPHA) including, MFTs, Interns, LCSWs and licensed or waived Psychologists. The contract agency is responsible for providing a list of name of clinicians providing supervision to the TBS Authorization Office.

VII. CRITERIA FOR TBS SERVICES:

1. Child/youth has Full-Scope Medi-Cal with Contra Costa County.
3. Child/youth is under the age of 20 years.
4. Identified consumer must meet any of the following criteria to be eligible for certified class membership (receive TBS services):
   a. Child/youth is placed in a group home facility of RCL 12 or above and/or locked treatment facility for the treatment of mental health needs; OR
   b. Child/youth is being considered by the county for placement in a facility described above; OR
   c. Child/youth has undergone, at least, one emergency psychiatric hospitalization related to his/her current presenting disability within the preceding 24 months; OR
   d. Child/youth has previously received TBS services while a member of the class.
5. Documentation must be provided with the following information:
   a. Child/youth is receiving other specialty mental health services and
   b. It is highly likely in the clinical judgment of the mental health provider that
      without additional short term support of TBS, the child/youth
      i. Will need to be placed in a higher level of residential care, including acute
         care because of changes in the child/youth's behaviors or symptoms,
         which places a risk of removal from the home or residential placement; OR
      ii. Will need this additional support to transition to a lower level of
         residential placement or return to the natural home.

VIII. PROCEDURE:

A. REFERRAL PROCESS

1. Contra Costa Health Plan organization provider clinician (County operated or
   community-based organization (CBO) contract agency) identifies a child/youth
   who qualifies for TBS (see section VII: Criteria for TBS).
   a. If the clinician determines that the consumer meets criteria for TBS and a
      referral for TBS services is made, the referring clinician should consult
      with his/her supervisor and TBS coordinator/team leader to obtain the
      TBS coordinator’s approval and signature.

2. The clinician must complete a TBS Referral Packet consisting of the following:
   a. Completed TBS referral checklist and cover sheet.
   b. Completed TBS referral form, Parts 1 and 2.
   c. Copy of current clinical assessment or psychosocial assessment.
   d. Copy of current Partnership Plan for Wellness.
      i. Clinician must update Partnership Plan for Wellness to indicate TBS as
         a service modality.
   e. Copy of current Consent to Participate in Coordinated Services
   f. Any other clinical information that would be helpful for the TBS provider
      to have (e.g., recent IEP, recent report from group home, psychological
      testing report, school reports regarding consumer’s behavior).

3. The TBS Referral Packet must be sent back to the County office.

4. The TBS Referral Packet will be reviewed by the TBS team leader/coordinator to
   ensure that the referral criteria are met and that the referral is appropriate and
complete. We ask the provider to obtain and send a signed approval of the referral by supervisor/manager.

5. All providers are informed to call County TBS Coordinator/Team Leader to discuss referrals before they are made to minimize the use of processing NOA’s.

6. If a referral was made and the case is deemed inappropriate or does not meet Medical Necessity Criteria, the TBS team leader will consult with the referring clinician. If indicated, a NOA will be initiated. Consumers and/or their authorized representative are informed both verbally and in writing of a proposed deferral, denial, modification, reduction, termination, or delay.

B. EXPEDITED AUTHORIZATION

1. Should a TBS provider identify a child/youth who meets criteria for TBS services, the TBS provider may complete the referral packet and request expedited TBS authorization to begin providing services.

2. The TBS Coordinator/Team Leader will respond within three (3) working days with notification of authorization/denial of expedited TBS expedited authorization is notes on the referral page.

C. NOTIFICATION OF TBS SERVICES

1. If accepted, the case will be assigned to a TBS provider. Notice of authorization is sent to TBS provider and the case manager or referring clinician.

2. The TBS Coordinator/Team Leader will notify the UR Clerical Specialist at the end of each week to include TBS Service on Service Authorization form (MHC 36-5 1/08).
   a. The County will make every effort to place the consumer as soon as possible after the TBS authorization. If unable to place with appropriate TBS provider in a timely manner, a NOA-E will be issued.
   b. TBS team leader will keep the referring clinician notified of the authorization and placement status.

3. An Initial Notification to the State Department of Mental Health regarding provision(s) of TBS. A completed form must be submitted by mail or faxed within the first thirty (30) days of billable contact between beneficiary and the staff clinician providing the one-to-one service.

4. NOA will be sent to DMH within (30) thirty days of issuance.
D. AUTHORIZATION PROCESS

1. If the TBS referral is deemed to meet the Medical Necessity Criteria, ten (10) hours of plan development will be authorized to the TBS service provider.

2. Direct service(s) may be delivered after TBS Provider has completed the required plan developmental/assessment for review and approval by the TBS Authorization Committee.

3. Approval of authorization to continue TBS services is granted when the initial TBS Form is sent to the TBS provider.
   a. Upon receipt of final plan and request for TBS payment authorization, TBS Coordinator will review and authorize TBS services.
   b. TBS service authorization form will be completed and faxed to the agency detailing the authorized number of hours per week, (not to the approved authorized hours) and the date the final plan is due.
   c. Final plan initialed must be reviewed to ensure that the required information and components are present prior to granting authorization.

4. TBS Final Plan (initial).
   a. Final plan based on history provided via Referral Packet must be submitted to TBS Coordinator/Team Leader within thirty (30) days. The Service Plan must have the following signatures: TBS service provider and TBS provider/service agency-licensed clinician, legal guardian, consumer and TBS provider.
   b. TBS Final Plan must be signed by the following:
      i. Consumer.
      ii. Parent/guardian/legal responsible party (mandatory if consumer is a minor under the age of 12).
      iii. TBS service provider.
      iv. TBS provider/service agency listed clinician (if direct service provider is not licensed).
      v. TBS Contra Costa County Authorization.
      vi. Behavioral Consultant Signature.
   c. If signature of consumer and/or parent/legal guardian cannot be obtained, a dated progress note must also be submitted, which details why the signatures were not obtained as well as subsequent attempts to obtain signatures.
   d. TBS service plan must consist of the following components:
i. Target behavior: specific description of the behavior jeopardizing placement. Description must include the frequency and severity of behavior and how it puts the consumer at risk of losing current placement.

ii. Function of Behavior.

iii. Triggers/precipitants to behavior.

iv. Strengths/motivators/environmental supports.

v. Interventions.

vi. Positive replacement behavior.

vii. Measurable outcome(s). Must be described in specific detail, including reduction of frequency and severity.

viii. Any anticipated barriers to success.

ix. Fade-out Plan (description when TBS services will be reduced and terminated using specific behavioral criteria).

x. Family/support giver transition plan (how will consumer, parent/caregiver and ongoing service providers continue progress achieved).

5. If the plan meets all the criteria and components, the TBS Coordinator/Team Leader will complete the TBS authorization form and fax it to the agency detailing the authorized number of hours/week and the date the monthly report is due.

6. If presented documents are insufficient to grant service authorization, the TBS Coordinator will consult with TBS provider as needed on how they can submit adequate documentation.

7. If requesting TBS payment for reauthorization, TBS service provider must complete and submit the following:

   a. A request for TBS payment authorization.

   b. A TBS monthly report. The TBS provider must complete a TBS monthly report and must outline the following components:

      i. Status regarding behavior goals must state whether behavioral goals have been achieved, progress or no change took place, or regression occurred.

      ii. Changes in the consumer’s residence. Information should include episodes of 5150s and hospitalizations in the past month.

      iii. Target behaviors currently being addressed (exactly as it appears on the final plan).
iv. Current Progress (List in terms of current frequency, intensity and duration of target behavior).

v. Interventions and Replacement Behaviors (discuss replacement behaviors, how generalization is promoted, include motivators, describe success of interventions during this reporting period, and discuss efforts at involving caregivers in interventions).

vi. Barriers to Success.


viii. Collateral Contacts

ix. Other Services, Current and Recommended

x. Monthly report must be signed/dated by the TBS service provider completing the form.

xi. If TBS service provider is not licensed or designated as a MHRS, a co-signature is required from the TBS agency licensed clinician.

8. Upon receipt of TBS monthly report and request for TBS payment authorization, CCMHP designated authorizing agents will review and if complete & adequate, will authorize TBS services.

9. If an authorization is granted, the TBS Coordinator/Team Leader member will complete the Authorization Form and fax it to the agency detailing the authorized number of hours/week and the date the monthly report is due.

10. TBS may be continued even after a child/youth has met the behavior goals in his/her TBS plan when TBS is still medically necessary to stabilize the child/youth’s behavior and reduce the risk of regression. The TBS service provider shall reflect this change in progress notes and a revised TBS service plan.

11. If the TBS service is focusing on different target behaviors from those previously authorized, an addendum plan must be submitted to the TBS Coordinator/Team Leader.
   a. The addendum treatment plan must consist of the following:
      i. New Target Behavior (description must include frequency, intensity, duration, latency, severity of behavior and how it puts the consumer at risk of losing current placement or support placement in lower level).
      ii. Function of New Behavior.
### Contra Costa County
Health Services Department
Behavioral Health Division - Mental Health Plan

#### POLICY:

**Utilization Review: Therapeutic Behavioral Services (TBS)**

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<td>Review Date: June 12, 2016</td>
<td>DATE APPROVED:</td>
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<tr>
<td>Initial Approval: February 11, 2005</td>
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iii. Positive Replacement Behavior.

v. Measurable Outcome.

vi. Describe any other changes.

b. Addendum treatment plan must be signed/dated by the following:
   i. Consumer
   ii. Parent/guardian/legal responsible party (mandatory if the consumer is a minor under the age of 12)
   iii. TBS service provider
   iv. TBS provider/service agency listed clinician (if direct service provider is not licensed)
   v. Contra Costa County Authorization
   vi. Behavioral Consultant Signature

c. An authorized agency representative must sign the attestation notice found at the bottom of the TBS payment authorization form.

### E. Termination Process

1. Termination of service shall commence once one of the following criteria has been met:
   a. Consumer has met behavioral goals as specified in TBS service plan.
   b. Consumer has not shown significant progress at four-months/sixteen weeks benchmark and it has been determined that TBS is not an effective tool/service for this consumer.

2. Termination of service may also commence if one of the following conditions exist:
   a. Consumer’s Medi-Cal eligibility changes:
      i. Consumer is no longer Contra Costa Medi-Cal eligible.
      ii. Consumer no longer has Full Scope Medi-Cal.
   b. Termination due to TBS provider agency personnel change.
      i. It is the TBS provider agency’s responsibility to find a new coach within five (5) working days. If unable to find a replacement within the agency, the case should be terminated at that agency and must notify CCMHP. CCMHP will refer the case to another TBS program to continue care.

3. Termination Report and Episode Closing Form must be submitted within two (2) weeks of termination of service.
a. Termination Report must summarize service(s) provided and outline recommendations provided to consumer and family/support persons.

F. TBS AUDIT/REVIEW PROTOCOL

1. Contra Costa Mental Health Plan requires agencies providing TBS to undergo random chart reviews. Utilization review staff along with TBS Coordinator will order random samples and use protocol tool to conduct review. In addition to the above, TBS providers are expected to conduct their own in house reviews to ensure compliance with title 9 regulations.

2. TBS provider agencies must provide their TBS medical record(s) for audit/review.

3. The purpose of the audit is to ensure the following:
   a. Contra Costa Mental Health Plan documentation standards are being met by TBS provider agencies.
   b. Progress or lack of progress is accurately documented within their progress notes
   c. Documentation, which indicates parents/legal guardian and/or support persons are receiving training/assistance so that progress will be maintained after TBS services are terminated.
   d. Documentation that indicates communication between County or contract agency clinician (County Mental Health point person) at a minimum of one (1) time per month.
   e. Documentation is located for each service claimed.
   f. If applicable, documentation that justifies an increase or decrease in recommended hours of service(s). It is expected that the number of hours will decrease as service progresses.
   g. Documentation indicates transition plans and when the beneficiary not a minor (18-20). The transition plan will involve parents, caregivers or significant support persons in the beneficiary life only with appropriate consent from the beneficiary.

4. If, after TBS chart review, documentation of a direct service is found not to meet TBS documentation standards, the TBS provider agency will receive a notice that the claim for that direct service is subject to disallowance.
**POLICY:**  DOCUMENTATION REQUIREMENTS: EPISODE CLOSING/BILLING PROCEDURES

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**I. PURPOSE:**

The purpose of this policy is to ensure that Contra Costa Mental Health Plan (CCMHP) service providers close consumer episodes in a timely manner. In addition, the policy will outline what documentation requirements exist and how service providers shall bill the closing activity.

**II. REFERENCES:**

Title, 9, California Code of Regulations, Chapter 11
Contra Costa Mental Health Plan for Consolidated Specialty Medi-Cal Mental Health Services.

**III. POLICY:**

It is the policy of Contra Costa Mental Health Plan that service providers complete required closing documents for the medical record and correctly bill this activity when one of the following conditions exists: 1) A decision has been made to discontinue services, 2) Consumer has dropped out or has not received services within the last six months, 3) Consumer is deceased.

Under some circumstances, an episode may not be closed in order to maintain the UR track, i.e., if the consumer is only receiving services from a contract agency.

**IV. AUTHORITY/RESPONSIBILITY:**

CCMHP Service Provider
Program Supervisor/Manager
Utilization Review/Clerk
Clinic Coordinator/Clerical Staff
Medical Record Staff

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**POLICY NO. 711**

Review Date: February, 2017

Date Initial Approval February 2005
Date Reviewed: February 26, 2014

By: [Signature]

Cynthia Belon, LCSW
Director of Behavioral Health
V. PROCEDURE:

A. REQUIRED FORMS FOR CLOSING DOCUMENTATION

1. Mental Health Discharge Summary/Billing Form (MHC 22), or Administrative Discharge/Summary Form MHC022A) or Progress Note/Billing Form (MHC 17-9, MHC 055-9).
2. CSI Update Form (MHC 28-4).
3. Closing Portion of the Episode Opening/Closing Form (MHC 099)
4. Unusual Occurrence Notification Form (if applicable) (MHA 021-4).

B. CLOSING PROCEDURE FOR PLANNED DISCHARGES

For all planned discharges, the following must occur:

1. Documentation in a Progress Note/Billing Form of plan to discontinue services.
2. Completion of the required closing documentation.
   a. Mental Health Discharge Summary/Billing Form or Progress Note/Billing Form.
   b. CSI Update Form.
   c. Closing Portion of the Episode Opening/Closing form.
      i. Clinician must designate a “Reason for Discharge.”
3. If a decision regarding termination was given during a session, the service provider must document the closing by completing either a closing summary on Progress Note/Billing Form or the Mental Health Discharge Summary/Billing Form.
   a. If the clinician uses the Progress Note/Billing Form for the discharge summary, the progress note should contain:
      i. Discharge diagnosis, course and dates of treatment, discharge medications and outcomes, discharge plans and referrals.
      ii. Clinician must document a Reason for Discharge in the narrative of the note.
4. Episode Opening/Closing form shall be forwarded to Utilization Review (UR) Clerk for review and closure approval.
   a. Under some circumstances, the episodes may not be closed in order to maintain the UR track, if the consumer is receiving services from a contract agency.
5. MRT/medical records staff shall ensure that all progress notes and closing documentation have been interfiled within the medical record and will file the chart in the inactive section.
6. Claiming documentation time.
a. Use the most appropriate from the following list of procedures codes:
   i. 315 Plan Development
   ii. 571 Case Management Plan Development
   iii. 364 Medication Support: Plan Development
b. Must be done within five (5) days of last contact or notification of planned discontinuance of services.
c. Should be for the purpose of documenting decision making regarding medical necessity, or
d. Documentation should be such that consumer will benefit, i.e., to ensure continuity of care, or to facilitate the communication of pertinent information to another provider.
e. If these requirements described in b, c, and d are not met, non-billing codes shall be used.
   i. 540 Non-Medi-Cal billable MHS
   ii. 560 Non-Medi-Cal billable CM
   iii. 580 Non-Medi-Cal billable Lockout (Jail/Juvenile Hall, IMD)

C. CLOSING PROCEDURE FOR CONSUMER WHO HAS DROPPED OUT OR HAS NOT RECEIVED SERVICES FOR SIX (6) MONTHS

If a consumer has dropped out, or has not received services for six (6) months, the service provider must document and close the episode. Regarding medication only clients, the episodes closing at 6 months is at the discretion of the psychiatrist. However, medication only clients that have not received services for one (1) year should be closed. The following shall take place:

1. If appropriate, document attempts and any responses made to contact the consumer.
2. Completion of required closing documentation.
   a. Mental Health Discharge Summary/Billing Form or Progress Note/Billing Form
   b. CSI Update Form
   c. Closing Portion of the Episode Opening/Closing form
      1. Clinician must designate a “Reason for Discharge”.
3. Episode Opening/Closing form shall be forwarded to Utilization Review (UR) Clerk for review and closure approval.
   a. Under some circumstances, the episodes may not be closed in order to maintain the UR track, if the consumer is receiving services from a contract agency.
4. MRT/medical records staff shall ensure that all progress notes and closing documentation have been interfiled within the medical record and will file the chart in the inactivate section.
a. Non-billing codes shall be used for administrative closing of non-active clients.
   i. 540 Non-Medi-Cal billable MHS
   ii. 560 Non-Medi-Cal billable CM
   iii. 580 Non-Medi-Cal billable Lockout (Jail/Juvenile Hall, IMD)

D. CLOSING PROCEDURE FOR DECEASED CONSUMER

Upon notification of consumer’s death, the following must occur:
1. Documentation of notification of consumer’s death on Progress Note/Billing Form for medical record.
   a. Procedure Code 540, non-Medi-Cal billable Mental Health Service, shall be used for all closing activity and for any service provided to the consumer’s family. (Consumer’s benefits cease upon his/her death.)

2. Completion of required closing documentation:
   a. Mental Health Discharge Summary/Billing Form or Progress Note/Billing Form
   b. CSI Update Form
   c. Closing Portion of the Episode Opening/Closing form
   d. Unusual Occurrence Notification Form.

3. Unusual Occurrence Notification Form should be completed in accordance with CCMHP Policy No. 806, and forwarded to Mental Health Administration. It is not to be filed in, or referred to in the medical record.

4. Episode Opening/Closing form shall be forwarded to Utilization Review (UR) Clerk for review and closure.
   a. Clinician must signify “Reason for Discharge” as “6” = Consumer Died” in the closing episode data.

5. MRT/medical records staff or medical record clerk shall ensure that all progress notes and closing documentation have been interfiled within the medical record and will deliver the medical record to Office of Quality Improvement, CCMHP Administrative Suite.