Assessment & Treatment Plan Day Treatment & Intensive In-Home Therapy Services

CHORUS COMMUNITY HEALTH PLANS

Please submit as attachment via CCHP Provider Portal or fax to: **(414) 266-4726** **DATE:** _____

SECTION 1: MEMBER INFORMATION

NAME (FIRST, MIDDLE INITIAL, LAST)	MEMBER'S DATE OF BIRTH (MM/DD/YYYY)
MEMBER NUMBER (ON MEMBER ID CARD)	

SECTION 2: RENDERING PROVIDER INFORMATION

RENDERING PROVIDER NAME	RENDERING PROVIDER NPI NUMBER
RENDERING PROVIDER PHONE NUMBER	RENDERING PROVIDER CREDENTIALS

ENTER THE NAME AND CREDENTIALS OF THE SECOND TEAM MEMBER. INCLUDE HIS OR HER DEGREE AND THE NUMBER OF HOURS OF SUPERVISED CLINICAL WORK HE OR SHE HAS DONE WITH SEVERE EMOTIONAL DISTURBANCES (SED) CHILDREN IN THE SPACE PROVIDED. (FOR INTENSIVE IN-HOME THERAPY ONLY.)

SECTION 3: COORDINATION OF CARE

DOCUMENT YOUR COORDINATION OF SERVICES WITH THE SERVICE SYSTEMS NOTED ABOVE. PROVIDE THE CONTACT INFORMATION FOR THE PRIMARY INDIVIDUAL WORKING WITH THE CHILD, THE TYPES OF SERVICES PROVIDED AND THE GOALS THAT AGENCY IS ADDRESSING AND HOW YOU'RE COORDINATING WITH THE RESPECTIVE PROVIDER/ ENTITY. NOTE PROGRESS SEEN IN EACH AREA SINCE THE LAST REVIEW (N/A FOR INITIAL REQUEST).

CARE COORDINATING AND PLANNING

1. PCP OR PEDIATRICIAN	CLINIC AND CONTACT INFORMATION

CURRENT SERVICES PROVIDED:

GOAL (MEASURABLE):

DESCRIBE PROGRESS SINCE LAST REVIEW:

2. PSYCHIATRIST	CLINIC AND CONTACT INFORMATION

CURRENT SERVICES PROVIDED:

GOAL (MEASURABLE):

DESCRIBE PROGRESS SINCE LAST REVIEW:

SECTION 3: CARE COORDINATING AND PLANNING (continued)

3. THERAPIST	CLINIC AND CONTACT INFORMATION
CURRENT SERVICES PROVIDED:	
GOAL (MEASURABLE):	
DESCRIBE PROGRESS SINCE LAST REVIEW:	

4. CASE MANAGER	CLINIC AND CONTACT INFORMATION
CURRENT SERVICES PROVIDED:	
GOAL (MEASURABLE):	
DESCRIBE PROGRESS SINCE LAST REVIEW:	

5. SCHOOL PERSONNEL	SCHOOL AND CONTACT INFORMATION
CURRENT SPECIAL EDUCATION SERVICES PROVIDED. (PLEASE SPECIFY IF ON IEP OR 504 PLAN.)	
GOAL (MEASURABLE):	
DESCRIBE PROGRESS SINCE LAST REVIEW:	

6. JUVENILE COURT PERSONNEL	AGENCY AND CONTACT INFORMATION
CURRENT SERVICES PROVIDED:	
GOAL (MEASURABLE):	
DESCRIBE PROGRESS SINCE LAST REVIEW:	

SECTION 3: CARE COORDINATING AND PLANNING (continued)

7. OTHER	AGENCY AND CONTACT INFORMATION
CURRENT SERVICES PROVIDED:	
GOAL (MEASURABLE):	
DESCRIBE PROGRESS SINCE LAST REVIEW:	

SECTION 4: BIO PSYCHOSOCIAL ASSESSMENT

8. COMPLETE THE CHECKLIST BELOW TO DETERMINE WHETHER OR NOT THE INDIVIDUAL MEETS THE CRITERIA FOR SED. CRITERIA FOR MEETING THE FUNCTIONAL SYMPTOMS AND IMPAIRMENTS ARE FOUND IN THE INSTRUCTIONS. THE DISABILITY MUST BE EVIDENCED BY A,B,C AND D LISTED BELOW.

A. PRIMARY PSYCHIATRIC DIAGNOSIS OF MENTAL ILLNESS OR SED. DOCUMENT DIAGNOSIS USING THE MOST RECENT VERSION OF THE ICD-10.

PRIMARY DIAGNOSIS:_____ SECONDARY DIAGNOSIS: _____

B. SYMPTOMS

- ☐ PSYCHOTIC SYMPTOMS
- ☐ SUICIDAL
- ☐ VIOLENCE

FUNCTIONAL IMPAIRMENTS

- ☐ FUNCTIONING IN SELF CARE
- ☐ FUNCTIONING IN THE COMMUNITY
- ☐ FUNCTIONING IN SOCIAL RELATIONSHIPS
- ☐ FUNCTIONING IN THE FAMILY
- ☐ FUNCTIONING AT SCHOOL / WORK

C. DESCRIBE THE CURRENT SYMPTOMS / PROBLEMS

☐ ANXIOUSNESS	☐ HALLUCINATIONS	☐ OBSESSIONS / COMPULSIONS	☐ SEXUAL ISSUES
☐ APPETITE DISRUPTION	☐ HOMICIDAL	☐ OPPOSITIONAL	☐ SLEEPLESSNESS
☐ DECREASED ENERGY	☐ HOPELESSNESS	☐ PANIC ATTACKS	☐ SOMATIC COMPLAINTS
☐ DELUSIONS	☐ HYPERACTIVITY	☐ PARANOIA	☐ SUBSTANCE USE
☐ DEPRESSED MOOD	☐ IMPAIRED CONCENTRATION	☐ PHOBIAS	☐ SUICIDAL
☐ DISRUPTION OF THOUGHTS	☐ IMPAIRED MEMORY	☐ POLICE CONTACT	☐ TANGENTIAL
☐ DISSOCIATION	☐ IMPULSIVENESS	☐ POOR JUDGMENT	☐ TEARFUL
☐ ELEVATED MOOD	☐ IRRITABILITY	☐ SCHOOL PROBLEMS	☐ VIOLENCE
☐ GUILT	☐ MANIC	☐ SELF- INJURY	☐ WORTHLESSNESS

D. COMPREHENSIVE HISTORY SUPPORTING THE ABOVE:

SEVERITY OF SYMPTOMS: ☐ MILD ☐ MODERATE ☐ SEVERE

9. PLEASE DEFINE FREQUENCY, TENDENCY, DURATION, ETC.:

10. PLEASE PROVIDE DEVELOPMENTAL HISTORY:

SECTION 4: BIO PSYCHOSOCIAL ASSESSMENT (continued)

11. THE INDIVIDUAL IS RECEIVING SERVICES FROM ONE OR MORE OF THE FOLLOWING SERVICE SYSTEMS IN ADDITION TO THE MENTAL HEALTH SERVICE SYSTEM. (THE MULTI-AGENCY TREATMENT PLAN MUST BE DEVELOPED BY REPRESENTATIVES FROM ALL SYSTEMS IDENTIFIED ON THE SED ELIGIBILITY CHECKLIST, ADDRESS THE ROLE OF EACH SYSTEM IN THE OVERALL TREATMENT AND THE MAJOR GOALS FOR EACH AGENCY INVOLVED.)

- ☐ SOCIAL SERVICES
- ☐ CHILD PROTECTIVE SERVICES
- ☐ JUVENILE JUSTICE
- ☐ SPECIAL EDUCATION
- ☐ OTHER (PLEASE DEFINE):

12. MEDICAL AND MEDICATION HISTORY:

13. HAS THERE BEEN A CONSULTATION TO CLARIFY DIAGNOSIS / TREATMENT? ☐ YES ☐ NO (IF YES, BY WHOM?)

- ☐ PSYCHIATRIST
- ☐ APNP/PSYCHIATRY / MH SPECIALTY
- ☐ MASTER'S LEVEL PSYCHOTHERAPIST
- ☐ SUBSTANCE ABUSE COUNSELOR
- ☐ PH.D. PSYCHOLOGIST
- ☐ OTHER: _____

SECTION 5: RECOVERY / TREATMENT PLAN

Document the goals and objectives to meet those goals on the recovery/ treatment plan that is based on the strength-based assessment. Document the signs of improved functioning that will be used to measure progress toward specific objectives at identified intervals, agreed upon by the provider and member. Please supply copies of any completed assessments.

14. TREATMENT PLAN, AS AGREED UPON WITH THE MEMBER. ATTACH YOUR TREATMENT PLAN OR FILL OUT THE INFORMATION BELOW. PLEASE ENSURE THIS SECTION INCLUDES COMPREHENSIVE TREATMENT PLAN GOALS, MEASURABLE ACCOMPLISHMENTS RELATED TO TREATMENT PLAN GOALS, EXPECTED DURATION OF TREATMENT AND DETAILED PLAN FOR DISCHARGE.

SHORT-TERM (WITHIN ONE TO THREE *WEEKS*):

LONG-TERM (WITHIN ONE TO THREE *MONTHS*):

WHAT ARE THE THERAPIST/MEMBER AGREED UPON SIGNS FOR IMPROVED FUNCTIONING?	DESCRIBE PROGRESS SINCE LAST REVIEW	CHANGES IN GOAL/ OBJECTIVE
1.		
2.		
3.		
4.		

15. INDICATE THE RATIONALE FOR REQUESTED LEVEL OF CARE. FOR AN INITIAL PRIOR AUTHORIZATION (PA) REQUEST, PROVIDE A DETAILED HISTORY OF ALL PREVIOUS MENTAL HEALTH SERVICES UTILIZED BY THIS CHILD, PARTICULARLY HIGHLIGHTING ATTEMPTS AT MAINTAINING THE CLIENT IN A LOWER LEVEL OF CARE (E.G., OUTPATIENT COUNSELING). NOTE THE REASONS WHY THIS TREATMENT WAS NOT SUCCESSFUL AND HOW THE REQUESTED SERVICE WILL BETTER MEET THE MEMBER'S NEEDS. FOR A CONTINUING PA REQUEST, IF LITTLE OR NO PROGRESS IS REPORTED, DISCUSS WHY THE PROVIDER BELIEVES FURTHER TREATMENT IS NEEDED AND HOW THE PROVIDER PLANS TO ADDRESS THE NEED FOR CONTINUED TREATMENT. WHAT STRATEGIES WILL THE PROVIDER, AS THE THERAPIST, USE TO ASSIST THE MEMBER IN MEETING HIS OR HER GOALS? IF PROGRESS IS REPORTED, GIVE RATIONALE FOR CONTINUED SERVICES.

SECTION 5: RECOVERY / TREATMENT PLAN (continued)

16. INDICATE THE EXPECTED DATE FOR TERMINATION OF REQUESTED SERVICE. DESCRIBE ANTICIPATED SERVICE NEEDS AND DETAILED AFTERCARE PLANS FOLLOWING COMPLETION OF DAY TREATMENT OR INTENSIVE IN-THERAPY AND TRANSITION PLANS.

17. IS MEMBER TAKING ANY PSYCHOACTIVE MEDICATION? ☐ YES ☐ NO	NAME/ CREDENTIALS OF PRESCRIBER:
	DATE OF LAST MEDICATION CHECK:

18. IF YES, NOTE WORK WITH THE PRESCRIBER PROVIDER TO COORDINATE CARE.

19. IF YES, LIST PSYCHOACTIVE MEDICATIONS AND DOSAGES (ATTACH LIST IF ADDITIONAL SPACE IS NEEDED).

MEDICATION AND DOSAGES	TARGET SYMPTOMS
MEDICATION AND DOSAGES	TARGET SYMPTOMS
MEDICATION AND DOSAGES	TARGET SYMPTOMS

20. IF NO, DETAIL REASONS FOR LACK OF MEDICATION.

SECTION 6: SIGNATURES

SIGNATURE - CERTIFIED PSYCHOTHERAPIST / SUBSTANCE ABUSE COUNSELOR	CREDENTIALS	DATE SIGNED
SIGNATURE - MEMBER / LEGAL GUARDIAN		DATE SIGNED

INTERPRETER SERVICES

Chorus Community Health Plans (CCHP) complies with all applicable civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age, disability, or other legally protected status, in its administration of the plan, including enrollment and benefit determinations.

- On-site interpreter services are provided to CCHP members through Language Source.
- Telephonic interpreter services are provided to CCHP members through Pacific Interpreters. Please call a Provider Relations Representative to request this service at **1-844-229-2775**
- For sign language services, call a CCHP Member Advocate at **1-877-900-2247.**

Language Source

- Phone: (414) 607-8766
- Fax: (414) 607-8767
- Pager: (414) 201-0014Email: schedule@langsource.com
- TTY users, call: 711