**This report is a(n):  Initial Treatment Plan  Treatment Plan Update  Discharge Summary**

**Modality:  Individual  Conjoint/Family**

**If this is an Initial Treatment Plan (ITP), the due date to Optum TERM is within 14 calendar days of the initial authorization start date.**

**For Medi-Cal funding:** Authorization for continued services is dependent on Medical Necessity review of the ITP. Providers will be notified of determination within fourteen (14) business days of ITP submission.

**NOTE:** Treatment Plan Updates are due every 12 weeks after ITP due date.

|  |  |  |  |
| --- | --- | --- | --- |
| Provider: |  | Phone: | Fax#: |
| SW Name: |  | SW Phone: | SW Fax: |
| **ATTENDANCE** | | | |
| Date of Initial Session: Click or tap to enter a date. | | Last Date Attended: Click or tap to enter a date. | Number of  Sessions Attended: |
| Date of Absences: | | Reasons for Absences: | |
| Service Delivery Type: Telehealth  In-Person | | Service delivery type has been assessed and continues to be clinically appropriate: Yes  No | |

**The child or youth has been referred for individual or group treatment because formal mental health services have been recommended to address identified mental health concerns and functional impairment (behaviors).**

**I received and reviewed the following records provided by the PSW or Optum (required prior to the intake assessment):**

**For cases involving Juvenile Court:**

Therapy Referral Form (04-176A)

Case Plan

Child and Adolescent Needs & Strengths (CANS)

Court Reports (e.g., Detention Hearing Report, Jurisdiction/Disposition Report, etc.)

Copies of additional significant court reports, if available

Authorization to Use or Disclose Private Health Information (04-24A-P or 04-29) or Special Matter Order (SMO) - Release of Health InformationOrder

**For Voluntary Services Cases:**

Case Notes

**Additional Items as applicable:**

Copies of all prior psychological evaluation(s) and treatment plan(s)

All prior mental health and other pertinent records

Copies of History & Physical and Discharge Summary written by psychiatrist

Consent to Treat (04-24P or 04-24C)

IEP (and Triennial evaluation)

Other (please describe):

**RISK ASSESSMENT:**

**(**Risk factors must be addressed with treatment goals and plan below)

|  |  |  |
| --- | --- | --- |
| **Date(s) of Assessment:** *Click or tap to enter a date.*  (This should be ongoing and include all risk factors documented on the 04-176A and known to the provider): | **Suicidal**: | N/A     Ideation     Plan    Intent    Hopelessness  Family History  History of Self-Harm/Suicide Attempt  History of hospitalizations |
| **Homicidal:** | N/A  Ideation  Plan  Intent    Current  History of harm to others     History of hospitalizations  Family History |
| **Other Risk Considerations:** | |  |  | | --- | --- | | Psychotic Symptoms | Violent Behavior(s) | | Substance Abuse | Bullying (aggressor or victim) | | Recent Loss or Critical Event  Refugee/Asylum | Lived Discrimination/Marginalization (e.g., racial, cultural, gender identity, sexual orientation) | | CSEC/Human Trafficking | Disordered Eating | | Adaptive Living Skills (including medication compliance) | Other e.g., prior child abuse history, trauma history, social isolation, lack of support system, medical co-morbidity, etc. (please describe): | |
| Date of Last Hospitalization: Click or tap to enter a date.  Description of Last Hospitalization:  Date of Last Incident (self-harm, aggression, etc.): Click or tap to enter a date.  Description of Last Incident: | | |

**TREATMENT GOALS:**

|  |
| --- |
| Per the TERM Provider Handbook, treatment goals for youth should focus on ameliorating the effects of the abuse and neglect. Treatment issues are directly related to the child and youth’s social, emotional, and/or behavioral symptoms and functioning.  **NOTE:** Treatment goals and interventions should be measurable and may change over time. For each update, please include new progress in applicable section and do not delete previous entries. Add/delete rows as needed. |
| **TREATMENT GOAL:**  **EVIDENCE BASED TREATMENT INTERVENTIONS UTILIZED (e.g., CBT, TF-CBT):**  **Update progress in applicable section below (supported with behavioral examples). Include date of update(s) below.**  **ITP:**  **First Update:**  **Second Update:**  **Third Update:**  **Fourth Update:** |

|  |
| --- |
| **TREATMENT GOAL:**  **EVIDENCE BASED TREATMENT INTERVENTIONS UTILIZED (e.g., CBT, TF-CBT):**  **Progress since last treatment report and how assessed (i.e., changes in symptoms and biopsychosocial functioning) as reported by child/youth, caregiver, and or SW. Include date of update(s) below.**  **ITP:**  **First Update:**  **Second Update:**  **Third Update:**  **Fourth Update:** |
| **TREATMENT GOAL:**  **EVIDENCE BASED TREATMENT INTERVENTIONS UTILIZED (e.g., CBT, TF-CBT):**  **Progress since last treatment report and how assessed (i.e., changes in symptoms and biopsychosocial functioning) as reported by child/youth, caregiver, and or SW. Include date of update(s) below.**    **ITP:**  **First Update:**  **Second Update:**  **Third Update:**  **Fourth Update:** |
| **TREATMENT GOAL:**  **EVIDENCE BASED TREATMENT INTERVENTIONS UTILIZED (e.g., CBT, TF-CBT):**  **Progress since last treatment report and how assessed (i.e., changes in symptoms and biopsychosocial functioning) as reported by child/youth, caregiver, and or SW. Include date of update(s) below.**    **ITP:**  **First Update:**  **Second Update:**  **Third Update:**  **Fourth Update:** |

**DISCHARGE SUMMARY:**

|  |  |
| --- | --- |
| Date of Discharge: Click or tap to enter a date. | Date SW Notified: Click or tap to enter a date. |
| Reason for Discharge:  ☐ Successful completion/met goals\* ☐ Poor attendance ☐ Office of Child Safety Case Closed   ☐ Other (specify): | |

**I have reviewed this plan with the youth in an age/developmentally appropriate manner. Date of review:**

**DIAGNOSIS:** List your diagnostic impressions of the child/youth. Record as many coexisting mental disorders, general medical conditions, and other factors as are relevant to the care and treatment of the individual.

The Primary Diagnosis should be listed first:

|  |  |
| --- | --- |
| **ICD-10 Code** | **DSM-5-TR Diagnosis** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**NOTE: Provider must document diagnostic criteria met for diagnosis, any diagnostic rule outs, reason for diagnostic changes, and any other significant information.**  **All diagnosis identified on the referral should be included as endorsed, rule out, or criteria not met. If diagnosis was made by previous provider and is being maintained by history, state so.**

|  |
| --- |
|  |

**Brief assessment of youth’s psychosocial functioning (Mental Status Assessment):**

**Child/Youth’s strengths regarding engaging in treatment:**

**Child/Youth’s obstacles regarding engaging in treatment (including ability to engage in current service delivery type):**

**Additional Comments:**

|  |  |
| --- | --- |
| **PROVIDER SIGNATURE:** | |
| Provider Printed Name: | License/Registration #: |
| Signature: | Signature Date: Click or tap to enter a date. |
| Provider Phone Number: | Provider Fax Number: |

|  |  |
| --- | --- |
| ***Required for Interns Only*** | |
| Supervisor Printed Name: | Supervisor Signature: |
| License type and #: | Date: Click or tap to enter a date. |
| Submit Initial Treatment Plan/Update as per the authorized reporting schedule to Optum TERM at Fax: 1(877) 624-8376. Optum TERM will conduct a quality review and will be responsible for forwarding approved Quarterly Progress Reports to the Protective Services Worker.  Date faxed to Optum TERM: Click or tap to enter a date. | | |