Assessment & Treatment Plan Day Treatment Services

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

Section 1: Member Information

Name (First, Middle Initial, Last):	
Member's Date of Birth (MM/DD/YYYY):	
Member's Number (On Member ID Card):	

Section 2: Rendering Provider Information

Rendering Provider Name:	
Rendering Provider NPI Number:	
Rendering Provider Phone Number:	
Rendering Provider Credentials:	

Section 3: Coordination of Care

Document your coordination of services with the service systems noted above. Provide the contact information for primary individual working with the child, the types of services provided and the goals that agency is addressing and how you are coordinating with the respective provider / entity. Note progress seen in each areas since the last review (N/A for initial request).	
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:	

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:	
7. Other:	
Agency and Contact Information:	
Current Services Provided:	
Goal (Measurable):	
Describe Progress Since Last Review:	

Section 4: Bio Psychosocial Assessment (complete this checklist)

A primary psychiatric diagnosis of mental illness. Document diagnosis using the most recent version of the ICD-10.

Primary diagnosis:	Secondary diagnosis:

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

Describe the current symptoms / problems:

☐ Anxiousness	☐ Homicidal	☐ Panic Attacks	☐ Substance Abuse
☐ Appetite Disruption	☑ Hopelessness	☐ Paranoia	☐ Suicidal
☐ Decreased Energy	☐ Hyperactivity	☐ Phobias	☐ Tangential
☐ Delusions	☐ Impaired Concentration	☐ Police Contact	☐ Tearful
☐ Depressed Mood	☐ Impaired memory	☐ Poor Judgment	☐ Violence
☐ Disruption of Thoughts	☐ Impulsiveness	☐ School Problems	☐ Worthlessness
☐ Dissociation	☐ Irritability	☐ Self Injury	
☐ Elevated Mood	☐ Manic	☐ Sexual Issues	
☐ Guilt	☐ Obsessions / Compulsions	☐ Sleeplessness	
☐ Hallucinations	☐ Oppositional	☐ Somatic Complaints	

Comprehensive History Supporting the Above:

Severity of Symptoms: ☐ Mild ☐ Moderate ☐ Severe

Please Define Frequency, Tendency, Duration, Etc.:

Please Provide Developmental History:

Please provide information if the individual is receiving services from one or more of the following service systems addition to the mental health service system. (The multi-agency treatment plan must be developed by representatives and 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):

Medical and Medication History:

Has there been a consultation to clarify diagnosis / treatment?

- ☐ Yes (By Whom?) _____
- ☐ No
- ☐ Psychiatrist
- ☐ APNP / Psychiatry / MH Specialty
- ☐ Master's Level Pscyhotherapist
- ☐ Substance abuse counselor
- ☐ 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.

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.		

16. 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 be better meet the member's needs. For a continuing prior authorization 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.

17. 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.

18. Is member taking any psychoactive medication?

☐ Yes ☐ No

Name / Credentials of Prescriber:

Date of Last Medication Check:

19. If yes, note work with the prescriber provider to coordinate care.

20. If yes, list psychoactive medications and dosages (attach list if additional space is needed).

Medication and Dosages:	Target Symptoms:
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21. 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	