# TERM Network

**Psychotherapy Treatment**

**Provider Application**

**Writing Sample Packet**

Include with Credentialing Application

**Important:** The Writing Sample must be typed.

Handwritten forms will not be accepted**.\***

\* Client Name may be handwritten on the header of the

treatment plan if needed to indicate the identified family member.

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**#1 Writing Sample - PARENTA**

Initial Treatment Plan/Treatment Plan Update: Child Welfare Services PARENT with Mental Health Concerns A

**#2 Writing Sample – CHILD/YOUTHB**

Initial Treatment Plan/Treatment Plan Update: Child Welfare Services CHILD/YOUTH with Mental Health Concerns B

## Hypothetical TERM Case Vignette and Instructions

Please review the following hypothetical TERM case vignette and develop a written individual therapy treatment plan for **ONE** of the family members. Please take into consideration the following instructions when developing your sample plan.

* The sample plan should specify the vignette client for which the plan was developed (Mr. X, Mrs. X, minor age 15, minor age 7, minor age 4).
* Treatment goals should be specific to the presenting concerns and identified safety threats and risk factors for the hypothetical client you have selected.
* Client progress should be related specifically to the identified client’s progress (or lack thereof).
* The writing sample must be typed and completed using the current Youth OR Parent CWS Treatment Plan Form. The form is available at: [www.optumsandiego.com](http://www.optumsandiego.com) (BHS Provider Resources 🡪 TERM Providers 🡪 CWS Treatment)
* The sample plan should reflect your competence in treating Child Welfare Services clients, and should be consistent with the treatment philosophy and documentation requirements outlines in the TERM Provider Handbook and TERM Treatment Plan Documentation Resources located on the Optum website at: [www.optumsandiego.com](http://www.optumsandiego.com) (BHS Provider Resources 🡪 TERM Providers 🡪 Manuals 🡪 TERM Provider Handbook **AND** BHS Provider Resources 🡪 TERM Providers 🡪 CWS Treatment 🡪 TERM Treatment Plan Documentation Resources)

Thank you for your time completing the TERM application and writing sample process and for your shared commitment to delivering quality services to the clients of San Diego County Child Welfare.

## TERM Applicant Writing Sample Vignette

Names/ages of each family member: Mr. X (father) age 38, Mrs. X (mother) age 35, Minor (male) age 15, Minor (female) age 7, Minor (male) age 3.

Safety Threats and Risk Factors: General Neglect, Physical Abuse, Domestic Violence, Mental Health Concerns and Substance Abuse

Services Are:Court-ordered

### Incident that brought the family to CWS attention:

On XX/XX/XX, the hotline received a child abuse report stating Mrs. X was using methamphetamine in the presence of her children. On investigation, the X family home was found to be dirty, and a bag of methamphetamine and drug paraphernalia was found in an area accessible to the minors. The kitchen had a sink full of unwashed dishes and trash was found throughout the house. Children appeared unkempt. Mrs. X was arrested for possession of methamphetamine, drug paraphernalia and felony child endangerment, and was sent to Las Colinas jail. The father, Mr. X, was not home and unable to be located during the time of the incident. The minors were removed from their parents’ care due to the mother's current drug use and inability of both parents to adequately care for and protect their children.

Upon further investigation, Mr. X reported several domestic violence altercations with Mrs. X in the last year, in which Mrs. X was reportedly intoxicated. The children identified Mr. X as the primary aggressor. In addition, children reported they are often babysat by random neighbors while the parents used illegal substances. Both Mr. and Mrs. X have previous mental health concerns.

The children are currently residing with the paternal grandparents and parents have supervised visits with the children once per week. Mother has been recently released from jail and is residing in a sober living facility. Mother may initiate conjoint therapy with the 3-year-old in the near future.

### Prior CWS referrals:

* (2 years ago) Sexual Abuse Substantiated. It was reported that a neighbor who babysat for the minors had inappropriately touched Minor age 7 in her genital region. The neighbor was arrested. Case was closed.
* (3 years ago) General Neglect Substantiated. Minor age 3 was taken into protective custody and became a dependent of Juvenile Court. He tested positive for methamphetamine at birth. The family participated in services and was successfully reunified. Case was closed.

### Why is this service being requested at this time:

* Mrs. X (Mother):Mrs. X has a history of impulsive and dangerous behavior and grandiose ideation. Mrs. X has a tendency to engage in abusive relationships. When Mrs. X lost her children and was incarcerated, she became rageful and panic stricken. She has a childhood history of involvement with Child Welfare due to neglect and substance abuse in her family of origin. Mrs. X has a long history of unsuccessful treatment of drug abuse. She was recently released from jail and is residing in a sober living facility. Mother has been previously diagnosed with Stimulant Use Disorder, R/O Bipolar Disorder, R/O PTSD, and Major Depressive Disorder. In addition, mother has also recently reported difficulty sleeping, having trouble concentrating, reported having crying spells, and irritability. Mother has been hospitalized 2 years ago due to suicidality. Accepts responsibility of true findings.
* Mr. X (Father): Mr. X has a long history of depression and has been hospitalized with two past suicide attempts; he recently acknowledges worsening of depressive symptoms since his children were removed and has endorsed passive suicidal ideation without plan or intent. He has a childhood history of physical abuse, neglect, and exposure to domestic violence in his family of origin. Mr. X reports to have used methamphetamines with his wife at home and states to drink alcohol at least 5x a week after work. Father has been previously diagnosed with Major Depressive Disorder, Mood Disorder NOS, Alcohol Use Disorder, and Stimulant Use Disorder. Mr. X has had two inpatient hospitalizations during the last 5 years due to suicide attempts. The first attempt was by overdose and the second attempt was running into traffic. Mr. X reported to have been prescribed Zoloft in the past but to have not been compliant with medications. Mr. X is currently attending AA groups and reports to have been sober for a month. Per Mr. X he has had unsuccessful treatment for drug use in the past as well. Accepts responsibility of true findings.
* 15-year-old: The grandparents report that the 15-year-old youth is extremely disrespectful, screams profanity when his grandmother attempts to punish him for misbehavior, threatens to hit her, destroys objects in the home when angry, and bullies his 7-year-old sibling. The 3-year-old sibling is reported be very scared when his brother behaves in this manner. The grandparents report that whenever the youth attends school, he exhibits significant difficulties, including hyperactivity, disorganization, lack of attention, and a general disregard for school rules. He has been suspended from school multiple times and is failing most of his classes. The grandparents report that the youth may be abusing drugs, as they recently found drug paraphernalia in his room. The minor refuses to speak about the violence he witnessed between his parents but did disclose to his school counselor that his father has beat him with a belt on several occasions. His grandparents recently found grisly drawings the minor completed in which he depicts multiple nightmares he has had in recent months. The minor's caregivers report that they do not know how to deal with the minor's difficulties and would like assistance in understanding and managing his behavior.
* 7-year-old:According to grandparents the 7-year-old minor is struggling with her mood and having behavioral problems. Services are being requested for emotional and behavioral concerns for the 7-year-old. At school, minor has been having trouble following directions, is disruptive in class and does poorly with her schoolwork. At home, youth is withdrawn, anxious of strangers, and having crying spells, temper tantrums, bedwetting, and nightmares. Client was diagnosed with adjustment disorder with depressed mood in the past. Two years ago, minor disclosed to a schoolteacher that a neighbor who babysat for the minors had inappropriately touched her genital region on multiple occasions. At the time, minor kept getting in trouble because she was trying to touch the genital region of boys in the classroom. She attended a few therapy sessions after the sexual abuse incident was reported to CPS. Minor has no current contact with offender.
* 3-year-old:Grandparents report that the 3-year-old is withdrawn and often isolates himself. Child

(3) shows indications for developmental delays (does not speak) and is under responsive to efforts to engage him (often seems withdrawn). This social worker has noticed a change in affect when in the presence of his mother during visitations. Child appears to increase in irritability and mouths his hands in excess. In addition, Mother does not attempt to engage him but does appear to enjoy taking pictures of him on her cell phone. He shows no preference for adults and prefers to self-soothe. Child is reported to hide food in his mouth for hours and appears distressed when it is discovered. Services are being requested to address concerns related to the child's social- emotional, developmental, and psychosocial domains of functioning. CA Early Start services will end soon due to age cutoff. CWS is recommending conjoint therapy, if appropriate, to support reunification. Conjoint therapy with grandparents may be clinically appropriate at this time to address issues related to disrupted primary relationships, exposure to parental substance abuse, untreated parental mental health concerns, and exposure to domestic violence.

**TERM Network**

# Psychotherapy Treatment

# Provider Application

## Writing Sample #1

PARENT

Initial Treatment Plan/Treatment Plan Update: Child Welfare Services PARENT with Mental Health Concerns

**Important:** The Writing Sample must be typed.

Handwritten forms will not be accepted**.\***

\* Client Name may be handwritten on the header of the

treatment plan if needed to indicate the identified family member.

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

**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 four (4) 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: | |

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

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 additional court reports, if available

**For Voluntary Services Cases:**

Case Notes

**Additional Items as Applies:**

Copies of all prior psychological evaluations and treatment plans

All prior mental health and other pertinent records

Copies of History & Physical and Discharge Summary written by psychiatrist

Other (please describe):



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| --- | --- | --- |
| **Risk Assessment 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 Factors:** | Psychotic Symptoms  Violent Behavior(s)  Substance Abuse  Recent Loss or Critical Event  Other e.g., trauma history, social isolation, etc. Please describe:  **Risk factors must be addressed with treatment goals and plan below.** |
| 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: | | |

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| Per the TERM Provider Handbook, treatment goals for parents focus on the protective issue. It is essential that therapists working with CWS parents accept the true finding of the Juvenile Court as a fact of the case. If CWS offers the family Voluntary Services instead of filing a petition with the Court to take jurisdiction, a true finding does not apply; however, the therapist is expected to accept the allegations of abuse as facts of the case.  **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):**  **Progress since last treatment report and how assessed (i.e., changes in symptoms and biopsychosocial functioning) as reported by SW, parent self-report, and behavioral observations of parent in sessions. Include date of update(s) below.**  **ITP:**  **First Update:**  **Second Update:**  **Third Update:**  **Fourth Update:** |

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| **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 SW, parent self-report, and behavioral observations of parent in sessions. Please 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 SW, parent self-report, and behavioral observations of parent in sessions. Please 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 SW, parent self-report, and behavioral observations of parent in sessions. Please 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 ☐ CWS Case Closed   ☐ Other (specify): | |

**PARENT SIGNATURE**

I have discussed this  Initial Treatment Plan  Treatment Plan Update  Discharge Summary with my provider.

**Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**

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

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| **ID (ICD-10)** | **Description** | **Corresponding DSM-5 Diagnostic Code** | **Corresponding DSM-5 Diagnostic Description** |
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**NOTE:** Provider must document diagnostic criteria met for diagnosis, any diagnostic rule outs, reason for diagnostic changes, and any other significant information. All diagnoses 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.

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**Brief assessment of parent’s functioning (Mental Status Assessment), parent’s awareness of own mental health concerns and the impact or potential impact on children:**

**Parent strengths regarding engaging in treatment:**

**Parent obstacles regarding engaging in treatment:**

**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. | | |

**TERM Network**

# Psychotherapy Treatment

# Provider Application

## Writing Sample #2

CHILD/YOUTH

Initial Treatment Plan/Treatment Plan Update: Child Welfare Services CHILD/YOUTH with Behavioral Health Concerns

**Important:** The Writing Sample must be typed.

Handwritten forms will not be accepted**.\***

\* Client Name may be handwritten on the header of the

treatment plan if needed to indicate the identified family member.

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

**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 four (4) 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: | |

**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):

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| **Risk Assessment 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 Factors:** | Psychotic Symptoms  Violent Behavior(s)  Substance Abuse  Bullying (aggressor or victim)  Recent Loss or Critical Event  LGBTQ+  Other e.g., feeding, sleep, CSEC, prior CWS history, trauma history, social isolation, etc. (please describe):  **Risk factors must be addressed with treatment goals and plan below.** |
| 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: | | |

|  |
| --- |
| 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:** |

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| --- |
| **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 ☐ CWS 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:

|  |  |  |  |
| --- | --- | --- | --- |
| **ID (ICD-10)** | **Description** | **Corresponding DSM-5 Diagnostic Code** | **Corresponding DSM-5 Diagnostic Description** |
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**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.

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**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:**

**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. | | |