**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.

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| 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 [ ]   |

**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):

**RISK ASSESSMENT:**

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

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| **Date 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[ ]  Refugee/Asylum [ ]  Human Trafficking [ ]  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: |

**TREATMENT GOALS:**

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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 CFWB parents accept the true finding of the Juvenile Court as a fact of the case. If CFWB 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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**DISCHARGE SUMMARY:**

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| 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):       |

**PARENT SIGNATURE**

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

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

**If the client is receiving telehealth treatment, the treatment plan shall be reviewed with the client and the review must be documented below.**

Select One was reviewed with parent by the provider on this date: Click or tap to enter a date.

Provider Name:       Date: Click or tap to enter a date.

Provider Signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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-TR Diagnostic Code** | **Corresponding DSM-5-TR Diagnostic Description** |
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|       |       |       |       |
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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:**

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| **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. |