

DOCUMENTATION: THERAPY INTAKE ASSESSMENT

Enter the basic information:

- Client ID
- Client's Name (make sure it's not misspelled = must match EHR)
- Session Date
- Start Time
- End Time
- Age
- The duration and number of units will auto-calculate
- Where the session took place
- Who participated in the session (client, parent? Someone else was there too?)

Note – The service code at the top of the page will change to the appropriate code once you select the setting and the client's age.

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In-Depth Assessment (H0031-HO)

Complete the checklist of presenting problems.

Then use narrative to put in detail what exactly the problems are. Include client/parent quotes.

Presenting Problems (details): *



How does the client perceive his/her problems?

- In a simple sentence, tell us if the client is aware of the problem, doesn't care, etc.

Based on the age of the client, you will then need to complete the sections that populated.

- Please be as specific as you can.
- If nothing applies, be professional and write out "Not applicable to this client".
- Make sure the sections have enough content to be acceptable.
 - For example, for family functioning, explain how the family interacts with each other, problems, etc.
 - For educational history, tell us what school the client is in, what grade, what kind of grades he gets, discipline issues, learning problems, etc.

Complete the mental status exam.

Summary of Findings.

- This is a narrative summary of all the sections above.
- Write 5 or 6 sentences summarizing the problem and identifying important information about the case.

Summary of Findings *

What does the client or parent want from our services?

- Ask the client/parent... what do you want out of counseling?

Desired Services or Outcomes from the client's point of view:

Indicate what the Primary Diagnosis is. Write the ICD-10 code + the name. --- "F90.1 – ADHD -xxxx"

- If you are not licensed, that's OKAY, this would be a "provisional" diagnosis until the licensed person completes the LE form, and later you complete the Master Treatment Plan.

Enter a secondary diagnosis if necessary.

- Here you can enter diagnosis from history, meaning ones that were previously given.

Primary Diagnosis

Secondary Diagnosis (if any)

Justification for Diagnosis

Complete The Justification for Diagnosis

- TIP – Have a word file with all the DSM-5 criteria for the most common diagnoses.

- So, for ADHD, for example, you would just copy/paste the ADHD criteria here, and then adjust accordingly to what the client is showing as far as symptoms.

Select the plan – Individual therapy? TBOS? PSR?

Complete your name, credentials (e.g. LMHC), Sign your name, and date it.

Click NEXT

Complete the CFARS/FARS.

Enter the basic information:

- Start Time
- End Time
- Where the session took place
- Leave it as INITIAL

* Note – The CFARS is the same form as the FARS. If something doesn't apply to your client, enter 0, or 1 for checklist.

For example...

in-home behavior does not apply to adults, so put 1 for that one if you are doing an adult intake.

SEVERITY RATINGS

1 = No problem 2 = Less than Slight 3 = Slight Problem
 4 = Slight to Moderate 5 = Moderate 6 = Moderate to Severe 7 = Severe
 8 = Severe to Extreme 9 = Extreme Problem

Depression 1	Anxiety 1	Thought Process 1	Cognitive Perfor... 1
Medical/Physical 1	Traumatic Stress 1	Hx of Substance ... 1	Interpersonal Rel... 1
Work/School 1	Danger to Others 1	Danger to Self 1	ADL Functioning 1
Security Needs 1	Socio-Legal 1	Substance Use 1	Hyperactivity 1
Hyper Affect 1	Family Relations... 1	Family Environm... 1	Ability to Care fo... 1

Complete the severity ratings for each area:

- You will want to stick to between 4 and 7.
- Anything below 3 is not worth having therapy.
- Anything over 8, then the client should probably be hospitalized to a residential setting.

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Hyper Affect 1	Family Relations... 1	Family Environm... 1	Ability to Care fo... 1

Enter the number of school days available in the past 30 days (usually 22), and the days attended.

Was the client admitted to DJJ? Press Yes or No.

Total number of days spent in the community in the past 30? Usually 30 unless client was in residential setting.

Enter your CFARS/FARS ID and select your Rater Degree.

Practitioner =Form.Signature.PractitionersName	Credentials =Form.Signature.Cre	CFARS/FARS Rater ID * A Textbox (Single Line)
Rater Degree Choice (Drop Down)		

Sign your name and **UPLOAD** the signed intake consents from the client (which if they signed, they should had been automatically emailed to you as a PDF).

If you are not licensed, you will **SUBMIT** the intake assessment. Then you will contact the licensed person assigned to that case, and you'll let them know to complete the LE.

If you are not licensed,
You will now SUBMIT the “Assessment NL”
(and remember to save a copy of the file – instructions later on)

If you are licensed,
Click NEXT

You will now complete the Master Treatment Plan.

If you are not licensed, you must complete the separate file called “Master Treatment Plan” on the website.

- You must do this AFTER the LE is completed, and the licensed person either confirmed your diagnosis, or gave you a new one for the Master Treatment Plan.

Enter the basic information:

- Session Date
- Start Time
- End Time
- Where the session took place
- Enter the diagnoses if not already populated.

Complete the following 3 text boxes with the appropriate response:

Strengths

A Textbox (Multiple Lines)

Needs

A Textbox (Multiple Lines)

Challenges to Treatment

A Textbox (Multiple Lines)

Problems – Goals – Objectives

Problem 1

Name of Problem: e.g. Depression

Measurable Baseline

Goals

Goal 1

Description: from the client's point of view

Objectives

Objective 1

Measurable Description

Target Date

Each client should have at least 1 Problem,
to a max of 3, maybe 4.



Each Problem should have at least 1 Goal.



Each Goal should have at least 3 Objectives.

Name of the Problem

- Use the Bio-Psychosocial Checklist
- Examples – “Defiance”. “Depression”. “Anxiety”. Those are the problems.

Measurable Baseline

- For Defiance, for example, how many times a week is the client experiencing this problem.
- *“Client curses, talks back, and shows disrespectful behaviors at least 15 times a week, as reported by the parent and by the teachers”*
 - o *Client curses, talks back, and shows disrespectful behaviors* it describes what kind of defiance
 - o *at least 15 times a week* it quantifies the number of instances and the frequency
 - o *as reported by the parent and by the teachers* it tells you WHO thinks this

The Goal

- Always from the client’s point of view, even with quotations.
- Example: *“I want Johnny to learn how to behave around others and stop all disrespect – Mother stated”*
- Goal should be generalized (later, the objectives will be measurable).

Goal 1

Description

from the client's point of view

The Objectives

- Objectives are specific. They are measurable & need to follow this 3-part format (to make Medicaid happy).
- You should have at least 3 objectives per goal.

Objectives

Objective 1

Measurable Description

Target Date

- The target date for each objective should be 6 months from the date of the plan.
 - o e.g. Treatment Plan date = 01.01.20, then target dates should be 07.01.20
- Example
“Johnny will learn at least 4 anger management techniques per week, over the next 6 months, as reported by the parent or self-reported by the client himself”.

- o *Learn at least 4 anger management techniques* it QUANTIFIES it and says WHAT they need to do
 - o *per week, over the next 6 months* shows frequency and duration
 - o *as reported by the parent or self-reported by the client himself* it tells you how you would know
- More Examples (for additional examples... see Cheat Sheet... But never use the same objectives over and over and over and over for all the clients!!! – Always tweak them somewhat)

Client will reduce depressed mood down to 0 x per week over a period of 6 months, as reported by client, guardian, or observed by the clinician.

Client will learn and role-play 4 ways to feel happier about her life, over the next 6 months, as reported by the client during sessions with the clinician.

Client will explore and verbalize at least 5 triggers of depressed mood in the next 5 months, as evidenced by discussions with clinicians and as reported by client.

The Discharge Criteria should be a small narrative about “what needs to happen for the client to be discharged”.

Complete the Service Grid

- Individual Therapy You should put **4** units per week
- TBOS You should put **8** units per week
 - o Even if TBOS is requested, you can leave IT with 4 units
 - o Because if we don't get “insurance authorized” for TBOS, then at least we have IT to use.
 - o You can also start off with IT, and then utilize TBOS.
 - o Important TIP
 - You should NEVER go back and forth using IT and TBOS.
 - For example, you should never bill IT one week, and then TBOS for a while, and then go back to IT, then TBOS again.
- If you are recommending PSR or Group, then enter 4 units for Group, and 12 for PSR.
- You are authorizing all of the services “clinically”.
- If the insurance company requires an authorization for these, then we'll need to authorize them too.

TBOS or PSR Certifications

- If you selected TBOS, or PSR in the grid, you need to “justify” why.
- Complete the select certifications as needed.
- Pay attention to make sure you are checking-off what’s needed.

Complete your name, credentials (e.g. LMHC), Sign your name, and date it.

Upload any files if necessary (e.g. drawings, client reports, etc.).

UPLOAD the signed intake consents from the client (which if they signed, they should have been automatically emailed to you as a PDF).

SUBMIT the Intake Assessment (or Master Treatment Plan if unlicensed).

(if you are doing an intake for someone else, save the file – instructions later on in this PDF)

Can I do an individual session with the intake?

YES!

You can do an individual session, and bill a note for H2019-HR, after you are done with your Medicaid intake.

DO make sure, in the progress note, that you address the problems or concerns related to your case’s treatment plan, even if not yet fully developed.