CLINICAL CONNECTIONS TRAINING PROGRAMS

50 HOUR CLASS TO INCLUDE

ON-LINE AND AT HOME

EXERCISES

ATTACHED PACKET FOR STUDENTS

2020

Topics to review for the TCM exam

Utilize You Tube for a lot of your studying and use **the FCB free online trainings** for more education ongoing education to help you study your exam

Care Coordination and collaboration with other providers and what is best practice

Community Resources and Benefits Nationwide

Case Management and how to link and explain to your client your job, also most cost- effective way to advocate for them

Special Populations and diagnosis regarding TCM services

Insurance and Enrollments to MMA

Linkage to Resources

Advocacy and Communication Skills as well as non -verbal and verbal communication, listening skills

Reducing Stigma and what is stigma

Multidisciplinary Teamwork : who is on the team you create for the client

Confidentiality Laws and Regulations regarding mental health (HIPPA Part 1 and part 2)

Building Partnerships and Strategies to reduce hospitalization and ongoing crisis for clients

Assessment Instruments and Procedures

Screening Instruments and Procedures

Risk Factors/Risk Assessment (suicide or homicidal)

Client Engagement and motivational interviewing

Client Needs and what is medical necessity

Functional Assessment (Global Assessment Functioning: FARS and CFARS) training online available

Assessment, Treatment Progress, Discharge Planning

Clinical Documentation and SOAP notes

Electronic Health Records and laws surrounding it in State of Florida

Privacy and Confidentiality laws regarding Hippa for psychiatric records

Mandating Reporting in State of Florida: what types of abuse exist

Record Keeping and Management in State of Florida

Boundaries/Transference and what is appropriate or not regarding clients

Relationships/Dual Relationships (what are they)

Sexual Misconduct and penalties regarding this, what is the Boards rules on this

Computer Ethics regarding HIPPA

Cultural Competence

Principles of Recovery and Empowerment

Ethical Decision Making/Code of Ethics (read the 18 pages on the Boards Website)

Laws/Rules and Regulations (Medicaid rules, AHCA class)

Policy in Human Services (Patients Rights)

Strengths-based and Client Centered Service Planning

Developing Goals and Objectives

Stages of Change

Evidence Based Practices

Human Development (Eriksons Theory)

Development of Service Plans and what is the purpose

Health Literacy

The Components of a SOAP Note

The SOAP stands for subjective, objective, assessment, TCM's plan.

- **Subjective.** This describes the patient's self-report of their current condition in a narrative form.
- **Objective.** This outlines the objective observation of the condition and details all information and factors that can be measured. (note their affect, mood, interactive or not, insight, appearance etc.)
- **Assessment.** The assessment is the diagnosis or conditions the patient has. This also details the opinion of the TCM regarding whether the client is making progress or reasons why he/she may not be (example: client's mood has shown improvement, client more talkative, or client detached and not responding as usual)
- **Plan.** This is where the TCM plans on how to address the client's condition and what they will do to link the client, monitor the client and or assist or advocate for the client

Progress Note

Client's Name: ______________________ Case Number: ____________________

Date: ______________ Time: ______________ Location: ______________

Subjective:

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Objective:

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Assessment:

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Planned:

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____

End Time: Minutes: Units: TCM signature: __________________

Progress Note

Client's Name: ________________________________ Case Number: ____________________________

Date: __________________ Time: __________________ Location: __________________

Subjective:

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Objective:

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Assessment:

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Planned:

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End Time: Minutes: Units: TCM signature: ______________________

Writing Exercise

CASE MANAGEMENT ASSESSMENT

SECTION I: CLIENT'S INFORMATION

Client's Name: ______________________________ Case Number: ________________

Address: ______________________________ City, State, Zip: ______________________

Home Phone № ______________ Cell Phone № ________________ Other ________________

Email Address *(optional)*: ____

DOB: ____________ Age: _____ SSN: ______________ Gender: ☐ Male ☐ Female

Race: ________________ Ethnicity: ____________________ Marital Status: ______________

Primary Language: ________________ Other Language: ______________ ☐Read ☐Speak ☐Understand

Legal Decision-Maker or Authorized Representative *(if applicable)*

☐ None ☐ Legal Guardian ☐ Guardian-ad-Litem ☐ Parent ☐ Attorney-in-fact ☐ Other: ______________

Name: ____ Phone № ________________

Address: ______________________________ City, State, Zip: ______________________

**Attach copies of Court disposition and support documentation regarding legal representation, custody or guardianship when applicable*

Need of Special Accommodations? ☐ No ☐ Yes Specify:

TYPE OF ASSESSMENT:

☐ Initial ☐ Annual ☐ Significant Change ☐ Other: ______________________________

SECTION II: REFERRAL AND INFORMATION SOURCES

**Is client currently receiving Case Management services throughanother provider?* ☐ Yes ☐ No

Referred by: ______________________________ Phone № ______________________

Address: ______________________________ City, State, Zip: ______________________

Title/Position: ____________________ Agency *(if applicable)*: ______________________________

This assessment was based on the information obtained from the following sources *(check all that apply)*:

☐ Client's input and own assessment ☐ Family and friends ☐ Referring Agency/Provider ☐ School

☐ Treating Providers ☐ Caregiver ☐ Review of client's records ☐ Other: ______________

Please list individuals/agencies providing information other than client:

Name	***Agency*** *(if applicable)*	***Relationship***

*All the information used for the completion of this assessment was obtained with proper consent(s) of the client. Refer to *Consent for Release and Request of Information* form on client's chart.

Client's Name: ______________________ Case Number: xyz123

SECTION III: PRESENTING PROBLEMS

Describe reason for referral, elaborating on client's presenting problems and chief complaints. Use client's own words and include prominent symptoms and precipitating events. Describe how current situation and problems are affecting client's normal functioning, emotional stability, safety and wellbeing.

Date of onset of present problem(s): ______________________ Previous psychiatric problem(s): ☐ No ☐ Yes

SECTION IV: FAMILY INFORMATION

A. Parents Information *(children only)*

What are the child's parent's names? ______________________ ______________________

Child's Mother *Child's Father*

Parent's marital status: ☐ Married ☐ Divorced ☐ Separated ☐ Never married

Are child's parents living together? ☐ Yes ☐ No If No, provide the following information for the non-custodial parent:

Name: ______________________ Phone № ______________________

Address: ______________________ City, State, Zip: ______________________

**May we contact the non-custodial parent if necessary?* ☐ Yes ☐ No ☐ N/A

B. Household Composition

List all family members living in the same household and indicate their ability to support and take care of the client

Name	***Age***	***Relationship***	***Supporting and Caretaking Ability***

SECTION V: PAST AND CURRENT SERVICES AND EFFECTIVENESS

List past and current services provided to client starting with the most recent on top. Identify providers, dates and effectiveness

TYPE OF SERVICE	***PROVIDER / AGENCY***	***DATE RECEIVED***	***EFFECTIVENESS***
		TO	
		TO	
		TO	
		TO	
		TO	
		TO	

Additional information: ______________________

Client's Name: ______________________ Case Number: xyz123

SECTION VI: CURRENT MEDICATIONS

List any current medication being taking by client including medical, psychiatric and over-the-counter

MEDICATION	DOSES/FREQUENCY	PRESCRIBING PHYSICIAN	REASON/PURPOSE

How does client remember to take his/her medications? *(Check all that apply)*

- ❑ By following directions
- ❑ Pill Organizer
- ❑ Family/Caregiver
- ❑ Calendar reminder
- ❑ Electronic reminder
- ❑ RN/HHA Set-up
- ❑ Keeping them visible
- ❑ Daily task association
- ❑ Other: ______________________

How well does client self-administer medication?

- ❑ With no help or supervision
- ❑ With a lot of help or constant supervision
- ❑ With some help or occasional supervision
- ❑ Unable to administer own medications/caregiver gives them

Has the client had problems getting the medication dispensed or refilled on time? ❑ Yes ❑ No

What pharmacy does client use? ______________________ Phone #: ______________

Any other significant medication issue or concern *(e.g. medication side effect, drug interaction, adjustment, effectiveness, cost, etc.)*?

SECTION V: AREAS OF FUNCTIONING AND NEEDS ASSESSMENT

1. MENTAL HEALTH / BEHAVIORAL / SUBSTANCE ABUSE

Mental Health / Psychiatric History *(include client and family history)*:

Psychiatrist: ______________________ Phone № ______________________

Address: ______________________ City, State, Zip: ______________________

Primary Diagnosis (Axis I): ________ (Code) ______________________ (Descriptor)

Client's Name: ____________________ Case Number: xyz123

MENTAL HEALTH / BEHAVIORAL / SUBSTANCE ABUSE (Continued)

Does the client currently have or have had any of the following? *(Check all that apply)*

- ☐ Depression
- ☐ Sadness
- ☐ Hopelessness
- ☐ Helplessness
- ☐ Negative thoughts
- ☐ Withdrawal
- ☐ Self-neglect
- ☐ Loss of interest
- ☐ Low self-esteem
- ☐ Anxiety
- ☐ Nervousness
- ☐ Irritability
- ☐ Sleep disturbance
- ☐ Poor concentration
- ☐ Panic attacks
- ☐ Fearfulness
- ☐ Paranoia
- ☐ Obsessive behaviors
- ☐ Aggressiveness
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Mood Swings
- ☐ Hallucinations
- ☐ Delusions

Has the client ever been hospitalized due to mental health/behavior issues? *If so, please give the following information:*

Hospital or Institution	***Date***	***Reason***

RISK ASSESSMENT

Has client ever had or currently has any of the following? *(Check all that apply)*

☐ Suicidal Attempt/Ideation ☐ Homicidal Attempt/Ideation ☐ Abuse/Violence (Physical / Sexual / Emotional)

Provide details:

Describe any risk taking behavior that client may have:

SUBSTANCE ABUSE / CHEMICAL DEPENDENCY HISTORY

Have you ever used alcohol or other drugs? ☐ Yes ☐ No If Yes, complete information below:

Type of Drug/Substance	***Date Begin***	***Age***	***Frequency***	***Last Time Used***

Have you ever been to any rehab/detox treatment or program? ☐ Yes ☐ No If Yes, complete information below:

When was the first time? ***How many times since then?*** ***Date of most recent*** ***Outcome of treatment***

Does the client feel that he/she currently has an addiction problem? ☐ Yes ☐ No

Describe any other issues related to client's mental health:

Client's Name: ______________________ Case Number: xyz123

2. PHYSICAL HEALTH / MEDICAL / DENTAL

Primary Care Physician (PCP):______________________ Phone № ______________

Place of Practice *(Hospital, Medical Center, Private Practice, etc.)*: ______________________

Address:______________________City, State, Zip: ______________________

List any medical problems/conditions that client or family currently have or have had in the past

Medical Problem/Condition	***Client***	***Family***	***Comments***
Allergy ❑ No ❑ Yes Specify:			

Has client undergone any surgical procedure? ❑ Yes ❑ No If Yes, complete information below:

Type of Surgery	***Date***	***Hospital***	***Outcome***

Hearing:

❑ No hearing impairment.
❑ Hearing impairment managed through assistive devices
❑ Hearing difficulty at level of conversation.
❑ Hears only very loud sounds.
❑ No useful hearing.
❑ Not determined.

Vision:

❑ Has no impairment of vision.
❑ Vision impairment managed through assistive devices
❑ Has difficulty seeing at level of print (far-sighted).
❑ Has difficulty seeing objects in environment (near-sighted).
❑ Has no useful vision.
❑ Not determined.

Pregnancy:

Is client currently pregnant? ❑ Yes ❑ No ❑ N/A

Is she receiving prenatal care? ❑ Yes ❑ No Does she understand the risks of pregnancy? ❑ Yes ❑ No

Issues/complications during pregnancy: ______________________

Preventive Care:

Are all immunizations/vaccines current? ❑ Yes ❑ No If No, explain: ______________________

____

Are you on a physician ordered special diet? ❑ No ❑ Yes Specify: ______________________

How active are you? I exercise or engage in physical activities ______________________
(Frequency)

Client's Name: ______________________ Case Number: xyz123

PHYSICAL HEALTH / MEDICAL / DENTAL (Continued)

Please indicate the last time (date) the following preventive procedures were conducted:

Physical Exam: ______________ Pap and HPV Test: ______________

Dental Exam: ______________ Mammogram: ______________

Lab Works: ______________ Colon Cancer Screening: ______________

Other *(specify)*: ______________________________

Additional information about medical problems/conditions:

3. VOCATIONAL / EMPLOYMENT

A. Vocational/Employment history *(briefly describe client's work history indicating previous employers, occupations, vocational goals, etc.):*

Is client currently employed? ❑ Yes *(Indicate Status and complete section B)* ❑ No *(Indicate Status and go to section C)*

Employment Status: ______________________________

B. Current Employer: ______________________________

Address: ______________________ City, State, Zip: ______________

Contact Person: ______________________ Phone № ______________

**May we leave/send voice/text messages to the above contact if necessary?* ❑ Yes ❑ No

C. Is the client able to work or perform any gainful and productive activity? ❑ Yes ❑ No ❑ Yes but with limitations

If *Yes*, would he/she like to obtain a job? ❑ Yes ❑ No ❑ Not at this time

Does client need assistance or support to seek, obtain and sustain employment? ❑ Yes ❑ No If Yes, explain:

4. SCHOOL / EDUCATION

A. CHILDREN ONLY (Go to section B for ADULTS)

Is client currently attending school or any educational program? ❑ Yes ❑ No

If No, explain why: ______________________________

School: ______________________ District: ______________ Grade: ________

Address: ______________________ City, State, Zip: ______________

School Program: ❑ Regular ❑ ESE ❑ EBD ❑ ESOL ❑ HHIP (Homebound) ❑ Other

Teacher or Counselor Name: ______________________ Phone № ______________

Client's Name: ______________________ Case Number: xyz123

SCHOOL / EDUCATION *(Continued)*

Has client ever experienced difficulties in any of the following areas? *(Check all that apply and indicate in what school level)*

Areas	***Pre-School***	***Elementary***	***Middle School***	***High School***
Academic performance (low grades, failed subjects)				
Behavior (misconduct, bullying, suspensions)				
Relationship with students, teachers, school staff				
Attendance and punctuality, skipping classes				
Fail to pass the grade, grade retention				
Participation in extracurricular activities				
Learning disabilities				

Is client involved in any extra-curricular activities? ❑ Yes ❑ No Specify: ______________________

Is there any aide, tutor or mentor assigned to the child? ❑ Yes ❑ No If Yes, provide the following information:

Name: ______________________ Phone № ______________________

Describe client's educational strengths: *(children only)*

Describe any school based weaknesses, adjustment and/or educational placement problems: *(children only)*

B. ADULTS

What is the highest level of education client has completed?

❑ No School
❑ Elementary School
❑ Middle School
❑ Some High School
❑ GED
❑ Graduated Special Education
❑ High School Graduate
❑ Trade School
❑ Some College
❑ College Graduate
❑ Graduate Degree
❑ Unknown

Is client interested in furthering his/her education? ❑ Yes ❑ No

If yes, what area would client want to further his/her education in? ______________________

Does client need assistance or support in gaining access to educational services? ❑ Yes ❑ No

Explain: ______________________

5. SOCIAL / SUPPORT SYSTEM / RECREATIONAL

Describe client's cultural affiliations and/or spiritual/religious beliefs: ______________________

____

Does the client currently participate in any social activity or program in the community? ❑ Yes ❑ No
If Yes provide details:

Client's Name: ______________________________ Case Number: xyz123

SOCIAL / SUPPORT SYSTEM / RECREATIONAL *(Continued)*

What activities or things does client enjoy doing or which ones would he/she like to do?

Briefly describe client's social skills *(e.g. ability to interact and get along with others, ability to make and maintain relationships, etc.)*

Describe client's relationships and support system *(family, friends, peers, landlord, neighbors, caretaker, providers, significant others, etc.)*

List any needs or concern related to social functioning:

6. ACTIVITIES OF DAILY LIVING

Identify the activities that client has difficulties to perform and indicate level of dependency *(check all that apply)*:

ACTIVITIES OF DAILY LIVING	Assistive Technology	INDEPENDENT	SUPERVISION AND VERBAL PROMPTS	PHYSICAL ASSISTANCE NEEDED	TOTAL DEPENDENCE
a. Feeding/eating					
b. Grooming and personal hygiene					
c. Bathing/showering					
d. Dressing					
e. Transferring and mobility					
f. Cooking/preparing meals					
g. Doing laundry, housekeeping					
h. Making/answering phone calls					
i. Shopping/errands					

Describe other needs, concerns or safety risks related to the performing of activities of daily living:

7. HOUSING / LIVING ENVIRONMENT

Residential Status: ______________________________

Number of person living in the same house:______ Number of bedrooms in the house: _____

Person-per-Bedroom (PPB) ratio: _______ *(According to HUD standards, a PPB above 2 is considered household overcrowding and housing assistance may be needed)*

Describe client's living and sleeping arrangements *(rent/own, where client sleeps, whether he/she shares bed/bedroom, etc.)*:

Client's Name: ________________________ Case Number: xyz123

HOUSING / LIVING ENVIRONMENT (Continued)

Please indicate area(s) where there are potential safety risks or accessibility/mobility barriers:

- ❑ Structural damage
- ❑ Electrical hazards
- ❑ Poor lighting
- ❑ No hot or running water
- ❑ Fire hazards
- ❑ Tripping/fall hazards
- ❑ Unsanitary conditions
- ❑ No air conditioning/heat
- ❑ Stairs/steps unsafe
- ❑ No telephone *(or not working)*
- ❑ Excessive clutter
- ❑ Insects or other pests
- ❑ Flooring/carpet loose
- ❑ Bathtub/shower unsafe
- ❑ Appliances not working

Describe neighborhood *(urban/rural, location, crime level, safety, accessibility to community resources and services, etc.)*:

Does the client feel safe in the current living arrangement? ❑ Yes ❑ No

If No, explain: ________________________

Would the client like to continue to live in the current place, or is there somewhere else he/she would prefer to live?

- ❑ Continue to live here
- ❑ Continue to live here only if housing condition improves
- ❑ Prefer to live elsewhere
- ❑ Doesn't know / not sure

If there are any housing needs or concern not listed above, please describe:

8. ECONOMIC / FINANCIAL

Monthly Family Income *(include income from all household members)*: ____________

What is the main source(s) of income for the client and/or family? ________________________

Other financial resources available to client: ________________________

Is the client or the client's family currently having any financial difficulties? ❑ Yes ❑ No If *Yes*, please describe:

9. BASIC NEEDS *(Food, clothing, furniture, etc.)*

Does the client receive or use any of the following types of food assistance?

Assistance type	*Receive/use?*	*How often?*	*Provider?*
Food Stamps/S.N.A.P.	❑ Yes ❑ No		
Food Pantry/Food Banks	❑ Yes ❑ No		
Home delivered meals	❑ Yes ❑ No		
Congregate meals *(Meals served in community settings such as senior centers, churches, etc.)*	❑ Yes ❑ No		
Other:	❑ Yes ❑ No		

Does the client have other basic needs? *(e.g. clothing, school uniforms and supplies, furniture, necessary household items, etc.)*

Client's Name: ______________________________ Case Number: xyz123

10. TRANSPORTATION

How does client get to the places he/she want or need to go? *(Check all that apply)*

- ❑ Walks
- ❑ Drives
- ❑ Takes a bus or taxi
- ❑ Friend or family member drives
- ❑ Staff/Provider
- ❑ Other: ______________________________

How well is client able to use public transportation or drive to places beyond walking distance?

- ❑ Needs no help or supervision
- ❑ Needs some help or occasional supervision
- ❑ Needs a lot of help or constant supervision
- ❑ Can't do it at all

Does the client have any other transportation needs? ❑ Yes ❑ No

If Yes, explain: ______________________________

11. LEGAL / IMMIGRATION

A. Court / Department of Juvenile Justice (DJJ) Involvement

Has client ever been arrested? ❑ Yes ❑ No How many times? ____ Last time arrested: __________

If Yes, were there criminal charges pressed against client? ❑ Yes ❑ No

Is there any current and ongoing legal process: ❑ Yes ❑ No Probation Officer? ❑ Yes ❑ No

Name of Probation Officer: ______________________________ Phone № ____________________

B. Immigration

Country of Birth: ____________________ Year entered USA: ________ Status: ❑ Citizen ❑ Resident

❑ Other: ______________________________

Additional information in reference to *legal/immigration* status:

12. OTHER *(Use this section to assess any other area of functioning not listed above)*

SECTION VI: SUMMARY OF CLIENT'S STRENGHTS AND WEAKNESS

A. List client's current and potential strengths, abilities, assets, interests, preferences, resources that may contribute to his/her recovery and wellbeing:

B. List client's current and potential weakness, needs, barriers, challenges, etc. that may interfere with his/her recovery and wellbeing:

Client's Name: ______________________ Case Number: xyz123

SECTION VII: RECOMMENDED SERVICES

- ❑ Mental Health / Substance Abuse
- ❑ Physical Health / Medical / Dental
- ❑ Vocational / Employment / Job Training
- ❑ School / Education
- ❑ Recreational / Social Support
- ❑ Activities of Daily Living *(ADL and IADL)*
- ❑ Housing / Shelter
- ❑ Economic / Financial
- ❑ Basic Needs *(food, clothing, furniture, etc.)*
- ❑ Transportation
- ❑ Legal / Immigration
- ❑ Other *(specify)*: ______________________

SECTION VIII: SIGNATURES

I certify that either one of the following requirements was met prior to the completion of client's Assessment:

❑ A home visit was conducted prior to the completion of this Assessment on: ______________

OR

❑ Case Manager was unable to complete a home visit due to:

____

However, a face-to-face interview was conducted on: ______________ and a required home visit was scheduled for: ______________

Case Manager Print Name	Credentials	Signature	Date
Senior/Lead Case Manager Name	Credentials	Signature	Date
Case Manager Supervisor Name	Credentials	Signature	Date

Example pg 1

Mental Health Targeted Case Management Program

CASE MANAGEMENT SERVICE PLAN

SECTION I

DATE OF SERVICE PLAN: April 21, 2020

Recipient Name: Jane Smith

Case Number: xyz123

DOB: 1/1/86

Age: 34

Gender: ❑ Male ❑✠✠ Female

Diagnosis Provided by a Licensed Practitioner	
CODE (Axis I)	DESCRIPTOR
F33.1	Major Depressive Disorder

Services Provided Prior to Development of Service Plan					
SERVICE	DATE	SERVICE	DATE	SERVICE	DATE
Medication Mgt	1/5/2020				
Therapy	10/1/2019				

Strengths, Abilities, Resources, Interests, Preferences	***Weakness, Needs, Barriers, Challenges***
Client is good verbally and is able to express her feelings and needs	The client is financially struggling and is unbale to get a good job since she never finished High School

Transition / Discharge Criteria

Client will successfully complete goals at about 70% or better and feel confident and stable upon discharge

Recipient Name: Jane Smith **Case Number:** xyz123 pg 2

SECTION II

#	Domains	Date Identified	Needs Identified
1	Mental Health Behavioral Substance Abuse	4/21/2020 □	Client is not on medicine that helps reduce her depression. She also has insomnia as a result
2	Physical Health Medical/Dental		
3	Vocational Employment Job Training		
4	School Education Academic	4/21/2020	Client needs to complete her GED in order to get gainful employment
5	Environmental Recreational Social Support		
6	Activities of Daily Living (ADLs / IADLs)		
7	Housing Shelter	4/21/2020	Client is living in a homeless shelter and needs permanent housing
8	Economic Financial Basic Needs		
9	Transportation		
10	Legal Immigration		
11	Other (specify)		

Recipient Name: JAne SmiTH **Case Number:** XY2123 (pg 3)

SECTION III: LONG TERM GOALS / SHORT TERM OBJECTIVES

(Expectations of the individual, where does the individual see himself/herself in the future, what would he/she like to accomplish. It must be realistic and attainable and must be written in conjunction with the individual and family members when applicable)

DOMAIN #

Identified service needs from SECTION II:

Long Term Goal: (include recipient's own words)
"I want medication that actually helps me"
The client reports that she is not sleeping good, gets easily frustrated and is feeling tired all the time.

Objective **Task/Case Management Strategy** (Who Will Do What, When and How)	Start Date	Target Date	End Date
The client will see a new psychiatrist that TCM will refer her to. The client will discuss medication issues and side effects that she may have had in the past. The client will attend all scheduled appointments and reschedule when necessary in a timely matter.	4/21/2020	10/21/20	To be reviewed 10/20/20
	Responsible Provider and Resources		
	Client to attend appointments and take meds TCM to assist in scheduling and monitoring Psychiatrist to set appointments monthly and assess client's progress		

Objective **Task/Case Management Strategy** (Who Will Do What, When and How)	Start Date	Target Date	End Date
Client will register with a pharmacy that delivers to avoid lapses in doses or refills. TCM will monitor compliance and assist as needed.	4/21/2020	10/21/20	To be reviewed 10/20/20
	Responsible Provider and Resources		
	TCM, Client and pharmacy		

Objective **Task/Case Management Strategy** (Who Will Do What, When and How)	Start Date	Target Date	End Date
Client will get labs as ordered to ensure medications are not causing toxicity or unusual side effects	4/21/20	10/21/20	To be reviewed 10/20/20
	Responsible Provider and Resources		
	Psychiatrist and client		

Recipient Name: Jane Smith **Case Number:** ______ pg 7

SECTION IV

Service Plan Signatures

We, the members of the case management team, hereby certify that this recipient is eligible for case management services which will be rendered through Access 2 Improvement, Inc.
The signatures below indicate that the goals and objectives as outlined in the Service Plan have been developed in partnership with the recipient and the legal guardian/custodian (when applicable) **and are valid for a period of six (6) months, unless extended due to reasonable criteria.**

The expected review date of this Service Plan should be no later than: 10/21/20

This Service Plan has been explained to me in all its extent in terms I can understand, I have agreed with the goals and objectives as written and I have given consent to services involved in its development and implementation. A copy of the Service Plan has been offered to me: ❑Yes ❑No

[signature] 4/21/20
Recipient's Signature Date

N/A.
Parent/Legal Guardian's Signature Date

[signature] Annemarie Mahaney BS 4/21/20
Case Manager's Signature Case Manager's Print Name Credentials Date

[signature] James Gordon BS 4/21/20
CM Supervisor's Signature CM Supervisor's Print Name Credentials Date

Writing exercise

Mental Health Targeted Case Management Program

CASE MANAGEMENT SERVICE PLAN

SECTION I

DATE OF SERVICE PLAN:

Recipient Name: ____________________

Case Number: xyz123

DOB: ____________

Age:

Gender: ☐ Male Female

Diagnosis Provided by a Licensed Practitioner	
CODE (Axis I)	DESCRIPTOR

Services Provided Prior to Development of Service Plan					
SERVICE	DATE	SERVICE	DATE	SERVICE	DATE

Strengths, Abilities, Resources, Interests, Preferences	*Weakness, Needs, Barriers, Challenges*

Transition / Discharge Criteria

Recipient Name: ______________ **SECTION II** **Case Number:** xyz123

#	Domains	Date Identified	Needs Identified
1	Mental Health Behavioral Substance Abuse	☐	
2	Physical Health Medical/Dental		
3	Vocational Employment Job Training		
4	School Education Academic		
5	Environmental Recreational Social Support		
6	Activities of Daily Living (ADLs / IADLs)		
7	Housing Shelter		
8	Economic Financial Basic Needs		
9	Transportation		
10	Legal Immigration		
11	Other (specify)		

Recipient Name: ______________________________ **Case Number:** ____________________

SECTION III: LONG TERM GOALS / SHORT TERM OBJECTIVES

(Expectations of the individual, where does the individual see himself/herself in the future, what would he/she like to accomplish. It must be realistic and attainable and must be written in conjunction with the individual and family members when applicable)

DOMAIN #

Identified service needs from SECTION II:

Long Term Goal: (include recipient's own words)

"

Objective	**Task/Case Management Strategy** (Who Will Do What, When and How)	**Start Date**	**Target Date**	**End Date**
		Responsible Provider and Resources		

Objective	**Task/Case Management Strategy** (Who Will Do What, When and How)	**Start Date**	**Target Date**	**End Date**

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Recipient Name: ______________________________ **Case Number:** ____________________

SECTION III: LONG TERM GOALS / SHORT TERM OBJECTIVES
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Long Term Goal: (include recipient's own words)

Objective	**Task/Case Management Strategy** (Who Will Do What, When and How)	**Start Date**	**Target Date**	**End Date**
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Recipient Name: ______________________________ **Case Number:** ____________________

SECTION III: LONG TERM GOALS / SHORT TERM OBJECTIVES

(Expectations of the individual, where does the individual see himself/herself in the future, what would he/she like to accomplish. It must be realistic and attainable and must be written in conjunction with the individual and family members when applicable)

DOMAIN #

Identified service needs from SECTION II:

Long Term Goal: (include recipient's own words)

Objective	**Task/Case Management Strategy** (Who Will Do What, When and How)	**Start Date**	**Target Date**	**End Date**
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		Responsible Provider and Resources		

Objective	**Task/Case Management Strategy** (Who Will Do What, When and How)	**Start Date**	**Target Date**	**End Date**
		Responsible Provider and Resources		

Recipient Name:_______________________________ **Case Number:** ____________________

SECTION IV

Service Plan Signatures

We, the members of the case management team, hereby certify that this recipient is eligible for case management services which will be rendered through Access 2 Improvement, Inc.
The signatures below indicate that the goals and objectives as outlined in the Service Plan have been developed in partnership with the recipient and the legal guardian/custodian (when applicable) **and are valid for a period of six (6) months, unless extended due to reasonable criteria.**

The expected review date of this Service Plan should be no later than: ____________________

This Service Plan has been explained to me in all its extent in terms I can understand, I have agreed with the goals and objectives as written and I have given consent to services involved in its development and implementation. A copy of the Service Plan has been offered to me: ❑*Yes* ❑*No*

______________________________	______________________
Recipient's Signature	Date
______________________________	______________________
Parent/Legal Guardian's Signature	Date

______________________________	______________________________	__________	__________
Case Manager's Signature	Case Manager's Print Name	Credentials	Date
______________________________	______________________________	__________	__________
CM Supervisor's Signature	CM Supervisor's Print Name	Credentials	Date

Discharge Summary

Date: ____

Client Name: ______________________________________

Medicaid # ________________________ **Social Security #:** ___________________________

Address: ____

City: ______________________________ State ___________________ Zip: _____________

___Married ___Separated ___Divorced ___Single ___Widowed

Ethnicity: ___Hispanic/Latino ____ Non Hispanic/Non-Latino

Race: ___ Caucasian ___African American ___ American Indian

Primary Language: _____English ___Spanish _____French ___Creole

Other_____________

Case Management Services Provided: ____

____

____

Service Plan:

Did the client reach measurable goals: _____y ____n

If yes, explain the goals reached: ____

____

____

If no, explain the goals that were not met and why:

____

____

____

Referrals and Recommendation made at discharge:

____

____

____

Prognosis at Discharge: (good, guarded, poor, fair, or unavailable due to short length of commitment): ______________________________.

Provide details: ______________________________

____

____

Client's Response to Recommendations: (if available)

____

____

____

If the client is not available explain:

____

____

____

Client's Signature: ______________________ **Date:** ____________

TCM's Signature: ______________________ **Date:** ____________

TCM Supervisor Signature: ______________________ **Date :** ____________

Maslow	Erikson
Individuals move up the motivational stages / pyramid in order to reach self-actualisation. The first four stages are like stepping stones.	Successful completion of each stage results in a healthy personality and the acquisition of basic virtues. Basic virtues are characteristic strengths used to resolve subsequent crises.

(summary)

Psychosocial Stages Summary

Like Freud and many others, Erik Erikson maintained that personality develops in a predetermined order, and builds upon each previous stage. This is called the epigenetic principle.

(1) Trust vs. Mistrust

This stage begins at birth and lasts through around one year of age.

The infant develops a sense of trust when interactions provide reliability, care, and affection.

A lack of this will lead to mistrust.

(2) Autonomy vs. Shame and Doubt

This stage occurs between the ages of 18 months to approximately age two to three years.

The infant develops a sense of personal control over physical skills and a sense of independence.

Erikson states it is critical that parents allow their children to explore the limits of their abilities within an encouraging environment which is tolerant of failure.

Success leads to feelings of autonomy, failure results in feelings of shame and doubt.

(3) Initiative vs. Guilt

This stage occurs during the preschool years, between the ages of three and five.

The child begins to assert control and power over their environment by planning activities, accomplishing tasks and facing challenges. Success at this stage leads to a sense of purpose.

If initiative is dismissed or discourages, either through criticism or control, children develop a sense of guilt.

(4) Industry vs. Inferiority

This stage occurs during childhood between the ages of five and twelve.

It is at this stage that the child's peer group will gain greater significance and will become a major source of the child's self-esteem. The child is coping with new learning and social demands.

Success leads to a sense of competence, while failure results in feelings of inferiority.

(5) Identity vs. Role Confusion

The fifth stage occurs during adolescence, from about 12-18 years.

Teenagers explore who they are as individuals, and seek to establish a sense of self, and may experiment with different roles, activities, and behaviors.

According to Erikson, this is important to the process of forming a strong identity and developing a sense of direction in life.

6

Intimacy vs. Isolation

This stage takes place during young adulthood between the ages of approximately 19 and 40.

During this period, the major conflict centers on forming intimate, loving relationships with other people. Success leads to strong relationships, while failure results in loneliness and isolation.

7

Generativity vs. Stagnation

This stage takes place during middle adulthood between the ages of approximately 40 and 65.

People experience a need to create or nurture things that will outlast them, often having mentees or creating positive changes that will benefit other people.

Success leads to feelings of usefulness and accomplishment, while failure results in shallow involvement in the world.

8

Ego Integrity vs. Despair

This stage takes place after age 65 and involves reflecting on one's life and either moving into feeling satisfied and happy with one's life or feeling a deep sense of regret.

Success at this stages leads to feelings of wisdom, while failure results in regret, bitterness, and despair.

How to reference this article:

McLeod, S. A. (2018, May 03). *Erik Erikson's stages of psychosocial development*. Retrieved from https://www.simplypsychology.org/Erik-Erikson.html

Sponsored Content

The Stages of Change

1) PRECONTEMPLATION STAGE

"It isn't that we cannot see the solution. It's that we cannot see the problem."

Precontemplators usually show up in therapy because of pressures from others... spouses, employers, parents, and courts... Resist change. When their problem comes up, they change the topic of conversation. They place responsibility for their problems on factors such as genetic makeup, addition, family, society, destiny, the police, etc. They feel the situation is HOPELESS.

2) CONTEMPLATION STAGE

"I want to stop feeling so stuck!"

Contemplators acknowledge that they have a problem and begin to think about solving it. Contemplators struggle to understand their problems, to see its causes, and wonder about possible solutions. Many contemplators have indefinite plans to take action within the next few months.

"You know your destination, and even how to get there, but you're not ready to go."

It is not uncommon for contemplators to tell themselves that some day they are going to change. When contemplators transition to the preparation stage of change, their thinking is clearly marked by two changes. First, they begin to think more about the future than the past.

The end of contemplation stage is a time of ANTICIPATION, ACTIVITY, ANXIETY, and EXCITEMENT.

3) PREPARATION STAGE

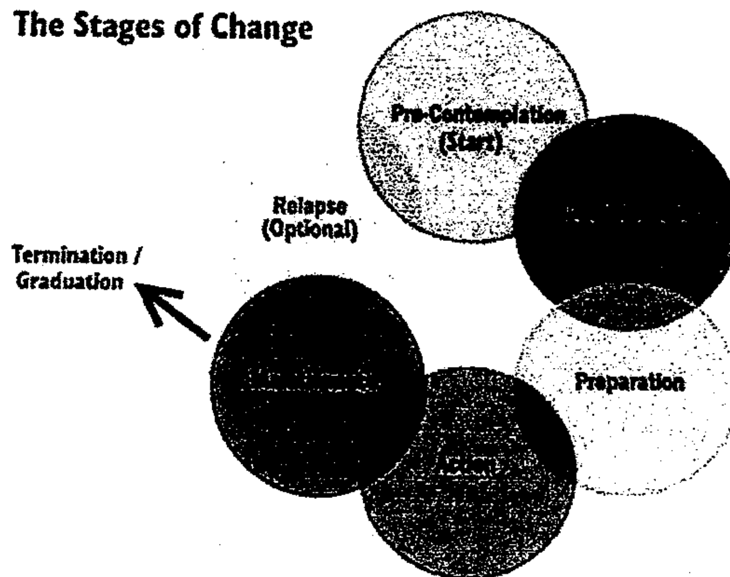
Most people in the preparation stage are planning to take action and are making the final adjustments before they begin to change their behavior. Have not yet resolved their AMBIVALENCE. Still need a little convincing.

Your gift to the Volunteer Month Scholarship Fund trains new volunteers.
Matching gifts are available

CHANGE IS MORE VISIBLE TO OTHERS.

5) MAINTENANCE STAGE

Change never ends with action. Without a strong commitment to maintenance, there will surely be relapse, usually to precontemplation or contemplation stage.



Most successful self-changers go through the stages three or four times before they make it through the cycle of change without at least one slip. Most will return to the contemplation stage of change. Slips give us the opportunity to learn.

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'The Four Stages of Recovery', from Mark Ragins

MAY 31, 2013 BY DAVID CLARK LEAVE A COMMENT

Mark Ragins is a leading recovery figure in the mental health field. He was a pioneer in setting up MHA Village, a recovery community based in Los Angeles. His writings are well worth a read. Here is what Mark has to say about the four stages of recovery in an article entitled The Road to Recovery. What Mark says here is just as relevant to people recovering from addiction.

'Recovery has four stages: (1) hope, (2) empowerment, (3) self-responsibility and (4) a meaningful role in life.

Hope

During times of despair, everyone needs a sense of hope, a sense that things can and will get better. Without hope, there is nothing to look forward to and no real possibility for positive action.

Hope is a great motivator, but for hope to be truly motivating, it has to be more than just an ideal. It has to take form as an actual, reasonable vision of what things could look like if they were to improve. It's not so much that people with mental illness will attain precisely the vision they create, but that they need to have a clear image of the possibilities before they can make difficult changes and take positive steps.

Empowerment

To move forward, people need to have a sense of their own capability and their own power. Their hope needs to be focused on things they can do for themselves rather than on new cures or fixes that someone else will discover or give them.

To be empowered, they need access to information and the opportunity to make their own choices. They may need encouragement to start focusing on their strengths instead of their losses. Sometimes they need another person to believe in them before they're confident enough to believe in themselves.

"Readiness" often occurs only in retrospect after they have done something successfully, so waiting until a person with mental illness is ready to move on can often be stagnating and disempowering. Often people have to experience success before they believe they can be successful.

Self-Responsibility

As people with mental illness move toward recovery, they realize they have to take responsibility for their own lives. This means they have to take risks, try new things and learn from their mistakes and failures. It also means they need to let go of the feelings of blame, anger and disappointment associated with their illness.

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This is a particularly difficult stage for people with mental illness and their caregivers. Old patterns of dependency must be broken, and mental health professionals need to encourage clients to take charge instead of settling for the ease and safety of being taken care of.

A Meaningful Role in Life
Ultimately, in order to recover, people with mental illness must achieve some meaningful role in their lives that is separate from their illness. Being a victim is not a recovered role, and frankly, neither is being a survivor.

Newly acquired traits like increased hopefulness, confidence and self-responsibility need to be applied to "normal" roles such as employee, son, mother and neighbor. It is important for people to join the larger community and interact with people who are unrelated to their mental illness. Meaningful roles end isolation and help people with mental illness recover and "get a life."

This series of stages can provide a roadmap, albeit a fluid one, of the process of recovery that can be applied, specifically, to helping people recover from having a serious mental illness. For me, it has been a much better roadmap than the medical model's version.

Although the medical model relies on objective, measurable signs and symptoms and scientifically defined illnesses, psychiatric histories rarely feel "real." On the other hand, subjective, experiential stories of recovery almost always do. I have heard many moving accounts by people with serious mental illness who have described to me what it is like to travel on a road to recovery.'

So let's just summarise here some of the key factors that facilitate a person's recovery from addiction:

Hope, that takes the form of an actual, reasonable vision of what things could look like if they were to improve. This hope needs to be focused on things the person can do for themselves rather than on new cures or fixes that someone else will discover or give them.

Empowerment, the person having a sense of their own capability and their own power. To be empowered, the person needs:

- access to information and the opportunity to make their own choices
- encouragement to start focusing on their strengths instead of their losses
- another person to believe in them before they're confident enough to believe in themselves.

Self-responsibility for their own lives, which means taking risks, trying new things and learning from mistakes and failures. The person must also let go of the feelings of blame, anger and disappointment associated with their illness.

A meaningful role in life that is separate from the person's substance use problems. Being a victim is not a recovered role. The person must attain "normal" roles, such as employee, son, mother and neighbour, rather than be an "addict" or "alcoholic". They must join the larger community and interact with people who do not have a substance use problem. Meaningful roles end isolation and help people to recover and "get a life."

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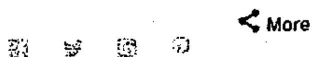

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