Mental Health Targeted Case Management Program

CASE MANAGEMENT SERVICE PLAN

Example

P9 (1)

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

Example

Recipient Name: Jane Smith **Case Number:** xyz123 p92

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 (P4 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 3

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*

Jane Smith — Recipient's Signature
4/21/20 — Date

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

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

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

BLANK

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

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Recipient Name: _____ **Case Number:** _____

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SOAP FORMAT

S= Self report from client (summary) =

This describes the patient's **self-report** of their current condition in a narrative form. What did the client say and summarize it.

Start off your note with: "Client reported….

O= Observation/Objective =

This outlines the **objective** observation of the condition and details all information and factors that can be measured. (mood, affect, body language, appearance) use ABACATT HERE|!!

Start your note off with "Client appeared….

A = Assessment (diagnostic impression) 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 (example, client's mood has shown improvement, client more talkative, or client withdrawn etc.)

Start your note off with "TCM believes …

P = Plan

This is where 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 and what is the plan for to help the client.

Start your note off with "TCM will do the following to assist the client.

ABSCATT: TIPS ON WRITING A GOOD NOTE

ALWAYS INCLUDE THIS SUMMARY IN YOUR FACE-TO-FACE NOTES! BE AS SPECIFIC AND INDIVIDUALIZED

Appearance:

Behavior:

Speech:

Cognition:

Affect/Mood:

Thought Process:

Thought Content:

Progress Note

Client's Name: _____ **Case Number:** _____

Date: _____ **Time:** _____ **Location:** _____

Subjective:

Objective:

Assessment:

Planned:

End Time: **Minutes:** **Units:** **TCM signature:** _____

Always Be prepared to ask All there Questions

Example to ask for Assessment

ASSESSMENT

Sample of one ↓

We wish to provide you with the best possible services. To do so, we need to obtain the following information. This information will be used to provide you with Case Management Services.

Client: _____ Medicaid Number: _____

Social Security number: _____ Date of Birth: _____

Location of Assessment: _____Date: _____

1. Presenting Problem
   a. What is the client's presenting problem (s) (in the client's on words).:
   _____
   _____
   b. Describe detailed events: _____
   _____
   _____
   c. What service (s) is the client asking for: _____
   _____
   _____
2. Developmental History
   a. Health at birth: _____
   b. Developmental concerns: _____
   c. Special services received: _____
3. Education and Occupation:
   a. School currently attending: _____Grade _____
   b. Education History *(learning problems, school issues)* highest grade completed:
   _____
   c. Employment history (if applicable): _____
   _____
4. **Family Origin of History**
   a. Family's current or past psychiatric history: _____
   b. Family's or client's physical/sexual /emotional abuse history: _____
   _____
   _____
   c. Family substance use / abuse history: _____

d. Other Agencies/ Systems the child is involved with or receiving services from *(include the name and primary contact person):*_____

5. Client's Legal History: _____

_____Probation start/stop dates: _____/_____

_____Restraining order

____None reported.

(*If on probation give name of the Probation Office:*_____

Community Service:_____

Substance Abuse History

_____None reported _____Caffeine _____Alcohol _____Stimulants.

_____ Marijuana _____ Tobacco _____Inhalants _____Sedatives ____Tranquilizers

_____Over the counter Medication ___Hallucinogens _____Cocaine _____Barbiturates

_____Opiates __Methamphetamines

Substance	Age of 1st Use	Greatest amount Frequency used	Current amount/Frequency used	Date last used	Method of use
RX Drugs, Valium, Librium, Xanax, Percocet, Darvon					
Marijuana, Pot Hashish, Hash oil					
Amphetamines Crystal meth, speed, ice, diet pills					
Heroin, Opiates, Codeine, Morphine					
Crack Cocaine					
Hallucinogens, LSD, PCP, Mescaline, Mushrooms					
Tranquilizers, Haldol, Thorazine					

a. Does the client have blackouts, or a history of withdrawals, seizures, etc.? ____Yes____ No

b. Has the client received treatment for drug or alcohol issues? _____Yes _____No

(*If yes, list name of treatment facility*) _____

Tobacco Use:

Have you ever used tobacco? ____Y _____n

Age of first use: _____ Age of regular use: _____ When was your last use? _____

How often do you currently use tobacco? ____none _____ daily _____1-3 times per week

____4-6 times per week _____ 2 times per month ____ monthly

Do you think of tobacco use is harmful to your health: ____y ____ n?

Has your use of tobacco caused you problems? ____y ____n

Alcohol use:

Have you ever used alcohol? ____y _____n

If yes, what type used: _____ Age of first use: _____ age of regular use: _____

When was your last use: _____

How often do you currently use: ____none _____daily ____1-3 times per week?

___4-6 times per week __ 2 times per month ___ monthly ____ other

Do you think alcohol is harmful to your health? ____y ____ n

If yes, why? _____.

Has your use of alcohol ever caused you problems? ___ y ____n

If yes, explain: _____

Is there a family history of excessive use of alcohol? ____y _____n

If yes, how were they related to you? _____

Describe how much and how often they drank: _____

Do you feel that their use of alcohol has affected you? ___y ____n

If yes, describe: _____

Have you ever felt guilty about your alcohol use? ___y ____n

Have you ever experienced memory loss when drinking or using drugs? ___y ____n

Is your family environment supportive of you making positive change? _____ y ____n

Abuse History

Have you ever been a victim of:

____ emotional abuse/neglect (examples: screaming and yelling; threatening harm or damage; threats to take away children; punching walls; name calling or humiliation)

____ physical abuse (examples; slapping, punching; choking, hair pulling, restraining, etc.)

____ sexual abuse (examples; pressured into sexual activity; involved in violent sex)

____ domestic violence OR witness to domestic violence (Violence by anyone related to the client or living with them)

____ I have never been a victim of abuse.

Have you ever committed/been accused of committing?

____ emotional abuse/neglect ____ physical abuse ____ sexual violence ____ domestic violence

____ I have never been a perpetrator of abuse.

Risk Behaviors

Have you ever engaged in fire setting? ___ y _____n

Have you ever been mean to animals? ____ y _____n

Are you ever afraid that you may physically hurt another person during or after an argument/ fight? ___ y ____n

Do you own any weapons? ____y _____n

If yes, what type of weapon(s)? _____

Where are they kept? _____

Have you ever attempted suicide? ___y ____n

When? _____

How? _____

Do you currently have, or have you recently had thoughts of harming yourself? ____y ____n

If yes, describe: _____.

Have you ever attempted to harm yourself (such as cutting): ____y ____n

When? _____

How? _____

Do you currently have or have you recently had thoughts of harming another? ____y _____n

If yes, describe: _____

Have you ever attempted to harm another? ____y ____n

How? _____

Do you have any intense fears/phobias? ____ y ___ n

If yes, specify: _____.

Client Mental Health History

DSM- diagnosis: _____ (put what you think until you have official evaluation)

a. Current and past psychiatric history: _____.

_____

b. ___Client reports no psychiatric concerns.

c. Current service provider (s): _____

d. Past service provider (s): _____

6. *Documented past and present medical conditions including allergies*): _____

_____Client reports no outstanding medical problems:

_____ Client reports no known allergies:

_____ Client reports the following medical conditions: _____

_____

Primary care physician: _____

Are you currently involved in divorce proceedings _____ child custody proceedings _____

Bankruptcy proceedings _____

What are some of your strengths? _____

What are some of your weaknesses? _____

Behavioral Health History

Have you ever had any outpatient counseling? ____y _____n

If yes, place (s) for outpatient counseling: _____

Date (s) of mental health treatment: _____

Reason (s) for mental health treatment: _____

Have you ever had inpatient/residential treatment: _____ y _____n

If yes, places for mental health treatment: _____

Date(s) of mental health treatment: _____

Reason(s) for mental health treatment: _____

Are you currently seeing a counselor or psychiatrist: ____y _____n

Have you taken psychiatric medication in the past? ____y _ ____n

If yes, specify type(s): _____

Is there a family history of mental health problems? _____y _____n

If yes, describe: _____

7. Medication History:
   a. Current psychiatric medication(s): _____

_____

_____none reported by client.

Drug Name	Dose/Frequency	Prescribing Doctor	When prescribed?	Next Refill Date

Does the client follow medication regimen? _____Yes _____No

Explain: _____

Based on this client's self-assessment, what service (s) are you going to provide?

_____

_____

What is the client's health status: ____ Agitated__ Comatose __ Forgetful

_____ Lethargic _____Depressed ____ Disoriented ____ Oriented

2. When was your last medical exam? _____.

3. Have you ever experienced an injury to your head? _____y _____n

4. Do you have any physical pain? _____y ____n

If yes, explain: _____

Are you in pain now? _____y _____n

Are you taking any over the counter medication? _____y _____n

If yes, describe _____

Do you have any diet restrictions? _____y _____n

If yes, describe _____

Sexual History

Birth control and/or precautions for STD used: _____

Do you/have you engaged I behaviors that might place you at risk for HIV infection (multiple partners, needle sharing, unprotected sex, etc.) _____y _____n

How many children does the client have? _____

Does the client have custody of child/children: ____y ___ n

If no, explain: _____

Is the client pregnant or expecting a baby? _____y _____n

If yes, the unborn is: __ 1-3 months ___ 4-6 months ____ 7-9 months.

Is the unborn baby receiving prenatal care? _____y _____n

Total number of pregnancies: _____

Are sexual behaviors part of the reason you are seeking treatment? _____y _____n

If yes, explain: _____.

Cultural Background

Are there any areas of your upbringing or family heritage that would conflict with the treatment process? _____y _____n

If yes, specify: _____

Does your ethnic background or family heritage contribute in some way to your current problem (s)? _____y ____n

If yes, explain: _____

_____

What is the primary language spoken at home? _____

Do you speak other languages fluently? _____y _____n If yes, specify: _____

Religious/Spiritual Background

Describe the religious/spiritual tradition you grew up in: _____

Do you go to church? _____y _____n Affiliation: _____

Is there anything else you would like your Case Manager to know about you? __y ___n

If yes, explain: _____

Legal History

Have you ever been arrested? _____y _____n

Charge	Date	Disposition	

Are you currently involved with the legal system/have charges pending? _____y _____n

Do you have a probation /parole officer? ____y _____n

If yes, please provide officer's name (s): _____

Social/Economic Background

Are any members of your family receiving government assistance? ____y _____n

_____Food stamps _____ AFDC ____ Medicaid ___ Medicare _____ SSI _____ SSDI

_____Other, specify: _____

What is your primary source of income? _____ Salary _____ Disability _____Retirement/pension _____SSI ____ NA

____ other, specify: _____

My income is $_____ _____per week ___ Month ____ Year

TCM signature:_____ Medicaid Provider # _____

Client Signature:_____ Date: _____

TCM Supervisor Signature:_____ Date:_____

GOALS:

DREAMS

HOPE

SKILLS/ABILITIES

BARRIERS