

Peer Support Group

Date of service *

Member Name *

Start Time & Duration *

-Notes must be daily, weekly, or monthly **

-Must have all of the dates & times the Member attended *

Location of the service (Community or CMHC) *

Goal of service, which must coincide with a current treatment plan *

Summary of each service or reference to a specific curriculum **

Plan for the next meeting ***

Progress and/or response to intervention *

Signature of the person providing the service / Credentials if licensed. Electronic Signature & Title is acceptable. *

Key:

* Medicaid Requirement - KMAP General Benefits 8/1/2008; KMAP non-PAHP Manual 8/1/2008; KMAP SED 8/1/08

** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

Case Conference

Date of service *

Member Name *

Start Time & Duration *

Location of the service (Community or CMHC) *

Goal of service, which must coincide with a current treatment plan *

Summary conference *

List the role and title of each participant△

Signature of the person providing the service / Credentials if licensed. Electronic Signature & Title is acceptable. *

Key:

* Medicaid Requirement - KMAP General Benefits 8/1/2008; KMAP non-PAHP Manual 8/1/2008; KMAP SED 8/1/08

** KHS Requirement – Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

△ CPT 2008 Standard Edition AMA page 28

CRISIS SERVICES GUIDELINES

August Version

When to bill a Crisis Service code:

1. The eligibility for crisis services is as follows:
 - a. All individuals who self-identify as experiencing a seriously acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it are eligible. An individual in crisis may be represented by a family member or other collateral contact that has knowledge of the individual's capabilities and functioning. Individuals in crisis who require this service may be using substances during the crisis. Substance use should be recognized and addressed in an integrated fashion as it may add to the risk increasing the need for engagement in care.

As a general rule, all the crisis service codes should be utilized if a person has psychiatric symptoms that are interfering with their functioning to the point that they cannot do daily life functions and without intervention would immediately be at risk for higher level of care such as hospitalization or other out of home placement. Members may also self-report that they are in an initial crisis. This service can be provided without having face to face contact with a QMHP or KHS-designated LMHP. If the Member is new to the CMHC and the person to provide the crisis intervention is not a QMHP or KHS-designated LMHP then phone contact is required with a QMHP or KHS-designated LMHP to determine if a screen is needed or if to proceed with crisis services.

2. Crisis Intervention and Stabilization Provided by an Attendant:

Crisis Intervention-Emergent-Attendant is when a Member needs to have an Attendant Care worker with them because of an inability to regulate their behavior without the assistance of another person. The attendant care worker will assist with de-escalating the crisis and will provide support with maintaining the person in their home and community. This type of intervention may occur when assistance is needed to stabilize a person prior to an emergent screen, during a screen, or immediately following a screen. This is short term and should not exceed 6 hours per episode per provider (more than one provider may be providing this level of care).

Crisis Stabilization-Ongoing-Attendant care is when without the assistance of an Attendant Care staff person to assist in daily personal living, the person will go back into a crisis state. This is short term in nature and should not exceed 66 hours per episode.

Crisis Intervention and Stabilization provided by an Attendant should not exceed 72 continuous hours.

3. Crisis Intervention and Stabilization Provided by a Bachelors Level Provider:

Crisis Intervention-Emergent-Bachelors is the same as above, but it is felt that a person with more skilled or higher trained is needed in order to provide more symptom reduction services rather than simply supportive services. This is short term and should not exceed 6 hours per episode. Billing should not exceed this amount of time.

Crisis Stabilization-Ongoing-Bachelors is the same as Crisis-Stabilization-Ongoing-Attendant Care only a more skilled or higher trained person is needed in order to help reduce symptoms. This is short term in nature and should not exceed 66 hours per episode. Billing should not exceed this amount of time.

Crisis Intervention and Stabilization provided by a Bachelors level person should not exceed 72 hours. This is not required to be provided continuously and can be spread across the duration of the episode. Billing should not exceed this amount of time.

4. Crisis Intervention and Stabilization Provided by a LMHP:

Crisis Intervention-Emergent-LMHP is the same as above only if it is felt that a Clinician's skills are needed in order to provide a higher level of clinical intervention. This is a face to face intervention. This would include a preliminary assessment of risk which may include a mental status, and the need for further evaluation or other mental health services. This service also includes contact with the client, family members, or other collateral sources (e.g. caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to other alternative mental health services at an appropriate level. This also includes a clinician utilizing specific treatment interventions such as cognitive behavioral therapeutic techniques or other techniques that only a clinician who has had a higher level of training can provide.

5. Crisis Services can be billed concurrently for the purpose of safety of the consumer and staff when the rules listed below are followed:

- a. Emergent Crisis Interventions at all levels can be billed concurrently with Emergent Crisis Intervention provided by a second staff member for the first 3 hours of the crisis intervention.
- b. Ongoing Crisis Stabilization provided by a Bachelors level provider or an Attendant Care Provider can be billed concurrently with a second staff member for up to the first 24 hours of the crisis episode.
- c. Each episode must be face to face. The ongoing intervention for Crisis Services cannot exceed 14 days.

6. All documentation in the chart must reflect the actual crisis, what interventions were used, the Member's response to the interventions, family involvement and when the crisis is resolved. (An outline for documentation of all levels of interventions for these codes can be found below).

7. Generally crisis interventions should not be billed post discharge from an acute care hospitalization as the person is to have been stabilized.

8. An episode is defined as the initial face to face contact with the Member until the current crisis is resolved, not to exceed 14 days. The Member’s chart must reflect resolution of the crisis which marks the end of the current episode. If the beneficiary has another crisis within seven calendar days of a previous episode, it shall be considered part of the previous episode, and a new episode will not be allowed. This means that 7 days after the initial onset of a crisis episode a new episode cannot be billed. If a person goes back into crisis before the 7 days after the episode has resolved then the treatment team may want to consider a higher level of care.

A new episode is determined by a lapse in time. There must be 7 days after an episode has been resolved prior to restarting crisis services.

Crisis Intervention - Emergent

| Associates | Bachelors | LMHP |
|---|----------------------------------|---|
| Up to 6 hours per episode per provider | Up to 6 hours per episode | Up to 6 hours: only if episode requires clinical interventions at the masters’ level. |

Multiple providers may bill for Crisis Intervention-Emergent services as long as it is medically necessary and documented in the Member’s record.

Crisis Stabilization- Ongoing

| Associates | Bachelor’s | LMHA |
|-----------------------------------|-----------------------------------|-------------|
| Up to 66 hours per episode | Up to 66 hours per episode | N/A |

Episode: Is a single specific occurrence requiring direct specialized clinical interventions, time limited, and symptom specific.

GUIDELINES FOR DOCUMENTING INITIAL AND ONGOING CRISIS SERVICES

- A. Date of Service *
- A. Member Name *
- A. Start Time & Duration *
- A. Location of the service (Community or CMHC) *
- A. List all participants during service (family, local law enforcement, or other staff) *
- A. Goal of service, which may not coincide with a current treatment plan if Member is new to services or has a new problem. The goal could be assess or stabilize; working toward reducing symptoms that are causing the crisis. *
- A. Brief Mental Status, including but not limited to affect, orientation, and thought content. (LMHP's only) **
- I. Summary of the crisis and symptoms that indicate the person is in a crisis **

Documentation demonstrates the staff person is assisting the Member with regaining or maintaining the ability to make independent choices and to take a proactive role in treatment including discussing questions or concerns about medications, diagnosis, or treatment with his or her clinician. *

Documentation demonstrates the staff person is assisting the Member to identify and effectively respond to or avoid identified precursors or triggers that result in functional impairments. *

- A. Summary of the intervention/service *
- A. Response to intervention *

A plan for what will be worked on with the Member. How will this be worked on for ongoing crisis intervention? Include a crisis plan in case things escalate. **

List other services to be utilized to help the Member and when those services are to take place. **

Resolution of the crisis must be clearly documented *

- A. Signature of the person providing the service. Credentials if licensed. Electronic Signature & Title is acceptable. *

Key:

A. Denotes Always Document

I. Denotes Document Only for an Initial Crisis Service

Note: All listed that do not have an A- or an I- are to be documented when it is appropriate

* Medicaid Requirement - KMAP General Benefits 8/1/2008; KMAP non-PAHP Manual 8/1/2008; KMAP SED 8/1/2008

** KHS Requirement - Provider Manual –Effective December 1, 2008

Outpatient Therapy

Group Outpatient Psychotherapy

Date of service *

Member Name *

Start Time & Duration *

Goal of service, which must coincide with a current treatment plan *

Summary of the intervention/service *

Member progress and/or response to intervention *

Plan for next group ***

Signature & Credentials of the person providing the service. Electronic Signature & Title is acceptable. *

Key:

* Medicaid Requirement - KMAP General Benefits 8/1/2008; KMAP non-PAHP Manual 8/1/2008; KMAP SED 8/1/08

** KHS Requirement – Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

Outpatient Therapy

Individual Therapy

Date of service *

Member Name *

Start Time & Duration *

Goal of service, which must coincide with a current treatment plan *

Summary of the intervention/service *

Member progress and/or response to intervention *

Plan for next session (homework, time frame between appointments) ***

Signature & Credentials of the person providing the service. Electronic Signature & Title is acceptable. *

Key:

* Medicaid Requirement - KMAP General Benefits 8/1/2008; KMAP non-PAHP Manual 8/1/2008; KMAP SED 8/1/08

** KHS Requirement – Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

Admission Summary / Intake

Date of Service *

Member Name *

Start Time & Duration *

Date of Birth **

ID Number *

Gender ***

Marital status if applicable ***

Referral source ***

Chief complaint/Presenting problem/s *

Current symptoms *

Current and/or past substance use or dependence and present and/or past mental health and/or substance abuse treatment (Pertinent past & present history) ***

Family history of mental health or substance abuse problems ***

Level of education completed and any significant issues regarding school performance or behavior ***

Meeting or when met developmental milestones ‡

Current or past physical, emotional or sexual abuse. Current or past neglect. Either victim or perpetrator (Pertinent past & present history) ***

Current medications *

Mental status **

Diagnosis to include all 5 axes *

Special Health Care Needs Status **

Strengths and preferences of the Member ***

Treatment recommendations and response to recommendations ***

Signature of the person providing the service. Electronic Signature & Title is acceptable. *

Key:

* Medicaid Requirement - KMAP General Benefits 8/1/2008; KMAP non-PAHP Manual 8/1/2008; KMAP SED 8/1/08

** KHS Requirement – Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

‡ KHS suggestion for children only

Outpatient Medical Service

Medication Administration by Injection

Date of service *

Member Name *

Start Time & Duration *

Reason for visit *

Goal of service, which must coincide with a current treatment plan *

Summary of the intervention/service *

- Name & dosage of medication **
- Anatomic site of injection & route of administration (IV, IM, SQ) **

Document any reported side effects **

If there are any changes, document the change and rationale *

Signature & Credentials of the person providing the service. Electronic Signature & Title is acceptable. *

The Member record is to include a corresponding physician's order and chart note to support this service. **

(Bullet points are elements that evidence the Medicaid requirements.)

Key:

* Medicaid Requirement - KMAP General Benefits 8/1/2008; KMAP non-PAHP Manual 8/1/2008; KMAP SED 8/1/08

** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

(Intended for codes 90772, J0515, J2680, J1631, J2794, J3490)

Outpatient Medical Service

Medical Evaluation and Management Services

Date of service *

Member Name *

Start Time & Duration *

Goal of service, which must coincide with a current treatment plan *

Summary of the intervention/service *

Informed consent (discussion of potential risks, benefits, & alternatives) must be documented for new medications **

Document Changes in Medication & Doses (also Rationale for Changes) *

All Rx to Include: Name, Amount, Directions, Number of Refills **

Member progress and/or response to intervention *

Diagnosis **

Signature & Credentials of the person providing the service. Electronic Signature & Title is acceptable. *

NOTE: Documentation must include required elements to support the level of service billed, as specified by CMS and the CPT manual.

Key:

* Medicaid Requirement - KMAP General Benefits 8/1/2008; KMAP non-PAHP Manual 8/1/2008; KMAP SED 8/1/08

** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

Outpatient Medical Service

Medication Management

Date of service *

Member Name *

Start Time & Duration *

Goal of service, which must coincide with a current treatment plan *

Summary of the intervention/service *

Informed consent (discussion of potential risks, benefits, & alternatives) must be documented for new medications **

Document Changes in Medication & Doses (also Rationale for Changes) *

All Rx to Include: Name, Amount, Directions, Number of Refills **

Member progress and/or response to intervention *

Diagnosis **

Signature & Credentials of the person providing the service. Electronic Signature & Title is acceptable. *

Key:

* Medicaid Requirement - KMAP General Benefits 8/1/2008; KMAP non-PAHP Manual 8/1/2008; KMAP SED 8/1/08

** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

Outpatient Medical Services

Individual Therapy with Medical Evaluation and Management Services

Date of service *

Member Name *

Start Time & Duration *

Goal of service, which must coincide with a current treatment plan *

Summary of the intervention/service *

Summary of issues addressed in therapy **

Therapy homework to be done prior to the next session, if relevant ***

Informed consent (discussion of potential risks, benefits, & alternatives) must be documented for new medications **

Document Changes in Medication & Doses (also Rationale for Changes) *

All Rx to Include: Name, Amount, Directions, Number of Refills **

Member progress and/or response to intervention *

Diagnosis **

Signature & Credentials of the person providing the service. Electronic Signature & Title is acceptable. *

Key:

* Medicaid Requirement - KMAP General Benefits 8/1/2008; KMAP non-PAHP Manual 8/1/2008; KMAP SED 8/1/08

** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

Peer Support

Date of service *

Member Name *

Start Time & Duration *

Location of the service (Community or CMHC) *

Goal of service, which must coincide with a current treatment plan *

Summary of the intervention/service *

Plan for the next meeting ***

Progress and/or response to intervention *

Signature of the person providing the service / Credentials if licensed. Electronic Signature & Title is acceptable. *

Key:

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** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

PRTF Alternative Waiver Service

Employment Preparation and Support

Date of service *

Member Name *

Start Time & Duration *

Location of the service (Community or CMHC) *

Goal of service, which must coincide with a current treatment plan *

Summary of the intervention/service (employment preparation and support does not include supervision activities provided as a part of a normal business setting) *

Member progress and/or response to intervention *

Signature of the person providing the service / Credentials if licensed. Electronic Signature & Title is acceptable. *

Key:

* Medicaid Requirement - KMAP General Benefits 8/1/2008; KMAP non-PAHP Manual 8/1/2008; KMAP SED 8/1/08

** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

PRTF Alternative Waiver Service

Attendant Care

Date of service *

Member Name *

Start Time & Duration *

Location of the service (Community or CMHC) *

Goal of service, which must coincide with a current treatment plan *

Summary of the service *

Member behavior and/or response to service *

Signature of the person providing the service / Credentials if licensed. Electronic Signature & Title is acceptable. *

Key:

* Medicaid Requirement - KMAP General Benefits 8/1/2008; KMAP non-PAHP Manual 8/1/2008; KMAP SED 8/1/08

** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

PRTF Alternative Waiver Service

Independent Living / Skills Building

Date of service *

Member Name *

Start Time & Duration *

Location of the service (Community or CMHC) *

Goal of service, which must coincide with a current treatment plan *

Summary of the intervention/service *

Member progress and/or response to intervention *

Plan for the next meeting ***

Signature of the person providing the service / Credentials if licensed. Electronic Signature & Title is acceptable. *

Key:

* Medicaid Requirement - KMAP General Benefits 8/1/2008; KMAP non-PAHP Manual 8/1/2008; KMAP SED 8/1/08

** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

PRTF Alternative Waiver Service

Parent Support

Date of service *

Member Name *

Start Time & Duration *

Location of the service (Community or CMHC) *

Goal of service, which must coincide with a current treatment plan *

Summary of the intervention/service *

Progress and/or response to intervention *

Plan for next meeting ***

Signature of the person providing the service / Credentials if licensed. Electronic Signature & Title is acceptable. *

Key:

* Medicaid Requirement - KMAP General Benefits 8/1/2008; KMAP non-PAHP Manual 8/1/2008; KMAP SED 8/1/08

** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

PRTF Alternative Waiver Service

Professional Resource Family Care (Crisis Stabilization)

Date of service *

Member Name *

Goal of service, which must coincide with a current treatment plan *

Summary of the intervention/service *

Member progress and/or response to intervention *

Plan for the future if indicated ***

Signature of the person providing the service / Credentials if licensed. Electronic Signature & Title is acceptable. *

There must be at a minimum one progress note per day **

Key:

* Medicaid Requirement - KMAP General Benefits 8/1/2008; KMAP non-PAHP Manual 8/1/2008; KMAP SED 8/1/08

** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

PRTF Alternative Waiver Service

Respite

Date of service *

Member Name *

Start Time & Duration *

Location of the service (Community or CMHC) *

Goal of service, which must coincide with a current treatment plan *

Summary of the intervention/service *

Member progress and/or response to intervention *

Plan for the future if indicated ***

Signature of the person providing the service / Credentials if licensed. Electronic Signature & Title is acceptable. *

Key:

* Medicaid Requirement - KMAP General Benefits 8/1/2008; KMAP non-PAHP Manual 8/1/2008; KMAP SED 8/1/08

** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

Psychological Testing

Date of Service *

Member Name *

Start Time & Duration *

ID Number ***

Tool/s Administered *

Member behavior and/or response to service *

Signature & Credentials of the person providing the service. Electronic Signature & Title is acceptable. *

Key:

* Medicaid Requirement - KMAP General Benefits 8/1/2008; KMAP non-PAHP Manual 8/1/2008; KMAP SED 8/1/08

** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

HCBS SED WAIVER

Attendant Care

Date of service *

Member Name *

Start Time & Duration *

Location of the service (Community or CMHC) *

Goal of service, which must coincide with a current treatment plan *

Summary of the service *

Member behavior and/or response to service *

Signature of the person providing the service / Credentials if licensed. Electronic Signature & Title is acceptable. *

Key:

* Medicaid Requirement - KMAP General Benefits 8/1/2008; KMAP non-PAHP Manual 8/1/2008; KMAP SED 8/1/08

** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

HCBS SED Waiver Service

Independent Living / Skills Building

Date of service *

Member Name *

Start Time & Duration *

Location of the service (Community or CMHC) *

Goal of service, which must coincide with a current treatment plan *

Summary of the intervention/service *

Member progress and/or response to intervention *

Plan for next meeting ***

Signature of the person providing the service / Credentials if licensed. Electronic Signature & Title is acceptable. *

Key:

* Medicaid Requirement - KMAP General Benefits 8/1/2008; KMAP non-PAHP Manual 8/1/2008; KMAP SED 8/1/08

** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

HCBS SED Waiver Service

Parent Support

Date of service *

Member Name *

Start Time & Duration *

Location of the service (Community or CMHC) *

Goal of service, which must coincide with a current treatment plan *

Summary of the intervention/service *

Plan for the next meeting ***

Progress and/or response to intervention *

Signature of the person providing the service / Credentials if licensed. Electronic Signature & Title is acceptable. *

Key:

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** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

HCBS SED Waiver Service

Professional Resource Family Care (Crisis Stabilization)

Date of service *

Member Name *

Goal of service, which must coincide with a current treatment plan *

Summary of the intervention/service *

Member progress and/or response to intervention *

Plan for future services ***

Signature of the person providing the service / Credentials if licensed. Electronic Signature & Title is acceptable. *

There must be at a minimum one progress note per day **

Key:

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** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

HCBS SED Waiver Service

Respite

Date of service *

Member Name *

Start Time & Duration *

Location of the service (Community or CMHC) *

Goal of service, which must coincide with a current treatment plan *

Summary of the intervention/service *

Member progress and/or response to intervention *

Plan for future services ***

Signature of the person providing the service / Credentials if licensed. Electronic Signature & Title is acceptable. *

Key:

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** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

HCBS Waiver Service

Wrap Around

Date of service *

Member Name *

Start Time & Duration *

Location of the service (Community or CMHC) *

Goal of service, which must coincide with a current treatment plan *

Summary of the intervention/service *

Member progress and/or response to intervention *

List the role of all participants unless there is a POC done at this meeting **

Signature of the person providing the service / Credentials if licensed. Electronic Signature & Title is acceptable. *

Key:

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** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

Targeted Case Management

Date of service *

Member Name *

Start Time & Duration *

Goal of service, which must coincide with a current treatment plan *

Summary of the intervention/service *

Plan for future and/or next meeting ***

Signature of the person providing the service / Credentials if licensed. Electronic Signature & Title is acceptable. *

Note: If TCM is being provided a physician must sign the treatment plan.

Key:

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** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

Psychological Testing Final Report

Date of Service *

Member Name *

Start Time & Duration *

ID Number ***

Reason for Referral & Referral Source *

DSM IV-TR (or use most current DSM) diagnosis ***

Identify Questions & Issues Addressed *

Pertinent Past & Present history *

Brief Mental Status, including but not limited to affect, orientation, and thought content. (LMHP's only) *

Summary of the intervention/service *

Illustrate Need for Initiating or Continuing Intervention (rationale the test/testing)*

Interpretation of Findings with Impressions & Observations *

Suggestions/Recommendations Related to Everyday Existence when applicable *

Member behavior and/or response to service *

Signature & Credentials of the person providing the service. Electronic Signature & Title is acceptable. *

Key:

* Medicaid Requirement - KMAP General Benefits 8/1/2008; KMAP non-PAHP Manual 8/1/2008; KMAP SED 8/1/08

** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

PRTF Alternative Waiver Service

Wrap Around

Date of service *

Member Name *

Start Time & Duration *

Location of the service (Community or CMHC) *

Goal of service, which must coincide with a current treatment plan *

Summary of the intervention/service *

Member progress and/or response to intervention *

List the role of all participants unless there is a POC done at this meeting **

Signature of the person providing the service / Credentials if licensed. Electronic Signature & Title is acceptable. *

Key:

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** KHS Requirement - Effective December 1, 2008

*** KHS Suggestion - Effective December 1, 2008

Treatment Plan

Date of Service *

- Treatment plan must be completed within 14 days of admission to treatment services and reviewed and updated no later than every 90 days thereafter. *
- Members receiving medication services only do not require treatment plan reviews as the progress note is the equivalent.*

Member Name *

Date of Birth **

ID Number *

DSM Diagnosis (utilizing the most current DSM and Axis I and II required) *

Goal(s) *

Treatment Objectives and/or Action Steps *

Strengths and Preferences ***

Treatment regimen to achieve objectives. Services or treatment modalities to be utilized (identify what types of services such as therapy, psychotherapy group, parent support, pharmacotherapy etc.) and duration of treatment *

Projected schedule for service delivery (daily, weekly, monthly etc...) *

Type of personnel required to deliver the services *

Identify individual to coordinate treatment ***

Special Health Care Needs Status **

Signature and credentials of LMHP approving the plan. Electronic signature and title is acceptable. *

Signature of Member or documentation that Member participated in the development of the treatment plan. *

Special Note:

1. Follow Waiver Guidelines for Members on the HCBS SED and PRTF Waiver.
2. Prognosis that has been reviewed and updated within the last 90 days needs to also be documented within the Member's chart *
3. If TCM is provided a physician must sign the treatment plan. *
4. If you are working at a Community Mental Health Center you will still need to know your licensing requirements and any other credentialing requirements that your center may have obtained.

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