To:	**BHS Short-Term Residential Therapeutic Program (STRTP) Contracted Service Providers**
From:	**BHS Children Youth and Families (CYF)**
Date:	**November 20, 2020**
Title	**STRTP Forms – Revised Forms Effective November 2020** **Replaces CYF Memo #07 – 19/20 "STRTP Forms – Effective July 2019"**

In July 2019, BHS CYF created documentation templates to help STRTP providers meet Department of Health Care Services (DHCS) Interim Mental Health Program Approval Protocol requirements. In November 2020, BHS CYF reviewed and updated these templates in accordance with the release of DHCS Interim STRTP Regulations (Version 2). This Notice provides a summary of the individually released mandated forms which include:

- **Admission Statement** - Per DHCS requirements, all clients in an STRTP must have an Admission Statement completed and signed by the Head of Service within 5 calendar days of arrival at the STRTP. *Released June 24, 2019.*
- **Admission Statement Explanation Form** – Provides instructions on how to complete the Admission Statement. *Released June 24, 2019.*
- **Medication Progress Note Templates** – The medication progress note templates for Service Codes 24-28 were updated to meet DHCS requirements for STRTPs. A progress note template titled "STRTP Meds Not Prescribed" for Service Code 11 was developed to document a "Medication Evaluation Progress Note – Service" when a medication evaluation occurs for a child that is not prescribed medication. *Released June 24, 2019.*
- **Behavioral Health Assessment (BHA)** – The BHA was updated to include help text assisting STRTPs to meet all DHCS requirements. *Released June 24, 2019.*
- **Client Plan** – The Client Plan form fill version was updated to include text assisting STRTPs to meet all DHCS requirements. *Released June 10, 2019, updated November 20, 2020.*
- **STRTP Utilization Management (UM) Request** (STRTP Outpatient Only) – The STRTP UM Request was developed for STRTP providers to have a Utilization Management form specific to the STRTP level of care. The STRTP UM request includes a section to document the STRTP Interim Version 2 requirements for the "Clinical Review, Collaboration, and Transition Determination Report". STRTP UM Requests need to be completed every 90 calendar days for each child residing in a STRTP. STRTP UM Requests are reviewed by the BHS CCR team. *Released November 20, 2020 (replaces the Interim Intensive Service Request (Outpatient)).*
- **STRTP UM Request Explanation Form** (STRTP Outpatient Only) – Provides instructions on how to complete the STRTP UM Request. *Released November 20, 2020.*
- **Prior Authorization for Day Services Request (DSR)** (STRTP Day Services Providers Only) – The Prior Authorization for Day Services Request (DSR) is utilized to request authorization prior to the provision of Day Services, in accordance with DHCS Information Notice 19-026 which outlines specific mental health services requiring prior authorization. The DSR includes a section to document the STRTP Interim Version 2 requirements for the "Clinical Review, Collaboration, and Transition Determination Report." The DSR is submitted to Optum at least 5 days prior to the provision of Day Services, and within 5 calendar days from the expiration of the previous authorization, which is every 90 calendar days for STRTP. *Released December 19, 2019, updated November 20, 2020.*
- **Prior Authorization for Day Services Request (DSR) Explanation Form** (STRTP Day Services Providers Only) – Provides instructions on how to complete the DSR. *Released December 19, 2019, updated November 20, 2020.*
- **Transition Determination Plan** – The Transition Determination Plan was updated to include revised timelines for completion, additional information for living placement upon discharge, additional medical information and the date the school and placing agency are notified of transition from the STRTP. The Transition Determination Plan is completed for each client in the STRTP within 5 calendar days prior to discharge from the STRTP (done prior to

For More Information:

- Contact your Contracting Officer's Representative (COR) or
- Seth Williams, BHS Program Manager, Seth.Williams@sdcounty.ca.gov , 619-584-3042

To:	**BHS Short-Term Residential Therapeutic Program (STRTP) Contracted Service Providers**
From:	**BHS Children Youth and Families (CYF)**
Date:	**November 20, 2020**
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aftercare, when applicable). A copy of the Transition Determination Plan is offered to the client, parent/caregiver or guardian, and placing agency representative. Signatures from the client and parent/caregiver/guardian are documented on the hard copy signature page. *Released June 24, 2019, updated November 20, 2020.*

- **Transition Determination Plan Explanation Form** – Provides instructions on how to complete the Transition Determination Plan. *Released June 24, 2019, updated November 20, 2020.*
- **STRTP Discharge Summary** – The STRTP Discharge Summary is completed for each client in the STRTP within 7 calendar days after discharge from the STRTP and is a companion to the Transition Determination Plan. The STRTP Discharge Summary has a tab pre-populated with the Transition Determination Plan, which can be updated as needed upon completion of the STRTP Discharge Summary. For youth who transition to STRTP aftercare, the STRTP Discharge Summary is completed upon conclusion of aftercare. *Released July 12, 2019.*
- **STRTP Discharge Summary Explanation Form** – Provides instructions on how to complete the STRTP Discharge Summary. *Released July 12, 2019.*

Attachments

- Admission Statement – *released June 24, 2019*
- Admission Statement Explanation Form – *released June 24, 2019*
- Medication Progress Note Templates – *released June 24, 2019*
- Behavioral Health Assessment – *released June 24, 2019*
- Client Plan – *updated November 20, 2020*
- STRTP Utilization Management Request – *released November 20, 2020*
- STRTP Utilization Management Request Explanation Form – *released November 20, 2020*
- Prior Authorization for Day Services Request – *updated November 20, 2020*
- Prior Authorization for Day Services Request Explanation Form – *updated November 20, 2020*
- Transition Determination Plan – *updated November 20, 2020*
- Transition Determination Plan Explanation Form – *updated November 20, 2020*
- STRTP Discharge Summary – *released July 12, 2019*
- STRTP Discharge Summary Explanation Form – *released July 12, 2019*

References

- DHCS MHSUDS Information Notice No.: 20-005 Dated February 28, 2020: Statewide Criteria for Mental Health Program Approval for Short-Term Residential Therapeutic Programs and Enclosure 1 – Interim STRTP Regulations (Version 2)
- DHCS MHSUDS Information Notice No.: 17-016 Dated May 5, 2017; Statewide Criteria for Interim Mental Health Program Approval for STRTP and Enclosure 2 – Draft Interim STRTP Regulations

cc: Optum Public San Diego

For More Information:

- Contact your Contracting Officer's Representative (COR) or
- Seth Williams, BHS Program Manager, Seth.Williams@sdcounty.ca.gov , 619-584-3042

San Diego County Mental Health Services
Short-Term Residential Program (STRTP)
ADMISSION STATEMENT

***Client Name:** **Client's Preferred Pronouns**

***Case #:**

***Intake Date:** ***STRTP Name:**

The Admission Statement is to be completed by the Head of Service or acting Head of Service within 5 days of a child's arrival into the STRTP.

1. Head of Service has read the child's Behavioral Health Assessment? ☐ **Yes** ☐ **No**

2. Head of Service has considered the child's needs and safety? ☐ **Yes** ☐ **No**

3. Head of Service has considered the needs and safety of the other children placed at the STRTP named above? ☐ **Yes** ☐ **No**

4. Head of Service affirms that the child meets criteria for admission established in California Welfare Institutions Code section 11462.01(b): *Child must meet all three criteria for admission to a STRTP.*

   a. Does the child require inpatient care in a licensed health facility (i.e. inpatient psychiatric hospitalization)?
   ☐ **Does not require inpatient care** ☐ **Requires inpatient care**

   b. The child has been assessed as requiring the level of services provided in a STRTP in order to maintain the safety and well-being of the child or others due to behaviors, including those resulting from traumas, that render the child or those around the child unsafe or at risk of harm, or that prevent the effective delivery of needed services and supports provided in the child's own home or in other family settings, such as with a relative, guardian, foster family, resource family, or adoptive family?
   ☐ **Yes** ☐ **No**

   c. The child has been assessed as having a commonality of needs with the other children in the STRTP?
   ☐ **Yes** ☐ **No**

5. And the child meets <u>at least</u> one of the following conditions: *The child may meet more than one of the following conditions.*

    a. The child has been assessed as meeting Medical Necessity criteria for Medi-Cal Specialty Mental Health Services?

    ☐ Yes ☐ No ☐ N/A

    b. The child has been assessed as Seriously Emotionally Disturbed as defined in subdivision (a) of section 5600.3?

    ☐ Yes ☐ No ☐ N/A

    c. The child requires emergency placement in a STRTP <u>prior</u> to Interagency Placement Committee approval pursuant to paragraph (3) of subdivision (h)?

    ☐ Yes ☐ No

        i. If the child requires emergency placement prior to Interagency Placement Committee approval, a licensed mental health professional has made a written determination within 72 hours of the child's placement that the child requires the level of services and supervision provided by the STRTP in order to meet his or her behavioral or therapeutic needs?

        ☐ Yes ☐ No

        ii. Head of service certifies that the child or youth will be evaluated by the Interagency Placement Committee within 30 days of the emergency placement?

        ☐ Yes ☐ No

    d. The assessment by the Interagency Placement Committee indicated the child requires the level of services provided by the STRTP in order to meet their behavioral or therapeutic needs?

    ☐ Yes ☐ No ☐ N/A

6. Based on these considerations, the Head of Service or acting Head of Service affirms that the child meets criteria for admission into the STRTP and admittance is appropriate? ☐ Yes ☐ No

SIGNATURE

***Signature of Head of Service/Accepting the Assessment**:

_____ Date:

Signature

Printed Name: CCBH ID number:

SHORT-TERM RESIDENTIAL THERAPEUTIC PROGRAM ADMISSION STATEMENT

2019

WHEN: Completed within **five (5)** days of the youth's arrival into the Short-Term Residential Therapeutic Program (STRTP).

ON WHOM: **All clients** in a STRTP program are required to have a signed Admission Statement.

COMPLETED BY: **Head of Service** or acting Head of Service.

MODE OF COMPLETION: Completed in the **Electronic Health Record**.

REQUIRED ELEMENTS: ***Enter youth **demographic information** (name, preferred pronouns, case number)
***Enter **intake date** and **STRTP name**

Questions 1-6 shall be completed by the head of service or acting head of service:

1. Head of Service has read the child's Behavioral Health Assessment?

- Head of Service has read all of child's mental health assessments/behavioral health assessments completed within the last 6 months.
- If no mental health/behavioral health assessments have been provided by the placing agency, the Head of Service has read the BHA completed by the STRTP within 5 days of intake.

2. Head of Service has considered the child's needs and safety?

- Head of service has reviewed all documentation provided by placing agency and considered risk factors related to the child's needs and safety.

3. Head of Service has considered the needs and safety of the other children placed at the STRTP named above?

- Head of service has reviewed all documentation provided by placing agency and considered the needs and safety of other children within the STRTP milieu.

4. A STRTP may accept for placement a child who meets the following criteria from WIC section 11462.01:

- For admittance into a STRTP a child shall meet all criteria in questions 4(a) through 4(c):

4a. Does the child require inpatient care in a licensed health facility (i.e. inpatient psychiatric hospitalization)?

  - If a child requires inpatient care they are not eligible for placement in a STRTP.

4b. The child has been assessed as requiring the level of services provided in a STRTP in order to maintain the safety and well-being of the child or others due to behaviors, including those resulting from traumas, that render the child or those around the child

unsafe or at risk of harm, or that prevent the effective delivery of needed services and supports provided in the child's own home or in other family settings, such as with a relative, guardian, foster family, resource family, or adoptive family?

- The Head of Service has reviewed intake packet to determine that lower levels of care were attempted prior to placement in the STRTP.

c. The child has needs in common with other children in the care of the facility, consistent with subdivision (c) of Section 16514?

5. In addition to meeting the requirements of 4(a) through 4(c), a child must also meet **at least one** of the conditions in questions **5(a) and 5(b):**

a. The child has been assessed as meeting medical necessity criteria for Medi-Cal Specialty Mental Health Services as defined in Section 1830.205 of the California Code of Regulations

b. The child has been assessed as seriously emotionally disturbed (SED) as defined in subdivision (a) of WIC section 5600.3?

- SED is defined as minors under the age of 18 who have a mental disorder identified in the most recent Diagnostic and Statistical Manual, other than a primary substance use disorder, which results in behavior inappropriate to the child's age according to expected developmental norms.

c. The child requires emergency placement prior to Interagency Placement Committee approval pursuant to paragraph (3) of the subdivision (h) within WIC code 11462.01? If No, skip to 5(d), if Yes, complete 5c (i) and 5c (ii).

- Questions i and ii are only completed if the child was placed in the STRTP on emergency basis prior to IPC approval.

i. If the child requires emergency placement prior to Interagency Placement Committee approval, a licensed mental health professional has made a written determination within 72 hours of the child's placement that the child requires the level of services and supervision provided by the STRTP in order to meet his or her behavioral or therapeutic needs?

- In the case of emergency placement into the STRTP a BHA shall be completed within 72 hours. The Head of Service or Acting Head of Service will determine if the child meets criteria for questions 1 through 5b of this Admission Statement, based on the STRTP BHA and intake documents from the placing agency.

ii. Head of Service certifies that the child will be evaluated within 30 days of emergency placement by Interagency Placement Committee who shall determine if the placement is appropriate with recommendations from the Child and Family Team.

- The Head of Service shall coordinate with the placing agency representative to coordinate an Interagency Placement Committee review within 30 days of placement in the STRTP.

d. The child has been assessed by an Interagency Placement Committee (IPC) as requiring the level of services provided by the STRTP in order to meet his or her behavioral or therapeutic needs? All County Letter NO. 17-122

- The Head of Service has reviewed documentation that the IPC recommendation is the level of care provided by the STRTP.

6. Based on these considerations, the Head of Service affirms that admitting the child into the STRTP named above is appropriate?

- By signing the Admission Statement the Head of Service certifies that they have evaluated all criteria in questions 1-5 and placement in the STRTP is appropriate at this time.

Signature of head of service accepting the assessment and date
Print name of head of service accepting the assessment and CCBH ID number

BILLING: Can only occur when connected to a direct client service.

Client:		Case #:	Program:	
Date of Service:		Unit:	SubUnit:	
Server ID:	Service Time:		Travel Time:	Documentation Time:
Person Contacted:	Place:	Outside Facility:	Contact Type:	Appointment Type:
Billing Type (Language Service Provided In):	Intensity Type (Interpreter Utilized):		EBP (Homework/CFT):	
Diagnosis At Service: ICD-10 Code(s):			Service:	

MEDICATION PROGRESS NOTE – SERVICE CODE 24 – MEDS EM MINIMAL PROBELM

Diagnosis:

Chief Complaint/Current Condition:

Current Substance Use:

Response to Medication (Include effectiveness/compliance/side effects):

Service Provided: (Provide justification for continued medication use or any other changes to the medication plan):

Other Information (Review of CURES Database)**:**

Answer the Following Question(s) for Children or Youth Residing in a Short-Term Residential Therapeutic Program (Not applicable if client is not residing in an STRTP. The client plan is used in place of the Needs and Services Plan for the purpose of the STRTP Mental Health Program):

1.The Psychiatrist has considered the goals and objectives of the Client Plan and medication prescribed is consistent with this Plan (Provide a YES or NO answer)

2. If No, provide an explanation of needed updates to the Client Plan:

*Signature/Title/Credential Date Printed Name/Credential/Server ID#

* I certify that the service/s shown on this sheet was provided by me personally and the service/s were medically necessary.

Co-Signature/Title/Credential Date Printed Name/Credential/Server ID#

Client:		Case #:	Program:	
Date of Service:		Unit:	SubUnit:	
Server ID:	Service Time:		Travel Time:	Documentation Time:
Person Contacted:	Place:	Outside Facility:	Contact Type:	Appointment Type:
Billing Type (Language Service Provided In):	Intensity Type (Interpreter Utilized):		EBP (Homework/CFT):	
Diagnosis At Service: ICD-10 Code(s):			Service:	

MEDICATION PROGRESS NOTE – SERVICE CODE 25 – MEDS EM MINOR PROBLEM

Diagnosis (Include rule out(s). Include status: improved, well controlled, resolving or resolved; or inadequately controlled, worsening, or failing to change as expected):

Chief Complaint:

History (Brief history of present illness or problem, associated signs/symptoms):

Vitals (See nursing progress note or Doctor's Homepage entry from today's visit):

Current Substance Use:

Psychiatric Exam (Description of speech, thought process, associations, abnormal or psychotic thoughts, judgment and insight, MSE, SI/HI, etc.):

Response to Medication (Include effectiveness/compliance/side effects):

Service Provided (Provide justification for continued medication use or any other changes to the medication plan):

Other Information (Review of CURES Database):

Answer the Following Questions for children or Youth Residing in a Short-Term Residential Therapeutic Program (Not applicable if client is not residing in an STRTP. The client plan is used in place of the Needs and Services Plan for the purpose of the STRTP Mental Health Program):

1. **The Psychiatrist has considered the goals and objectives of the Client Plan and**

medication prescribed is consistent with this Plan (Provide a YES or NO answer)

If no, provide an explanation of needed updates to the Client Plan:

*Signature/Title/Credential Date Printed Name/Credential/Server ID#

* I certify that the service/s shown on this sheet was provided by me personally and the service/s were medically necessary.

Co-Signature/Title/Credential Date Printed Name/Credential/Server ID#

Client:		Case #:	Program:	
Date of Service:		Unit:	SubUnit:	
Server ID:	Service Time:		Travel Time:	Documentation Time:
Person Contacted:	Place:	Outside Facility:	Contact Type:	Appointment Type:
Billing Type (Language Service Provided In):	Intensity Type (Interpreter Utilized):		EBP (Homework/CFT):	
Diagnosis At Service: ICD-10 Code(s):			Service:	

MEDICATION PROGRESS NOTE – SERVICE CODE 26 – MEDS EM EXPANDED LOW

Diagnosis (Include rule out(s). Include status: improved, well controlled, resolving or resolved; or inadequately controlled, worsening, or failing to change as expected):

Chief Complaint:

History (Brief history of present illness, problem pertinent system review, associated signs/symptoms):

Vitals (See nursing progress note or Doctor's Homepage entry from today's visit):

Psychiatric Exam (Description of speech, thought process, associations, abnormal or psychotic thoughts, judgment and insight, MSE, SI/HI, etc.):

Physical Health (Changes to non-psychotropic medication, changes in health status, medication interactions, medical referrals):

Current Substance Use:

Response to Medication (Include effectiveness/compliance/side effects):

Current Medication Changes (Indicate reason for change such as critical decision points, diagnosis change, symptoms worse/lack of progress, client preference, side-effects intolerable):

Plan of Care (Include diagnostic exam, lab tests, target symptoms, psychotherapeutic needs, progress on recovery/resiliency goals):

Other Information (Review of CURES Database):

Answer the Following Question(s) for Children or Youth Residing in a Short-Term Residential Therapeutic Program (Not applicable if client is not residing in an STRTP. The client plan is used in place of the Needs and Services Plan for the purpose of the STRTP Mental Health Program):

1. The Prescribing Physician has considered the goals and objectives of the Client Plan and medication prescribed is consistent with this Plan (Provide a YES or NO answer)

2. If no, provide an explanation of needed updates to the Client Plan:

*Signature/Title/Credential Date Printed Name/Credential/Server ID#

* I certify that the service/s shown on this sheet was provided by me personally and the service/s were medically necessary.

Co-Signature/Title/Credential Date Printed Name/Credential/Server ID#

Client:		Case #:	Program:	
Date of Service:		Unit:	SubUnit:	
Server ID:	Service Time:		Travel Time:	Documentation Time:
Person Contacted:	Place:	Outside Facility:	Contact Type:	Appointment Type:
Billing Type (Language Service Provided In):	Intensity Type (Interpreter Utilized):		EBP (Homework/CFT):	
Diagnosis At Service: ICD-10 Code(s):			Service:	

MEDICATION PROGRESS NOTE – SERVICE CODE 27 – MEDS EM DETAILED MODERATE

Diagnosis (Include rule out(s). Include status: improved, well controlled, resolving or resolved; or inadequately controlled, worsening, or failing to change as expected):

Chief Complaint:

History (Extended history of problem, problem pertinent system review extended to include a review of a limited number of additional systems, associated signs/symptoms):

Past, Family and/or Social History (Pertinent past, family and/or social history directly related to client's problems):

Vitals (See nursing progress note or Doctor's Homepage entry from today's visit):

Psychiatric Exam (General appearance, examination of gait and station, description of speech, thought process, associations, abnormal or psychotic thoughts, judgment and insight, MSE, SI/HI, etc.):

Physical Health (Changes to non-psychotropic medication, changes in health status, medication interactions, medical referrals):

Current Substance Use:

Response to Medication (Include effectiveness/compliance/side effects):

Current Medication Changes (Indicate reason for change such as critical decision points, diagnosis change, symptoms worse/lack of progress, client preference, side-effects intolerable):

Other Information (Review of CURES Database)**:**

Plan of Care (Include diagnostic exam, lab tests, target symptoms, psychotherapeutic needs, progress on recovery/resiliency goals):

Answer the Following Questions for children or Youth Residing in a Short-Term Residential Therapeutic Program (Not applicable if client is not residing in an STRTP. The client plan is used in place of the Needs and Services Plan for the purpose of the STRTP Mental Health Program):

1. The Psychiatrist has considered the goals and objectives of the Client Plan and medication prescribed is consistent with this Plan (Provide a YES or NO answer)

2. If no, provide an explanation of needed updates to the Client Plan:

*Signature/Title/Credential Date Printed Name/Credential/Server ID#

* I certify that the service/s shown on this sheet was provided by me personally and the service/s were medically necessary.

Co-Signature/Title/Credential Date Printed Name/Credential/Server ID#

Client:		Case #:	Program:	
Date of Service:		Unit:	SubUnit:	
Server ID:	Service Time:		Travel Time:	Documentation Time:
Person Contacted:	Place:	Outside Facility:	Contact Type:	Appointment Type:
Billing Type (Language Service Provided In):	Intensity Type (Interpreter Utilized):		EBP (Homework/CFT):	
Diagnosis At Service: ICD-10 Code(s):			Service:	

MEDICATION PROGRESS NOTE – SERVICE CODE 28 – MEDS EM COMPREHENSIVE HIGH

Diagnosis (Include rule out(s). Include status: improved, well controlled, resolving or resolved; or inadequately controlled, worsening, or failing to change as expected):

Chief Complaint:

History (Extended history of problem, review of systems that is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems):

Past, Family and Social History (Complete past, family and social history):

Vitals (See nursing progress note or Doctor's Homepage entry from today's visit):

Psychiatric Exam (General appearance, assessment of muscle strength and tone, examination of gait and station, description of speech, thought process, associations, abnormal or psychotic thoughts, judgment and insight, MSE, SI/HI, etc.):

Physical Health (Changes to non-psychotropic medication, changes in health status, medication interactions, medical referrals):

Current Substance Use:

Response to Medication (Include effectiveness/compliance/side effects):

Current Medication Changes (Indicate reason for change such as critical decision points, diagnosis change, symptoms worse/lack of progress, client preference, side-effects intolerable):

Plan of Care (Requires management options such as intensive monitoring of medications, closed door seclusion, suicide observation, ECT, co-morbid conditions):

Other Information (Review of CURES Database)**:**

Answer the Following Question(s) for Children or Youth Residing in a Short-Term Residential Therapeutic Program (Not applicable if client is not residing in an STRTP. The client plan is used in place of the Needs and Services Plan for the purpose of the STRTP Mental Health Program):

1. The Psychiatrist has considered the goals and objectives of the Client Plan and medication prescribed is consistent with this Plan (Provide a YES or NO answer)

2. If no, provide an explanation of needed updates to the Client Plan:

*Signature/Title/Credential Date Printed Name/Credential/Server ID#

* I certify that the service/s shown on this sheet was provided by me personally and the service/s were medically necessary.

Co-Signature/Title/Credential Date Printed Name/Credential/Server ID#

Client:		Case #:	Program:	
Date of Service:		Unit:	SubUnit:	
Server ID:	Service Time:		Travel Time:	Documentation Time:
Person Contacted:	Place:	Outside Facility:	Contact Type:	Appointment Type:
Billing Type (Language Service Provided In):	Intensity Type (Interpreter Utilized):		EBP (Homework/CFT):	
Diagnosis At Service: ICD-10 Code(s):			Service:	

STRTP MEDICATION NOT PRESCRIBED – SERVICE CODE 11 – MEDICATION EVALUATION.
***Completed at a minimum of every 90 days for youth residing in an STRTP**

Diagnosis (Include rule out(s). Include status: improved, well controlled, resolving or resolved; or inadequately controlled, worsening, or failing to change as expected):

Psychiatric Exam (Description of speech, thought process, associations, abnormal or psychotic thoughts, judgment and insight, MSE, SI/HI, etc.):

Plan of Care (Include recommendations for care, psychotherapeutic needs, progress on recovery/resiliency goals etc.):

The Psychiatrist has reviewed the course of treatment/considered the goals and objectives of the Client Plan (YES/NO) If no, psychiatrist must review client plan per STRTP requirements:

* Client Plan used in place of Needs and Services Plan for the STRTP Mental Health Program

_____

*Signature/Title/Credential Date Printed Name/Credential/Server ID#

* I certify that the service/s shown on this sheet was provided by me personally and the service/s were medically necessary.

_____

Co-Signature/Title/Credential Date Printed Name/Credential/Server ID#

San Diego County Mental Health Services
BEHAVIORAL HEALTH ASSESSMENT – CHILDREN

***Client Name**: ***Case #:**

***Assessment Date** ***Program Name**:

BHA CHILDREN TAB

PATHWAYS TO WELL-BEING/KTA

Client is involved with Child Welfare Services ☐ No ☐ Yes

May call CWS at 858-514-6995 to obtain name of current worker.

CWS PSW: PSW Phone: PSW Email:

1. Legal Status for CWS client:
   - ☐ VS – Voluntary Services *(CWS has not filed a petition due to intent to divert from dependency by providing services; Court does not have jurisdiction.)*
   - ☐ Pre-Adjudication *(CWS has filed a petition in Court; child may be with parents or may have been removed and dependency has not yet been established.)*
   - ☐ FM – Family Maintenance *(Court has jurisdiction; dependent placed at home with parent.)*
   - ☐ FR – Family Reunification *(Court has jurisdiction; dependent in out of home placement.)*
   - ☐ EFC – Extended Foster Care
   - ☐ PP – Permanent Plan: Court has jurisdiction – specify:
     i. ☐ APPLA: another planned permanent living arrangement
     ii. ☐ Legal Guardianship is pending; once finalized, dependency ends
     iii. ☐ Adoption is pending; once finalized, dependency ends

2. CWS Child Living Arrangement:
   - ☐ Parents
   - ☐ Relative
   - ☐ Non-Relative Extended Family Member (NREFM)
   - ☐ Licensed Foster Home
   - ☐ San Pasqual Academy
   - ☐ Supervised Independent Living Placement (SILP)
   - ☐ Foster Family Agency Home (FFA)
   - ☐ Licensed Group Home (LGH)
   - ☐ Residential Treatment Center (RTC) [LGH with a Mental Health Contract]
   - ☐ Short Term Residential Therapeutic Program (STRTP)

   FFA Name:
   LGH Name:
   RTC Name: ☐ RTC Level 12 ☐ RTC Level 14
   STRTP Name:

3. Petition True Finding (may be multiple): (*Based on Welfare and Institution Code, Section 300, as adjudicated by Juvenile Court)*

- ☐ Physical Abuse
- ☐ Neglect (general or severe)
- ☐ Emotional Abuse
- ☐ Sexual Abuse
- ☐ Severe Physical Abuse of child under the age of five
- ☐ Death of another child (caused by parent)
- ☐ No parent or guardian
- ☐ Freed for adoption and adoption petition not granted
- ☐ Cruelty
- ☐ Child/client at risk due to abuse of sibling

4. Katie A. Class or Sub-Class status (select one based on completed Katie A. Eligibility form): *(Not member of class or Sub-Class; no Child Welfare Services involvement; CWS section not applicable. Eligibility status pending; must determine Class vs. Sub-Class status within 30 days of assignment opening.)*

- ☐ Member of Class
- ☐ Member of Sub-Class
- ☐ Not member of Class or Sub-Class
- ☐ Eligibility status pending

OTHER AGENCY INVOLVEMENT: ☐ Regional Center ☐ Probation ☐ Other:

***SOURCE OF INFORMATION:** *(Select from Source of Information Table located in the Instructions sheet)*

If other, specify
Reports Reviewed:

Referral Source: *(Select from Referral Source Table located in the Instructions sheet. Include name, person or agency, relationship, and contact information.)*

If Other, specify:

PRESENTING PROBLEMS/NEEDS *(Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and history of present illness. Summary of client's request for services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors; include experiences of stigma and prejudice, if any.)*

PAST PSYCHIATRIC HISTORY *(Previous history of symptoms and/or mental health treatment. Describe in chronological order - where, when, and length of time. Include dates and providers related to any prior psychiatric treatment, history, traumatic and/or significant events, and/or trauma related to treatment. Include the most recent periods of stability and the characteristics of those periods.)*

HISTORY OF EARLY INTERVENTIONS:

☐ Speech-Language	☐ Occupational	☐ Behavioral
☐ Physical	☐ Hearing	☐ Counseling
☐ Parent Training	☐ Educational	☐ Developmental
☐ Psychological	☐ Special Education	

Describe:

EDUCATION:

Area of Concerns: ☐Academic ☐Behavioral ☐Social
☐No issue reported ☐Other:

Education (last grade completed):
Failed the following grade(s):

Client has an active 504 Plan:	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Client has an active IEP:	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Special Education:	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Is Client receiving mental health services through a school district?	☐ No	☐ Yes	☐ Refuse/Cannot Assess

Describe:

Educational Strengths:

EMPLOYMENT: ☐Does not apply

History of volunteer/community service:	☐ No	☐ Yes	☐ Refuse/Cannot Assess
History of work experience:	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Current work experience:	☐ No	☐ Yes	☐ Refuse/Cannot Assess

Last date worked:

Area of Concerns: ☐Skills Readiness ☐Barriers ☐Training ☐Job retention
☐No issue reported/NA ☐Other:

Describe:

Employment Strengths:

SOCIAL CONCERNS:

Peer/Social Support	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Substance use by peers	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Gang affiliations	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Family/community support system	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Religious/spirituality	☐ No	☐ Yes	☐ Refuse/Cannot Assess
*Justice system	☐ No	☐ Yes	☐ Refuse/Cannot Assess

A YES response to any of the above requires detailed documentation:

FAMILY HISTORY:

Living Arrangement*: Select from Living Arrangement Table listed on the Instruction Sheet.*

Those living in the home with client:

Have any relatives ever been impacted by the following:-*(Select from Relatives table listed in the Instructions Sheet. Indicate who and expand below if applicable)*

Suicidal thoughts, attempts:
Violence:
Domestic violence:
Substance abuse or addiction:
Other addictions:
Gang involvement:
Emotional/mental health issues:
Physical health conditions:
Intellectual developmental disorder:
Developmental delays:
Arrests:
Abuse:

Abuse reported: ☐ N/A ☐ No ☐ Yes ☐ Refuse/Cannot Assess

Include relevant family information impacting the client (*Provide relevant family history and current family information*):

Family strengths:

CULTURAL INFORMATION*: (Considerations could include language of client/family, primary language spoken at home, religious, spiritual beliefs, family structures, customs, moral/legal systems, life-style changes, socio-economic background, ethnicity, race, immigration history/experience, age, and subculture (homelessness, gang affiliations, substance use, foster care, military background), exposure to violence, abuse and neglect, experience with racism, discrimination, and social exclusion. Describe unique cultural and linguistic needs and strengths that may impact treatment. Cultural information includes an understanding of how client's mental health is impacted. Consider using the Cultural Formulation Interview in the DSM 5 for further guidance).*

SEXUAL ORIENTATION: *(Help Text see Appendix A)*

Select all that apply:

☐ Heterosexual/Straight ☐ Bisexual ☐ Lesbian ☐ Gay ☐ Queer
☐ Another sexual orientation ☐ Questioning/Unsure ☐ Decline to state

GENDER IDENTITY: *(Help Text see Appendix A)*

Assigned at birth (Select one): ☐ Male ☐ Female ☐ Decline to state

Current Gender (Select all that apply):

☐ Male ☐ Female ☐ Transgender ☐ Genderqueer
☐ Another gender identity ☐ Questioning/Unsure ☐ Decline to state

Clinical Considerations:

HISTORY OF SELF-INJURY/SUICIDE/VIOLENCE:

History of self-injury (cutting, burning)	☐ No	☐ Yes	☐ Refuse/Cannot Assess
History of suicide attempt/s:	☐ No	☐ Yes	☐ Refuse/Cannot Assess
History of violence toward another:	☐ No	☐ Yes	☐ Refuse/Cannot Assess
History of significant property destruction:	☐ No	☐ Yes	☐ Refuse/Cannot Assess
History of domestic violence:	☐ No	☐ Yes	☐ Refuse/Cannot Assess
History of abuse:	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Abuse reported: ☐ N/A	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Experience of traumatic event/s:	☐ No	☐ Yes	☐ Refuse/Cannot Assess

A YES or REFUSE/CANNOT assess response to any of the above requires detailed documentation:

SUBSTANCE USE INFORMATION:

Have you ever used tobacco/nicotine products? ☐No ☐Yes ☐ Refuse/Cannot Assess

At what age did you first use tobacco/nicotine products:

Smoker Status:

In the past 30 days, what tobacco product did you use most frequently?
If other, specify:

What age did you stop using tobacco/nicotine products?

Has the client been informed of the risks? (Smoking is a serious health risk that leads to cancer, cardiovascular disease and possibility of premature death.) ☐No ☐Yes ☐ Refuse/Cannot Assess

Have Smoking Cessation Resources been offered? ☐No ☐Yes ☐ Refuse/Cannot Assess

CRAFFT (Administer measure by providing handout or reading questions verbatim, in order and without interpretation)

For more information, contact infor@CRAFFT.org or visit www.crafft.org

HAVE YOU EVER?	Yes	No
C-Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?		

R-Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?		
A-Do you ever use alcohol or drugs while you are by yourself ALONE?		
F-Do you ever FORGET things you did while using alcohol or drugs?		
F-Does your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?		
T-Have you ever gotten into TROUBLE while you were using alcohol or drugs?		

2 or more "Yes" answers suggest a significant problem. **TOTAL:**

Have you ever experimented (only 1-3 times) with any substances? ☐ No ☐Yes ☐ Refuse/Cannot Assess
("Yes" is only to be endorsed when client is exclusively experimenting and has not progressed to regular use or abuse of any substances.)
Client has a parent or caregiver with a substance abuse problem? ☐ No ☐ Yes ☐ Refuse/Cannot Assess

History of Substance Use? (*Include use of alcohol, caffeine, over-the-counter and illicit drugs*.)
☐ No ☐ Yes ☐ Refuse/Cannot Assess

(if yes, specify substances used)

Name of Drug	Priority	Method of Admin-istration	Age 1st used	Freq-uency of Use	Days of use in last 30 days	Date of last use	Amount of last use	Amount used on a typical Day	Largest Amount Used in One Day

History of substance use treatment: *(Types of treatment, level of care, length of treatment, etc.)*

Does client have a co-occurring disorder (COD): ☐No ☐Yes ☐Refuse/Cannot Assess

Quadrant:
☐Q. I: Low / Low ☐Q. II: High / Low
☐Q III: Low / High ☐Q. IV: High / High

Stages of Change: Substance Abuse Recovery
☐Pre-Contemplation ☐Contemplation
☐Preparation/Determination ☐Action
☐Maintenance ☐Not applicable

When applicable, describe how substance use impacts current level of functioning:

Recommendation for substance use treatment: ☐No ☐Yes ☐Not applicable
If Yes:

Gambling:
Have you ever felt the need to bet more and more money? ☐No ☐Yes ☐Refuse/Cannot Assess
Have you ever had to lie to people important to you about how much you gambled? ☐No ☐Yes ☐Refuse/Cannot Assess
If Yes:

PROSPECTIVE RISK ANALYSIS TAB

ASSESSMENT OF RISK FACTORS: Any "yes" response should be addressed in the overall risk and treatment planning section. For all unlicensed staff and trainees, documentation of a consultation with a licensed staff is required. **Any "yes" response for questions with an (*) should elicit enhanced precaution, which would require review and creation of a safety plan with a licensed supervisor prior to the end of session with client.**

Has client had suicidal ideation in the past 12 months: ☐Yes ☐No ☐Unable to Assess
If Yes:
Thoughts but not intention or plan? ☐Yes ☐No ☐Unable to Assess
Thoughts with intention, but no plan? ☐Yes ☐No ☐Unable to Assess
*Thoughts, intention and plan? (method/means?) ☐Yes ☐No ☐Unable to Assess

Does client have past suicidal behaviors? ☐Yes ☐No ☐Unable to Assess
(Things to consider: first attempt, most serious attempt, substance involvement, complications, how was it prevented?)

Has client had violent/homicidal ideation or impulses in the past 12 months? ☐Yes ☐No ☐Unable to Assess
If Yes:
Thoughts/impulses, but no intention or plan? ☐Yes ☐No ☐Unable to Assess
Thoughts/impulses with intention, but no plan? ☐Yes ☐No ☐Unable to Assess
*Thoughts/impulses with intention and plan? (method/means?) ☐Yes ☐No ☐Unable to Assess

Does the client have past violent behaviors? ☐Yes ☐No ☐Unable to Assess
(Things to consider: toward property or animals, toward people, domestic violence, antisocial, intimidation, predatory)

Does client have non-suicidal self-injurious behaviors? ☐Yes ☐No ☐Unable to Assess

(Things to consider: method, severity, frequency, remote vs. ongoing)

Does the client have any recent (within the past 12 months) activating stressors? (select all that apply)

- ☐ Family/primary support group
- ☐ Social environment
- ☐ Economic/occupational/educational problems
- ☐ Housing problems
- ☐ Health problems
- ☐ Legal problems
- ☐ Other

*If yes, are these stressors experienced as "catastrophic" or insurmountable? ☐Yes ☐No ☐Unable to Assess

Does the client have any historic stressors? (select all that apply)

- ☐ Family/primary support group
- ☐ Social environment
- ☐ Economic/occupational/educational problems
- ☐ Housing problems
- ☐ Health problems
- ☐ Legal problems
- ☐ Other

*If yes, are these stressors experienced as "catastrophic" or insurmountable? ☐Yes ☐No ☐Unable to Assess

CONCURRENT CLINICAL FACTORS:

Active severe mental illness or serious emotional disturbance not yet stabilized or in remission? ☐Yes ☐No ☐Unable to Assess

Active self-destructive and/or impulsive personality traits such as that found in borderline, histrionic and/or antisocial personality disorder? ☐Yes ☐No ☐Unable to Assess

Active moderate or severe substance use disorder and/or recent relapse? ☐Yes ☐No ☐Unable to Assess

Active physical illness which causes severe pain, immobility, life dysfunction or risk of death? ☐Yes ☐No ☐Unable to Assess

*Currently experiencing hopelessness, excessive guilt/responsibility/family burden, isolation, extreme psychological pain and suffering, extreme bullying/victimization or making pre-death arrangements? ☐Yes ☐No ☐Unable to Assess

*Currently experiencing extreme confusion, paranoia, command auditory hallucinations, restlessness/agitation, anxiety/panic or severe sleep disturbance? ☐Yes ☐No ☐Unable to Assess

PROTECTIVE FACTORS: (strong religious, cultural, or inherent values against harming self/others, strong social support system, positive planning for future, engagement in treatment, valued care giving role (people or pets) and strong attachment/responsibility to others.)

OVERALL RISK AND TREATMENT PLANNING:

Based on the above analysis, along with the completed comprehensive assessment, summarize concerns with respect to client's risk for suicide, self-injury and violence, and describe what will be done to manage or mitigate these risks in the treatment plan. In addition, be sure to address any yes or yes* response in the overall treatment plan:

MENTAL STATUS EXAM TAB

☐ Unable to assess at this time.

Level of Consciousness
☐ Alert ☐ Lethargic ☐ Stuporous

Orientation
☐ Person ☐ Place ☐ Day ☐ Month ☐ Year ☐ Current Situation
☐ All Normal ☐ None

Appearance
☐ Good Hygiene ☐ Poor Hygiene ☐ Malodorous ☐ Disheveled
☐ Reddened Eyes ☐ Normal Weight ☐ Overweight ☐ Underweight

Speech
☐ Normal ☐ Slurred ☐ Loud ☐ Soft ☐ Pressured
☐ Slow ☐ Mute

Thought Process
☐ Coherent ☐ Tangential ☐ Circumstantial ☐ Incoherent ☐ Loose Association

Behavior
☐ Cooperative ☐ Evasive ☐ Uncooperative ☐ Threatening ☐ Agitated ☐ Combative

Affect
☐ Appropriate ☐ Restricted ☐ Blunted ☐ Flat ☐ Labile ☐ Other

Intellect
☐ Average ☐ Below Average ☐ Above Average ☐ Poor Vocabulary

☐ Poor Abstraction ☐ Paucity of Knowledge ☐ Unable to Rate

Mood

☐ Euthymic ☐ Elevated ☐ Euphoric ☐ Irritable ☐ Depressed ☐ Anxious

Memory

☐ Normal ☐ Poor Recent ☐ Poor Remote ☐ Inability to Concentrate
☐ Confabulation ☐ Amnesia

Motor

☐ Age Appropriate/Normal ☐ Slowed/Decreased ☐ Psychomotor Retardation
☐ Hyperactive ☐ Agitated ☐ Tremors ☐ Tics ☐ Repetitive Motions

Judgment

☐ Age Appropriate/Normal ☐ Poor ☐ Unrealistic
☐ Fair ☐ Limited ☐ Unable to Rate

Insight

☐ Age Appropriate/Normal ☐ Poor ☐ Fair ☐ Limited ☐ Adequate ☐ Marginal

Command Hallucinations

☐ No ☐ Yes, specify:

Auditory Hallucinations

☐ No ☐ Yes, specify:

Visual Hallucinations

☐ No ☐ Yes, specify:

Tactile Hallucinations

☐ No ☐ Yes, specify:

Olfactory Hallucinations

☐ No ☐ Yes, specify:

Delusions

☐ No ☐ Yes, specify:

Other observations/comments when applicable :

MEDICAL TAB

***ALLERGIES AND ADVERSE MEDICATION REACTIONS**:
(Share this allergy information with your medical staff.)

☐ No ☐ Yes ☐ Unknown/Not Reported
If yes, specify:

Does client have a Primary Care Physician? ☐ No ☐ Yes ☐ Unknown
If No, has client been advised to seek primary care? ☐ No ☐ Yes
Primary Care Physician:

Phone Number:

Seen within the last: ☐ 6 months ☐ 12 months ☐ Other:

Address of primary care physician (required if client is residing in a STRTP): ☐N/A

Hospital of choice (physical health):

Been seen for the following:

Date of last dental exam:

Hearing seems to be normal: ☐ No ☐ Yes

Hearing has been tested: ☐ No ☐ Yes

If Yes, when? Where? Results?

Vision seems normal: ☐ No ☐ Yes

Vision has been tested: ☐ No ☐ Yes

If Yes, when? Where? Results?

Wears glasses: ☐ No ☐ Yes

Physical Health issues: ☐ None at this time ☐ Yes

If yes, specify:

Is condition followed by Primary Care Physician? ☐ No ☐ Yes ☐ N/A

Physical health problems affecting mental health functioning:

Head injuries: ☐ No ☐ Yes

If yes, specify:

Medical and/or adaptive devices:

Healing and Health *(Alternative healing practices and beliefs. Complementary and alternative medications. Apart from mental health professionals, who or what helps client deal with disability/illness and/or to address substance use issues? Describe.)*

PREGNANCY/BIRTH HISTORY

During pregnancy, did the mother:

Have any medical problems or injuries? ☐ No ☐ Yes ☐ Refuse/Cannot Assess

Take any medications? ☐ No ☐ Yes ☐ Refuse/Cannot Assess

Use any drugs or alcohol? ☐ No ☐ Yes ☐ Refuse/Cannot Assess

Use tobacco? ☐ No ☐ Yes ☐ Refuse/Cannot Assess

Was the pregnancy or delivery unusual or difficult in any way? ☐ No ☐ Yes ☐ Refuse/Cannot Assess

Mother was unable to take the baby home with her when she left the hospital? ☐ No ☐ Yes ☐ Refuse/Cannot Assess

Did the child have any medical problems in infancy? ☐ No ☐ Yes ☐ Refuse/Cannot Assess

Baby's birth weight: ____ lbs _____oz

A <u>YES</u> response to any of the above requires detailed documentation:

DEVELOPMENTAL MILESTONES:

Age at which child first:

Crawled:
Sat up alone:
Walked alone:
Weaned:
Fed self:
Bladder control:
Bowel trained:
First words:
Spoke in complete sentences:

☐all within normal limits ☐unknown

Significant Developmental Information (when applicable):

MEDICAL CHECKLIST:

Has the child ever had any of the following:

Speech problems	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Head banging	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Day time wetting	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Night time wetting	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Poor bowel control	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Sleep problems	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Eating problems	☐ No	☐ Yes	☐ Refuse/Cannot Assess
More interested in things than people	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Ear infections	☐ No	☐ Yes	☐ Refuse/Cannot Assess
High fevers	☐ No	☐ Yes	☐ Refuse/Cannot Assess
TB	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Seizures or loss of consciousness	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Medical hospitalizations	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Operations	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Serious illness	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Child menstruating	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Pregnancies	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Venereal diseases	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Do you know child's HIV status	☐ No	☐ Yes	☐ Refuse/Cannot Assess

A YES response to any of the above requires detailed documentation:

BHA SIGNATURE PAGE TAB

CLINICAL FORMULATION: *(Justification for diagnosis and medical necessity. Summarize and integrate all information gathered from other sources to render clinical judgments regarding intensity, length of treatment and recommendations for services. Clearly state those emotional or behavioral symptoms that interfere with normal functioning. Include evaluation of client'sstrengths, ability and willingness to solve the presenting problems, address both mental health and substance issues from an integrated perspective.)*

MEDICAL NECESSITY MET: ☐ No ☐ Yes

When "No," note date NOA-A issued [Medi-Cal clients only]:

CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE? ☐Yes Date:

Local mental health program shall inform Clients receiving mental health services, including parents or guardians of children / adolescents, verbally or in writing that:

☐ Acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services;

☐ They retain the right to access other Medi-Cal or Short Doyle/Medi-Cal reimbursable services and have the right to request a change of provider, staff person, therapist, and/or case manager.

☐ **Guide to Medi-Cal Mental Health Services was explained and offered on:**

☐ **Grievance and Appeal Process explained and Brochure with form fill and envelope offered on:**

☐ **Provider List explained and offered on:**

☐ **Mental Health Plan's Notice of Privacy Practices (NPP) was offered on:**

☐ **Language/Interpretation services availability reviewed and offered when applicable on:**

☐ **Advanced Directive brochure was offered on:**

☐ **Voter registration material offered to client at intake or change of address:**

Signature of Clinician Requiring Co-signature:

_____ Date:

Signature

Printed Name Cerner ID number:

***Signature of Clinician Completing/Accepting the Assessment:**

_____ Date:

Signature

Printed Name Cerner ID number:

Appendix A:

Sexual Orientation: The type of sexual, romantic, and/or physical attraction someone feels towards others. Who a person is primarily attracted to physically, romantically, and/or emotionally, for example, males, females, both, neither; enduring emotional, romantic or sexual attraction to other people. One's sexual behavior affects the choices one makes in responding to sexual orientation. It is the attraction that shapes one's orientation.

Another sexual orientation- not attracted to either female or male; can refer to a person who is asexual and does not have a sexual attraction or desire to any group of people. Asexuality is not the same as celibacy.

Bisexual-is romantic attraction, sexual attraction, or sexual behavior toward both males and females or romantic or sexual attraction to people of any sex or gender identity. A person who is "bi" may not have had an equal amount of sexual experiences with people of the same sex

Decline to state: client may be unsure or unwilling to disclose.

Gay- emotionally, romantically, and/or physically attracted to people of the same sex; although it can be used for any sex (e.g., gay man, gay woman, gay person), "lesbian" is sometimes the preferred term for women who are attracted to women; a gay person may not have had any sexual experience; it is the attraction that shapes sexual orientation.

Heterosexual/straight- emotionally, romantically, and/or physically attracted to people of the opposite gender.

Lesbian- a woman who is emotionally, romantically, and/or physically attracted to other women; women may also use the term gay to describe themselves; a gay or lesbian woman may not have had any sexual experience.

Queer- Think of queer as an umbrella term. It includes anyone who: a) wants to identify as queer and b) who feels somehow outside the societal norm in regards to gender or sexuality. This therefore, could include the person who highly values queer theory concepts and would rather not identify with any particular label, the gender fluid bisexual, the gender fluid heterosexual, the questioning LGBT person, and the person who just doesn't feel like they quite fit in to societal norms and wants to bond with a community over that. Originally pejorative for gay; this term has been reclaimed by some gay men, lesbians, bisexuals and transgendered persons as a self-affirming umbrella term. It is a fluid label as opposed to a solid label.

Questioning/Unsure-exploring sexual orientation, gender identity, gender expression.

Gender Identity: The sense of "being" male, female, genderqueer, agender, etc. For some people, gender identity is in accord with physical anatomy. For transgender people, gender identity may differ from physical anatomy or expected societal roles. It is important to note that gender identity, biological sex, and sexual orientation are separate and that you cannot assume how someone identifies in one category based on how they identify in another category.

Another gender identity: some of both male and female or neither; refer to genderqueer for more information.

Genderqueer: Genderqueer is most commonly used to describe a person who feels that his/her gender identity does not fit into the socially constructed "norms" associated with his/her biological sex. Genderqueer identities can include one or more of the following: both man and woman, neither man or woman [genderless], moving between genders [gender fluid], third gender or other gender, those who do not or cannot place a name to their gender, and having an overlap of, or blurred lines between gender identity and sexual orientation.

Questioning/unsure: exploring sexual orientation, gender identity, gender expression.

Transgender: It is frequently used as an umbrella term to refer to people who do not identify with their assigned gender at birth. This includes transsexuals, cross-dressers, genderqueer, drag kings, two spirit people and others. Some transgender people feel like they exist not within one of the two standard gender categories, but rather somewhere in between, beyond, or outside of those two genders.

County of San Diego Mental Health Services
CLIENT PLAN

Client Name: **Case #:**

Program Name: **Unit/SubUnit:**

Client Plan Begin Date: **Client Plan End Date**:

PLANNING TIERS

Strength: (Identify client strength(s) from the Strengths Table. These are what the client/support persons/staff identifies as general strengths for the client. Identify strength and individualize. Document strength(s) and how the client will utilize his/her strength(s) to meet the treatment objective(s) in the narrative areas below)

Strength: (Choose from Strengths Table):
Narrative:
Strength: (Choose from Strengths Table):
Narrative:
Strength: (Choose from Strengths Table):
Narrative:
Strength: (Choose from Strengths Table):
Narrative:

Area of Need: (Choose from Area of Need Options. This is an area in which a level of impairment is identified by the client/support persons/staff. Identify the need and individualize. Document the client's specific emotional/behavioral/psychiatric need for treatment. Use client's own words to individualize. For youth residing in a STRTP, Area of Need shall include client's need for rapid and successful transition back to community-based mental health care and include the anticipated length of stay in the STRTP.)

Area of Need:
Narrative:

Goal: (Enter Goal determined by Area of Need selected.)

Goal:
Narrative: SEE OBJECTIVE(S) PLANNING TIER

Objective: (Identify an objective from the Objectives listed under the Area of Need selected. These are action steps that the client will focus on in order to achieve his/her goal. Identify the objective and individualize.

County of San Diego Mental Health Services
CLIENT PLAN

Please Note: (If there are several Areas of Need being the focus of treatment it is possible to choose one general Objective and then list the Objectives numerically. All Areas of Need must be addressed in an Objective Tier. Objective(s) shall be specific, observable, measurable and related to the Area of Need. For youth residing in a STRTP, objectives shall address transition goals that support the rapid and successful transition of the client back to community based mental health care and consider the impact of client's history of trauma in planning objectives.)

Objective #1:

Narrative:

Objective #2:

Narrative:

Objective #3:

Narrative:

Interventions: (Identify each regularly used interventions. Service codes are considered interventions – Each intervention must be individualized for how it will be used to assist the client achieve each Objective listed. For every objective utilizing an intervention, describe the specific strategies used and how the strategies will address the functional impairment(s) or prevent deterioration or if under 21, allow developmental progress or correct/ameliorate the condition.)

Intervention:

Frequency: **Duration:**

Narrative:

Intervention:

Frequency: **Duration:**

Narrative:

Intervention:

Frequency: **Duration:**

Narrative:

Intervention:

Frequency: **Duration:**

Narrative:

Intervention:

Frequency: **Duration:**

Narrative:

Intervention:

Frequency: **Duration:**

Narrative:

Intervention:
Frequency: **Duration:**
Narrative:

Intervention:
Frequency: **Duration:**
Narrative:

Intervention:
Frequency: **Duration:**
Narrative:

Intervention:
Frequency: **Duration:**
Narrative:

County of San Diego Mental Health Services
CLIENT PLAN

Explained in client's primary language of:

No ☐ (if no, document reason):

Explained in guardian's primary language of:

No ☐ (if no, document reason):

Client offered a copy of the plan:

Yes ☐

No ☐ (if no, document reason):

SIGNATURES:

Client:_____ **Date**: _____

☐ **Refused to sign** **Explanation:**

Parent/Guardian Signature: _____ **Date:** _____

Conservator Signature: _____ **Date:** _____

Other Signature: _____ **Date:** _____

Signature of Staff Requiring Co-Signature:

_____ **Date:** _____

_____ **ID Number:** _____

Printed Name

***Signature of Staff Completing/Accepting Client Plan:**

_____ **Date:** _____

_____ **ID Number:** _____

Printed Name

STRTP UTILIZATION MANAGEMENT (UM) REQUEST
CYF - Outpatient Treatment

FOR CCR SUBMISSION: THE CLIENT NAME AND NUMBER MUST BE REDACTED (utilize initials vs. full client name)

A. Program UM Cycle:

☐ STRTP follows a 90 Day UM Cycle

B. CURRENT SERVICES:

☐ Therapy ☐ CM/ICC ☐ Rehab/IHBS ☐ Meds

Youth & Child and Family Team (CFT) requesting additional services?

☐ YES ☐ NO ☐ Other

Explain:

ADMISSION DATE:

DIAGNOSIS:

☐ Pathways to Well-Being Enhanced Services (Subclass)

DESCRIPTION OF SYMPTOMS:

C. Psychiatric Hospitalizations: ☐ YES ☐ NO

Provide most recent dates of hospitalization and relevant history when applicable:

Other Behavioral Health Services Client is Receiving *when applicable*:

D. Child and Adolescent Needs and Strengths (CANS)

Date of most current CANS (*Required at UM Cycle)*:

Number of CANS 'High Need' (items rated a '3') (*from current Assessment Summary)*:

Number of CANS 'Help is Needed' (items rated a '2') (*from current Assessment Summary)*:

List the CANS 'Strengths to Leverage' items (*from current Assessment Summary)*:

☐ *CANS Assessment Summary is available for UM reviewer*

E. Pediatric Symptom Checklist (PSC): (*Required at UM Cycle)*

Date of most current Parent PSC:

☐ Parent did not complete

Date of most current Youth PSC:

☐ Not applicable, child is 10 years old or younger

☐ Youth did not complete

	Parent PSC Score	Youth PSC Score	Clinical Cutoff Score
Attention Problems Subscale (0-10)			At-Risk if score is 7 or higher
Internalizing Problems Subscale (0-10)			At-Risk if score is 5 or higher
Externalizing Problems Subscale (0-14)			At-Risk if score is 7 or higher
***Total Scale Score**			

***Parent:** *Total score of 28 or higher for ages 6-18 or scale score of 24 or higher for ages 3-5 indicates impairment*

***Youth:** *Score of 30 or higher for ages 11-18 indicates impairment*

☐ *PSC Assessment Summary is available for UM reviewer*

F. ☐ **Updated Client Plan completed prior to UM request** (reviewed by STRTP UM Committee)

G. PRIMARY ELIGIBILITY CRITERIA:

☐ Client continues to meet **Medical Necessity** and demonstrates benefit from STRTP services

☐ **CANS** indicate at least one actionable need (rated 2 or 3) on the 'Child Behavioral and Emotional Needs', 'Risk Behaviors' OR 'Life Functioning'

☐ Client meets the criteria for **Serious Emotional Disturbance** based upon the following:

As a result of a mental disorder the child has substantial and persistent impairment in at least two of the following areas:

- ☐ Self-care and self- regulation
- ☐ Family relationships
- ☐ Ability to function in the community
- ☐ School functioning

AND One of the following occurs:

☐ Child has been removed from home due to a mental disorder

☐ Mental disorder/impairment is severe and has been present for six months, or is highly likely to continue for more than one year without treatment.

OR The child displays:

☐ acute psychotic features (within the last month)

☐ imminent or recent high risk for suicide (within the last month)

☐ imminent or recent high risk of violence to others due to a mental disorder (within the last month)

H. STRTP ELIGIBILITY CRITERIA

Client has met the above criteria as indicated AND meets all of the following criteria (based on Interagency Placement Committee requirements for continued placement in a STRTP):

☐ Youth is experiencing emotional and behavioral problems in the home, community, and/or treatment setting

☐ Youth is not sufficiently emotionally or behaviorally stable to be treated outside of a structured 24-hour therapeutic environment; **and**

☐ Least restrictive environments have been tried and were unsuccessful; or are not appropriate to meet the youth's needs at this time

I. CLINICAL REVIEW REPORT:

1. **Describe the type and frequency of services provided by the STRTP during previous 90-day review period:**
2. **Describe the impact of these services toward the achievement of Client Plan Goals** (Include progress toward goals of transitioning to a lower level of care)
3. **Date of most recent mental health program staff meeting, which must include Head of Service or Licensed Mental Health Professional, where diagnosis, mental health progress, treatment planning, and transition planning were discussed** (must occur at least every 90 days and prior to submittal of STRTP UM Request)**:** _____
4. **Date of most recent CFT meeting where Clinical Review Recommendation was discussed** (must occur at least every 90 days and prior to submittal of STRTP UM Request): _____

The CFT/Treatment Team agree that the STRTP continues to meet the specific therapeutic needs of the youth:
☐ Yes ☐ No ☐ Other _____

The CFT Meeting Summary and Action Plan is available based on UM reviewer request: ☐ Yes ☐ No

5. **Clinical Review Recommendation:**

☐ Continued Treatment in STRTP; rationale for continued treatment:

☐ Transition from the STRTP, include transition recommendation:

☐ Other**:**

- **Recommendation for continued treatment or transition must be supported in client record and CFT documentation**

J. Requestor's Name, Credential:

Signature: _____ Date:

Licensed Clincian's Name, Credential:

Co-signature: _____ Date:

K. BHS CYF UM DETERMINATION / APPROVAL

☐ UM Approved ☐ Modified UM Request ☐ UM Not Approved

Approver's Name, Credential: Date range of approval: to (90 days)

Program transcribes BHS CYF determination onto form and attaches BHS CYF determination correspondence

2020

County of San Diego Mental Health Plan
Utilization Management Request (UM)
Short Term Residential Therapeutic Programs

COMPLETED BY:
- Licensed/Waivered Psychologist
- Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
- Licensed/Registered Professional Clinical Counselor
- Physician (MD or DO)
- Nurse Practitioner

SUBMITTED TO BHS CYF BY:
- Program Manager or Designated Program UM Committee

APPROVAL COMPLETED BY:
- BHS – CYF Continuum of Care Reform Liaison and/or BHS CYF COR

COMPLETION REQUIREMENTS:
- STRTP UM form is completed by the STRTP Mental Health Program staff and reviewed by the STRTP Program Manager or designated STRTP UM Committee
- Once reviewed and approved by the STRTP Program Manager/UM Committee, the STRTP UM Request is faxed or sent by secure email to the BHS CYF Continuum of Care Reform Liaison and/or BHS CYF COR (Transport Layer Security [TLS] or encrypted) or removing identifiable information (client initials only)
- BHS CYF reviews the STRTP UM and provides approval/modification within 5 business days
- STRTP UM Requests shall be submitted to BHS CYF within 90 days of arrival into the STRTP and within every 90 days thereafter
- STRTP UM Requests must have all required elements (listed below) completed within the form
- In addition to completing the STRTP UM form, the following tasks are required prior to submitting the UM request:
    - Updated CANS entered in CYF mHOMS
    - Updated PSC-35 entered in CYF mHOMS
    - Client Plan must be reviewed and new client signatures need to be obtained
    - Mental health program staff meeting, including the head of service or a Licensed or Waivered/Registered Mental Health Professional, must be held to discuss the Clinical Review Recommendation
    - CFT meeting to discuss specific therapeutic needs of the youth and treatment recommendations

DOCUMENTATION STANDARDS: ***The following elements of the STRTP UM Request form shall be addressed:***

A. Program UM Cycle: STRTP follows a 90 Day UM Cycle

B. Current Services: Identify current services, whether the Youth/Child and Family Team are requesting additional services, admission date, diagnosis, Pathways status, and description of symptoms

C. Psychiatric Hospitalizations: Provide information pertaining to recent hospitalizations; including most recent dates and other services client is receiving when applicable

D. Child and Adolescent Needs and Strengths: Provide completion date of CANS for current UM request. Utilize information from the CYF mHOMS Assessment Summary to identify the number of needs rated at a '2' (Help is Needed) and '3' (High Need). List the Strengths from the assessment summary that could be leveraged to meet treatment goals and reduce symptomology

F. Pediatric Symptom Checklist: Provide completion date of PSC and PSC-Y (when applicable) for current UM request. Utilize information from the CYF mHOMS PSC Assessment Summary to identify the total scale score for both the Parent PSC and Youth PSC. If the Parent PSC or Youth PSC was not completed for the current UM request, indicate on form

G. Updated Client Plan: Must update the client plan in CCBH prior to initiating the UM request. The updated client plan must be reviewed by Program UM Committee and presented to the youth/family for input and signatures

I. Primary Eligibility Criteria: First three items (Medical necessity, CANS and SED criteria) must be completed. An additional risk factor must be identified for 1) child has been removed from home due to a mental disorder or mental disorder/impairment is severe and has been present for 6 months, or is highly likely to continue for more than one year without treatment **or** 2) acute psychotic features, imminent or recent risk for suicide or imminent or recent risk for violence has been displayed in past month by the client

H. STRTP Eligibility Criteria: Client must meet all three STRTP eligibility criteria for continued treatment in a STRTP: 1) Experiencing emotional and behavioral problems in home, community and/or treatment setting 2) Not sufficiently emotionally or behaviorally stable to be treated out side of a structured 24-hour therapeutic environment **and** 3)Least restrictive environments have been tried and were unsuccessful; or are not appropriate to meet the youth's needs at this time

I. Clinical Review Report: Required by the Interim STRTP Regulations Version 2; Section 14 titled "Clinical Reviews, Collaboration, and Transition Determination"

1. Must describe the type and frequency of services provided during the previous 90-day authorization period
2. Must describe the impact of services toward the achievement of Client Plan Goals and include goals of transitioning to lower level of care
3. Must provide the date of the most recent mental health program staff meeting, which must include Head of Service, or Licensed or Registered/Waivered Mental Health Professional, where diagnosis, mental health progress, treatment planning, and transition planning were discussed **(must occur at least every 90 days and be completed prior to submittal of the STRTP UM Request)**
4. Must provide the date of the most recent CFT meeting **(must occur at least every 90 days and be completed prior to submittal of the STRTP UM Request)**
    - Indicate if the CFT/treatment team agrees that the STRTP continues to meet the specific therapeutic needs of the youth (answer yes, no or other - if other explain)
    - Indicate if the "CFT Meeting Summary and Action Plan" form is available based on UM reviewer request (answer yes or no). "CFT Meeting Summary and Action Plan" only required to be submitted if requested by the UM reviewer
5. Must provide a Clinical Review Recommendation for either: Continued Treatment in the STRTP, Transition from the STRTP, or Other
    - If Transition is selected, describe the recommendation for transition
    - If Other is selected, describe the treatment recommendation

❖ Recommendation for transition or continued treatment must be supported in the client record and CFT documentation

J. Requestor Name and Credential: Type in requestor's name and date. Provide signature prior to filing in Hybrid record. If requestor is not a licensed mental health professional, the STRTP UM Request must be reviewed and co-signed by a licensed mental health professional.

K. BHS CYF UM Determination/Approval: Program will fill in approval status based on BHS CYF COR/CCR Liaison determination, COR/CCR Liaison name and credential, and date range approved

County of San Diego Mental Health Plan

Prior Authorization Day Services Request (DSR)

Submit At Least 5 Business Days Prior To Projected Start Date

Please Check: ☐ **Initial Request (prior to services)**
☐ **Continuing Request (STRTP and STEPS required every 90 Days, SPA every 180 Days)**

FAX TO: (866) 220-4495
Optum Public Sector San Diego
Phone: (800) 798-2254, Option 3, then Option 4

CLIENT INFORMATION

Client Name: _____

Client ID: _____

Client Date of Birth: _____

Placing/Referring Agency: ☐CWS ☐Probation ☐ Dual Placement ☐ Other: _____

Out of County Client - Through: ☐ CWS ☐ Probation

Out of County Client - Must Include Either:

☐ AB1299; for STRTP only, a copy of Notice of Presumptive Transfer (foster youth)

☐ AAP/KinGAP; for STRTP must include SAR copy and written COR approval to serve youth under County contract due to discharge to San Diego residence

DAY PROGRAM INFORMATION

Legal Entity: _____ **Program Name:** _____ **Phone**: _____

Fax: _____ **Unit#:** _____ **Day Program Subunit#**: _____

SCOPE, AMOUNT AND DURATION OF DAY SERVICES REQUEST

SCOPE AND DURATION OF AUTHORIZATION REQUEST (To Be Completed Prior to the Provision of Day Services, Choose one):

☐ STRTP Hybrid Day Rehab and Outpatient Services (Up to 90 days)

☐ STEPS Day Intensive (Up to 90 days)

☐San Pasqual Academy (SPA) Day Rehab (Up to 180 Days)

AMOUNT OF DAY SERVICES REQUESTED (Program Not to Exceed Day Program Schedule Approved by BHS Quality Management)

☐ Up to 5 Days Per Week ☐ Up to 6 Days Per Week

MEDICAL NECESSITY CRITERIA FOR DAY SERVICES

DIAGNOSIS: Provide the Title 9 included diagnoses that are the focus of mental health treatment.

Diagnosis 1: **Diagnosis 2:** **Diagnosis 3:**

Title 9 Medical Necessity Criteria: Must respond to questions #1-3 for all requests, and #4 for continuing requests

1. **Client demonstrates impairment as a result of the included diagnosis** (*choose at least one*):

   ☐ Significant impairment in an important area of life functioning (e.g., living situation, daily activities, or social support) **OR**
   Explain: _____

   ☐ A reasonable probability of significant deterioration in an important area of life functioning **OR**
   Explain: _____

   ☐ A reasonable probability a person under 21 years of age will not progress developmentally as individually appropriate
   Explain: _____

2. **Day Services intervention criteria** *(must complete A, B, and C):*

   A. ☐ The focus of the Day Services will address the condition/impairment. Explain: _____

   B. ☐ The focus of the Day Services will significantly diminish the impairment, prevent significant deterioration or allow the child to progress developmentally as appropriate. Explain: _____

   C. ☐ The condition would not be responsive to physical health care-based treatment.

Day Services Necessity Criteria: *(Set by the Mental Health Plan (MHP) per DMH Letter No. 02-01)*

3. Client requires structured Day Services in order to move from higher level of care to lower level of care or to prevent deterioration and admission to a higher level of care. Describe: _____
4. **Continuing service requests only -** Current treatment goals have not been met. **Describe progress** toward treatment goals or how progress is expected to be made during the next authorization cycle: _____

ANCILLARY SERVICES REQUEST (INTERNAL)

STRTP and SPA must request ancillary authorization if client is going to receive Day Services and Outpatient Services from the same provider/program

STRTP/SPA/STEPS must submit a stand-alone (external) Ancillary Specialty Mental Health Services (SMHS) Request Form for any client receiving Day Services and SMHS from another provider/program

Outpatient Subunit#: _____

1. **SELECT THE AMOUNT OF OUTPATIENT SMHS REQUESTED PER DAY (Inclusive of all Individual, Collateral, ICC, IHBS and Group SMHS provided by Day Service provider in addition to Day Program Services):**

   ☐ Up to 8 hours per day

2. **MEDICAL NECESSITY FOR OUTPATIENT SMHS (must select at least one):**

   ☐ Requested service(s) is not available during day program hours. Describe why service is not available: _____

   ☐ Continuity or transition issues make these services necessary for a limited time. Describe the need: _____

   ☐ These concurrent services are essential for coordination of care. Describe why services are essential: _____

CLINICAL REVIEW REPORT: Section 14 of Interim Mental Health Program Approval for STRTP

FOR STRTP CONTINUING (90 DAY) REQUESTS ONLY

1. **Describe the type and frequency of services that have been provided by the STRTP during the previous 90-day review period:**

   ☐ Day Services - Describe the type and frequency of Day Services provided by the STRTP during the past 90 days:
   _____

   ☐ Outpatient Services (OP) - Describe the type and frequency of OP services provided by the STRTP during the past 90 days:
   _____

2. **Describe the impact of these services towards the achievement of Client Plan Goals (include progress toward goals of transitioning to lower level of care):** _____

3. **Date of most recent mental health program staff meeting, which must include Head of Service or Licensed or Registered/Waivered Mental Health Professional, where diagnosis, mental health progress, treatment planning, and transition planning were discussed** (must occur at least every 90 days and prior to submittal of DSR): _____

4. **Date of most recent CFT meeting** (must occur at least every 90 days and prior to submittal of DSR): _____

   The CFT/mental health program staff agree that the STRTP continues to meet the specific therapeutic needs of the youth:
   ☐ **Yes** ☐ **No** ☐ **Other** _____

   The CFT Meeting Summary and Action Plan is available based on UM reviewer request: ☐ **Yes** ☐ **No**

5. **Clinical Review Recommendation**: ☐ Continued treatment in STRTP ☐ Transition from the STRTP, include transition recommendation _____ ☐ Other _____
   - ❖ **Recommendation for transition or continued treatment must be supported in client record and CFT documentation**

Program Clinician (Print): _____ **Credentials:** _____

Signature: _____ **Date:** _____

Licensed Clinician (Print): _____ **Credentials:** _____

Co-Signature: _____ **Date:** _____

- ❖ **Co-Signature required if Program Clinician is not a Licensed Mental Health Professional**

FOR OPTUM USE ONLY

Optum completes and retains. Within 5 business days of Optum receipt, authorization determination status will be viewable to the requesting provider in the CCBH Clinicians Home Page Authorizations Tab.

DAY SERVICES PRIOR AUTHORIZATION DETERMINATION

☐ **Day Services scope, amount and duration authorized: START DATE:_____END DATE: _____**

Day Service request is ☐ denied ☐ modified ☐ reduced ☐ terminated or ☐ suspended as follows: _____

NOABD was issued to the beneficiary and provider on the following date: _____

ANCILLARY SERVICES DETERMINATION (INTERNAL)

☐ **Internal Ancillary OP SMHS authorized: START DATE:_____END DATE: _____**

Internal Ancillary OP SMHS request is ☐ denied ☐ modified ☐ reduced ☐ terminated or ☐ suspended as follows: _____

NOABD was issued to the beneficiary and provider on the following date: _____

CLINICAL REVIEW REPORT DETERMINATION

☐ **Clinical Review Report is complete and addresses all four components; see Clinical Review Report section**

Follow up for the Clinical Review Report will occur through the County CCR team when indicated.

ANCILLARY SERVICES DETERMINATION (EXTERNAL)

(External authorization requests are submitted to Optum when indicated through a separate Ancillary SMHS Request Form)

☐ **External Ancillary SMHS authorized: START DATE:_____END DATE: _____**

External Ancillary SMHS request is ☐ denied ☐ modified ☐ reduced ☐ terminated or ☐ suspended as follows: _____

NOABD was issued to the beneficiary and provider on the following date: _____

Optum clinician Signature/Date/Licensure:

2020

County of San Diego Mental Health Plan
Prior Authorization Day Services Request (DSR)

COMPLETED BY:

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Nurse Practitioner

CO-SIGNATURE:

- Prior Authorization Day Service Requests must be completed by or co-signed by a Licensed Mental Health Professional
- Co-signature from Licensed Mental Health Professional indicates they have reviewed and agree with the findings of the request

COMPLETION REQUIREMENTS:

1. Prior Authorization Day Services Request form is completed by the Day Services provider and submitted to Optum via FAX (866) 220-4495 for all clients prior to the initial provision of Day Services
2. Continuing Prior Authorization Day Services Requests are completed by the Day Services provider and submitted prior to expiration of the initial authorization period (within 90 days for STRTP and STEPS, and 180 days for San Pasqual Academy)
3. Continuing Prior Authorization Day Services Requests shall be submitted at least 5 business days prior to the expiration of Day Services Authorization, and can be submitted up to 10 business days prior to the expiration
4. Prior authorization shall be obtained before Day Services are initiated. For hybrid programs, Outpatient Services may be provided prior to the authorization of Day Services

DOCUMENTATION STANDARDS:
The following elements of the Prior Authorization Day Services Request form shall be addressed:

1. Client Information

- Include Name, Client ID and Date of Birth
- Include the Placing or Referring agency
- For Out of County clients, the request shall include either:
  - (STRTP only) A copy of the Notice of Presumptive Transfer Form for foster youth placed through AB1299 Presumptive Transfer in a STRTP or
  - A copy of the SAR for youth placed through AAP/KinGAP. For youth in a STRTP the request shall include written COR approval, obtained by emailing the COR, to serve youth under the County contract due to planned discharge to a San Diego residence.

2. Day Program Information

- Include Legal Entity, Program Name, Phone number, Fax number, Unit number, and Day Services Program Subunit number

3. Scope, Amount and Duration of Day Services Request

- Identify the scope and duration of Day Services to be provided (STRTP – 90 days, STEPS – 90 days or SPA – 180 days).
- Include the amount of services requested (select Up to 5 Days Per Week or Up to 6 Days Per Week) which shall not exceed the Day Program schedule that has been approved by BHS QM

4. **Medical Necessity Criteria for Day Services**
   - **Diagnosis -** Provide the name of the Title 9 included diagnoses that are the focus of mental health treatment
   - **Title 9 Medical Necessity Criteria**
     1. Select and explain at least one area of client impairment that is a result of the Title 9 included diagnoses
     2. Day Services intervention criteria A, B and C must be met for client to meet medical necessity for Day Services:
        A. Select and explain how Day Services will address the client's condition/impairment
        B. Select and explain how the Day Services will significantly diminish the impairment, prevent significant deterioration of the impairment, or allow the child to progress developmentally as appropriate
        C. Select if the condition would not be responsive to physical health care-based treatment
   - **Day Services Necessity Criteria**: Set by the Mental Health Plan (MHP) per DMH Letter No. 02-01
     3. Describe client's needs for Day Services in order to move from a higher level of care to a lower level of care, or to prevent deterioration and admission to a higher level of care
     4. For **continuing service requests only** – Describe progress made towards treatment goals during the current authorization period, and/or explain how progress is expected to be made towards treatment goals during the next authorization cycle

5. **Ancillary Services Request (Internal)**
   - STRTPs and SPA must complete the Ancillary Request section for the STRTP or SPA to provide Day Services and Outpatient Specialty Mental Health Services (SMHS) during the course of treatment
   - If youth at SPA are receiving Day Services, in addition to Day Services SPA shall only provide the Outpatient SMHS of Intensive Care Coordination (ICC) for the purpose of a Child and Family Team (CFT) meeting outside of Day Service hours
   - STRTP hybrid Day Service and Outpatient programs shall only provide select Outpatient SMHS outside of scheduled Day Service hours, or during scheduled Day Service hours if the youth is unable to attend the Day Program that day

     The following Outpatient SMHS are never allowed to be claimed on the same day that Day Services have been claimed:

     - Collateral
     - Case Management

     Additionally, the following SMHS are never allowed to be claimed as Outpatient Services at any time while a client is enrolled in Day Services, as they are bundled with Day Services

     - Assessment
     - Client Plan

   - For Outpatient SMHS that are provided on the same day as Day Services, the provider must document rationale for ancillary Outpatient SMHS, inclusive of:

     1. Reason why; requested service(s) is not available during day program hours
     2. Reason why; continuity or transition issues make these services necessary for a limited time
     3. Reason why; these concurrent services are essential for coordination of care

- Provide the Day Program Outpatient Subunit number
    1. Select the amount of Outpatient SMHS requested per day (up to 8 hours)
    2. Select and describe at least one reason Outpatient SMHS are medically necessary in addition to Day Services
- Note; if the client is receiving ancillary SMHS from **another program or provider**, the Day Services Provider shall coordinate with the separate Outpatient Provider to **complete a stand-alone Ancillary SMHS Request Form**

6. **Clinical Review Report:** Required by the Interim STRTP Regulations Version 2 section 14 titled "Clinical Reviews, Collaboration, and Transition Determination"
    - Clinical Review Report section is completed for STRTPs requesting continued Day Services. SPA and STEPS, which are not STRTPs, shall therefore always leave this section blank. STRTPs shall also leave this section blank on the initial Prior Authorization Day Services Request
        1. Describe the type and frequency of services provided during the previous 90-day authorization period for both Day Services and Outpatient Services
        2. Describe the impact of services toward the achievement of Client Plan Goals and include goals of transitioning to lower level of care
        3. Provide the date of the most recent mental health program staff meeting, which must include Head of Service, or Licensed or Registered/Waivered Mental Health Professional, where diagnosis, mental health progress, treatment planning, and transition planning were discussed (must occur at least every 90 days and be completed prior to submittal of the DSR)
        4. Provide the date of the most recent CFT meeting (must occur at least every 90 days and prior to submittal of the DSR)
            a. Indicate if the CFT/treatment team agrees that the STRTP continues to meet the specific therapeutic needs of the youth (answer yes, no or other - if other explain)
            b. Indicate if the "CFT Meeting Summary and Action Plan" form is available based on UM reviewer request (answer yes or no). Copy of "CFT Meeting Summary and Action Plan" is only provided if requested by the UM reviewer
        5. Provide a Clinical Review Recommendation for: Continued Treatment in the STRTP, Transition from the STRTP, or Other
            - If Transition is selected, describe the recommendation for transition
            - If Other is selected, describe the treatment recommendation
    - The Clinical Review Report shall be reviewed for completion by Optum upon submittal
    - The Clinical Review Report shall be reviewed by the BHS Continuum of Care Reform (CCR) team, who will follow up directly with the program when indicated
    - Recommendation for transition or continued treatment must be supported in the client record and CFT documentation
7. **Signature(s)**
    - Must include the printed/typed name, credentials, signature and date of the Program Clinician completing the request

- Must include the printed/typed name, credentials, signature and date of a Licensed Mental Health Professional if the Program Clinician completing the request is not a Licensed Mental Health Professional

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OPTUM AUTHORIZATION SECTION

- ❖ The following sections are completed by Optum upon receipt from the Day Services provider
- ❖ Optum will review and retain the Prior Authorization Day Services Request (DSR) form
- ❖ Within 5 business days of Optum receiving the DSR, authorization(s) will be viewable in the CCBH Clinician Home Page Authorizations Tab

- **Day Services Prior Authorization Determination**
  - When the scope, amount and duration of services are authorized, the start date and end date shall be viewable to the requesting provider in the CCBH Clinician Home Page Authorizations Tab. Day Services authorizations will be indicated as "Medi-Cal/DT" with the legal entity name in the "Benefit Plan" column (see image below)
  - When the Prior Authorization Day Service Request is denied, modified, reduced, terminated, or suspended a NOABD shall be issued by Optum to the Medi-Cal beneficiary and requesting provider

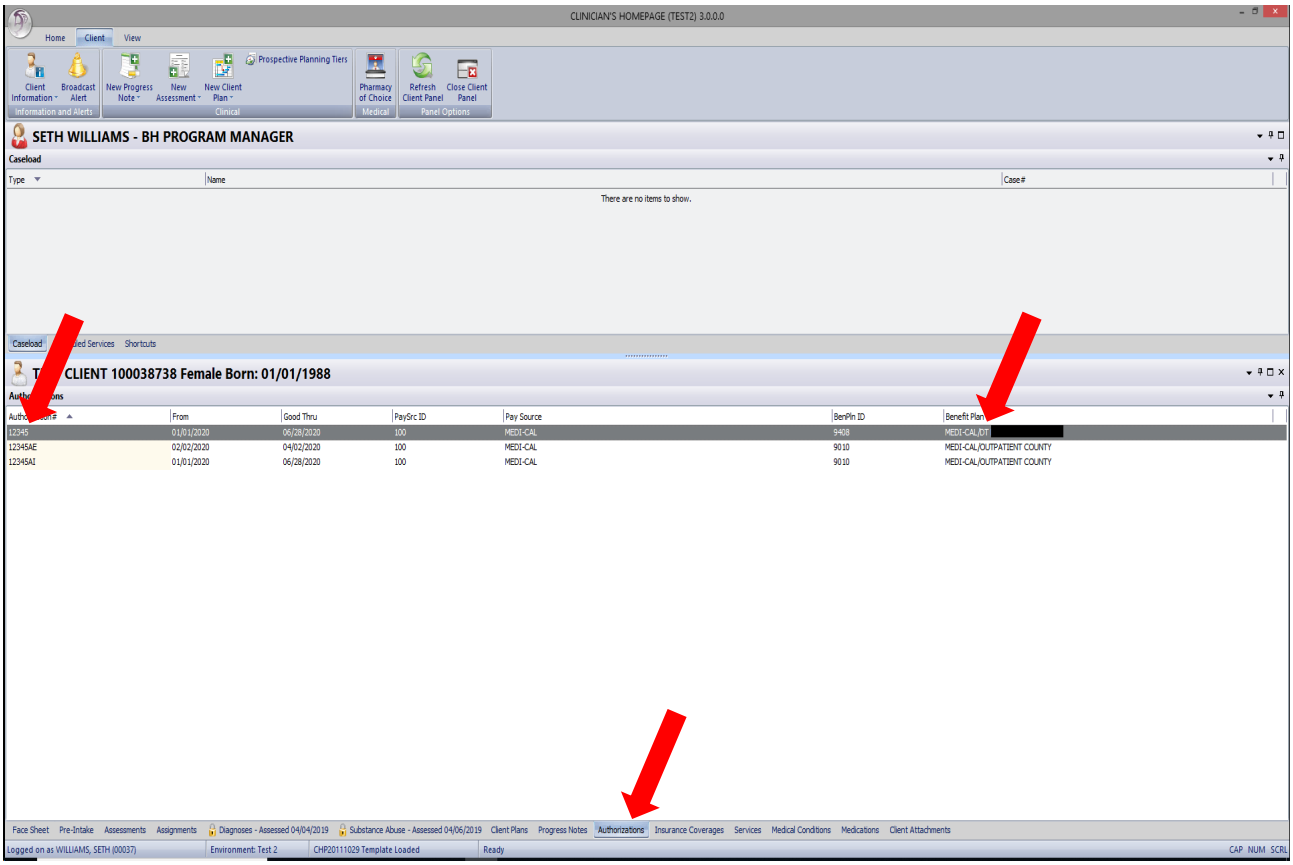
- **Ancillary Services Determination (Internal)**
  - When the Internal Ancillary Outpatient Services are authorized, the start date and end date shall be viewable to the requesting provider in the CCBH Clinician Home Page Authorizations Tab. Internal Ancillary Services will be indicated by an "AI" next to the authorization number in the "Authorization #" column (see image below)
  - When the Prior Authorization Day Service Request is denied, modified, reduced, terminated, or suspended a NOABD shall be issued by Optum to the Medi-Cal beneficiary and requesting Day Service provider

- **Clinical Review Report Determination** (completed by STRTPs only)
  - For STRTP providers Optum shall review the Clinical Review Report for completion. If incomplete, Optum shall send notification to the requesting provider to resubmit with required data elements
  - Optum shall send the completed Clinical Review report to the BHS CCR team for review
  - The BHS CCR team shall follow up with the STRTP regarding the Clinical Review Report when indicated

- **Ancillary Services Determination (External)**
  - When an ancillary Specialty Mental Health Provider (SMHP) begins treatment, a stand-alone "Ancillary SMHS Request" form must be submitted to Optum by the Day Service provider to request ancillary SMHS from a separate program/provider in addition to Day Services
  - When external ancillary services are authorized, the start date and end date shall be viewable to the requesting provider and the ancillary SMHP in the CCBH Clinician Home Page Authorizations Tab. External ancillary services will be indicated by an "AE" next to the authorization number in the "Authorization #" column (see image below)

- When the External Ancillary Services Request is denied, modified, reduced, terminated, or suspended a NOABD shall be issued by Optum to the Medi-Cal beneficiary and the requesting Day Service Provider, who shall communicate with the ancillary SMHP within 3 business days
- See "Ancillary SMHS Request" form and explanation form for additional information

CCBH Clinician Home Page Authorizations Tab:



Note: The Prior Authorization Day Services Request (DSR) form replaces the Intensive Services Request (ISR) form effective 1/1/2020

References: DHCS MHSUDS INFORMATION NOTICE NO.: 19-026 Dated 5/31/19: Authorization of Specialty Mental Health Services

DMH LETTER NO.: 02-01 Dated 4/16/2002: Clarification Regarding Medi-Cal Reimbursement for Day Treatment for Children and Youth in Group Home Programs

DMH INFORMATION NOTICE NO.: 02-06 Dated 10/1/02: Changes in Medi-Cal Requirements for Day Treatment Intensive and Day Rehabilitation

DHCS MHSUDS Information Notice No.: 20-005 Dated February 28, 2020; Statewide Criteria for Mental Health Program Approval for STRTP and Enclosure 1 – Interim STRTP Regulations Version II

San Diego County Mental Health Services
Short-Term Residential Program (STRTP)
TRANSITION DETERMINATION PLAN

***Client Name:**	**Client Preferred Pronouns:**
***Case #:**	***STRTP Name:**
***Date of Admission:**	***Anticipated transition date:**

- Transition Determination Plan to be completed prior to child or youth's discharge from the STRTP.

***1. REASON FOR ADMISSION:** *Describe events in sequence leading to admission to your program. Describe primary need upon admission*:

***2. REASON FOR DISCHARGE FROM STRTP PLACEMENT:** *Choose most appropriate reason for transition. If selecting Other or Alternate STRTP/Residential Setting, provide explanation for reason for transition:*

☐ Higher level of care ☐ Lower level of care ☐ Client did not return/AWOL
☐ Alternate STRTP/Residential Setting ☐ Other *Explain*:

***3. LIVING PLACEMENT UPON DISCHARGE FROM STRTP**: *Choose most appropriate placement. If other provide explanation of living placement:*

☐ Biological Family ☐ Extended Family Member ☐ Non-Related Extended Family Member
☐ Resource Family ☐Foster Family Agency ☐ Extended Foster Care/Transitional Housing Program ☐ San Pasqual Academy ☐ Alternate STRTP ☐ Other *Explain*:
Specific Name of caregiver and relationship to youth:

***4. COURSE OF TREATMENT DURING THE CHILD'S ADMISSION:** *Include mental health treatment interventions and the child or youth's response. Include the child's transition plan goals and child's progress toward those goals*

***5. MENTAL HEALTH DIAGNOSIS AND FOLLOW UP REQUIRED:**

a. Current Diagnosis: *List all diagnosis in order of priority*
b. Symptoms related to diagnosis and follow up required:
c. Goals and expected outcomes for follow up treatment:

***6. RECOMMENDATIONS REGARDING TREATMENT THAT IS RELEVENT TO THE CHILD'S CARE:** *Review with child or youth prior to transition. Use child or youth's own language when applicable.*

a. Resiliency Strategies:

- Preferred activities or hobbies
- Soothing or calming techniques
- Identified sources of support (person, place, object)
- Caregiving strategies that promote resiliency
- Other

b. Triggers: *Include social, emotional or environmental factors that may decrease the child or youth's ability to be successful in next placement.*

c. Other: *Any other pertinent information which will enhance the child or youth's successful transition.*

***7. SUBSTANCE USE TREATMENT RECOMMENDATIONS:**

☐ Not Applicable ☐ Yes *explain*:

***8. MEDICAL INFORMATION:**

a. Medical and Dental Services Received While Residing in the STRTP

Service	Date	Follow Required (yes/no)	Next Appointment Date	Next Appointment Time	Upcoming Due Dates (If no appt. scheduled)

b. Current Medications (Non-Mental Health)

Medication	Dose	Frequency

c. Psychotropic Medications - Attach documentation from prescribing physician, such as JV220, for potential and reported side effects of medication

Medication	Dose	Frequency

d. Allergies and Adverse Medication Reactions

9. EDUCATIONAL INFORMATION: Include grade, grade level functioning, educational needs, education plans (for example IEP or 504 plan) and follow up required.*

a. Current grade:
b. Educational strengths:
c. Educational needs:
d. Educational Plans (i.e. Individualized Education Plan, 504 plan, other):
e. Date the school was notified of discharge from the STRTP:

***10. REFERRAL(S)**:

☐ Wraparound ☐ TBS ☐ FFAST ☐ CASS ☐ School-Based Therapy ☐ Outpatient Mental Health Clinic ☐ TERM Provider ☐Teen Recovery Center (TRC) ☐Incredible Families ☐ Other explain:

Referral Contact Information:

Type of Service	Program Name	Program Contact Name	Program Contact Phone Number	Appointment Date if Applicable

☐ Client or caregiver declined referral(s)

Explained in client's primary language of:

No ☐ (if no, document reason):

Explained in guardian's primary language of:

No ☐ (if no, document reason):

Client offered a copy of the Transition Determination Plan:

Yes ☐

No ☐ (if no, document reason):

Copy of Transition Determination Plan offered to: (Check the following as applicable. Copy shall be made available to at least one of the following)

Parent ☐ **Conservator** ☐ **Guardian** ☐ **Other** ☐ If other, relationship:

Copy of Transition Determination Plan offered to: (Copy shall be made available to one of the following)

Placing Agency Representative: ☐ CWS PSW ☐ Juvenile Probation Officer

Placing Agency Representative Contact Information: Name Phone Number

Date Placing Agency Representative notified of transition from the STRTP:

SIGNATURES:

Client:_____ **Date**: _____

☐ **Refused to sign** **Explanation:**

Parent/Guardian Signature: _____ **Date:** _____

Conservator Signature: _____ **Date:** _____

Placing Agency Representative Signature: _____ **Date:** _____

Other Signature: _____ **Date:** _____

Signature of Staff Completing Transition Determination Plan:

_____ **Date:** _____

_____ **ID Number:** _____

Printed Name

2020

San Diego County Mental Health Services
Short-Term Residential Therapeutic Program (STRTP)
TRANSITION DETERMINATION PLAN

WHEN: Completed and signed prior to the child's/youth's discharge from a Short-Term Residential Therapeutic Program (STRTP).

ON WHOM: All children/youth placed in the STRTP.

COMPLETED BY: A licensed/registered/waivered mental health clinician.

MODE OF COMPLETION: Entered in the Electronic Health Record (EHR).
*A copy shall be provided, as applicable, to the parent, guardian, conservator, or person identified by the court to participate in the decision to place the child/youth in the STRTP.

REQUIRED ELEMENTS:
Client name: Enter the client's name.
Client Preferred Pronouns: Enter pronouns based on child's preference.
Case number from EHR: Enter the client's unique client number.
STRTP name: Enter the name of the STRTP facility.
Date of admission: Enter the date the client was admitted to the program.
Anticipated transition date: Enter the planned date of discharge from the STRTP (not including aftercare services provided by the STRTP).

1. **Reason for Admission**
   - Describe events in sequence leading to admission into the STRTP.
   - Describe primary need upon admission to the STRTP.
2. **Reason for Discharge from STRTP Placement**
   - Choose the most appropriate reason for discharge from the drop-down menu (higher level of care, lower level of care, alternate STRTP/residential setting, client did not return/AWOL, other)
   - If a child/youth transitions to a family or home-based placement select- Lower level of care.
   - If the child/youth was hospitalized or incarcerated select- Higher level of care.
   - If other is selected, provide an explanation of reason for transition.
3. **Living Placement upon Discharge from STRTP**
   - Choose the most appropriate living placement from the drop-down menu (biological family, extended family member, non-related extended family member, resource family, foster family agency, extended foster care/transitional housing program, San Pasqual Academy, alternate STRTP, other).
   - If other is selected, provide explanation of living placement at discharge.
   - Provide the specific name of caregiver and relationship to youth.
4. **Course of Treatment during the Child's Admission**
   - Provide summary services provided over the course of treatment.
   - Include mental health treatment interventions (frequency/duration) used to promote stability in placement, client's response to interventions, and outcomes of treatment provided.
   - Include the child's transition plan goals and progress made toward those goals during treatment
5. **Mental Health Diagnosis and Follow Up Required:**
   - List all current diagnosis in order of priority.
   - Provide a brief description of symptoms and follow up required to address symptoms.
   - Include goals and expected outcomes of follow-treatment (once child transitions from STRTP).

San Diego County Mental Health Services
Short-Term Residential Therapeutic Program (STRTP)
TRANSITION DETERMINATION PLAN

6. **Recommendations Regarding Treatment that are Relevant to the Child's Care**
   - The following questions (a-c) should be reviewed with the child/youth prior to transition. Use the child/youth's own language when applicable.
     a. **Resiliency Strategies:** Identify the child/youth's preferred activities, hobbies and soothing or calming techniques. Identify persons of support, transitional objects, or other strategies that will contribute to child or youth's success in next placement. Include specific caregiving strategies that promote resiliency and wellbeing.
     b. **Triggers:** Discuss with child/youth social, emotional or environmental factors that may trigger traumatization or otherwise decrease the child/youth's ability to be successful in next placement. Discuss methods to reduce triggering events and promote stability.
     c. **Other:** Include recommendations not previously listed to improve safety, permanency and well-being with transition that are pertinent to the child/youth's successful transition.
7. **Substance Use Treatment Recommendations:**
   - If applicable provide an explanation of substance use treatment recommendations.
8. **Medical Information:**
   a. List Medical and Dental services and date of services received while admitted to the STRTP.
      - Indicate if follow up is required, and the scheduled date and time of appointment if applicable.
      - If follow up is needed and appointment is yet to be scheduled, provide the upcoming due dates for the service.

   b. List current non-psychotropic medications including dose and frequency.
   c. List current psychotropic medications including dose and frequency. Attach documentation from the prescribing physician, such as the JV220 that contains potential or reported side effects of medication and provide to caregiver along with copy of Transition Determination Plan
   d. Note any allergies and adverse medication reactions as listed on JV220.
9. **Educational Information**
   - Include grade, grade level functioning, educational needs, education plans (for example IEP or 504 plan) and follow up required.
     a. Enter child/youth's current grade, if on summer break enter grade that will begin the following school year.
     b. Enter Educational strengths, which may include academic skills, preferred academic subjects, extracurricular activities, educational goals as expressed by the child/youth, etc.
     c. Enter educational needs/areas in which child/youth requires academic support.
     d. Enter educational plans child/youth has in place and/or any recommendations to begin process to make an educational plan.
        - Include next scheduled educational meeting or follow up required.
     e. Provide the date the school was notified of child or youth's discharge from the STRTP.
10. **Referral(s)**
    - Check all that apply (Wraparound, TBS, FFAST, CASS, School-Based Therapy, Outpatient Mental Health Clinic, TERM provider, Teen Recovery Center TRC, Incredible Families or other).
    - If other, explain referral.
    - Include referrals to providers of mental health and non-mental health services not listed in medical information.
    - If no referrals provided, provide explanation for reason why no referrals were provided.

San Diego County Mental Health Services
Short-Term Residential Therapeutic Program (STRTP)
TRANSITION DETERMINATION PLAN

Preferred Language

- Document the client's and the caregiver/guardian's primary/preferred language.
- Was the Transition Determination Plan explained in the client's and caregiver/guardian's primary language? Mark yes or no.
- If no, include reason why the Transition Determination Plan was not explained in the primary language noted.

Copies of Transition Determination Plan

- It is required for a copy to be offered to the client and as applicable, to the parent, guardian, conservator, or person identified by the court to participate in the decision to place the child/youth in the STRTP.
- It is required for copy of the Transition Determination Plan to be offered to the placing agency representative.
- Note the placing agency (CWS PSW or Juvenile Probation Officer) representative name and phone number.
- Provide the date the placing agency representative was notified of child/youth's transition from the STRTP

Signatures

Obtain signatures from client, parent, guardian, conservator, placing agency, and/or person identified by the court to place the youth in the STRTP.

Print, Sign and date the assessment in the appropriate signature section include CCBH ID number

BILLING: Can only occur when connected to a direct client service

San Diego County Mental Health Services
Short-Term Residential Therapeutic Program (STRTP)
Discharge Summary

2019

WHEN: Completed and signed within seven (7) days after child's/youth's discharge from a Short-Term Residential Therapeutic Program

ON WHOM: All children/youth placed in the STRTP

COMPLETED BY: Licensed/Waivered Psychologist
Licensed/Registered/Waivered Social Worker
Licensed/Registered/Waivered Marriage and Family Therapist
Licensed/Registered Professional Clinical Counselor**

MODE OF COMPLETION: Entered in the Electronic Health Record (EHR).

REQUIRED ELEMENTS:
Client name: enter the client's full name.
Case number from the EHR: Enter the client's unique client number.
STRTP name: Enter the name of the STRTP facility.
Date of admission: Enter the date the client was admitted to the program.

1. **Discharge Date from STRTP**
   - Enter the date the child/youth was discharged from the STRTP. This is the date of the child or youth transitioned from the STRTP to an alternate placement.
   - Do not include aftercare services in the Discharge Date.

2. **Aftercare provided by the STRTP**
   - Check Yes or No to indicate if aftercare services were provided by the STRTP.

3. **Discharge date from Aftercare**
   - Enter the date the child/youth was discharged from aftercare services.
   - If aftercare services where not provided, mark N/A.

4. **Summary of Services provided during aftercare**
   - If aftercare services were not provided mark N/A.
   - If aftercare services were provided, summarize services provided during aftercare. Include treatment interventions used to promote stability in placement, client's response to interventions, and outcomes of aftercare treatment provided. Also include recommendations for continued treatment if applicable.

5. **Discharge Reason**
   - Enter the most appropriate reason for discharge by selecting from the Table below:

Reason for Discharge	
1-Requires Higher Level of Care	8- Client/Family Dissatisfied
2-No longer requires services at this level of care	9-Left Against medical Advice
3-Lost Contact	10-Refused services
4-Ineligible for services/does not meet medical necessity	11-Death- suicide
5- Moved Away from Service Area	12-Death- non-suicide
6- Change in Medical Insurance	13-Incarcerated
7- Client Receiving Services/Tx Elsewhere	14-Other

San Diego County Mental Health Services
Short-Term Residential Therapeutic Program (STRTP)
Discharge Summary

- If a child/youth transitions to a family or home-based placement select #2 - No longer requires services at this level of care.
- If a child/youth is hospitalized or transitions to an alternate STRTP select #1 - Requires higher level of care.
- If the answer is Other, Specify the reason.

6. Discharge Destination

- Enter the most appropriate response in the space provided from choices listed in the Table below:

A-Transferred to Primary Care Physician B- Transferred to EQUIVALENT level of care C- Transferred to HIGHER LEVEL of care	D- Transferred to LOWER level of care E- Self-care/family/general community support F-Unknown: Referred to non-county services	G-Unknown: Never returned H- Unknown: Not eligible for services I-Jail/Prison J-Not applicable K-Other

- If a child/youth transitions to a family or home-based placement select E – Self-care/family/general support
- If a child/youth transitions to an alternate STRTP within San Diego County select B – Transferred to EQUIVALENT level of care.
- If a child/youth transitions to an alternate STRTP outside of San Diego County select C – Transferred to HIGHER LEVEL of care.
- If other provide explanation of destination at discharge.

7. Were Client plan goals met?

- If the client has not met at least 50% of the Client Plan goals (including leaving treatment prior to completing goals), select No.
- If the client has met all goals, select Yes.
- If the client has met at least 50% of goals, select Partially.
- If no goals were established prior to discharge, select No Goals Established.

Signature of Clinician Requiring Co-signature/Signature of Clinician Completing/Accepting the assessment:

Print, Sign and date the assessment in the appropriate signature section include CCBH ID number

BILLING: Can only occur when connected to a direct client service.

**Note: Programs within the CYF SOC must verify that all training requirements have been met in order for an LPCC/PCI to provide services to youth and families.

San Diego County Mental Health Services
Short-Term Residential Program (STRTP)
DISCHARGE SUMMARY

***Client Name:** ***Case #:**

***STRTP Name:** ***Date of Admission:**

- STRTP Discharge Summary to be completed within 7 Calendar days after child or youth's discharge from the STRTP and aftercare services (if applicable), and is a companion to the Transition Determination Plan.

***1. DISCHARGE DATE FROM STRTP PLACEMENT:** *not including aftercare provided by STRTP*:

***2. AFTERCARE PROVIDED BY THE STRTP:** ☐ Yes ☐ No

***3. DISCHARGE DATE FROM AFTERCARE:** *Include only if aftercare provided by STRTP*:
☐ N/A

***4. SUMMARY OF SERVICES PROVIDED DURING AFTERCARE:** *Only complete if aftercare services were provided.*
☐ N/A

*5. **DISCHARGE REASON:** Choose an item.

***6. DISCHARGE DESTINATION:** Choose an item.

***7. WERE THE CLIENT PLAN GOALS MET?**
☐ Yes ☐ No ☐ Partially ☐ No Goals Established

Signature of Clinician Requiring Co-signature:

_____ Date:
Signature

Printed Name: CCBH ID number:

***Signature of Clinician Completing/Accepting the Assessment:**

_____ Date:
Signature

Printed Name: CCBH ID number:

***Signature of Staff Entering Information (if different from above):**

_____ Date:
Signature

Printed Name: CCBH ID number: