

Bucks County    Cambria County    Delaware County    Lehigh County    Montgomery County    Northampton County

**Select the appropriate level of care/documentation below:**

- |  |  |
|--|--|
| <input type="checkbox"/> Partial Hospitalization           | <input type="checkbox"/> Intensive Case Management             |
| <input type="checkbox"/> Resource Case Management          | <input type="checkbox"/> Blended Case Management               |
| <input type="checkbox"/> Matrix Attached (ICM/BCM/RC Only) | <input type="checkbox"/> Treatment Plan/Service Plan/WRAP Plan |

**Type of Request:**     Initial Request                       Concurrent Request

**Member Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**MA ID Number:** \_\_\_\_\_

I. Referral Source: \_\_\_\_\_

II. Admission Date to Level of Care: \_\_\_\_\_

III. Presenting Problem (Current Behavior, Mental Status, and Risk related to functional impairment and/or dangerousness)

\_\_\_\_\_

\_\_\_\_\_

IV. Member's Identified Strengths (Level of responsibility for managing symptoms, ability to make choices consistent with goals, involvement in self-help/support activities, present vs. latent strengths)

\_\_\_\_\_

\_\_\_\_\_

V. Treatment /Service Plan, Recovery/WRAP Plan (with strengths based/measurable/objective goals, and identifying updates since previous review). Please attach copies.

\_\_\_\_\_

\_\_\_\_\_

VI. Progress of Treatment towards Goals (Behavioral and cognitive) (Concurrent Requests Only)

\_\_\_\_\_

\_\_\_\_\_

VII. Barriers to the member's improvement and/or inability to progress towards goals

\_\_\_\_\_

\_\_\_\_\_

What actions have been and/or will be taken to address these barriers?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Member Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

VIII. Frequency of contacts with the member or attendance per week

---

---

---

IX. Member's substance use since last review

---

---

X. Other current supports and services involved with member (family, community, support groups, and other mental health and substance abuse services)

---

---

---

How is your agency collaborating with these supports and services?

---

---

---

XI. Current Medications, medication education provided for member and/or family, and adherence to taking medications as prescribed

---

---

---

Reported side effects from medication/allergies

---

---

---

XII. Discharge Plan and Projected Discharge Date (include mental health, substance abuse, and natural supports)

---

---

---

XIII. Last admissions to Acute Inpatient Hospital/Crisis Residential/Detox and reason for admission

---

---

---

XIV. Abnormal Involuntary Movement Scale (AIMS) completed?  Yes  No

XV. List labs completed

---

---

---

**Member Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

---

---

*I verify that the information provided in this report is an accurate representation of member's status.*

\_\_\_\_\_  
Person Completing Form

\_\_\_\_\_  
Date

\_\_\_\_\_  
Licensed Supervisor (if person completing form is unlicensed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Psychiatrist (only necessary when medications are prescribed)

\_\_\_\_\_  
Date