Plan of Care

Date of Service:	Cost Center or Program:	Direct: _____ Documentation: _____ Travel: _____ Total: _____ Service Code:
Clinician's Name & License:		Client Identifier:
Client's Name:	Date of Birth:	Gender:
Guardian's Name:	Guardian's Phone:	
Address:	City: Zip:	Phone Number:
Ethnicity:	Preferred Language:	Provider speaks preferred language: ☐ Yes No ☐
Is interpreter needed? ☐ Yes No ☐	Client accepts offer of interpretive services: ☐ Yes No ☐	

PLAN OF CARE Aimed at Mental Health Symptom Reduction. Please use behavioral terms showing observable quantifiable goals, cite frequency of symptom(s) and behavioral goal(s). Identify expected duration of services.

Diagnosis: _____

Spell out problems and objectives, including client's desired outcome:

Behavioral Goals:

1. _____
2. _____
3. _____

Individual Therapy:	☐ Non-MD	☐ MD	Duration & Frequency:
Techniques to Achieve Goals:			
Family Therapy:	☐ Non-MD	☐ MD	Duration & Frequency:
Techniques to Achieve Goals:			
Group Therapy:	☐ Non-MD	☐ MD	Duration & Frequency:
Techniques to Achieve Goals:			
Individual Rehabilitation:	☐ Non-MD	☐ MD	Duration & Frequency:
Techniques to Achieve Goals:			

(The following must be present on all pages.)

Client Signature	Date
Parent/Guardian Signature	Date
Clinician's Signature / License and ID#	Date
Clinician's Name & License Printed	Client's Name: _____ Client Identifier: _____

Plan of Care

Group Rehabilitation:	☐ Non-MD	☐ MD		Duration & Frequency:
Techniques to Achieve Goals:				
Collateral:	☐ Non-MD	☐ MD	☐ Group	Duration & Frequency:
Techniques to Achieve Goals:				
Case Management: (Linkage, Consultation, & Placement):	☐ Non-MD	☐ MD		Duration & Frequency:
Techniques to Achieve Goals:				
Intensive Care Coordination (ICC):	☐ Non-MD	☐ MD		Duration & Frequency:
Techniques to Achieve Goals:				
Intensive Home Base Service (IHBS):	☐ Non-MD	☐ MD		Duration & Frequency:
Techniques to Achieve Goals:				
TBS:	☐ Non-MD	☐ MD		Duration & Frequency:
Techniques to Achieve Goals:				
Day Treatment Intensive:	☐ Non-MD	☐ MD		Duration & Frequency:
Techniques to Achieve Goals:				
Med Interview:	☐ MD	☐ Med Admin		Duration & Frequency:
☐ **Plan Development:**				Duration & Frequency:
☐ **Other:**				Duration & Frequency:
Estimated Duration of Treatment:				
Discharge Criteria:				

☐ Plan of Care Discussed in Client's Preferred Language ☐ Copy of Plan of Care Accepted by Client

☐ Copy of Plan of Care Declined by Client

(The following must be present on all pages.)

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Clinician's Signature / License and ID# _____ Date _____

Clinician's Name & License Printed _____ Client's Name: _____

Client Identifier: _____