

Agency:  
 Program:  
 Phone:  
 Fax:

**SHASTA COUNTY  
 MENTAL HEALTH PLAN  
 INITIAL ASSESSMENT AND  
 CLIENT TREATMENT PLAN  
 (IACP)**

PROGRAM ADMIT DATE:  
 ASSESSMENT TIME:  
 SERVICE COORDINATOR:

Client:

Chart # DOB:

AUTHORIZATION PERIOD FROM: TO: TODAY'S DATE:  
 LANGUAGE: NAME OF INTERPRETER:

**POTENTIAL REQUIRED DISCLOSURES** (Report of suspected child/elder abuse; imminent intent to harm self or others; records subject to imminent subpoena under certain conditions):

**INFORMING MATERIALS:**

Shasta County MHP       HIPAA       Freedom of Choice Discussed       Consumer Rights  
 Advanced Health Directive    Alternate Format Offered?  No  Yes Type:       TBS Offered  
 Advisement Given for Potential Required Disclosures

Condition NOT expected to respond to physical health care treatment only:  Yes  No

**CURRENT LEGAL STATUS:**

- Voluntary       LPS Conservatorship       Probate Conservatorship       FNRC  
 Parole       Probation       Registered Sex Offender

elaborate:

Name of Conservator or Probation/Parole Officer (if applicable): Phone Number:

**PRESENTING PROBLEM:** (Identifying Data/Chief Complaint and History of Present Illness. Summarize client's request for services including client's most recent baseline and the subjective description of the problem. Include precipitating factors that led to deterioration and describe events in sequence leading to present visit. Include objective impairing behaviors, including experiences and stigma, if any, prejudice and client's requests/needs. Address S/I, H/I)

**PAST PSYCHIATRIC HISTORY:** (Previous mental health treatment, in chronological order: where, when, for how long. Include dates/providers related to any prior psychiatric treatment, history, traumatic and/or significant events, include immigration history and impact, if any. Describe most recent periods of stability and the characteristics of those time periods.)

**Any family members with a history of the following?** (Please check all that apply).

	Mental Health Issues	Substance Abuse	Suicide	Other	Effective Treatments
Parent	<input type="checkbox"/>				
Sibling	<input type="checkbox"/>				
Children	<input type="checkbox"/>				
Aunt/Uncle	<input type="checkbox"/>				
Grandparent	<input type="checkbox"/>				

**Narrative:**

*Adult Comprehensive Initial Assessment  
 And Client Treatment Plan*

Client :  
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**FAMILY HISTORY:**

**CULTURE/FAMILY AND RECOVERY POTENTIAL:**

Birthplace:  USA  Other:

Language of choice for services:  English  Spanish  Mien  Other:

Ethnicity:  Latino/Hispanic  African American  Asian/Pacific Islander (specify):

Caucasian/White  American Indian  Other (specify):

**Culture specific symptomology/explanations for behavior (May reference Appendix I of DSM-IV-TR):**

**Family/Community Support System** (Describe, including alternative relationship support, if any, for mental health and/or substance use. Who is supportive? Community groups, i.e., AA, NA, etc.):

**Socio-Economic Factors** (Educational achievement, occupation, income source and level):

**Religious/Spiritual Issues** (Is R/S important in client's life? If yes, is it a source of strength in client's recovery process? Describe how, who, persons, practices, etc.):

**Assets/Strengths** (What abilities or skills does client have that they would chose to develop during their recovery? What new ones might they choose to develop? Describe strengths that contributed to recent treatment success, sobriety, etc.):

**Medical History** (Indicate any significant medical history related to client's current mental health or substance abuse condition, including dates/providers related to prior to treatment, as well as client's adjustment to co-occurring disabilities.):

Current Medication(s)	Dose	Frequency	Taken as Prescribed?	
			Prescribed by:	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Prescribed by:	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Prescribed by:	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Prescribed by:	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Prescribed by:	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Prescribed by:	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Prescribed by:	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Prescribed by:	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Prescribed by:	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Prescribed by:	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Prescribed by:	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Prescribed by:	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Prescribed by:	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Prescribed by:	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Prescribed by:	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Allergies and Adverse Medication Reactions:**  NKA(s)

Reported allergies and adverse medication reactions, per client report:

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

NAME OF CURRENT PRIMARY CARE PHYSICIAN:

Address/Phone:

May we consult?  Yes  No Date last seen:

Release of information form?  Yes  No

**MENTALLY ILL DRUG & ALCOHOL SCREENING (MIDAS)**

(Provided with permission from Kenneth Minkoff, MD)

Each question refers to the past six months:

1. Do you feel that you have a problem with your use of drugs and/or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you use drugs and alcohol even though your doctor or other treaters recommended that you do not?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is your family concerned about your drug and alcohol use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are your treaters concerned about your drug and alcohol use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had legal problems or engaged in illegal activity (other than using drugs) due to drug and alcohol use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you had medical problems related to, or worsened by, drug and alcohol use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do you use drugs and alcohol to relieve mental health symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Do you find that using drugs and alcohol worsens your mental health symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Do you have problems taking your psychiatric medication as prescribed because of drug or alcohol use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you gotten in trouble, including getting in trouble at a mental health treatment program, because of drug or alcohol use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you had ER visits or psychiatric hospitalizations that were connected to drug or alcohol use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Do you ever feel guilty about your drug and alcohol use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Have you experienced withdrawal symptoms or intense cravings to use drugs or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Have you attended self-help (i.e., 12 Step) meetings related to drug and alcohol addiction?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Have you received any addiction treatment, including detoxification?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Have you felt unable to control your use of any drug or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Do you consider yourself to be an active alcoholic or drug addict?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Scoring:**

Any YES answer on questions 1 to 12 indicates probable abuse.

Any YES answer on questions 13 to 17 indicates probable dependence.

\*Address in interpretive summary.

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**SUBSTANCE USE INFORMATION:**  Indicate if no history of abuse  History Unknown

(Describe the most recent baseline and characteristics in terms of symptoms, functioning, substance use, treatment, successful intervention and factors (in sequence) that led to present deterioration. Identify periods of abstinence or minimal use of substances.)

Substance	CURRENT SUBSTANCE USE							
	Age at first use	Date last used	None	Current Use	Current Abuse	Current Dependence	In Recovery	Client-perceived problem?
<input type="checkbox"/> ALCOHOL			<input type="checkbox"/>					
<input type="checkbox"/> AMPHETAMINES/METHAMPHETAMINES (SPEED, UPPERS, CRANK, RITALIN)			<input type="checkbox"/>					
<input type="checkbox"/> COCAINE/CRACK			<input type="checkbox"/>					
<input type="checkbox"/> OPIATES (HEROIN, OPIUM, METHADONE)			<input type="checkbox"/>					
<input type="checkbox"/> HALLUCINOGENS (LSD, MUSHROOMS, PEYOTE)			<input type="checkbox"/>					
<input type="checkbox"/> SLEEPING PILLS, PAIN KILLERS, VALIUM OR SIMILAR DRUGS			<input type="checkbox"/>					
<input type="checkbox"/> PCP (PHENCYCLIDINE) OR DESIGNER DRUGS (HGB)			<input type="checkbox"/>					
<input type="checkbox"/> INHALANTS (PAINT, GAS, GLUE)			<input type="checkbox"/>					
<input type="checkbox"/> MARIJUANA/HASHISH			<input type="checkbox"/>					
<input type="checkbox"/> TOBACCO/NICOTINE			<input type="checkbox"/>					
<input type="checkbox"/> CAFFEINE (ENERGY DRINKS, CAFFEINATED SOFT DRINKS, ETC.)			<input type="checkbox"/>					
<input type="checkbox"/> OVER-THE-COUNTER MEDICATIONS			<input type="checkbox"/>					
<input type="checkbox"/> PRESCRIPTION MEDICATIONS			<input type="checkbox"/>					

Narrative:

<b>MENTAL STATUS EXAM</b> <i>Note: Clarification/details of MSE may be addressed in Assessment Progress Note.</i>						
Level of Consciousness:	<input type="checkbox"/> Alert	<input type="checkbox"/> Lethargic	<input type="checkbox"/> Stuporous	<input type="checkbox"/> Distracted	<input type="checkbox"/> Hypervigilant	<input type="checkbox"/> Apathetic
Orientation:	<input type="checkbox"/> Person	<input type="checkbox"/> Place	<input type="checkbox"/> Time <input type="checkbox"/> Day	<input type="checkbox"/> Month <input type="checkbox"/> Year	<input type="checkbox"/> Current Situation	<input type="checkbox"/> Other
Appearance:	<input type="checkbox"/> Clean	<input type="checkbox"/> Well Nourished	<input type="checkbox"/> Malnourished	<input type="checkbox"/> Disheveled	<input type="checkbox"/> Malodorous	<input type="checkbox"/> Reddened Eye
Speech:	<input type="checkbox"/> WNL	<input type="checkbox"/> Slurred	<input type="checkbox"/> Loud	<input type="checkbox"/> Pressured	<input type="checkbox"/> Slow	<input type="checkbox"/> Mute
Thought Process:	<input type="checkbox"/> Coherent	<input type="checkbox"/> Tangential	<input type="checkbox"/> Circumstantial	<input type="checkbox"/> Incoherent	<input type="checkbox"/> Loose Association	<input type="checkbox"/> Other:
Behavior:	<input type="checkbox"/> Cooperative	<input type="checkbox"/> Evasive	<input type="checkbox"/> Uncooperative	<input type="checkbox"/> Threatening	<input type="checkbox"/> Agitated	<input type="checkbox"/> Aggressive
Affect:	<input type="checkbox"/> Appropriate	<input type="checkbox"/> Restricted	<input type="checkbox"/> Blunted	<input type="checkbox"/> Flat	<input type="checkbox"/> Labile	<input type="checkbox"/> Other:
Intellect:	<input type="checkbox"/> WNL	<input type="checkbox"/> Below normal	<input type="checkbox"/> Paucity of Knowledge	<input type="checkbox"/> Vocabulary Poor	<input type="checkbox"/> Abstraction Poor	<input type="checkbox"/> Uncooperative
Mood:	<input type="checkbox"/> Euthymic	<input type="checkbox"/> Elevated	<input type="checkbox"/> Euphoric	<input type="checkbox"/> Depressed	<input type="checkbox"/> Anxious	<input type="checkbox"/> Irritable
Memory:	<input type="checkbox"/> WNL	<input type="checkbox"/> Poor Recent	<input type="checkbox"/> Poor Remote	<input type="checkbox"/> Inability to Concentrate	<input type="checkbox"/> Confabulation	<input type="checkbox"/> Amnesia
Judgment:	<input type="checkbox"/> WNL	<input type="checkbox"/> Poor	<input type="checkbox"/> Unrealistic	<input type="checkbox"/> Unmotivated	<input type="checkbox"/> Uncertain	<input type="checkbox"/> Recent Change
Motor:	<input type="checkbox"/> WNL	<input type="checkbox"/> Decreased	<input type="checkbox"/> Agitated	<input type="checkbox"/> Tremors	<input type="checkbox"/> Tics	<input type="checkbox"/> Repetitive Motions
Insight:	<input type="checkbox"/> WNL	<input type="checkbox"/> Adequate	<input type="checkbox"/> Marginal	<input type="checkbox"/> Poor		<input type="checkbox"/> Blames Others
Concentration:	<input type="checkbox"/> Attentive	<input type="checkbox"/> Distracted	<input type="checkbox"/> Inability to concentrate			

Visual Hallucinations:  No  Yes Explain:

Auditory Hallucinations:  No  Yes Explain:

Delusions:  No  Yes Explain:

Paranoia:  No  Yes Explain:

Command:  No  Yes Explain:

**Other:**

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POTENTIAL FOR HARM (Include risk factors, i.e., chronic illness, recent loss of job, age):

- CURRENT SI**       Past Attempts       Depressed, Helpless, Hopeless       Ideation       Plan/Intent Access  
 Impulsive Behavior       Substance Abuse       Recent Loss or Anniversary       Chronic Illness/Pain       Realistic Means to carryout plan  
 Sleep Disturbance       Unstable Living Cond       Gender/Age (Persons under 19 & males over 45 at higher risk)  
 Family History of Suicide Attempts

Client plan for safety/protection:       No       Yes      Specify in Progress Notes:

- CURRENT HI:**       No       Yes      Specify plan, method, vague, passive, imminent:  
Identified Victim?       No       Yes      Name and Contact Information:  
Tarasoff Warning?:       No       Yes      Explain:  
**History of Violence?**       No       Yes      Specify type, past, current:  
**History of Domestic Violence?**       No       Yes      Specify:  
**History of Abuse?**       No       Yes      Specify type, past, current:  
Abuse Reported?       No       Yes  
**Plan to address any risk factors identified above?**       Yes       No

**Safety Plan:**

**PROTECTIVE:**

- Belief System  
 Religion/Spiritual  
 Legacy/Children  
 Support  
 Resilience

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**COMMUNITY FUNCTIONING AND SATISFACTION:**

(This section to be completed with the client in order to identify areas on which the client wants to work):

<p><b>1. EMPLOYMENT</b> Current status: None <input type="checkbox"/> Paid Hrs/Wk: ____ Vol Hrs/Wk: ____</p> <p><input type="checkbox"/> <b>Client's goal in this area (optional):</b></p>	<p>How satisfied are you with your current employment situation?</p> <p>Very Satisfied <input type="checkbox"/> Mostly Satisfied <input type="checkbox"/> Mixed <input type="checkbox"/> Mostly Dissatisfied <input type="checkbox"/> Very Dissatisfied <input type="checkbox"/></p>
<p><b>2. EDUCATION/TRAINING</b> Current status: Hrs/Wk: ____</p> <p><input type="checkbox"/> <b>Client's goal in this area (optional):</b></p>	<p>How satisfied are you with your current education or training?</p> <p>Very Satisfied <input type="checkbox"/> Mostly Satisfied <input type="checkbox"/> Mixed <input type="checkbox"/> Mostly Dissatisfied <input type="checkbox"/> Very Dissatisfied <input type="checkbox"/></p>
<p><b>3. LEISURE</b> Current hobbies/leisure activities:</p> <p><input type="checkbox"/> <b>Client's goal in this area (optional):</b></p>	<p>How satisfied are you with your current leisure activities?</p> <p>Very Satisfied <input type="checkbox"/> Mostly Satisfied <input type="checkbox"/> Mixed <input type="checkbox"/> Mostly Dissatisfied <input type="checkbox"/> Very Dissatisfied <input type="checkbox"/></p>
<p><b>4. TRANSPORTATION &amp; MOBILITY</b> Current resources: Do you sometimes miss events or appointments due to lack of transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> <b>Client's goal in this area (optional):</b></p>	<p>How satisfied are you with your transportation arrangements?</p> <p>Very Satisfied <input type="checkbox"/> Mostly Satisfied <input type="checkbox"/> Mixed <input type="checkbox"/> Mostly Dissatisfied <input type="checkbox"/> Very Dissatisfied <input type="checkbox"/></p>
<p><b>5. FAMILY RELATIONS</b> Do you have contact with your family? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, skip to #6)</p> <p>Are you satisfied with the amount of contact you have with your family? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you feel you can count on family members to support you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you feel your family understands your disability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> <b>Client's goal in this area (optional):</b></p>	<p>How satisfied are you with your family relationships?</p> <p>Very Satisfied <input type="checkbox"/> Mostly Satisfied <input type="checkbox"/> Mixed <input type="checkbox"/> Mostly Dissatisfied <input type="checkbox"/> Very Dissatisfied <input type="checkbox"/></p>
<p><b>6. SOCIAL SUPPORT</b></p> <p>Do you have friends or acquaintances with whom you socialize? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have friends you can count on to help you with your problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you involved in any self-help groups or activities? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you involved in any religious or spiritual activities? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> <b>Client's goal in this area (optional):</b></p>	<p>How satisfied are you with your social support network?</p> <p>Very Satisfied <input type="checkbox"/> Mostly Satisfied <input type="checkbox"/> Mixed <input type="checkbox"/> Mostly Dissatisfied <input type="checkbox"/> Very Dissatisfied <input type="checkbox"/></p>
<p><b>7. CULTURAL FACTORS</b></p> <p>Do you identify with any specific ethnic, racial or cultural group(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have difficulty with other's cultural/expectations of you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you been the victim of any type of discrimination in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> <b>Client's goal in this area (optional):</b></p>	<p>How satisfied are you with other's acceptance of your cultural identity?</p> <p>Very Satisfied <input type="checkbox"/> Mostly Satisfied <input type="checkbox"/> Mixed <input type="checkbox"/> Mostly Dissatisfied <input type="checkbox"/> Very Dissatisfied <input type="checkbox"/></p>
<p><b>8. LIVING ARRANGEMENTS</b> Current living situation:</p> <p>Do you feel safe in your current living situation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you want to stay where you are living now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> <b>Client's goal in this area (optional):</b></p>	<p>How satisfied are you with your current living situation?</p> <p>Very Satisfied <input type="checkbox"/> Mostly Satisfied <input type="checkbox"/> Mixed <input type="checkbox"/> Mostly Dissatisfied <input type="checkbox"/> Very Dissatisfied <input type="checkbox"/></p>

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**REHABILITATION/RECOVERY RECOMMENDATIONS** (List in-house clinical services, as well as names of agencies providing treatment or being recommended for treatment):

1. <input type="checkbox"/> Mental Health Rehab	7. <input type="checkbox"/> Recovery Programs/Socialization Services	13. <input type="checkbox"/> CalWORKS/BHT
2. <input type="checkbox"/> Case Management Services	8. <input type="checkbox"/> Substance Abuse Program (note level of care)	14. <input type="checkbox"/> Community Services
3. <input type="checkbox"/> Medication Management	9. <input type="checkbox"/> Psycho-Education Group	15. <input type="checkbox"/> Medical Treatment
4. <input type="checkbox"/> Education/Support	10. <input type="checkbox"/> Group Therapy	16. <input type="checkbox"/> Support Group
5. <input type="checkbox"/> Employment Services	11. <input type="checkbox"/> Individual Therapy	17. <input type="checkbox"/> Crisis Residential/Hospitalization
6. <input type="checkbox"/> Housing Services	12. <input type="checkbox"/> WRAP Plan	18. <input type="checkbox"/> Other (specify):

**Number and explanation below:**

##

- Program Services:
- Proposed Referrals:
- Program Services:
- Proposed Referrals:
- Program Services:
- Proposed Referrals:

**Diagnosis Source:**                  **Diagnosis Staff Name:**                  **Date:**

ICD 9 Code: (Pri) \_\_\_\_\_

Axis I: (Pri) \_\_\_\_\_

Axis I: (Sec) \_\_\_\_\_

Axis I: (Sec) \_\_\_\_\_

Axis I: (Substance Abuse—consider stages of remission) \_\_\_\_\_

Axis II: (Pri) \_\_\_\_\_

Axis II: (Sec) \_\_\_\_\_

Axis II: (Sec) \_\_\_\_\_

Axis III: \_\_\_\_\_

- Axis IV:
- Problems with primary support group: Specify
  - Problems related to the social environment: Specify
  - Educational problems: Specify
  - Occupational problems: Specify
  - Housing problems: Specify
  - Economic problems: Specify
  - Problems with access to health care services: Specify
  - Problems related to interaction with the legal system/crime: Specify
  - Other psychosocial and environmental problems: Specify
  - (No Change): Specify

Axis V:                  Current GAF:                  Past Year GAF:

**Updated Diagnosis**—See supporting note and updated Client Data Sheet dated: \_\_\_\_\_

**INTERPRETIVE SUMMARY: Justification for diagnosis and medical necessity.** (Briefly 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 impair normal functioning.** Include evaluation of client’s ability and willingness to solve their presenting problems, addressing both mental health and substance issues from an integrated perspective.)

**Introduction Progress Note: to include in-depth clinical information gathered during assessment on other—reassessment progress note:**

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**Plan Development Time:**

**CLIENT TREATMENT PLAN**

Treatment Goals (Must be measurable and specific, including case management goal if applicable.)

Goal 1

Goal 2

Client strengths to achieve treatment goal(s):

Challenges to achievement of goal(s):

Intervention Plan (Include all anticipated services and types of interventions):

Proposed duration of interventions:

Medical Necessity for multiple services:

Responsible Identified:

Other providers and services authorized:

Plan for service coordination among providers:

I participated in and agree with the development of this plan.

Copy of Plan was offered to client.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician/Personal Services Coordinator

\_\_\_\_\_  
Clinician Co-Signature (if necessary)

\_\_\_\_\_  
Date

**Explanation for no Client Signature** (may include reason, date(s) and manner/number of attempts made to obtain signature):

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**SHASTA COUNTY MENTAL HEALTH TREATMENT AUTHORIZATION REQUEST**

Mental Health Services by: \_\_\_\_\_  Day Rehabilitation: \_\_\_\_\_  
 Case Management by: \_\_\_\_\_  Day Treatment: \_\_\_\_\_  
 Medication Evaluation/Support by: \_\_\_\_\_ Number of Days per Week: \_\_\_\_\_  
 TBS Referral Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

**SCMHP AUTHORIZATION**

**SCMHP USE ONLY**

Mode of services authorized as follows:  
(For additional service request on update initial and date by service.)

Mental Health Services by: \_\_\_\_\_  Day Rehabilitation: \_\_\_\_\_  
 Case Management by: \_\_\_\_\_  Day Treatment: \_\_\_\_\_  
 Medication Evaluation/Support by: \_\_\_\_\_ Number of Days per Week: \_\_\_\_\_

Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_

TBS Referral Authorized by: \_\_\_\_\_ Date: \_\_\_\_\_

Intensity of services by multiple providers appropriate.

Authorization:  Approved  Deferred  Denied  Modified By: \_\_\_\_\_ Date: \_\_\_\_\_  
*Name of reviewer*

Date NOA Completed: \_\_\_\_\_ Type of NOA Completed: \_\_\_\_\_

Authorized by: \_\_\_\_\_ Date: \_\_\_\_\_  
*Name of reviewer*

Resubmitted for Authorization: Date: \_\_\_\_\_

Approved: \_\_\_\_\_ Date: \_\_\_\_\_  
*Name of reviewer*

**COMMENTS/REASON FOR DEFERRAL, MODIFICATION OR DENIAL:**

*Distribution: Forward to Medical Records*

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