Solano County Mental Health Plan –Managed Care Network Provider

Client Biopsychosocial Assessment Update

Name of Assessor: _____ **Date of this Assessment Update:** _____

SECTION I: Relevant Client Updates

Please describe any changes to the following areas since the most recent Client Assessment dated: _____ (required)

Type of Assessment Update (must check one): ❑Annual ❑Periodic

Resources (Interests, family, community, school and peers, etc.):	☐ Continued on Addendum Page
Mental Status Exam:	☐ Continued on Addendum Page
Significant Events:	☐ Continued on Addendum Page
Substance Use:	☐ Continued on Addendum Page
Relevant Physical Health Conditions:	☐ Continued on Addendum Page
Cultural Factors:	☐ Continued on Addendum Page
Social Factors:	☐ Continued on Addendum Page
Developmental Status:	☐ Continued on Addendum Page
Medications:	☐ Continued on Addendum Page
Coordinated Services/Agencies:	☐ Continued on Addendum Page

Section II: Medical Necessity Criteria and Justification

Diagnostic Criteria (List included Title 9 diagnosis): _____

Impairment Criteria (must have ONE of the following impairments as a result of the included Title 9 diagnosis):

1. A significant impairment in an important area of life functioning, OR ☐ Yes ☐ No

2. A probability of significant deterioration in an important area of life functioning, OR ☐ Yes ☐ No

3. A probability that the child/youth will not progress developmentally as individually appropriate, OR ☐ Yes ☐ No

4. For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate. ☐ Yes ☐ No

Intervention Criteria (must meet 5,6, & 7 OR 7 & 8):

5. The focus of treatment is to address the condition identified in the Impairment Criteria. ☐ Yes ☐ No

6. It is expected the client will benefit from treatment by diminishing the impairment or preventing significant deterioration in an important area of life functioning. ☐ Yes ☐ No

7. The condition would not be responsive solely to physical health care based treatment. ☐ Yes ☐ No

8. For full-scope Medi-Cal beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate. ☐ Yes ☐ No

Provide brief description of impairments/presenting problems in activities of daily living, social, occupational/academic or other important area(s) of life functioning:

_____

_____

_____

Section III: Symptoms to Support Diagnosis (include DSM diagnostic criteria and functional impairment)**:**

_____

_____

_____

☐ Continued on Addendum Page

Section IV: Current Diagnosis(check only one Primary Diagnosis)

Axis I ☐ Pri ☐ Sec DSM Code: _____ Name: _____

Axis II ☐ Pri ☐ Sec DSM Code: _____ Name: _____

Axis III General Medical Condition ICD Code: _____ Name: _____

Axis IV Psychosocial and Environmental Problems ***Check all that apply*:**

☐ A. primary support group ☐ E. housing ☐ I. other psychosocial/environmental

☐ B. social environment ☐ F. economics ☐ J. inadequate information

☐ C. education ☐ G. access to health care

☐ D. occupational ☐ H. interaction with legal system

Axis V Current **GAF**: _____ Highest **GAF** (in past 12 months): _____

Section V: Individual &/or Family Strengths Relevant to Achieving Treatment Goals

_____

_____

_____

Client Name: _____ **Date of Birth:** _____

Section VI: Treatment Plan

Treatment goals must be specific observable and/or specific quantifiable. You should be able to tell when the client has reached their goal, e.g. "as evidenced by…"

Goal #1: _____

_____

Proposed Method for Achieving Goal/Interventions: _____

_____

Proposed Duration: _____

_____

Progress Since Last Report: ☐ New Goal ☐ Much Worse ☐ Slight Improvement ☐ Somewhat Worse ☐ Significant Improvement ☐ No Change ☐ Resolved

Goal #2: _____

_____

Proposed Method for Achieving Goal/Interventions: _____

_____

Proposed Duration: _____

_____

Progress Since Last Report: ☐ New Goal ☐ Much Worse ☐ Slight Improvement ☐ Somewhat Worse ☐ Significant Improvement ☐ No Change ☐ Resolved

Section VII: Re-Authorization of Services Request

Service Type		Frequency		Totals	
Individual Therapy:	☐ Monthly	☐ Every other week	☐ Weekly	**Total** Sessions Requested	_____
Group Therapy:	☐ Monthly	☐ Every other week	☐ Weekly	**Total** Sessions Requested	_____
Family Therapy:	☐ Monthly	☐ Every other week	☐ Weekly	**Total** Sessions Requested	_____

Section VIII: Signatures

The signatures below indicate that the client and provider have agreed to this plan and that the client was offered a copy of this plan.

Check one: ☐ Client *accepted* a copy of this plan ☐ Client *declined* a copy of this plan

Client Signature _____ Date _____

Provider Signature and Licensure/Degree _____ Date _____

Parent/Caregiver/Guardian _____ Date _____

Print Provider Name and Licensure/Degree _____

If no client signature, document why and describe how the client/caregiver was involved in the development of this plan and how they have indicated agreement with the plan: _____

_____

_____

Client Name: _____ **Date of Birth:** _____

Addendum Page

Additional Clinical Information (Reference Section #)

Signature & License | Print Name | Date

Client Name: _____ **Date of Birth:** _____