Cathexis Specialty Assessment/Service Plan

Date: ___________

Section 1A - Client/Guardian to complete this section:

Client's Name:	Date of Birth:	Gender: Male Female Other
Street Address, City, St, Zip:	Client/Guardian Cell Phone:	Client/Guardian Home Phone:
Client/Guardian Email:	Preferred Method of Contact:	May I leave a message at the above phone numbers? __Yes __No
If you have AHCCCS, and know your AHCCCS ID: A________________ Do you have other insurance in addition to AHCCCS? __Yes__No	**If you have other insurance in addition to AHCCCS, please provide your therapist with a copy of your other insurance card, as AHCCCS is a payer of last resort.**	Emergency Contact Name/Number

Purpose for Psychotherapy and Counseling: Why did you decide to seek services at this time? What are your main concerns? (Circle as many as are appropriate)

Anxiety/Panic	Depression	Eating Disorder/Concern	Fears/Phobia
Sexual Concern	Sleeping Issues	Addictive Behaviors	Mood Swings
Phase of Life Changes	Relationship Concerns	Drugs/Alcohol	Medical Illness
Recent Loss	Caring for Family Client	Spiritual Concerns	Anger/Rage
Other :			

Are you currently seeing a psychiatrist, psychologist or other counselor or health provider? ________________

If yes, please provide the following:

Provider Name:	Purpose:
Address:	Telephone:
Are you willing to sign a release of information so that I may speak to this provider? ☐ Yes ☐ No	

Provider Name:	Purpose:
Address:	Telephone:
Are you willing to sign a release of information so that I may speak to this provider? ☐ Yes ☐ No	

Tell me about the special people in your life (their relationship to you and why they are important):

____

____

Tell me about any pets that are important to you: ____

Section 1B - Complete only if you are the client and an adult. If client is a minor, please skip to Section 1C.

Social Relationships - Is client married, in a domestic partnership, or in a committed long-term relationship?

Name of Partner:	Age:	Length of Relationship:	Are you satisfied with the relationship?

Does client have children? If yes, please provide:

Name:	Age:	Name:	Age:
Name:	Age:	Name:	Age:

Describe client's support system:

____

____

____

Career/Professional Life – Is client currently employed? ☐Yes ☐ No Hours per Week? ______

Job Title/Position: ____

Highest Education Level: ____

Other career/professional information: ______________________________________

____

____

____

Military Experience – Military Service? ☐Yes ☐ No

Combat Experience? ☐Yes ☐ No Where/How many tours? ________________________________

Branch	Rank
Date Enlisted/Drafted	Date Discharged & Type

Other military information:

____

____

Section 1C - Parent/Guardian to complete if client is a minor.

Family Relationships – Is the parent/guardian married, in a domestic partnership, or in a committed long-term relationship? If yes, please provide:

Name of Parent's/Guardian's Partner	Age	Length of Relationship	Are you satisfied with the relationship?

Are other children in the home? If yes, please provide:

Name	Age	Name	Age
Name	Age	Name	Age
Name	Age	Name	Age

Other family information:

____

____

School - Is the child in school? ☐Yes ☐ No If yes, which school? ____________________________

Grade__________________ Teacher's Name: ____

Has child's performance or behavior in school recently changed? ☐Yes ☐ No – Skip this section.

If yes, please explain:

____

____

____

Extracurricular activities? ☐Yes ☐ No

If yes, which ones?

____

____

Does child have close friends and peers? ☐Yes ☐ No

Does child have other concerns related to school? ☐Yes ☐ No
If yes, please explain:

____

____

____

Thank you for completing Section 1. Your therapist will complete the remainder of this document.

Section 2 - Clinician to complete for all clients:

Presenting Concern:

____

____

____

____

Signs and Symptoms Resulting in Concern(s) (Include current symptoms in social, occupational, thoughts and feelings, physical functioning):

____

____

____

____

History of Presenting Concern - Events, precipitating factors, stressors, and/or incidents (including accidents or injuries) leading to need for services:

____

____

____

Describe client's mood lately - ____

Family history of mental health diagnosis/illness or hospitalization/treatment for a mental health issue? ☐Yes ☐ No – Skip this Section

Father:
Mother:
Sibling:
Sibling:
Other:

Legal - Previous or current legal/criminal justice system involvement. Custody/guardianship & pending litigation issues:

____

____

Chemical Use History - ☐Yes ☐ No – Skip this section.

Substance	Age first use	Last Use	Frequency	Method
ETOH				
MJ				
Amphetamines/Cocaine				
Depressants/Opioids				
Hallucinogenic				
Inhalants				
Other				
Other				

Previous episode of care at treatment facility or attended groups for substance use? ☐Yes ☐ No

____

____

Current concern about use of alcohol or substances? ☐Yes ☐ No

____

____

Counseling/Prior Treatment History - ☐Yes ☐ No – Skip this section.

____

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____

____

Development - Are there special, unusual, or traumatic circumstances (including accidents or injuries) that affected the client's development at any time during his/her life?

____

____

____

Child abuse history? ☐Yes ☐ No
If yes, was the abuse: ☐Sexual ☐Emotional/Verbal ☐ Physical ☐Neglect

As a child/adolescent, did client experience any of the following? ☐Bullying ☐Poverty ☐Malnutrition ☐ Discrimination ☐Death of a family client ☐ Being Adopted ☐ Parent with an addiction

Cultural/Ethnic – Client's cultural/ethnic group(s). ____

Are you or have you experienced any problems due to cultural or ethnic issues: ☐ Yes ☐ No

Other cultural/ethnic concern, preferences or other information:

____

Personal Strengths - ____

Spiritual/Religious – Spiritual/Religious affiliation? ____

Other spiritual/religious information:

____

____

Physical Health/Wellness/Fitness - Any relevant health issues? ☐ Yes – Please explain. ☐ No

____

____

____

Currently taking any medications? ☐ Yes ☐ No

If yes, please provide:

Medication:	Dosage:	Prescribed For:
Medication:	Dosage:	Prescribed For:
Medication:	Dosage:	Prescribed For:

Activity Level

____

____

Leisure activities/hobbies

____

____

Estimated daily consumption of: Tobacco ______ Caffeine ______ Sugar _______

Treatment Considerations:

Is treatment determined to be medically necessary? ☐Yes ☐No

If no: What type of services are appropriate:____

If yes: Tx modality: ☐ Indiv. ☐ Conjoint ☐Family ☐ Group

Frequency/Number of Hours:____

Applicable Procedure Codes (circle all that apply) 90834 90837 90847 H0004 T1016

Diagnosis Code	Description

Prognosis: ☐Poor ☐Marginal ☐Guarded ☐Moderate ☐ Good ☐Excellent
Qualifiers to prognosis: ☐Med compliance ☐Tx compliance ☐ Home environment
☐Activity changes ☐Behavioral changes ☐Attitudinal changes ☐Education/training
☐Other: ____

Adjunctive Services Needed:

☐Physical exam ☐School records ☐Psychiatric evaluation ☐Psychological testing

☐Patient records (specify): ____

☐Other (specify): ____

Recovery Goal(s) (e.g. Personal/Family Vision):

____

____

____

____

Discharge Plan:

____

____

____

____

Additional Notes:

____

____

Section 3 - Must be signed by Clinician and Client/Guardian.

Clinicians: Remember to include a copy of the TherapyNotes Treatment Plan with this document to complete the Specialty Assessment/Service Plan

Service Plan Rights Acknowledgment for Person who are Title XIX/XXI and/or SMI

My service plan has been reviewed with me by my behavioral health counselor. I understand the type of services I will be getting, and the frequency. All changes in the services have been/will be explained to me. I know that in most cases, any reductions, terminations, or suspensions of current services will begin no earlier than 10 days from the date of this plan, and that I can ask for this to be sooner.

I have had the opportunity to note in this document if I do not agree with some or all of the services that have been authorized on the plan. I know that if a service I have been requested is denied to me, my counselor will give me a letter explaining the reason for the denial, and how to submit an appeal. The letter will detail my rights to appeal, and further explain how I can request continued services.

My behavioral health provider has instructed me that if I wish to submit an appeal I must do so in writing to the Clinical Director, Tim Mills. I have been made aware that I can also appeal services I do not agree with, and that I can change my mind about services detailed in my Service Plan at any time.

I know that if I need more services or other services than what are detailed in my Service Plan, I can call my counselor at 520-329-1250 to discuss changes to my plan. My counselor will call me back within 3 business days. After discussing my request with my counselor, he/she has up to 10 business days to consider the request and get back to me. If more time is needed to consider the request, my counselor will advise me in writing.

_____ I have received a copy of my Cathexis Specialty Assessment and Service Plan, and am in agreement with its contents.

__No, I disagree with some or all parts of my Service Plan. I understand that by checking this box I will receive the service in which I am in agreement, and may appeal any decision to withhold services in which I have requested. The part(s) of the Service Plan I do not agree with are: ____

Client/Guardian Signature ______________________________ Date Signed ______________

Printed Name ______________________________ Relationship to Client ______________

Therapist Signature ______________________________ Date Signed ______________

Printed Name ______________________________ Credentials ______________

For Non-BHP Clinicians Only:

Reviewed by Signature ______________________________ Date Signed ______________

Printed Name ______________________________ Credentials ______________