

**Instructions for
BHI INTEGRATED SERVICE PLAN**

- Check the appropriate box and fill in the Provider/Facility information
- **Name:** Name of consumer
- **Date:** Effective date of this service plan (can be different than the date you are filling the form out)
- **Consumer Name:** Please list legal name; do not use nicknames unless in quotes
- **DOB:** Consumer date of birth
- **Medicaid #:** Begins with a letter and has six (6) numbers
- **CID:** Ignore these boxes
- **Diagnosis:** Please use Diagnosis codes for Axes I and II. Please indicate the DSM criteria that supports your diagnosis. Write out the Axis III, indicate problem areas for Axis IV (e.g. Primary support group, education, etc. Give a number to Axis V Global Assessment of Functioning.
- **Medications** – list all current medications and dosages and prescribing physician
- **Consumer Strengths and Resources to address problem(s):** Please indicate the strengths the client will bring to problem resolution
- **List the problems by priority and** describe the problem including the symptoms. Please describe problem in functional/behavioral terms. Rate the problem by checking the appropriate box.
- **Goals:** should be measurable and objective – a reader should be able to tell what is being sought and when the desired result is accomplished.
- **Intervention:** What will the provider do and how often (e.g. family therapy twice a month)?
- **Target Date:** Expected date of resolution
- **Responsible Person:** Clinician doing the treatment
- **Specific Criteria for Discharge:** When will you and the client know therapy is complete, what has changed or needs to change for discharge to be appropriate?
- **Case Management Plan:** What is the purpose of the case management? Who will be contacted? For what reason? For what purpose? For what goal? Case management is generally linkage to resources outside therapy, clarifying the treatment plan and goals, and monitoring the progress and following up with the external resource that the person has engaged in the service the consumer was referred to.
- **Type of service, frequency, and number of visits/units:** Indicate the number and type of service you are requesting by putting a number in the box beside the code that matches the service you are requesting. If you are not a physician, please do not use 90801 for the first appointment, use H0031. If the code you wish to request is not on this list, please request it under **Other**. Only the codes listed in your contract can be requested.
- **Consumer Comments** – any comments the consumer wants to make about this service plan are entered here.
- **Signatures:** Please have the consumer and or parent/guardian sign and date the Service Plan and give the consumer a copy. Have the consumer indicate where there is disagreement (if there is any). Provider signs and dates the Service Plan.
- **BHI/MHC Only:** Leave this page blank, it is for our office use only.