



## INSTRUCTIONS FOR OUTPATIENT INTEGRATED SERVICE PLAN

Print the name of client on the top right hand corner of each page in the space provided.

### Identifying information:

At the top of the form, check the box that best describes what type of service plan you are submitting:

**Initial Service Plan:** 1<sup>st</sup> plan constructed under this provider for authorization request.

**Discharge:** Plan constructed to complete therapy for consumer.

**Extension of Services:** Updated plan for request for additional services.

**Other (hospital, jail, change):** Alternative plan not fitting in any other category.

**Medication Only Status:** Plan constructed for client to receive psychiatric care only/ no psychotherapy.

Print provider information:

**Provider/Facility Name:** Name of professional or agency/facility providing the services requested.

**Site Address:** Address where services will be provided.

**Phone:** Phone number of professional/agency/facility named above

**Fax:** Fax number of professional/agency/facility named above

Print client information:

**Client Name:** Full name of client to who services will be provided.

**Date:** Date this plan is completed.

**DOB:** Date of birth for client named above

**Medicaid #:** Medicaid number of client named above

**CID:** Identify the Mental Health Center responsible for consumer's care:

Ad = Community Reach Center

Ar = Arapahoe/Douglas Mental Health Network

Au = Aurora Mental Health Center

### Diagnosis and Medication Information:

Print the appropriate DSM information for the client named above.

**Axis I Primary:** The main clinical disorder of focus.

**Code:** Write out the full DSM numerical code for the primary Axis I diagnosis.

**Description:** Print the name of the clinical disorder identified above.

**DSM Criteria:** List brief descriptions of the DSM criteria met to arrive at above diagnosis.

**Axis I Secondary:** Any other clinical disorder that may be a focus of clinical attention (*leave blank if no secondary axis I diagnosis is present*)

**Code:** Write out the full DSM numerical code for the secondary Axis I diagnosis.

**Description:** Print the name of the clinical disorder identified above.

**DSM Criteria:** List brief descriptions of the DSM criteria met to justify above diagnosis.

**Axis II:** Personality disorder(s) or Mental Retardation

**Code:** Write out the full DSM numerical code for the secondary Axis I diagnosis. (including no diagnosis or diagnosis deferred).

**Description:** Print the name of the personality disorder identified above.

**DSM Criteria:** List brief descriptions of the DSM criteria met to justify above diagnosis.

**Axis III:** General Medical Conditions

Print name of medical condition(s) in the blank(s) provided (*leave blank if no medical condition exists*)

**Axis IV:** Psychosocial and Environmental Problems

Using DSM descriptors, print psychosocial/environmental problem(s) in blank(s) provided.

**Axis V:** Global Assessment of Functioning

Write current GAF number in the blank provided

**Current Medications:** In blanks provided, print any medications the consumer is taking regularly for the clinical disorders or general medical conditions listed above  
(include milligrams and dosages)

**Prescribing MD:** Print name of physician(s) prescribing medications listed above.

**Service Plan Information:**

**Problem 1:** First priority problem (concern to be the main or first focus of clinical attention)  
Describe problem in functional/behavioral terms

Identify the main area/most concerning area the person is not functioning in or what specific behaviors are of greatest concern.

- The consumer is not able to go to work/school
- The consumer is not sleeping/eating/dressing.
- The consumer is screaming and crying nightly for two hours.

**Current Problem Severity:** Check the box that describes the current level of difficulty of this problem

**Consumer Strengths and Resources to address this problem:** List personal strengths (insight, good judgment, open to change) and resources (supportive grandparent, spouse, good transportation, and friends) the person already has in place that may help address the problem area listed above

**Goals:** Describe the main goal associated to the problem. **This should be a short term goal of 3-6 months.** Describe the goal in behavioral/functional terms:

Identify how you will know the problem above is better. What specific changes in functioning or behavior will be observed or reported?

- The consumer will go to work 5 out of 5 days/week, three weeks in a row.
- The consumer will shower and get dressed one time per day by 10am, and eat two meals per day.
- The consumer will sleep through the night 3 out of 7 nights per week.

**Interventions:** Identify the specific type of therapy that will be provided to address the problem (individual cognitive/behavioral therapy, family therapy with parents and siblings) how often (one time per week, per month) and how long (one hour, thirty minutes)

**Target date:** Write the projected date that this goal will be accomplished.

**Responsible person:** Write the name of the person who will be responsible for providing this service or working with the consumer on this goal.

**Problem 2:** (same as above, but for second problem of clinical focus)

**Discharge criteria:** How will you know when the consumer has completed therapy? What specific functioning or behavioral indicators will be observed and/or reported?

- The consumer will go to work 5 out of 5 days per week for three weeks.
- The consumer will take a shower and get dressed by 10am at least every other day for one month.
- The consumer will go through the night with no screaming, and the ability to calm himself within 15-30 minutes of waking 6 out of 7 nights per week for two weeks.

**Clinical Justification for Provision of Services Through External Provider:** Identify the specific reasons consumer needs to receive services through an external provider rather than through mental health center. This may include, consumer preferences, special needs, provider qualifications, etc.

**Level of Service Requested Information:** Check the box of the level of care/service requested by the provider to meet the client's present problem areas.

**Type of Service:** Identify the type of service(s) requested by filling in the associated information to the right of the service type.

**Frequency:** How often are you requesting the services be delivered/offered (one time per week; one time per month)?

**Number of Visits/Units:** Identify number of visits requested for 6 months, Units are 15 minute increments for individual, group, family and psychiatric visits (2 one hour visits = 8 units)

**Specify:** Complete this when requesting specialized services

**Consumer Comments:** Any comments the consumer would like to submit about this plan for services.

**Consumer Signature and Date:** The signature and date of signature of the named consumer on the service plan.

**Parent/Guardian Signature and Date:** The signature and date of signature of the named consumer's parent or guardian (if applicable)

**Provider Signature and Date:** The signature and date of signature of the provider submitting the authorization request and who will be providing the primary services.

The ISP will not be considered complete without the necessary signatures.

The box at bottom of Request page is for office use only.