Network Provider Annual Update Form

➔ **MANDATORY: Progress note(s) justifying billing for completing annual is/are dated:**

Provider Last Name, First Name (and Group name, if applicable)			**Location where client will receive services.**	
Beneficiary Name (Last, First, Middle)			**Gen (Jr. Sr. Etc)**	**Current Phone Number**
Current Street Address			**City**	**Zip Code**
Birth Date	**CIN (Medi-Cal ID #)**		**MRN (Medical Record #)**	
Emergency Contact	**Relationship**	**Current Address**		**Phone Number**

Sexual Orientation:
☐Heterosexual / Straight ☐Lesbian ☐Gay ☐Bisexual ☐Queer
☐Questioning ☐Unknown ☐Declined to State ☐Other:

Special Considerations (include cultural diversity, physical, and linguistic considerations):

	DSM-5 CODE:	**DSM-5 NAME:** ***Must write full diagnosis narrative, no abbreviations***	**ICD-10 CODE:**
(P)			F
(S)			F

Substance Use Issue: (cannot be primary)	☐ Yes ☐ No	DSM-5 Code:	ICD-10 Code: F

(Note Add'l DX in Presenting Problem)

CURRENT PRESENTING PROBLEM (Must document symptoms/ functional impairments that meet the criteria for the DSM-5 included diagnosis. Include life stressors and other relevant factors. Document client progress or provide clinical justification for lack of progress. If appropriate, include how treatment will be adjusted to achieve progress. Also note any changes in Substance Use which impact mental health treatment & daily functioning.)	

SAFETY RISK: ☐ None Identified ☐ Not Currently Acute ☐ Danger to Self ☐ Danger to Others ☐ Domestic Violence
☐ Inability to Care for Self ☐ Physical Abuse ☐ Sexual Abuse ☐ Neglect

REPORT FILED: ☐ CPS ☐ APS ☐ Duty to Warn ☐ Weapons Confiscated

Provide additional detail for any box checked above:

Beneficiary Name: ____________________ Provider Name: ____________________

Psychiatric Admissions in last year? ☐ Yes ☐No Number of admissions in last year:
Receiving other outpatient MH Services? ☐ Yes ☐ No Describe:

For YOUTH ONLY Lives with: ☐ Family of Origin ☐ Independent ☐ Relative Caregiver ☐ Foster Family ☐ Other

MEDICAL HISTORY

Primary Care Provider: Last Physical Exam: Last Dental Exam:

☐ If client has no PCP, then referral information has been provided (CCCHS Clinic @1-800-495-8885 or Private PCP)

Current Medical Conditions	☐No Change ☐Update (Describe):			
Allergies MANDATORY (Medication/Food)	☐None ☐Yes (Describe type of allergy and reaction/severity):			
Current Medications (Prescribed and over the counter)	**Name**	**Dose**	**Frequency**	**Target Symptoms**

MENTAL STATUS: *(Check and/or describe if abnormal or impaired)*

Appearance/Grooming: ☐ Unremarkable ☐ Remarkable for: ____

Behavior/Relatedness: ☐ Unremarkable ☐ Motor Agitated ☐ Inattentive ☐ Avoidant ☐ Impulsive ☐ Motor Retarded ☐ Hostile ☐ Suspicious/Guarded ☐ Other: ____

Speech: ☐ Unremarkable ☐ Remarkable for: ____

Mood/Affect: ☐ Unremarkable ☐ Depressed ☐ Elated/Expansive ☐ Anxious ☐ Labile ☐ Irritable/Angry ☐ Other: ____

Thought Processes: ☐ Unremarkable ☐ Concrete ☐ Distorted ☐ Disorganized ☐ Odd/Idiosyncratic ☐ Blocking ☐ Paucity of Content ☐ Circumstantial ☐ Tangential ☐ Obsessive ☐ Flight of Ideas ☐ Racing Thoughts ☐ Loosening of Assoc ☐ Other: ____

Thought Content: ☐ Unremarkable ☐ Suicidal Ideation ☐ Homicidal Ideation ☐ Paranoid Ideation ☐ Other: ____

Perceptual Content: ☐ Unremarkable ☐ Hallucinations ☐ Delusions ☐ Flashbacks ☐ Ideas of Reference ☐ Depersonalization ☐ Derealization ☐ Dissociation ☐ Other: ____

Fund of Knowledge: ☐ Unremarkable ☐ Remarkable for: ____

Orientation: ☐ Unremarkable ☐ Remarkable for: ____

Memory: ☐ Intact ☐ Impaired

Intellect: ☐ Unremarkable ☐ Remarkable for: ____

Insight/Judgment: ☐ Unremarkable ☐ Remarkable for: ____

Additional Observations/Comments:

NOTE: Check off boxes in BOTH columns. MUST have at least one Impairment & Intervention.

Impairment Criteria (must have at least one of the following impairments): **AND**		**Intervention Criteria** (must have at least one proposed intervention):	
☐**A**	Significant impairment in an important area of life functioning.	☐**A**	Significantly diminish impairment.
☐**B**	Probability of significant deterioration in an important area of life functioning.	☐**B**	Prevent significant deterioration in an important area of life functioning.
☐**C**	(Under 21) Without treatment will not progress developmentally as individually appropriate.	☐**C**	(Under 21) Probably allow the child to progress developmentally as individually appropriate.
☐**D**	Does not meet criteria. ***(Cannot be authorized)***	☐**D**	Condition would not be responsive to physical health care-based treatment. ***(Must be checked to authorize)***

Beneficiary Name: ______________________ Provider Name: ______________________

PARTNERSHIP PLAN FOR WELLNESS

Beneficiary and/or Family Strengths that will be incorporated into treatment.	
Life Goals: What does the Beneficiary and/or beneficiary's parents/family/guardian hope to work toward?	**Please use quotes.**

Treatment Goals: Must be specific, observable and/or quantifiable goals (with timeframes) that link to diagnosis with the goal of decreasing their impairments or symptoms. Treatment plans should be updated when there are significant changes in symptoms, functioning, or life events. **Requested Treatment Plan Duration**:	 **Months** (max of 12 mos)	**Modality & Frequency Requested by clinician completing this form:** **Modality** ☐ Individual Therapy ☐ Group Therapy ☐ Family Therapy ☐ (MD) Med Mgt Frequency ☐ Weekly (Child) ☐ Every other Week (Adult) ☐ Other: Other Modalities: ☐ Collateral ☐ Therapy w/Meds (Child)
Strategies to Achieve Goals: Specify actions to be taken by client/family and provider to achieve the above goals. Specify modality needed for interpreter. ☐ **TBS Referral Made. Date of Referral**:		**PARTIES INVOLVED** ☐ Beneficiary ☐ Family ☐ Clinicians ☐ Social Workers ☐ Interpreter ☐ Others:

FOR PRESCRIBERS ONLY	☐ Current medication consents on file ☐ JV-223 form on file for CCC Foster Children and Juvenile Dependents

Beneficiary Signature for Treatment Plan: ______________________ Date: __________

(For Beneficiary 12 yrs. and older.)

Parent/Guardian Signature: ______________________ Date: __________

(Required if Beneficiary is 11 yrs. or younger.)

If Child is a dependent of the Juvenile Court (ages 0-11), one of the following must be checked:

☐ CFS worker has signed above as legal guardian

☐ CFS SW verbally agreed to Partnership Plan and on: __________ Provider faxed a copy to SW for signature & return

☐ **Unable to obtain signature prior to submission. Document reason in progress note.** Date of progress note: __________

Note*: Continued efforts to obtain signature should be documented in* ***every*** *progress note until signature is obtained.*

Copy of Partnership Plan offered to Beneficiary/Guardian (MANDATORY)**:** ☐ Accepted ☐ Declined Date: __________

Provider: __________ (Print) __________ (Signature) __________ (License/Regist.) __________ Date

Provider's Signature certifies that the above information is accurate and all required documentation is on file.

Provider Data**:** Phone __________ Fax *(as on file with CMU)* __________

Beneficiary: ______________________________ Provider: ______________________________

Space for Data Continuation ***(Specify which item you are continuing from)***