CLEAR FORM

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

PROJECT BRAVO
BEHAVIORAL HEALTH REDESIGN FOR ACCESS, VALUE & OUTCOMES

# Enhanced Services Individual Service Plan (ISP) Template

| MEMBER INFORMATION | | PROVIDER INFORMATION | |
|---|---|---|---|
| Member First Name: | | Organization Name: | |
| Member Last Name: | | Group NPI #: | |
| Medicaid #: | | Provider Tax ID #: | |
| Member Date of Birth: | | Provider Phone: | |
| Gender: | | Provider Fax: | |
| Member Plan ID #: | | Provider E-Mail: | |
| Member Street Address: | | Provider Address: | |
| Member City, State, ZIP: | | Provider City, State, ZIP: | |

**Individualized Service Plan includes the following Enhanced Services:**

- ☐ Mental Health Intensive Outpatient {S9480}
- ☐ Mental Health Partial Hospitalization Program {H0035}
- ☐ Assertive Community Treatment {H0040}

**Initial date of admission to current service:**

| | |
|---|---|
| **Primary ICD-10 and Corresponding DSM5 Diagnosis** | |
| **Secondary Diagnosis(es)** | |

**CARE COORDINATION**

Please list all medical/behavioral services or community interventions/supports the individual has participated in since the last Authorization, as well as any changes:

| Name of Service/Support | Provider Contact Info | Frequency | *For any changes, note if:* New, Ended or Changed in frequency/intensity from last authorization |
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**Describe Care Coordination activities with these other services/supports:**

**SERVICE PLAN**

**Resources and Strengths:** *Describe the unique strengths, preferences, and resources that the individual identifies as relevant to their recovery.*

**Barriers to Participation:** *The treatment plan should include a list of ongoing or evolving barriers to treatment, additional resources that would support the individual in overcoming these barriers, and a plan for how to address them.*

| ***Barrier*** | ***Plan of Support*** |
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**Treatment Goal 1**

**Objective Measure**

| *Measure* | *Rater/Reporter of Measure* | *Method of Measurement (how will it be tracked?)* |
|---|---|---|
| | | |

Member Full Name: Medicaid #:

| **Interventions** | | |
|---|---|---|
| *Provider Type (LMHP/QMHP/Peer/CSAC)* | *Specific Interventions* | *Dose of Intervention (Frequency)* |
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| **Treatment Progress Notes** |
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| **Treatment Goal 2** |
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| **Objective Measure** | | |
|---|---|---|
| *Measure* | *Rater/Reporter of Measure* | *Method of Measurement (how will it be tracked?)* |
| | | |

| **Interventions** | | |
|---|---|---|
| *Provider Type (LMHP/QMHP/Peer/CSAC)* | *Specific Interventions* | *Dose of Intervention (Frequency)* |
| | | |
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| **Treatment Progress Notes** |
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| **Treatment Goal 3** |
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| **Objective Measure** | | |
|---|---|---|
| *Measure* | *Rater/Reporter of Measure* | *Method of Measurement (how will it be tracked?)* |
| | | |

| **Interventions** | | |
|---|---|---|
| *Provider Type (LMHP/QMHP/Peer/CSAC)* | *Specific Interventions* | *Dose of Intervention (Frequency)* |
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| **Treatment Progress Notes** |
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| **Treatment Goal 4** |
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| **Objective Measure** | | |
|---|---|---|
| *Measure* | *Rater/Reporter of Measure* | *Method of Measurement (how will it be tracked?)* |
| | | |

| **Interventions** | | |
|---|---|---|
| *Provider Type (LMHP/QMHP/Peer/CSAC)* | *Specific Interventions* | *Dose of Intervention (Frequency)* |
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| **Treatment Progress Notes** |
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| **Treatment Goal 5** |
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| **Objective Measure** | | |
|---|---|---|
| *Measure* | *Rater/Reporter of Measure* | *Method of Measurement (how will it be tracked?)* |
| | | |

| **Interventions** | | |
|---|---|---|
| *Provider Type (LMHP/QMHP/Peer/CSAC)* | *Specific Interventions* | *Dose of Intervention (Frequency)* |
| | | |
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**Treatment Progress Notes**

**RECOVERY PLAN**

Discharge plans are an important tool to emphasize hope and plans for recovery. Planning for discharge from services should begin at the first contact with the individual. Recovery planning should include discussion about how the individual and service providers will know that sufficient progress has been achieved to move to a lower, less intensive level of care or into full recovery with a maintenance plan.

*What would progress/recovery look like for this individual?*

*What barriers to progress/recovery can the individual, their natural supports, and/or the service provider identify?*

*What types of outreach, additional formal services or natural supports, or resources will be necessary to reach progress/recovery?*

*At this time, what is the vision for the level of care this individual may need at discharge from this service?*

*What is the best estimate of the discharge date for this individual?*

*By my signature (below), I am attesting that 1) an LMHP, LMHP-R, LMHP-S or LMHP-RP has reviewed the individual's psychiatric history and completed the appropriate assessment or addendum; and 2) that this assessment indicates that the individual meets the medical necessity criteria for the identified service. The assessment or applicable addendum for this service was completed on the following date(s): _____*

Signature (actual or electronic) of LMHP (Or R/S/RP): _____

Printed Name of LMHP (Or R/S/RP): _____

Credentials: _____

Date: _____

**Notes Section**