AmeriHealth Caritas Louisiana

Comprehensive Mental Health Treatment Plan

Member name:	
Date of treatment plan:	DOB:

☐ **Initial treatment plan** ☐ **Updated treatment plan**
Diagnosis (ICD-10):
Current medications:
Existing problem:
Manifested by:
Evaluation tool(s) used (attach to plan); results and dates of meetings/evaluations:
Discharge plan:
Strengths, Needs, Abilities, and Preferences: S — N — A — P —
Long-term goal:
The target date to reach the goal is ___ months from the date the treatment plan is signed.
Short-term goal/Objective #1 (SMART)
Objective #1, Intervention #1

Member name:	
Date of treatment plan:	DOB:

Service location:	
Staff providing intervention:	
Duration of service:	Frequency of intervention:
Progress on goals (only complete if updating treatment plan):	
Objective #1, Intervention #2:	

Service location:	
Staff providing intervention:	
Duration of service:	Frequency of intervention:
Progress on goals (only complete if updating treatment plan):	
Objective #1, Intervention #3:	

Member name:	
Date of treatment plan:	DOB:

Service location:	
Staff providing intervention:	
Duration of service:	Frequency of intervention:
Progress on goals (only complete if updating treatment plan):	
Objective #1, Intervention #4:	

Service location:	
Staff providing intervention:	
Duration of service:	Frequency of intervention:
Progress on goals (only complete if updating treatment plan):	
Objective #1, Intervention #5:	

Member name:	
Date of treatment plan:	DOB:

Service location:	
Staff providing intervention:	
Duration of service:	Frequency of intervention:
Progress on goals (only complete if updating treatment plan):	
Objective #2, Intervention #1:	

Service location:	
Staff providing intervention:	
Duration of service:	Frequency of intervention:
Progress on goals (only complete if updating treatment plan):	
Objective #2, Intervention #2:	

Member name:	
Date of treatment plan:	DOB:

Service location:	
Staff providing intervention:	
Duration of service:	Frequency of intervention:
Progress on goals (only complete if updating treatment plan):	
Objective #2, Intervention #3:	

Service location:	
Staff providing intervention:	
Duration of service:	Frequency of intervention:
Progress on goals (only complete if updating treatment plan):	
Objective #2, Intervention #4:	

Member name:	
Date of treatment plan:	DOB:

Service location:	
Staff providing intervention:	
Duration of service:	Frequency of intervention:
Progress on goals (only complete if updating treatment plan):	
Objective #2, Intervention #5:	

Service location:	
Staff providing intervention:	
Duration of service:	Frequency of intervention:
Progress on goals (only complete if updating treatment plan):	
Objective #3, Intervention #1:	

Member name:	
Date of treatment plan:	DOB:

Service location:	
Staff providing intervention:	
Duration of service:	Frequency of intervention:
Progress on goals (only complete if updating treatment plan):	
Objective #3, Intervention #2:	

Service location:	
Staff providing intervention:	
Duration of service:	Frequency of intervention:
Progress on goals (only complete if updating treatment plan):	
Objective #3, Intervention #3:	

Member name:	
Date of treatment plan:	DOB:

Service location:	
Staff providing intervention:	
Duration of service:	Frequency of intervention:
Progress on goals (only complete if updating treatment plan):	
Objective #3, Intervention #4:	

Service location:	
Staff providing intervention:	
Duration of service:	Frequency of intervention:
Progress on goals (only complete if updating treatment plan):	
Objective #3, Intervention #5:	

Member name:	
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Transition plan		
Expected treatment length:	Anticipated posted DC services:	Plan for transition/discharge:
Crisis plan		
De-escalation plan		
☐ Member requires de-escalation plan as part of accommodations.	☐ Member does not require de-escalation plan as part of accommodations at this time. ☐ Pull-outs as needed	☐ Coping skills listed below ☐ Additional:
Current safety risks		
☐ None/Denied ☐ Thoughts of hurting or killing self	☐ Thoughts of hurting or killing someone else ☐ Reports feeling unsafe or reports of abuse	☐ Other:
Current coping skills		
☐ Listen to music ☐ Talk to a friend ☐ Deep breathing ☐ Go for a walk ☐ Exercise ☐ Read a book ☐ Color	☐ Journal ☐ Take a bath/shower ☐ Punch a pillow ☐ Play video games ☐ Watch funny videos ☐ Clean something ☐ Draw	☐ Call a family member ☐ Meditate/yoga ☐ Dance ☐ Pace back and forth ☐ Other:
Personal safety plan		
Public safety plan		
Parent/Guardian communication plan		
Contact parent/guardian to update them on the treatment plan. Therapist will always contact the parent/guardian with any safety concerns.		

Member name:	
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Case management needs:		
☐ None identified ☐ PCP referral ☐ Housing referral	☐ Family counseling ☐ SNAP benefits ☐ Medication management	☐ Substance use referral ☐ Other:

Participants	Name, title and credentials	Signature	Date
Client			
Guardian/ Legal representative/ Caregiver			
LMHP			
Treatment team staff			
Treatment team staff			
Treatment team staff			