Legal Name	**Preferred Name *(if applicable)***
DOB	**Student ID**

Plan Creation Date	**Next Review Date**	**Annual Review Date**

Method of Service(s)	**Frequency**	**Duration**	**Location**

Treatment Code(s) (ICD-10)	**Current Medication(s)/Dosage**

Presenting Issue(s)
Client's Strengths
Obstacles to Treatment
Cultural Considerations
Long Term Goals
Short Term Objectives
Clinical Interventions

Who was involved in developing this treatment plan?

☐ **Student**
☐ **Parent(s)/legal guardian(s) name/relationship**
☐ **Family member name/relationship**
☐ **Other name/relationship**

Provider Name/Credentials	**Provider Signature**	**Date**
Supervisor Name/Credentials *(if applicable)*	**Supervisor Signature** *(if applicable)*	**Date**

Legal Name John Doe Jr.	**Preferred Name *(if applicable)*** *Use this section when a student's preferred name affirms their identified gender versus legally listed name. In addition, ensure the student's preferred name and/or pronouns are used in the accompanying documentation. Leave section blank or write "NA" if it does not apply.*		
DOB 01/01/2008	**Student ID** 000000000		
Plan Creation Date 09/01/2022	**Plan Creation Date** 09/01/2022	**Next Review Date** 12/01/2022	**Annual Review Date** 09/01/2023

Method of Service(s)	**Frequency**	**Duration**	**Location**
Individual Therapy	1x week	1 hour	School
Group Therapy	1x every two weeks	1 hour	School

Treatment Code(s) (ICD-10) F41.1 Generalized Anxiety Disorder	**Current Medications/Dosage** Fluoxetine/10 mg

Presenting Issue(s)

The student is experiencing panic attacks 3-4 times per week. The student stated having uncomfortable somatic symptoms such as difficulty breathing, sweating, a racing heart, and thoughts he is "going to lose control" when having a panic attack. The student reports difficulty attending classes due to increased anxiety during class, resulting in poor attendance over the past two months. There have been two reports by the student teachers that he appears distracted in class and has difficulty concentrating, which has resulted in a decline of grades over the past month.

Client's Strengths

The student has a strong support network at school with a group of close friends, the student disclosed his anxiety issues with his family and is receiving support at home. The student has high motivation and reports being "really ready" to start treatment.

Obstacles to Treatment

The student has poor school attendance over the past two months due to his presenting symptoms. An obstacle may be in difficulty attending individual therapy if he continues to miss school.

Cultural Considerations

The student reports being involved in his religious community. The student is fluent in both English and Spanish.

Long Term Goals

"I want to be able to feel normal again and go to school without thinking I'm going to have a panic attack."

Short Term Objectives

Decrease incidence of panic attacks from 3-4 a week to 1-2 a week in the next three months.
The student will learn and implement at least two coping skills in his daily life, within the next three months.
Establish and maintain a therapeutic relationship with the individual and group counselor.

Clinical Interventions

Use the Antecedent, Behavior, Consequence (ABC) method to identify triggers to anxiety/panic attacks.
Identify how the student's sociocultural environment contributes to his anxiety.
Utilize a mindfulness treatment protocol to teach the student mindfulness and relaxation strategies.

Who was involved in developing this treatment plan?

☒ **Student**
☒ **Parent(s)/Legal Guardian(s) name/relationship** Jane Doe (mother), John Doe Sr. (father)
☒ **Family member name/relationship** Mary Doe (grandmother)
☐ **Other name/relationship**

Provider Name, LMSW **Provider Name/Credentials**	Provider Signature *(electronic signature accepted)* **Provider Signature**	09/01/2022 **Date**
Supervisor Name, LCSW **Supervisor Name/Credentials** *(if applicable)*	Supervisor Signature *(electronic signature accepted)* **Supervisor Signature** *(if applicable)*	09/01/2022 **Date**

***This document is for example purposes only. Utilize your supervisor (if applicable), professional ethics, professional judgment, and any other appropriate personnel/resources to make clinical decisions.**

Legal Name	**Preferred Name** ***(if applicable)***		
DOB	**Student ID**	**Date of Plan Revision**	
Method of Service(s) (Updates)	**Frequency** (Updates)	**Duration** (Updates)	**Location** (Updates)
Treatment Code(s) (ICD-10 - Updates)			
Current Medication(s)/Dosage (Updates)			
Presenting Issue(s) (New issues)			
Client's Strengths (Updates)			
Obstacles to Treatment (Updates)			
Cultural Considerations (Updates)			
Long Term Goals (List goals completed, revisions and/or new goals)			
Short Term Objectives (List objectives completed, revisions and/or new objectives)			
Clinical Interventions (List clinical interventions completed, revisions and /or new interventions)			
Who was involved in updating this treatment plan? ☐ **Student** ☐ **Parent(s)/Legal Guardian(s) name(s)/relationship** ☐ **Family member name/relationship** ☐ **Other name/relationship**			
Provider Name/Credentials	**Provider Signature**	**Date**	
Supervisor Name/Credentials *(if applicable)*	**Supervisor Signature** *(if applicable)*	**Date**	

Checklist for Behavioral Health Care Plan

☐The care plan is completed **prior** to services being rendered *(exceptions for unplanned services).*

☐ List the eligible recipient's **legal name, preferred name** *(if applicable),* **DOB** and **student ID**.

☐Develop the care plan in conjunction with the **appropriate qualified medical provider(s)** listed in NMAC 8.320.6.11 *(NMAC 8.320.6.13.B2).*

☐**Review the care plan annually**, at a minimum, to establish ongoing medical necessity for services *(NMAC 8.320.6.13.A).* The care plan can be **reviewed more often**, as medically necessary.

- ☐List the date the care plan was created.
- ☐List the annual review date.
- ☐List any review dates that may occur before the annual review date *(if applicable).*

☐State the eligible recipient's identified behavioral health condition(s) using **ICD-10 treatment code(s)** *(NMAC 8.320.6.12.H),* this determination must be made by a qualified medical provider.

☐Define the **method of services** (e.g., individual therapy, group therapy) *(NMAC 8.320.6.9).*

☐ Identify the **location** services will be rendered *(home, school).*

☐Define the **frequency of services** (how often and for how long) *(NMAC 8.320.6.14.A2).*

☐Define the **duration of services** (length of the care plan, start/end dates) *(NMAC 8.320.6.14.A2).*

☐Ensure that the **services defined in the care plan are medically necessary** to treat the eligible recipient's behavioral health condition(s) *(NMAC 8.320.6.13.B1).*

☐Define **treatment goals** *(NMAC 8.320.6.14.A1)* and **treatment objectives** *(NMAC 8.320.6.14.A1).*

☐Define **clinical interventions** that aim to treat or attain, maintain or regain functional capacity and prevent deterioration, of the eligible recipient's health condition *(NMAC 8.320.6.9).*

☐Develop the care plan with the eligible recipient and their family *(if appropriate, consider minor consent laws and confidentiality) (NMAC 8.320.6.14.B).*

☐ Include the **printed name, credentials** (e.g., LMHC, LMSW) and **signature** (or electronic equivalent) of the qualified provider and **date** the document *(NMAC 8.320.6.13.B2).*

For non-independently licensed LBSW, LMSW, LMHC, LAMFT and School Psychologists Level I providers (*NMAC 8.320.6.11 b(ii) and c(ii))*

☐Ensure the treatment code(s) **(ICD-10) was/were determined by the provider's supervisor.**

☐Ensure the provider's **supervisor prints** and **signs** their name (or electronic equivalent), lists their **credentials** (e.g., LPCC, LCSW), and **dates** the document.

Revisions and Addendums

☐**Revise and update** the care plan to ensure accuracy as changes arise *(e.g., frequency of services change).*

☐List the **date** of the care plan revision and/or addendum.

☐ Include the **printed name, credentials, signature and date** of the licensed provider and their supervisor (if applicable) in any care plan revisions and/or addendums.

Legal Name		**Preferred Name** ***(if applicable)***	
DOB	**Student ID**	**Date of Service**	**Location** ☐**School** ☐**Home**
Start Time	**End Time**	**Total Duration**	**Treatment Code(s) (ICD-10)**
Description of Service	**Procedure Code(s)**	**Modifier(s)** ☐SC ☐ TM ☐ GT ☐ U2 ☐ U3 ☐ U4	
Care Plan Objective(s) Addressed			
Data			
Assessment			
Plan			

Provider Name/Credentials	**Provider Signature**	**Date**
Supervisor Name/Credentials *(if applicable)*	**Supervisor Signature** *(if applicable)*	**Date**

Legal Name John Doe Jr.		**Preferred Name *(if applicable)*** *(Use this section when a student's preferred name affirms their identified gender versus legally listed name. In addition, ensure the student's preferred name and/or pronouns are used in the accompanying documentation. Leave section blank or write "N/A" if it does not apply.)*	
DOB 01/01/2008	**Student ID** 000000000	**Date of Service** 10/01/2022	**Location** ☒**School** ☐**Home**
Start Time 2:00pm	**End Time** 3:00pm	**Total Duration** 1 hour	**Treatment Code(s) (ICD-10)** F41.1 Generalized anxiety disorder F41.0 Panic disorder without agoraphobia
Description of Service Individual Therapy	**Procedure Code(s)** 90832	**Modifier(s)** ☒SC ☐ TM ☐ GT ☐ U2 ☐ U3 ☐ U4	

Care Plan Objective(s) Addressed

Decrease incidence of panic attacks from 3-4 a week to 1-2 a week in the next three months.
Establish and maintain a therapeutic relationship with the individual and group therapist.

Data

The client reported having a panic attack the night before. The client and clinician met for the purpose of identifying triggers to the client's panic attacks. The client reported having "lots of fast thoughts" over the past two days. The clinician provided a grounding exercise. The client identified two home-related stressors and one school-related stressor that the he associated with impacting his mood before a panic attack. The clinician provided psychoeducation related to the physiological response of a panic attack.

Assessment

The client stated that his thoughts become "slower" when he engages in deep breathing and guided visualization exercises. The client's ability to slow down his racing thoughts through these interventions is an indicator that mindfulness-based interventions may effectively reduce his anxiety. The client appeared to respond positively to psychoeducation, as he asked several follow up questions about the window of tolerance.

Plan

Between sessions, the client intends to practice deep breathing and mindful stretching for 10 minutes a day. The next individual therapy session is scheduled for 10/08/2022.

Provider Name, LMSW **Provider Name/Credentials**	Provider Signature *(electronic signature accepted)* **Provider Signature**	10/01/2022 **Date**
Supervisor Name, LCSW **Supervisor Name/Credentials** *(if applicable)*	Supervisor Signature *(electronic signature accepted)* **Supervisor Signature** *(if applicable)*	10/01/2022 **Date**

***This document is for example purposes only. Utilize your supervisor (if applicable), professional ethics, professional judgment, and any other appropriate personnel/resources to make clinical decisions.**

Legal Name John Doe		**Preferred Name *(if applicable)*** *Use this section when a student's preferred name affirms their identified gender versus legally listed name. In addition, ensure the student's preferred name and/or pronouns are used in the accompanying documentation. Leave section blank or write "N/A" if it does not apply.*	
DOB 01/01/2006	**Student ID** 000000000	**Date of Service** 12/01/2022	**Location** ☒**School** ☐**Home**
Start Time 10:00am	**End Time** 11:00am	**Total Duration** 1 hour	**Treatment Code(s) (ICD-10)** F33.1 Major Depressive Disorder
Description of Service Individual Therapy	**Procedure Code(s)** 90832	**Modifier(s)** ☒SC ☐ TM ☐ GT ☐ U2 ☐ U3 ☐ U4	

Care Plan Objective(s) Addressed
Create a behavioral activation plan that the student engages in for at least two weeks.

Data
The student reported "oversleeping," stating he has slept for more than 12 hours per night over the past two days. The student denied suicidal ideation/homicidal ideation (SI/HI). The student identified two environmental triggers and one cognitive distortion that precipitates their decreased energy and lowered mood. The student and provider created a behavioral activation plan that includes three activities that the student agreed to engage in throughout the upcoming week.

Assessment
The student was observed to be tired, evident by yawning throughout the session and appeared to have a flattened expression. The student was able to answer questions asked from the provider and appeared to have good insight into triggers that affected his mood.

Plan
Between sessions, the student intends to engage in the activities outlined in his behavioral action plan. The next individual session is scheduled for 12/08/2022.

Provider Name, LMFT **Provider Name/Credentials**	Provider Signature *(electronic signature accepted)* **Provider Signature**	12/01/2022 **Date**
Supervisor Name/Credentials *(if applicable)*	**Supervisor Signature** *(if applicable)*	**Date**

***Relevant documents can be attached to this progress note. In this example, the behavioral activation plan could be attached.**

****This document is for example purposes only. Utilize your supervisor (if applicable), professional ethics, professional judgment, and any other appropriate personnel/resources to make clinical decisions.**

Checklist for Behavioral Health Progress Note (non-crisis service)

☐ Eligible recipient's **legal name**.

☐ *(If applicable*) Eligible recipient's preferred name.

☐ Eligible recipient's **date of birth**.

☐ Eligible recipient's **student ID**.

☐ **Date** the service was provided.

☐ **Location** the service was provided.

☐ **ICD-10** treatment code(s).

☐ **Procedure code(s**) and applicable **modifiers**.

☐ **Start and end time** of service *(NMAC 8.302.1.17.C).*

☐ **Total duration** of service.

☐ The duration and frequency of services provided **do not** exceed what is specified in the care plan *(NMAC 8.320.6.13.B.4)* and the care plan is in place **before** services are rendered.

☐ Clearly indicate the **type of service** provided (e.g., individual therapy, group therapy).

☐ Clearly identify **interventions** applied *(NMAC 8.320.6.13.A*1) and describe how the service was medically necessary *(NMAC 8.302.1.17).*

☐ Clearly document the **client's response** to the interventions (NMAC 8.320.6.12.B.2).

☐ Describe how **services relate to the goals and objectives** listed in the eligible recipient's care plan (NMAC 8.320.6.12.B.3.d).

☐ Address the **progress**, or lack of progress towards treatment goals (NMAC 8.320.6.12.B.3.d).

☐ Document **follow-up care**, or as appropriate, a discharge summary.

☐ List the rendering **provider's name**, **signature** (or electronic equivalent), **credentials** and **date** the note.

☐ (*If applicable)* List the rendering provider's supervisor's **name**, **signature** (or electronic equivalent), **credentials** and **date** the note.

Legal Name		**Preferred Name** ***(if applicable)***	
DOB	**Student ID**	**Date of Service**	**Location** ☐**School** ☐**Home**
Start Time	**End Time**	**Total Duration**	**Treatment Code(s) (ICD-10)**
Description of Service	**Procedure Code(s)**	**Modifier(s)** ☐SC ☐ TM ☐ GT ☐ U2 ☐ U3 ☐ U4	
Current Presenting Problem(s)			
Precipitating Event(s)			
Intervention(s)			
Client's Response to Intervention(s)			
Suicidal Ideation	**Notes**		
Homicidal Ideation	**Notes**		
Risk Factors ***(safety assessment)***			
Protective Factors ***(safety assessment)***			
Follow up Plan and Recommendations			

Provider Name/Credentials	**Provider Signature**	**Date**
Supervisor Name/Credentials *(if applicable)*	**Supervisor Signature** *(if applicable)*	**Date**

Legal Name John Doe		**Preferred Name** ***(if applicable)*** Jane Doe *Use this section when a student's preferred name affirms their identified gender identity versus legally listed name. In addition, ensure the student's preferred name and/or pronouns are used in the accompanying documentation. Leave section blank or write "N/A" if this section does not apply.*	
DOB 01/01/2009	**Student ID** 000000000	**Date of Service** 12/01/2022	**Location** ☒**School** ☐**Home**
Start Time 10:00 am	**End Time** 11:00 am	**Total Duration** 1 hour	**Treatment Code(s) (ICD-10)** R45.851 Suicidal Ideations
Description of Service Crisis Mental Health Service, Individual Therapy	**Procedure Code(s)** S9484	**Modifier(s)** ☒SC ☐ TM ☐ GT ☐ U2 ☐ U3 ☐ U4 *For all unplanned/crisis services using procedure code S9484, the modifier "SC," indicating non-IEP services,* ***must*** *be applied.*	

Current Presenting Problem(s) *(Describe the immediate situation that requires an immediate response, what is the client doing and/or saying?)*

The student reports having suicidal ideations (SI) that began last night. The student reports having a history of SI for the month, but it has been passive, until the current occurrence. The student stated, "I don't want to be here anymore" and "I'm going to take pills." The student did not have a clear plan when they would take the pills. The student does not have access to means (prescription medication) at school but is reported to have access to means at home. The student was found by their teacher crying in the bathroom, when they were not in class.

In this section, document the student's current presentation that justifies the medical necessity of providing clinical services to treat the current condition and/or prevent further deterioration of the student. It may be helpful to document the severity of the student's presentation, state how daily functioning is impacted and describe clinical symptoms that may be present.

Precipitating Event(s) *(When known, describe any events or stressors that may have influenced this unplanned event to occur.)*

The student reports that their SI thoughts began last night and states they got into a "big fight" with their friend.

In this section, the clinician has further opportunity to provide evidence that the current event requires immediate attention. This section can also be used to further support the ICD-10 selection.

Intervention(s) *(Used or attempted, how were these actions necessary to decrease the severity of crisis and/or prevent further deterioration?)*

The clinician engaged in crisis stabilization and utilized de-escalation techniques, engaged in grounding exercises, and assessed the student for safety. Due to safety concerns (such as means of harm being present in the home), the student was informed that their parents would be called. The student's parents were notified of the crisis, and they were asked to remove/secure prescription pills in their home. Their parents stated the prescription pills are locked in a secure cabinet that the student would not be able to access. The student and clinician collaboratively created a safety plan (attached to this document).

In this section, list the clinical interventions that were used to target the presenting issues and/or prevent further deterioration in student functioning. This section can also include clinical decisions and justification for the provider's decision process (e.g., the need to break confidentiality and notify their parents due to a risk of harm to self).

Client's Response to Intervention(s)

The student was receptive to clinical intervention and was open to engage in de-escalation techniques such as deep breathing and progressive muscle relaxation. The student and clinician collaboratively created a safety plan in which the student was willing to contribute their ideas. The client became upset, evident by crying, when asked about the details of the fight with their parents. The student was able to de-escalate by the end of the session, evident by increased self-regulation and reporting they no longer wanted to "take pills" but they needed help to "make things feel okay."

This section may provide additional data to determine if ongoing services are needed, provide details to support a clinical case formulation, and can provide feedback about what is working or not working for future treatment planning purposes.

Suicidal Ideation Ideation, with intent, no immediate plans, means removed.	**Notes** The student identified access to prescription medication (not prescribed to the student) at home but has no access to means in the school setting. The student's parents were able to remove the access to means in the home.

Homicidal Ideation Denied	**Notes** N/A

Risk Factors *(safety assessment)*
The student reports being bullied at school over the six months, a history of passive SI over the past month, and reports they engage in isolative behaviors when upset.

Protective Factors *(safety assessment)*
The student's father works from home and reports being able to supervise the student closely for at least one week. The student has a close relationship with extended family members such as their aunt who lives next door, the student has two close friends, and enjoys engaging in music and art.

Follow up Plan and Recommendations *(E.g., actions stated in safety plan, referrals, coordination of care, if an involuntary hold was necessary.)*
Due to the student's ability to de-escalate within the session, the student's lack of plan or means that could produce immediate and imminent harm, as well as the cooperation from the student's parent to closely supervise within the student's home, there is no follow up for an involuntary hold. The clinician plans to engage in follow up services including daily check in calls with the student's parents for the next week and has scheduled an individual session with the student the following day (12/02/2022). The clinician plans to follow up with the student on 12/02/2022 for an assessment to determine if ongoing services are needed. If further services are needed, the clinician and student will collaboratively create a plan of care.

The clinician should continually be assessing if the student needs ongoing services. If ongoing services are needed, the clinician can create a plan of care. In addition, any clinical decisions regarding involuntary holds, following safety plan steps, or other measures to ensure student safety can be documented here.

Name, LMHC **Provider Name/Credentials**	Provider Signature *(electronic signature accepted)* **Provider Signature**	12/01/2022 **Date**
Name, LPCC **Supervisor Name/Credentials** *(if applicable)*	Supervisor Signature *(electronic signature accepted)* *Ensure that the supervisor is assessing for the appropriate ICD-10 treatment code(s).* **Supervisor Signature** *(if applicable)*	12/01/2022 **Date**

***Relevant documents can be attached to this progress note. In this example, the safety plan could be attached.**

****This document is for example purposes only. Utilize your supervisor (if applicable), professional ethics, professional judgment, and any other appropriate personnel/resources to make clinical decisions.**

Legal Name Jane Doe	**Preferred Name** ***(if applicable)*** *(Use this section when a student's preferred name affirms their identified gender identity versus legally listed name. In addition, ensure the student's preferred name and/or pronouns are used in the accompanying documentation. Leave section blank or write "N/A" if it does not apply.)*

DOB	**Student ID**	**Date of Service**	**Location**
01/01/2009	000000000	12/01/2022	☒**School** ☐**Home**

Start Time	**End Time**	**Total Duration**	**Treatment Code (ICD-10)**
10:00 am	11:00 am	1 hour	Z65.5 Exposure to disaster, war and other hostilities

Description of Service	**Procedure Code**	**Modifier(s)**
Crisis Mental Health Service, Group Therapy	S9484	☒SC ☐ TM ☐ GT ☐ U2 ☐ U3 ☒ U4 *(For all unplanned/crisis services using procedure code S9484, the modifier "SC," indicating non-IEP services, **must** be applied.)*

Current Presenting Problem(s) *(Describe the immediate situation that requires an immediate response, what is the client doing and/or saying?)*

The student reports that she has not been sleeping well over the past three days and is having difficulty focusing on daily tasks (e.g., schoolwork, hygiene) due to a preoccupation with "the fires." The student reports she is having nightmares about "my family having nowhere to live" and feels "really scared."

In this section, document the student's current presentation that justifies the medical necessity of providing clinical services to treat the current condition and/or prevent further deterioration of the student. It may be helpful to document the severity of the student's presentation, state how daily functioning is impacted and describe clinical symptoms that may be present.

Precipitating Event(s) *(When known, describe any events or stressors that may have influenced this unplanned event to occur.)*

The student and her immediate family were evacuated from their home five days ago due to a fire that has impacted their surrounding community and has destroyed several houses nearby. The student and her family have been staying with extended family while they are closely monitoring if their house will be damaged by the fire.

In this section, the clinician has further opportunity to provide evidence that the current event requires immediate attention. This section can also be used to further support the ICD-10 selection.

In this example, the treatment code/ICD-10 code "exposure to disaster, war and other hostilities" is supported through documenting the student's exposure to the fire/nature disaster.

Intervention(s) *(Used or attempted, how were these actions necessary to decrease severity of crisis and/or prevent further deterioration?)*

The student engaged in a group psychotherapy session aimed at building a support network of students who are experiencing displacement due to the fires. Interventions included sharing individual feelings about how the fires are impacting them, identifying shared group experiences, teaching coping skills for anxiety management, providing psychoeducation related to grief/loss, and identifying resources and support networks for short- and long-term support.

In this section, list the clinical interventions that were used to target the presenting issues and/or prevent further deterioration in student functioning.

Client's Response to Intervention(s)

The student became tearful when sharing about her current experience with the fires. The student was observed to listen attentively while other group members spoke. The student was receptive to learning about loss as she asked two questions related to the topic. The client responded positively to identifying a local support network as she identified several people in her family that she could speak to for ongoing support.

This section may provide additional data to determine if ongoing services are needed, provide details to support a clinical case formulation, and can provide feedback about what is working or not working for future treatment planning purposes.

Suicidal Ideation None/Denied	**Notes**
Homicidal Ideation None/Denied	**Notes**

Risk Factors ***(safety assessment)***

The student may experience a significant life change and additional crisis if her family's home is impacted by the fires.

Protective Factors *(safety assessment)* The student has a large network of extended family in the local community, and she easily connects with her support system when she experiences stress.		
Follow up Plan and Recommendations *(E.g., actions stated in safety plan, referrals, coordination of care, if an involuntary hold was necessary.)* The clinician plans to engage in an evaluative assessment on 12/02/2022 to assess for follow-up care, which may include additional group psychotherapy sessions for students impacted by the current fires, family therapy, and/or individual therapy. If additional services are warranted, the clinician will create a plan of care in collaboration with the student. *The clinician should continually be assessing if the student needs ongoing services. If ongoing services are needed, the clinician would create a plan of care.*		
Name, LMSW **Provider Name/Credentials**	Provider Signature *(electronic signature accepted)* **Provider Signature**	12/01/2022 **Date**
Name, LCSW **Supervisor Name/Credentials** *(if applicable)*	Supervisor Signature *(electronic signature accepted)* *Ensure that the supervisor is assessing for the appropriate ICD-10 treatment code(s).* **Supervisor Signature** *(if applicable)*	12/01/2022 **Date**
**If there are multiple providers delivering services (e.g., co-therapy, co-facilitators), add additional providers (and supervisors if applicable). In this example, there are two group psychotherapy facilitators and two supervisors that oversee their work.*		
Name, LMHC **Provider Name/Credentials** *(if applicable)*	Provider Signature *(electronic signature accepted)* **Provider Signature**	12/01/2022 **Date**
Name, LPCC **Supervisor Name/Credentials** *(if applicable)*	Supervisor Signature *(electronic signature accepted)* *Ensure that the supervisor is assessing for the appropriate ICD-10 treatment code(s).* **Supervisor Signature** *(if applicable)*	12/01/2022 **Date**

***This document is for example purposes only. Utilize your supervisor (if applicable), professional ethics, professional judgment, and any other appropriate personnel/resources to make clinical decisions.**

Legal Name John Doe		**Preferred Name (*if applicable)*** *(Use this section when a student's preferred name affirms their identified gender versus legally listed name. In addition, ensure the student's preferred name and/or pronouns are used in the accompanying documentation. Leave section blank or write "N/A" if it does not apply)*	
DOB 01/01/2006	**Student ID** 000000000	**Date of Service** 12/01/2022	**Location** ☒**School** ☐**Home**
Start Time 2:00 pm	**End Time** 3:00 pm	**Total Duration** 1 hour	**Treatment Code (ICD-10)** Z63.4 Bereavement
Description of Service Crisis Mental Health Service, Individual Therapy	**Procedure Code** S9484	**Modifier(s)** ☒SC ☐ TM ☐ GT ☐ U2 ☐ U3 ☐ U4 *(For all unplanned/crisis services using procedure code S9484, the modifier "SC," indicating non-IEP services, **must** be applied)*	

Current Presenting Problem(s) *(Describe the immediate situation that requires an immediate response, what is the client doing and/or saying?)*

The student reports difficulty concentrating in class and states he feels "numb." The student states, "I don't know how to move on" and says he has constant thoughts about his cousin, who passed away last week. The referring student's teacher states that he has skipped class three times over the past week and appears "unable to concentrate" when he does show up for class.

In this section, document the student's current presentation that justifies the medical necessity of providing clinical services to treat the current condition and/or prevent further deterioration of the student. It may be helpful to document the severity of the student's presentation, state how daily functioning is impacted and describe clinical symptoms that may be present.

Documentation best practice: avoid using other names besides the student receiving services. In this example, "cousin" is used versus their name. This is especially important if the cousin is a student at the school.

Precipitating Event(s) *(When known, describe any events or stressors that may have influenced this unplanned event to occur.)*

The student's cousin passed away last week. The student and his cousin were reported to be "very close" and "like a brother" to the student. The student reports his cousin's death was sudden and unexpected.

In this section, the clinician has further opportunity to provide evidence that the current event requires immediate attention. This section can also be used to further support the ICD-10 selection.

Intervention(s) *(Used or attempted, how were these actions necessary to decrease severity of crisis and/or prevent further deterioration?)*

The clinician provided validation, normalization and brief psychoeducation about the grief process. The clinician and student identified resources and support systems for short- and long-term support. The clinician taught the student how to engage in grief journaling to promote emotional expression and processing. The clinician provided resource information related to a weekly grief group offered at the school.

In this section, list the clinical interventions that were used to target the presenting issues and/or prevent further deterioration in student functioning.

Client's Response to Intervention(s)

Initially, the client was observed to have difficulty communicating his internal states, as he took several tries to answer, "how are you feeling?" related to his cousin's passing. By the end of the session the client reported he felt "sad" and stated, "I don't feel as numb as before." The student was receptive to joining the weekly grief group.

This section may provide additional data to determine if ongoing services are needed, provide details to support a clinical case formulation, and can provide feedback about what is working or not working for future treatment planning purposes.

Suicidal Ideation None/Denied	**Notes**
Homicidal Ideation None/Denied	**Notes**

Risk Factors *(safety assessment)*

The student reports a history of risk-taking behaviors such as using drugs and alcohol when upset.

Protective Factors *(safety assessment)* The student reports a good relationship with his family, a close group of friends, and a strong connection to his spiritual community.		
Follow up Plan and Recommendations *(E.g., actions stated in safety plan, referrals, coordination of care, if an involuntary hold was necessary.)* The clinician and student plan to meet on 12/04/2022 for an assessment to determine if further follow up care is needed. If additional services are warranted, the clinician will create a plan of care with the student. The clinician will continue to monitor for safety. The student will be referred to the weekly school-based grief group. *The clinician should continually be assessing if the student needs ongoing services. If ongoing services are needed, the clinician would create a plan of care.*		
Name, LMFT **Provider Name/Credentials**	Provider Signature *(electronic signature accepted)* **Provider Signature**	12/01/2022 **Date**
Supervisor Name/Credentials *(if applicable)*	**Supervisor Signature** *(if applicable)*	**Date**

***This document is for example purposes only. Utilize your supervisor (if applicable), professional ethics, professional judgment, and any other appropriate personnel/resources to make clinical decisions.**

Checklist for Unplanned/Crisis Behavioral Health Progress Note

☐ Eligible recipient's **legal name**.

☐ *(If applicable*) Eligible recipient's preferred name.

☐ Eligible recipient's **date of birth**.

☐ Eligible recipient's **student ID**.

☐ **Date** the service was provided.

☐ **Location** the service was provided.

☐ **ICD-10** treatment code(s).

☐ **Procedure code(s**) and applicable **modifiers**.

☐ **Start and end time** of service *(NMAC 8.302.1.17.C).*

☐ **Total duration** of service.

☐ Clearly indicate the **type of service** provided (e.g., individual therapy, group therapy).

☐ **Describe how the service was medically necessary** *(NMAC 8.302.1.17).*

☐ State the **present issue(s)** which require crisis intervention.

☐ Clearly identify **interventions** applied *(NMAC 8.320.6.13.A*1).

☐ Clearly document the **client's response** to the interventions (NMAC 8.320.6.12.B.2).

☐ Document **follow-up care**, such as ongoing assessment for services.

☐ List the rendering **provider's name**, **signature** (or electronic equivalent), **credentials** and **date** the note.

☐ (*If applicable)* List the rendering provider's supervisor's **name**, **signature** (or electronic equivalent), **credentials** and **date** the note.