Coordination of Care Plan

Date:

Client: DOB: Medicaid #:

Program Name:

Clinical Rationale for this level of care:

Admission Date:

Legal Status:

Supervisor of Coordination of Care Plan:

Diagnosis:

Therapist (Case Manager, CTA, Day Program Coordinator) Name:

Supervisor Name:

Treatment plan goals (or attach treatment plan- treatment plan must be measurable, clear, achievable, and time limited)

Frequency of face to face contact with member:

Program Name:

Clinical Rationale for this level of care:

Admission Date:

Diagnosis:

Therapist (Case Manager, CTA, Day Program Coordinator):

Supervisor Name:

Treatment plan goals, (or attach treatment plan- treatment plan must be measurable, clear, achievable, and time limited)

Frequency of face to face contact with member:

Program Name:

Clinical Rationale for this level of care:

Admission Date:

Diagnosis:

Therapist (Case Manager, CTA, Day Program Coordinator)

Supervisor Name:

Treatment plan goals, (or attach treatment plan- treatment plan must be measurable, clear, achievable, and time limited)

Frequency of face to face contact with member:

WRAP Plan (or attach plan):

Plan for coordination of care (frequency of contact with provider (s), frequency of team meetings, Supervisor of Coordination of Care Plan):

Plan for communication to address barriers to member progress in each level of care:

Plan to address how treating clinicians will avoid contradicting each other and double binding the member as these goals and approaches are implemented:

How much time commitment is involved in the member's treatment (include travel, time in session and between session assignments)?

Member's response to the time commitment and to the Coordination of Care plan:

_____
Therapist/Date

_____
Therapist/Date

_____
Case Manager/Date

_____
Day rehab representative/Date

_____
Supervisor of Coordination of Care/Date