CONTRA COSTA HEALTH
MENTAL HEALTH SERVICES

Targeted Case Management Care Plan and Level of Care Determination

NAME/MRN

This form should be used in conjunction with a progress note when a Targeted Case Management Plan is created or revised and/or when a Level of Care determination needs to be made. Completion of this form should be mentioned on the accompanying progress note.

Facility Name: _____ ID: _____ Program Name: _____ ID: _____

Provider: _____ ID: _____ Service Date: _____

TARGETED CASE MANAGEMENT CARE PLAN.

Client or legal representative participated and agreed ☐

1. Describe goals, including client's participation in development goals.

2. List actions/interventions.

3. Describe transition plan for when client has achieved goals.

NAME/MRN

LEVEL OF CARE DETERMINATION

Clients continuing to receive Specialty Mental Health Services

1. Symptoms due to mental health disorder:

2. Impairment or reasonable probability of impairment:

3. **(Under 21 years of age only)** Condition placing at high risk for mental health disorder – significant trauma, child welfare involvements, juvenile justice involvement, or experiencing homelessness.

4. **(Under 21 years of age only)** Reasonable probability of not progressing developmentally as appropriate.

Clients transitioning to Non-specialty Mental Health Services or **Other Health Services**

Plan for transition (to a different level of care, if applicable):