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| **This form is not for claiming, service must be documented in a progress note in order to be claimed** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SUD Treatment Plan** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Client: | | |  | | | | | | | | |  | | | | | | |  | | | | | | |
|  | | | InSyst # | | | | | | | | | Last Name | | | | | | | First Name | | | | | | |
| Services were provided in: | | | | | |  | | | | | | | | | | by  interpreter or  clinician | | | | | | | | | |
|  | | | | | |  | | | | | | | | | |  | | | | | | | | | |
| **STAFF INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Provider: |  | | | | | | | | | | | | | | | | | | | | | RU: | |  | |
| Primary Counselor/LPHA: | | | | |  | | | | | | | | | | | | |  | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SUD PLAN INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Episode Opening Date: | | | | |  | | | | | | | | | Plan Dates - from: | | | |  | | | to: |  | | | | |
| Plan Type: | | | Initial (new to this RU or client). | | | | | | | | | | | | | | | | | | | | | | | |
| For RES initial plan is due 10 days from EOD. NTP 28 days from EOD. All other SUD programs, 30 days from EOD. | | | | | | | | | | | | | | | | | | | | | | | |
| Update (90 day or change to current plan) | | | | | | | | | | | | | | | | | | | | | | | |
| Date of previous plan: | | | | | | |  | | | | | | Next scheduled plan update due date: | | | | | | | |  | |  |
|  | | |  | | | | | | |  | | | | |  | | | | | | | | |  | |  |
| Primary Included SUD ICD-10 Code: | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| Primary Included SUD DSM-5/ICD-10 Name: | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Additional Diagnosis ICD-10 Code: | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| Additional Diagnosis DSM-5/ICD-10 Name: | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| **MY OVERALL STRENGTHS** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| INDIVIDUAL/FAMILY STRENGTHS TOWARD OVERCOMING BARRIERS AND ACHIEVING DESIRED RESULTS: | | | | | | | | | | | | | | | | | | | | | | | | | | |

Treatment Plan Challenges/Problems, Goals, and Actions Steps on next page. Copy additional pages as needed.

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| **GOAL #:** | | | | |
| **TYPE OF CHALENGE** | | **STAGE OF CHANGE** | | |
|  | |  | | |
| INDIVIDUAL/FAMILY DESIRED RESULTS FROM INTERVENTIONS (Client quote if possible): | | | | |
| **CHALLENGES** | | | | |
| Specific challenges or functional impairments related to diagnoses signs & symptoms (include date identified by provider): | | | | |
|  | | | | |
| Deferred (must write clinical reason why deferred below. Do not complete Action Steps Section): | | | | |
| **CLIENT OBJECTIVES/ACTION STEPS**: | | | | |
| Obj #: | Short-Term Achievable Objectives/Actions: | | Target Date (3 months unless specified): | At Reassessment (Optional). When appropriate indicate level of improvement, date and initial.  Not Improved  Somewhat Improved  Very Much Improved  Date Initials |
| Met: |

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| **GOAL #:** | | | | |
| **TYPE OF CHALENGE** | | **STAGE OF CHANGE** | | |
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| INDIVIDUAL/FAMILY DESIRED RESULTS FROM INTERVENTIONS (Client quote if possible): | | | | |
| **CHALLENGES** | | | | |
| Specific challenges or functional impairments related to diagnoses signs & symptoms (include date identified by provider): | | | | |
|  | | | | |
| Deferred (must write clinical reason why deferred below. Do not complete Action Steps Section): | | | | |
| **CLIENT OBJECTIVES/ACTION STEPS**: | | | | |
| Obj #: | Short-Term Achievable Objectives/Actions: | | Target Date (3 months unless specified): | At Reassessment (Optional) When appropriate indicate level of improvement, date and initial.  Not Improved  Somewhat Improved  Very Much Improved  Date Initials |
| Met: |

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| **PROVIDER SERVICES**: | | | | | | | | | | | |
| **MODALITY** | | | | | **FREQUENCY** | | | | | | **DURATION** |
| Case Management | | | |  | | |  | | | |  |
| Description of services to be provided: | | | |  | | | | | | | |
| Collateral | | | |  | | |  | | | |  |
| Description of services to be provided: | | | |  | | | | | | | |
| Individual | | | |  | | |  | | | |  |
| Description of services to be provided: | | | |  | | | | | | | |
| Group | | | |  | | |  | | | |  |
| Description of services to be provided: | | | |  | | | | | | | |
| Family Therapy | | | |  | | |  | | | |  |
| Description of services to be provided: | | | |  | | | | | | | |
| Medication Services | | | |  | | |  | | | |  |
| Description of services to be provided: | | | |  | | | | | | | |
| Withdrawal Management | | | |  | | |  | | | |  |
| Description of services to be provided: | | | |  | | | | | | | |
| Patient Education | | | |  | | |  | | | |  |
| Description of services to be provided: | | | |  | | | | | | | |
| Other: | | | |  | | |  | | | |  |
| Description of services to be provided: | | | |  | | | | | | | |
| Other: | | | |  | | |  | | | |  |
| Description of services to be provided: | | | |  | | | | | | | |
| **DISCHARGE PLAN** | | | | | | | | | | | |
| DISCHARGE PLAN (Readiness/Time Frame/Expected Referrals, etc.): | | | | | | | | | | | |
| **ADDITIONAL COMMENTS** | | | | | | | | | | | |
| (Client, Provider, Family, etc. and provide name and title of other Treatment Team members): | | | | | | | | | | | |
| **AUTHORIZATION/REJECT NOTES** | | | | | | | | | | | |
|  | Plan was discussed in primary language | | | | | | | |  | | |
|  | Individual/Family was offered a copy of this plan | | | | | | | |  | | |
|  | Individual/Family participated in the development of, and agreed to, this plan. | | | | | | | |  | | |
|  | Treatment team member participated in the development of the Plan | | | | | | | |  | | |
|  | Provider attests that individual signed the plan on this date: | | | | | | | |  | | |
|  | Provider attests that legal representative (Parent, Legal Guardian, Conservator, etc.) signed or verbally accepted this Plan on this date due to Individual inability to sign. | | | | | | | |  | | |
|  | Individual/Family verbally accepts this plan but not able to sign on this date (explain below). | | | | | | | |  | | |
|  | Individual/Family was offered a copy of this plan | | | | | | | |  | | |
|  | Individual/Family declines to sign (explain below). | | | | | | | |  | | |
|  | See progress note describing development of the plan with Individual/Family, dated: | | | | | | | |  | | |
| **TREATMENT TEAM** | | | | | | | | | | | |
|  | LPHA | |  | | | | | | | | |
|  | Physician | |  | | | | | | | | |
|  | Psychiatrist | |  | | | | | Client is being treated by a non-BHCS psychiatrist | | | |
|  | Program Supervisor | |  | | | | | | | | |
|  | Medical Director | |  | | | | | | | | |
|  | Other | |  | | | | | | | | |
| This plan also sent to: | |  | | | | | | | | | |
| **AUTHORIZATION/REJECT NOTES** | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | |  | | | |  | |
| Client Signature | | | | | | Printed Name | | | | Date | |
|  | | | | | |  | | | |  | |
| Counselor Signature | | | | | | Printed Name | | | | Date (plan date) | |
|  | | | | | |  | | | |  | |
| MD/LPHA Signature\* | | | | | | Printed Name | | | | Date | |
| \*MD/LPHA co-signature required when signed by SUD counselor. Co-signature is required within 15 days of counselor signing the plan and within plan due date requirements. | | | | | | | | | | | |