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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** |
|   |   |
| 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. |