CLIENT PLAN

Name:	
InSyst #:	
RU#:	
□ (If NOT check box)	**Client is an ACBHCS long-term beneficiary.**

PLAN TYPES (check one)	**□ Initial**	**□ Update**

LIFE GOALS: CLIENT'S DESIRED RESULTS FROM MH INTERVENTIONS (Client quote if possible)

CLIENT/FAMILY STRENGTHS TOWARD OVERCOMING BARRIERS AND ACHIEVING DESIRED MH RELATED RESULTS

IMPAIRMENTS OF FUNCTIONING IN DAILY LIVING

Area of Difficulty: Community Life, Family Life, Education, Vocation, Independent Living, Health, etc.	**Level of Difficulty: Moderate, Severe**	**Describe Specific Functional Impairments related to MH Diagnosis's Signs & Symptoms. [For Case Mgt, must indicate need for C/M service, i.e. ct. is homeless. Also, be sure to include severe Symptoms/Impairments resulting from MH Diagnosis that prevents client from accessing/maintaining needed services, or for child that the lack of such services (caretaker not providing) exacerbates child's MH symptoms/impairments.]**

Long Term MH GOALS (Links life goals & MH objectives)**:**	(Optional)
DISCHARGE PLAN (readiness/timeframe/expected referrals/etc.):	

Short–Term Mental Health Objectives: Specific, quantifiable or observable outcomes of target symptoms, behaviors, or impairments in functioning.	**Target Date:** (12 months unless specified)	**At Reassessment:** When appropriate indicate level of improvement, date and initial.
OBJ#		
		□ Not Improved □ Somewhat Improved □ Very much Improved □ Met Date: Initials:

CLIENT PLAN

Name:	
InSyst #:	
RU#:	

Short–Term Mental Health Objectives: Specific, quantifiable or observable outcomes of target symptoms, behaviors, or impairments in functioning.	**Target Date:** (12 months unless specified)	**At Reassessment:** When appropriate indicate level of improvement, date and initial.
OBJ#		□ Not Improved □ Somewhat Improved □ Very much Improved □ Met Date: Initials:

SERVICE MODALITIES

MODALITY	FREQUENCY	DURATION
☐ Case Management		
☐ Medication Management		
☐ Individual Rehab		
☐ Group Rehab		
☐ Individual Therapy		
☐ Family Therapy		
☐ Other:		
☐ Other:		

DESCRIBE SPECIFIC AND DETAILED INTERVENTIONS FOR EACH MODALITY:

Provider(s): **(☑ ALL THAT APPLY)**	**Detailed Intervention(s):**	**MODALITY:**
□ Case Manager □ Clinician □ MD/NP/PA □ Peer □ Family Partner □ Other:_____		
□ Case Manager □ Clinician □ MD/NP/PA □ Peer □ Family Partner □ Other:_____		
□ Case Manager □ Clinician □ MD/NP/PA □ Peer □ Family Partner □ Other:_____		

Client/Conservator Signature

By signing, I agree that I have: 1) participated in the development of the Treatment Plan, and 2) have been offered a copy of the plan.

		DATE
CLIENT (IF NO SIGNATURE, PLEASE SEE PROGRESS NOTE DATED:_____ FOR EXPLANATION & WHEN NEXT ATTEMPT WILL BE).		
GUARDIAN/PARENT (IF NO SIGNATURE, PLEASE SEE PROGRESS NOTE DATED:_____ FOR EXPLANATION & WHEN NEXT ATTEMPT WILL BE.)		
PROVIDER COMPLETING PLAN	INDICATE M/C CREDENTIAL	
LICENSED LPHA SUPERVISOR (IF NEEDED)	INDICATE LICENSED M/C CREDENTIAL	
PSYCHIATRIST/OTHER PRESCRIBER (REQUIRED WHEN PRESCRIBING)	INDICATE M/C CREDENTIAL: MD, DO, NP, CNS	