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| **Beneficiary Name:** | **Clt ID#:** | | **Assigned Primary Therapist/Counselor (legibly print name):** | | | **Intake Date:** |
| **Initial Plan**  **Update**  **Date of Most Recent Plan: \_\_\_\_\_\_\_\_\_\_\_**  Date therapist/counselor signed previous plan (N/A if initial plan),plan updates due 90 days from date of most recent signed plan. | | **Primary DSM-5 SUD Diagnosis** (code and name required): | | | **Secondary DSM-5 SUD Diagnosis** (code and name required): | |
| **Current Stage of Change:** **P**re-**C**ontemplation (PC) **C**ontemplation (C) **P**reparation (P) **A**ction (A) **M**aintenance (M) **R**elapse (R) | | **Index of Challenges:** **1)** Substance Use Disorder **2)** Mental Health **3)** Physical Health **4)** Employment/Education **5)** Financial/Housing **6)** Legal **7)** Psycho-Social /Family **8)** Spirituality  **9)** Deferred Challenge(s) | | | | |
| Treatment Plan Action Steps must include a **description of services**, including type of counseling, to be provided. For example: Groups (Relapse Prevention, Anger Management, etc.); Collateral (Family concerns, Relationships, or Develop Support Network, etc.). | | | | | | |
|  | | | | | | |
| **Indicate Scheduled Types of Services (Intake, treatment planning, crisis, and discharge planning are not required on the plan)** | | | | | | |
| **Group, frequency: times per and as needed** | | | | **Other Services and frequency:** | | |
| **Collateral, frequency: times per and as needed** | | | |  | | |

| **Date Goal Identified** | **Stage of Change** | **Index of Challenges** | **Identified Challenges**  **(All challenges from assessment)** | **Specific SUD Treatment Goals**  **(Best if observable, Measureable, w/Timeframe)**  **If deferred, MUST indicate reason** | **Action Steps-Include Description of Services**  **(For each indicate responsible party; client or counselor)** | **Target Date** | **Date Completed** |
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| **Client Name** | **Client Signature** | **Date** | **Client must sign initial plan within 30 days of admission. For updates client signature is due within 30 days of therapist/counselor signing the update.**  **If the client is unavailable to sign, state efforts to contact or reason why\*** |
| **Therapist/Counselor Name, Title** | **Therapist/Counselor Signature, Credentials** | **Date** | **This is the effective plan date. Therapist/Counselor signature required within 30 days from date of admission OR 90 days from date of most recent plan\*** |
| **Physician Name, Title** | **Physician Signature, Credentials** | **Date** | **Physician sig. required within 15 calendar days of therapist/counselor dated signature. If no meds are prescribed by the physician, a Lic. Psychologist may sign plan updates\*** |

\*Narcotic Treatment Programs - Treatment plans are due 28 days from start of maintenance treatment and updates are due *at least* every 3 months from the date of admission. MD and supervising counselor must review the treatment plan within 14 days from the date counselor/therapist signs the plan and within specified timeframes.