|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MED. PLAN TYPES *(check one):*** | | | □ **Initial** | | □ **Update *(includes Annual)*** | | | |
| **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* | | | | | | | | |
|  | | | | | | | | |
| **DISCHARGE PLAN** *(readiness/timeframe/expected referrals/etc.):* | |  | | | | | | |
| **SHORT–TERM MENTAL HEALTH OBJECTIVES (SMART):** | | | | | | |  | |
| **MH OBJECTIVE # 1** | | | | | | | **Target Date:**  12 MONTHS or: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | | | | | | |
|  | | | | | | |
|  | | | | | | |
| **MH OBJECTIVE # 2** | | | | | | | **Target Date:**  12 MONTHS or: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | | | | | | |
|  | | | | | | |
|  | | | | | | |
| **SERVICE MODALITY AND IT’S DETAILED INTERVENTIONS:** | | | | | | | | |
| **MODALITY** | **Detailed Intervention(s):** | | | | | **Optional:** *Check any Individuals involved--not limited to.* | | |
| ***MEDICATION SERVICES MONTHLY, OR AS NEEDED, FOR 12 MONTHS*** |  | | | | | □ Case Manager  □ Clinician  □ MD/NP/PA  □ Peer  □ Family Partner  □ Other:\_\_\_\_\_\_\_\_ | | |
| ***Client or Parent/Caretaker:*** ***By signing, I agree that I have: 1) participated in the development of the Treatment Plan, and 2) have been offered a copy.*** | | | | | | | | DATE |
| CLIENT/GUARDIAN/PARENT (IF NO SIGNATURE, PLEASE SEE PROGRESS NOTE DATED:\_\_\_\_\_\_\_\_\_\_\_\_ FOR EXPLANATION & WHEN NEXT ATTEMPT WILL BE). | | | | | | | |  |
| PSYCHIATRIST/NURSE PRACTITIONER/ETC. SIGNATURE (MUST BE LEGIBLE) | | | | INDICATE LICENSED M/C CREDENTIAL: MD, NP, etc. | | | |  |