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| **€ (If NOT check box)** | **Client is an ACBHCS long-term beneficiary.** |

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| --- | --- | --- |
| **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.]** |
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| **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: |

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| **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 |  |