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