|  |  |  |
| --- | --- | --- |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
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|  |
| **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. |  |