

Partners in Recovery

PART D: BEHAVIORAL HEALTH SERVICE PLAN

Name _____ CIS Client ID# _____ Program: _____ Today's Date: _____

PARTICIPANTS

LONG TERM VIEW / VISION / RECOVERY GOAL:

<u>Living Situation:</u>	<u>Learning/Working:</u>	<u>Social/Leisure:</u>
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PERSON/FAMILY STRENGTHS & CULTURAL PREFERENCE:

Empty box for PERSON/FAMILY STRENGTHS & CULTURAL PREFERENCE.

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SPECIAL ASSISTANCE YES NO If yes, identify how Special Assistance need is being met:

IDENTIFIED NEEDS and SPECIFIC OBJECTIVES (to address these needs)) and Target Date	Current Measure	INTERVENTIONS to MEET OBJECTIVES		Desired Measure	Achieved Measure (at target date)	Measure Met (Y/N)
		Specific Services and Frequency	Strengths Used			
Target Date:						
Target Date:						
Target Date:						

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Target Date:						
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DISCHARGE PLAN (add discharge date if known)/**Future Issues Not to be Addressed in this Plan:**

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Person / Guardian _____ Date: _____

Yes, I am in agreement with the types and levels of services included in my service plan.

No, I disagree with the types and/or levels of some or all of the services included in my service plan. By checking this box, I will receive the services that I have agreed to receive and may appeal the treatment team's decision to not include all the types and/or levels of services that I have requested. *

Clinical Liaison:	Date:	Other:	Date:
Prescribing Clinician:	Date:	Other:	Date:
Case Manager:	Date:	Other:	Date:
Nurse:	Date:	Other:	Date:
Rehab/Voc Specialist:	Date:	Other:	Date:
Other:	Date:	Other:	Date:

*If no is checked, a Title XIX/XXI eligible person and/or person determined to have a serious mental illness must be given the Notice of Intended Action Form (PM Form 5.1.1)

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BEHAVIORAL HEALTH SERVICE PLAN REVIEW OF PROGRESS

Name:

I. Review of Progress

Provide a summary below of the progress the person has made toward meeting the objectives identified on the service plan. In addition, indicate any adjustments that are being made to the service plan objectives and/or measures, including the justification and any additional needs or strengths that have been identified.

II. Current Diagnostic Summary

Describe and explain any changes in diagnoses and functioning of person:

III. Team Members Present at Plan Review Meeting (CFT Planning):

IV. Date of Next Plan Review (CFT Planning) Meeting: _____

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BEHAVIORAL HEALTH SERVICE PLAN REVIEW OF PROGRESS

V. Clinical Liaison (responsible for reviewing clinical record)

_____ Consumer Signature	_____ Date	
_____ Guardian's Name (print) / Signature	_____ Date	
_____ Doctor's Name (print) / Signature	_____ Credentials/Position	_____ Date
_____ Nurse's Name (print) / Signature	_____ Credentials/Position	_____ Date
_____ Rehab/Voc Specialist's Name (print) / Signature	_____ Credentials/Position	_____ Date
_____ Clinical Liaison's Name (print) / Signature	_____ Credentials/Position	_____ Date
_____ Behavioral Health Professional Reviewer Name (print) / Signature	_____ Credentials/Position	_____ Date