

PLANS

NOTE: Training for the Client Plans and Progress Notes in the EHR began in October 2011. Training will continue throughout the calendar year 2012. Programs not yet trained to use the EHR to document Client Plans and Progress Notes will continue to use paper during the transition and will be held to the same documentation timelines and standards as outlined in the following descriptions unless noted otherwise.

- WHEN:** The initial Client Plan must be completed by the end of the assessment period, which is a maximum of 30 calendar days from opening the client's assignment. Additionally, a Client Plan (CP) shall be completed whenever there is a significant change in the client's planned care. **EFFECTIVE January 1, 2012:** All Client Plans can be active for up to 12 months for meds only and meds plus Plans and must be driven by the appropriate authorization process.
- Providers are responsible to track the interval covered and assure that there is an active CP in the client chart to cover all services claimed.
- Unplanned services such as Crisis Intervention (CI), or inpatient stays do not require a CP. Crisis Residential programs will complete the Client Plan START and Plan may only be active for up to 14 days.
- ON WHOM:** All clients with open assignments of thirty days or longer, excluding unplanned services such as CI or inpatient stays.
- COMPLETED BY:** Staff delivering services within scope of practice. Must be signed by:
Physician,
Licensed/Waivered Psychologist,
Licensed/Registered/Waivered Social Worker,
Licensed/Registered/Waivered Marriage Family Therapist,
Licensed/Registered Professional Clinical Counselor, or
Licensed Psychiatric Technician, or
Registered Nurse, or Nurse Practitioner..
Trainee, Licensed Vocational Nurse, and MHRS can complete but must be co-signed by one of the above.
Co-signatures must be completed within timelines.
- MODE OF COMPLETION:** Data must be entered into the Electronic Health Record.
- REQUIRED ELEMENTS:** All elements of the CP must be addressed.
For the CP to be active (cover services claimed), it must contain the signature of the client and/or the parent/guardian/care provider AND the service staff listed above (with co-signatures obtained within timelines).
Make sure to cross-reference the date of a progress note to explain:
- when a client's signature is not obtained, why, and level of agreement with participation in treatment, and/or

CLIENT PLAN – ADULT MENTAL HEALTH

2014

Efforts shall be made to obtain the client's signature and involvement in CP development. At a later time, when client is available to sign, signature shall be obtained.

Signature updates shall be obtained whenever an addition or modification is made to the CP.

NOTE:

A client plan that is not final approved (status is “open green locked”) is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Client plans are not viewed as complete and active until the assessment is final approved (red locked) with the appropriate signatures.

WHEN:

The initial Client Plan must be completed by the end of the assessment period, which is a maximum of 30 calendar days from opening the client’s assignment. Additionally, a Client Plan (CP) shall be completed whenever there is a significant change in the client’s planned care. CP can be active for up to 12 months maximum and must be driven by the appropriate authorization process.

Outpatient Treatment Sessions Authorized (UM – 13/18 sessions):

To be used by Outpatient providers. The CP shall also be rewritten prior to presenting the client’s case for Utilization Management (UM). This must occur prior by the end of the first 13 sessions of treatment, and subsequently following the recommendation of the UM authorization. (See UTILIZATION MANAGEMENT REQUEST AND AUTHORIZATION Outpatient Treatment & Case Management Programs Implemented 01-01-2010). CP may be completed up to one month prior to the CP due date.

Day Treatment Intensive:

To be used for Day Treatment Intensive (full and half-day) Programs. The CP must be updated 3 months following the opening of the client’s assignment, and every 3 months following. However, the CP must be rewritten annually utilizing the assignment opening date as the guide.

Day Treatment Rehabilitation

To be used for Day Treatment Rehabilitation (full and half-day) Programs. CP must be updated six months following the opening of the client’s assignment, and every 6 months following. However, the CP must be rewritten annually utilizing the assignment opening date as the guide.

OP Interval Covered (exception from COTR):

To be used by outpatient programs that do not fall within the parameters outlined above. In this case, the Program Manager must contact the COTR for a waiver to use an interval (months) in place of the UM 13/13 sessions.

Providers are responsible to track the interval covered and assure that there is an active CP in the client chart to cover all services claimed.

Unplanned services such as Crisis Intervention (CI), or inpatient stays do not require a CP. Beginning at the conclusion of the MH MIS Client Plan training, medication only cases will require a CP and each

CLIENT PLAN – CHILDREN’S MENTAL HEALTH

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medication only CP can be active for a maximum of 12 months.
Therapeutic Behavioral Services complete the Client Plan TBS.

- ON WHOM:** All clients with open assignments of thirty days or longer, excluding unplanned services such as CI or inpatient stays.
- COMPLETED BY:** Staff delivering services within scope of practice. Must be signed by:
Physician,
Licensed/Waivered Psychologist,
Licensed/Registered/Waivered Social Worker,
Licensed/Registered/Waivered Marriage Family Therapist,
Licensed Professional Clinical Counselor, or
Licensed Psychiatric Technician, or
Registered Nurse.
Trainee and MHRS can complete but must be co-signed by one of the above.
Co-signatures must be completed within timelines.
- MODE OF COMPLETION:** Data must be entered into the Electronic Health Record.
- REQUIRED ELEMENTS:** All elements of the CP must be addressed.
For the CP to be active (cover services claimed), it must contain the signature of the client and/or the parent/guardian/care provider AND the service staff listed above (with co-signatures obtained within timelines).
Make sure to cross-reference the date of a progress note to explain:
- when a client’s signature is not obtained, why, and level of agreement with participation in treatment, and/or
 - when client is a Dependent of the Court and therefore no signature is obtained, and/or
 - when the parent/guardian/care provider is not available to sign the CP but provides verbal authorization, and/or
 - when explaining why a guardian’s signature is not obtained for any other reason.
- Efforts shall be made to obtain the guardian’s signature and involvement in CP development. At a later time, when guardian is available to sign, signature shall be obtained.
- Signature updates shall be obtained whenever an addition or modification is made to the CP.

NOTE:

When a client receives TBS services during the assignment, a copy of the TBS Client Plan should be available in the electronic health record.

A client plan that is not final approved (status is “open green locked”) is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Client plans are not viewed as complete and active until the assessment is final approved (red locked) with the appropriate signatures.

**County of San Diego Mental Health Services
CLIENT PLAN**

Client Name: _____

Case #: _____

Program Name: _____

Unit/SubUnit: _____

Client Plan Begin Date: _____

Client Plan End Date: _____

PLANNING TIERS

Strengths (Identify client strength from the strengths table. These are what the client/support persons/staff identifies as general strengths for the client. Identify strength and individualize)

Strength: _____

Strength: _____

Strength: _____

Strength: _____

Area of Need # 1 (Identify need from the instructions. This is an area in which a level of impairment is identified by the client/support persons/staff. Identify the need and individualize)

Need: _____

Goal for Need #1 (Identify the goal from the identified need. This is the broad goal that the client wants to achieve in treatment. Whenever possible the client's own words should be documented. Identify the goal and individualize)

Goal: _____

Applied Strength for Goal/Need # 1 (Identify one of the strengths above. This is a specific strength that the client can utilize to achieve this goal. Identify the applied strength and individualize)

Applied _____

Strength: _____

**County of San Diego Mental Health Services
CLIENT PLAN**

Client Name: _____

Case #: _____

Objective # ____ **for Goal/Need #** ____ (Identify the objective from the identified goal. There are no limits on the number of objectives for each goal – be sure to number each objective to match the designated goal. These are action steps that the client will focus on in order to achieve his/her goal. Identify the objective and individualize)

Objective: _____

Interventions for Objective # _____ (Identify each intervention. Service codes are considered interventions – each intervention may be individualized for how it will be used to assist the client achieve his/her goal)

Intervention: _____

**County of San Diego Mental Health Services
CLIENT PLAN**

Client Name: _____

Case #: _____

Area of Need # ____ (Identify need from the instructions. This is an area in which a level of impairment is identified by the client/support persons/staff. Identify the need and individualize)

Need: _____

Goal for Need # ____ (Identify the goal from the identified need. This is the broad goal that the client wants to achieve in treatment. Whenever possible the client's own words should be documented. Identify the goal and individualize)

Goal: _____

Applied Strength for Goal/Need # ____ (Identify one of the strengths above. This is a specific strength that the client can utilize to achieve this goal. Identify the applied strength and individualize)

Applied Strength: _____

(Objective/s and Interventions on following page)

**County of San Diego Mental Health Services
CLIENT PLAN**

Client Name: _____ **Case #:** _____

Explained in client's primary language of: _____

Explained in guardian's primary language of: _____

Client offered a copy of the plan:

Yes _____

No _____ (if no, document reason): _____

SIGNATURES:

Client: _____ **Date:** _____

Refused to sign **Explanation:** _____

Parent/Guardian Signature: _____ **Date:** _____

Conservator Signature: _____ **Date:** _____

Other Signature: _____ **Date:** _____

NOTES:

The following items are required for an Anasazi Client Plan to be valid:

- Client Plan completed
- Client Plan electronically signed by Staff
- Client Plan co-signed electronically (if required)
- Client signature on this form
- Client Plan Final Approved in Anasazi

Client Plans will be valid on the date when the last of the above is completed.

**County of San Diego Mental Health Services
CLIENT PLAN**

Client Name: _____ **Case #:** _____

Explained in client's primary language of: _____

Explained in guardian's primary language of: _____

Client offered a copy of the plan:

Yes ___

No _____ (if no, document reason): _____

SIGNATURES:

Client: _____ **Date:** _____

Refused to sign **Explanation:** _____

Parent/Guardian Signature: _____ **Date:** _____

Conservator Signature: _____ **Date:** _____

Other Signature: _____ **Date:** _____

NOTES:

The following items are required for an Anasazi Client Plan to be valid:

- Client Plan completed
- Client Plan electronically signed by Staff
- Client Plan co-signed electronically (if required)
- Client signature on this form
- Client Plan Final Approved in Anasazi

Client Plans will be valid on the date when the last of the above is completed.

WHEN: A Therapeutic Behavioral Services (TBS) Client Plan must be completed prior to the TBS Coach(s) start date. At least a minimal Client Plan shall be completed by the end of the initial authorization period (thirty days from the contractor’s opening the client’s assignment).

Additionally, a Client Plan shall be reviewed and updated at each monthly review meeting and whenever there is a significant change in the client’s planned care. When services continue to be needed, the Client Plan shall also be rewritten at the third month review meeting.

The TBS case manager shall provide a copy of all Client Plans and updates to the County TBS facilitator.

ON WHOM: All clients who receive TBS services. Occasionally there are clients who are approved for TBS, but for some reason do not actually receive services. These clients are not required to have a TBS Client Plan.

COMPLETED BY: Staff delivering services within scope of practice. Must be signed by:
 Physician,
 Licensed/Waivered Psychologist,
 Licensed/Registered/Waivered Social Worker,
 Licensed/Registered/Waivered Marriage Family Therapist,
 Licensed/Registered Professional Clinical Counselor, or
 Licensed Psychiatric Technician
 Registered Nurse.
 Trainee and MHRs can complete but must be co-signed by one of the above.

Co-signatures must be completed within timelines.

The case manager for the TBS contractor is required to complete a Client Plan for each client. The case manager shall have the TBS team sign the TBS Client Plan and offer a copy of the plan to each team member, which includes the client. The County facilitator approves services based on the TBS Client Plan.

MODE OF COMPLETION: Data must be entered into the Electronic Health Record.

REQUIRED ELEMENTS: All elements of the CP must be addressed. For the CP to be active (cover services claimed), it must contain the following signatures: Client (Cross reference date of progress note when no client signature is present. Progress notes outlines reason.)

1. Parent/Guardian (caretaker)
2. Specialty Mental Health Provider – SMHP (therapist)
3. TBS Case Manager – Contractor
4. TBS Facilitator – County

5. TBS Coach(s)

NOTE:

When a client receives TBS services, a copy of the TBS Client Plan should be provided to the Specialty Mental Health Provider (SMHP).

**County of San Diego Mental Health Services
TBS CLIENT PLAN**

Client Name: _____

Case #: _____

Program Name: _____

Unit/SubUnit: _____

Client Plan Begin Date: _____

Client Plan End Date: _____

PLANNING TIERS

Strengths (Identify client strength from the strengths table. These are what the client/support persons/staff identifies as general strengths for the client. Identify strength and individualize)

Strength: _____
Strength: _____
Strength: _____
Strength: _____

Area of Need # _____ (Identify need from the instructions. This is an area in which a level of impairment is identified by the client/support persons/staff. Identify the need and individualize)

Need: _____

SPECIFIC TARGET BX: _____

FREQUENCY/DURATION/INTENSITY of BX: _____

ANTECEDENTS: _____

Goal for Need # _____ (Identify the goal from the identified need. This is the broad goal that the client wants to achieve in treatment. Whenever possible the client's own words should be documented. Identify the goal and individualize)

Goal: _____

**County of San Diego Mental Health Services
TBS CLIENT PLAN**

Client Name: _____

Case #: _____

Applied Strength for Goal/Need # _____ (Identify one of the strengths above. This is a specific strength that the client can utilize to achieve this goal. Identify the applied strength and individualize)

Applied Strength: _____

Objective # _____ for Goal/Need # _____ (Identify the objective from the identified goal. There are no limits on the number of objectives for each goal – be sure to number each objective to match the designated goal. These are action steps that the client will focus on in order to achieve his/her goal. Identify the objective and individualize)

Objective: _____

MONTH 1 OBJECTIVE: _____

MONTH 2 OBJECTIVE: _____

MONTH 3 OBJECTIVE: _____

MONTH 4 OBJECTIVE: _____

CLT WILL: _____

CAREGIVER WILL: _____

COACH WILL: _____

**County of San Diego Mental Health Services
TBS CLIENT PLAN**

Client Name: _____

Case #: _____

SPECIALTY MENTAL HEALTH PROVIDER (SMHP) WILL: _____

SUPPORT STAFF WILL: _____

Interventions for Objective # _____ (Identify each intervention. Service codes are considered interventions – each intervention may be individualized for how it will be used to assist the client achieve his/her goal)

Intervention: _____

Intervention: _____

Intervention: _____

Intervention: _____

(Additional Areas of Need, Goals, Objectives, Interventions on following pages
Print as necessary)

County of San Diego Mental Health Services TBS CLIENT PLAN

Client Name: _____

Case #: _____

*Client was offered a copy of plan? Yes No

*Explained in Client's Primary Language, which is: *(Select from Language Table in Instructions)*

If not, explain: _____

*Explained in Caretaker's Primary Language, which is: *(Select from Language Table in Instructions)*

If not, explain: _____

*Transition Plan:

Outcome Goal (Identify)	Achieved	Explanation (If No or N/A)
<input type="checkbox"/> Avoid psychiatric hospitalization	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	_____
<input type="checkbox"/> Prevent higher level of care	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	_____
<input type="checkbox"/> Move to lower level of care	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	_____

Coach Start Date: _____ Anticipated Discharge Date: _____

TBS Hours

From	To	Days/Times	Hours

Signature of TBS Staff Requiring Co-Signature:

Date: _____

ID Number: _____

Printed Name

***Signature of TBS Staff Completing/Accepting Client Plan:**

Date: _____

ID Number: _____

**County of San Diego Mental Health Services
TBS CLIENT PLAN SIGNATURE PAGE**

Client Name: _____ Case #: _____

Explained in client's primary language of: _____

Explained in guardian's primary language of: _____

Client offered a copy of the plan:

Yes _____

No _____ (if no, document reason): _____

SIGNATURES:

Client: _____ Date: _____

Refused to sign Explanation: _____

Parent/Guardian Signature: _____ Date: _____

Signature of TBS Staff Requiring Co-Signature:

_____ Date: _____

_____ ID Number: _____

Printed Name

*Signature of TBS Staff Completing/Accepting Client Plan:

_____ Date: _____

_____ ID Number: _____

Printed Name

TBS Coach Signature: _____ Date: _____

ID Number: _____

SMHP Signature: _____ Date: _____

Title

Other Signature: _____ Date: _____

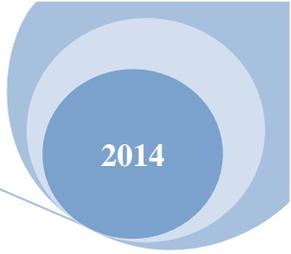
Title

Other Signature: _____ Date: _____

Title

Other Signature: _____ Date: _____

Title



- WHEN:** Used when completing Client Plans to assist with menu choices
- ON WHOM:** All clients for whom a client plan is required.
- UTILIZED BY:** Clinicians completing the client plan
- MODE OF USE:** Used as a resource to make it easier to select tiers for the plan.
- NOTE:** Clinicians are reminded to individualize each tier selected for the client. See each page to find the correct Need, Goal, and Objective choices.

STRENGTHS TABLE

Ability to Form and Maintain Relationships
Ability to Manage Activities of Daily Living
Ability to Navigate Public Transportation
Academic History
Accepts Feedback from Others
Accepts Responsibility
Actively Seeking Information about Change
Adaptable
Adaptive Distancing/Resistance
Adequate Decision-making Skills
Adventurous
Affectionate
Alert
Ambitious
Artistic
Athletic
Attentive
Bold
Brave
Calm
Capable
Charming
Cheerful
Clean-cut Appearance
Communicates Well
Communication
Compassion/Altruism
Competent
Conscientious
Considerate
Creative

Curious
Daily Living Skills
Dependable
Drug-free
Easy-going Appearance
Effective
Efficient
Empathy/Caring
Energetic
Enterprising
Exercises Regularly
Faith/Spirituality
Flexibility
Forgiving
Goal-Directed/Motivated
Hard-working
Has Transportation
Hobbies/Special Interests
Honest
Humble
Independent
Insight/Critical Thinking
Intelligent
Internal Locus of Control
Kind
Likeable
Living Environment
Long-term Sobriety in Past
Loyal
Maintaining Personal Changes
Manages Finances Adequately

STRENGTHS TABLE

Mature	Responsible
Meticulous	Responsiveness
Open to Change	Self-Awareness
Open-minded	Self-Efficacy/Mastery
Optimism/Hope	Self-sacrificing
Organized	Sense of Empowerment
Other	Sense of Humor
Outgoing	Sense of Meaning
Patient	Sensitive
Peaceful	Serious
Physically Active	Stable Environment
Physically Attractive	Stable Family Life
Physically Healthy	Steady Demeanor
Physically Strong	Strong Cultural Identity
Physically Tough	Support System
Physically Versatile	Sympathetic
Planning	Tactful
Positive Identity	Taking Action for Personal Change
Positive Relationship with Parents	Tolerant
Positive Relationship with Siblings	Trusting
Practices Good Nutrition	Trustworthy
Prayerful	Utilizes Agreed-Upon Treatment Recommendations
Previous Positive Experience in Treatment	Verbal
Professional Demeanor	Vocational Skills
Quick Learner	Wants to Work
Reflective	Warm Personality
Relaxed	Wholesome
Religious	Wise
Reserved	Work History
Resourcefulness	

Area of Need: Abuse/Addiction Substance/Non-Substance

Goal: Increase freedom from abuse/addiction

Objectives:

Accept Feedback from Others	Identify Barriers	Learn/Practice Relaxation Techniques
Access Resources/Natural Support in Comm	Identify Behavioral Consequences	Learn/Practice Safe Sex
Address Abuse/Neglect Issues	Identify Irrational Thoughts	Learn/Practice Self-Monitoring
Address Cultural Identity Issues	Identify Medication Side Effects	Learn/Practice Social Skills
Address Gender Identity/Practices Issues	Identify Patterns in Compulsive Behavior	Learn/Practice Symptom Management
Address Outstanding Financial Issues	Identify Personal Strengths	Linkage to PCP or Comm'ty Medical Clinic
Address Outstanding Legal Issues	Identify Physical Health Care Needs	Obtain Medication Services
Address Sexual Issues	Identify Resources/Natural Support in Com	Other
Assessment of Risk	Identify Triggers for Behavior	Participate in Recovery Classes
Attend 12-Step Meetings Regularly	Improve Self Identity/Esteem	Participate in Reunification Plan
Attend Classes	Increase Periods of Abstinence	Reduce Avoidance and Isolation
Complete Treatment as Planned	Learn to Identify Symptoms	Reduce Compulsive/Addictive Behavior
Complete Withdrawal/Detox Phase	Learn/Follow Housing Rules	Reduce Family Stress
Comply with Drug/Alcohol Screens	Learn/Pract Appropriate Emotional Expres	Reduce Frequency/Intensity of Symptoms
Comply with Laws	Learn/Practice Alternative Behaviors	Reduce Hopelessness and Desperation
Develop Artistic/Creative Activities	Learn/Practice Anger Management	Reduce Hospitalization
Develop Coping Skills to Manage Issue(s)	Learn/Practice Communication Skills	Reduce Incarceration
Develop Recreational/Leisure Activities	Learn/Practice Community Living Skills	Reduce Individual Level of Stress
Develop Wellness Recovery Action Plan	Learn/Practice Coping Skills	Reduce Physical Aggression
Develop/Follow Routine or Structure	Learn/Practice Goal Setting	Reduce Risk of Harm
Develop/Practice Personal Safety Skills	Learn/Practice Good Nutrition	Reduce Self-Injurious Behaviors
Develop/Use Relapse Prevention Plan	Learn/Practice Good Sleep Habits	Reduce Social Anxiety
Educate Parent/Guardian	Learn/Practice Healthy Boundaries	Reduce Use of Drugs Including Alcohol
Educate Spouse/Partner	Learn/Practice Healthy Disagreement	Schedule/Attend Neuropsychological Eval
Educate Support System/Family/Friends	Learn/Practice Identifying Needs	Understand Need for Medication
Encourage Connection to PrimaryCare Prov	Learn/Practice Maintaining Friendships	
Engage with Peer Recovery Resources	Learn/Practice Medication Adherence	
Evaluate/Change/Stabilize LivingSituatio	Learn/Practice Money Management	
Expand and Utilize Support System	Learn/Practice Organization and Planning	
Explore Spirituality	Learn/Practice Pers Daily Living Skills	
Identify/Access Community Activities	Learn/Practice Problem Solving Skills	
Identify Alternative Behaviors	Learn/Practice Regular Exercise	

Area of Need: Basic Needs – Food, Clothing, Shelter

Goal: Meet basic needs

Objectives:

Access Resources/Natural Support in Comm
Address Outstanding Financial Issues
Address Outstanding Legal Issues
Adjust to Life-Cycle Transition
Assess Situation and Identify Needs
Attend Classes
Complete Treatment as Planned
Comply with Laws
Cooperate with Criminal Justice System
Develop Coping Skills to Manage Issue(s)
Develop/Follow Routine or Structure
Develop/Practice Personal Safety Skills
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Evaluate/Change/Stabilize Living Situatio
Expand and Utilize Support System
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Personal Strengths
Identify Resources/Natural Support in Com
Identify Start/Root of Issue
Interact Appropriately with Others
Learn/Follow Housing Rules
Learn/Practice Alternative Behaviors
Learn/Practice Communication Skills
Learn/Practice Community Living Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Good Nutrition
Learn/Practice Healthy Boundaries
Learn/Practice Identifying Needs
Learn/Practice Money Management

Learn/Practice Organization and Planning
Learn/Practice Pers Daily Living Skills
Learn/Practice Problem Solving Skills
Learn/Practice Public Transport Skills
Learn/Practice Symptom Management
Obtain Financial Assistance/Benefits
Other
Participate in Medical/Dental Treatment
Participate in Mental Health Treatment
Provide for Own Food/Clothing/Shelter
Secure/Hold Stable Employment

Area of Need: Education

Goal: Improve educational status

Objectives:

Accept Feedback from Others
Access Resources/Natural Support in Comm
Assess Interests and Abilities
Assess Situation and Identify Needs
Attend Classes
Clarify Educational Needs
Complete Treatment as Planned
Develop Coping Skills to Manage Issue(s)
Develop/Follow Routine or Structure
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Evaluate/Change Education Environment
Exhibit Appropriate School Behavior
Expand and Utilize Support System
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Issues Regarding Separation
Identify Personal Strengths
Identify Resources/Natural Support in Com
Identify Start/Root of Issue
Identify Triggers for Behavior
Identify/Improve Technical Skills
Improve Self Identity/Esteem
Interact Appropriately with Others
Learn to Identify Symptoms
Learn/Pract Appropriate Emotional Expres
Learn/Practice Alternative Behaviors
Learn/Practice Anger Management
Learn/Practice Communication Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Good Sleep Habits

Learn/Practice Healthy Boundaries
Learn/Practice Identifying Needs
Learn/Practice Maintaining Friendships
Learn/Practice Medication Adherence
Learn/Practice Organization and Planning
Learn/Practice Pers Daily Living Skills
Learn/Practice Problem Solving Skills
Learn/Practice Public Transport Skills
Learn/Practice Relaxation Techniques
Learn/Practice Self-Monitoring
Learn/Practice Social Skills
Learn/Practice Symptom Management
Other
Participate in Education/Training Progrm
Reduce Avoidance and Isolation
Reduce Frequency/Intensity of Symptoms
Reduce Individual Level of Stress
Reduce Physical Aggression
Reduce Reaction to Trauma Triggers
Reduce Risk of Harm
Reduce Self-Injurious Behaviors
Reduce Social Anxiety
Schedule/Attend Neuropsychological Eval
Understand Need for Medication

Area of Need: Emotional-Behavioral/Psychiatric

Goal: Improve/Maintain functioning

Objectives:

Accept Feedback from Others	Identify Medication Side Effects	Learn/Practice Regular Exercise
Access Resources/Natural Support in Comm	Identify Patterns in Compulsive Behavior	Learn/Practice Relaxation Techniques
Address Abuse/Neglect Issues	Identify Personal Strengths	Learn/Practice Safe Sex
Address Cultural Identity Issues	Identify Physical Health Care Needs	Learn/Practice Self-Monitoring
Address Gender Identity/Practices Issues	Identify Resources/Natural Support in Com	Learn/Practice Social Skills
Address Sexual Issues	Identify Source(s) of Family Conflict	Learn/Practice Symptom Management
Adjust to Life-Cycle Transition	Identify Start/Root of Issue	Linkage to PCP or Comm'ty Medical Clinic
Assessment of Risk	Identify Triggers for Behavior	Obtain Medication Services
Complete Treatment as Planned	Identify/Acknowledge Trauma	Other
Develop Artistic/Creative Activities	Identify/Obtain Health Insurance	Participate in Mental Health Treatment
Develop Coping Skills to Manage Issue(s)	Improve Child-Parent Interactions	Participate in Recovery Classes
Develop Cultural Identity/Practices	Improve Family Relationships	Participate in Reunification Plan
Develop Recreational/Leisure Activities	Improve Self Identity/Esteem	Provide for Own Food/Clothing/Shelter
Develop Wellness Recovery Action Plan	Increase Quality Time in Relationship	Reduce Avoidance and Isolation
Develop/Follow Routine or Structure	Interact Appropriately with Others	Reduce Compulsive/Addictive Behavior
Develop/Practice Personal Safety Skills	Learn to Identify Symptoms	Reduce Family Stress
Develop/Use Journaling	Learn/Pract Appropriate Emotional Express	Reduce Frequency/Intensity of Symptoms
Develop/Use Relapse Prevention Plan	Learn/Practice Alternative Behaviors	Reduce Hopelessness and Desperation
Educate Parent/Guardian	Learn/Practice Anger Management	Reduce Hospitalization
Educate Spouse/Partner	Learn/Practice Communication Skills	Reduce Incarceration
Educate Support System/Family/Friends	Learn/Practice Community Living Skills	Reduce Individual Level of Stress
Encourage Connection to PrimaryCare Prov	Learn/Practice Coping Skills	Reduce Physical Aggression
Engage with Peer Recovery Resources	Learn/Practice Goal Setting	Reduce Reaction to Trauma Triggers
Evaluate/Change Education Environment	Learn/Practice Good Nutrition	Reduce Risk of Harm
Evaluate/Change Work Environment	Learn/Practice Good Sleep Habits	Reduce Self-Injurious Behaviors
Evaluate/Change/Stabilize LivingSituatio	Learn/Practice Healthy Boundaries	Reduce Social Anxiety
Exhibit Appropriate School Behavior	Learn/Practice Healthy Disagreement	Reduce Use of Drugs Including Alcohol
Expand and Utilize Support System	Learn/Practice Identifying Needs	Schedule/Attend Neuropsychological Eval
Explore Spirituality	Learn/Practice Maintaining Friendships	Understand Need for Medication
Identify/Access Community Activities	Learn/Practice Medication Adherence	
Identify Alternative Behaviors	Learn/Practice Organization and Planning	
Identify Barriers	Learn/Practice Pain Management	
Identify Behavioral Consequences	Learn/Practice Pers Daily Living Skills	
Identify Irrational Thoughts	Learn/Practice Problem Solving Skills	
Identify Issues Regarding Separation	Learn/Practice Public Transport Skills	

Area of Need: Family Stress

Goal: Reduce family stress

Objectives:

- | | | |
|--|---|--|
| Accept Feedback from Others | Identify Issues Regarding Separation | Participate in Recovery Classes |
| Access Resources/Natural Support in Comm | Identify Personal Strengths | Participate in Reunification Plan |
| Address Abuse/Neglect Issues | Identify Physical Health Care Needs | Reduce Avoidance and Isolation |
| Address Cultural Identity Issues | Identify Resources/Natural Support in Com | Reduce Compulsive/Addictive Behavior |
| Address Gender Identity/Practices Issues | Identify Source(s) of Family Conflict | Reduce Family Stress |
| Address Outstanding Financial Issues | Identify Start/Root of Issue | Reduce Frequency/Intensity of Symptoms |
| Address Outstanding Legal Issues | Identify Triggers for Behavior | Reduce Hospitalization |
| Address Sexual Issues | Identify/Acknowledge Trauma | Reduce Incarceration |
| Adjust to Life-Cycle Transition | Identify/Obtain Health Insurance | Reduce Individual Level of Stress |
| Assess Situation and Identify Needs | Improve Care Giving Skills | Reduce Physical Aggression |
| Assessment of Risk | Improve Child-Parent Interactions | Reduce Reaction to Trauma Triggers |
| Attend 12-Step Meetings Regularly | Improve Family Relationships | Reduce Risk of Harm |
| Attend Classes | Increase Quality Time in Relationship | Reduce Self-Injurious Behaviors |
| Complete Treatment as Planned | Interact Appropriately with Others | Reduce Use of Drugs Including Alcohol |
| Comply with Laws | Learn/Pract Appropriate Emotional Expres | Secure/Hold Stable Employment |
| Cooperate with Criminal Justice System | Learn/Practice Acculturation | |
| Develop Coping Skills to Manage Issue(s) | Learn/Practice Alternative Behaviors | |
| Develop Cultural Identity/Practices | Learn/Practice Anger Management | |
| Develop Recreational/Leisure Activities | Learn/Practice Communication Skills | |
| Develop Wellness Recovery Action Plan | Learn/Practice Coping Skills | |
| Develop/Follow Routine or Structure | Learn/Practice Goal Setting | |
| Develop/Practice Personal Safety Skills | Learn/Practice Good Sleep Habits | |
| Develop/Use Journaling | Learn/Practice Healthy Boundaries | |
| Educate Parent/Guardian | Learn/Practice Healthy Disagreement | |
| Educate Spouse/Partner | Learn/Practice Identifying Needs | |
| Educate Support System/Family/Friends | Learn/Practice Medication Adherence | |
| Engage with Peer Recovery Resources | Learn/Practice Money Management | |
| Evaluate/Change/Stabilize LivingSituatio | Learn/Practice Organization and Planning | |
| Exhibit Appropriate School Behavior | Learn/Practice Pers Daily Living Skills | |
| Expand and Utilize Support System | Learn/Practice Problem Solving Skills | |
| Explore Spirituality | Learn/Practice Relaxation Techniques | |
| Identify/Access Community Activities | Learn/Practice Self-Monitoring | |
| Identify Alternative Behaviors | Learn/Practice Social Skills | |
| Identify Barriers | Learn/Practice Symptom Management | |
| Identify Behavioral Consequences | Other | |

Area of Need: Financial
Goal: Improve financial situation
Objectives:

Access Resources/Natural Support in Comm
Address Outstanding Financial Issues
Address Outstanding Legal Issues
Assess Situation and Identify Needs
Assessment of Risk
Attend 12-Step Meetings Regularly
Attend Classes
Clarify Job Dissatisfaction
Complete Treatment as Planned
Develop Coping Skills to Manage Issue(s)
Develop/Follow Routine or Structure
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Evaluate/Change Work Environment
Evaluate/Change/Stabilize Living Situatio
Expand and Utilize Support System
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Patterns in Compulsive Behavior
Identify Personal Strengths
Identify Resources/Natural Support in Com
Identify Start/Root of Issue
Learn/Practice Alternative Behaviors
Learn/Practice Avoiding Impulsivity
Learn/Practice Communication Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Medication Adherence
Learn/Practice Money Management

Learn/Practice Organization and Planning
Learn/Practice Problem Solving Skills
Learn/Practice Self-Monitoring
Learn/Practice Symptom Management
Obtain Financial Assistance/Benefits
Obtain Legal Representation/Services
Other
Participate in Mental Health Treatment
Provide for Own Food/Clothes/Shelter
Reduce Compulsive/Addictive Behavior
Reduce Family Stress
Reduce Individual Level of Stress
Reduce Risk of Harm
Reduce Use of Drugs Including Alcohol
Secure/Hold Stable Employment

Area of Need: Identity Issues: Cultural/Gender

Goal: Reduce stress of identity issues

Objectives:

Access Resources/Natural Support in Comm
Address Abuse/Neglect Issues
Address Cultural Identity Issues
Address Gender Identity/Practices Issues
Address Sexual Issues
Adjust to Life-Cycle Transition
Complete Treatment as Planned
Develop Artistic/Creative Activities
Develop Coping Skills to Manage Issue(s)
Develop Recreational/Leisure Activities
Develop/Practice Personal Safety Skills
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Evaluate/Change Work Environment
Evaluate/Change/Stabilize Living Situatio
Exhibit Appropriate School Behavior
Expand and Utilize Support System
Explore Spirituality
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Personal Strengths
Identify Resources/Natural Support in Com
Identify Source(s) of Family Conflict
Identify/Acknowledge Trauma
Improve Care Giving Skills
Improve Self Identity/Esteem
Learn/Pract Appropriate Emotional Expres
Learn/Practice Alternative Behaviors
Learn/Practice Communication Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Healthy Boundaries

Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Maintaining Friendships
Learn/Practice Medication Adherence
Learn/Practice Problem Solving Skills
Learn/Practice Safe Sex
Learn/Practice Social Skills
Learn/Practice Symptom Management
Other
Reduce Avoidance and Isolation
Reduce Compulsive/Addictive Behavior
Reduce Individual Level of Stress
Reduce Self-Injurious Behaviors
Reduce Social Anxiety
Reduce Use of Drugs Including Alcohol
Understand Need for Medication

Area of Need: Intimate Relationships

Goal: Improve intimate relationships

Objectives:

Accept Feedback from Others
Access Resources/Natural Support in Comm
Address Abuse/Neglect Issues
Address Cultural Identity Issues
Address Gender Identity/Practices Issues
Address Outstanding Financial Issues
Address Outstanding Legal Issues
Address Sexual Issues
Adjust to Life-Cycle Transition
Assess Situation and Identify Needs
Assessment of Risk
Attend 12-Step Meetings Regularly
Complete Treatment as Planned
Comply with Laws
Cooperate with Criminal Justice System
Develop Coping Skills to Manage Issue(s)
Develop Recreational/Leisure Activities
Develop/Follow Routine or Structure
Develop/Practice Personal Safety Skills
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Expand and Utilize Support System
Explore Spirituality
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Issues Regarding Separation
Identify Personal Strengths
Identify Resources/Natural Support in Com
Identify Source(s) of Family Conflict
Identify Start/Root of Issue
Identify Triggers for Behavior
Identify/Acknowledge Trauma

Improve Care Giving Skills
Improve Child-Parent Interactions
Improve Family Relationships
Improve Self Identity/Esteem
Increase Quality Time in Relationship
Interact Appropriately with Others
Learn/Pract Appropriate Emotional Expres
Learn/Practice Alternative Behaviors
Learn/Practice Anger Management
Learn/Practice Communication Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Maintaining Friendships
Learn/Practice Medication Adherence
Learn/Practice Money Management
Learn/Practice Organization and Planning
Learn/Practice Problem Solving Skills
Learn/Practice Safe Sex
Learn/Practice Self-Monitoring
Learn/Practice Social Skills
Learn/Practice Symptom Management
Other
Participate in Reunification Plan
Reduce Avoidance and Isolation
Reduce Compulsive/Addictive Behavior
Reduce Family Stress
Reduce Frequency/Intensity of Symptoms
Reduce Hopelessness and Desperation
Reduce Individual Level of Stress
Reduce Physical Aggression
Reduce Reaction to Trauma Triggers
Reduce Risk of Harm
Reduce Self-Injurious Behaviors

Reduce Social Anxiety
Reduce Use of Drugs Including Alcohol
Secure/Hold Stable Employment
Understand Need for Medication

Area of Need: Lack of Physical Health Care

Goal: Obtain physical health care

Objectives:

Access Resources/Natural Support in Comm
Address Outstanding Financial Issues
Adjust to Life-Cycle Transition
Assessment of Risk
Complete Physical Exam and/or Lab Work
Complete Treatment as Planned
Develop Coping Skills to Manage Issue(s)
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Encourage Connection to PrimaryCare Prov
Engage with Peer Recovery Resources
Expand and Utilize Support System
Identify/Access Community Activities
Identify Barriers
Identify Physical Health Care Needs
Identify Resources/Natural Support in Com
Identify/Obtain Health Insurance
Learn/Practice Communication Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Identifying Needs
Learn/Practice Problem Solving Skills
Learn/Practice Public Transport Skills
Linkage to PCP or Comm'ty Medical Clinic
Obtain Medical/Dental Exam
Obtain Medication Services
Other
Reduce Family Stress
Reduce Individual Level of Stress
Reduce Risk of Harm

Area of Need: Legal
Goal: Fulfill legal obligations
Objectives:

Accept Feedback from Others
Access Resources/Natural Support in Comm
Address Outstanding Financial Issues
Address Outstanding Legal Issues
Assess Situation and Identify Needs
Assessment of Risk
Complete Treatment as Planned
Comply with Drug/Alcohol Screens
Comply with Laws
Cooperate with Criminal Justice System
Develop Coping Skills to Manage Issue(s)
Develop/Follow Routine or Structure
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Expand and Utilize Support System
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Patterns in Compulsive Behavior
Identify Personal Strengths
Identify Resources/Natural Support in Com
Identify Triggers for Behavior
Learn/Pract Appropriate Emotional Expres
Learn/Practice Alternative Behaviors
Learn/Practice Anger Management
Learn/Practice Avoiding Impulsivity
Learn/Practice Communication Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Medication Adherence
Learn/Practice Money Management

Learn/Practice Organization and Planning
Learn/Practice Problem Solving Skills
Learn/Practice Self-Monitoring
Learn/Practice Social Skills
Learn/Practice Symptom Management
Obtain Legal Representation/Services
Other
Reduce Family Stress
Reduce Frequency/Intensity of Symptoms
Reduce Hopelessness and Desperation
Reduce Incarceration
Reduce Individual Level of Stress
Reduce Physical Aggression
Reduce Risk of Harm
Reduce Use of Drugs Including Alcohol

Area of Need: Meaningful Role (tied to self-determination)

Goal: Increase self-determination

Objectives:

Accept Feedback from Others	Increase Quality Time in Relationship
Access Resources/Natural Support in Comm	Learn/Practice Community Living Skills
Address Abuse/Neglect Issues	Learn/Practice Coping Skills
Address Cultural Identity Issues	Learn/Practice Goal Setting
Address Gender Identity/Practices Issues	Learn/Practice Healthy Boundaries
Address Sexual Issues	Learn/Practice Healthy Disagreement
Adjust to Life-Cycle Transition	Learn/Practice Identifying Needs
Assess Interests and Abilities	Learn/Practice Job Skills
Assess Situation and Identify Needs	Learn/Practice Medication Adherence
Clarify Educational Needs	Learn/Practice Pers Daily Living Skills
Clarify Job Dissatisfaction	Learn/Practice Problem Solving Skills
Complete Treatment as Planned	Learn/Practice Regular Exercise
Comply with Laws	Learn/Practice Relaxation Techniques
Develop Artistic/Creative Activities	Learn/Practice Self-Monitoring
Develop Coping Skills to Manage Issue(s)	Learn/Practice Symptom Management
Develop Recreational/Leisure Activities	Other
Develop Wellness Recovery Action Plan	Participate in Education/Training Progrm
Educate Parent/Guardian	Reduce Avoidance and Isolation
Educate Spouse/Partner	Reduce Frequency/Intensity of Symptoms
Educate Support System/Family/Friends	Reduce Hospitalization
Engage with Peer Recovery Resources	Reduce Incarceration
Evaluate/Change Education Environment	Reduce Use of Drugs Including Alcohol
Evaluate/Change Work Environment	Secure/Hold Stable Employment
Evaluate/Change/Stabilize LivingSituatio	
Expand and Utilize Support System	
Explore Spirituality	
Identify/Access Community Activities	
Identify Alternative Behaviors	
Identify Barriers	
Identify Behavioral Consequences	
Identify Personal Strengths	
Identify Resources/Natural Support in Com	
Identify Start/Root of Issue	
Identify/Acknowledge Trauma	
Identify/Improve Technical Skills	
Improve Self Identity/Esteem	

Area of Need: Neglect/Abuse

Goal: Reduce threat to safety

Objectives:

Access Resources/Natural Support in Comm
Address Abuse/Neglect Issues
Address Cultural Identity Issues
Address Gender Identity/Practices Issues
Address Sexual Issues
Adjust to Life-Cycle Transition
Assess Situation and Identify Needs
Assessment of Risk
Attend Classes
Complete Physical Exam and/or Lab Work
Complete Treatment as Planned
Comply with Laws
Cooperate with Criminal Justice System
Develop Coping Skills to Manage Issue(s)
Develop Wellness Recovery Action Plan
Develop/Follow Routine or Structure
Develop/Practice Personal Safety Skills
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Evaluate/Change/Stabilize Living Situatio
Exhibit Appropriate School Behavior
Expand and Utilize Support System
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Issues Regarding Separation
Identify Personal Strengths
Identify Resources/Natural Support in Com
Identify Source(s) of Family Conflict
Identify Start/Root of Issue
Identify Triggers for Behavior
Identify/Acknowledge Trauma
Improve Care Giving Skills

Improve Child-Parent Interactions
Improve Family Relationships
Interact Appropriately with Others
Learn/Follow Housing Rules
Learn/Pract Appropriate Emotional Expres
Learn/Practice Alternative Behaviors
Learn/Practice Anger Management
Learn/Practice Communication Skills
Learn/Practice Community Living Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Medication Adherence
Learn/Practice Problem Solving Skills
Learn/Practice Safe Sex
Learn/Practice Self-Monitoring
Learn/Practice Symptom Management
Other
Participate in Recovery Classes
Participate in Reunification Plan
Reduce Family Stress
Reduce Frequency/Intensity of Symptoms
Reduce Hospitalization
Reduce Incarceration
Reduce Individual Level of Stress
Reduce Physical Aggression
Reduce Risk of Harm
Reduce Self-Injurious Behaviors
Reduce Use of Drugs Including Alcohol
Understand Need for Medication

Area of Need: Neurological/Brain Impairment

Goal: Improve daily functioning

Objectives:

Accept Feedback from Others	Learn/Pract Appropriate Emotional Express	Reduce Physical Aggression
Access Resources/Natural Support in Comm	Learn/Practice Alternative Behaviors	Reduce Risk of Harm
Address Cultural Identity Issues	Learn/Practice Anger Management	Reduce Self-Injurious Behaviors
Address Outstanding Legal Issues	Learn/Practice Communication Skills	Reduce Social Anxiety
Address Sexual Issues	Learn/Practice Community Living Skills	Reduce Use of Drugs Including Alcohol
Adjust to Life-Cycle Transition	Learn/Practice Coping Skills	Schedule/Attend Neuropsychological Eval
Attend Classes	Learn/Practice Goal Setting	Understand Need for Medication
Complete Treatment as Planned	Learn/Practice Good Nutrition	
Develop Artistic/Creative Activities	Learn/Practice Good Sleep Habits	
Develop Coping Skills to Manage Issue(s)	Learn/Practice Healthy Boundaries	
Develop Recreational/Leisure Activities	Learn/Practice Healthy Disagreement	
Develop Wellness Recovery Action Plan	Learn/Practice Identifying Needs	
Develop/Follow Routine or Structure	Learn/Practice Maintaining Friendships	
Develop/Practice Personal Safety Skills	Learn/Practice Medication Adherence	
Educate Parent/Guardian	Learn/Practice Money Management	
Educate Spouse/Partner	Learn/Practice Organization and Planning	
Educate Support System/Family/Friends	Learn/Practice Pers Daily Living Skills	
Encourage Connection to PrimaryCare Prov	Learn/Practice Problem Solving Skills	
Engage with Peer Recovery Resources	Learn/Practice Public Transport Skills	
Exhibit Appropriate School Behavior	Learn/Practice Regular Exercise	
Expand and Utilize Support System	Learn/Practice Relaxation Techniques	
Identify/Access Community Activities	Learn/Practice Safe Sex	
Identify Alternative Behaviors	Learn/Practice Self-Monitoring	
Identify Barriers	Learn/Practice Social Skills	
Identify Behavioral Consequences	Learn/Practice Symptom Management	
Identify Medication Side Effects	Linkage to PCP or Comm'ty Medical Clinic	
Identify Personal Strengths	Other	
Identify Physical Health Care Needs	Participate in Mental Health Treatment	
Identify Resources/Natural Support in Com	Participate in Recovery Classes	
Identify Start/Root of Issue	Provide for Own Food/Clothing/Shelter	
Identify Triggers for Behavior	Reduce Avoidance and Isolation	
Improve Child-Parent Interactions	Reduce Compulsive/Addictive Behavior	
Increase Quality Time in Relationship	Reduce Frequency/Intensity of Symptoms	
Interact Appropriately with Others	Reduce Hospitalization	
Learn to Identify Symptoms	Reduce Incarceration	
Learn/Follow Housing Rules	Reduce Individual Level of Stress	

Area of Need: Physical Health Problems

Goal: Improve physical health

Objectives:

Access Resources/Natural Support in Comm
Address Cultural Identity Issues
Address Gender Identity/Practices Issues
Address Outstanding Financial Issues
Address Sexual Issues
Adjust to Life-Cycle Transition
Assessment of Risk
Attend Classes
Complete Physical Exam and/or Lab Work
Complete Treatment as Planned
Develop Coping Skills to Manage Issue(s)
Develop Recreational/Leisure Activities
Develop Wellness Recovery Action Plan
Develop/Follow Routine or Structure
Develop/Use Relapse Prevention Plan
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Encourage Connection to PrimaryCare Prov
Engage with Peer Recovery Resources
Expand and Utilize Support System
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Medication Side Effects
Identify Patterns in Compulsive Behavior
Identify Personal Strengths
Identify Physical Health Care Needs
Identify Resources/Natural Support in Com
Identify Start/Root of Issue
Identify Triggers for Behavior
Identify/Obtain Health Insurance
Learn to Identify Symptoms
Learn/Practice Alternative Behaviors
Learn/Practice Communication Skills

Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Good Nutrition
Learn/Practice Good Sleep Habits
Learn/Practice Identifying Needs
Learn/Practice Medication Adherence
Learn/Practice Pain Management
Learn/Practice Pers Daily Living Skills
Learn/Practice Problem Solving Skills
Learn/Practice Regular Exercise
Learn/Practice Relaxation Techniques
Learn/Practice Safe Sex
Learn/Practice Self-Monitoring
Learn/Practice Symptom Management
Linkage to PCP or Comm'ty Medical Clinic
Obtain Medical/Dental Exam
Obtain Medication Services
Other
Participate in Medical/Dental Treatment
Reduce Compulsive/Addictive Behavior
Reduce Frequency/Intensity of Symptoms
Reduce Hospitalization
Reduce Individual Level of Stress
Reduce Risk of Harm
Reduce Self-Injurious Behaviors
Reduce Use of Drugs Including Alcohol
Schedule/Attend Neuropsychological Eval
Understand Need for Medication

Area of Need: Potential for Harm Self/Others

Goal: Reduce potential for harm

Objectives:

Accept Feedback from Others
Access Resources/Natural Support in Comm
Address Abuse/Neglect Issues
Address Sexual Issues
Assessment of Risk
Attend Classes
Complete Physical Exam and/or Lab Work
Complete Treatment as Planned
Cooperate with Criminal Justice System
Develop Coping Skills to Manage Issue(s)
Develop Wellness Recovery Action Plan
Develop/Follow Routine or Structure
Develop/Practice Personal Safety Skills
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Evaluate/Change/Stabilize Living Situation
Expand and Utilize Support System
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Personal Strengths
Identify Resources/Natural Support in Comm
Identify Source(s) of Family Conflict
Identify/Acknowledge Trauma
Improve Care Giving Skills
Improve Child-Parent Interactions
Improve Family Relationships
Learn to Identify Symptoms
Learn/Pract Appropriate Emotional Expressions
Learn/Practice Alternative Behaviors
Learn/Practice Anger Management
Learn/Practice Communication Skills

Learn/Practice Community Living Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Good Sleep Habits
Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Medication Adherence
Learn/Practice Personal Daily Living Skills
Learn/Practice Problem Solving Skills
Learn/Practice Regular Exercise
Learn/Practice Relaxation Techniques
Learn/Practice Safe Sex
Learn/Practice Self-Monitoring
Learn/Practice Symptom Management
Other
Participate in Education/Training Program
Participate in Mental Health Treatment
Participate in Reunification Plan
Reduce Compulsive/Addictive Behavior
Reduce Family Stress
Reduce Frequency/Intensity of Symptoms
Reduce Hospitalization
Reduce Incarceration
Reduce Individual Level of Stress
Reduce Physical Aggression
Reduce Risk of Harm
Reduce Self-Injurious Behaviors
Reduce Use of Drugs Including Alcohol
Understand Need for Medication

Area of Need: Social Functioning

Goal: Improve social functioning

Objectives:

Accept Feedback from Others	Identify Medication Side Effects	Learn/Practice Self-Monitoring
Access Resources/Natural Support in Comm	Identify Personal Strengths	Learn/Practice Social Skills
Address Abuse/Neglect Issues	Identify Resources/Natural Support in Com	Learn/Practice Symptom Management
Address Cultural Identity Issues	Identify Source(s) of Family Conflict	Other
Address Gender Identity/Practices Issues	Identify Start/Root of Issue	Participate in Education/Training Progrm
Address Outstanding Financial Issues	Identify Triggers for Behavior	Participate in Mental Health Treatment
Address Sexual Issues	Identify/Acknowledge Trauma	Participate in Recovery Classes
Adjust to Life-Cycle Transition	Improve Care Giving Skills	Participate in Reunification Plan
Assess Interests and Abilities	Improve Child-Parent Interactions	Reduce Avoidance and Isolation
Assess Situation and Identify Needs	Improve Family Relationships	Reduce Compulsive/Addictive Behavior
Assessment of Risk	Improve Self Identity/Esteem	Reduce Family Stress
Attend Classes	Increase Quality Time in Relationship	Reduce Frequency/Intensity of Symptoms
Complete Treatment as Planned	Interact Appropriately with Others	Reduce Hospitalization
Develop Artistic/Creative Activities	Learn to Identify Symptoms	Reduce Incarceration
Develop Coping Skills to Manage Issue(s)	Learn/Follow Housing Rules	Reduce Individual Level of Stress
Develop Cultural Identity/Practices	Learn/Pract Appropriate Emotional Expres	Reduce Physical Aggression
Develop Recreational/Leisure Activities	Learn/Practice Acculturation	Reduce Risk of Harm
Develop Wellness Recovery Action Plan	Learn/Practice Alternative Behaviors	Reduce Self-Injurious Behaviors
Develop/Follow Routine or Structure	Learn/Practice Anger Management	Reduce Social Anxiety
Develop/Practice Personal Safety Skills	Learn/Practice Communication Skills	Reduce Use of Drugs Including Alcohol
Educate Parent/Guardian	Learn/Practice Community Living Skills	Understand Need for Medication
Educate Spouse/Partner	Learn/Practice Coping Skills	
Educate Support System/Family/Friends	Learn/Practice Goal Setting	
Engage with Peer Recovery Resources	Learn/Practice Good Sleep Habits	
Evaluate/Change Education Environment	Learn/Practice Healthy Boundaries	
Evaluate/Change Work Environment	Learn/Practice Healthy Disagreement	
Evaluate/Change/Stabilize LivingSituatio	Learn/Practice Identifying Needs	
Exhibit Appropriate School Behavior	Learn/Practice Maintaining Friendships	
Expand and Utilize Support System	Learn/Practice Medication Adherence	
Explore Spirituality	Learn/Practice Organization and Planning	
Identify/Access Community Activities	Learn/Practice Pers Daily Living Skills	
Identify Alternative Behaviors	Learn/Practice Problem Solving Skills	
Identify Barriers	Learn/Practice Public Transport Skills	
Identify Behavioral Consequences	Learn/Practice Regular Exercise	
Identify Irrational Thoughts	Learn/Practice Relaxation Techniques	
Identify Issues Regarding Separation	Learn/Practice Safe Sex	

Area of Need: Spiritual
Goal: Increase inner peace
Objectives:

Accept Feedback from Others	Learn to Identify Symptoms
Access Resources/Natural Support in Comm	Learn/Pract Appropriate Emotional Expres
Address Cultural Identity Issues	Learn/Practice Alternative Behaviors
Address Gender Identity/Practices Issues	Learn/Practice Anger Management
Address Outstanding Financial Issues	Learn/Practice Communication Skills
Address Outstanding Legal Issues	Learn/Practice Coping Skills
Address Sexual Issues	Learn/Practice Goal Setting
Adjust to Life-Cycle Transition	Learn/Practice Healthy Disagreement
Attend Classes	Learn/Practice Identifying Needs
Complete Treatment as Planned	Learn/Practice Maintaining Friendships
Develop Artistic/Creative Activities	Learn/Practice Medication Adherence
Develop Coping Skills to Manage Issue(s)	Learn/Practice Organization and Planning
Develop Recreational/Leisure Activities	Learn/Practice Problem Solving Skills
Develop/Follow Routine or Structure	Learn/Practice Regular Exercise
Develop/Practice Personal Safety Skills	Learn/Practice Relaxation Techniques
Develop/Use Journaling	Learn/Practice Self-Monitoring
Educate Parent/Guardian	Learn/Practice Symptom Management
Educate Spouse/Partner	Other
Educate Support System/Family/Friends	Participate in Reunification Plan
Engage with Peer Recovery Resources	Reduce Avoidance and Isolation
Exhibit Appropriate School Behavior	Reduce Compulsive/Addictive Behavior
Expand and Utilize Support System	Reduce Family Stress
Explore Spirituality	Reduce Frequency/Intensity of Symptoms
Identify/Access Community Activities	Reduce Hospitalization
Identify Alternative Behaviors	Reduce Incarceration
Identify Barriers	Reduce Individual Level of Stress
Identify Behavioral Consequences	Reduce Physical Aggression
Identify Personal Strengths	Reduce Reaction to Trauma Triggers
Identify Resources/Natural Support in Com	Reduce Risk of Harm
Identify Source(s) of Family Conflict	Reduce Self-Injurious Behaviors
Identify Start/Root of Issue	Reduce Social Anxiety
Identify Triggers for Behavior	Understand Need for Medication
Identify/Acknowledge Trauma	
Improve Self Identity/Esteem	
Increase Quality Time in Relationship	
Interact Appropriately with Others	

Area of Need: Stress

Goal: Reduce Stress

Objectives:

Accept Feedback from Others	Identify/Access Community Activities	Learn/Practice Maintaining Friendships
Access Resources/Natural Support in Comm	Identify Alternative Behaviors	Learn/Practice Medication Adherence
Address Abuse/Neglect Issues	Identify Barriers	Learn/Practice Money Management
Address Cultural Identity Issues	Identify Behavioral Consequences	Learn/Practice Organization and Planning
Address Gender Identity/Practices Issues	Identify Issues Regarding Separation	Learn/Practice Pers Daily Living Skills
Address Outstanding Financial Issues	Identify Personal Strengths	Learn/Practice Problem Solving Skills
Address Outstanding Legal Issues	Identify Physical Health Care Needs	Learn/Practice Regular Exercise
Address Sexual Issues	Identify Resources/Natural Support in Com	Learn/Practice Relaxation Techniques
Adjust to Life-Cycle Transition	Identify Source(s) of Family Conflict	Learn/Practice Safe Sex
Assessment of Risk	Identify Triggers for Behavior	Learn/Practice Self-Monitoring
Attend Classes	Identify/Acknowledge Trauma	Learn/Practice Social Skills
Clarify Job Dissatisfaction	Identify/Improve Technical Skills	Learn/Practice Symptom Management
Complete Physical Exam and/or Lab Work	Improve Care Giving Skills	Linkage to PCP or Comm'ty Medical Clinic
Complete Treatment as Planned	Improve Child-Parent Interactions	Other
Cooperate with Criminal Justice System	Improve Family Relationships	Participate in Mental Health Treatment
Develop Artistic/Creative Activities	Improve Self Identity/Esteem	Participate in Recovery Classes
Develop Coping Skills to Manage Issue(s)	Increase Quality Time in Relationship	Participate in Reunification Plan
Develop Recreational/Leisure Activities	Interact Appropriately with Others	Reduce Avoidance and Isolation
Develop Wellness Recovery Action Plan	Learn to Identify Symptoms	Reduce Compulsive/Addictive Behavior
Develop/Follow Routine or Structure	Learn/Follow Housing Rules	Reduce Family Stress
Develop/Practice Personal Safety Skills	Learn/Pract Appropriate Emotional Expres	Reduce Frequency/Intensity of Symptoms
Educate Parent/Guardian	Learn/Practice Alternative Behaviors	Reduce Hospitalization
Educate Spouse/Partner	Learn/Practice Anger Management	Reduce Incarceration
Educate Support System/Family/Friends	Learn/Practice Communication Skills	Reduce Individual Level of Stress
Encourage Connection to PrimaryCare Prov	Learn/Practice Community Living Skills	Reduce Physical Aggression
Engage with Peer Recovery Resources	Learn/Practice Coping Skills	Reduce Reaction to Trauma Triggers
Evaluate/Change Education Environment	Learn/Practice Goal Setting	Reduce Risk of Harm
Evaluate/Change Work Environment	Learn/Practice Good Nutrition	Reduce Self-Injurious Behaviors
Evaluate/Change/Stabilize LivingSituatio	Learn/Practice Good Sleep Habits	Reduce Social Anxiety
Exhibit Appropriate School Behavior	Learn/Practice Healthy Boundaries	Reduce Use of Drugs Including Alcohol
Expand and Utilize Support System	Learn/Practice Healthy Disagreement	Secure/Hold Stable Employment
Explore Spirituality	Learn/Practice Identifying Needs	Understand Need for Medication

Area of Need: Trauma

Goal: Reduce effects of trauma

Objectives:

Accept Feedback from Others
Access Resources/Natural Support in Comm
Address Abuse/Neglect Issues
Address Cultural Identity Issues
Address Gender Identity/Practices Issues
Address Sexual Issues
Assessment of Risk
Attend Classes
Complete Physical Exam and/or Lab Work
Complete Treatment as Planned
Develop Coping Skills to Manage Issue(s)
Develop Wellness Recovery Action Plan
Develop/Follow Routine or Structure
Develop/Practice Personal Safety Skills
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Expand and Utilize Support System
Explore Spirituality
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Irrational Thoughts
Identify Issues Regarding Separation
Identify Patterns in Compulsive Behaviors
Identify Personal Strengths
Identify Physical Health Care Needs
Identify Resources/Natural Support in Com
Identify Source(s) of Family Conflict
Identify Triggers for Behavior

Identify/Acknowledge Trauma
Improve Care Giving Skills
Improve Child-Parent Interactions
Improve Family Relationships
Improve Self Identity/Esteem
Interact Appropriately with Others
Learn to Identify Symptoms
Learn/Pract Appropriate Emotional Expres
Learn/Practice Alternative Behaviors
Learn/Practice Anger Management
Learn/Practice Communication Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Maintaining Friendships
Learn/Practice Medication Adherence
Learn/Practice Problem Solving Skills
Learn/Practice Relaxation Techniques
Learn/Practice Self-Monitoring
Learn/Practice Symptom Management
Other
Participate in Reunification Plan
Reduce Avoidance and Isolation
Reduce Compulsive/Addictive Behavior
Reduce Family Stress
Reduce Frequency/Intensity of Symptoms
Reduce Hospitalization
Reduce Incarceration
Reduce Individual Level of Stress
Reduce Physical Aggression

Reduce Reaction to Trauma Triggers
Reduce Risk of Harm
Reduce Self-Injurious Behaviors
Reduce Social Anxiety
Reduce Use of Drugs Including Alcohol
Schedule/Attend Neuropsychological Eval
Understand Need for Medication

Area of Need: Vocational/Employment

Goal: Improve vocational status

Objectives:

Accept Feedback from Others
Access Resources/Natural Support in Comm
Address Outstanding Financial Issues
Adjust to Life-Cycle Transition
Attend Classes
Clarify Educational Needs
Clarify Jon Dissatisfaction
Complete Treatment as Planned
Develop Coping Skills to Manage Issue(s)
Develop/Follow Routine or Structure
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Evaluate/Change Education Environment
Evaluate/Change Work Environment
Exhibit appropriate School Behavior
Expand and Utilize Support System
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Personal Strengths
Identify Recources/NaturalSupport in Com
Identify/Improve Technical Skills
Learn/Pract Appropriate Emotioanl Expres
Learn/Practice Alternative Behaviors
Learn/Practice Anger Management
Learn/Practice Communication Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Good Sleep Habits

Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Job Skills
Learn/Practice Medication Adherence
Learn/Practice Money Management
Learn/Practice Organization and Planning
Learn/Practice Pers Daily Living Skills
Learn/Practice Problem Solving Skills
Learn/Practice Transport Skills
Learn/Practice Self-Monitoring
Learn/Practice Social Skills
Learn/Practice Symptom Management
Other
Participate in Education/Training Program
Reduce Frequency/Intensity of Symptoms
Reduce Individual Level of Stress
Reduce Physical Aggression
Reduce Social Anxiety
Reduce Use of Drugs Including Alcohol
Secure/Hold Stable Employment
Understand Need for Medication

- WHEN:** “My Safety Plan” should be completed when there is risk or concern that crisis intervention may be needed. It should be updated throughout treatment as needed.
- ON WHOM:** As clinically indicated.
- COMPLETED BY:** Client, guardian (if applicable), and service provider. Formulation of the plan is a collaborative effort. A copy of the plan will be given to the client and/or caregiver.
- MODE OF COMPLETION:** Handwritten or typed. A hard copy shall be filed in paper hybrid chart. Document the completion of the plan in the Electronic Health Record (EHR).
- REQUIRED ELEMENTS:** All elements are required.
- NOTE:**
- “My Safety Plan” is intended to be a helpful resource for clients and families during times of crises or risk of crises. This form replaced the “Crisis Prevention Plan” and “Crisis Recovery Plan”. Additionally, it shall be completed in lieu of a “Safety Contract” and “No Harm Contract”.
 - In reference to item #2 on “My Safety Plan”, include both client’s words/preferences, and clinically appropriate interventions, as well as helpful things client identified in their WRAP Plan if he/she completed one.
 - In reference to item #3 on “My Safety Plan”, list as many relevant supports as available. Do not limit to just professional supports.
 - In reference to item #5 on “My Safety Plan”, list professional supports such as the client’s counselor, Care Coordinator, and the program’s on-call counselor after business hours.

My Safety Plan

We understand that there may be times when life feels overwhelming. During these times, sometimes people feel hopeless or think things will never get better. Your safety is our highest priority and our goal is to help you stay safe when difficult times arise. The items below help to identify when you may need more support and action steps you and the people in your life can take to help.

1. Early warning signs that tell me I may need help are:

2. Things I can do to help myself during these times are:

3. People who can support me (family, friends, community, etc.) are (list name, relationship and phone numbers):

Name	Relationship	Phone Number

4. Things my support persons can do to help are:

5. Members of my treatment team I can call:

Name	Relationship	Phone Number

6. If the above resources are not available, other community resources available to me are (check all that apply):

- The Access & Crisis Line at 888-724-7240.** Available 24 hours/7 days a week. Languages other than English are available.
- 911.** If you feel you are in immediate danger of emergency, do not hesitate to call. Ask if PERT is available.
- San Diego County Emergency Psychiatric Unit at 619-692-8200, located at 3853 Rosecrans Street, San Diego, CA 92110.** Available to adults for emergency psychiatric assistance.
- San Diego County Emergency Screening Unit at 619-421-6900, located at 730 Medical Center Court, Chula Vista, CA, 91911.** Available to children and adolescents for emergency psychiatric assistance.
- Youth Talkline at 1-877-450-5463.** For children and teens seeking peer support and referrals concerning substance abuse or mental health issues for themselves or someone they care about. Mon – Fri, 12 p.m. – 6 p.m.
- Consumer-to-Consumer WARM Line at 1-800-930-9276 (WARM).** Daily: 3:30 p.m.—11:00 p.m.
- National Suicide Prevention Hotline at 1-800-273-8255 (TALK).** A 24-hour hotline available to anyone in crisis.
- SD County Behavioral Health Emergency Response Plan (ERP).** This is a document for me to fill out and keep with me. It has important information to share with emergency response teams if they are called to assist me. (If checked, this indicates you've completed an ERP).
- Other** (list name and phone #) _____

Hospital or Crisis House of choice: (list name and phone #): _____

I understand that the staff is trying to help me and I will do my best to stay safe .

Client Signature: _____ Date Signed: _____

Parent/Guardian Signature: _____ Date Signed: _____

Mi Plan de Seguridad

Entendemos que puede haber etapas en la vida cuando uno se siente agobiado. Durante estas etapas, a veces la gente se siente sin esperanza o piensa que las cosas nunca se mejorarán. Tu seguridad es nuestra prioridad más alta y nuestra meta es ayudarte a mantenerte seguro cuando ocurran estas etapas. Los siguientes puntos ayudan a identificar los momentos en los que podrías necesitar más apoyo, y los pasos de acción que las personas en tu vida pueden tomar para ayudarte.

1. Primera señales de alarma que me indican que puedo necesitar ayuda son: _____

2. Las cosas que puedo hacer para ayudarme durante estos tiempos son: _____

3. Las personas que pueden apoyarme (familia, amigos, comunidad, etc.) son (escribe el nombre, relación y números de teléfonos):

Nombre	Relación	Número de Teléfono

4. Las cosas que mis personas de apoyo pueden hacer para auxiliarme: _____

5. Los miembros de mi equipo de tratamiento (consejero, siquiatra, terapeuta) que puedo llamar:

Nombre	Relación	Número de Teléfono

6. Si los recursos mencionados arriba no están a mi disposición, otros recursos de la comunidad que están a mi disposición son (seleccione todos lo que apliquen):

- Línea de Acceso y Crisis al 1-888-724-7240.** Disponible las 24 horas/7 días a la semana. Otros idiomas disponibles.
- 911.** Si usted siente que está en peligro inmediato, no dude en llamar. Pregunte si PERT (Equipo de Respuesta Frente a una Emergencia Psiquiátrica) está disponible.
- Unidad/Hospital Psiquiátrica del Condado de San Diego al 619-692-8200, localizada en 3853 Rosecrans Street, San Diego, CA, 92110.** Disponible para Adultos para asistencia psiquiátrica de emergencia.
- Unidad de Chequeo de Urgencia del Condado de San Diego al 619-421-6900, localizada en 730 Medical Center Court, Chula Vista, Ca, 91911.** Disponible para niños y adolescentes para asistencia psiquiátrica de emergencia.
- Línea de Apoyo para Jóvenes Peer2Peer al 1-877-450-5463.** Para niños y adolescentes que buscan apoyo y recursos acerca de abuso de drogas o salud mental para ellos mismos o para sus seres queridos. Lunes a Viernes, 12 pm – 6 pm.
- Línea de WARM (Apoyo al Consumidor) al 1-800-930-9276 (WARM).** Diario: 3:30 pm – 11 pm.
- Línea Nacional de Prevención de Suicidio al 1-800-273-8255 (TALK).** Una línea de acceso disponible a cualquier persona en crisis las 24 horas.
- Plan de Respuesta a un Urgencia de la Salud Conductual del Condado de San Diego (ERP).** Este es un documento para que yo lo llene y conserve conmigo. Contiene la información importante para compartir con el equipo de respuesta a una emergencia si son llamados para asistirme. (De ser seleccionado, esto indica que usted ha completado un ERP).
- Otro: Centro de Crisis Rady Children's al 1-760-730-5900.** Asistencia de salud mental urgente para personas menores de 17 años. Lunes a Viernes, 12 pm – 8 pm.
- Otros** (escriba el nombre y número de teléfono): _____

Hospital o Casa de Crisis de su preferencia: (escriba el nombre y # de teléfono): _____

Entiendo que el personal de este programa trata de ayudarme y haré todo lo posible por mantenerme seguro/a.

Nombre del Cliente: _____ **Firma del Cliente:** _____ **Fecha:** _____

Firma del Padre/ Tutor Legal: _____ **Fecha:** _____

Day Programs & Ancillary Services

NOTE:

Forms are generated by OptumHealth (Optum) which became the Point of Authorization for Day Intensive and Day Rehabilitation Programs (Half or Full) on 01-01-03. Outpatient Mental Health Services (MHS) offered on the same day (ancillary services) must also be authorized by Optum, with the CMBR component still subject to outpatient Utilization Management/Review (UM/UR). Medication only cases, TBS, and unplanned services such as Crisis Intervention (CI) are excluded from the Optum and UM/UR authorization process.

In circumstances where retroactive authorization is needed, it may be granted through Optum. Department of Mental Health (DMH) will not accept claims that are over one year old, and it takes up to 3 months for services to clear the system and be claimed. Thus, retroactive authorization should not be requested for services more than 9 months in the past. The Program Monitor must be notified via e-mail when submitting a retroactive authorization request.

Clients placed through Child Welfare continue to require a quarterly report to be completed and submitted to the Child Welfare Worker – the DPR will not suffice.

WHEN:

- Prior authorization is required for Day Programs that occur more than five days per week.
- Initial authorization for Day Programs (and therefore ancillary programs) must be obtained by the seventh visit or twenty days after the Day Provider opens a client episode in EHR (whichever comes first).
- **Day Intensive must be re-authorized every three months.** Utilizing the Continued Day Program Request Form. Submitted to OPTUM at least 15 days before previous authorization expires. (For Day Intensive an authorization cycle may look like: Initial DPR 1/1/06 - 3/31/06, Continued DPR 4/1/06 - 6/30/06, etc.)
- **Day Rehabilitation must be re-authorized every six months.** Utilizing the Continued Day Program Request Form. Submitted to OPTUM at least 15 days before previous authorization expires. (For Day Rehab an authorization cycle may look like: Initial DPR 1/1/06 - 5/31/06, Continued DPR 6/1/06 - 11/30/06, etc.)
- Outpatient providers (ancillary services) treating a client who is enrolled in a Day Program must obtain authorization through the Day Program Provider. Authorization is only required for Mental Health Services (not for Medication Support, TBS, Crisis Intervention, or CMBR which follow outpatient UR procedures). Ancillary providers must submit the Specialty Mental Health Services DPR Form to the Day Provider at least fifteen days prior to the end of the previous authorization so all forms can be submitted to OPTUM.

**INITIAL DAY PROGRAM REQUEST, CONTINUED DAY PROGRAM REQUEST
SPECIALTY MENTAL HEALTH SERVICES DPR**

2014

- ON WHOM:** All day program clients. Only DPRs for MediCal clients are to be submitted to Optum for review.
- Outpatient (ancillary services) clients who are simultaneously enrolled in a Day Program obtain authorization through the Day Provider (until the client leaves the day treatment program). All providers are to ensure no duplication of service occurs.
- COMPLETED BY:** Request submitted by: MD, Clinical or waived Psychologist, licensed or waived LCSW, licensed or waived MFT, RN (with Masters Degree and psychiatric specialty), or trainee with co-signature by LPHA.
- MODE OF COMPLETION:** Legibly handwritten, typed, or word-processed on most current OPTUM form(s). Authorization request forms are available on line at www.Optumpublicsector.com/sandiego/sdforms.htm
- REQUIRED ELEMENTS:** Staff requesting services must complete all sections of the form that correspond with the requested authorization period.
- Adult, Child and Youth Ancillary Service Necessity Criteria
 - CFARS
 - Signatures
- NOTE:** DPR forms were revised in August 2005, and implemented by October 1, 2005. DPR now include the CFARS which provides clinicians a standardized measure to evaluate client's progress. Starting in July 1, 2005 the CFARS findings are entered and tracked by the SOCE Data Entry System at the program level and downloaded to the SOCE team quarterly. This is done at intake, every 3 or 6 months (depending on authorization cycle), and at discharge (using the discharge summary MHS-653 form). Having a standardized measure allows for tracking and trending treatment effectiveness on a client and program level, and provides a move towards evidence based treatment.
- DPRs should be filed in the medical record in the Plans section, or be accessible upon request. Optum will generate an Authorization Letter and send it to the Provider at the address provided to Optum within 14 business days. If a Provider does not receive the Letter within the 14 day timeline and is unable to access the information in EHR, please contact OPTUM directly. Authorization Letters should be attached to the corresponding DPR.

<p>This form should be used to request authorization of payment for Specialty Mental Health Services.</p>	<p>County of San Diego Mental Health Plan Specialty Mental Health Services DPR</p> <div style="border: 1px solid black; width: 100%; height: 20px; margin: 5px 0;">RECEIVED:</div>	<p>Form must be submitted to OptumHealth Public Sector by client's Day Program provider. OptumHealth Public Sector cannot accept this form if submitted by Specialty Mental Health Services Provider</p>
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CLIENT INFORMATION *****CONFIDENTIAL*****

Client Name: <i>(First & Last)</i> _____	Client Anasazi ID #: _____	Date of Birth _____
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DAY PROGRAM INFORMATION

Legal Entity & Day Program Name: *Please print clearly*
 _____ Phone: : _____
 Day Program Unit# _____ Subunit# _____

SPECIALTY MENTAL HEALTH SERVICES PROGRAM INFORMATION

Legal Entity & Specialty Mental Health Program Name: *Please print clearly*
 _____ Phone: : _____
 Specialty Mental Health Program Uni# _____ Subunit# _____

REQUEST FOR AUTHORIZATION of Specialty Mental Health Services delivered by Organizational County Contracted providers on the same day as Day Program Services.

*** Treatment must include coordination with the other professionals treating client. Authorization is required only for ancillary services delivered on the same day client receives Day Program Services. Ancillary Services delivered to client in an Intensive Day Program require continued authorization within 3 months. Ancillary Services delivered to client in a Day Rehab program require continued authorization within 6 months. Medication Management, Case Management, TBS, and Crisis Intervention Services do not require authorization. ***

Complete the request by writing below the total # of visits requested per week to include all Individual Mental Health Services, Collateral Mental Health Services, Group Mental Health Services, or Other Mental Health Services covered under Specialty Mental Health Services.

Request: Specialty Mental Health Services _____ sessions per week.

Start date of this authorization: ____/____/____ End date of this authorization: ____/____/____
MM/DD/YYYY MM/DD/YYYY

Ancillary Assignment Open Date: ____/____/____

Community services/self help do not require authorization but must be coordinated comprehensively with all mental health and psychosocial rehab services.
 Community services/self help (please list) _____

ADULT/OLDER ADULT Ancillary Service Necessity Criteria: CHECK ALL THAT APPLY and complete description.

- The client is unable to receive these services while attending the Day Rehabilitation program due to client's specific clinical needs or family/caregiver needs. (Describe needs) _____
- Client transition issues make these services necessary for a time limited interval. (Describe why transition services are needed and length of interval) _____
- These concurrent services are essential to coordination of care. (Describe why services are essential for coordination) _____

CHILD and YOUTH Ancillary Service Necessity Criteria: CHECK ALL THAT APPLY and complete description.

- Requested service(s) is not available through the day program. (Describe why service is not available through day program) _____
- Continuity or transition issues make these services necessary for a time limited interval. (Describe why transition services are needed and time interval) _____
- These concurrent services are essential to coordination of care. (Describe why services are essential for coordination) _____

CURRENT FUNCTIONING (CFARS Rating) :

1	2	3	4	5	6	7	8	9
No problem	Less than Slight	Slight Problem	Slight to Moderate	Moderate Problem	Moderate to Severe	Severe Problem	Severe to Extreme	Extreme Problem
Depression				Anxiety				
<input type="checkbox"/> Depressed Mood		<input type="checkbox"/> Happy		<input type="checkbox"/> Sleep Problems		<input type="checkbox"/> Anxious/Tense		<input type="checkbox"/> Guilt
<input type="checkbox"/> Sad		<input type="checkbox"/> Hopeless		<input type="checkbox"/> Lacks Energy / Interest		<input type="checkbox"/> Phobic		<input type="checkbox"/> Anti-Anxiety Meds
<input type="checkbox"/> Irritable		<input type="checkbox"/> Withdrawn		<input type="checkbox"/> Anti-Depression Meds		<input type="checkbox"/> Obsessive		<input type="checkbox"/> Panic
Hyper activity				Thought Process				
<input type="checkbox"/> Manic		<input type="checkbox"/> Inattentive		<input type="checkbox"/> Agitated		<input type="checkbox"/> Illogical		<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Sleep Deficit		<input type="checkbox"/> Overactive / Hyperactive		<input type="checkbox"/> Mood Swings		<input type="checkbox"/> Paranoid		<input type="checkbox"/> Command Hallucinations
<input type="checkbox"/> Pressured Speech		<input type="checkbox"/> Relaxed		<input type="checkbox"/> Impulsivity		<input type="checkbox"/> Derailed Thinking		<input type="checkbox"/> Intact
<input type="checkbox"/> ADHD Meds		<input type="checkbox"/> Anti-Manic Meds				<input type="checkbox"/> Oriented		<input type="checkbox"/> Anti-Psych Meds
Cognitive Performance				Medical / Physical				
<input type="checkbox"/> Poor Memory		<input type="checkbox"/> Low Self-Awareness		<input type="checkbox"/> Acute Illness		<input type="checkbox"/> Hypochondria		<input type="checkbox"/> Good Health
<input type="checkbox"/> Poor Attention/Concentration		<input type="checkbox"/> Developmental Disability		<input type="checkbox"/> CNS Disorder		<input type="checkbox"/> Chronic Illness		<input type="checkbox"/> Need Med./Dental Care
<input type="checkbox"/> Insightful		<input type="checkbox"/> Concrete Thinking		<input type="checkbox"/> Pregnant		<input type="checkbox"/> Poor Nutrition		<input type="checkbox"/> Enuretic/ Encopretic
<input type="checkbox"/> Impaired Judgment		<input type="checkbox"/> Slow Processing		<input type="checkbox"/> Eating Disorder		<input type="checkbox"/> Seizures		<input type="checkbox"/> Stress-Related Illness
Traumatic Stress				Substance Use				
<input type="checkbox"/> Acute		<input type="checkbox"/> Dreams/Nightmares		<input type="checkbox"/> Alcohol		<input type="checkbox"/> Drug(s)		<input type="checkbox"/> Dependence
<input type="checkbox"/> Chronic		<input type="checkbox"/> Detached		<input type="checkbox"/> Abuse		<input type="checkbox"/> Over the Counter Drugs		<input type="checkbox"/> Cravings/Urges
<input type="checkbox"/> Avoidance		<input type="checkbox"/> Repression/Amnesia		<input type="checkbox"/> DUI		<input type="checkbox"/> Abstinent		<input type="checkbox"/> I.V . Drugs
<input type="checkbox"/> Upsetting Memories		<input type="checkbox"/> Hyper Vigilance		<input type="checkbox"/> Recovery		<input type="checkbox"/> Interfere w/Functioning		<input type="checkbox"/> Med. Control
Interpersonal Relationships				Behavior in "Home" Setting				
<input type="checkbox"/> Problems w/Friends		<input type="checkbox"/> Diff. Estab./ Maintain		<input type="checkbox"/> Disregards Rules		<input type="checkbox"/> Defies Authority		
<input type="checkbox"/> Poor Social Skills		<input type="checkbox"/> Age-Appropriate Group		<input type="checkbox"/> Conflict w/Sibling or Peer		<input type="checkbox"/> Conflict w/Parent or Caregiver		
<input type="checkbox"/> Adequate Social Skills		<input type="checkbox"/> Supportive Relationships		<input type="checkbox"/> Conflict w/Relative		<input type="checkbox"/> Respectful		
<input type="checkbox"/> Overly Shy				<input type="checkbox"/> Responsible				
ADL Functioning				Socio-Legal				
<input type="checkbox"/> Handicapped		<input type="checkbox"/> Not Age Appropriate In:		<input type="checkbox"/> Disregards Rules		<input type="checkbox"/> Offense/Property		<input type="checkbox"/> Offense/Person
<input type="checkbox"/> Permanent Disability		<input type="checkbox"/> Communication		<input type="checkbox"/> Self Care		<input type="checkbox"/> Fire Setting		<input type="checkbox"/> Pending Charges
<input type="checkbox"/> No Known Limitations		<input type="checkbox"/> Hygiene		<input type="checkbox"/> Recreation		<input type="checkbox"/> Dishonest		<input type="checkbox"/> Incompetent to Proceed
		<input type="checkbox"/> Mobility		<input type="checkbox"/> Detention/ Commitment				<input type="checkbox"/> Street Gang Member
Select: <input type="checkbox"/> Work <input type="checkbox"/> School				Danger to Self				
<input type="checkbox"/> Absenteeism		<input type="checkbox"/> Poor Performance		<input type="checkbox"/> Regular		<input type="checkbox"/> Suicidal Ideation		<input type="checkbox"/> Current Plan
<input type="checkbox"/> Dropped Out		<input type="checkbox"/> Learning disabilities		<input type="checkbox"/> Seeking		<input type="checkbox"/> Past Attempt		<input type="checkbox"/> Self-Injury
<input type="checkbox"/> Employed		<input type="checkbox"/> Doesn't Read/Write		<input type="checkbox"/> Tardiness		<input type="checkbox"/> "Risk-Taking" Behavior		<input type="checkbox"/> Serious Self-Neglect
<input type="checkbox"/> Defies Authority		<input type="checkbox"/> Not Employed		<input type="checkbox"/> Suspended				<input type="checkbox"/> Inability to Care for Self
<input type="checkbox"/> Disruptive		<input type="checkbox"/> Terminated/ Expelled		<input type="checkbox"/> Skips Class				
Danger to Others				Security/ Management Needs				
<input type="checkbox"/> Violent Temper		<input type="checkbox"/> Threatens Others		<input type="checkbox"/> Home w/o Supervision		<input type="checkbox"/> Suicide Watch		
<input type="checkbox"/> Causes Serious Injury		<input type="checkbox"/> Homicidal Ideation		<input type="checkbox"/> Behavioral Contract		<input type="checkbox"/> Locked Unit		
<input type="checkbox"/> Use of Weapons		<input type="checkbox"/> Homicidal Threats		<input type="checkbox"/> Protection from Others		<input type="checkbox"/> Seclusion		
<input type="checkbox"/> Assaultive		<input type="checkbox"/> Homicide Attempt		<input type="checkbox"/> Home w/Supervision		<input type="checkbox"/> Run/Escapes Risk		
<input type="checkbox"/> Cruelty to Animals		<input type="checkbox"/> Accused of Sexual Assault		<input type="checkbox"/> Restraint		<input type="checkbox"/> Involuntary Exam/ Commitment		
<input type="checkbox"/> Does not appear dangerous to Others		<input type="checkbox"/> Physically Aggressive		<input type="checkbox"/> Time-Out		<input type="checkbox"/> PRN Medications		
				<input type="checkbox"/> Monitored House Arrest		<input type="checkbox"/> One-to-One Supervision		

Clinician requesting authorization: (print) _____ Phone: _____ Date: _____

Countersignature by Licensed Clinician: _____ Phone: _____ Date: _____

CLIENT INFORMATION ****CONFIDENTIAL****		
Client Name: <i>(First & Last)</i>	Client Anasazi ID #:	Date of Birth:

CLIENT AREAS of STRENGTH	DESCRIBE STRENGTHS IN DETAIL (For children, include family strengths)
Job, School, Daily Activities	
Relationships, Family, Social Supports	
Social Activities, Interests	

TREATMENT GOALS: List goals directed at improving functioning. Progress Rating Scale: N – New Goal, 1 – Much worse, 2 – Somewhat worse, 3 – No change, 4 – Slight Improvement, 5 – Great improvement, R – Resolved			
Measurable Behavioral Goal:	As Demonstrated by:	Method(s) for Achieving Goal	Progress since last report

Client received psychiatric evaluation? <input type="checkbox"/> Yes <input type="checkbox"/> No NAME OF PSYCHIATRIST:			
CURRENT MEDICATIONS	Current Dose	CURRENT MEDICATIONS	Current Dose

REQUIRED ATTACHMENTS
<p>PLEASE SUBMIT THE FOLLOWING DOCUMENT WITH THIS CONTINUING DAY PROGRAM REQUEST:</p> <p><input type="checkbox"/> Specialty Mental Health Services DPR if the client receives ancillary services in addition to Day Program Services.</p>

CURRENT FUNCTIONING (CFARS Rating):

1	2	3	4	5	6	7	8	9
No problem	Less than Slight	Slight Problem	Slight to Moderate	Moderate Problem	Moderate to Severe	Severe Problem	Severe to Extreme	Extreme Problem
Depression				Anxiety				
<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Happy	<input type="checkbox"/> Sleep Problems	<input type="checkbox"/> Anxious/Tense	<input type="checkbox"/> Calm	<input type="checkbox"/> Guilt			
<input type="checkbox"/> Sad	<input type="checkbox"/> Hopeless	<input type="checkbox"/> Lacks Energy / Interest	<input type="checkbox"/> Phobic	<input type="checkbox"/> Worried/ Fearful	<input type="checkbox"/> Anti-Anxiety Meds			
<input type="checkbox"/> Irritable	<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Anti-Depression Meds	<input type="checkbox"/> Obsessive/Compulsive	<input type="checkbox"/> Panic				
Hyper activity				Thought Process				
<input type="checkbox"/> Manic	<input type="checkbox"/> Inattentive	<input type="checkbox"/> Agitated	<input type="checkbox"/> Illogical	<input type="checkbox"/> Delusional	<input type="checkbox"/> Hallucinations			
<input type="checkbox"/> Sleep Deficit	<input type="checkbox"/> Overactive / Hyperactive	<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Paranoid	<input type="checkbox"/> Ruminative	<input type="checkbox"/> Command Hallucination			
<input type="checkbox"/> Pressured Speech	<input type="checkbox"/> Relaxed	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Derailed Thinking	<input type="checkbox"/> Loose Associations	<input type="checkbox"/> Intact			
<input type="checkbox"/> ADHD Meds	<input type="checkbox"/> Anti-Manic Meds		<input type="checkbox"/> Oriented	<input type="checkbox"/> Disoriented	<input type="checkbox"/> Anti-Psych Meds			
Cognitive Performance				Medical / Physical				
<input type="checkbox"/> Poor Memory	<input type="checkbox"/> Low Self-Awareness	<input type="checkbox"/> Acute Illness	<input type="checkbox"/> Hypochondria	<input type="checkbox"/> Good Health				
<input type="checkbox"/> Poor Attention/Concentration	<input type="checkbox"/> Developmental Disability	<input type="checkbox"/> CNS Disorder	<input type="checkbox"/> Chronic Illness	<input type="checkbox"/> Need Med./Dental Care				
<input type="checkbox"/> Insightful	<input type="checkbox"/> Concrete Thinking	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Poor Nutrition	<input type="checkbox"/> Enuretic/ Encopretic				
<input type="checkbox"/> Impaired Judgment	<input type="checkbox"/> Slow Processing	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Seizures	<input type="checkbox"/> Stress-Related Illness				
Traumatic Stress				Substance Use				
<input type="checkbox"/> Acute	<input type="checkbox"/> Dreams/Nightmares	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Drug(s)	<input type="checkbox"/> Dependence				
<input type="checkbox"/> Chronic	<input type="checkbox"/> Detached	<input type="checkbox"/> Abuse	<input type="checkbox"/> Over Counter Drugs	<input type="checkbox"/> Cravings/Urges				
<input type="checkbox"/> Avoidance	<input type="checkbox"/> Repression/Amnesia	<input type="checkbox"/> DUI	<input type="checkbox"/> Abstinent	<input type="checkbox"/> I.V. Drugs				
<input type="checkbox"/> Upsetting Memories	<input type="checkbox"/> Hyper Vigilance	<input type="checkbox"/> Recovery	<input type="checkbox"/> Interfere w/Functioning	<input type="checkbox"/> Med. Control				
Interpersonal Relationships				Behavior in "Home" Setting				
<input type="checkbox"/> Problems w/Friends	<input type="checkbox"/> Diff. Estab./ Maintain	<input type="checkbox"/> Disregards Rules	<input type="checkbox"/> Defies Authority					
<input type="checkbox"/> Poor Social Skills	<input type="checkbox"/> Age-Appropriate Group	<input type="checkbox"/> Conflict w/Sibling or Peer	<input type="checkbox"/> Conflict w/Parent or Caregiver					
<input type="checkbox"/> Adequate Social Skills	<input type="checkbox"/> Supportive Relationships	<input type="checkbox"/> Conflict w/Relative	<input type="checkbox"/> Respectful					
<input type="checkbox"/> Overly Shy		<input type="checkbox"/> Responsible						
ADL Functioning				Socio-Legal				
<input type="checkbox"/> Handicapped	<input type="checkbox"/> Not Age Appropriate In:	<input type="checkbox"/> Disregards Rules	<input type="checkbox"/> Offense/Property	<input type="checkbox"/> Offense/Person				
<input type="checkbox"/> Permanent Disability	<input type="checkbox"/> Communication	<input type="checkbox"/> Self Care	<input type="checkbox"/> Fire Setting	<input type="checkbox"/> Comm. Control/Reentry	<input type="checkbox"/> Pending Charges			
<input type="checkbox"/> No Known Limitations	<input type="checkbox"/> Hygiene	<input type="checkbox"/> Recreation	<input type="checkbox"/> Dishonest	<input type="checkbox"/> Use/Con Other(s)	<input type="checkbox"/> Incompetent to Proceed			
	<input type="checkbox"/> Mobility		<input type="checkbox"/> Detention/ Commitment	<input type="checkbox"/> Street Gang Member				
Select: <input type="checkbox"/> Work <input type="checkbox"/> School				Danger to Self				
<input type="checkbox"/> Absenteeism	<input type="checkbox"/> Poor Performance	<input type="checkbox"/> Regular	<input type="checkbox"/> Suicidal Ideation	<input type="checkbox"/> Current Plan	<input type="checkbox"/> Recent Attempt			
<input type="checkbox"/> Dropped Out	<input type="checkbox"/> Learning disabilities	<input type="checkbox"/> Seeking	<input type="checkbox"/> Past Attempt	<input type="checkbox"/> Self-Injury	<input type="checkbox"/> Self-Mutilation			
<input type="checkbox"/> Employed	<input type="checkbox"/> Doesn't Read/Write	<input type="checkbox"/> Tardiness	<input type="checkbox"/> "Risk-Taking" Behavior	<input type="checkbox"/> Serious Self-Neglect	<input type="checkbox"/> Inability to Care for Self			
<input type="checkbox"/> Defies Authority	<input type="checkbox"/> Not Employed	<input type="checkbox"/> Suspended						
<input type="checkbox"/> Disruptive	<input type="checkbox"/> Terminated/ Expelled	<input type="checkbox"/> Skips Class						
Danger to Others				Security/ Management Needs				
<input type="checkbox"/> Violent Temper	<input type="checkbox"/> Threatens Others	<input type="checkbox"/> Home w/o Supervision	<input type="checkbox"/> Suicide Watch					
<input type="checkbox"/> Causes Serious Injury	<input type="checkbox"/> Homicidal Ideation	<input type="checkbox"/> Behavioral Contract	<input type="checkbox"/> Locked Unit					
<input type="checkbox"/> Use of Weapons	<input type="checkbox"/> Homicidal Threats	<input type="checkbox"/> Protection from Others	<input type="checkbox"/> Seclusion					
<input type="checkbox"/> Assaultive	<input type="checkbox"/> Homicide Attempt	<input type="checkbox"/> Home w/Supervision	<input type="checkbox"/> Run/Escapes Risk					
<input type="checkbox"/> Cruelty to Animals	<input type="checkbox"/> Accused of Sexual Assault	<input type="checkbox"/> Restraint	<input type="checkbox"/> Involuntary Exam/ Commitment					
<input type="checkbox"/> Does not appear dangerous to Others	<input type="checkbox"/> Physically Aggressive	<input type="checkbox"/> Time-Out	<input type="checkbox"/> PRN Medications					
		<input type="checkbox"/> Monitored House Arrest	<input type="checkbox"/> One-to-One Supervision					

Day Program Clinician: (print) _____ Date: _____

Countersignature by Licensed Clinician: _____ Date: _____

For OptumHealth Disposition Only: DOCUMENT AUTHORIZATIONS FOR DAY PROGRAM and ANCILLARY SERVICES	
OptumHealth Clinician #: _____	Day Program Authorization Period: Begin Date: _____ End Date: _____
Approved # Days: _____	Frequency (# times/week) _____ Review Date: _____ Circle approved AS on next page(s) Logged <input type="checkbox"/>
Reduce DP Request: <input type="checkbox"/>	Deny DP Request: <input type="checkbox"/> Date NOA Sent: _____ Reduce AS Request: <input type="checkbox"/> Deny AS Request: <input type="checkbox"/>
Date NOA Sent: _____	
Date DP Auths Entered: _____	Date AS Auths Entered: _____ D/E Name: _____ Logged <input type="checkbox"/>