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.

CLIENT PLAN – ADULT MENTAL HEALTH

2014

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

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

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 my be individualized for how it will be used to assist the client achieve his/her goal)

Intervention: _____

_____

Intervention: _____

_____

Intervention: _____

_____

Intervention: _____

_____

Intervention: _____

_____

Intervention: _____

_____

Intervention: _____

_____

Intervention: _____

_____

Intervention: _____

_____

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.

CLIENT PLAN – THERAPEUTIC BEHAVIORAL SERVICES

2014

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 my 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)

 *Denotes Required Field in Anasazi

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)**
☐ Avoid psychiatric hospitalization	☐ Yes	☐ No	☐ N/A	_____
☐ Prevent higher level of care	☐ Yes	☐ No	☐ N/A	_____
☐ Move to lower level of care	☐ Yes	☐ No	☐ 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:** _____

*Denotes Required Field in Anasazi

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

Client Plan Tiers Tables

2014

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
CompassionAlturism
Competent
Conscientious
Considerate
Creative
Curious
Daily Living Skills
Dependable
Drug-free
Easy-going Appearance
Effective
Efficient
Empathy/Caring
Energetic
Enterprising
Exercises Regularly
Faith/Spiritulatiy
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
Meticulous
Open to Change
Open-minded
Optimism/Hope
Organized
Other
Outgoing
Patient
Peaceful
Physically Active
Physically Attractive
Physically Healthy
Physically Strong
Physically Tough
Physically Versatile
Planning
Positive Identity
Positive Relationship with Parents
Positive Relationship with Siblings
Practices Good Nutrition
Prayerful
Previous Positive Experience in Treatment
Professional Demeanor
Quick Learner
Reflective
Relaxed
Religious
Reserved
Resourcefulness
Responsible
Responsiveness
Self-Awareness
Self-Efficacy/Mastery
Self-sacrificing
Sense of Empowerment
Sense of Humor
Sense of Meaning
Sensitive
Serious
Stable Environment
Stable Family Life
Steady Demeanor
Strong Cultural Identity
Support System
Sympathetic
Tactful
Taking Action for Personal Change
Tolerant
Trusting
Trustworthy
Utilizes Agreed-Upon Treatment Recommendations
Verbal
Vocational Skills
Wants to Work
Warm Personality
Wholesome
Wise
Work History

Area of Need: Abuse/Addiction Substance/Non-Substance
Goal: Increase freedom from abuse/addiction
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
Assessment of Risk
Attend 12-Step Meetings Regularly
Attend Classes
Complete Treatment as Planned
Complete Withdrawal/Detox Phase
Comply with Drug/Alcohol Screens
Comply with Laws
Develop Artistic/Creative Activities
Develop Coping Skills to Manage Issue(s)
Develop Recreational/Leisure Activities
Develop Wellness Recovery Action Plan
Develop/Follow Routine or Structure
Develop/Practice Personal Safety Skills
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
Evaluate/Change/Stabilize LivingSituatio
Expand and Utilize Support System
Explore Spirituality
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Irrational Thoughts
Identify Medication Side Effects
Identify Patterns in Compulsive Behavior
Identify Personal Strengths
Identify Physical Health Care Needs
Identify Resources/Natural Support in Com
Identify Triggers for Behavior
Improve Self Identity/Esteem
Increase Periods of Abstinence
Learn to Identify Symptoms
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 Good Nutrition
Learn/Practice Good Sleep Habits
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 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 Social Skills
Learn/Practice Symptom Management
Linkage to PCP or Comm'ty Medical Clinic
Obtain Medication Services
Other
Participate in Recovery Classes
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 Hospitalization
Reduce Incarceration
Reduce Individual Level of Stress
Reduce Physical Aggression
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: 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 LivingSituatio
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
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
Assessment of Risk
Complete Treatment as Planned
Develop Artistic/Creative Activities
Develop Coping Skills to Manage Issue(s)
Develop Cultural Identity/Practices
Develop Recreational/Leisure Activities
Develop Wellness Recovery Action Plan
Develop/Follow Routine or Structure
Develop/Practice Personal Safety Skills
Develop/Use Journaling
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
Evaluate/Change Education Environment
Evaluate/Change Work Environment
Evaluate/Change/Stabilize LivingSituatio
Exhibit Appropriate School Behavior
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 Medication Side Effects
Identify Patterns in Compulsive Behavior
Identify Personal Strengths
Identify Physical Health Care Needs
Identify Resources/Natural Support in Com
Identify Source(s) of Family Conflict
Identify Start/Root of Issue
Identify Triggers for Behavior
Identify/Acknowledge Trauma
Identify/Obtain Health Insurance
Improve Child-Parent Interactions
Improve Family Relationships
Improve Self Identity/Esteem
Increase Quality Time in Relationship
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 Community Living Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Good Nutrition
Learn/Practice Good Sleep Habits
Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Maintaining Friendships
Learn/Practice Medication Adherence
Learn/Practice Organization and Planning
Learn/Practice Pain Management
Learn/Practice Pers Daily Living Skills
Learn/Practice Problem Solving Skills
Learn/Practice Public Transport Skills
Learn/Practice Regular Exercise
Learn/Practice Relaxation Techniques
Learn/Practice Safe Sex
Learn/Practice Self-Monitoring
Learn/Practice Social Skills
Learn/Practice Symptom Management
Linkage to PCP or Comm'ty Medical Clinic
Obtain Medication Services
Other
Participate in Mental Health Treatment
Participate in Recovery Classes
Participate in Reunification Plan
Provide for Own Food/Clothing/Shelter
Reduce Avoidance and Isolation
Reduce Compulsive/Addictive Behavior
Reduce Family Stress
Reduce Frequency/Intensity of Symptoms
Reduce Hopelessness and Desperation
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: Family Stress
Goal: Reduce family stress
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
Attend Classes
Complete Treatment as Planned
Comply with Laws
Cooperate with Criminal Justice System
Develop Coping Skills to Manage Issue(s)
Develop Cultural Identity/Practices
Develop Recreational/Leisure Activities
Develop Wellness Recovery Action Plan
Develop/Follow Routine or Structure
Develop/Practice Personal Safety Skills
Develop/Use Journaling
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Evaluate/Change/Stabilize LivingSituatio
Exhibit Appropriate School Behavior
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 Physical Health Care Needs
Identify Resources/Natural Support in Com
Identify Source(s) of Family Conflict
Identify Start/Root of Issue
Identify Triggers for Behavior
Identify/Acknowledge Trauma
Identify/Obtain Health Insurance
Improve Care Giving Skills
Improve Child-Parent Interactions
Improve Family Relationships
Increase Quality Time in Relationship
Interact Appropriately with Others
Learn/Pract Appropriate Emotional Expres
Learn/Practice Acculturation
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 Medication Adherence
Learn/Practice Money Management
Learn/Practice Organization and Planning
Learn/Practice Pers Daily Living Skills
Learn/Practice Problem Solving Skills
Learn/Practice Relaxation Techniques
Learn/Practice Self-Monitoring
Learn/Practice Social Skills
Learn/Practice Symptom Management
Other
Participate in Recovery Classes
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 Use of Drugs Including Alcohol
Secure/Hold Stable Employment

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 LivingSituatio
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 LivingSituatio
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
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 Interests and Abilities
Assess Situation and Identify Needs
Clarify Educational Needs
Clarify Job Dissatisfaction
Complete Treatment as Planned
Comply with Laws
Develop Artistic/Creative Activities
Develop Coping Skills to Manage Issue(s)
Develop Recreational/Leisure Activities
Develop Wellness Recovery Action Plan
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Evaluate/Change Education Environment
Evaluate/Change Work Environment
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
Increase Quality Time in Relationship
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 Job Skills
Learn/Practice Medication Adherence
Learn/Practice Pers Daily Living Skills
Learn/Practice Problem Solving Skills
Learn/Practice Regular Exercise
Learn/Practice Relaxation Techniques
Learn/Practice Self-Monitoring
Learn/Practice Symptom Management
Other
Participate in Education/Training Progrm
Reduce Avoidance and Isolation
Reduce Frequency/Intensity of Symptoms
Reduce Hospitalization
Reduce Incarceration
Reduce Use of Drugs Including Alcohol
Secure/Hold Stable Employment

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 LivingSituatio
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
Access Resources/Natural Support in Comm
Address Cultural Identity Issues
Address Outstanding Legal Issues
Address Sexual Issues
Adjust to Life-Cycle Transition
Attend Classes
Complete Treatment as Planned
Develop Artistic/Creative Activities
Develop Coping Skills to Manage Issue(s)
Develop Recreational/Leisure Activities
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
Encourage Connection to PrimaryCare Prov
Engage with Peer Recovery Resources
Exhibit Appropriate School Behavior
Expand and Utilize Support System
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Medication Side Effects
Identify Personal Strengths
Identify Physical Health Care Needs
Identify Resources/Natural Support in Com
Identify Start/Root of Issue
Identify Triggers for Behavior
Improve Child-Parent Interactions
Increase Quality Time in Relationship
Interact Appropriately with Others
Learn to Identify Symptoms
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 Good Nutrition
Learn/Practice Good Sleep Habits
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 Pers Daily Living Skills
Learn/Practice Problem Solving Skills
Learn/Practice Public Transport Skills
Learn/Practice Regular Exercise
Learn/Practice Relaxation Techniques
Learn/Practice Safe Sex
Learn/Practice Self-Monitoring
Learn/Practice Social Skills
Learn/Practice Symptom Management
Linkage to PCP or Comm'ty Medical Clinic
Other
Participate in Mental Health Treatment
Participate in Recovery Classes
Provide for Own Food/Clothing/Shelter
Reduce Avoidance and Isolation
Reduce Compulsive/Addictive Behavior
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 Social Anxiety
Reduce Use of Drugs Including Alcohol
Schedule/Attend Neuropsychological Eval
Understand Need for Medication

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 LivingSituatio
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 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 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 Good Sleep Habits
Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Medication Adherence
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
Other
Participate in Education/Training Progrm
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
Access Resources/Natural Support in Comm
Address Abuse/Neglect Issues
Address Cultural Identity Issues
Address Gender Identity/Practices Issues
Address Outstanding Financial Issues
Address Sexual Issues
Adjust to Life-Cycle Transition
Assess Interests and Abilities
Assess Situation and Identify Needs
Assessment of Risk
Attend Classes
Complete Treatment as Planned
Develop Artistic/Creative Activities
Develop Coping Skills to Manage Issue(s)
Develop Cultural Identity/Practices
Develop Recreational/Leisure Activities
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 Education Environment
Evaluate/Change Work Environment
Evaluate/Change/Stabilize LivingSituatio
Exhibit Appropriate School Behavior
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 Medication Side Effects
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 to Identify Symptoms
Learn/Follow Housing Rules
Learn/Pract Appropriate Emotional Expres
Learn/Practice Acculturation
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 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 Regular Exercise
Learn/Practice Relaxation Techniques
Learn/Practice Safe Sex
Learn/Practice Self-Monitoring
Learn/Practice Social Skills
Learn/Practice Symptom Management
Other
Participate in Education/Training Progrm
Participate in Mental Health Treatment
Participate in Recovery Classes
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 Risk of Harm
Reduce Self-Injurious Behaviors
Reduce Social Anxiety
Reduce Use of Drugs Including Alcohol
Understand Need for Medication

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

Accept Feedback from Others
Access Resources/Natural Support in Comm
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
Attend Classes
Complete Treatment as Planned
Develop Artistic/Creative Activities
Develop Coping Skills to Manage Issue(s)
Develop Recreational/Leisure Activities
Develop/Follow Routine or Structure
Develop/Practice Personal Safety Skills
Develop/Use Journaling
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
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 Start/Root of Issue
Identify Triggers for Behavior
Identify/Acknowledge Trauma
Improve Self Identity/Esteem
Increase Quality Time in Relationship
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 Disagreement
Learn/Practice Identifying Needs
Learn/Practice Maintaining Friendships
Learn/Practice Medication Adherence
Learn/Practice Organization and Planning
Learn/Practice Problem Solving Skills
Learn/Practice Regular Exercise
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
Understand Need for Medication

Area of Need: Stress
Goal: Reduce Stress
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
Assessment of Risk
Attend Classes
Clarify Job Dissatisfaction
Complete Physical Exam and/or Lab Work
Complete Treatment as Planned
Cooperate with Criminal Justice System
Develop Artistic/Creative Activities
Develop Coping Skills to Manage Issue(s)
Develop Recreational/Leisure Activities
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
Encourage Connection to PrimaryCare Prov
Engage with Peer Recovery Resources
Evaluate/Change Education Environment
Evaluate/Change Work Environment
Evaluate/Change/Stabilize LivingSituatio
Exhibit Appropriate School Behavior
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 Physical Health Care Needs
Identify Resources/Natural Support in Com
Identify Source(s) of Family Conflict
Identify Triggers for Behavior
Identify/Acknowledge Trauma
Identify/Improve Technical Skills
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 to Identify Symptoms
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 Good Nutrition
Learn/Practice Good Sleep Habits
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 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 Social Skills
Learn/Practice Symptom Management
Linkage to PCP or Comm'ty Medical Clinic
Other
Participate in Mental Health Treatment
Participate in Recovery Classes
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
Secure/Hold Stable Employment
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

MY SAFETY PLAN –CHILD and ADULT– Paper

2014

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.

☐ **Peer2Peer Youth Text: 1-619-377-7111.** Text Support services available for youth and TAY, from 2-6 p.m., Monday through Friday. English and Spanish. Anonymous and confidential. For those struggling with behavioral health issues including alcohol or drugs.

☐ **Peer2Peer Live Chat, www.mhsinc.org/peer2peer.** Chat Support services available for youth and TAY, from 2-6 p.m., Monday through Friday. English and Spanish. Anonymous and confidential. For those struggling with behavioral health issues including alcohol or drugs.

☐ **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 I'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:** _____

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

2014

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 REQUES
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 waivered Psychologist, licensed or waivered LCSW, licensed or waivered 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.

This form should be used to request authorization of payment for **Specialty Mental Health Services.**	**County of San Diego Mental Health Plan** **Specialty Mental Health Services DPR** RECEIVED:	**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**

CLIENT INFORMATION *******CONFIDENTIAL*******

Client Name: (*First & Last*)	Client Anasazi ID #:	Date of Birth

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: _____/___/_____ (MM/DD/YYYY) End date of this authorization: _____/___/_____ (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**		
☐Depressed Mood	☐Happy	☐Sleep Problems	☐Anxious/Tense	☐Calm	☐Guilt
☐Sad	☐Hopeless	☐Lacks Energy / Interest	☐Phobic	☐Worried/ Fearful	☐Anti-Anxiety Meds
☐Irritable	☐Withdrawn	☐Anti-Depression Meds	☐Obsessive	☐Panic	
Hyper activity			**Thought Process**		
☐Manic	☐Inattentive	☐Agitated	☐Illogical	☐Delusional	☐Hallucinations
☐Sleep Deficit	☐Overactive / Hyperactive	☐Mood Swings	☐Paranoid	☐Ruminative	☐Command Hallucinations
☐Pressured Speech	☐Relaxed	☐Impulsivity	☐Derailed Thinking	☐Loose Associations	☐Intact
☐ADHD Meds	☐Anti-Manic Meds		☐Oriented	☐Disoriented	☐Anti-Psych Meds

Cognitive Performance		**Medical / Physical**		
☐Poor Memory	☐Low Self-Awareness	☐Acute Illness	☐Hypochondria	☐Good Health
☐Poor Attention/Concentration	☐Developmental Disability	☐CNS Disorder	☐Chronic Illness	☐Need Med./Dental Care
☐Insightful	☐Concrete Thinking	☐Pregnant	☐Poor Nutrition	☐Enuretic/ Encopretic
☐Impaired Judgment	☐Slow Processing	☐Eating Disorder	☐Seizures	☐Stress-Related Illness
Traumatic Stress		**Substance Use**		
☐Acute	☐Dreams/Nightmares	☐Alcohol	☐Drug(s)	☐Dependence
☐Chronic	☐Detached	☐Abuse	☐Over the Counter Drugs	☐Cravings/Urges
☐Avoidance	☐Repression/Amnesia	☐DUI	☐Abstinent	☐I.V . Drugs
☐Upsetting Memories	☐Hyper Vigilance	☐Recovery	☐Interfere w/Functioning	☐Med. Control

Interpersonal Relationships		**Behavior in "Home" Setting**	
☐Problems w/Friends	☐Diff. Estab./ Maintain	☐Disregards Rules	☐Defies Authority
☐Poor Social Skills	☐Age-Appropriate Group	☐Conflict w/Sibling or Peer	☐Conflict w/Parent or Caregiver
☐Adequate Social Skills	☐Supportive Relationships	☐Conflict w/Relative	☐Respectful
☐Overly Shy		☐Responsible	

ADL Functioning			**Socio-Legal**		
☐Handicapped	☐Not Age Appropriate In:		☐Disregards Rules	☐Offense/Property	☐Offense/Person
☐Permanent Disability	☐Communication	☐Self Care	☐Fire Setting	☐Comm. Control/Reentry	☐Pending Charges
☐No Known Limitations	☐Hygiene	☐Recreation	☐Dishonest	☐Use/Con Other(s)	☐Incompetent to Proceed
	☐Mobility		☐Detention/ Commitment		☐Street Gang Member
Select: ☐ Work ☐School			**Danger to Self**		
☐Absenteeism	☐Poor Performance	☐Regular	☐Suicidal Ideation	☐Current Plan	☐Recent Attempt
☐Dropped Out	☐Learning disabilities	☐Seeking	☐Past Attempt	☐Self-Injury	☐Self-Mutilation
☐Employed	☐Doesn't Read/Write	☐Tardiness	☐"Risk-Taking" Behavior	☐Serious Self-Neglect	☐Inability to Care for Self
☐Defies Authority	☐Not Employed	☐Suspended			
☐Disruptive	☐Terminated/ Expelled	☐Skips Class			

Danger to Others		**Security/ Management Needs**	
☐Violent Temper	☐Threatens Others	☐Home w/o Supervision	☐Suicide Watch
☐Causes Serious Injury	☐Homicidal Ideation	☐Behavioral Contract	☐Locked Unit
☐Use of Weapons	☐Homicidal Threads	☐Protection from Others	☐Seclusion
☐Assaultive	☐Homicide Attempt	☐Home w/Supervision	☐Run/Escape Risk
☐Cruelty to Animals	☐Accused of Sexual Assault	☐Restraint	☐Involuntary Exam/ Commitment
☐Does not appear dangerous to Others	☐Physically Aggressive	☐Time-Out	☐PRN Medications
		☐Monitored House Arrest	☐One-to-One Supervision

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

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

Created by UBH 01-1-05 Revised 9.01.10

This form should be used to request *continued authorization* of payment for Day Program services	County of San Diego Mental Health Plan ***CONTINUED*** **Day Program Request** RECEIVED:	Fax/Mail to: **OptumHealth Public Sector,** **3111 Camino del Rio North,** **Suite 500** **San Diego, CA 92108** **Phone: (800) 798-2254, option 4** **Fax: (866) 220-4495**

CLIENT INFORMATION *******CONFIDENTIAL*******

Client Name: (*First & Last*)	Client Anasazi ID #	Date of Birth

DAY PROGRAM INFORMATION

Legal Entity & Day Program Name: *Please print clearly* _____

Phone: _____ Assignment Open Date _____

Day Program Unit# _____ Subunit# _____

Anticipated Discharge Date: _____ Current Session Frequency : _____ days a week
mm/dd/yyyy

CONTINUED AUTHORIZATION REQUEST: ☐ Intensive Day Treatment ☐ Day Rehab Frequency : _____ days a week

Begin Date for this Request: _____ End Date for this Request: _____
mm/ dd/ yyyy mm/ dd/ yyyy

HISTORY

☐ **Significant Life Events Since Last Review** : _____

DAY PROGRAM SERVICE NECESSITY CRITERIA **COMPLETE DIAGNOSIS and CHECK ALL THAT APPLY**

DIAGNOSIS ***TIP:*** Use **DSM-IV** Codes; include all Axes**.** **Client must also meet Title 9 Medical Necessity Criteria**

Axis I - Primary _____ **Axis II** - _____ **Axis III** - _____

Secondary _____

Axis IV _____ **Axis V** (*GAF*) Current _____ **Highest in last 12 months** _____

For adult clients only: Day Program Services Medical Necessity # _____ (Please review Day Program Medical Necessity Grid to determine this number)

SERVICE NECESSITY CRITERIA

1) Client exhibits an impairment in functioning due to the above diagnosis as demonstrated by one or more of the following:

A. ☐ Substantial impairment in living arrangement, daily activities, social relationships, and/or age appropriate ADL skills as demonstrated by: (describe)_____

B. ☐ Risk factors such as recurring psychotic symptoms, suicidal or homicidal ideation without evidence of plan, or other violent ideation or behavior as demonstrated by: (describe) _____

C. ☐ Demonstrative history that without day program services there is a substantial risk of recurrence of A. or B. (describe behavior/history supporting risk.)_____

D. ☐ *(For children/youth* Probability that child will not progress developmentally as individually appropriate or will deteriorate developmentally as demonstrated by:_____

2) ☐ Client (and family for children) has been in, or is currently in lower level of care and the client has not demonstrated progress or stabilization (describe progress or lack of progress)_____

3) ☐ Client requires structured Day Program in order to move successfully from higher level of care to lower level of care or to prevent deterioration in functioning and admission to a higher level of care. (describe how is this determined)_____

4) ☐ Present living situation and functioning indicate need for structured day program. Describe living situation & functioning that supports need for Day Program. _____

5) ☐ Current treatment goals have not been met. There is progress toward treatment goals or a reasonable expectation that progress will be made during the next authorization cycle. _____

CLIENT INFORMATION	*******CONFIDENTIAL*******	
Client Name: (*First & Last*)	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? ☐ Yes ☐ No **NAME OF PSYCHIATRIST**:

CURRENT MEDICATIONS	**Current Dose**	**CURRENT MEDICATIONS**	**Current Dose**

REQUIRED ATTACHMENTS

PLEASE SUBMIT THE FOLLOWING DOCUMENT WITH THIS CONTINUING DAY PROGRAM REQUEST:

☐ Specialty Mental Health Services DPR if the client receives ancillary services in addition to Day Program Services.

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

Reduce DP Request:☐ Deny DP Request:☐ Date NOA Sent: _____ Reduce AS Request:☐ Deny AS Request:☐
Date NOA Sent:_____

Date DP Auths Entered:_____ **Date AS Auths Entered:**_____ **D/E Name:**_____ **Logged** ☐

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