INDIVIDUAL SERVICE PLAN

Member name:	Admission date:
Medicaid ID number:	Care coordinator:
Date of most recent CCAR:	Claim number:

☐ Initial service plan ☐ Service plan update (review period:)

CURRENT RISK STATUS

Current risk status: ☐ None ☐ Low ☐ Moderate* ☐ High* (*must be addressed in the service plan)

Special needs (cultural, linguistic, or other):

Current supports, strengths, other resources:

Consumer statement of treatment needs:

Clinician assessment of treatment needs:

CLINICAL TREATMENT SERVICES

1. Treatment focus:

Current severity: ☐ Very high ☐ High ☐ Medium ☐ Low ☐ Minimal

Strength-based goal:

Measurable objectives:

Program or level of care:	Responsible clinician:

Intervention methods and frequency:

Timeframe or target date for goal attainment:

2. Treatment focus:

Current severity: ☐ Very high ☐ High ☐ Medium ☐ Low ☐ Minimal

Strength-based goal:

Measurable objectives:

Program or level of care:	Responsible clinician:

Intervention methods and frequency:

Timeframe or target date for goal attainment:

MEDICATION MANAGEMENT SERVICES Responsible provider:

☐ Not needed/wanted at the present time. Will assess need for medication evaluation as clinical condition warrants.

Treatment focus:

Strength-based goal:

Measurable objectives:

Frequency of medication reviews:

COORDINATION OF CARE SERVICES Responsible provider/care manager:

List all coordination efforts with other providers/agencies (requires: coordination with physical health care providers for all clients, and with school personnel for children/adolescents when school performance is affected)

1. Purpose/objective:

Activity: ☐ Linkage ☐ Monitoring/follow up ☐ Referral ☐ Advocacy ☐ Services planning ☐ Crisis management

Contact person: Contact phone:

Agency:

Expected frequency: Valid ROI in member's chart: ☐ Yes ☐ Need to obtain

2. Purpose/objective:

Activity: ☐ Linkage ☐ Monitoring/follow up ☐ Referral ☐ Advocacy ☐ Services planning ☐ Crisis management

Contact person: Contact phone:

Agency:

Expected frequency: Valid ROI in member's chart: ☐ Yes ☐ Need to obtain

3. Purpose/objective:

Activity: ☐ Linkage ☐ Monitoring/follow up ☐ Referral ☐ Advocacy ☐ Services planning ☐ Crisis management

Contact person: Contact phone:

Agency:

Expected frequency: Valid ROI in member's chart: ☐ Yes ☐ Need to obtain

MEMBER READ AND SIGN: I acknowledge that I participated in the development of this service plan. I **DO/DO NOT** (*circle one*) agree with the service plan we developed. If not, please explain which part you do not agree with.

Client/Parent/Legal guardian signature Date

If not signed, state why and explain efforts made to communicate service plan:

PROVIDER READ AND SIGN: I have reviewed this client's service plan, history, diagnosis, current status, and progress toward treatment objectives. I find the level of care and treatment to be appropriate and medically necessary.

Provider signature Date

☐ Copy of service plan given to client/parent/guardian on (*date*):

INDIVIDUAL SERVICE PLAN REVIEW

Member name:	Admission date:
Medicaid ID number:	Care coordinator:
Date of most recent CCAR:	Claim number:
Period of review:	Date of review:

SUMMARY OF TREATMENT FOR PERIOD OF REVIEW

Services delivered:

Coordination of care contacts:

Progress toward goals:

Barriers to treatment:

Treatment focus/needs for next period:

Current mental status/clinical condition:

Current medications:

Labs/tests/consults: ☐ Completed ☐ Needed:

CURRENT DIAGNOSIS

Axis I (primary):

Axis I (other):

Axis II:

Axis III:

Axis IV: ☐ Support group ☐ Health care access ☐ Occupational ☐ Educational ☐ Economic ☐ Housing ☐ Legal system/crime ☐ Social environment ☐ Other:

Axis V (GAF):

Current risk status: ☐ None ☐ Low ☐ Moderate* ☐ High* (*must be addressed in the service plan)

Psychosocial/physical health status updates:

Discharge criteria/discharge plans:

Provider signature Date

Supervisor signature Date