## INDIVIDUAL SERVICE PLAN

<table>
<thead>
<tr>
<th>Member name:</th>
<th>Admission date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid ID number:</td>
<td>Care coordinator:</td>
</tr>
<tr>
<td>Date of most recent CCAR:</td>
<td>Claim number:</td>
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☐ 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

☐ 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

<table>
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<tr>
<td>Period of review:</td>
<td>Date of review:</td>
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### 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:**

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Provider signature

Date

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Supervisor signature

Date