COUNTY OF SAN MATEO
HEALTH SYSTEM
BEHAVIORAL HEALTH
& RECOVERY SERVICES

BHRS Client Treatment & Recovery Plan

CLIENT_____MH#_____ DOB_____
PROGRAM_____ STAFF DEVELOPING PLAN_____

CLIENT'S OVERALL GOAL/DESIRED OUTCOME: *What the client wants to accomplish from treatment, in client's words.*

PLAN START DATE		**PLAN END DATE**	

Goal # 1
DIAGNOSIS ADDRESSED: _____ MEDICAL NECESSITY GOAL? Yes☐ No☐
DIAGNOSIS/PROBLEMS/IMPAIRMENTS – Signs, symptoms and behavioral problems resulting from the diagnosis that impede client from achieving desired outcome. Impairments related to the diagnosis must be addressed in all **medical necessity** goals.

GOAL - Development of new skills/behaviors and reduction, stabilization, or removal of symptoms/impairments.

OBJECTIVES - Client's next steps to achieving goal. Must be **observable, measurable and time-limited** objectives that address **symptoms/impairments** linked to the **primary diagnosis**.

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Goal 1# INTERVENTIONS – Describe in detail the interventions proposed for each service type: Individual Therapy, Rehabilitation, Collateral, Case Management…etc. (E.g. – Clinician will provide individual therapy, utilizing cognitive-behavioral techniques, to assist client with decreasing his depressive symptoms.)

INTERVENTION	DURATION (# months)	FREQUENCY (# per wk/per mo.)	AGENCY/PROVIDER
Medication Support			
Rehab/Rehab Group			
Individual Therapy			
Group Therapy			
Family Tx/Collateral			
Case Management			
Collateral			
TBS			

Goal # 2
DIAGNOSIS ADDRESSED: _____ MEDICAL NECESSITY GOAL? Yes ☐ No ☐
DIAGNOSIS/PROBLEMS/IMPAIRMENTS – Signs, symptoms and behavioral problems resulting from the diagnosis that impede client from achieving desired outcome. Impairments related to the diagnosis must be addressed in all **medical necessity** goals.

GOAL - Development of new skills/behaviors and reduction, stabilization, or removal of symptoms/impairments.

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OBJECTIVES - Client's next steps to achieving goal. Must be **observable, measurable and time-limited** objectives that address **symptoms/impairments** linked to the **primary diagnosis**.

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SIGNATURES

Client_____ Date_____

If no client signature, see progress note dated _____

Parent/Guardian_____ Date_____

LPHA AUTHORIZING PLAN_____ Date_____

Program Staff Member_____ Date_____

Co-Signature_____ Date_____

☐ Copy was offered to client and accepted
☐ *Copy was offered and declined*
☐ *Unable to offer Copy: See progress note dated* _____