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**.

"Confidential Patient Information: See California Welfare and Institutions Code Section 5328"

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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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COUNTY OF SAN MATEO HEALTH SYSTEM
BEHAVIORAL HEALTH & RECOVERY SERVICES

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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* ________

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