

Client Name: _____ Client ID: _____

Initial Treatment Plan

CLIENT INFORMATION		
Name:	Client Id#:	Admission Date:
Primary Counselor Name:	Case Manager Name:	
DSM-5 Diagnosis(es):		
Date of Initial Treatment Plan:		
Was a physical exam completed? <input type="checkbox"/> If yes, provide the date of physical (must be completed within last 12 months): _____ <input type="checkbox"/> If no, include the goal of obtaining a physical exam under the appropriate problem area below (must remain a goal until completed)		
Assessments Reviewed: <input type="checkbox"/> ASI or YAI <input type="checkbox"/> Risk Assessment <input type="checkbox"/> Other:	<input type="checkbox"/> ASAM LOC Recommendation <input type="checkbox"/> Health Questionnaire	If client's preferred language is not English, were linguistically appropriate services provided? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please explain below)
What does the client want to obtain from treatment (use client's own words):		
Client Strengths/Resources/Abilities/Interests (to be used to reach treatment plan goals):		
PROBLEM #1		
Select related ASAM Dimension: <input type="checkbox"/> 1. Acute Intoxication and/or Withdrawal Potential; <input type="checkbox"/> 2. Biomedical Conditions and Complications; <input type="checkbox"/> 3. Emotional, Behavioral or Cognitive Conditions/Complications; <input type="checkbox"/> 4. Readiness to Change; <input type="checkbox"/> 5. Relapse, Continued Use, or Continued Problem Potential; <input type="checkbox"/> 6. Recovery Environment		
Problem Statement(s):		
Goals (Specific & Quantifiable):	Target Date(s):	Resolution Date(s):
Action Steps (Identify if steps will be taken by the provider and/or client to accomplish identified goals):	Target Date(s):	Resolution Date(s):

Client Name: _____

Client ID: _____

PROBLEM #2

Select related ASAM Dimension: ☐ 1. Acute Intoxication and/or Withdrawal Potential; ☐ 2. Biomedical Conditions and Complications; ☐ 3. Emotional, Behavioral or Cognitive Conditions/Complications; ☐ 4. Readiness to Change; ☐ 5. Relapse, Continued Use, or Continued Problem Potential; ☐ 6. Recovery Environment

Problem Statement(s):**Goals** (Specific & Quantifiable):**Target Date(s):****Resolution Date(s):****Action Steps** (Identify if steps will be taken by the provider and/or client to accomplish identified goals):**Target Date(s):****Resolution Date(s):****PROBLEM #3**

Select related ASAM Dimension: ☐ 1. Acute Intoxication and/or Withdrawal Potential; ☐ 2. Biomedical Conditions and Complications; ☐ 3. Emotional, Behavioral or Cognitive Conditions/Complications; ☐ 4. Readiness to Change; ☐ 5. Relapse, Continued Use, or Continued Problem Potential; ☐ 6. Recovery Environment

Problem Statement(s):**Goals** (Specific & Quantifiable):**Target Date(s):****Resolution Date(s):****Action Steps** (Identify if steps will be taken by the provider and/or client to accomplish identified goals):**Target Date(s):****Resolution Date(s):**

Client Name: _____

Client ID: _____

PROPOSED TYPE OF INTERVENTION/MODALITY FOR SUCCESSFUL GOAL COMPLETION
(Include proposed frequency and duration)

- ☐ Outpatient Services (OS): _____ x weekly for _____
- ☐ Intensive Outpatient Services (IOS): _____ x weekly for _____
- ☐ Residential Treatment (indicate ASAM level and duration established via ongoing Re-Assessment/Authorization process): _____
- ☐ Recovery Services: _____ x weekly ☐ or monthly ☐ for _____

**** Indicate type of services below ****

- ☐ Individual Counseling: _____ x weekly ☐ or monthly ☐ for _____
- ☐ Group Counseling: _____ x weekly ☐ or monthly ☐ for _____
- ☐ Case Management: _____ x weekly ☐ or monthly ☐ for _____
- ☐ Collateral Services: _____ x weekly ☐ or monthly ☐ for _____
- ☐ Patient Education: _____ x weekly ☐ or monthly ☐ for _____
- ☐ OTP/NTP _____ x weekly for _____ ☐ Withdrawal Management Services: _____

Does this treatment plan include the Treatment Plan Addendum form for additional problems? ☐ Yes ☐ No
 If yes, how many total problems are documented in this entire treatment plan? _____

TREATMENT PLAN SIGNATURES

Client was offered a copy of the plan: ☐ YES

☐ NO (if no, document why): _____

Client Signature		Date
If client refuses or is unavailable to sign the treatment plan, please explain:		
Counselor Name	Counselor Signature	Date
LPHA or MD Name	LPHA or MD Signature	Date