



CLIENT RECOVERY PLAN

Diagnostic Symptoms and Related Impairments

Diagnostic (DX) Symptoms:
Observable, measurable, functional impairments related to DX Symptoms:

(Individually based) (how symptoms present themselves in behavioral events or episodes)

Clients' Desired Outcomes

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Client Driven Goals *(negotiated with individual) (structured format)*

To be achieved by _____ <small>(goal target date)</small>
1. Client will _____ from _____ times per _____ <small>(select one) (observable, measureable behavior) (Frequency) (hr., day, wk., mo.)</small>
To a goal of _____ times per _____ / _____ as measured by _____ <small>(<or>(frequency) (hr.,day,wk.,mo.) (sustained for) (self-report, observation, collateral report, etc.)</small>
2. Client will _____ from _____ times per _____ <small>(select one) (observable, measureable behavior) (Frequency) (hr., day, wk., mo.)</small>
To a goal of _____ times per _____ / _____ as measured by _____ <small>(<or>(frequency) (hr.,day,wk.,mo.) (sustained for) (self-report, observation, collateral report, etc.)</small>
3. Client will _____ from _____ times per _____ <small>(select one) (observable, measureable behavior) (Frequency) (hr., day, wk., mo.)</small>
To a goal of _____ times per _____ / _____ as measured by _____ <small>(<or>(frequency) (hr.,day,wk.,mo.) (sustained for) (self-report, observation, collateral report, etc.)</small>

Service Coordinator/Provider Interventions:

Modality:	Frequency:	Service Start Date:	Expected End Date:
Focus/Purpose:			
Date:	Provider Printed Name:	Provider Signature:	



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Service Coordinator/Provider Interventions: Focus/Purpose (List full names, DOB and relationship to member participating):

Modality:	Frequency:	Service Start Date:	Expected End Date:
Focus/Purpose (List full names, DOB and relationship to member participating):			
Date:	Provider Printed Name:	Provider Signature:	

Service Coordinator/Provider Interventions:

Modality:	Frequency:	Service Start Date:	Expected End Date:
Focus/Purpose:			
Date:	Provider Printed Name:	Provider Signature:	

Client/Caregiver Involvement in Recovery Plan

Client Signature:	Date:
Caregiver Signature:	Date:
<i>This Recovery Plan has been discussed with the client and/or the caregiver, and the client/caregiver acknowledges and understands their involvement in the Plan as indicated by their signature above.</i>	
Client/Caregiver Was Given or Sent a Copy of the Recovery Plan:	Date:
Client/Caregiver Declined a Copy of the Recovery Plan:	Date:
Client/Caregiver Refused to Sign the Client Recovery Plan: See Progress Note(s) Dated: _____	Date:
Reason for Client/Caregiver Late Signature Date on the Recovery Plan: See Progress Note(s) Dated: _____	Date:

DATE OF ENTRY:		PLAN START DATE:	
Date:	Provider Printed Name:	Provider Signature:	