Department of Behavioral Health
CLIENT RECOVERY PLAN/ ISSP

"A Partnership in Wellness"

PLANNED SERVICES: ❑**MHS** ❑**MSS** ❑**CM** ❑ **DTI** ❑ **DTR**

Client is member of FSP/(24/7) - ❑ ***Yes*** ❑ ***No*** ***(for TBS, see separate TBS 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

Client Driven Goals *(negotiated with individual)*

To be achieved by _____
(goal target date)

1. Client will reduce/increase _____ from _____ times per _____
(circle one) ***(observable, measurable behavior)*** *(frequency)* *(hr.,day,wk.,mo.)*
To a goal of _____ times per _____/_____ as measured by _____
(<)(frequency) *(hr.,day,wk.,mo.)* *(sustained for)* *(self-report,, observation, collateral report, etc.)*
2. Client will reduce/increase _____ from _____ times per _____
(circle one) ***(observable, measurable behavior)*** *(frequency)* *(hr.,day,wk.,mo.)*
To a goal of _____ times per _____/_____ as measured by _____
(<)(frequency) *(hr.,day,wk.,mo.)* *(sustained for)* *(self-report,, observation, collateral report, etc.)*

Service Coordinator/Provider Actions:

Modality:	Frequency:	Plan Start Date:	Planned End Date:
Focus/Purpose:			
Date:	Provider Printed Name:	Provider Signature:	
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CLIENT RECOVERY PLAN/ISSP
San Bernardino County
Department of Behavioral Health
Confidential Patient Information
See W & I Code 5328
Revised 01/30/09 BLUE

NAME:
CHART NO:
DOB:
PROGRAM:

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Service Coordinator/Provider Actions: ***(additional goals and treatment modalities)***
Additional Client Driven Goals ***(free format)***

To be achieved by ______________________________ *(goal target date)*

(be sure to include all of the elements of a complete behavioral goal with timeframes, observable, measurable behaviors, and methods of measurement)

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Focus/Purpose:			
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CLIENT/CAREGIVER INVOLVEMENT IN RECOVERY PLAN	
Client Signature:	Date:
Caregiver Signature:	Date:
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.	
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 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:		PLAN END DATE:
Date:	Service Coordinator Printed Name:	Service Coordinator Signature:
Date:	* Supervisor Printed Name:	* Supervisor Signature:

**Required if staff is not an LPHA Licensed Waivered/Registered Professional.*

A New Recovery Plan is Required at least every 12 months.

Additional Information: