Department of Behavioral Health CLIENT RECOVERY PLAN/ ISSP

"A Partnership in Wellness"

 \Box DTI \Box DTR

 $\Box MSS \quad \Box CM$

PLANNED SERVICES:

Page ____ of ____

	ember of FSP/(24/7) - 🖸 Yes		(f	for TBS, see separate	TBS plan)
	ymptoms and related impairm	ients			
Diagnostic (Dx)	Symptoms:				
Observable, mea	surable, functional impairments related	l to Dx Syn	ptoms:		
Clianta' Dog	· · · · ·	v based) (how	symptoms present th	hemselves in behavioral	events or episodes)
Clients' Des	ired Outcomes				
Client Drive	n Goals (negotiated with individ	dual)			
10 be define ved	by(goal target date)				
1. Client will red	duce/increase(<i>observable, m</i>	agurable bebe	wier)	from	times per(<i>hr.,day,wk.,mo.</i>)
To a goal of	(<)(frequency) (hr.,day,wk.,mo.) (su	a	s measured by _	(frequency)	(nr.,uay,wk.,mo.)
2 Client will rea	(<)(frequency) (hr.,day,wk.,mo.) (su duce/increase	ustained for)		(self-report,, observation	on, collateral report, etc.)
	(circle one) (observable me	easurable behav	ior)	frequency)	times per(<i>hr.,day,wk.,mo.</i>)
To a goal of	times per/(susternation, metric of the set of the s	(untain of form)	as measured by	(aslf use out a hasmost	on, collateral report, etc.)
Service Coor	dinator/Provider Actions:	ustainea for)		(self-report,, observatio	m, collateral report, etc.)
Modality:		Frequer	icy:	Plan Start Date:	Planned End Date:
-		-	-		
Focus/Purpose	e:				
Date:	Provider Printed Name:		Provide	r Signature:	
Date.	riovider rinned ivanie.		TIOVICE	i Signature.	
Date:	Provider Printed Name:		Provide	r Signature:	
Modality:		Frequer	ICV.	Plan Start Date:	Planned End Date:
Wodanty.		Trequer	icy.	Than Start Date.	Tianned End Date.
Focus/Purpose	e:				
Date:	Provider Printed Name:		Provide	r Signature:	
Date:	Provider Printed Name:		Provide	r Signature:	
				-	
CLIE	NT RECOVERY PLAN/ISSP	NAI	ME:		
Ľ	San Bernardino County Department of Behavioral Health	СН	ART NO:		
	Confidential Patient Information		in 110.		

See W & I Code 5328

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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)

Modality:		Frequency:	Plan Start Date:	Planned End Date:
Focus/Purpose:				
Date:	Provider Printed Name:	Provide	er Signature:	
Date:	Provider Printed Name:	Provide	er Signature:	

Modality:		Frequency:	Plan Start Date:	Planned End Date:
Focus/Purpose:				I
Date:	Provider Printed Name:	Provide	er Signature:	
Date:	Provider Printed Name:	Provide	er Signature:	

Modality:		Frequency:		Plan Start Date:	Planned End Date:
Focus/Purpose:					
Date:	Provider Printed Name:	Pro	ovider	Signature:	
Date:	Provider Printed Name:	Pro	ovider	Signature:	

CLIENT RECOVERY PLAN/ISSP	NAME:		
San Bernardino County	INAME:		
Department of Behavioral Health	CHART NO:		
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Department of Behavioral Health CLIENT RECOVERY PLAN/ ISSP

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Modality:		Frequency:	Plan Start Date:	Planned End Date:
Focus/Purpose:				
Date:	Provider Printed Name:	Provid	er Signature:	
Date:	Provider Printed Name:	Provid	er Signature:	

CLIENT/CAREGIVER INVOLV	EMENT IN RECO	VERY PLAN	N
Client Signature:			Date:
Caregiver Signature:	Date:		
This Recovery Plan has been discussed with the client and/or the caregiver, an Plan as indicated by th		dges and understan	ds their involvement in the
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 Pla 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 DA	ATE:	
Date: Service Coordinator Printed Name:	Service Coordinator	Signature:	
Date: * Supervisor Printed Name:	* Supervisor Signatur	re:	

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

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

Additional Information:

CLIENT RECOVERY PLAN/ISSP San Bernardino County	NAME:
Department of Behavioral Health Confidential Patient Information	CHART NO:
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