SAN BERNARDINO COUNTY | **Behavioral Health**

Recovery Services Plan

Provider:	Provider RU:	Today's date:
Client name:	Client number:	
Client completed treatment at:	Date treatment was completed:	
☐ Level 1.0	☐ Level 3.3	
☐ Level 2.1	☐ Level 3.5	
☐ Level 3.1		

For each component that will be provided as part of the Client's Recovery Services Plan, please indicate which particular element of Recovery Services will be utilized and identify the duration for each element. If the particular service is not applicable, please mark N/A. Please also indicate the location where the service will be provided.

Outpatient Counseling Services (individual or group counseling)	☐ N/A
Location where Service Provided: ☐In Person ☐Phone Duration:	

Recovery Monitoring (including recovery coaching and monitoring via telephone / telehealth)	☐ N/A
Location where Service Provided: ☐In Person ☐Phone Duration:	

Substance Abuse Assistance (Ex: Alumni support; informal networking; relapse prevention)	☐ N/A
Location where Service Provided: ☐In Person ☐Phone Duration:	

Support for Education and Job Skills (Ex: Referrals for Vocational Rehab Services; providing info to EDD; Adult Education referrals; resume building and job application support)	☐ N/A
Location where Service Provided: ☐In Person ☐Phone Duration:	

Family Support (Ex: family communication suggestions; links to child care/children's supportive linkages; parent education; family support linkages to youth services; family/marriage education)	☐ N/A
Location where Service Provided: ☐In Person ☐Phone Duration:	

Ancillary Services (Ex: linkages to housing assistance; Transportation, DMV/Insurance/Social Security support and individual services coordination)	☐ N/A
Location where Service Provided: ☐In Person ☐Phone Duration:	

Recovery Support Individual Counseling Services - include a description of the individual counseling services provided	☐ N/A
Location where Service Provided: ☐In Person ☐Phone Duration:	

Recovery Support Group Counseling Services - include a description of the individual counseling services provided	☐ N/A
Location where Service Provided: ☐In Person ☐Phone Duration:	

Client was offered a copy of the plan: ☐ Yes ☐ No

If no, explain why: _____

_____ _____ _____
CLIENT PRINTED NAME   **CLIENT SIGNATURE**   **DATE**
If a client refuses or is unavailable to sign the Recovery Services plan, please indicate and explain:
☐ Unavailable   ☐ Refuses to sign

Explanation: _____

_____ _____
 PROGRAM STAFF PRINTED NAME   **PROGRAM STAFF SIGNATURE**   **DATE**

_____ _____ _____
MEDICAL DIRECTOR/LPHA PRINTED NAME   **MEDICAL DIRECTOR/LPHA SIGNATURE**   **DATE**

Recovery Services Plan Instructions

A Recovery Services Plan is required for clients receiving Recovery Services

Complete Recovery Services Plan within the following timelines:

- **Initial Recovery Plan** – Within 30 days of admission into Recovery Services.

- **Updated Recovery Plan** – Within 90 days of the date the last Recovery Services Plan was completed **OR** as needed when a significant change occurs.

Note: LPHA, Counselor and client must *jointly* complete the Recovery Service Plan based upon the information obtained during the client's transition/admission into Recovery Services.

REQUIRED ELEMENTS (do not leave any blanks):

1. **Provider:** Name of Agency
2. **Provider RU:** Reporting Unit assigned to your agency by San Bernardino County
3. **Today's Date:** Date of the Recovery Services Plan development
4. **Client Name:** Client's full name
5. **Client Number:** Unique number assigned to Client by the San Bernardino County
6. **Client Completed Treatment at:** Location Client completed SUD treatment
7. **Date Treatment was Completed:** Date Client completed SUD treatment
   (No further verification necessary to provide Recovery Services)
8. Check level of treatment client completed.
9. Indicate which specific Recovery Services elements will be provided as part of the client's Recovery Services Plan. Indicate the duration of each specific recovery service and indicate the location the service will be provided. If a particular service is not applicable, mark N/A.
10. **Client was offered a copy of the plan:** Check Yes or No (if no, explain why).
11. **Client Signature:** Client to print, sign and date document.
12. **Program Staff Signature:** Program Staff to print, sign and date document.
13. **MD or LPHA Signature:** MD or LPHA to print, sign and date document.

Note: The client must be present and participate in the Recovery Plan in order to bill for recovery planning services. Client signature provides evidence of client participation and agreement with the recovery planning process. If a client refuses to sign the Recovery Plan, document the reason for refusal and the strategy that will be used to engage client for participation in Recovery Plan. Future attempts to obtain the client's signature on the Recovery Plan should be documented in progress notes.