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) (structured format)*

To be achieved by ______________________________
(goal target date)

1. Client will reduce/increase ____ from ________ times per ________
   (select one) ***(observable, measurable behavior)*** *(frequency)* *(hr.,day,wk.,mo.)*
   To a goal of _____________times per ___________/____________ as measured by___________________________
   (<or>)(frequency) *(hr.,day,wk.,mo.) (sustained for)* *(self-report, observation, collateral report, etc.)*
2. Client will reduce/increase ____ from ________ times per ________
   (select one) ***(observable, measurable behavior)*** *(frequency)* *(hr.,day,wk.,mo.)*
   To a goal of _____________times per ___________/____________ as measured by___________________________
   (<or>)(frequency) *(hr.,day,wk.,mo.) (sustained for)* *(self-report, observation, collateral report, etc.)*

Service Coordinator/Provider Interventions:

Modality:	Frequency:	Service Start Date:	Expected End Date:
Focus/Purpose:			
Date:	Provider Printed Name:	Provider Signature:	
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CLIENT RECOVERY PLAN/ISSP

Confidential Patient Information
See W & I Code 5328

Revised 05/09 BLUE

NAME:

CHART NO:

DOB:

PROGRAM:

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GOALS AND INTERVENTIONS: *(CONTINUED)*
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:	Service Start Date:	Expected End Date:
Focus/Purpose:			
Date:	Provider Printed Name:	Provider Signature:	
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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 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:		PLAN END DATE:
Date:	Service Coordinator Printed Name	Service Coordinator Signature:
Date:	*LPHA Staff Printed Name:	*LPHA Staff Signature:

**Required if Service Coordinator is not an LPHA licensed/waivered/registered professional.*

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

Additional Information: *(e.g.-client strengths, and expectation of client action in treatment, and/or variables related to the delivery of culturally competent services,etc.)*