Department of Behavioral Health
HOST CARE PLAN

PLANNED SERVICES: ☐ **MHS** ☐ **MSS** ☐ **CM** ☐ **DTI** ☐ **DTR**
Client is member of FSP/(24/7) - ☐ ***Yes*** ☐ ***No*** ***(for TBS, see separate TBS plan)***

Strengths Based Discussion:

Describe recent or relevant periods to success:
Client Driven Goals and Objectives: To be achieved by _____ (goal target date)

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

Clients' Desired Outcomes:

Client's Actions to Meet Desired Outcomes:
Staff's Actions to Meet Desired Outcomes:

Possible Risk Factors Related to Diagnosis (if applicable):

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Mainstream Connections and Referrals:

Type	R	L
ACCESS Unit	☐	☐
All Inclusive Care Program	☐	☐
APS DCFS	☐	☐
Clubhouse	☐	☐
Community Based Organization	☐	☐
Community MH Provider	☐	☐
CCRT	☐	☐
DBH Outpatient Clinic/Program	☐	☐
Entitlements/Advocate/Assistance	☐	☐
Faith Based Organization	☐	☐
Food Bank	☐	☐
Housing Authority	☐	☐

Type	R	L
InnovAge	☐	☐
Gaining Identification	☐	☐
Inpatient Drug Treatment	☐	☐
Law Enforcement	☐	☐
Legal Aid	☐	☐
Managed Care/IEHP/Molina	☐	☐
NA/AA	☐	☐
NAMI	☐	☐
Outpatient Drug Treatment	☐	☐
Primary Care Physician	☐	☐
Transportation	☐	☐
Utility Assistance	☐	☐

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 Care 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.)*

Notes: *LPHA = Licensed Practitioner of the Healing Arts*