Individual Service Plan

Community Counseling Services

Rev 01/17

Case Name

Case Id#

Date of Admission

Date Plan Developed

New □ Re-Write □ Addendum□

Diagnosis - DSM 5	Codes
Dx 1	
Dx 2	
Dx 3	
Dx 4	
Dx 5	
Dx 6	
Dx7	

Individual's Strengths

Long Term Goals:

Short Term Goals:

Identified Barriers (Based on Functional Assessment)

Individual's Areas of Need

Objective #1:

Interventions	Service Area Assigned	Criteria/Outcomes for Completion	Initiation Date	Target Date *(no longer than a year)*
1.				
2.				
3.				

Objective #2:

Interventions	Service Area Assigned	Criteria/Outcomes for Completion	Initiation Date	Target Date *(no longer than a year)*
1.				
2.				
3.				

Objective #3:

Interventions	Service Area Assigned	Criteria/Outcomes for Completion	Initiation Date	Target Date *(no longer than a year)*
1.				

2.				
3.				

Objective #4:

Interventions	Service Area Assigned	Criteria/Outcomes for Completion	Initiation Date	Target Date (*no longer than a year*)
1.				
2.				
3.				

Objective #5:

Interventions	Service Area Assigned	Criteria/Outcomes for Completion	Initiation Date	Target Date (*no longer than a year*)
1.				
2.				
3.				

Recommended Services:

□ **Medication Evaluation**	□ **IOP Program Services**	□ _____
□ **Nurse Assessment**	□ **A&D IOP**	
□ **Injection**	□ **A&D Residential Services**	□ _____
□ **Therapy Services**	□ **Structured Intervention**	
□ **Community Support Services**	□ **Recovery Support**	□ _____
□ **Crisis Services**		
□ **Targeted Case Management**	□ _____	□ _____
□ **Day Treatment Child**		
□ **PSR/Elderly PSR**	□ _____	□ _____
□ **Peer Support Services**		

Community Support has been offered to me and I choose:

☐ **Yes, I do want to participate (See Recovery Support Plan)** _____**(initials of individual receiving services)**

☐ **No, I do NOT want to participate** _____**(initials of individual receiving services)**

Individual Receiving Services	Date	Parent/Legal Guardian	Date
Signature/Credential	Date	Signature/Credential	Date
Signature/Credential	Date	Signature/Credential	Date
Signature/Credential	Date	Signature/Credential	Date
Signature/Credential	Date	Signature/Credential	Date

Physician/Clinical Psychologist/Nurse Practitioner, LCSW, LMFT,PA, Alzheimer's Day Program Supervisor, LPC — Date