Treatment Plan Template

Participant Name		**SSN #**	
Healthy Connections Physician:		**MEDICAID #**	
Healthy Connection #		**CAFAS Score #**	
Provider Agency completing the Service Plan:			
DATE OF AMENDMENT (if applicable):			
Comment (What is being amended and why):			
DATE OF PLAN:	**120 Day Rev.**	**240 Day Rev.**	**Annual Update:**

(P)= Principal Diagnosis **DIAGNOSTIC SUMMARY**

(check if applicable): ☐ **Severe Emotional Disturbance** ☐ **Severe and Persistent Mental Illness**

Axis I :

Axis II :

Axis III :

Axis IV :

Axis V : Current GAF _____ **Highest Past GAF** _____

Duration of Principal Diagnosis	**Functional Areas Identified as Deficits in the Assessment** **(See IDAPA 16.03.10.113)**			
☐ Less than one year	☐ Health/Medical	☐ Social/interpersonal	☐ Housing	
☐ One to two years	☐ Vocational/Educational	☐ Family	☐ Community/Legal	
☐ More than two years	☐ Financial	☐ Basic Living Skills		

Functional Area I: **Issue I:** **Goal I:** **Objective I.A.** (concrete and measurable and include time frames for completion) **Task I.A.1.** (Specific, time-limited activities) **Task I.A.2.** (Specific, time-limited activities)	Expected End Date I.A.	**Type, freq & hrs**
Functional Area II: **Issue II:** **Goal II:** **Objective II.A.** (concrete and measurable and include time frames for completion) **Task II.A.1.** (Specific, time-limited activities) **Task II.A.2.** (Specific, time-limited activities)	Expected End Date II.A.	**Type, freq & hrs**
Functional Area III: **Issue III:** **Goal III:** **Objective III.A.** (concrete and measurable and include time frames for completion) **Task III.A.1.** (Specific, time-limited activities) **Task III.A.2.** (Specific, time-limited activities)	Expected End Date III.A.	**Type, freq & hrs**

Functional Area IV: **Issue IV:** **Goal IV:** **Objective IV.A.** (concrete and measurable and include time frames for completion) **Task IV.A.1.** (Specific, time-limited activities) **Task IV.A.2.** (Specific, time-limited activities)	Expected End Date IV.A.	**Type, freq & hrs**
Functional Area V: **Issue V:** **Goal V:** **Objective V.A.** (concrete and measurable and include time frames for completion) **Task V.A.1.** (Specific, time-limited activities) **Task V.A.2.** (Specific, time-limited activities)	Expected End Date V.A.	**Type, freq & hrs**
Functional Area VI: **Issue VI:** **Goal VI:** **Objective VI.A.** (concrete and measurable and include time frames for completion) **Task VI.A.1.** (Specific, time-limited activities) **Task VI.A.2.** (Specific, time-limited activities)	Expected End Date VI.A.	**Type, freq & hrs**

SIGNATURES OF PARTICIPANTS IN DEVELOPING THE TREATMENT PLAN

I have been informed that I have a choice of Providers. My choices of Provider(s) are:

_____ _____

_____ _____

I participated in the development of this Treatment Plan, have received a copy, and I agree to its content.
I give my consent for information exchange among the MHA and the service provider(s) as necessary for my care and treatment until this plan is amended or for one year, whichever comes first.

Participant/Guardian: _____ **Date:** _____

Mental Health Professional: _____ **Date:** _____

Other: _____ **Date:** _____

I reviewed this participant's plan and record, and indicate that the provision of Mental Health Services, specifically, _____ is medically necessary.

Physician Signature: _____ **Date:** _____