Community Mental Health Center of Crawford County
Treatment Plan

DSM IV Diagnosis

Reviewed Diagnosis: ☐ New ☐ No Change ☐ Change (Attach Diagnosis Change Form)

Plan Date:

Plan Update Due:

Axis	Diagnosis Code	Diagnosis
I		
II		
III		

Axis IV: Problems With (Check all that apply)

☐ Primary Sup. Group:	☐ Housing:
☐ Social Environment:	☐ Economic:
☐ Education:	☐ Access/Health Care:
☐ Job/Occupation:	☐ Legal/Crime:
☐ Other:	

Axis V:	Current GAF:	Highest GAF Last yr.	Expected GAF at Discharge:

Prognosis: ☐ Guarded ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Presenting Problem (s):

Abilities (List measurable/observable skills and tasks that the consumer can perform, related to achieving the goals):

Strengths/Supports (List those environmental and other factors that may support positive outcomes, e.g., strong family support, a network of supportive friends. They may not be specific to the consumer and may not be measurable and or observable):

Preferences/Requests of the Consumer (List goal or service-related conditions or contingences that are important to the consumer):

Recommended Treatment Regimen: (Services Authorized)

Treatment Modality	Frequency	Duration	Responsible Person/Title	Treatment Modality	Frequency	Duration	Responsible Person/Title
Individual Therapy				Crisis Services			
Family Therapy				Psychological Testing			
Group Therapy				Waiver Only: Respite			
Case Management				Waiver Only: Wrap Around			
Psychosocial Group				Waiver Only: Ind. Living Skills			
Attendant Care/ICS				A&D Only: Intermediate			
Supportive Employment				A&D Only: Reintegration			
Medication Mgmt.				A&D Only: Day Treatment			
Comp. Med Services (Med Box)				Other:			
Parent Support				Other:			

I have had an opportunity to provide input into this plan and I agree with it. **Consumer Signature:**	**Date:**	**Guardian Signature (if applicable):**	**Date:**

QMHP/SAP:	**Title:**	**Date:**

I have reviewed this case and concur that the diagnostic classification(s), goal)s), objectives(s), therapeutic interventions, services, frequency, responsible persons(s) and duration are accurate and services (ordered within all pages of this Plan is (are) clinically/medically appropriate and necessary: I hereby order the consumer noted to receive the services documented in this treatment Plan.

Physician:	**Title:**	**Date:**

Consumer Name:	**Consumer Case Number:**

A/D Consumers Only: ASI Category:	Score:	KCPC Dimension:
Problem:		
Long Term Goal: (In the words of the Consumer)		
Short Term Goal(s)/Objective(s)		

Tasks: What	**Who**	**How Often**	**Date to Be Done**

Consumer Signature:	**Date:**	**Primary CMHCCC Staff Signature:**	**Date:**
Supportive Services:			

A/D Consumers Only: ASI Category:	Score:	KCPC Dimension:
Problem:		
Long Term Goal: (In the words of the Consumer)		
Short Term Goal(s)/Objective(s)		

Tasks: What	**Who**	**How Often**	**Date to Be Done**

Consumer Signature:	**Date:**	**Primary CMHCCC Staff Signature:**	**Date:**
Supportive Services:			

Consumer Name:	**Consumer Case Number:**	**Plan Date:**

Discharge Plans / Level of Care Change:			
Consumer Statement of Expectations/Criterion:			
Case Coordinator Statement of Expectations/Criterion:			
List of Possible Natural / Community Supports Needed (for Level of Care Change): **Needed at Discharge:**			
Discharge Criteria: (Check all that apply)		**Anticipated Discharge Date:**	
☐ Reduction in symptoms as evidenced by:		☐ Return to highest GAF or GAF = _____	
Treatment Team Signatures:			
Printed Name	**Signature**	**Credentials**	**Date**
Consumer Name:	**Consumer Case Number:**		**Plan Date:**