Client Name: Client ID:

Updated Treatment Plan

CLIENT INFORMATION	
Name:	**Primary Counselor:**
Client Id #:	**Admission Date:**
DSM-5 Diagnosis(es):	
Date of Last Treatment Plan:	**Date of Current Treatment Plan:**
Was a physical exam completed? ☐ If yes, provide the date of physical (must be completed within last 12 months) ______________________________ ☐ If no, include the goal of obtaining a physical exam under the appropriate problem area below (must remain a goal until completed)	
Assessments/Forms Reviewed: ☐ ASI or YAI ☐ ASAM LOC Recommendation ☐ Risk Assessment ☐ Health Questionnaire ☐ Other: ____ ____	**If client's preferred language is not English, were linguistically appropriate services provided?** ☐ Yes ☐ No **If no, please explain:** ____
What does the client want to change on their current treatment plan from the previous treatment plan (use client's own words)?	
Client Strengths/Resources/Abilities/Interests (to be used to reach treatment plan goals):	

CURRENT NEEDS AT TIME OF TREATMENT PLAN UPDATE

☐	Client is making progress but not yet achieved treatment plan goals. **Continue services at present LOC**
☐	Client is not yet making progress but has capacity to resolve treatment plan problems as is actively working on treatment plan goals. **Continue services at present LOC**
☐	New problems have been identified and they are best addressed at current LOC (the current LOC is the least intensive at which the client's new problems can be addressed effectively) **Continue services at present LOC**
☐	Client has achieved goals on treatment plan. Problems that justified admission to the current LOC are resolved. **Discharge (or transfer to lower LOC) is indicated.**
☐	Client has been unable to resolve the problem(s) that justified admission, despite changes to the treatment plan. **Discharge and treatment at another LOC is indicated.**
☐	Client has not embraced or applied recovery components to resolve problem(s) at current LOC. **Discharge and treatment at another LOC is indicated**
☐	Client's problem(s) have worsened, or new problem(s) developed that cannot be treated effectively at current LOC. **Discharge and transfer to another LOC is indicated**

An updated ASAM LOC Recommendation form is to be completed at the time of a treatment plan update. Answer the following questions based on that updated ASAM LOC Recommendation form:

Recommended Level of Care (LOC): ____________________ Actual Level of Care (LOC): ______________________

Client Name: Client ID:

PROBLEM #1		
Select related ASAM Dimension(s): ☐ 1. Acute Intoxication and/or Withdrawal Potential; ☐ 2. Biomedical Conditions and Complications; ☐ 3. Emotional, Behavioral or Cognitive Conditions/Complications; ☐ 4. Readiness to Change; ☐ 5. Relapse, Continued Use, or Continued Problem Potential; ☐ 6. Recovery Environment		
Problem Statement(s):		
Goals (Specific & Quantifiable):	**Target Date(s):**	**Resolution Date(s):**
Action Steps (Identify if steps will be taken by the provider and/or client to accomplish identified goals):	**Target Date(s):**	**Resolution Date(s):**
PROBLEM #2		
Select related ASAM Dimension(s): ☐ 1. Acute Intoxication and/or Withdrawal Potential; ☐ 2. Biomedical Conditions and Complications; ☐ 3. Emotional, Behavioral or Cognitive Conditions/Complications; ☐ 4. Readiness to Change; ☐ 5. Relapse, Continued Use, or Continued Problem Potential; ☐ 6. Recovery Environment		
Problem Statement(s):		
Goals (Specific & Quantifiable):	**Target Date(s):**	**Resolution Date(s):**
Action Steps (Identify if steps will be taken by the provider and/or client to accomplish identified goals):	**Target Date(s):**	**Resolution Date(s):**
PROBLEM #3		
Select related ASAM Dimension(s): ☐ 1. Acute Intoxication and/or Withdrawal Potential; ☐ 2. Biomedical Conditions and Complications; ☐ 3. Emotional, Behavioral or Cognitive Conditions/Complications; ☐ 4. Readiness to Change; ☐ 5. Relapse, Continued Use, or Continued Problem Potential; ☐ 6. Recovery Environment		
Problem Statement(s):		

Client Name: Client ID:

Goals (Specific & Quantifiable):	**Target Date(s):**	**Resolution Date(s):**
Action Steps (Identify if steps will be taken by the provider and/or client to accomplish identified goals):	**Target Date(s):**	**Resolution Date(s):**

PROPOSED TYPE OF INTERVENTION/MODALITY FOR SUCCESSFUL GOAL COMPLETION
(Include proposed frequency and duration)

☐ Individual Counseling _____ x a week for _________ ☐ Group Counseling _____ x a week for _________
☐ Community Support Group _____ x a week for ____________ ☐ Case management _____ x a week for ________
☐ Withdrawal Management Services _____ x a week for ______ ☐ Collateral Services _____ x a week for ________
☐ Intensive Outpatient Treatment (IOT) _____ x a week for ____________
☐ Residential Treatment (indicate ASAM level. Duration to be established via ongoing re-assessment/Authorization process): _________
☐ OTP/NTP _____ x a week for ______________ ☐ Recovery Services _____ x a week for _____________________

Does this treatment plan include the Treatment Plan Addendum form for additional problems? ☐ Yes ☐ No
If yes, how many total problems are documented in this entire treatment plan? ____

TREATMENT PLAN SIGNATURES

Client was offered a copy of the plan: ☐ YES
☐ NO (if no, document why): ____

Client Signature:		**Date:**
If client refuses or is unavailable to sign the treatment plan, please explain:		
Counselor/Therapist Name:	**Counselor/Therapist Signature:**	**Date:**
***MD Name (If applicable):**	***MD Signature (If applicable):**	**Date:**

**Per Title 22, MD signature is required on a Treatment Plan within 15 days for outpatient services billed to DMC. For residential programs not currently billing DMC, MD signature is not required.*