Cornerstone Behavioral Healthcare
Medication Management Individual Treatment Plan

Client Name (Print):	DOB:	Client#

☐**Initial** ☐**Review** ☐**Annual**

Participants Involved in ITP development: Clinician, Client ☐Other (please identify):

Identifying Problems:

As Evidenced By:

Primary Diagnosis:	Secondary Diagnosis:

Goals/Objectives are measured by: ☐Self-Report ☐Clinician Observation ☐Other:

Long Term Goals	**Objectives**	**Progress (please explain your answers)**	**Projected Date of Completion**
1.			
2.			
3.			
Short Term Goals	**Objectives**	**Progress (please explain your answers)**	**Projected Date of Completion**

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1.			
2.			
3.			

Provider Name	Type of Service	Frequency/Duration
	Therapy	Frequency: ☐weekly ☐bi-weekly ☐monthly ☐other: Duration: ☐1 hour ☒1 ½ hours ☐2 hours ☐other:
	Med Management	Frequency: ☐weekly ☐bi-weekly ☐monthly ☐other: Duration: ☐1/2 hour ☐other:
	Substance Abuse	Frequency: ☐weekly ☐bi-weekly ☐monthly ☐other: Duration: ☐1 hour ☐1 ½ hours ☐2 hours ☐other:
	Case Management	Frequency: ☐weekly ☐bi-weekly ☐monthly ☐other: Duration: ☐1 hour ☐1 ½ hours ☐2 hours ☐other:
	Medication Assisted Treatment	Frequency: ☐weekly ☐bi-weekly ☐monthly ☐other: Duration: ☐1 hour ☐1 ½ hours ☐2 hours ☐other:
	Other	Frequency: ☐weekly ☐bi-weekly ☐monthly ☐other: Duration: ☐1 hour ☐1 ½ hours ☐2 hours ☐other:

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Physical Accommodations and Barriers: ☐**N/A** ☐**Yes- (**Please explain):

Risk Assessment (please identify 1-10 & explain)

Unmet needs please identify (e.g. dental provider, PCP, etc.): ☐N/A

Justification for not addressing unmet need: ☐N/A ☐Unavailable ☐Yes- (Please explain)

Discharge criteria is based on above measurements and:

Address/phone change: ☐Yes ☐No
If yes, update:

Reviewed Crisis Plan: ☐Yes ☐No

AMHI class member: ☐Yes ☐No

Risk and Benefits Statement

I have developed my ITP and Safety Plan with my provider. We have reviewed the risks and benefits associated with these plans. I have been offered a copy of these plans and agree to work towards these goals.

☐Yes ☐No (If no, please explain):

Participant Names & Signatures	Signature Dates
Client:	
Parent/Guardian:	

Client Name (Print):	DOB:	Client#
Other Participant(s):		
Provider:		
Supervisor:		

Is this Treatment Plan Review late (and still in effect)? ☐**No** ☐**Yes**

If yes, please provide the reason for it being late:

☐ Client cancellations/no shows ☐Client did not return for services

☐ Infrequency of client visits ☐ Other:

☐ Provider error: