Cornerstone Behavioral Healthcare **Acehelosu, a division of Cornerstone**

OHH Individualized Treatment Plan

Client #

☐OHH ☐MAT

Client Name (Print):	DOB:

Is this Plan late (and still in effect)? ☐No ☐Yes (please explain)

Identifying Problems (check all that apply)

☐Client is dependent on opioids	☐Client has a seizure disorder
☐Client uses tobacco products	☐Client has an acquired brain injury
☐Client is overweight or obese (BMI over 25)	☐Client has developmental or intellectual disorder

☐Client is dependent on substance other than opioids (please specify):

☐Client is experiencing symptoms of mental illness (please specify):

☐Client is experiencing symptoms of physical illness (please specify):

☐Others identified by client (please specify):

As Evidenced By: Client report and Provider's observations

Diagnosis

Primary Dx	Secondary Dx	Tertiary Dx

Strengths and Resources (check all that apply)

☐Housing	☐Personality Characteristics (please specify):
☐Transportation	
☐Family Support	
☐Community Support	

Provider Team

Team Member	Role	Frequency
	MAT provider	☐weekly ☐bi-weekly ☐monthly ☐other:
	Clinical Counselor	☐weekly ☐bi-weekly ☐monthly ☐other:
	Clinical Counselor	☐weekly ☐bi-weekly ☐monthly ☐other:
	Nurse Care Manager	☐weekly ☐bi-weekly ☐monthly ☐other:

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	Medical Assistant	☐weekly ☐bi-weekly ☐monthly ☐other:
	Patient Navigator	☐weekly ☐bi-weekly ☐monthly ☐other:
	Peer Recovery Coach	☐weekly ☐bi-weekly ☐monthly ☐other:
	PCP	☐weekly ☐bi-weekly ☐monthly ☐other:
	Other (please specify)	☐weekly ☐bi-weekly ☐monthly ☐other:

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

Long-term Goals (in client's words and reflects client's wishes and hopes for themselves)

Goal	Date Established	Projected Date of Completion

Short-term Goals (in client's words and reflects the client's wishes and hopes for themselves)

Goal	Date Established	Projected Date of Completion

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Measurable Objectives		
Action Steps/Measurable Objectives	Frequency	Duration
Interventions		

Dosage Plan*	
Induction Phase	Client and Provider Team will determine appropriate dose based upon the Clinical Opiate Withdrawal Scale, client report of symptoms and provider observation.
Stabilization Phase	Dose changes will be documented in progress notes, including rationale and outcome of dose change.
Maintenance Phase	It is our expectation that dose will not change significantly during maintenance phase, which is expected to last an indefinite period, but not less than two years. If dose does need to change, this will be documented in progress notes as indicated above.
Termination Phase	Client and Provider Team will meet to determine an appropriate taper schedule, with the expectation that the client will successfully taper off Medication Assisted Treatment without relapse. This taper schedule is subject to change, based upon client need.

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* This schedule and any changes will be documented in the progress notes, as indicated above.

Domains (The following goal areas should be considered in the context of the individual's recovery. Please check each domain that is an active need to be addressed on this treatment plan, indicate a status and designate a responsible team member)

Please see Initial Assessment dated _____ for further information.

STATUS KEY: *GE (Goal Established); AN (Assessed, No Need at this time); AO (Assessment On-going); CC (Client Chooses not to address at this time); GA (Goal Achieved); C (Continuing); D (Dissolved): UN (Unmet Need)*

Domain	Status	Team Member(s) Responsible
☐ Substance Use		
☐ Mental Health		
☐ Health Care		
☐ Housing		
☐ Financial		
☐ Education		
☐ Transportation		
☐ Vocation		
☐ Legal		
☐ Social/Recreation		
☐ Spiritual/Cultural		
☐ Outreach		
☐ Other (please specify):		

For all unmet needs listed above, please document the reason, and indicate a plan to address these:

Current Treatment Plan Assessments

Stages of Change for Primary Diagnosis *(indicate one for the review period to the right)*	
Assessment of Risk (1=Low, 10=High) *(indicate one for the review period to the right)*	

Physical Accommodations & Barriers ☐N/A ☐Yes (please explain below)

Justification for not addressing unmet need ☐N/A ☐Unavailable ☐Yes (please explain below)

Discharge Criteria is based on above measurements and:

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Client will be discharged when he/she no longer requires medication management from this provider, as evidenced by client/provider agreement.		
Signature Section		
☐Initial Plan	☐Review	☐Annual Plan
We have been informed of, offered a copy and have agreed to participate in this treatment plan.	**☐Yes ☐No (please explain):**	

Participant Signatures (*see printed names under Provider Team)	**Signature Dates**
Client	
Parent/Guardian	
Provider*	
Counselor*	
Counselor*	
Care Manager*	
Med Assistant*	
Navigator*	
Coach*	
PCP*	
Other*	