



**SUBSTANCE ABUSE PREVENTION AND CONTROL
TREATMENT PLAN FORM**

Mail: Substance Abuse Prevention and Control
1000 S. Fremont Ave, Bldg. A9 East, 3rd Floor, Alhambra, CA 91803
To check submission status call: (XXX) XXX-XXXX

Website: <http://publichealth.lacounty.gov/sapc/>
Fax: (XXX) XXX-XXXX

1. Name (Last, First, and Middle) Doe, John		2. Date of Birth (MM/DD/YY): 1/1/1989		3. Medi-Cal Identification Number: 123-45-6789	
4. Primary Counselor's Name: Greg Lollipop			5. Treatment Provider: Healing SUD Treatment Center		
6. DSM-5 Diagnosis(es): Opioid Use Disorder (Severe)					
7. Is Patient's Physical Examination Result Available? <input type="checkbox"/> If yes, provide the date the physical exam was completed: 8/21/2015 <input type="checkbox"/> If no, provide the date of scheduled physical exam appointment:					
8. Assessment Date: 1/21/2016			9. Updated Treatment Plan Date:		
ASAM Dimensions: 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 Severity: 0 - None; 1 - Mild, 2 - Moderate, 3 - Severe, and 4 - Very Severe.					
PROBLEM # 1					
10. Problem Statement: Opioid abuse					
11. Long-Term Goal: "I want to stop using drugs"					
12. Treatment Start Date: 1/21/2016		13. Dimension: 5		14. Severity: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4	
15. Short-Term Goal(s) (SMART): 1. Client will learn to recognize at least 3 triggers to reduce the chance of relapse within 1 month. 2. Client will increase control over cravings by learning to use coping skills from 0 per week to 3 per week to prevent relapse. 3. Client will continue with Suboxone as prescribed by the MAT provider.			16. Action Steps: 1.a Client will participate in relapse prevention group sessions 3 times a week. 2.a CBT group counseling by SUD provider 3 times a week. 3.a Will follow up with Client on experience with MAT and coordinate care with MAT prescriber weekly.		
17. Target Date: 1.a 2/21/2016 2.a 3/21/2016 3.a 4/21/2016			18. Complete Date:		
PROBLEM # 2					
10. Problem Statement: Currently living on friends' couches.					
11. Long-Term Goal: "To have my own place to live"					
12. Treatment Start Date: 1/21/2016		13. Dimension: 6		14. Severity: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	
15. Short-Term Goal(s) (SMART): 1. Identify at least 2 housing options within 1 month.			16. Action Steps: 1.a Refer to Case Manager this week. 1.b Find sober living housing listing and contact at least 2 facilities. 1.c Refer to DPSS for general relief financing within the next 2 weeks.		
17. Target Date: 1.a 1/28/2016 1.b 2/21/2016 1.c 2/4/2016			18. Complete Date:		

<small>This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.</small>	Client Name: John Doe	Medi-Cal ID: 123-45-6789
	Treatment Agency: Healing SUD Treatment Center	

PROBLEM # 3**10. Problem Statement:**

No social support from family and friends.

11. Long-Term Goal:

"To have supportive people surrounding me"

12. Treatment Start Date:

1/21/2016

13. Dimension:

6

14. Severity: 0 1 2 3 4**15. Short-Term Goal(s) (SMART):**

1. Client will engage in social activities with family and friends at least once a week for the next month.
2. Client will identify a sponsor within next 2 weeks.

16. Action Steps:

- 1a. Client will attend social activities or have a phone conversation with family or friends at least once a week for the next month.
- 2a. Provide client with the resource list with self-help groups .
- 2b. Client will call at list 3 support groups to explore the possibility of connecting with a sponsor within next week
- 2c. Will follow up on client's progress in acquiring a sponsor in the next 2 weeks.

17. Target Date:

1.a 2/21/2016 2.a. 1/28/2016 2.b. 1/28/2016 2.c. 2/4/2016

18. Complete Date:**PROBLEM # 4****10. Problem Statement:**

Patient reported symptoms of depression.

11. Long-Term Goal:

"I have been feeling upset and having flashbacks from accidents."

12. Treatment Start Date:

1/21/2016

13. Dimension:

3

14. Severity: 0 1 2 3 4**15. Short-Term Goal(s) (SMART):**

1. The client will have a complete Mental Health Assessment within 1 month.

16. Action Steps:

- 1a. Refer for mental health assessment now and make an appointment within 1 month.

17. Target Date:

1/21/2016

18. Complete Date:**TYPE OF SERVICES PROVIDED**

19. Individual Counseling as needed: _____ x week Group Counseling: 3 x week Community Support Group: 3 x week
 UA/Breathalyzer: _____ x week Case Management: 1 x week Recovery Services: _____ x week
 Crisis Intervention: _____ x week Other: _____
 Referred for Medication-Assisted Treatment (MAT)? Yes No Reason(s), Yes or No: Client has strong cravings MAT will be beneficial

Use the addendum for additional problems to complete the treatment plan if necessary.

20. Patient's Signature:

John Doe

21. Date:

1/21/2016

22. If the above required patient signature is absent, please explain the refusal or unavailability of the patient's signature. Include the plan to engage the patient to participate in treatment plan development/updates: Not Applicable**23. Print Counselor's Name:**

Gregg Lollipop

24. Counselor's Signature:

Greg Lollipop

25. Date:

1/21/2016

26. Print LPHA's Name:

Mary Sunshine, LCSW

27. LPHA's Signature:

Mary Sunshine, LCSW

28. Date:

1/21/2016

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Client Name:

John Doe

Medi-Cal ID:

123-45-6789

Treatment Agency:

Healing SUD Treatment Center

TREATMENT PLAN FORM INSTRUCTIONS

1. Enter the patient's name in the order of last name, first name, and middle name.
2. Enter the patient's date of birth.
3. Enter the patient's Medi-Cal number.
4. Enter the primary counselor's name.
5. Enter the agency's name.
6. Enter the patient's DSM-5 Diagnosis(es).
7. Answer the question "Is Patient's Physical Examination Result Available?" If the answer is affirmative, mark the "yes" box; if the physical exam result is not available mark the "no" box and enter the date of scheduled physical exam appointment.
8. Enter the date the patient assessment was performed.
9. Enter the date the treatment plan is updated.

PROBLEM(S) # 1-4

10. Enter the problem statement. Problem statements focus on the patient's current areas of concern and their most immediate areas of need.
11. Enter the long-term goal for this problem. Long-term goals are the ultimate results desired when a plan is established or revised.
12. Enter the treatment start date.
13. Enter the relevant ASAM dimension for respective problem.
14. Select severity level for the respective problem (0 for none; 1 for mild, 2 for moderate, 3 for severe, and 4 for very severe).
15. Enter the short-term goal for this problem. Short-term goals can be achieved in a limited period of time and frequently lead to the achievement of a long-term goal. Short-term goal(s) must be SMART: Specific, Measurable, Attainable within the treatment plan review period, Realistic, and Time-bound. SMART goals must be linked to the patient's functional impairment and diagnosis, as documented in the assessment. Multiple short-term goals should be prioritized numerically (1, 2, 3, etc).
16. Enter the action steps that will be implemented to achieve the correlated short-term goal. Multiple action steps should be prioritized sequentially (1a, 1b, 1c, etc).
17. Enter the projected target date for the patient to achieve the correlated short-term goal(s).
18. Enter the completion date the patient actually achieved the short-term goal(s).
19. Mark the type and frequency of services to be provided to the patient. ("x week" means the number of times the marked service will be provided to the patient per week).
Additionally, indicate if the patient is referred for Medication-Assisted Treatment (MAT) and provide the reasons why patient is referred or not referred (e.g., opioid user, patient is already on MAT, patient declined, etc.).

NAME AND SIGNATURE OF INVOLVED PARTIES

20. Enter the patient's signature.
21. Enter the date the patient signs the treatment plan.
22. Mark "Not Applicable" if patient's signature is present. If the required patient signature is absent, provide explanation of the refusal or unavailability of the patient signature and document the plan to engage the patient to participate in treatment plan development/updates.
23. Enter the counselor's name.
24. Enter the counselor's signature.
25. Enter the date the counselor signs the treatment plan.
26. Enter the LPHA's name.
*Note: Licensed Practitioner of the Healing Arts [LPHA] includes Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists [LCP], Licensed Clinical Social Workers [LCSW], Licensed Professional Clinical Counselors [LPCC], and Licensed Marriage and Family Therapists [LMFT] and licensed-eligible practitioners working under the supervision of licensed clinicians.
27. Enter the LPHA's signature.
28. Enter the date the LPHA reviews and signs the treatment plan.

INTERNAL SAPC USE ONLY

This section reserved for internal SAPC use only.

<i>SUBMIT THE TREATMENT PLAN FORM TO:</i>	
Mail:	Substance Abuse Prevention and Control 1000 S. Fremont Ave., Bldg. A9 East, 3rd Floor Alhambra, CA 91803
Fax:	(XXX) XXX-XXXX
Website:	http://publichealth.lacounty.gov/sapc/

ADDENDUM - TREATMENT PLAN

PROBLEM #

10. Problem Statement: Chronic back pain related to the bike accident 3 years ago		
11. Long-Term Goal: "I want to go back to work, but this back pain is killing me."		
12. Treatment Start Date: 1/21/2016	13. Dimension: 2	14. Severity: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
15. Short-Term Goal(s) (SMART): 1. Ensure the client have an appointment to see his primary care provider (PCP) for pain management within next week.		16. Action Steps: 1a. Client will call his PCP to make an appointment by next week. 1b. Case manager/coordinator will follow up to ensure the client has made an appointment with PCP by next week.
17. Target Date: 1.a 1/28/2016 1.b. 1/28/2016		18. Complete Date:

PROBLEM #

10. Problem Statement:		
11. Long-Term Goal:		
12. Treatment Start Date:	13. Dimension:	14. Severity: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
15. Short-Term Goal(s) (SMART):		16. Action Steps:
17. Target Date:		18. Complete Date:

PROBLEM #

10. Problem Statement:		
11. Long-Term Goal:		
12. Treatment Start Date:	13. Dimension:	14. Severity: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
15. Short-Term Goal(s) (SMART):		16. Action Steps:
17. Target Date:		18. Complete Date:

TYPE OF SERVICES PROVIDED

<input type="checkbox"/> Individual Counseling as needed: _____ x week	<input type="checkbox"/> Group Counseling: _____ x week	<input type="checkbox"/> Community Support Group: _____ x week
<input type="checkbox"/> UA/Breathalyzer: _____ x week	<input type="checkbox"/> Case Management: _____ x week	<input type="checkbox"/> Recovery Services: _____ x week
<input type="checkbox"/> Crisis Intervention: _____ x week	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Referred for Medication-Assisted Treatment (MAT)? <input type="checkbox"/> Yes <input type="checkbox"/> No Reason(s), Yes or No: _____		

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