



Person-Centered Planning Meeting Information

Date: _____

Case #: _____

Client Name: _____

Primary Clinician: _____

Location of Meeting: _____

Time: _____ to _____

of units per month: _____

People who contributed to the plan:

Client

Primary Clinician

NAME	RELATIONSHIP	PARTICIPATED IN PLAN?	PROGRESS REVIEW COMPLETED AND BROUGHT TO MEETING?	ATTENDED MEETING?

Integrated Treatment and Care Coordination:

	NAME	ADDRESS	PHONE	METHOD OF COMMUNICATION	FREQUENCY OF COMMUNICATION
Primary Case Holder					
LifeWays Medical Services					
Primary Care Physician					
Other Providers					
Others – please list					
Others – please list					

Stage of Change:

ENGAGEMENT

EARLY PERSUASION

LATE PERSUASION

EARLY ACTIVE TREATMENT

LATE ACTIVE TREATMENT

IN REMISSION OR RECOVERY

RELAPS PREVENTION

Level of Readiness:

PRE-CONTEMPLATIVE

CONTEMPLATIVE

PREPARATION

ACTION

MAINTENANCE

Preferences & Accommodations

PREFERENCES AS INDICATED IN THE ASSESSMENT AND OR TREATMENT PLANNING PROCESS (INCLUDE NON-VERBAL NEEDS).

ACCOMMODATIONS MADE TO ASSIST WITH FULL PARTICIPATION IN THE TREATMENT PLANNING PROCESS AND MEET PREFERENCES (INCLUDING NON-VERBAL ACCOMMODATIONS).

Health & Safety

SUMMARY OF HEALTH & SAFETY RISKS AS INDICATED IN THE ASSESSMENT AND/OR PCP PROCESS.

SUPPORTS TO ADDRESS HEALTH & SAFETY NEEDS.

TRANSPORTATION SAFEGUARDS.

Any Barriers?

Symptoms?

PCP MEETING AND TREATMENT PLAN: Original Goals

Please state INDIVIDUAL'S DESIRED OUTCOME/MOTIVATION FOR REQUESTING SERVICES

GOAL 1:

OBJECTIVE:

INTERVENTIONS:

GOAL 2:

OBJECTIVE:

INTERVENTIONS:

GOAL 3:

OBJECTIVE:

INTERVENTIONS:

GOAL 4:

OBJECTIVE:

I
NTERVENTIONS

GOAL 5:

OBJECTIVE:

I
NTERVENTIONS:

Supports that may participate in assisting the individual – even those the individual may not want to develop.

Formal Review of effectiveness of the Treatment Plan shall occur not less than annually.

INDIVIDUAL/GUARDIAN/FAMILY WILL PROVIDE ON-GOING FEEDBACK REGARDING THEIR TREATMENT PLAN USING THE FOLLOWING METHODS.

INDIVIDUAL SELF-REPORT

SCHEDULE FACE-TO-FACE CONTACTS

TELEPHONE CALLS

Progress towards established discharge criteria

HOW WILL PROGRESS BE DETERMINED?

HOW WILL YOU KNOW WHEN THESE GOALS HAVE BEEN ACCOMPLISHED? (D/C INDICATORS)

Crisis Plan: USE CRISIS PLAN FORM

***GET TREATMENT AGREEMENT AND OTHER ANNUAL PAPERWORK SIGNED**

EXAMPLE: CONSENTS, FINANCIAL DETERMINATION, MEETING MINUTES, PLAN, ETC.

PERSON CENTERED PLANNING MEETING ATTENDANCE

Client Name: _____

Case #: _____

Location of Meeting: _____

Date: _____

Time: _____ to _____

Attendees

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

CSM Signature: _____ Date: _____

Other Signature: _____ Agency: _____ Date: _____

Other Signature: _____ Agency: _____ Date: _____

Other Signature: _____ Agency: _____ Date: _____

Other Signature: _____ Agency: _____ Date: _____

Other Signature: _____ Agency: _____ Date: _____

Other Signature: _____ Agency: _____ Date: _____

Other Signature: _____ Agency: _____ Date: _____

Other Signature: _____ Agency: _____ Date: _____