RECOVERY TECHNOLOGY L.L.C.

Post Hospital - Person Centered Planning Meeting Information

Client Name: _____ Case Number: _____
Date: _____ CSM: _____
Time: _____-_____ # of Units Requested: _____
Location of Meeting: _____

Attendees

Name	Relationship to Client	Organization

Dates of Hospitalization: _____--_____

Location of Hospitalization _____

This Hospitalization Was

◯ Medical ◯ Psychiatric ◯ Both

Reason(s) for Hospitalization:

_____
_____
_____
_____
_____
_____
_____
_____

Outcome(s) of Hospitalization (i.e. new medications, diagnosis changes, referrals/treatment providers, etc.):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Team agrees that an IPOS Addendum is ◯ Needed ◯ Not Needed

(Complete only if an addendum is needed)

New and/or Modified Goals Discussed:

_____
_____
_____
_____
_____
_____
_____
_____

New and/or Modified Objectives Discussed:

_____
_____
_____
_____
_____
_____
_____
_____

Other Applicable Information (i.e. LOR, additional referrals needed, etc.):

_____
_____
_____
_____
_____
_____

POST HOSPITAL - PERSON CENTERED PLANNING MEETING ATTENDANCE

Client Name: _____ Case Number: _____

Date: _____ Time: _____-_____

Location of Meeting: _____

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: _____