

PROGRAM NAME:



SACRAMENTO COUNTY
Mental Health Plan



**ADULT MENTAL HEALTH SERVICES
SERVICE PLAN**

PROVIDER START DATE:

Annual Plan
 Amended Plan

Authorization Period: FROM:	TO:	Today's Date:
Client Name:		Client ID#:
Life Goal:		
Strengths:		
Challenges:		
Personal Supports:		

#	Treatment Goal (specific, measurable):	Status
1		
2		
3		
4		
5		

Goal #	Services (connect to goal – include specific service, frequency and responsibility of client, support person or staff):	Completion Date

Client Name:	Client ID#:
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Service Coordination					
Type	N/A	Note Specific Need	Task	Date Started	Date Resolved
Income					
Benefits					
Housing					
Primary or Specialty Health					
Vocational					
Education					
ADS – residential / detox					
Other (specify):					

SIGNATURES (Client and Provider have agreed to this plan and to participate in the treatment process. Client has received a copy of this plan and will receive additional copies upon request.)		
Client Signature: X		Date:
Provider Signature:	Title:	Date:
Co-Signature (if Required):	Title:	Date:
Document reason if there is no client (or LPS Conservator if applicable) signature:		

<p>INSTRUCTIONS:</p> <ul style="list-style-type: none"> <u>Progress Notes:</u> (1) Describe the process of plan development with the client including involvement of client, support person and staff. Incorporate goals, services, client's inclusion and response, strengths and challenges. (2) At time of annual service completion, a progress note should be written summarizing treatment goal progress or revisions. (3) Use the treatment goal numbers to link progress note entries to goals, services, and client response. <u>Service:</u> Should have sufficient detail noting type of service, staff, roles, and tasks of client or support person(s), frequency, etc. to accomplish the treatment goals. <u>Service Coordination:</u> Should be documented regularly to demonstrate monitoring of progress in each identified area.
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