City and County of San Francisco
Department of Public Health
COMMUNITY BEHAVIORAL HEALTH SERVICES

ADULT/ OLDER ADULT MH TREATMENT PLAN

Name: DRAFT DOCUMENT 5/2016

BIS #: THIS CANNOT BE USED IN

RU #: MEDICAL RECORDS -- THIS IS A "WORKSHEET"

Plan Effective Date: __/__/__ *Plan Last Update:*

Plan Type: *Initial* *Update*

Plan End Date: __/__/__

Client was linked to culture specific and/ or linguistic services
○ Yes ○ No

Client has been informed of the Grievance/ Appeal process at least annually
○ Yes ○ No

Client has been informaed of the DPH Notice HIPPA Privacy Practices at least annually
○ Yes ○ No

	Role	*Staff ID*	*Participant Name*	*Plan Author*	*Notification*
1					
2					
3					
4					

Client Strengths (List Strength that will help client accomplish TPOC Goals and Objectives)

☐ Psychiatric Symptom Severity
☐ Behavioral Issues
☐ Homeless/Housing
☐ Social/Family/Relationship/Role Stressor
☐ Language Barriers
☐ Current RISK
☐ Basic Needs
☐ Substance Abuse/ Dependence
☐ Medical/Health
☐ Legal Status/Criminal Involvement

Plan for Discharge or Step-Down (What is the plan to help client progress toward a) reduced intensity/ frequency of treatment, b) step-down to a lower level of care, or c) discharge form treatment?)

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ADULT/ OLDER ADULT MH TREATMENT PLAN

Name:

BIS #:

RU #:

Problem Code: Date of Onset: Date of Problem Identified:	Status: Other:

Treatment Plan Problem Description

	Date Identified:

Goal related to Problem (Include Client's own words):

	Date Identified

Objective: (The Section should a) list specific quantifiable/observable outcomes, b) describe how the objective will be measured/demonstrated; c) relate to the mental health needs/symptom/behaviors; and) state the specific functional impairments)

	Date Identified:

Intervention: This section should describe the proposed treatment intervention including a) modality (individual, group, case management), b) proposed frequency c) duration d) and how they address the functional

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Treatment Plan Problem Description	

	Date Identified:
Goal related to Problem (Include Client's own words):	

	Date Identified
Objective: (The Section should a) list specific quantifiable/observable outcomes, b) describe how the objective will be measured/demonstrated; c) relate to the mental health needs/symptom/behaviors; and) state the specific functional impairments)	

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City and County of San Francisco Department of Public Health COMMUNITY BEHAVIORAL HEALTH SERVICES ADULT/ OLDER ADULT MH TREATMENT PLAN	Name: BIS #: RU #:

Clinician/Staff Name and Credential (Print)

Clinician/Staff Signature
(For MH, if not LPHA, must have a LPHA Co-Signature)

Date

Date

(For MH- LPHA approval)

☐ I agree that I have participated in the development of the Treatment plan of care and have been given a copy of the Treatment Plan of Care, if requested.

☐ *The Treatment Plan of Care was explained in the Clients' preferred language.*

Clients Signature

Date

Parent/Guardian/Conservator/Other Legal Representative Signature

Date

IF NO CLIENT SIGNATURE, Document reason in progress notes(s) dated:

City and County of San Francisco
Department of Public Health
Community Behavioral Health Services

CYF 0/18 TREATMENT PLAN OF CARE

Name

BIS #:

RU #:

Plan effective Date: _ _ / _ _ / _ _

Plan Type: Initial Update

Plan End Date: _ _ / _ _ / _ _

Plan Last Updated: _ _ / _ _ / _ _

Client was linked to culture specific and/ or linguistic services

○ Yes ○ No

Plan Participants

	Role	Staff ID	Participant Name	Plan Author	Notification
1					
2					
3					
4					
5					

Parent/Youth Input

Strengths-based treatment planning: (Describe how child/youth and family strengths (as identified in CANS assessment) inform treatment plan goals and how interventions delivered will draw upon these strengths.)

Discharging Planning

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CYF 0/18 TREATMENT PLAN OF CARE

Name:

BIS #:

RU #:

Problem Code: Date of Onset: Date of Problem Identified:	Status: Other:
Treatment Plan Problem Description	

	Date Identified:
Goal related to Problem (Include Client's own words):	

	Date Identified
Objective: (Expected Behavioral Change)	

	Date Identified
Intervention: (Describe type, frequency, expected duration of intervention and to whom it will be applied)	

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CYF 0/18 TREATMENT PLAN OF CARE

Name:

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Problem Code:	Status:
Date of Onset:	Other:
Date of Problem Identified:	

Treatment Plan Problem Description

	Date Identified:

Goal related to Problem (Include Client's own words):

	Date Identified

Objective: (Expected Behavioral Change)

	Date Identified:

Intervention: (Describe type, frequency, expected duration of intervention and to whom it will be applied)

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Objective: (Expected Behavioral Change)

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Confidential Patient Information

- THIS IS A WORKSHEET

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NOT TO BE USED AS "REAL" TPOC