Health Care for the Homeless

INFORMATION RESOURCE CENTER

888/429-3300 • Fax 518/439-7612

#15. TREATMENT PLAN

Addiction treatment plan – Diagnosis and formulation of problems (*BAL 22*)
Aftercare plan (*BAL 23*)
Case coordination (*THU 5*)
Client case management plan (*COM 2*)
Interdisciplinary care plan (*BAL 52*)
Ninety-day treatment plan - 1st & Follow-up (*LOS 6R*)
Drug abuse day care services – Treatment plan update (*HCLA 2*)
Drug abuse day care services – 90-day treatment plan (*HCLA 3*)
Treatment plan review/agreement (*POR 6*)
Youth treatment plan (*TRA 5*)

DAL 22-1

HCH Addiction Treatment Plan
Diagnosis and Formulation of Problems

Diagnosis:

Axis I: _____. ___ ___ _____. ___ ___ _____. ___ ___

Axis II: _____. ___ ___

Axis III: _____

Axis IV: **Problems with or related to:** (check all those that apply) ***state actual problem on list below***

- ☐ Primary support group
- ☐ Occupation
- ☐ Access to health care
- ☐ Social Environment
- ☐ Housing
- ☐ Legal System
- ☐ Education
- ☐ Economic
- ☐ Other

Axis V: **Current GAF** _____

Number	I = Initial Assessment R = Case Review	Addiction Problem List	Date	Date/Status
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Date - Date problem is identified	**Status Changes: RTX** = Resolved by Treatment
Date/Status - Date of status change	**N/RTX** = Not resolved by Treatment
I = Identified in Initial Assessment	**CANC** = Cancelled (removed from treatment plan) **(Progress note must state why)**
R = Identified in Case Review	**DEF** = Deferred to long term status

ALL NOTATIONS OF STATUS CHANGE MUST BE DATED IN "DATE/STATUS" COLUMN

Client Name:	**HCH Number:**
Date of Treatment Plan:	**Admit Date:**

BAL 22-2

HCH Treatment Plan
Program Goals

Problem: _____

Goal: _____

Objective: _____

Completion Date: _____

Monitoring Staff: _____

Objective: _____

Completion Date: _____

Monitoring Staff: _____

Objective: _____

Completion Date: _____

Monitoring Staff: _____

Client Name:	HCH Number:
Date of Treatment Plan:	Admit Date:

BAL 22-3

HCH Treatment Plan

Problem # ____

Description: _____

Statement of Goal	Target Date	Date/Status

Objectives	Target Date	Date/Status
1.		
2.		
3.		
4.		

Status of Goal or Objectives can be: 1) Attained
2) Cancelled
3) Revised

Number each **Goal and each Objective.**
For each objective include in parentheses the person responsible for measuring or verifying completion, e.g., (Counselor), (Nurse), etc.

Client Name:	HCH Number:
Date of Treatment Plan:	Admit Date:

BAL 23

HEALTH CARE FOR THE HOMELESS

AFTERCARE PLAN

Now that I have completed treatment at Health Care for the Homeless, I know that in order to maintain my sobriety and improve my recovery, I have to continue to maintain a recovery plan.

My recovery plan is as follows:

1. I will attend _____ NA/AA meetings per week.
2. I will maintain contact with my sponsor _____ times per week.
3. I will attend the _____ weekly and have chosen that meeting to be my Home Group.
4. I will _____
5. I will _____
6. I will _____
7. I will _____
8. I will _____
9. I will _____
10. I will _____

I understand that I am encouraged to call my counselor at Health Care for the Homeless (410-837-5533) or stop in for addiction walk-in services if I have any trouble with my plan as listed above or with maintaining my recovery.

_____ _____

Client Signature Date

_____ _____

Counselor Signature Date

CLIENT LAST NAME:		FIRST:		HCH#:	

THU 5

Initial Assessment Person doing initial assessment	Date	F/up needed
Social Service:		Yes No
Substance Abuse:		Yes No
Financial Resources:		Yes No
Case management:		Yes No

THUNDERMIST HEALTH ASSOCIATES

CASE COORDINATION

Patient Name: _____ DOB : _____ Medical Record #: _____

Date	Risk/Problems	Initial Plan-Objectives	Staff Respon-sible	Action taken	Date	F/U Plans

COM 2

COMMUNITY HEALTH CARE
HOMELESS PROGRAM
CLIENT CASE MANAGEMENT PLAN

Client_____ DOB_____ Chart #_____

Case Manager_____ Intake Date_____ Case Management Discharge Date_____

Category	Treatment Goals	Estab.	Compl.	Rev.
Medical				
Dental				
Basic Human Needs				
Mental Health				
Entitlement/ Finance				
Employment				
Education				
Chemical Dependency				
Other				

___ CHECK ANY CONCERNS

___ MEDICAL CONERNS

___ DOMESTIC VIOLENCE

___ FURNITURE

___ ENTITLEMENTS

___ JOB SKILLS

___ EMPLOYMENT

___ HOUSING

___ HIV/AIDS

___ UTILITIES

___ EDUCATION

___ BUDGET COUNSELING

___ CLOTHING

___ PARENTING EDUCATION

___ DENTAL

___ RELATIONSHIP PROBLEMS

___ SEXUAL ABUSE

___ EMOTIONAL PROBLEMS

___ LEGAL ASST.

___ ALCOHOL/DRUGS

___ FOOD

___ CHILD CARE

___ OTHER

PLEASE LIST ANY AGENCIES YOU ARE WORKING WITH OR RECEIVING ANY ASSTISTANCE FROM;

ADDITIONAL INFORMATION;

REVIEWED BY;---

CLIENT LAST NAME:

FIRST:

HCH#:

Health Care for the Homeless, Inc.
INTERDISCIPLINARY CARE PLAN

Case Manager: _____ **Date:** _____

Goal	Objective	Action / Date	Outcome
1. Increase client access to income through employment and entitlements	☐ Obtain Employment ☐ Obtain Entitlements	**Refer to / Monitor application:** ☐ Genesis Job _____ ☐ Voc. Rehab. _____ ☐ Other _____ **Apply / Monitor application:** ☐ TEMHA _____ ☐ Bus Pass _____ ☐ FS _____ ☐ SSDI, SSI _____ ☐ Other _____	
2. Increase client access to housing through application and referral to community housing resources	☐ Obtain Transitional Housing ☐ Obtain Subsidized Housing ☐ Obtain Private Housing ☐ Obtain Supportive/Assisted Housing	**Apply / Monitor application:** ☐ PLASE _____ ☐ Other _____ **Apply:** ☐ HABC, Sec. 8 _____ ☐ HESU _____ ☐ S+C _____ ☐ RAP _____ ☐ Other _____ ☐ **Landlords** _____ _____ **Refer/Monitor application:** ☐ APS _____ ☐ Dom Care _____ ☐ BMHS _____ ☐ Project HOME _____	
3. Increase client access to health insurance through facilitating the application process	☐ Obtain / Keep MPC ☐ Obtain / Keep Health Choice Coverage	☐ **Apply / Monitor MPC** _____ ☐ **Apply / Monitor Health Choice** _____	
4. Improve health outcomes in coordination with the inter-disciplinary plan of care	Coordinate the interdisciplinary plan of care.	☐ **Monitor compliance with appts** ☐ **Track referrals and follow-up**	
5. Improve outcomes for mental health and/or addiction services.	☐ Obtain / Keep SA Tx. Services ☐ Obtain / Keep MH Services	☐ **Refer for / Maintain SA TX.** _____ ☐ Individual SA TX plan completed _____ ☐ Other _____ ☐ **Refer for / Maintain MH TX.** _____ ☐ Individual MH TX plan completed _____ ☐ Connect to specialized MH TX _____ ☐ Other: _____	

Date: _____

Case Transferred to: _____

Client Signature: _____

BAL 52

LOS 6R

HOMELESS HEALTH CARE LOS ANGELES
DRUG ABUSE HOMELESS DAY CARE SERVICES
1ST 90 DAY TREATMENT PLAN

CLIENT NAME_____ CLIENT ID# _____ DATE OF LAST DRUG USE _____

Use index number for each problem/goal/action step.

1-DRUG USE 2-PSYCHOSOCIAL 3-MEDICAL/DENTAL 4-HOUSING/BENEFITS 5-LEGAL/ADVOCACY 6-EMPLOYMENT/VOCATIONAL

DATE IDENTIFIED	INDEX NUMBER	PROBLEM STATEMENT	GOAL STATEMENT	ACTION STEPS	TARGET DATE ST/LT	DATE RESOLVED
	1	Drug Use	Reduction/ Elimination of Drug Use	1.) Attend Treatment Sessions	30d. S/T	
	2	Psychosocial	HIV/ STD Health Education	2.) Participate in HIV Group & Ind. Counseling	90d. S/T	
	3	Medical/Dental	Medical Screening TB/Tetanus Dental Assessment	1.) See Clinician 2.) See Nurse 3.) Follow-up as needed	30d. S/T 30d. S/T 30d. S/T	
			Acupuncture			
	4	Housing	Housing Stability			

Primary Counselor_____ Date _____

Client Signature _____ Date _____

Clinical Director_____ Date _____

Chart Review
Name: _____
Date: _____

Medical Review
Name: _____
Date: _____

HHCLA:1989 Revised:5/97

LOS 6R

HOMELESS HEALTH CARE LOS ANGELES
DRUG ABUSE HOMELESS DAY CARE SERVICES
90 DAY TREATMENT PLAN

CLIENT NAME _____ CLIENT ID# _____ DATE OF LAST DRUG USE _____

Review previous treatment plan and progress notes. If any, carry forward all unresolved problem use original date on old problems. Use index number for each problem/goal/action step.
1-DRUG USE 2-PSYCHOSOCIAL 3-MEDICAL/DENTAL 4-HOUSING/BENEFITS 5-LEGAL/ADVOCACY 6-EMPLOYMENT/VOCATIONAL

DATE IDENTIFIED	INDEX NUMBER	PROBLEM STATEMENT	GOAL STATEMENT	ACTION STEPS	TARGET DATE ST/LT	DATE RESOLVED

Primary Counselor _____ Date _____

Client Signature _____ Date _____

Clinical Director _____ Date _____

Chart Review
Name: _____
Date: _____

Medical Review
Name: _____
Date: _____

HHCLA: 1989 REVISED: 8/96

HOMELESS HEALTH CARE LOS ANGELES
DRUG ABUSE HOMELESS DAY CARE SERVICES
TREATMENT PLAN UPDATE

CLIENT NAME_____ **CLIENT ID#** _____**DATE OF LAST DRUG USE**_____

Use index number for each problem/goal/action step.

DRUG USE PSYCHOSOCIAL MEDICAL/DENTAL HOUSING/BENEFITS LEGAL/ADVOCACY EMPLOYMENT/VOCATIONAL MISCELLANEOUS

DATE IDENTIFIED	INDEX NUMBER	PROBLEM STATEMENT	GOAL STATEMENT	ACTION STEPS	TARGET DATE	DATE RESOLVED

Primary Counselor: _____ **Date:** _____ **QA Audit Date:**_____

Client Signature: _____ **Date:** _____ **QA Audit Date:**_____

Clinical Director: _____ **Date:** _____ **QA Audit Date:**_____

HHCLA: 1989, revised 06/02

HCLA 2

HOMELESS HEALTH CARE LOS ANGELES
DRUG ABUSE HOMELESS DAY CARE SERVICES
90-DAY TREATMENT PLAN

CLIENT NAME_____ **CLIENT ID#** _____**DATE OF LAST DRUG USE**_____

Use index number for each problem/goal/action step.

DRUG USE PSYCHOSOCIAL MEDICAL/DENTAL HOUSING/BENEFITS LEGAL/ADVOCACY EMPLOYMENT/VOCATIONAL MISCELLANEOUS

DATE IDENTIFIED	INDEX NUMBER	PROBLEM STATEMENT	GOAL STATEMENT	ACTION STEPS	TARGET DATE	DATE RESOLVED
	1	Drug Use	Reduction/Elimination of Drug Use	1.) Attend Treatment Sessions		
	1	Drug Use	Attend Acupuncture Treatment	1.) ___ session(s) per week		
	2	Psychosocial	HIV/STD Health Education	1.) Participate in HIV education group and/or individual counseling	90 day S/T	
	7	Mental Health	Self-esteem, Communication, Relaxation, Anger Management, Depression, Anxiety			
	3	Medical/Dental	Medical Screening TB Dental Assessment	1.) See Clinician 2.) See Nurse 3.) Follow-up as needed	30 day S/T 30 day S/T 30 day S/T	
	4	Housing	Housing Stability			
	6	Employment/ Education				

Primary Counselor: _____ Date: _____ QA Audit Date:_____

Client Signature: _____ Date: _____ QA Audit Date:_____

Clinical Director: _____ Date: _____ QA Audit Date:_____

HHCLA: 1989, revised 06/02

HCLA 3

City of Portland, Health & Human Services Department, Public Health Division
Healthcare for the Homeless, Mental Health & Substance Abuse Services

Treatment Plan - Review

Side 1 of 2

Name: SS #: DOB:

I have read the review of my treatment plan or have had it explained to me. I understand the purpose, benefits and risks of this treatment plan. I have had the opportunity to ask any questions I might have about my care.

I agree with the treatment plan review and have been offered a copy.

****

Review #1 / comments:

Date: Client's/Guardian's signature:

Staff signature

****

Review #2/ comments:

Date: Client's/Guardian's signature:

Staff signature:

City of Portland, Health & Human Services Department, Public Health Division
Healthcare for the Homeless, Mental Health & Substance Abuse Services

Treatment Plan - Review

****

Review #3/ comments:

Date: _____ Client's/Guardian's signature: _____

Staff signature _____

****

Review #4/ comments:

Date: _____ Client's/Guardian's signature: _____

Staff signature _____

Larkin Street Youth Center----Youth Treatment Plan
Date_____ Review date_____

Case Presentation

1. Client's Name_____

2. Identifying Data: age, ethnicity, sexual orientaion, sex, origin, present living situation, referral source:

3. Runaway history & previous interventions:

4. History a. Family:

b. Placements, Legal status. PO/Social Worker:

c. Drug use, past and current:

d. Child abuse issues:

f. Education:

g. Medical/health issues:

h. Prostitution/Survial Sex issues:

i. Suicidal, current or past, ideation/attempts:

j. Overall Psychological asssessment, functioning, presentation:

Strengths:

Presenting Problems:

Short Term Objectives:

1.

2.

Methods:

1. DI:

   CM:

   OR:

   ED:

   MC:

   Other:

2. DI:

   CM:

   OR:

   ED:

   MC:

   Other: