Green Apple Counseling

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POLICY: TREATMENT PLANS

PURPOSE: To ensure that clients are receiving appropriate services by creating and implementing individual treatment plans.

Treatment Plans:

- Treatment plans will be assessed and staffed every 30 days for all SUD Programs.
- Treatment Plans will be assessed and staffed every 90 days for mental health programs.
- Treatment Plans will be completed within 5 contacts or 21 days, whichever is longer.
- The Treatment plan will, preferably, be face-to-face with client present. If a minor, then guardian/parent must be present.
- Will be conducted by at least one appropriately licensed clinical professional and should include persons who are involved in the member's treatment.
- The treatment plan includes:
    - identify, at a minimum, the member's name, member's primary diagnosis and any other diagnoses that are relevant to the service provided, treatment provider, rendering provider if different, treatment plan date, treatment plan review due date, and treatment plan review date if applicable.
    - identify treatment team members who are involved in the treatment.
    - identify individualized, member strengths
    - identify the problem area that will be the focus of the treatment to include symptoms, behaviors, and/or functional impairments
    - identify the goals that are person-centered, long-term, recovery oriented.
    - identify the objectives that are short-term designed to assist the member with accomplishing their goal that should be simple, straightforward, measurable, attainable, realistic, and time framed.

- describe the intervention and service with enough specificity to demonstrate the relationship between intervention and the stated objective
- include the signature and date of the licensed clinical professional who completed the treatment plan.
- The treatment plan assessment will include client's response, progress, and amending of treatment goals.
  - Level of care will be documented with each treatment assessment.

- **Discharging**
  - Discharge summary must be completed and filed in the clinical record within one month of the date of the member's formal discharge from services or within three months of the date of the member's last services when no formal discharge occurs.
  - For cases left open when a member has not received services for over 30 days, documentation must be entered into the record indicating the reason for leaving the case open.
  - The discharge summary must include:
    - the reason for discharge
    - a summary of the services provided by the provider including recommendations for aftercare services and referrals to other services, if applicable
    - an evaluation of the member's progress as measured by the treatment plan and the impact of the services provided.
    - the signature of the staff person who prepared the summary and the date of preparation.