Name:________________________

NEXT STEPS/INTERIM SERVICE PLAN

1. Identify specific people who may be supportive and helpful and who should be invited to be part of the person's ongoing Team, including phone numbers and action to be taken:____
____
____

2. Identify any additional documentation (e.g., medical records, IEP, probation report), which needs to be collected to assist in the ongoing assessment and service planning including the individuals and/or agencies and action to be taken to obtain this information:
____
____

3. Identify who the person and/or family/legal guardian/significant other should contact if the person needs immediate assistance before the next appointment:____
____

4. **Interim Service Plan.** Based on the person's presenting issues, your impressions and the preferences of the person and his/her family/legal guardian/significant other, describe in the Interim Service Plan on the next page recommended next steps (e.g., formation of Team, response to immediate risks and needs of the person, further assessment). Additionally, this Interim Service Plan should include:

- Any immediate next steps to be taken by the person and/or family/legal guardian/significant others.
- Referral to the person's primary care physician, if *physical health problems* have been identified.
- Additional considerations for urgent response for children removed by Child Protective Services (see shaded box below).

Assessors may also add a goal statement, if appropriate.

For urgent response for **children removed by Child Protective Services**, the assessor must include as part of the recommended next steps/interim service plan, identification of:

1. Actions needed to be taken immediately to mitigate the effects of the removal itself;
2. Supports and services the child's caregivers may need to meet the child's needs; and
3. A plan to ensure that even asymptomatic children are reassessed and observed for surfacing behavioral health needs within at least the next 23 days (or sooner if indicated).

The assessor may also provide any input he/she has regarding the types and amount/frequency of contact (e.g., visits, phone calls, e-mail), the child should have with parents, siblings, relatives and other individuals important to the child.

Name:_________________________

INTERIM SERVICE PLAN

Description of Next Steps (Action) to Be Taken	**Who** Will Be Responsible to Ensure Action Occurs	**Where** Action/Step Will Take Place (e.g., provider)	**When** Action/ Step Will Take Place

---

☐ Yes, I am in agreement with the types & levels of services included in the ~~Initial~~Interim Service Plan.

☐ **Yes, I have received a copy of this plan.**

☐ No, I disagree with the types and/or levels of some or all of the services included in this plan. (By checking this box, I will receive the services that I have agreed to receive and may appeal the treatment team's decision to not include all the types and/or levels of services that I have requested.)

- ☐ I have received a Notice of Action (PM Form 5.1.1 if disagreement concerns a Title XIX/XXI covered service~~s~~).
- ☐ I have received the Notice of Decision & Right to Appeal for Individuals with a Serious Mental Illness (PM Form 5.5.1 if disagreement pertains to a Non-Title XIX/XXI covered service).

Name:________________________

INTERIM SERVICE PLAN

Service Plan Rights Acknowledgement for Persons who are Title XIX/XXI and/or SMI:
My service plan has been reviewed with me by my behavioral health provider. I know what services I will be getting and how often. All changes in the services have been explained to me. I have marked my agreement and/or disagreement with each service above. I know that in most cases, any reductions, terminations, or suspensions (stopping for a set time frame) of current services will begin no earlier than 10 days from the date of the plan. I know that I can ask for this to be sooner.

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If I do not agree with some or all of the services that have been authorized in this plan, I have noted that above. I know if the service asked for was denied, reduced, suspended or terminated, that my behavioral health provider will give me a letter that tells me why the decision was made. That letter will tell me how to appeal the decision that has been made about my services. The letter will also tell me ~~about my appeal rights, including~~ how I can ~~to~~ request continued services.

My behavioral health provider has told me how the appeal process works. I know how I can appeal service changes I do not agree with. I know that I can change my mind later about services I agree with today. I know that if I change my mind before the changes go into effect, I will get a letter that tells me the reason my services changed. The letter will also tell me about my appeal rights.

I know that if I need more services or other services than what I am getting, I can call my behavioral health provider~~, as identified above,~~ at (____) ____-______ to talk about this. My behavioral health provider will call me back within 3 working days. Once I have talked with my behavioral health provider, s/he will give me a decision about that request within 14 days. If the behavioral health provider is not able to make a decision about my request within 14 days, s/he will send me a letter to let me know more time is needed to make a decision.

____ ________________
Person/Guardian Signature ____________Date

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____ __________________ ____________
Assessor's Name (print) / Signature Credentials/Position Date

____ __________________ ____________
Behavioral Health Professional Reviewer Name (print) / Signature Credentials/Position Date

____
Agency

Note: The assessor should make sure to provide the person/guardian with a copy of the interim service plan. The CPS specialist, however, should receive a copy of the entire next steps/ interim service plan section.

PART D: BEHAVIORAL HEALTH SERVICE PLAN

Name: ________________________________ CIS Client ID# ___________ Program:_____________________________ Today's Date: ____________

Individuals at Service Planning Meeting: ____

____

RECOVERY GOAL/PERSON-FAMILY VISION:

PERSON'S STRENGTHS:

Review Date (Objective Target Date): _______________

IDENTIFIED NEEDS and SPECIFIC OBJECTIVES (to address these needs)	Current Measure	INTERVENTIONS to MEET OBJECTIVES		Desired Measure	Achieved Measure (at target date)	Measure Met (Y/N)
		Specific Services and Frequency	Strengths Used			
1						
2						
3						

DISCHARGE PLAN (add discharge date if known):

☐ Yes, I am in agreement with the types and levels of services included in the ISP.

☐ No, I disagree with the types and/or levels of some or all of the services included in mythis plan. (By checking this box, I By checking this box, I will receive the services that I have agreed to receive &and may appeal the treatment team's decision to not include all the to not include all the types and/or levels of services that I have requested.)

☐ Yes, I have received a copy of this plan. ☐ I have received a Notice of Action (PM Form 5.1.1 if disagreement concerns a Title XIX/XXI covered service).

☐ **Yes, I have received a copy of this plan.** ☐ I have received the Notice of Decision & Right to Appeal for Individuals with a Serious Mental Illness (PM Form Form 5.5.1 if disagreement pertains to a Non-Title XIX/XXI covered service).

Effective 6/1/09
Revised 5/09

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PART D: BEHAVIORAL HEALTH SERVICE PLAN

Service Plan Rights Acknowledgement for Persons who are Title XIX/XXI and/or SMI:

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If I do not agree with some or all of the services that have been authorized in this plan, I have noted that above. I know if the service asked for was denied, reduced, suspended or terminated, that my behavioral health provider will give me a letter that tells me why the decision was made. That letter will tell me how to appeal the decision that has been made about my services. The letter will also tell me about my appeal rights, including how I can to request continued services.

My behavioral health provider has told me how the appeal process works. I know how I can appeal service changes I do not agree with. I know that I can change my mind later about services I agree with today. I know that if I change my mind before the changes go into effect, I will get a letter that tells me the reason my services changed. The letter will also tell me about my appeal rights.

I know that if I need more services or other services than what I am getting, I can call my behavioral health provider at (____) _____-_______, as identified above, to talk about this. My behavioral health provider will call me back within 3 working days. Once I have talked with my behavioral health provider, s/he will give me a decision about that request within 14 days. If the behavioral health provider is not able to make a decision about my request within 14 days, s/he will send me a letter to let me know more time is needed to make a decision.

Person / Guardian ____ Date:_________

Clinical Liaison____ Date:_________ Other_____________________________________ ________ Date:___________

BH Prof. Rev.____ Date:__________ Other____ _ Date:___________

Effective 6/1/09
Revised 5/09

BEHAVIORAL HEALTH SERVICE PLAN REVIEW OF PROGRESS

Name:_________________________

I. Review of Progress

Provide a summary below of the progress the person has made toward meeting the objectives identified on the service plan. In addition, indicate any adjustments that are being made to the service plan objectives and/or measures, including the justification and any additional needs or strengths that have been identified.

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II. Current Diagnostic Summary

Describe and explain any changes in diagnoses and functioning of person: ___________________________________
____
____
____
____

III. Team Members Present at Plan Review Meeting (CFT Planning):_____________________________
____
____

IV. Date of Next Plan Review (CFT Planning) Meeting:_____________

V. Clinical Liaison (responsible for reviewing clinical record)

____	______________	___________
Clinical Liaison's Name (print) / Signature	Credentials/Position	Date
____	______________	___________
Behavioral Health Professional Reviewer Name (print) / Signature	Credentials/Position	Date

Effective 6/1/09
Revised 5/09

BEHAVIORAL HEALTH SERVICE PLAN REVIEW OF PROGRESS

Name ____________________________________ Date of Birth ____________ Client CIS ID# ___________