COUNTY OF LOS ANGELES
Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL
TREATMENT PLAN FORM

Mail: Substance Abuse Prevention and Control
1000 S. Fremont Ave, Bldg. A9 East, 3rd Floor, Alhamabra, CA 91803
To check submission status call: (XXX) XXX-XXXX

Website: http://publichealth.lacounty.gov/sapc/
Fax: (XXX) XXX-XXXX

1. Name (Last, First, and Middle):	2. Date of Birth (MM/DD/YY):	3. Medi-Cal Identification Number:

4. Primary Counselor's Name:	5. Treatment Agency:

6. DSM-5 Diagnosis(es):

7. Is Patient's Physical Examination Result Available?

☐ **If yes, provide the date the physical exam was completed:**

☐ **If no, provide the date of scheduled physical exam:**

8. Assessment Date:	9. Updated Treatment Plan Date:

ASAM Dimensions: 1. Acute intoxication and/or Withdrawal Potential; 2. Biomedical Conditions and Complications; 3. Emotional, Behavioral or Cognitive Conditions/Complications; 4. Readiness to change; 5. Relapse Continued Use, or Continued Problem Potential; 6. Recovery Environment

Severity: 0 - None; 1 - Mild, 2 - Moderate, 3 - Severe, and 4 - Very Severe.

PROBLEM # 1

10. Problem Statement:

11. Long-Term Goal:

12. Treatment Start Date:	13. Dimension:	14. Severity: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

15. Short-Term Goal(s) (SMART):	16. Action Steps:

17. Target Date:	18. Completion Date:

PROBLEM # 2

10. Problem Statement:

11. Long-Term Goal:

12. Treatment Start Date:	13. Dimension:	14. Severity: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

15. Short-Term Goal(s) (SMART):	16. Action Steps:

17. Target Date:	18. Completion Date:

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

Client Name: **Medi-Cal ID:**

Treatment Agency:

PROBLEM # 3

10. Problem Statement:

11. Long-Term Goal:

12. Treatment Start Date:	13. Dimension:	14. Severity: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

15. Short-Term Goal(s) (SMART):	16. Action Steps:

17. Target Date:	18. Completion Date:

TYPE OF SERVICES PROVIDED

19.

☐ Individual Counseling as needed: ____ x week ☐ Group Counseling: ____ x week ☐ Community Support Group: ____ x week

☐ UA/Breathalyzer: ____ x week ☐ Case Management: ____ x week ☐ Recovery Services: ____ x week

☐ Crisis Intervention: ____ x week ☐ Other:

Referred for Medication-Assisted Treatment (MAT)? ☐ Yes ☐ No Reason(s), Yes or No:

Use the addendum for additional problems to complete the treatment plan if necessary.

20. Patient's Signature:	21. Date:

22. If the above required patient signature is absent, please explain the refusal or unavailability of the patient's signature. Include the plan to engage the patient to participate in treatment plan development/updates: ☐ Not Applicable

23. Counselor's Name:	24. Counselor's Signature:	25. Date:
26. LPHA's Name:	**27. LPHA's Signature:**	**28. Date:**

TREATMENT PLAN REVIEW

29. Treatment Plan Review Date:	30. Date of Progress Note Documenting Treatment Plan Review:

31. Additional Comments (if applicable):

32. Counselor/LPHA Name:	33. Counselor/LPHA Signature:

29. Treatment Plan Review Date:	30. Date of Progress Note Documenting Treatment Plan Review:

31. Additional Comments (if applicable):

32. Counselor/LPHA Name:	33. Counselor/LPHA Signature:

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Patient Name: **Medi-Cal ID:**

Treatment Agency:

TREATMENT PLAN FORM INSTRUCTIONS

1. Enter the patient's name in the order of last name, first name, and middle name.
2. Enter the patient's date of birth.
3. Enter the patient's Medi-Cal number.
4. Enter the primary counselor's name.
5. Enter the agency's name.
6. Enter the patient's DSM-5 Diagnosis(es).
7. Answer the question "Is Patient's Physical Examination Result Available?" If the answer is affirmative, mark the "yes" box; if the physical exam result is not available mark the "no" box and enter the date of scheduled physical exam appointment.
8. Enter the date the patient assessment was performed.
9. Enter the date the treatment plan is updated.

PROBLEM(S) # 1-4

10. Enter the problem statement. Problem statements focus on the patient's current areas of concern and their most immediate areas of need.
11. Enter the long-term goal for this problem. Long-term goals are the ultimate results desired when a plan is established or revised.
12. Enter the treatment start date.
13. Enter the relevant ASAM dimension for respective problem.
14. Select severity level for the respective problem (0 for none; 1 for mild, 2 for moderate, 3 for severe, and 4 for very severe).
15. Enter the short-term goal for this problem. Short-term goals can be achieved in a limited period of time and frequently lead to the achievement of a long-term goal. Short-term goal(s) must be SMART: Specific, Measurable, Attainable within the treatment plan review period, Realistic, and Time-bound. SMART goals must be linked to the patient's functional impairment and diagnosis, as documented in the assessment. Multiple short-term goals should be prioritized numerically (1, 2, 3, etc).
16. Enter the action steps that will be implemented to achieve the correlated short-term goal. Multiple action steps should be prioritized sequentially (1a, 1b, 1c, etc).
17. Enter the projected target date for the patient to achieve the correlated short-term goal(s).
18. Enter the completion date the patient actually achieved the short-term goal(s).
19. Mark the type and frequency of services to be provided to the patient. ("x week" means the number of times the marked service will be provided to the patient per week).
    Additionally, indicate if the patient is referred for Medication-Assisted Treatment (MAT) and provide the reasons why patient is referred or not referred (e.g., opioid user, patient is already on MAT, patient declined, etc.).

NAME AND SIGNATURE OF INVOLVED PARTIES

20. Enter the patient's signature.
21. Enter the date the patient signs the treatment plan.
22. Mark "Not Applicable' if patient's signature is present. If the required patient signature is absent, provide explanation of the refusal or unavailability of the patient signature and document the plan to engage the patient to participate in treatment plan development/updates.
23. Enter the counselor's name.
24. Enter the counselor's signature.
25. Enter the date the counselor signs the treatment plan.
26. Enter the LPHA's name.
    *Note: Licensed Practitioner of the Healing Arts [LPHA] includes Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists [LCP], Licensed Clinical Social Workers [LCSW], Licensed Professional Clinical Counselors [LPCC], and Licensed Marriage and Family Therapists [LMFT] and licensed-eligible practitioners working under the supervision of licensed clinicians.
27. Enter the LPHA's signature.
28. Enter the date the LPHA reviews and signs the treatment plan.

TREATMENT PLAN REVIEW

29. Enter the date the counselor/LPHA reviewed the treatment plan.
30. Enter the date for the progress note that documents details of treatment plan review.
31. Enter additional comments, if applicable.
32. Enter the counselor/LPHA's name.
33. Enter the counselor/LPHA's signature.

SUBMIT THE TREATMENT PLAN FORM TO:	
Mail:	Substance Abuse Prevention and Control 1000 S. Fremont Ave., Bldg. A9 East, 3rd Floor Alhambra, CA 91803
Fax:	(XXX) XXX-XXXX
Website:	http://publichealth.lacounty.gov/sapc/

ADDENDUM - TREATMENT PLAN

PROBLEM #

10. Problem Statement:

11. Long-Term Goal:

12. Treatment Start Date:	**13. Dimension:**	**14. Severity:** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

15. Short-Term Goal(s) (SMART):	**16. Action Steps:**
17. Target Date:	**18. Completion Date:**

PROBLEM #

10. Problem Statement:

11. Long-Term Goal:

12. Treatment Start Date:	**13. Dimension:**	**14. Severity:** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

15. Short-Term Goal(s) (SMART):	**16. Action Steps:**
17. Target Date:	**18. Completion Date:**

PROBLEM #

10. Problem Statement:

11. Long-Term Goal:

12. Treatment Start Date:	**13. Dimension:**	**14. Severity:** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

15. Short-Term Goal(s) (SMART):	**16. Action Steps:**
17. Target Date:	**18. Completion Date:**

TYPE OF SERVICES PROVIDED

19.

☐ **Individual Counseling as needed:** ____ **x week**	☐ **Group Counseling:** ____ **x week**	☐ **Community Support Group:** ____ **x week**
☐ **UA/Breathalyzer:** ____ **x week**	☐ **Case Management:** ____ **x week**	☐ **Recovery Services:** ____ **x week**
☐ **Crisis Intervention:** ____ **x week**	☐ **Other:**	

Referred for Medication-Assisted Treatment (MAT)? ☐ **Yes** ☐ **No** **Reason(s), Yes or No:**

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