COUNTY OF LOS ANGELES
Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL
TREATMENT PLAN

PATIENT INFORMATION			
1. Name (Last, First, and Middle):		2. Date of Birth (mm/dd/yyyy):	3. Medi-Cal or MHLA Number:
4. Address:			
5. Gender:	6. Preferred Language:	7. Race/Ethnicity:	8. Phone Number: Okay to Leave a Message? ☐ Yes ☐ No
9. DSM-5 Diagnosis(es):			
10. Was a Physical Exam Completed? ☐ If yes, provide the date the physical exam was completed: ☐ If no, provide the date of scheduled physical exam appointment:			
11. Initial treatment Plan Date:		12. Updated Treatment Plan Date:	

PROVIDER AGENCY		
13. Name:	14. Address:	15. Email:
16. Contact Person:	17. Phone Number:	18. Fax Number:

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

PROBLEM # 1			
19. Problem Statement:			
20. Long-Term Goal:			
21. Treatment Start Date:	22. Dimension(s):		
23. Short-Term Goal(s):	24. Action Steps:	25. Target Date:	26.Completion Date:

PROBLEM # 2			
19. Problem Statement:			
20. Long-Term Goal:			
21. Treatment Start Date:	22. Dimension(s):		
23. Short-Term Goal(s):	24. Action Steps:	25. Target Date:	26.Completion Date:

PROBLEM # 3			
19. Problem Statement:			
20. Long-Term Goal:			
21. Treatment Start Date:	22. Dimension(s):		
23. Short-Term Goal(s):	24. Action Steps:	25. Target Date:	26. Completion Date:

TYPE OF SERVICES PROVIDED

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

28. Was MAT offered: ☐ Yes ☐ No Please specifiy:

29. Patient Signature:_____	30. Date:

31. If the patient refuses or is unavailable to sign the treatment plan, please explain:

32. If the patient's preferred language is not English, were linguistically appropriate services provided? ☐ Yes ☐ No
If no, please explain:

33. Counselor Name (if applicable):	34. Counselor Signature (if applicable):		35. Date:
36. License eligible LPHA Name (if applicable):	37. License eligible LPHA Signature (if applicable):_____	38. License Eligible LPHA license Number:	39. Date:
40. Licensed LPHA Name:	41. Licensed LPHA Signature	42. Licensed LPHA License Number:	43. Date:

TREATMENT PLAN REVIEW

44. Treatment Plan Review Date:	45. Date of Progress Note Documenting Treatment Plan Review:

46. Explanation of Need for Ongoing Services and Justification of Level of Care, as applicable:

47. Counselor Name (if applicable):	48. Counselor Signature (if applicable):		49. Date:
50. License Eligible LPHA Name (if applicable):	51. License Eligible LPHA Signature (if applicable):	52. License Eligible LPHA License Number:	53. Date:
54. Licensed LPHA Name:	55. Licensed LPHA Signature	56. Licensed LPHA License Number:	57. 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, HIPAA Privacy Standards, and 42 CFR Part 2. 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.

EXTERNAL SAPC REVIEW *This section will include communication between SAPC and the agency/provider*

Comments:

Assigned Staff: Reviewed by: Signature: _____ Date:

INTERNAL SAPC USE ONLY *This section is reserved for internal SAPC use only.*
Comments:
Assigned Staff: Reviewed by: Signature: _____ Date:

TREATMENT PLAN FORM INSTRUCTIONS

PATIENT INFORMATION

1. Enter the patient name in the order of last name, first name, and middle name.
2. Enter the patient date of birth.
3. Enter the patient Medi-Cal or My Health LA (MHLA) number. If the number is not known, leave the space blank.
4. Enter the patient address.
5. Enter the patient gender
6. Enter the patient preferred language
7. Enter the patient race/ethnicity
8. Enter the patient phone number. Check box to indicate if it is okay to leave a message at this phone number.
9. Enter the DSM-5 Diagnosis(es).
10. Answer the question "Was a Physical Exam Completed". If a physical exam was completed, 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.
11. If the treatment plan is an initial plan please select initial treatment plan.
12. If the treatment plan is an update please select treatment plan update.

PROVIDER AGENCY

13. Enter the agency name.
14. Enter the agency address
15. Enter the agency email address
16. Enter the contact person at the agency
17. Enter the phone number for the contact person at the agency
18. Enter the agency fax number

PROBLEM(S) # 1-3

19. Enter the problem statement. A problem statement is a brief clinical statement of a condition that requires treatment. Problem statements focus on the patient's current areas of concern.
20. Enter the long-term goal for this problem. Long-term goals are the ultimate results desired when a plan is established or revised.
21. Enter the treatment start date.
22. Enter the ASAM dimension(s) which correspond to the problem.
23. 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**: **S**pecific, **M**easurable, **A**ttainable within the treatment plan review period, **R**ealistic, and **T**ime-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).
24. Enter the action steps that will be implemented to achieve the correlated short-term and long-term goals. Multiple action steps should be prioritized sequentially (1a, 1b, 1c, etc).
25. Enter the projected target date for the patient to achieve the short-term and long term goals.
26. Enter the completion date of the short-term and long-term goals.

27. Mark the type and frequency of services to be provided to the patient. ("x week" means the number of times the service will be provided to the patient per week).
28. Indicate if the patient is referred for Medication-Assisted Treatment (MAT), and provide a justification whether the patient was or was not referred for MAT (e.g., opioid user, patient is already on MAT, patient declined, etc.).

**FOR ADDITIONAL PROBLEMS PLEASE FILL OUT THE TREATMENT PLAN ADDENDUM*

NAME AND SIGNATURE OF INVOLVED PARTIES

29. Enter the patient signature.
30. Enter the date the patient signs the treatment plan.
31. If the patient refuses or is unavailable to sign the treatment plan, please explain
32. If the patient's preferred language is not English, were linguistically appropriate services provided? If not, please explain.
33. Enter the counselor name, if applicable
34. Enter the counselor signature, if applicable
35. Enter the date the counselor signs the treatment plan, if applicable
36. Enter the license eligible LPHA name, if applicable

    *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.
37. Enter the license eligible LPHA signature, if applicable
38. Enter the license eligible LPHA lience number, if applicable
39. Enter the date the license eligible LPHA reviews and signs the treatment plan, if applicable
40. Enter the licensed LPHA printed name, if the reviewing LPHA is not licensed
41. Enter the licensed LPHA signature, if the reviewing LPHA is not licensed
42. Enter the licensed LPHA license number, if the reviewing LPHA is not licensed
43. Enter the date the licensed LPHA signed the form.

TREATMENT PLAN REVIEW

44. Enter the date the counselor/LPHA reviewed the treatment plan.
45. Enter the date of the progress note that documents details of treatment plan review.
46. Enter explanation of need for ongoing services and justification of level of care, as applicable.
47. Enter the counselor name, if applicable
48. Enter the counselor signature, if applicable
49. Enter the date the counselor signs the treatment plan, if applicable
50. Enter the LPHA name, if applicable
51. Enter the LPHA signature, if applicable
52. Enter the LPHA lience number, if applicable
53. Enter the date the LPHA reviews and signs the treatment plan, if applicable
54. Enter the licensed LPHA printed name, if the reviewing LPHA is not licensed
55. Enter the licensed LPHA signature, if the reviewing LPHA is not licensed
56. Enter the licensed LPHA license number, if the reviewing LPHA is not licensed
57. Enter the date the licensed LPHA signed the form.

EXTERNAL SAPC REVIEW

This section will include communication between SAPC and the agency/provider

INTERNAL SAPC USE ONLY

This section is reserved for internal SAPC use only.

SUBMIT THIS FORM TO:

Fax: (323)-725-2045
Phone: (626)-299-4193

FOR ADDITIONAL SAPC DOCUMENTATION PLEASE SEE
http://publichealth.lacounty.gov/sapc/NetworkProviders/Forms.htm