

**Carbon-Monroe-Pike Mental Health and Developmental Services
Targeted Case Management Department
Individual Service Plan**

Consumer's Name: _____ Case Manager's Name: _____

DOB: _____ BSU Number: _____ MA Number: _____

Plan Date: _____ Plan covers date from _____ to _____

CURRENT SERVICES AND RESOURCES

***Natural Supports/Family** (include family, relatives, friends or any other support that consumer has consented to release information):

Name	Relationship	Phone Number

***BH Providers/Community Agencies** (Include BH providers, school, and other community resources):

Name	Type	Phone Number

***Physical Health Providers** (Include PCP, medical specialists, pharmacy, dental and other physical health practitioners)

Name	Type	Phone Number

***Hospitalizations** (Include hospital, admission and discharge dates, and reason for admission for behavioral and physical hospitalizations):

Hospital	Admission Date	Discharge Date	Reason for admission

***Current Medications** (list all medications, dosage, and reason for prescription):

Reported By	Medication/Dosage/Time	Reason for Rx	Prescribing Physician

***Safety/Crisis Plan** (Include (1) signs/symptoms of crisis situation, (2) methods to prevent crisis situation, (3) procedure for crisis resolution, (4) supports and programs to call in time of crisis. Also, mark below any signs/symptoms/triggers for crisis:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Aggressive/Violent Behavior | <input type="checkbox"/> Relationship/Family Issues |
| <input type="checkbox"/> Drug & Alcohol Use | <input type="checkbox"/> Abuse/Neglect | <input type="checkbox"/> Eating Disturbance | <input type="checkbox"/> Sleeping Disturbance |
| <input type="checkbox"/> Physical/Medical Issues | <input type="checkbox"/> Self Injury | <input type="checkbox"/> Helplessness | <input type="checkbox"/> Social Isolation |
| <input type="checkbox"/> Developmental Delays | <input type="checkbox"/> Delusions | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sexual Problems |
| <input type="checkbox"/> Suicidal Ideation/Threats/Attempts | | <input type="checkbox"/> Homicidal Ideation/Threats/Attempts | |

Describe Signs, Symptoms, and Triggers for Crisis	Methods to Prevent Crisis Situation	Steps for Crisis Resolution	Contact Information for Support
			CMP MH/DS: 1-800-338-6467 Local Office _____, TCM ext. ____ Crisis #: 1-800-849-1868

*=If additional space is needed for these sections, please use the Additional Information Section on Page 9

TCM SERVICE GOALS

Life Domain: Housing (Describe consumer's current housing/living situation)

Strengths:

Needs and Interests:

Level of assistance (check the box that best describes the level of assistance that is needed and/or requested by consumer/family):

- | | | | |
|---|--|---|--|
| NO ASSISTANCE
<input type="checkbox"/> | MINIMAL ASSISTANCE
<input type="checkbox"/> | MODERATE ASSISTANCE
<input type="checkbox"/> | SIGNIFICANT ASSISTANCE
<input type="checkbox"/> |
|---|--|---|--|

Recovery Goal: _____

Targeted Date of Achievement: _____

Consumer Steps and Activities (What steps are needed to achieve the recovery goal?):

- _____
- _____
- _____
- _____

TCM/Team Involvement: (How is the TCM assisting to achieve the recovery goal?):

- _____
- _____
- _____
- _____

Life Domain: Mental Health Treatment (Describe consumer's current mental health treatment)

Strengths:

Needs and Interests:

Level of assistance (check the box that best describes the level of assistance that is needed and/or requested by consumer/family):

NO ASSISTANCE

MINIMAL ASSISTANCE

MODERATE ASSISTANCE

SIGNIFICANT ASSISTANCE

Recovery Goal: _____

Targeted Date of Achievement: _____

Consumer Steps and Activities (What steps are needed to achieve the recovery goal?):

- _____
- _____
- _____
- _____

TCM/Team Involvement: (How is the TCM assisting to achieve the recovery goal?):

- _____
 - _____
 - _____
 - _____
-

Life Domain: Activities of Daily Living (Describe consumer's ability to perform ADLs)

Strengths:

Needs and Interests:

Level of assistance (check the box that best describes the level of assistance that is needed and/or requested by consumer/family):

NO ASSISTANCE

MINIMAL ASSISTANCE

MODERATE ASSISTANCE

SIGNIFICANT ASSISTANCE

Recovery Goal: _____

Targeted Date of Achievement: _____

Consumer Steps and Activities (What steps are needed to achieve the recovery goal?):

- _____
- _____
- _____
- _____

TCM/Team Involvement: (How is the TCM assisting to achieve the recovery goal?):

- _____
- _____
- _____
- _____

Life Domain: Education/Vocation (Describe consumer's current educational/vocational situation)

Strengths:

Needs and Interests:

Level of assistance (check the box that best describes the level of assistance that is needed and/or requested by consumer/family):

NO ASSISTANCE

MINIMAL ASSISTANCE

MODERATE ASSISTANCE

SIGNIFICANT ASSISTANCE

Recovery Goal: _____

Targeted Date of Achievement: _____

Consumer Steps and Activities (What steps are needed to achieve the recovery goal?):

- _____
- _____
- _____
- _____

TCM/Team Involvement: (How is the TCM assisting to achieve the recovery goal?):

- _____
- _____
- _____
- _____

Life Domain: Drug and Alcohol Treatment (Describe consumer's current drug and alcohol treatment)

Strengths:

Needs and Interests:

Level of assistance (check the box that best describes the level of assistance that is needed and/or requested by consumer/family):

NO ASSISTANCE

MINIMAL ASSISTANCE

MODERATE ASSISTANCE

SIGNIFICANT ASSISTANCE

Recovery Goal: _____

Targeted Date of Achievement: _____

Consumer Steps and Activities (What steps are needed to achieve the recovery goal?):

- _____
- _____
- _____
- _____

TCM/Team Involvement: (How is the TCM assisting to achieve the recovery goal?):

- _____
- _____
- _____
- _____

Life Domain: Income and Benefits (Describe consumer's current income situation)

Strengths:

Needs and Interests:

Level of assistance (check the box that best describes the level of assistance that is needed and/or requested by consumer/family):

NO ASSISTANCE

MINIMAL ASSISTANCE

MODERATE ASSISTANCE

SIGNIFICANT ASSISTANCE

Recovery Goal: _____

Targeted Date of Achievement: _____

Consumer Steps and Activities (What steps are needed to achieve the recovery goal?):

- _____
- _____
- _____
- _____

TCM/Team Involvement: (How is the TCM assisting to achieve the recovery goal?):

- _____
- _____
- _____
- _____

Life Domain: Socialization and Natural Supports (Describe consumer's current socialization/natural supports)

Strengths:

Needs and Interests:

Level of assistance (check the box that best describes the level of assistance that is needed and/or requested by consumer/family):

NO ASSISTANCE

MINIMAL ASSISTANCE

MODERATE ASSISTANCE

SIGNIFICANT ASSISTANCE

Recovery Goal: _____

Targeted Date of Achievement: _____

Consumer Steps and Activities (What steps are needed to achieve the recovery goal?):

- _____
- _____
- _____
- _____

TCM/Team Involvement: (How is the TCM assisting to achieve the recovery goal?):

- _____
- _____
- _____
- _____

Life Domain: Physical Health (Describe consumer's current physical health treatment and/or concerns)

Strengths:

Needs and Interests:

Level of assistance (check the number that best describes the level of assistance that is needed and/or requested by consumer/family):

NO ASSISTANCE

MINIMAL ASSISTANCE

MODERATE ASSISTANCE

SIGNIFICANT ASSISTANCE

Recovery Goal:

Targeted Date of Achievement:

Consumer Steps and Activities (What steps are needed to achieve the recovery goal?):

- _____
- _____
- _____
- _____

TCM/Team Involvement: (How is the TCM assisting to achieve the recovery goal?):

- _____
- _____
- _____
- _____

Life Domain: Other (Please specify) _____

Strengths:

Needs and Interests:

Level of assistance (check the number that best describes the level of assistance that is needed and/or requested by consumer/family):

NO ASSISTANCE

MINIMAL ASSISTANCE

MODERATE ASSISTANCE

SIGNIFICANT ASSISTANCE

Recovery Goal: _____

Targeted Date of Achievement: _____

Consumer Steps and Activities (What steps are needed to achieve the recovery goal?):

- _____
- _____
- _____
- _____

TCM/Team Involvement: (How is the TCM assisting to achieve the recovery goal?):

- _____
 - _____
 - _____
 - _____
-

Additional Information
(Please indicate the section of the ISP that requires additional information)

My signature indicates that I fully participated in the planning process and agree with objectives and safety plan.

CONSUMER'S SIGNATURE/DATE

PARENT/GUARDIAN'S SIGNATURE/DATE
(If consumer is under 14)

CASE MANAGER'S SIGNATURE/DATE

SUPERVISOR'S SIGNATURE/DATE
(If consumer is under 14)