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**Comprehensive Community Services**

**Recovery Plan**

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| **Consumer Name:**  Name | **Date of Recovery Plan Completion:** Completion Date |
|  | If not within 30 days of application, provide specific reason: Reason |
| **Service Facilitator:**  Name | **Dates of Recovery Plan** **Review:**  Review Dates  |
|  | (at least every six months or as consumer’s situation changes) |
| **Date the Recovery Planning Process was Explained to the Consumer and/or legal representative or family member:**  Date |

**Consumer strengths:**

Strengths

**Underlying Needs Statements:**

Underlying needs statements

**Barriers to meeting underlying needs:**

Barriers

**Discharge from the CCS shall be based on one of the following:**

* Consumer-specific criteria for discharge:

Describe changes in the individual and family’s current needs and circumstances that will have to occur in order to succeed in discharge or transition from CCS.

* The consumer has met / is meeting their recovery goals
* The consumer no longer wants psychosocial rehabilitation services
* DHS 36.17(5)(a)2.The whereabouts of the consumer are unknown for at least 3 months despite diligent efforts to locate the consumer
* [Down](http://docs.legis.wisconsin.gov/scroll/down/452/code/admin_code/dhs/030/36)
* [Up](http://docs.legis.wisconsin.gov/scroll/up/453/code/admin_code/dhs/030/36)
* DHS 36.17(5)(a)3.The consumer refuses services from the CCS for at least 3 months despite diligent outreach efforts to engage the consumer
* DHS 36.17(5)(a)4.The consumer enters a long-term care facility for medical reasons and is unlikely to return to community living
* DHS 36.17(5)(a)5.DHS 36.17(5)(a)6.Psychosocial rehabilitation services are no longer needed

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| **Goal #1** (As stated on the Assessment Summary. Goal should be stated in the individual’s own words, and include statement of dreams, hopes, role functions and visions of life.) |
| Goal #1 |
| **Associated Domain(s):** Choose a Domain, Choose a 2nd Domain (if applicable) , Choose a 3rd Domain (if applicable) |
| **OBJECTIVE #1** (Using action words, describe the specific changes expected in measurable and behavioral terms, utilizing “SMART” – Specific, Measurable, Achievable, Realistic, Time bound. Example: Consumer will………., as evidenced by …………, by (target date)

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| Objective #1 |

 |
| **INTERVENTIONS (Related to Objective #1)** (Describe the specific activity, service, or treatment, the provider or other responsible person (including the individual or a family member), and the intended purpose or impact as it relates to this objective. The intensity, frequency, and duration should also be specified.) |
| Service Category  | Intervention | Frequency/Intensity | Payment Source | Start Date | End Date |
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| **PROGRESS AND NEEDS UPDATE (Related to Objective #1)** |
| Date of Review | Status | Narrative Update (may include barriers, consumer and team discussion, consumer satisfaction with services) |
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| **OBJECTIVE #2** (Using action words, describe the specific changes expected in measurable and behavioral terms, utilizing “SMART” – Specific, Measurable, Achievable, Realistic, Time bound. Example: Consumer will………., as evidenced by …………, by (target date)

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| Objective #2 |

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| **INTERVENTIONS (Related to Objective #2)** (Describe the specific activity, service, or treatment, the provider or other responsible person (including the individual or a family member), and the intended purpose or impact as it relates to this objective. The intensity, frequency, and duration should also be specified.) |
| Service Category  | Intervention | Frequency/Intensity | Payment Source | Start Date | End Date |
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| **OBJECTIVE #3** (Using action words, describe the specific changes expected in measurable and behavioral terms, utilizing “SMART” – Specific, Measurable, Achievable, Realistic, Time bound. Example: Consumer will………., as evidenced by …………, by (target date)

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| Objective #3 |

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| **INTERVENTIONS (Related to Objective #3)** (Describe the specific activity, service, or treatment, the provider or other responsible person (including the individual or a family member), and the intended purpose or impact as it relates to this objective. The intensity, frequency, and duration should also be specified.) |
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| Goal #2 |
| **Associated Domain(s):** Choose a Domain, Choose a 2nd Domain (if applicable) , Choose a 3rd Domain (if applicable) |
| **OBJECTIVE #1** (Using action words, describe the specific changes expected in measurable and behavioral terms, utilizing “SMART” – Specific, Measurable, Achievable, Realistic, Time bound. Example: Consumer will………., as evidenced by …………, by (target date)

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**Service Provider Summary**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date (as of)** | **Provider** | **Service Array Category** | **Total Approved Hours of Treatment per Month** | **Total Approved Hours of Travel per Month** | **Notes** |
| Date | Provider | Service Category  | # Hours | # Hours | Notes |
| Date | Provider | Service Category  | # Hours | # Hours | Notes |
| Date | Provider | Service Category  | # Hours | # Hours | Notes |
| Date | Provider | Service Category  | # Hours | # Hours | Notes |
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| Date | Provider | Service Category  | # Hours | # Hours | Notes |
| Date | Provider | Service Category  | # Hours | # Hours | Notes |

**Comprehensive Community Services Signature Page**

Date of Plan:

I have been explained the service planning process by the service facilitator and/or mental health professional. I understand my options within the CCS Service Array. I have participated in the service planning process.

I am signing off on the plan as [ ]  Initial [ ]  Update [ ]  Final

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Consumer Dated

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Guardian Dated

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Service Facilitator Dated

I have reviewed and attest to this applicant’s need for psychosocial services as set forth in DHS 36 and medical and supportive services to address the desired recovery goals. I am authorizing services per the Recovery Plan.

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Substance Abuse Professional Dated

I have reviewed and attest to this applicant’s need for psychosocial services as set forth in DHS 36 and medical and supportive services to address the desired recovery goals. I am authorizing services per the Recovery Plan

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Mental Health Professional Dated

**Recovery Planning Meeting Roster**

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| --- | --- | --- | --- | --- |
| **Date** | **Name of Attendee/Relationship** | **Signature** | **Address** | **Telephone Number** |
| Date | Name |  | Address | Phone |
| Date | Name |  | Address | Phone |
| Date | Name |  | Address | Phone |
| Date | Name |  | Address | Phone |
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