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| DEPARTMENT OF HEALTH SERVICES Division of Care and Treatment Services  F-00202 (08/2016) | | | | | | STATE OF WISCONSIN | | | | |
| INDIVIDUAL SERVICE PLAN – COMMUNITY RECOVERY SERVICES (CRS) Completion of this form is voluntary; however, failure to complete the form will result in not being able to receive CRS. Personally identifiable information is collected and used to verify Medical Assistance (MA) eligibility. | | | | | | | | | | |
|  | | CRS  CSP  CCS  TCM | | | | | | Demographics Page | | |
| 1 Plan Type (Check ALL That Apply) | | | 2 Date of Birth | | 3 Medicaid ID Number | | | | 4 Service Plan Date | 5 Functional Screen Date |
| New  Annual Recertification  Six Month Review  Update | | |  | |  | | | |  |  |
| 6 Consumer’s Name | | | 7 Address ( Street, City, State, Zip Code) | | | | | | | |
|  | | |  | | | | | | | |
| 8 Mailing Address (If Different) | | | 9 Phone No. (Home/Cell) | | | | | | 10 Email Address | |
|  | | |  | | | | | |  | |
| 11 Person-centered planning has been explained to me and I have chosen who will participate in / attend my service-planning meeting. In attendance: | | | | | | | | | | | |
|  | | | | | | | | | | |
| 12 Current Living Arrangement - PPS Code | 13 Current Living Arrangement-Name/Type | | | | | | | | | | |
|  |  | | | | | | | | | | |
| 14 CRS Agency | 15 CRS Agency Mailing Address ( Street, City, State, Zip Code) | | | | | | 16 CRS Agency Phone No. | | | |
|  |  | | | | | |  | | | |
| 17 CRS Case Manager (CM) | 18 CRS CM Mailing Address (Street, City, State, Zip Code) | | | | | | 19 CRS CM Phone No./Ext | | | |
|  |  | | | | | |  | | | |
| 20 Name - Guardian | 21 Guardian Phone No. (Home/Cell) | | | | | | 22 Guardian Phone No. (Work) | | | |
|  |  | | | | | |  | | | |
| 23 Guardian Mailing Address (Street, City, State, Zip Code) | | | | | | | 24 Guardian Email Address | | | | |
|  | | | | | | |  | | | | |
| 25 Emergency Contact / Relationship | 26 Phone No. (Home/Cell) | | | | | | 27 Phone No. (Work) | | | | |
|  |  | | | | | |  | | | | |
| 28 Mailing Address (Street, City, State, Zip Code) | | | | 29 Email Address | | | | | | | |
|  | | | |  | | | | | | | |

Financial/Services Page

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| 30 Service Name | 31 Service Provider Name  Address and Phone No.  (Email, cell phone no., if known) | 32 Start Date | 33 End Date | 34 Unit Cost  ($/hr; day) | 35 Authorized Units of Service and  Frequency  (#/day or week or month) | 36 Funding Source |

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**INDIVIDUAL SERVICE PLAN – COMMUNITY RECOVERY SERVICES (CRS)**

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| 37 Service Plan Date | | 38 Plan Type | | | | | | |
|  | | New | | Annual Recertification | | Six Month Review | | Update |
| 39 Consumer Name | | 40 Case Manager/Agency | | | | | 41 Medicaid ID No. | |
|  | |  | | | | |  | |
| 42 Strengths (attributes, motivations, and personal attitudes that can be used to achieve the short-term goals/objectives) | | | 43 Barriers (challenges as a result of mental illness or addiction in reaching goals) | | | | | |
|  | | |  | | | | | |
| 44 Anticipated Discharge/Transition Criteria (describe changes in the individual’s and family’s current needs and circumstances that will have to occur in order to succeed in discharge or transition) | | | | | | | | |
|  | | | | | | | | |
| 45 Goal(s) – stated in the individual’s own words and includes statements of hope, dreams, vision for the future or role of functions  \*\*\*Goals should be limited in order to support capturing the individual’s/family’s vision of recovery, wellness and health. | 46 Objective(s) – uses actions words, describe the specific changes/outcomes expected in measurable, achievable, and behavioral terms. Should be understandable and builds upon strengths.  \*\*\*Objectives can be broken down into short-term/long-term objectives to support an individual working towards one’s identified goals within the identified treatment-planning period. | | | | 47 Interventions – describe the specific activity, service, and/or treatment that will be provided by the provider and other team members (including the individual and role) and the intended purpose or impact as it relates to the objective. Should include frequency, intensity, and duration of services to be provided.  \*\*\*All team members and their specific role should be included within the interventions to support meeting the identified objectives and should link to the identified service/provider listed on Financial/Services Page. | | | |

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Signature Page

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| 48  I have been informed of and understand my choices in the CRS program, including approval or rejection of the services and providers listed on this service plan.  I have been informed verbally and in writing of my rights and responsibilities, Client Rights, and the Grievance Procedure.  By my signature below I indicate I have chosen to accept community services through Community Recovery Services.  A copy was provided to participant and / or guardian / authorized representative / parent. |

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| **SIGNATURE** – Consumer | Date Signed | **SIGNATURE –** CRSCase Manager | Date Signed |
| **SIGNATURE** – Guardian/Authorized Representative/Parent | Date Signed | **SIGNATURE –** Team Member | Date Signed |
| **SIGNATURE** – Team Member | Date Signed | **SIGNATURE –** Team Member | Date Signed |
| **Distribution:** DHS, County Case Manager, Individual, Authorized Representative | | | |