This is a sample form developed by the "CCS Statewide QA/QI Work Group", and is available to CCS sites as a sample for consideration of use, modification, and customization. There is no implicit or explicit guarantee that this document meets the requirements for CCS as outlined in DHS 36, Medicaid, or other applicable laws, rules, or regulations. Individual counties and tribes are responsible for developing their own forms and ensuring adherence to all applicable laws, rules, and regulations. The hope is that this working draft is modified based on the experiences and expertise of state, county, and tribal partners, and as new information becomes available.

Comprehensive Community Services
Service Plan

Consumer Name: Enter Consumer's Name

Date of Service Plan Completion: Date of Completion
If not within 30 days of application, provide specific reason: If applicable, enter reason

Service Facilitator: Service Facilitator

Dates of Service Plan Review: Dates of Plan Review
(at least every six months or as consumer's situation changes)

Date the Service Planning Process was Explained to the Consumer and/or legal representative or family member: Date process explained

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Consumer strengths identified to support goal and objective achievement:

Enter consumer strengths

Consumer barriers related to goal and objective achievement:

Enter barriers

Discharge Criteria:

- The consumer has met recovery goals
- The consumer no longer wants psychosocial rehabilitation services.
- The whereabouts of the consumer are unknown for at least 3 months despite diligent efforts to locate the consumer.
- The consumer refuses services from the CCS for at least 3 months despite diligent outreach efforts to engage the consumer.
- The consumer enters a long-term care facility for medical reasons and is unlikely to return to community living.
- The consumer is deceased.
- Psychosocial rehabilitation services are no longer needed.

Consumer's Desired Outcome / Measurable 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.)

Enter measurable Goal #1

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)

Specific Change	Measured by	Target date of completion
Enter specific change	Measured by	Target date of completion

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.)

Choose an item	Specific activity, service, or treatment	Frequency	Payment Source	Start date	End date
Choose an item	Specific activity, service, or treatment	Frequency	Payment Source	Start date	End date
Choose an item	Specific activity, service, or treatment	Frequency	Payment Source	Start date	End date

PROGRESS AND NEEDS UPDATE (Related to Objective #1)

Date of Review:	
Status	**Narrative Update** (For example: how the objective was met or partially met; barriers to meeting the objective; consumer and team discussion; consumer satisfaction with services)
☐Met ☐Partially Met ☐ Not Met ☐Continue Objective ☐Drop Objective ☐Modified Objective ☐New Objective Identified	Enter narrative update

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)

Specific Change	Measured by	Target date of completion
Enter specific change	Measured by	Target date of completion

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.)

Choose an item	Specific activity, service, or treatment	Frequency	Payment Source	Start date	End date
Choose an item	Specific activity, service, or treatment	Frequency	Payment Source	Start date	End date
Choose an item	Specific activity, service, or treatment	Frequency	Payment Source	Start date	End date

PROGRESS AND NEEDS UPDATE (Related to Objective #2)

Date of Review:	
Status	**Narrative Update** (For example: how the objective was met or partially met; barriers to meeting the objective; consumer and team discussion, consumer satisfaction with services)
☐Met ☐Partially Met ☐ Not Met ☐Continue Objective ☐Drop Objective ☐Modified Objective ☐New Objective Identified	Enter narrative update

Consumer's Desired Outcome / Measurable Goal #2 (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.)

Enter measurable Goal #2

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)

Specific Change	Measured by	Target date of completion
Enter specific change	Measured by	Target date of completion

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.)

Choose an item	Specific activity, service, or treatment	Frequency	Payment Source	Start date	End date
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PROGRESS AND NEEDS UPDATE (Related to Objective #1)

Date of Review:	
Status	**Narrative Update** (For example: how the objective was met or partially met; barriers to meeting the objective; consumer and team discussion, consumer satisfaction with services)
☐Met ☐Partially Met ☐ Not Met ☐Continue Objective ☐Drop Objective ☐Modified Objective ☐New Objective Identified	Enter narrative update

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)

Specific Change	Measured by	Target date of completion
Enter specific change	Measured by	Target date of completion

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.)

Choose an item	Specific activity, service, or treatment	Frequency	Payment Source	Start date	End date
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Choose an item	Specific activity, service, or treatment	Frequency	Payment Source	Start date	End date

PROGRESS AND NEEDS UPDATE (Related to Objective #2)

Date of Review:	
Status	**Narrative Update** (For example: how the objective was met or partially met; barriers to meeting the objective; consumer and team discussion, consumer satisfaction with services)
☐Met ☐Partially Met ☐ Not Met ☐Continue Objective ☐Drop Objective ☐Modified Objective ☐New Objective Identified	Enter narrative update

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

_____ _____
Consumer Dated

_____ _____
Guardian Dated

_____ _____
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 plan.

_____ _____
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 plan.

_____ _____
Mental Health Professional Dated

Service Planning Meeting Roster

Date	Name of Attendee/Relationship	Signature	Address	Telephone Number