Partnership Plan for Wellness

Consumer's Name ______________________ **MRN** ______________________

Provider's Name ______________________ **Program** ______________________

Strengths:

List other services/agencies involved:

Life Goals: *What does the consumer or child and family hope to achieve or work toward? Please use their own words. Include hopes and dreams.*

Clinical Treatment Goals: *Must be specific, observable or quantifiable and improve ability to pursue goals and/or decrease impairment or symptoms related to diagnosis. fłbWY a YbhU \YUh\ [cU g UfY]XYbh]ZYXž mci a Um U`gc ]bWi XY WUgY a UbU[Ya Ybhž hUf[YhYX WUgY a UbU[Ya Ybh [cU`gŁ"*

Strategies to Achieve Goals: *Specify what Consumer/Family/Provider are to do, as appropriate.(For example, How do these actions help decrease symptoms, increase functionality?Ł*

Please select all appropriate treatment options:

☐ Individual	☐ Fam/Collateral	☐ Medication	☐ CM/TCM Case Mgmt	☐ Group	☐ Rehab Svcs
☐ Day Tx	☐ TBS	☐ Self-Help/WRAP	☐ Child Wraparound	☐ Other__________________	

Revisions or additions: ***Updated Plan Date___________***

Life Goals: *What does the consumer or child and family hope to achieve or work toward? Please use their own words. May include hopes and dreams, as appropriate.*

Treatment Goals: *Must be specific, observable or quantifiable and improve ability to pursue goals and/or decrease impairment or symptoms.*

Strategies to Achieve Goals: *Specify what Consumer/Family/Provider are to do, as appropriate.*

Proposed Duration ______ months.

Please select all appropriate treatment options:

☐ Individual	☐ Fam/Collateral	☐ Medication	☐ CM/TCM Case Mgmt	☐ Group	☐ Rehab Svcs
☐ Day Tx	☐ TBS	☐ Self-Help/WRAP	☐ Child Wraparound	☐ Other____________________	

I have participated in the development of this plan:

Consumer's Signature*	***Date***	*If consumer is a minor under age 12:* **Legal Party Responsible Signature**	***Date***
Provider's Signature	*Date*	*Licensed Signature (If Req'd)*	*Date*
Auth. Committee Signature	*Date*		
MD Signature	*Date*		

Consumer/Legal Responsible Party was offered a copy of Partner

☐ *A copy was* ***given***

☐ *A copy was* ***declined*** *(date_____________)*

***Document reason for no consumer signature on this Plan.**