

North Country Community Mental Health

Included in this Plan of Service are:

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|---|--|
| <input type="checkbox"/> Section A – Face Sheet (mandatory)
<input type="checkbox"/> Section B – Diagnostic Formulation (mandatory)
<input type="checkbox"/> Section C – Plan of Service GOALS (mandatory) | <input type="checkbox"/> Section D – Community Supports for Plan of Service (opt.)
<input type="checkbox"/> Section E – Discharge Planning/Rights (mandatory)
<input type="checkbox"/> Section F – Signature Page (mandatory) |
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Signatures: (We agree to work toward the goals and objectives outlined in this plan.)

Consumer _____	Parent/Guardian _____
Date _____	Date _____
CMH Representative _____	CMH Supervisor _____
Date _____	Date _____
Other _____	Other _____
Date _____	Date _____
Other _____	Other _____
Date _____	Date _____
Other _____	Other _____
Date _____	Date _____
Other _____	Other _____
Date _____	Date _____

Physician (If needed) **I order/prescribe/refer the identified services as requested** _____ Date _____

- Guardian Not Present**
- Verbal authorization obtained** Witness: _____ Date _____
- Letter of authorization sent** (Attach copy)

Indicate your preference: (Consumer must be provided a copy of the Plan of Service within 15 days of meeting.)

- Plan of Service was given to consumer on:** _____ (Date) _____ (Staff Initial)
- Plan of Service was mailed to consumer on:** _____ (Date) _____ (Staff Initial)
- Consumer offered copy of Plan, but declined:** _____ (Date) _____ (Consumer Initial)

Additional Copies Distributed to: _____

Start Time	Stop Time	Location	Activity Code	Cost Center

Name: _____	ID #: _____	Date: _____
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