Dane County CCS Recovery Plan & Recovery Meeting Roster Guidance

Service Plan Defined by DHS 36

> *"Service plan" means a written **plan of psychosocial services** to be provided or arranged for a consumer that is **based on an individualized assessment** of the consumer.*

Treatment Plan Expectations from ForwardHealth

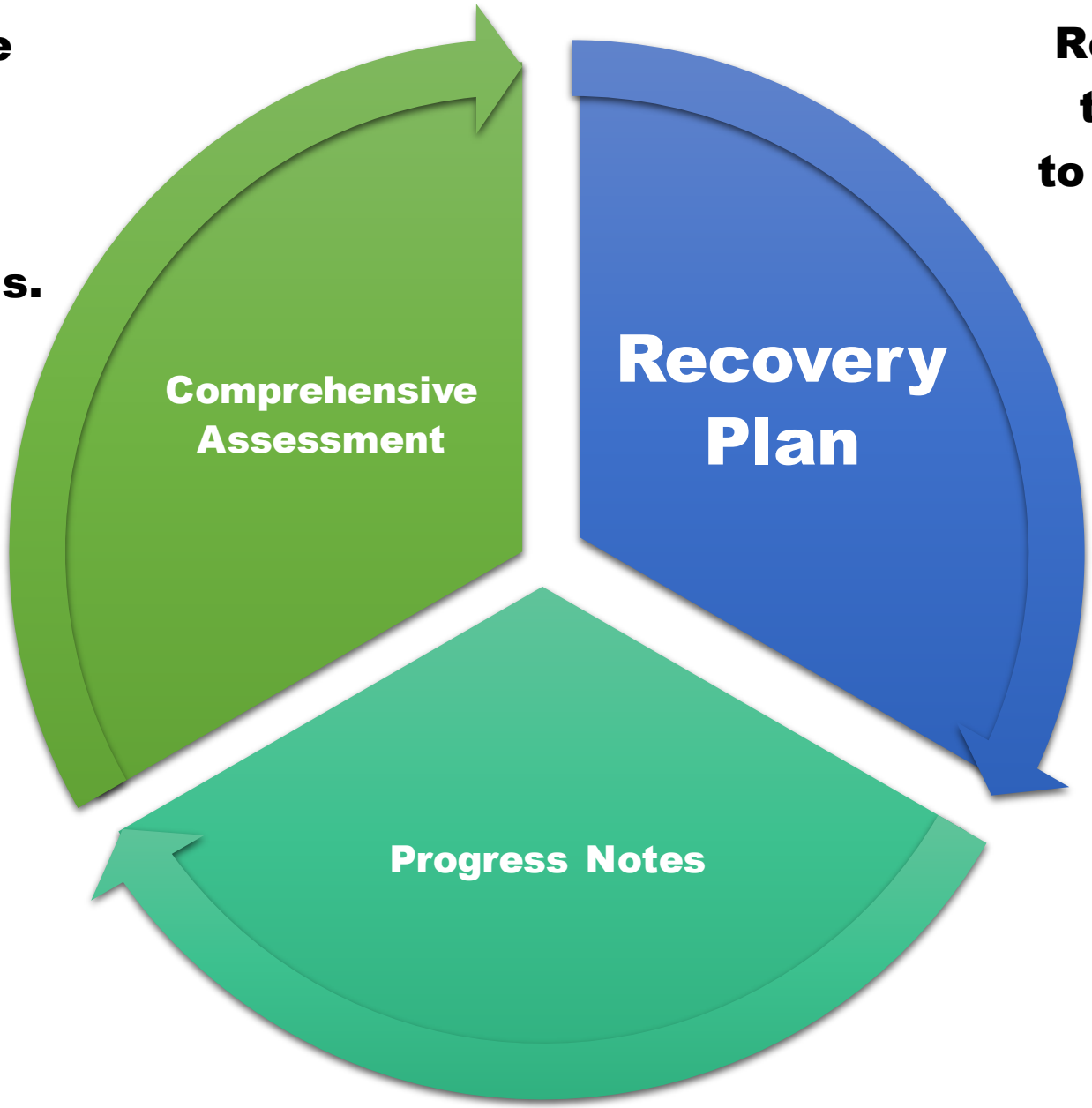
> *Treatment plans, including **treatment goals that are expressed in functional terms** that provide **measurable indices of performance, planned intervention, mechanics of intervention** (frequency, duration, responsible party[ies]) (disposition, recommendations, and instructions given to the member, including any prescriptions and plans of care or treatment provided)*

Recovery Plan Expectations from DHS 36

> *(2m) Service plan documentation.*
>
> *(a) The service plan shall include a description of all of the following:*
>
> *1. The service facilitation activities, that will be provided to the consumer or on the consumer's behalf.*
>
> *2. The psychosocial rehabilitation and treatment services, to be provided to or arranged for the consumer, including the schedules and frequency of services provided.*
>
> *3. The service providers and natural supports who are or will be responsible for providing the consumer's treatment, rehabilitation, or support services and the payment source for each.*
>
> *4. Measurable goals and type and frequency of data collection that will be used to measure progress toward desired outcomes.*
>
> *(b) An **attendance roster** shall be signed by each person, including recovery team members in attendance at each service planning meeting. The roster shall include the date of the meeting and the name, address, and telephone number of each person attending the meeting. Each original, updated, and partially completed service plan shall be maintained in the consumer's service record as required in s. DHS 36.18.*
>
> *(c) The completed service plan shall be signed by the consumer, a mental health or substance abuse professional and the service facilitator.*
>
> *(d) Documentation of the service plan shall be available to all members of the recovery team.*

Dane County CCS Guidance for Recovery Plans and RTM Rosters

Comprehensive Assessment = the Foundation of identifying needs and goals.



Recovery Plan = the "road map" to recovery. Who is doing what? How are goals going to be accomplished and by when?

Progress Notes = the name is self-explanatory. Clinical record notes are to document progress towards treatment goals.

Recovery Plans – Discharge Criteria and Measuring Goals

"CCS is a program that helps people of all ages live their best lives. It focuses on unique **needs** that relate to mental health and substance use." (Wisconsin Dept. of Health Services)
"CCS is meant to help with **recovery**. The program works to stabilize and address mental health and substance use concerns." (Wisconsin Dept. of Health Services)

Discharge Criteria – CCS offers intensive services and supports to eligible individuals to stabilize and facilitate recovery of mental health and substance use concerns with the goal of teaching them to self-manage their diagnoses at an outpatient level of needs and services. Discharge from CCS should be an ongoing conversation as soon as a client enters the program.

- What does recovery mean to the client?
- What will life look like when they no longer need CCS? **Use client quotes!**

Examples from Current Plans – incorporated unique client perspectives and client quotes.

DISCHARGE CRITERIA: I will be completely finished with the CCS program when:
1.) "I have graduated from my veterinarian technician program and have secured a good job for at least 6 months."
2.) "I have improved my overall mental health as observed by decreased frequency and intensity of anger outbursts with improved emotion regulation for at least a year."
3.) "I have significantly decreased or no longer experience somatic GI symptoms due to my mental health."
4.) "I have increased my life satisfaction rating from a 5 to a 7 by achieving the goals stated in this RP."

DISCHARGE CRITERIA: Discharge will occur under the following circumstances: "I would be living on my own, cleaning, taking medications, and showering without any help from anyone *for one year*." Client would complete all of their recovery goals, decides they no longer wish to participate in services, is screened and found ineligible for the program, is unable to follow program requirements, or they move outside of the service area.

DISCHARGE CRITERIA: Client will be ready for discharge when they are satisfied in their apartment for at least a year, is able to attend the gym once a week for 6 months independently, is able to attend the Senior Center 1-2x/week and is consistently reporting less than 5 "bad days" a month where they feel unable to get out of bed or attend to their needs.

How Progress will be Measured –Think **SMART Goals** (Specific, Measurable, Achievable, Relevant and Time-Bound)!

- Baseline + Timeline + Measuring Tool
    - **Baseline** – Where is the client today? If a baseline is identified, it is easier to see whether a client is making progress toward their goal at the end of the 6 month period.
    - **Timeline** – When does the client want to complete the stated goal by (days/months/year)?
    - **Measuring Tool** – While self-reporting is great, there is some ambiguity that comes with it, and it would be ideal to include a concrete measuring tool (counting, scaling, etc).
        - *Counting*: Find a baseline and develop a target [Frequency, Duration, and Intensity].
        - *Scaling*: Client can rate themselves on a scale [i.e. Feelings Thermometer].

Examples from SF/MHP Training

GOAL: "I really want to get a job soon. This is one of my top priorities. I want to have a full time job and successfully keep the job for a year or more."
HOW PROGRESS WILL BE MEASURED:
1. Jordan will apply to 2 jobs each week.
2. Jordan will secure a job within the time frame of this RP (by 5/1/2022).
3. Jordan will report a decrease in depressive symptoms as measured by the Beck Depression Inventory. Jordan is current coring "30" on this assessment tool. Jordan hopes to reach a score of "15" on this assessment tool by this date next year.
4. Jordan will report a decrease in anxiety symptoms as measured by the Beck Anxiety Inventory. Jordan is currently scoring "13" on this assessment tool. Jordan hopes to each a scored of "2" on this assessment tool by this date next year.

GOAL: "I want to be able to say my life satisfaction is a "4" on a 10 point scale after 6 months of working with my CCS team.
HOW PROGRESS WILL BE MEASURED:
Jordan has created a personalized 10 point scale of life satisfaction. Jordan will report a current life satisfaction score to the team on a monthly basis at recovery team meetings. Jordan's score at enrollment is a "2" and Jordan hopes to reach a score of "4" on this 10 point scale in 6 months.

Examples from Current Plans

GOAL: "I want to increase my life satisfaction from a 5 to a 6. I can work towards this rating change by doing well in school, graduating in 2 years with my veterinarian technician degree and finding a part-time job on or near campus once I'm settled in to my fall semester."
HOW PROGRESS WILL BE MEASURED:
By the end of this recovery plan in 6 months (3/7/2024), with the assistance of their CCS recovery team, client will have:
1. Started their fall semester at MATC in the veterinarian technician program in September and developed a system to stay on top of due dates,
2. High engagement and be observably focused on their studies as reflected in their grades,
3. Found a part-time job on or near campus before November that pays at least $15 an hour,
4. Increased their life satisfaction rating from a 5 to a 6 by meeting the above measurables and
5. Met with Service Facilitator in-person or virtually once per week to ensure services that align with their identified recovery plan goals are coordinated, monitored and modified as appropriate.

GOAL: Client's goal is to utilize known coping skills and motivational strategies to help them get out of bed on "bad days" and complete their daily scheduled that includes attending to ADLs, taking medications as prescribed, and engaging in meaningful activities with natural supports like AA meetings or church services.
HOW PROGRESS WILL BE MEASURED:
By the end of this recovery plan (6 months),
1. Client will increase their practicing of at least one coping skill daily to maintain daily schedule even when feeling symptoms of depression *[baseline – currently practicing weekly]*.
2. Client will get out of the house for an activity (church, Senior Center, gym, AA meetings, seeing friends) at least 3 days/week *[baseline – currently leaving their house 1 day/week]*.
3. Client will take medications as prescribed 7/7 days a week *[baseline – currently taking medications 5/7 days a week]*.
4. On "bad days," client has a goal of getting out of bed no later than 1pm so they can eat at least one meal and take PM medications *[baseline – currently getting out of bed around 3pm]*. Client will report how they have done with this during bi-weekly check ins with SF.
5. Will have at least one team meeting/check in that includes client's brother and sister-in-law.

GOAL: "I want to get an overall calm back in my life." Client wants to reduce their overall mental health symptoms so they have less of an impact on their daily life and they are able to become more independent. Client would like to increase their ability to independently manage mental health symptoms and reduce the frequency they need to reach out to providers.
HOW PROGRESS WILL BE MEASURED:
In the next 6 months, on a scale of 1-10, client will rate their mental health symptoms as a 1-2 in terms of the impact that they have on their mental health symptoms [baseline rating of 4-5]. Client will reduce the amount of times they reach out to providers for support to once or twice biweekly [baseline of contact with multiple providers weekly].

My Recovery Plan

Name: CCS Participant Name [123456] {DOB: xx/xx/xxxx}			
Agency / Program: SERVICE FACILITATION AGENCY			
Staff Name: ASSIGNED SF	Enrollment Date:	Plan Start Date:	Approval Date:
My Hopes and Dreams:			
My Overall Strengths:			

My Resources and Natural Supports: Do not forget to identify natural supports!

Discharge Criteria: Use client quotes! "What does recovery mean to you?" "What will life look like when you will know you no longer need CCS services?"

Life Area / Domain:		
Strengths:		
Need / Barrier: Ensure you update this section with current needs – needs drive the goal.		
Goal No.	1	**Recovery Goal:** Use client quotes! What do they want to improve about this domain? Only list the current goal! We do not need dated updates from past goals in this section – that information is captured in past goal progress updates.
Goal No.	1	**How Progress Will Be Measured:** Baseline + Timeline + Measuring Tool In regard to the identified goal: Where is the client currently? What is their target? When do they want to accomplish the goal by?
Goal No.	1	**Action Steps** Specific instructions for each team member (including the CCS client) who has a task to assist the client in reaching their goal. -Action steps must outline the service array, the agency name, and the task/responsibility of the provider. -No dated updates in this section, only include the current action steps.
[Update Date]	Use language about progress that correlates with How Progress will be Measured.	

Service Authorizations

MEDICAL NECESSITY CONSIDERATIONS DHS 101

- Need is identified in comprehensive assessment to justify service authorization
- Amount (frequency and duration) of service authorized is proportionate to need
- Effectiveness of service is expected to support participant's recovery
- Duplication of service is not occurring
- Service is not authorized solely for the convenience of participant or provider

Each Identified provider has a specific role and tasks stated in recovery plan to justify service authorization.

CCS Service Category	Domain - Goal Number	Service Provider Name and Address
Employment-Related Skill Training Would this be a better fit if there was a goal in the Employment Domain??	Housing Issues - 1 Life Satisfaction - 1 Mental Health - 1 Substance Use - 1	Employment Resources Inc Comprehensive Community Services 2701 INTERNATIONAL LN MADISON, WI 53704-3126
Individual Skill Development and Enhancement	Housing Issues - 1 Life Satisfaction - 1 Mental Health - 1 Substance Use - 1	Catalyst For Change, Inc Comprehensive Community Services 2075 WINNEBAGO ST MADISON, WI 53704

LIFE AREA / DOMAIN: Mental Health

Strengths:

Need / Barrier:

Goal No.	Recovery Goal	Action Steps	How Progress Will Be Measured
1	"I just want to stop being angry all the time."	____ will work with ISD from Catalyst for Change to implement mindfulness skills learned in therapy. _____ will work with ISD from Catalyst for Change to learn and practice healthy communication skills	• ISD will teach ____ 1 new communication skill each week for the next 6 months. • ___ will practice mindfulness and communication skills learned every week • ISD and ___ will report to team the number of communication and mindfulness skills implemented by 12/31/2021.

Revised 9/27/2023

Helpful Hints – Recovery Plans

What is QA reviewing with newly approved RPs?

QA Specialists are reviewing newly approved RPs on a daily basis. If there is an identified issue on the newly approved RP, this will be relayed to agencies through the comments on the chart audit. Please read the comments as these comments contain instructions on what information needs to be corrected.

- **Initials on Comments**: QA Specialists initial comments related to RP action steps and progress notes correlating with a RTM. Please connect directly with the QA Specialist if there are any questions about the comment and to ensure the changes are reviewed. If comments have no initials from QA Staff, please send your questions or fixes to CCS@danecounty.gov.
    - ***JG** = Jessica Gilbert / **ER** = Erin Rodell / **SK** = Sydney Kamp / **RS** = Rachel Sadogierski / **HR** = Holly Rasmussen*
- **Common Abbreviations Used in the Chart Audit Comments**:
    - ICM = Informed Consent for Medications
    - RMR = Recovery Meeting Roster
    - RTM = Recovery Team Meeting
    - RP = Recovery Plan
    - Service Authorizations
        - S&A = Screening and Assessment
        - SP = Service Planning
        - SF = Service Facilitation
        - DE = Diagnostic Evaluation
        - MM = Medication Management
        - PHM = Physical Health Monitoring
        - PS = Peer Support
        - ISD = Individual Skill Development & Enhancement
        - ERST = Employment-Related Skill Training
        - FP = Individual and/or Family Psychoeducation
        - WM = Wellness Management and Recovery/Recovery Support Services
        - PSYCH = Psychotherapy
        - SAT = Substance Abuse Treatment
- **What all needs to be included in the RP to receive a green check?**
    - All fields have information that is accurate, complete, and correlating with the Comprehensive Assessment.
    - Participant Signature.
    - Specific action steps that highlight all authorizations. Each action step **MUST** include the following pieces:
        - Array that is authorized (i.e. ISD, ERST, PSYCH, SF, etc.)
        - Agency name that is authorized (it is okay to include the provider's first name, but the agency name needs to be highlighted in the action step)
        - Role of the authorization (i.e. What is the provider doing? What is the unique task/responsibilities of the provider?) Please ensure tasks correlate with allowable services described in authorized service array!
    - All service authorizations connected to a goal must have a detailed action step specifying the service array, agency providing the service and unique task reflecting the goal domain. It is not

necessary to connect a service authorization to all goals unless the provider is truly working with the participant on all of those goals. Please see example below.

- **After fixes, please connect with the QA Specialist who left their initials.**
    - If fixes are complete and there is no signature on file, we will mark it as a **YELLOW TRIANGLE** to designate that we still need the RP with the client's signature.
    - If fixes are complete and there is a signature on file, we will mark it as a **GREEN CHECK**.

Authorizations Example on Jordan's RP:

Category	Domain - Goal Number	provider name	date authorized	end authorization	units	Status
Individual Skill Development and Enhancement	Substance Use - 1	*Agency 4* Comprehensive Community Services	11/1/2021	4/30/2022	6.00 Hours per W 144.00 total hours	Approved
Employment Related Skills Training	Employment – 1 Life Satisfaction - 1	*Agency* 3 Comprehensive Community Services	11/1/2021	4/30/2022	4.00 Hours per W 96.00 total hours	Approved
Psychotherapy	Employment – 1 Life Satisfaction - 1	*Agency* 2 Comprehensive Community Services	11/1/2021	4/30/2022	1.00 Hours per W 24.00 total hours	Approved
Screening and Assessment	Substance Use – 1 Employment – 1 Life Satisfaction - 1	*Agency* 1 Comprehensive Community Services	11/1/2021	4/30/2022	5.00 Hours per M 31.00 total hours	Approved
Service Facilitation	Substance Use – 1 Employment – 1 Life Satisfaction - 1	*Agency* 1 Comprehensive Community Services	11/1/2021	4/30/2022	15.00 Hours per M 91.00 total hours	Approved
Service Planning	Substance Use – 1 Employment – 1 Life Satisfaction - 1	*Agency 1* Comprehensive Community Services	11/1/2021	4/30/2022	5.00 Hours per M 31.00 total hours	Approved
Substance Abuse Treatment	Substance Use – 1 Life Satisfaction - 1	*Agency 2* Comprehensive Community Services	11/1/2021	4/30/2022	6.00 Hours per W 144.00 total hours	Approved

The table above highlights the authorizations on the RP and which goals these authorizations have been tied to on the RP. Here is how this information should be translated to the RP.

Life Area/Domain: Life Satisfaction	
Goal	"I want to be able to say my life satisfaction is a '4' on a 10 point scale after 6 months of working with my CCS team."
How Will Progress be Measured	Baseline + Timeline + Measuring Tool
Action Steps	• SF with Agency 1 will (insert role/task/responsibility of this provider on the team as it relates to the Life Satisfaction Goal). • Agency 3 will provide ERST to the client by (insert role/task/responsibility of this provider on the team as it relates to the Life Satisfaction Goal). • Agency 2 will provide psychotherapy to client by (insert role/task/responsibility of this provider on the team as it relates to the Life Satisfaction Goal). • Agency 2 will provide substance abuse treatment to client by (insert role/task/responsibility of this provider on the team as it relates to the Life Satisfaction Goal).

Life Area/Domain: Employment	
Goal	"I really want to get a job soon. This is one of my top priorities. I want to have a full-time job and successfully keep the job for a year or more."
How Will Progress be Measured	Baseline + Timeline + Measuring Tool
Action Steps	• SF with Agency 1 will (insert role/task/responsibility of this provider on the team as it relates to the Employment Goal). • Agency 3 will provide ERST to the client by (insert role/task/responsibility of this provider on the team as it relates to the Employment Goal). • Agency 2 will provide psychotherapy to client by (insert role/task/responsibility of this provider on the team as it relates to the Employment Goal).

Life Area/Domain: Substance Use	
Goal	"I want to be sober and remain sober."
How Will Progress be Measured	Baseline + Timeline + Measuring Tool
Action Steps	• SF with Agency 1 will (insert role/task/responsibility of this provider on the team as it relates to the Substance Use Goal). • Agency 2 will provide substance abuse treatment to the client by (insert role/task/responsibility of this provider on the team as it relates to the Substance Use Goal). • Agency 4 will provide individual skill development and enhancement to client by (insert role/task/responsibility of this provider on the team as it relates to the Substance Use Goal).

Helpful Hints – Recovery Team Meeting Rosters (RMR)

What is QA reviewing with RTM Rosters?

QA Specialists are reviewing RMRs sent to the CCS Inbox to ensure the meeting date correlates with a **Service Planning progress note** documenting a RTM. QA Specialists will add comments on the chart audit if there is no progress note or if the progress note does not document a RTM with the client and team. Please connect directly with the QA Specialist (identified by initials) if you have any questions or if you add a progress note to document a RTM and the QA Specialist will review.

- **Reminder – What constitutes a RTM?** A RTM is when recovery plan goals are created, edited, or reviewed. This meeting needs to be documented in progress notes indicating that the RP goals or services have been discussed. This meeting has to have the CCS Participant (14+ YO) and Service Facilitator present at a bare minimum. Best practice is that the whole team (MHP included) present for the RTM. At least one RMR has to be on file for each 6-month RP period DHS 36.17. It is okay to send more as long as it is documenting a RTM.
- **Did you know?** ForwardHealth requires providers to coordinate with each other at least once every 6 months, or more often if indicated by the CCS Participant's condition. Recovery Team meetings are a great opportunity for providers to collaborate and meet this expectation. This will ensure better coordination and continuity of care and will prevent duplication of services.

CCS RECOVERY TEAM MEETINGS & ROSTERS

CCS Participant must be present at recovery team meetings:

The service planning process shall be facilitated by the service facilitator **in collaboration with the consumer and recovery team**. (DHS 36)

The Service Facilitator **will bring together the recovery team members** at least every six months to review progress and update the recovery plan (DCDHS policy)

Progress note needed to document recovery team meeting:

The client, service facilitator, mental health professional/SUD professional, guardian and service providers, family, and other individuals of the client's choosing **will develop the plan**. **The client's participation in the development of the plan and goals will be documented in the record and evidenced by the client's signature on the plan.** (DCDHS policy)

Rosters:

An attendance roster shall be signed by each person, including recovery team members in attendance at each **service planning meeting** (*this is different than assessment meetings – assessment meetings do not require a recovery meeting roster*). The roster shall include the date of the meeting and the name, address, and telephone number of each person attending the meeting. Each original, updated, and partially completed service plan shall be maintained in the consumer's service record as required in s. DHS 36.18. (DHS 36)

If your CCS client is a minor age 14-17 and they struggle to attend team meetings, Document in your progress note that client is **AWARE** of the team meeting, client has been **INVITED** to the team meeting, client has declined to be present at the team meeting and **REASON** they have declined, and client has **CONSENTED** to allow their parent(s)/ guardian(s) to represent them at team meeting.

CCS Team Meeting Agenda Example

Client: _____

Date: _____ Time: _____ Location: _____

Team Members Present:

Recovery Goals:

Domain	Goal	Progress
Goal 1 – This goal addresses domain(s): *Mental Health, Trauma & Life Stressors*		 1……5 Past Present
Goal 2 – This goal addresses domain(s):		 1……5 Past Present
Goal 3 – This goal addresses domain(s):		 1……5 Past Present

Readiness for transition to outpatient level services look like:

Agenda:

- Review **Accomplishments** – What have we done and what's been going well?
- **Assess** whether the plan is working to meet underlying needs.
- **Adjust** things that are not working.
- **Assign** new tasks to team members.

Treatment recommendations are being followed:

☐ Yes

☐ No – Comments:

Comprehensive Community Services Program — Service Array

The CCS program provides individuals with psychosocial rehabilitation services. All CCS programs must provide the services covered under the CCS benefit that a member needs as determined by the assessment of all the domains in Wis. Admin. Code § DHS 36.16(4). The assessment domains included in Wis. Admin. Code § DHS 36.16(4), are: (a) life satisfaction, (b) basic needs, (c) social network and family involvement, (d) community living skills, (e) housing issues, (f) employment, (g) education, (h) finances and benefits, (i) mental health, (j) physical health, (k) substance use, (l) trauma and significant life stressors, (m) medications, (n) crisis prevention and management, (o) legal status, and (p) any other domain identified by the CCS program. The service array describes the services that are covered under the CCS benefit. All services must be in compliance with Wis. Admin. Code § DHS 36. All services should be person-centered and developed in partnership with the member.

Comprehensive Community Services Program — Service Array		
Service Category (Most Applicable DHS Wis. Admin. Code Sections)	**Allowable Services**	**Allowable Provider Types**
1. Screening and Assessment (Wis. Admin. Code §§ DHS 36.03, 36.13-36.16)	Screening and assessment services include: completion of initial and annual functional screens and completion of the initial comprehensive assessment and ongoing assessments as needed. The assessment must cover all the domains, including substance use, which may include using the Uniform Placement Criteria or the American Society of Addiction Medicine Criteria. The assessment must address the strengths, needs, recovery goals, priorities, preferences, values, and lifestyle of the member and identify how to evaluate progress toward the member's desired outcomes. Assessments for minors must address the minor's and family's strengths, needs, recovery and/or resilience goals, priorities, preferences, values, and lifestyle of the member including an assessment of the relationships between the minor and his or her family. Assessments for minors should be age (developmentally) appropriate.	Providers described in Wis. Admin. Code § DHS 36.10(2) (g)1-22.* ǂ All providers are required to act within their scope of practice.
2. Service Planning (Wis. Admin. Code §§§ DHS 36.03, 36.16(7), 36.17)	Service planning includes the development of a written plan of the psychosocial rehabilitation services that will be provided or arranged for the member. All services must be authorized by a mental health professional and a substance abuse professional if substance abuse services will be provided. This can be a single professional for whom mental health and substance abuse services are in scope. The service plan is based on the assessed needs of the member. It must include measureable goals and the type and frequency of data that will be used to measure progress toward the desired outcomes. It must be completed within 30 days of the member's application for CCS services. The completed service plan must be signed by the member, a mental health or substance abuse professional, and the service facilitator. The service plan must be reviewed and updated based on the needs of the member or at least every six months. The review must include an assessment of the progress toward goals and member satisfaction with the services. The service plan review must be facilitated by the service facilitator in collaboration with the member and the recovery team.	Providers described in Wis. Admin. Code § DHS 36.10(2) (g)1-22.* ǂ All providers are required to act within their scope of practice.

3. Service Facilitation (Wis. Admin. Code §§§ DHS 36.03, 36.10(2)(e) 4. , 36.17)	Service facilitation includes activities that ensure the member receives: assessment services, service planning, service delivery, and supportive activities in an appropriate and timely manner. It also includes ensuring the service plan and service delivery for each member is coordinated, monitored, and designed to support the member in a manner that helps the member achieve the highest possible level of independent functioning. Service facilitation includes assisting the member in self-advocacy and helping the member obtain other necessary services such as medical, dental, legal, financial, and housing services. Service facilitation for minors includes advocating, and assisting the minor's family in advocating, for the minor to obtain necessary services. When working with a minor, service facilitation that is designed to support the family must be directly related to the assessed needs of the minor. Service facilitation includes coordinating a member's crisis services but not actually providing crisis services. Crisis services are provided by Wis. Admin. Code ch. DHS 34, certified programs. All services should be culturally, linguistically, and age (developmentally) appropriate.	Providers described in Wis. Admin. Code § DHS 36.10(2) (g)1-21.* ǂ All providers are required to act within their scope of practice.
4. Diagnostic Evaluations	Diagnostic evaluations include specialized evaluations needed by the member, including, but not limited to, neuropsychological, geropsychiatric, specialized trauma, and eating disorder evaluations. For minors, diagnostic evaluations can also include functional behavioral evaluations and adolescent alcohol/drug assessment intervention program. The CCS program does not cover evaluations for autism, developmental disabilities, or learning disabilities.	Providers described in Wis. Admin. Code § DHS 36.10(2) (g)1-14.* All providers are required to be licensed/certified and acting within their scope of practice.
5. Medication Management	Medication management services for **prescribers** include: • Diagnosing and specifying target symptoms • Prescribing medication to alleviate the identified symptoms • Monitoring changes in the member's symptoms and tolerability of side effects • Reviewing data, including other medications, used to make medication decisions Prescribers may also provide all services the non-prescribers can provide as noted below.	Providers described in Wis. Admin. Code § DHS 36.10(2) (g)1-3, 7-8, and 11. All providers are required to be licensed/certified and acting within their scope of practice.
	Medication management services for **non-prescribers** include: • Supporting the member in taking their medications • Increasing the member's understanding of the benefits of medication and the symptoms it is treating • Monitoring changes in the member's symptoms and tolerability of side effects	Providers described in Wis. Admin. Code § DHS 36.10(2) (g)1-22.* ǂ All providers are required to act within their scope of practice.

Medication Management Service Array for Dane County CCS*	
Prescriber[1,2]: MD APNP PA	
Diagnosing and specifying target symptoms.	• Direct face to face client contact.
Prescribing medication to alleviate the identified symptoms.	• Submitting refill requests. • Pharmacy follow-up. • Completing or confirming re-fills. • Medication changes or titrating.
Monitoring changes in the member's symptoms and tolerability of side effects.	• Direct client contact: face to face or telehealth. • Telehealth follow up with client or legal guardian.
Reviewing data, including other medications, used to make medication decisions.	• Prescription drug monitoring program tasks which include reviewing all controlled substances client is are prescribed, when and where, prior to providing refills of controlled substances. • Coordination with Primary Care Physician and/ or other medical professionals of client's care team. • Review of Hospital Discharge Summaries, previous medication records.
Supporting the member in taking his or her medications.	• Direct client contact: face to face or telehealth. • Submitting refill requests. • Pharmacy follow-up. • Completing or confirming re-fills. • Coordination with schools regarding prescription medication administered at school. • Coordination with Primary Care Physician and/ or other medical professionals of client's care team.
Increasing the member's understanding of the benefits of medication and the symptoms it is treating.	• Direct client contact: face to face or telehealth. • Telehealth follow-up with client or legal guardian.

Non-Prescriber: RN	
Monitoring changes in the member's symptoms and tolerability of side effects.	• Direct client contact: face to face or telehealth. • Telehealth follow up with client or legal guardian.
Supporting the member in taking his or her medications.	• Direct client contact: face to face or telehealth. • Submitting refill requests. • Prescription drug monitoring program tasks, as needed, prior to authorizing refills. • Pharmacy follow-up. • Completing or confirming re-fills. • Coordination with schools regarding prescription medication administered at school. • Review of Hospital Discharge Summaries and coordination of medication f/u post discharge. • Communication with PCP office to coordinate medications
Increasing the member's understanding of the benefits of medication and the symptoms it is treating.	• Direct client contact: face to face or telehealth. • Telehealth follow-up with client or legal guardian.

1 https://www.forwardhealth.wi.gov/kw/pdf/2014-42.pdf

6. Physical Health Monitoring	Physical health monitoring services focus on how the member's mental health and/or substance abuse issues impact their ability to monitor and manage physical health and health risks. Physical health monitoring services include activities related to the monitoring and management of a member's physical health. Services may include assisting and training the member and the member's family to identify symptoms of physical health conditions, monitor physical health medications and treatments, and develop health monitoring and management skills.	Providers described in Wis. Admin. Code § DHS 36.10(2) (g)1-22.* ǂ All providers are required to act within their scope of practice.
7. Peer Support	Peer support services include a wide range of supports to assist the member and the member's family with mental health and/or substance abuse issues in the recovery process. These services promote wellness, self-direction, and recovery by enhancing the skills and abilities of members to meet their chosen goals. The services also help members negotiate the mental health and/or substance abuse systems with dignity and without trauma. Through a mutually empowering relationship, Certified Peer Specialists and members work as equals toward living in recovery.	Providers described in Wis. Admin. Code § DHS 36.10(2) (g)20.. * ǂ **Reminder:** All CCS peer specialists are required to be Wisconsin Certified Peer Specialists as noted by the ǂ throughout the array. All providers are required to act within their scope of practice.
8. Individual Skill Development and Enhancement	Individual skill development and enhancement services include training in communication, interpersonal skills, problem solving, decision-making, self-regulation, conflict resolution, and other specific needs identified in the member's service plan. Services also include training in daily living skills related to personal care, household tasks, financial management, transportation, shopping, parenting, accessing and connecting to community resources and services (including health care services), and other specific daily living needs identified in the member's service plan. Services provided to minors should also focus on improving integration into and interaction with the minor's family, school, community, and other social networks. Services include assisting the minor's family in gaining skills to assist the minor with individual skill development and enhancement. Services that are designed to support the family must be directly related to the assessed needs of the minor. Skill training may be provided by various methods, including, but not limited to, modeling, monitoring, mentoring, supervision, assistance, and cuing. Skill training may be provided individually or in a group setting.	Providers described in Wis. Admin. Code § DHS 36.10(2) (g)1-22. * ǂ All providers are required to act within their scope of practice.

9. Employment-Related Skill Training	Employment-related skill training services address the member's illness or symptom-related problems in finding, securing, and keeping a job. Services may include, but are not limited to, employment and education assessments; assistance in accessing or participating in educational and employment-related services; education about appropriate job-related behaviors; assistance with job preparation activities, such as personal hygiene, clothing, and transportation; on-site employment evaluation and feedback sessions to identify and manage work-related symptoms; assistance with work-related crises; and individual therapeutic support. The CCS program does not cover time spent by the member working in a clubhouse. The CCS program covers time spent by clubhouse staff in providing psychosocial rehabilitation services, as defined in the service array, for the member if those services are identified in the member's service plan.	Providers described in Wis. Admin. Code § DHS 36.10(2) (g)1-22. *ǂ All providers are required to act within their scope of practice.
10. Individual and/or Family Psychoeducation**	Psychoeducation services include: • Providing education and information resources about the member's mental health and/or substance abuse issues • Skills training • Problem solving • Ongoing guidance about managing and coping with mental health and/or substance abuse issues • Social and emotional support for dealing with mental health and/or substance abuse issues Psychoeducation may be provided individually or in a group setting to the member or the member's family and natural supports (i.e., anyone the member identifies as being supportive in their recovery and/or resilience process). Psychoeducation is not psychotherapy. Family psychoeducation must be provided for the direct benefit of the member. Consultation to family members for treatment of their issues not related to the member is not included as part of family psychoeducation. Family psychoeducation may include anticipatory guidance when the member is a minor. If psychoeducation is provided without the other components of the Wellness Management and Recovery/Recovery Support Services service category (#11), it should be included under this service category.	Providers described in Wis. Admin. Code § DHS 36.10(2) (g)1-22. *ǂ All providers are required to act within their scope of practice.

11. Wellness Management and Recovery**/Recovery Support Services	Wellness management and recovery services, which are generally provided as mental health services, include empowering members to manage their mental health and/or substance abuse issues, helping them develop their own goals, and teaching them the knowledge and skills necessary to help them make informed treatment decisions. These services include psychoeducation, behavioral tailoring, relapse prevention, development of a recovery action plan, recovery and/or resilience training, treatment strategies, social support building, and coping skills. Services can be taught using motivational, educational, and cognitive-behavioral strategies. If psychoeducation is provided without the other components of wellness management and recovery, it should be included under the Individual and/or Family Psychoeducation service category (#10). Recovery support services, which are generally provided as substance abuse services, include emotional, informational, instrumental, and affiliated support. Services include assisting the member in increasing engagement in treatment, developing appropriate coping strategies, and providing aftercare and assertive continuing care. Continuing care includes relapse prevention support and periodic follow-ups and is designed to provide less intensive services as the member progresses in recovery.	Providers described in Wis. Admin. Code § DHS 36.10(2) (g)1-22. *ǂ All providers are required to act within their scope of practice.
12. Psychotherapy	Psychotherapy includes the diagnosis and treatment of mental, emotional, or behavioral disorders, conditions, or addictions through the application of methods derived from established psychological or systemic principles for the purpose of assisting people in modifying their behaviors, cognitions, emotions, and other personal characteristics, which may include the purpose of understanding unconscious processes or intrapersonal, interpersonal, or psychosocial dynamics. Psychotherapy may be provided in an individual or group setting.	Providers described in Wis. Admin. Code § DHS 36.10(2) (g)1-10, 14, 22.* All providers are required to be licensed/certified and acting within their scope of practice.
13. Substance Abuse Treatment	Substance abuse treatment services include counseling of persons affected by problems related to the abuse of alcohol or drugs including individual, group, and family counseling. Substance abuse treatment services can be provided in day treatment (Wis. Admin. Code § DHS 75.52), outpatient (Wis. Admin. Code §§ DHS 75.49, 75.50, or 75.51), and residential (Wis. Admin. Code § DHS 75.54 or Wis. Admin. Code § DHS 75.53) settings. Substance abuse treatment services can be in an individual or group setting. The other categories in the service array also include psychosocial rehabilitation substance abuse services that support members in their recovery. The CCS program does not cover Operating While Intoxicated assessments, urine analysis and drug screening, detoxification services, medically managed inpatient treatment services, or narcotic treatment services (opioid treatment programs). Some of these services may be covered under Medicaid and BadgerCare Plus outside the CCS program.	Providers described in Wis. Admin. Code §§ DHS 36.10(2) (g)1, 2 (with knowledge of addiction treatment),4 (with knowledge of psychopharmacology and addiction treatment) and 16. Substance abuse professionals include: • Licensed Psychotherapists • Certified Substance Abuse Counselor • Substance Abuse Counselor • Certified Psychotherapists with MPSW (Marriage & Family Therapy, Professional Counseling & Social Worker) Examining Board 1.09 specialty All providers are required to be licensed/certified and acting within their scope of practice.

* Type I QTTs (qualified treatment trainees) are described in Wis. Admin. Code § DHS 36.10(2)(g)22., (clinical students) and Type II QTTs are described in Wis. Admin. Code § DHS 36.10(2)(g)9., (certified social workers, certified advance practice social workers, and certified independent social workers). Type I and Type II QTTs are required to be working through a Wis. Admin. Code § DHS 35, certified outpatient clinic. For the purposes of the CCS program, all clinical students are required to be Type I QTTs. For the purposes of Medicaid reimbursement, APSWs (advanced practice social workers) and ISWs (independent social workers)are required to enroll as certified psychotherapists.

** Information for these service categories is based on information provided by the federal SAMHSA (Substance Abuse and Mental Health Services Administration).

ǂ Wis. Admin. Code § DHS 36.10(2)(g)20, describes peer specialists. For the purposes of the CCS program, all CCS peer specialists are required to be Wisconsin Certified Peer Specialists. Individuals who are not Wisconsin Certified Peer Specialists could potentially act as rehabilitation workers if they meet the requirements described in Wis. Admin. Code § DHS 36.10(2)(g) 21.. Refer to the service array for which services rehabilitation workers can provide.

My Recovery Plan

Name: Jordan DCDHS Example			
Agency / Program: SF Agency 1			
Staff Name: Jessica (SF)	Enrollment Date: 10/1/2021	Plan Start Date: 11/1/2021	Approval Date: 10/25/2021
My Hopes and Dreams: Jordan has a vision for a future life that includes healthy living habits, a rewarding job and a savings account, a home in a safe neighborhood, and healthy relationships with family, friends, and a significant other.			
My Overall Strengths: Jordan presents with awareness of areas for personal growth. Jordan has developed resilience and a deep determination and independence to achieve a better life. This determination is built on personal confidence in problem solving, as well as a curious and creative spirit with artistic talent. Jordan presents with hope and optimism. Jordan identifies a network of supportive family and friends as a strength.			
My Resources and Natural Supports: Jordan identifies Marcella (sister), Casey (cousin), and the LGBTQ community as natural supports. Jordan identifies mom and a pastor were at one point in life natural supports and could potentially grow to be current natural supports. Jordan has been resourceful with finding employment and a place to live in the past.			
Discharge Criteria: Jordan will be ready for discharge when Jordan achieves the skills necessary to report a sense of security for the future; including maintaining employment, sobriety, and healthy relationships with family and friends.			
Life Area / Domain: Substance Use			
Strengths: Jordan has awareness of relationships and environments that lead to substance use. Jordan has a desire to be sober and took initiative to apply for CCS services to assist with becoming and remaining sober. Jordan's family does not condone Jordan's substance use.			
Need / Barrier: Jordan identified needing a structure to every day to avoid boredom which often leads to substance use. Jordan reported needing a social network that does not engage in substance use. Jordan identified needing new hobbies and interests that can support sobriety. Jordan identified needing better coping skills to deal with symptoms of depression and anxiety that have often led to substance use. Jordan reported being homeless and not accepted by family are barriers to sobriety.			
Goal No.	1 **Recovery Goal:** "I want to be sober and remain sober"		
Goal No.	1 **How Progress Will Be Measured:** Progress will be measured by Jordan's engagement in substance abuse treatment and self-reported success levels of abstaining from substance use. By the end of this recovery plan in 6 months, Jordan will be able to identify three strategies for continuing sobriety in independent living. By the end of this recovery plan in 6 months, Jordan will be able to report 3 healthy relationship skills successfully implemented within interactions with family and friends. By the end of this recovery plan in 6 months, Jordan will be able to report consistent use of 6 healthy coping skills to reduce symptoms of depression and anxiety. By the end of this recovery plan in 6 months, Jordan will be able to report 1 new healthy hobby and 1 new social connection that supports a sober lifestyle. By the end of this recovery plan in 6 months, Jordan will be able to report applying to 1 or more housing options.		
Goal No.	**Action Steps** 1 Service Facilitation (SF) with SF *Agency 1*, for up to 15 hours per month, will ensure that the Recovery Plan and the service delivery flowing from it is implemented, coordinated, and monitored. SF will ensure the Recovery Plan is designed to support Jordan in a manner that helps Jordan make informed decisions, initiate recovery, build on strengths, and gain or regain control in life. SF will work with Jordan to optimize autonomy and independence, to the greatest extent possible, by having Jordan lead, control, and exercise choice over treatment goals, and the services and supports that assist in recovery and resilience. SF will ensure that Jordan is being empowered and supported to achieve the highest possible level of independence and functioning. SF will encourage Jordan and members of the recovery team to consider community resources that have appeal to Jordan before relying on professional services. SF will explain and teach Jordan about rights and make sure Jordan understands the options of treatment available. SF will ensure that Jordan's Recovery Plan is being followed and continues to be useful to Jordan in meeting treatment goals. SF will empower Jordan throughout the treatment process. SF will provide strengths-based and trauma-informed direct assistance and support to Jordan including emotional support, social support, transportation assistance, problem-solving, accessing strengths and support systems, developing trust and maintaining a strong professional alliance. SF will ensure Jordan has assessment, service planning, service delivery, and supportive activities in an appropriate and timely manner. SF will coordinate, monitor and design the Recovery Plan as per the goals stated by Jordan. SF will assist with, advocate for, and teach self-advocacy to Jordan to assist Jordan in obtaining necessary services regarding mental health, substance use, medication, medical, dental, legal, financial, transportation, housing, employment, interpersonal relationships, scheduling, and any other services that may be needed to support the level of life satisfaction that Jordan would like to attain. SF will ensure Jordan gets needs met in the most effective and efficient ways. SF will monitor notes and services of providers to ensure services are appropriate and useful for Jordan. Jordan will work with Substance Abuse Treatment (SAT) provider at *Agency 2*; for up to 6 hours per week, participating in weekly individual behavioral therapy sessions and bi-weekly group behavioral therapy sessions to work to identify skills to get and stay sober and skills to navigate various situations without turning to substances. SAT provider will work with Jordan to identify triggers to depression and anxiety that lead to substance use and teach Jordan healthy coping skills to reduce symptoms of depression and anxiety. SAT provider will work with Jordan to identify barriers to healthy relationships due to substance use and teach Jordan skills to improve relationships with family and friends.		

Commented [GJ1]: Note each action step identifies Service Array + Provider Agency + task provider will complete.

Jordan will work with Individual Skill Development and Enhancement (ISDE) service provider with *Agency 4*, for up to 14 hours per month, ISDE provider will work with Jordan to identify ways and teach skills to create, implement, and follow through with elements of structure in every day. ISDE provider will work with Jordan to identify social networks that will aid in a sober lifestyle and teach skills to engage in networking processes. ISDE provider will work with Jordan to identify new hobbies and interests and teach skills to consistently engage in newly identified hobbies and interests, as well as skills to identify connections with others that will enhance engagement in newly identified hobbies and interests. ISDE provider will work with Jordan to identify feasible options for housing, teach Jordan skills to apply for housing, and assist with identification of resources or teaching of skills for independent living.

Life Area / Domain: Employment

Strengths: Jordan presents with awareness of the significant benefit of employment for independent living. Jordan presents with interest in working. Jordan has many skills to offer an employer.

Need / Barrier: Jordan reports a personal weakness of not prioritizing work and a history of showing up late without good reasons for being late. Jordan recognizes a lack of employment history is likely a barrier to obtaining employment. Jordan reported a need to learn about what resources exist for helping someone get a job they like. Jordan reported a need for transportation to work. Jordan identified a need for help with applications or resumes. Jordan identified a need for support and accountability in regards to prioritizing work. Jordan identified anxiety and depressive symptoms often gets in the way of taking steps to apply for jobs.

Goal No. 1

Recovery Goal:
"I really want to get a job soon. This is one of my top priorities. I want to have a full time job and successfully keep the job for a year or more."

Goal No. 1

How Progress Will Be Measured:
Progress will be measured by Jordan's attainment of employment and successfully retaining employment for one year or more.
By the end of this recovery plan in 6 months Jordan will have:
-created a resume
-applied to multiple jobs
-gained employment

Action Steps

Goal No. 1

Service Facilitation (SF) with SF *Agency 1*, for up to 15 hours per month, will ensure that the Recovery Plan and the service delivery flowing from it is implemented, coordinated, and monitored. SF will ensure the Recovery Plan is designed to support Jordan in a manner that helps Jordan make informed decisions, initiate recovery, build on strengths, and gain or regain control in life. SF will work with Jordan to optimize autonomy and independence, to the greatest extent possible, by having Jordan lead, control, and exercise choice over treatment goals, and the services and supports that assist in recovery and resilience. SF will ensure that Jordan is being empowered and supported to achieve the highest possible level of independence and functioning. SF will encourage Jordan and members of the recovery team to consider community resources that have appeal to Jordan before relying on professional services. SF will explain and teach Jordan about rights and make sure Jordan understands the options of treatment available. SF will ensure that Jordan's Recovery Plan is being followed and continues to be useful to Jordan in meeting treatment goals. SF will empower Jordan throughout the treatment process. SF will provide strengths-based and trauma-informed direct assistance and support to Jordan including emotional support, social support, transportation assistance, problem-solving, accessing strengths and support systems, developing trust and maintaining a strong professional alliance. SF will ensure Jordan has assessment, service planning, service delivery, and supportive activities in an appropriate and timely manner. SF will coordinate, monitor and design the Recovery Plan as per the goals stated by Jordan. SF will assist with, advocate for, and teach self-advocacy to Jordan to assist Jordan in obtaining necessary services regarding mental health, substance use, medication, medical, dental, legal, financial, transportation, housing, employment, interpersonal relationships, scheduling, and any other services that may be needed to support the level of life satisfaction that Jordan would like to attain. SF will ensure Jordan gets needs met in the most effective and efficient ways. SF will monitor notes and services of providers to ensure services are appropriate and useful for Jordan.

Jordan will work with Employment Related Skills Training (ERST) service provider with *Agency 3*, for up to 14 hours per month. ERST provider will teach Jordan about resources for employment, teach skills to create a resume, teach skills to complete 5 job applications each week until Jordan is offered a job that is a good fit, teach interviewing etiquette and skills, role play interviews, and provide support and accountability to Jordan as Jordan works to reach the stated employment goal. ERST provider will work with Jordan to identify transportation options and teach Jordan skills to navigate using various transportation options.

Goal No.

Jordan will work with Psychotherapy (PSYCH) provider from *Agency 2* 1 hour each week. Psychotherapy provider will work with Jordan to identify triggers to Jordan's anxiety and depression symptoms, teach coping skills to reduce anxiety and depression, and utilize effective therapeutic techniques to address the underlying historical factors affecting Jordan's levels of depression and anxiety that affect Jordan's independent functioning in regards to employment.

Life Area / Domain: Life Satisfaction

Strengths: Jordan identified 2 family relationships as a strength. Jordan identified a support network of friends as a strength. Jordan admitted personal strengths of resilience and hope. Jordan presented as aware of areas for growth and a slight sense of optimism about the future.

Commented [GJ2]: Note this domain was used as an example in the DCDHS CCS Comprehensive Assessment and Assessment Summary Guide and the Strengths, Need/ Barrier, and Goal sections are copied and pasted from the Comprehensive Assessment to the Recovery Plan.

My Recovery Plan

Need / Barrier: Jordan reported a need for support and skills around increasing stability for life. Jordan stated there are "so many barriers to my current life satisfaction." Jordan identified these specific barriers to stability and life satisfaction: strained relationship with mom, bad habits of drug use, lack of employment, and symptoms of depression that effect all areas that are considered barriers to stability and life satisfaction.

Goal No.	
	1 **Recovery Goal:** "I want to be able to say my life satisfaction is a "4" on a 10 point scale after 6 months of working with my CCS team."
	1 **How Progress Will Be Measured:** Progress will be measured by Jordan's self-report of life satisfaction on a 10 point scale of Jordan's creation. By the end of this recovery plan in 6 months Jordan wants to report the score has improved from a 2 to a 4 on this scale. By the end of this recovery plan in 6 months Jordan will be employed. By the end of this recovery plan in 6 months Jordan will report abstinence from substances.
Goal No.	By the end of this recovery plan in 6 months Jordan will report having an improved relationship with mom as evidenced by participating in family dinners with mom 1 time each week.
	Action Steps
	1 Service Facilitation (SF) with SF *Agency 1*, for up to 15 hours per month, will ensure that the Recovery Plan and the service delivery flowing from it is implemented, coordinated, and monitored. SF will ensure the Recovery Plan is designed to support Jordan in a manner that helps Jordan make informed decisions, initiate recovery, build on strengths, and gain or regain control in life. SF will work with Jordan to optimize autonomy and independence, to the greatest extent possible, by having Jordan lead, control, and exercise choice over treatment goals, and the services and supports that assist in recovery and resilience. SF will ensure that Jordan is being empowered and supported to achieve the highest possible level of independence and functioning. SF will encourage Jordan and members of the recovery team to consider community resources that have appeal to Jordan before relying on professional services. SF will explain and teach Jordan about rights and make sure Jordan understands the options of treatment available. SF will ensure that Jordan's Recovery Plan is being followed and continues to be useful to Jordan in meeting treatment goals. SF will empower Jordan throughout the treatment process. SF will provide strengths-based and trauma-informed direct assistance and support to Jordan including emotional support, social support, transportation assistance, problem-solving, accessing strengths and support systems, developing trust and maintaining a strong professional alliance. SF will ensure Jordan has assessment, service planning, service delivery, and supportive activities in an appropriate and timely manner. SF will coordinate, monitor and design the Recovery Plan as per the goals stated by Jordan. SF will assist with, advocate for, and teach self-advocacy to Jordan to assist Jordan in obtaining necessary services regarding mental health, substance use, medication, medical, dental, legal, financial, transportation, housing, employment, interpersonal relationships, scheduling, and any other services that may be needed to support the level of life satisfaction that Jordan would like to attain. SF will ensure Jordan gets needs met in the most effective and efficient ways. SF will monitor notes and services of providers to ensure services are appropriate and useful for Jordan. Jordan will work with Employment Related Skills Training (ERST) service provider with *Agency 3*, for up to 14 hours per month. ERST provider will teach Jordan about resources for employment, teach skills to create a resume, teach skills to complete 5 job applications each week until Jordan is offered a job that is a good fit, teach interviewing etiquette and skills, role play interviews, and provide support and accountability to Jordan as Jordan works to increase life satisfaction. Jordan will work with Psychotherapy (PSYCH) service provider from *Agency 2* 1 hour each week. Psychotherapy provider will work with Jordan to identify triggers to Jordan's anxiety and depression symptoms, teach coping skills to reduce anxiety and depression, and utilize effective therapeutic techniques to address the underlying historical factors affecting Jordan's levels of depression and anxiety that affect Jordan's life satisfaction. Psychotherapy provider will offer effective therapeutic interventions to assist Jordan in identifying barriers to healthy relationships along with teaching Jordan optimal skills for facilitating and maintaining healthy relationships. Jordan will work with Substance Abuse Treatment (SAT) service provider at *Agency 2*, for up to 6 hours per week, participating in weekly individual behavioral therapy sessions and bi-weekly group behavioral therapy sessions to work to identify skills to get and stay sober and skills to navigate various situations without turning to substances. SAT provider will work with Jordan to identify triggers to depression and anxiety that lead to substance use and teach Jordan healthy coping skills to reduce symptoms of depression and anxiety. SAT provider will work with Jordan to identify barriers to healthy relationships due to substance use and teach Jordan skills to improve relationships with family and friends.
Goal No.	

My Recovery Plan

CCS-FUNDED SERVICES

Category	Domain - Goal Number	provider name	date authorized	end authorization	units	Status
Individual Skill Development and Enhancement	Substance Use - 1	*Agency 4* Comprehensive Community Services	11/1/2021	4/30/2022	14.00 Hours per M 84.00 total hours	Approved
Employment Related Skills Training	Employment – 1 Life Satisfaction - 1	*Agency* 3 Comprehensive Community Services	11/1/2021	4/30/2022	14.00 Hours per M 84.00 total hours	Approved
Psychotherapy	Employment – 1 Life Satisfaction - 1	*Agency* 2 Comprehensive Community Services	11/1/2021	4/30/2022	1.00 Hours per W 25.00 total hours	Approved
Screening and Assessment	Substance Use – 1 Employment – 1 Life Satisfaction - 1	*Agency* 1 Comprehensive Community Services	11/1/2021	4/30/2022	5.00 Hours per M 31.00 total hours	Approved
Service Facilitation	Substance Use – 1 Employment – 1 Life Satisfaction - 1	*Agency* 1 Comprehensive Community Services	11/1/2021	4/30/2022	15.00 Hours per M 91.00 total hours	Approved
Service Planning	Substance Use – 1 Employment – 1 Life Satisfaction - 1	*Agency 1* Comprehensive Community Services	11/1/2021	4/30/2022	5.00 Hours per M 31.00 total hours	Approved
Substance Abuse Treatment	Substance Use – 1 Life Satisfaction - 1	*Agency 2* Comprehensive Community Services	11/1/2021	4/30/2022	6.00 Hours per W 150.00 total hours	Approved

Commented [GJ3]: Note that not every domain goal is assigned to every Provider Agency – only the goals those providers have been asked to work on are assigned to each Provider Agency.

NATURAL SUPPORTS

Natural Support	Domain - Goal Number	Start Date	End Date	Frequency
Marcella Casey				weekly

OTHER FUNDED SERVICES

SPC Description	SPC	Provider Name	Start Date	End Date	Frequency	Funding

PLACEMENTS

Provider	Start Date	End Date	End Reason	Service Type

My Recovery Plan

RECOVERY PLAN SIGNATURE PAGE

My signature below indicates that the service planning process was explained to me and that I am in agreement with the goals and services described in this Recovery Plan.

CCS Participant	Date
Parent/Legal Guardian (if applicable)	Date
Service Facilitator	Date
Mental Health Professional	Date
Substance abuse Professional (if applicable)	Date

*****Please submit signed Recovery Meeting Roster when submitting Recovery Plan Signature Page. Fax to CCS: (608) 283-2994*****