

**Carbon-Monroe-Pike Mental Health and Developmental Services  
Targeted Case Management Department  
Individual Service Plan**

Consumer's Name: \_\_\_\_\_ Case Manager's Name: \_\_\_\_\_

DOB: \_\_\_\_\_ BSU Number: \_\_\_\_\_ MA Number: \_\_\_\_\_

Plan Date: \_\_\_\_\_ Plan covers date from \_\_\_\_\_ to \_\_\_\_\_

**CURRENT SERVICES AND RESOURCES**

**\*Natural Supports/Family** (include family, relatives, friends or any other support that consumer has consented to release information):

Name	Relationship	Phone Number

**\*BH Providers/Community Agencies** (Include BH providers, school, and other community resources):

Name	Type	Phone Number

**\*Physical Health Providers** (Include PCP, medical specialists, pharmacy, dental and other physical health practitioners)

Name	Type	Phone Number

**\*Hospitalizations** (Include hospital, admission and discharge dates, and reason for admission for behavioral and physical hospitalizations):

Hospital	Admission Date	Discharge Date	Reason for admission

**\*Current Medications** (list all medications, dosage, and reason for prescription):

Reported By	Medication/Dosage/Time	Reason for Rx	Prescribing Physician

**\*Safety/Crisis Plan** (Include (1) signs/symptoms of crisis situation, (2) methods to prevent crisis situation, (3) procedure for crisis resolution, (4) supports and programs to call in time of crisis. Also, mark below any signs/symptoms/triggers for crisis:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Depression                         | <input type="checkbox"/> Anxiety       | <input type="checkbox"/> Aggressive/Violent Behavior         | <input type="checkbox"/> Relationship/Family Issues |
| <input type="checkbox"/> Drug & Alcohol Use                 | <input type="checkbox"/> Abuse/Neglect | <input type="checkbox"/> Eating Disturbance                  | <input type="checkbox"/> Sleeping Disturbance       |
| <input type="checkbox"/> Physical/Medical Issues            | <input type="checkbox"/> Self Injury   | <input type="checkbox"/> Helplessness                        | <input type="checkbox"/> Social Isolation           |
| <input type="checkbox"/> Developmental Delays               | <input type="checkbox"/> Delusions     | <input type="checkbox"/> Hallucinations                      | <input type="checkbox"/> Sexual Problems            |
| <input type="checkbox"/> Suicidal Ideation/Threats/Attempts |  | <input type="checkbox"/> Homicidal Ideation/Threats/Attempts |   |

Describe Signs, Symptoms, and Triggers for Crisis	Methods to Prevent Crisis Situation	Steps for Crisis Resolution	Contact Information for Support
			CMP MH/DS: 1-800-338-6467 Local Office _____, TCM ext. ____ Crisis #: 1-800-849-1868

\*=If additional space is needed for these sections, please use the Additional Information Section on Page 9

**TCM SERVICE GOALS**

**Life Domain: Housing** (Describe consumer's current housing/living situation)

Strengths:

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Needs and Interests:

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**Level of assistance** (check the box that best describes the level of assistance that is needed and/or requested by consumer/family):

- |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| NO ASSISTANCE            | MINIMAL ASSISTANCE       | MODERATE ASSISTANCE      | SIGNIFICANT ASSISTANCE   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Recovery Goal: \_\_\_\_\_

Targeted Date of Achievement: \_\_\_\_\_

**Consumer Steps and Activities (What steps are needed to achieve the recovery goal?):**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**TCM/Team Involvement: (How is the TCM assisting to achieve the recovery goal?):**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

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**Life Domain: Mental Health Treatment** (Describe consumer's current mental health treatment)

Strengths:

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Needs and Interests:

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**Level of assistance** (check the box that best describes the level of assistance that is needed and/or requested by consumer/family):

NO ASSISTANCE

MINIMAL ASSISTANCE

MODERATE ASSISTANCE

SIGNIFICANT ASSISTANCE

Recovery Goal: \_\_\_\_\_

Targeted Date of Achievement: \_\_\_\_\_

**Consumer Steps and Activities (What steps are needed to achieve the recovery goal?):**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**TCM/Team Involvement: (How is the TCM assisting to achieve the recovery goal?):**

- \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
- 

**Life Domain: Activities of Daily Living** (Describe consumer's ability to perform ADLs)

Strengths:

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Needs and Interests:

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**Level of assistance** (check the box that best describes the level of assistance that is needed and/or requested by consumer/family):

NO ASSISTANCE

MINIMAL ASSISTANCE

MODERATE ASSISTANCE

SIGNIFICANT ASSISTANCE

Recovery Goal: \_\_\_\_\_

Targeted Date of Achievement: \_\_\_\_\_

Consumer Steps and Activities (What steps are needed to achieve the recovery goal?):

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

TCM/Team Involvement: (How is the TCM assisting to achieve the recovery goal?):

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

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**Life Domain: Education/Vocation** (Describe consumer's current educational/vocational situation)

Strengths:

Needs and Interests:

**Level of assistance** (check the box that best describes the level of assistance that is needed and/or requested by consumer/family):

NO ASSISTANCE

MINIMAL ASSISTANCE

MODERATE ASSISTANCE

SIGNIFICANT ASSISTANCE

Recovery Goal: \_\_\_\_\_

Targeted Date of Achievement: \_\_\_\_\_

Consumer Steps and Activities (What steps are needed to achieve the recovery goal?):

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

TCM/Team Involvement: (How is the TCM assisting to achieve the recovery goal?):

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Life Domain: Drug and Alcohol Treatment** (Describe consumer's current drug and alcohol treatment)

Strengths:

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Needs and Interests:

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**Level of assistance** (check the box that best describes the level of assistance that is needed and/or requested by consumer/family):

NO ASSISTANCE

MINIMAL ASSISTANCE

MODERATE ASSISTANCE

SIGNIFICANT ASSISTANCE

Recovery Goal: \_\_\_\_\_

Targeted Date of Achievement: \_\_\_\_\_

**Consumer Steps and Activities (What steps are needed to achieve the recovery goal?):**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**TCM/Team Involvement: (How is the TCM assisting to achieve the recovery goal?):**

- \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
- 

**Life Domain: Income and Benefits** (Describe consumer's current income situation)

Strengths:

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Needs and Interests:

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**Level of assistance** (check the box that best describes the level of assistance that is needed and/or requested by consumer/family):

NO ASSISTANCE

MINIMAL ASSISTANCE

MODERATE ASSISTANCE

SIGNIFICANT ASSISTANCE

Recovery Goal: \_\_\_\_\_

Targeted Date of Achievement: \_\_\_\_\_

Consumer Steps and Activities (What steps are needed to achieve the recovery goal?):

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

TCM/Team Involvement: (How is the TCM assisting to achieve the recovery goal?):

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

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**Life Domain: Socialization and Natural Supports** (Describe consumer's current socialization/natural supports)

Strengths:

Needs and Interests:

**Level of assistance** (check the box that best describes the level of assistance that is needed and/or requested by consumer/family):

NO ASSISTANCE

MINIMAL ASSISTANCE

MODERATE ASSISTANCE

SIGNIFICANT ASSISTANCE

Recovery Goal: \_\_\_\_\_

Targeted Date of Achievement: \_\_\_\_\_

Consumer Steps and Activities (What steps are needed to achieve the recovery goal?):

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

TCM/Team Involvement: (How is the TCM assisting to achieve the recovery goal?):

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

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**Life Domain: Physical Health** (Describe consumer's current physical health treatment and/or concerns)

Strengths:

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Needs and Interests:

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**Level of assistance** (check the number that best describes the level of assistance that is needed and/or requested by consumer/family):

NO ASSISTANCE

MINIMAL ASSISTANCE

MODERATE ASSISTANCE

SIGNIFICANT ASSISTANCE

Recovery Goal:

Targeted Date of Achievement:

Consumer Steps and Activities (What steps are needed to achieve the recovery goal?):

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

TCM/Team Involvement: (How is the TCM assisting to achieve the recovery goal?):

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

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**Life Domain: Other** (Please specify) \_\_\_\_\_

Strengths:

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Needs and Interests:

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**Level of assistance** (check the number that best describes the level of assistance that is needed and/or requested by consumer/family):

NO ASSISTANCE

MINIMAL ASSISTANCE

MODERATE ASSISTANCE

SIGNIFICANT ASSISTANCE

Recovery Goal: \_\_\_\_\_

Targeted Date of Achievement: \_\_\_\_\_

Consumer Steps and Activities (What steps are needed to achieve the recovery goal?):

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

TCM/Team Involvement: (How is the TCM assisting to achieve the recovery goal?):

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



Additional Information (Please indicate the section of the ISP that requires additional information)

If individual receiving services is 18 years old or older, please complete wellness assessment.

Consumer is 17 years old or younger. SMART Goal is not applicable.

**Prioritized Wellness/SMART Goal Domain:** \_\_\_\_\_  
(Diet/Nutrition, Physical Activity, Sleep/Rest, Relaxation/Stress Management, Medical Care/Screening, Smoking Cessation, Taking Medication Effectively, Habits/Routines)

1 <sup>st</sup> Smart Wellness Goal

2 <sup>nd</sup> Smart Wellness Goal

3 <sup>rd</sup> Smart Wellness Goal

My signature indicates that I fully participated in the planning process and agree with objectives and safety plan.

\_\_\_\_\_  
CONSUMER'S SIGNATURE/DATE

\_\_\_\_\_  
PARENT/GUARDIAN'S SIGNATURE/DATE  
(If consumer is under 14)

\_\_\_\_\_  
CASE MANAGER'S SIGNATURE DATE

\_\_\_\_\_  
SUPERVISOR'S SIGNATURE/DATE  
(If consumer is under 14)