OAR 309-019-0145 Service Plan

- (1) The Service Plan shall be a written, individualized plan to improve the individual's condition to the point where the individual's continued participation in the program is no longer necessary. The Service Plan is included in the individual's service records and shall:
- (a) Be completed prior to the start of services;

Services cannot be provided before the service plan is completed.

(b) Reflect the full assessment and the level of care to be provided;

Golden Thread

- (c) Include a safety plan when the assessment indicates risk to the health and safety of the individual or to others and be updated as circumstances change. The safety plan may be a separate document from the Service Plan;
- (d) Include the participation of the individual;

This can be done either by signature of the individual, individual's statements in quotations/ notation that the individual participated.

- (e) Include the participation of family members as applicable; and
- (f) Be completed and signed by qualified program staff as follows:

When signing, sign with credentials Legible.

- (A) Supervisory or treatment staff in substance use disorders treatment and recovery programs, and
- (B) Supervisory or treatment staff in problem gambling treatment and recovery programs.

symptoms affecting their daily life? (Golden Thread that weaves the assessment and service plan together)
Goal: What does the individual want to change/overcome/accomplish as it relates to the assessment and symptomology? (Golden Thread)
Objective: Is it specific, measurable, attainable, realistic and time limited?
(2) At minimum, each service plan shall include:
(a) Treatment objectives that are:
(A) Individualized to meet the assessed needs of the individual; and
(B) Measurable for the purpose of evaluating, including a baseline evaluation. What is the baseline – where did the individual start? How will the individual and the therapist know when the objective is met? (S.M.A.R.T.)
Objective:
Baseline:
Objective:
Baseline:
Services:
(b) The specific services and supports used to meet the treatment objectives;

Individual therapy, group therapy, case management, peer support, medication

management, 1:1 counseling, group counseling, life skills, etc.

(c) A projected schedule for service delivery, including the expected frequency and duration of each type of planned therapeutic session or encounter;

1 time a week @ 55 min ea.

(d) The type of personnel furnishing the services; and (Not the name of the therapist but the credentials are listed)

Provided by a QMHP, QMHA, CADC, LMP, PSS

(e) A projected schedule for re-evaluating the service plan. (when will this objective be re-evaluated?)

Within 90 days, 60 days, one week, etc..

Questions to ask yourself:

Do the objectives relate to the assessment?

Do I have a baseline?

Are the objectives personalized?

Are the objectives measurable? How is measurable?

Have I identified the type of personnel that will be responsible for delivery of service?

Do I have a review date?

Do I have frequency and duration of each service?

Have I signed service plan with my credentials?

Have I demonstrated that the individual participated in this plan?

WORKSHEET	
Objective:	
Baseline:	
Objective:	
Baseline:	
Objective:	
Baseline:	