**Client Name**:       **Case #**:

**Program Name:**       **Unit/SubUnit**:

**Client Plan Begin Date**:       **Client Plan End Date**:

**PLANNING TIERS**

**(Print as many pages as needed)**

**Strengths** (Identify client strength from the strengths table. These are what the client/support persons/staff identifies as general strengths for the client. Identify strength and individualize)

**Strength**:

**Strength**:

**Strength**:

**Strength**:

**Area of Need #**  (Identify need from the instructions. This is an area in which a level of impairment is identified by the client/support persons/staff. Identify the need and individualize)

**Need**:

**SPECIFIC TARGET BX:**

**FREQUENCY/DURATION/INTENSITY of BX:**

**ANTECEDENTS:**

**Goal** for Need **#**  (Identify the goal from the identified need. This is the broad goal that the client wants to achieve in treatment. Whenever possible the client’s own words should be documented. Identify the goal and individualize)

**Goal**:

**Applied Strength** for Goal/Need **#**  (Identify one of the strengths above. This is a specific strength that the client can utilize to achieve this goal. Identify the applied strength and individualize)

**Applied Strength**:

**Objective** **#**  for Goal/Need **#** (Identify the objective from the identified goal. There are no limits on the number of objectives for each goal – be sure to number each objective to match the designated goal. These are action steps that the client will focus on in order to achieve his/her goal. Identify the objective and individualize)

**Objective**:

**MONTH 1 OBJECTIVE:**

**MONTH 2 OBJECTIVE:**

**MONTH 3 OBJECTIVE:**

**MONTH 4 OBJECTIVE:**

**CLT WILL:**

**CAREGIVER WILL:**

**COACH WILL:**

**SPECIALTY MENTAL HEALTH PROVIDER (SMHP) WILL:**

**SUPPORT STAFF WILL:**

**Interventions** for Objective **#**       (Identify each intervention. Service codes are considered interventions – each intervention my be individualized for how it will be used to assist the client achieve his/her goal)

**Intervention**:

**Intervention**:

**Intervention**:

**Intervention**:

(Additional Areas of Need, Goals, Objectives, Interventions on following pages

Print as many as needed)

\*Client was offered a copy of plan?  Yes  No

\*Explained in Client’s Primary Language, which is:

If not, explain:

\*Explained in Caretaker’s Primary Language, which is:

If not, explain:

\*Transition Plan:

**Outcome Goal (Identify) Achieved Explanation (If No or N/A)**

Avoid psychiatric hospitalization  Yes  No  N/A

Prevent higher level of care  Yes  No  N/A

Move to lower level of care  Yes  No  N/A

Coach Start Date:       Anticipated Discharge Date:

**TBS Hours:**

|  |  |  |  |
| --- | --- | --- | --- |
| **From** | To | Days/Times | Hours |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Signature of TBS Staff Requiring Co-Signature:**

**Date:**

**ID Number:**

**Printed Name**

**\*Signature of TBS Staff Completing/Accepting Client Plan:**

**Date:**

**ID Number:**

\* Denotes Required Fields in Anasazi