DMHAS WISE Program
Recovery Plan Review/Revision

Client Name: _____   Review Date: _____

Overall Progress

Goal #	**Objective**:

☐ Much Improved ☐ Somewhat Improved ☐ No Change ☐ Worse

☐ Met ☐ Continue ☐ Discontinue

Progress:

☐ *Change in Plan needed (see below)*

Goal #	**Objective:**

☐ Much Improved ☐ Somewhat Improved ☐ No Change ☐ Worse

☐ Met ☐ Continue ☐ Discontinue

Progress:

☐ *Change in Plan needed (see below)*

Goal #	**Objective:**

☐ Much Improved ☐ Somewhat Improved ☐ No Change ☐ Worse

☐ Met ☐ Continue ☐ Discontinue

Progress:

☐ *Change in Plan needed (see below)*

Client Name: _____   Recovery Plan

Plan Revisions

☐ **New Goal #**_____   ☐ **Same Goal #**_____   ☐ **New Objective #** _____   ☐ **New Intervention**

Goal #: _____   **Date Goal Established:** _____   **Linked to** _____ **Assessment dated** _____

Participant's Desired Goal (Note: In the person's own words): _____

Start Date		Target Completion Date	Adjusted Target Date	Reason for Adjustment
Objective # _____ : _____				

Provider/Service Type	Intervention & Purpose (Actions by person served/staff/ and natural supports)	Frequency, (e.g., 1X/wk)	Intensity (e.g., 30 min.)	Duration (e.g., for 3 mos.)

Objective #_____ : _____

Provider/Service Type	Intervention & Purpose: (Actions by person served/staff/ and natural supports)	Frequency, (e.g., 1X/wk)	Intensity (e.g., 30 min.)	Duration (e.g., for 3 mos.)

Actual Date of Completion	☐ Goal Discontinued	Reason for Discontinuation or Refer to Progress Note of _____
Comments on Revisions and/or Goal/Objective/Intervention Specific to Review of Progress ☐ No change to goals, objectives, interventions, or services as a result of this review.		

☐ Releases of Information forms are up to date (dated within 180 days)

☐ Client offered participation in Supported Employment Services if not currently provided

Client Involvement:
☐ *I have actively participated in the development of this assessment/plan.*
☐ *I have had an opportunity to review it and to ask questions.*
☐ *I have been offered a written copy to keep for my reference.*

Comments:

_____

_____

_____

_____

Client Signature: _____   **Date:** _____

Community Support Clinician Signature: _____   **Date:** _____

Community Support Clinician & Credential (please print):

_____

Representative Signature: _____   **Date:** _____

Representative Name & Relationship (please print):

_____

Reviewer/Supervisor Signature: _____   **Date:** _____