Opioid Health Home Care Plan

Provider Name: _____ Plan Date: _____

Client Name: _____ Medicaid ID: _____

Plan Type: Initial Continuation Client Phone: _____

Client Email: _____

OPIOID DIAGNOSIS PLAN

Primary SUD Problem:

Goal:

Objectives:

Interventions:

OTHER SUD DIAGNOSIS PLAN (one per each diagnosis)

Other SUD Problem:

Goal:

Objectives:

Interventions:

MENTAL HEALTH DIAGNOSIS PLAN (one per each diagnosis)

Mental Health Problem:

Provider:

Goal:

Objectives:

Interventions:

MEDICAL HEALTH RISK PLAN (one per each risk)

Risk Condition:

Provider:

Goal:

Objectives:

Interventions:

BEHAVIORAL HEALTH RISK PLAN (one per each risk)

Risk Condition:

Goal:

Objectives:

Interventions:

GENERAL GOALS AND OBJECTIVES

Goal:

Objectives:

Interventions:

GENERAL GOALS AND OBJECTIVES

Goal:

Objectives:

Interventions:

GENERAL GOALS AND OBJECTIVES

Goal:

Objectives:

Interventions:

Client Signature: _____ Date: _____

Provider Signature: _____ Date: _____