

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES



## Enhanced Services Individual Service Plan (ISP) Template

MEMBER INFORMATION	PROVIDER INFORMATION
Member First Name:	Organization Name:
Member Last Name:	Group NPI #:
Medicaid #:	Provider Tax ID #:
Member Date of Birth:	Provider Phone:
Gender:	Provider Fax:
Member Plan ID #:	Provider E-Mail:
Member Street Address:	Provider Address:
Member City, State, ZIP:	Provider City, State, ZIP:

Service:	
Initial date of admission to current service:	
Primary ICD-10 and Corresponding DSM5 Diagnosis	
Secondary Diagnosis(es)	

CARE COORDINATION         Please list all medical/behavioral services or community interventions/supports the individual has participated in since the last Authorization, as well as any changes:         Name of Service/Support       Provider Contact Info       Frequency       For any changes, note if: New, Ended or Changed in frequency/intensity from last authorization         Image: Contact Info       I						
the last Authorization, as well as any changes:         Name of Service/Support       Provider Contact Info         Frequency       For any changes, note if:         New, Ended or Changed in		CARE COORDINATION				
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Image: second				New, Ended or Changed in		
				frequency/intensity from last authorization		
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Describe Care Coordination activities with these other services/supports:			
	SERVICE PLAN		
Resources and Strengths: Describe the unique		s that the individual identifies as	
relevant to their recovery.			
<b>Barriers to Participation:</b> The treatment plan s additional resources that would support the inc	hould include a list of ongoing or evo dividual in overcomina these barriers	lving barriers to treatment, and a plan for how to address	
them.			
Barrier	Plan of Support		
Treatment Goal 1			
Objective Measure			
Measure	Rater/Reporter of Measure	Method of Measurement (how	
		will it be tracked?)	

Member Full Name: Medicaid #:				
Interventions				
Provider Type	Specific Interver	itions		Dose of Intervention
(LMHP/QŃHP/Peer/CSAC)				(Frequency)
Treatment Progress Notes				
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Treatment Goal 2				
Objective Measure				
Measure		Rater/Reporter of Measure	Method of	Measurement (how
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Interventions				
Provider Type (LMHP/QMHP/Peer/CSAC)	Specific Interver	itions		Dose of Intervention
(LMHP/QMHP/Peer/CSAC)				(Frequency)
<b>Treatment Progress Notes</b>				
Treatment Cool 2				
Treatment Goal 3				
Objective Measure				
Objective Measure Measure		Rater/Reporter of Measure	Nethod of	Measurement (how
<b>Objective Measure</b> <i>Measure</i>		Rater/Reporter of Measure	will it be tr	Measurement (how acked?)
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Objective Measure       Measure       Rater/Reporter of Measure       Measure	(LMHP/OMHP/Peer/CSAC)	Specific interven			(Frequency)
Treatment Goal 5         Objective Measure         Measure         Rater/Reporter of Measure         Method of Measurement (how					(
Treatment Goal 5         Objective Measure         Measure         Rater/Reporter of Measure         Method of Measurement (how					
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Member Full Name:			
Interventions			
Provider Type (LMHP/QMHP/Peer/CSAC)	Specific Interventions		Dose of Intervention (Frequency)
Treatment Progress Notes			
	RECOVERY PLAN		
Discharge also a second			and a second design of the
should begin at the first cont individual and service provid level of care or into full reco	rtant tool to emphasize hope and plans for fact with the individual. Recovery planning f ers will know that sufficient progress has b very with a maintenance plan.	should include discussio	n about how the
What would progress/recove	ry look like for this individual?		
What barriers to progress/re	covery can the individual, their natural supp	oorts, and/or the service	provider identify?
			. ,
what types of outreach, addi progress/recovery?	tional formal services or natural supports, o	or resources will be neces	ssary to reach
At this time, what is the visio	n for the level of care this individual may ne	ed at discharge from thi	s service?
What is the best estimate of	the discharge date for this individual?		

Member	Full	Name:
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Signature (actual or electronic) of LMHP\* (Or R/S/RP):\_\_\_\_\_\_

Printed Name of LMHP (Or R/S/RP): \_\_\_\_\_\_

Credentials: \_\_\_\_\_

Date: \_\_\_\_\_

\*For Applied Behavior Analysis must be LBA, fully licensed LMHP or LABA

**Notes Section**