## DMHAS WISE Program
Person Centered Recovery Plan

### Initial Plan [ ] Final Plan [ ]

**Client Name:**

**Goal #:**

**Date Goal Established:**

**Linked to**

**Assessment dated**

**Participant’s Desired Goal**

(Note: In the person’s own words):

### Strengths:
- 
- 
- 

### Barriers:
- 
- 
- 

### Objective:

#### Specific Services/Activities/Supports/Tasks

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<tr>
<th>Provider/Service Type</th>
<th>Intervention &amp; Purpose: (Actions by person served/staff/ and natural supports)</th>
<th>Frequency, (e.g., 1X/wk)</th>
<th>Intensity (e.g., 30 min.)</th>
<th>Duration (e.g., for 3 mos.)</th>
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Participant’s Desired Goal (Note: In the person’s own words): _____

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**Barriers:**
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Client Name:  

Recovery Plan

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: ________________

Strengths = Past accomplishments, current aspirations, personal attitudes, attributes, etc. which can be used to help accomplish goals.

Barriers = Challenges to reaching the goal. Be certain to identify barriers as a result of the mental illness or addictive disorder. You may also identify resource or environmental barriers.

Objectives = Incremental step toward goal/measure of progress. HOW will person know they are making progress? Using action words, describe the near-term specific changes expected in measurable and behavioral terms. Include the target date for completion, e.g., “Within 90 days, Mr. S will…”

NOTES: Participation in services is NOT an objective; Maximum of 2-3 objectives per goal recommended

Services/Activities/Action Steps = Consider Action Steps Person in Recovery will take; Services to be Provided by STAFF; Services/Assistance to be provided by Natural Supporters. Include PURPOSE of support.)