

**Pennsylvania Office of Mental Health & Substance Abuse Services
Comprehensive Individualized Treatment and Community Support Plan**

IDENTIFYING INFORMATION			
Individual's Name		Age	Date of CITCSP
		DOB	
Marital Status		Race/Sex	Admission Date
BSU Number	County	Facility Case Number	Discharge Date
Discharge Commitment Code		Expiration Date	Facility Name/Living Area
IDENTIFICATION/GUARDIAN			
Current Available Identification:	Driver's License: <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Social Security Card: <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Birth Certificate: <input type="checkbox"/> Yes <input type="checkbox"/> No		
	P.A. State ID: <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Where are these documents located?		
Representative Payee/ Financial Guardian/ Guardian of the Person	Name		
	Address		
	Phone		Relationship
ADVANCE DIRECTIVE OR CRISIS PLAN			
Physical Health	Information provided _____		Additional Info or Assistance Requested _____
	<input type="checkbox"/> Living Will <input type="checkbox"/> Advance Directive <input type="checkbox"/> Power of Attorney for Healthcare		
Mental Health	Information provided _____		Additional Info or Assistance Requested _____
	<input type="checkbox"/> Psychiatric Advance Directive		
Individual has a WRAP	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date Completed: _____
If yes, where is it? _____			
Burial Fund Available	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Details: _____

Inpatient services furnished since the previous certification/recertification were and continue to be medically necessary to provide treatment and/or diagnostic study. The treatment provided is expected to improve the person's condition and the person continues to need on a daily basis active inpatient treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel. The person will be informed of each treatment recommended, expected outcomes, potential side effects, the right to alternative choices and the right to have personal input.

Psychiatrist

Date

ASSESSMENT STAGE

Peer Assessment Summary

Strengths:	Interests/Likes:	Individual's Dislikes:
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Family Assessment Summary

Strengths:	Interests/Likes:	Individual's Dislikes:
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Clinical Assessment Summary (including discipline specific assessments)

Strengths:	Interests/Likes:	Individual's Dislikes:
Individual's Psychiatric and Behavioral Conditions to Consider:	Individual's Physical Conditions to Consider:	

MY SUCCESS FACTORS

(Strengths/Supports/Strategies that help me reach my goals and remain in the community)

My Strengths: (Please explain all checked boxes)

<input type="checkbox"/> I can read and write	<input type="checkbox"/> I exercise	<input type="checkbox"/> I'm in good health	<input type="checkbox"/> I have a supportive family	<input type="checkbox"/> I can manage my finances
<input type="checkbox"/> I have hobbies	<input type="checkbox"/> I can cook	<input type="checkbox"/> I can work at a job	<input type="checkbox"/> I have a sense of humor	<input type="checkbox"/> I have a place to live after I am discharged
<input type="checkbox"/> I have talents (art, music, sports, etc.)	<input type="checkbox"/> I enjoy learning	<input type="checkbox"/> I have spiritual or religious beliefs	<input type="checkbox"/> I know about community resources or programs	<input type="checkbox"/> I get strength from my cultural background
<input type="checkbox"/> I can use public transportation	<input type="checkbox"/> I am motivated by:	<input type="checkbox"/> I have communication skills	<input type="checkbox"/> I get along well with others	<input type="checkbox"/> I have friends

Other:

My Concerns: (Please explain all checked boxes)

<input type="checkbox"/> I do not like medications	<input type="checkbox"/> I get angry too often	<input type="checkbox"/> People bother me too much	<input type="checkbox"/> I am very depressed	<input type="checkbox"/> I am very nervous
<input type="checkbox"/> I hear voices that bother me	<input type="checkbox"/> I get upset easily	<input type="checkbox"/> I was arrested	<input type="checkbox"/> I had problems in prison	<input type="checkbox"/> I have no place to live
<input type="checkbox"/> I have family problems	<input type="checkbox"/> I have no money	<input type="checkbox"/> I can't hold down a job	<input type="checkbox"/> I am very forgetful	<input type="checkbox"/> I feel like hurting or killing myself at times specifically when
<input type="checkbox"/> A lot of bad things happened to me	<input type="checkbox"/> I have dental problems	<input type="checkbox"/> I need to learn solutions to my problems	<input type="checkbox"/> I want my religious values to be respected	<input type="checkbox"/> I feel like hurting or killing someone else at times specifically when
<input type="checkbox"/> I have medical problems	<input type="checkbox"/> I am in pain	<input type="checkbox"/> I want my cultural values to be respected	<input type="checkbox"/> I have Co-Occurring Issues	<input type="checkbox"/> Other:

“It Helps Me When I...”				
<input type="checkbox"/> Get enough sleep	<input type="checkbox"/> Eat well	<input type="checkbox"/> Read	<input type="checkbox"/> Exercise	<input type="checkbox"/> Watch television
<input type="checkbox"/> Listen to the radio	<input type="checkbox"/> Write	<input type="checkbox"/> Talk to staff	<input type="checkbox"/> Can be alone	<input type="checkbox"/> Play games
<input type="checkbox"/> Talk to my family	<input type="checkbox"/> Walk	<input type="checkbox"/> Work on a project	<input type="checkbox"/> Discuss my problems in groups	<input type="checkbox"/> Take medication
<input type="checkbox"/> Do something with my hands	<input type="checkbox"/> Count to 10	<input type="checkbox"/> Get good medical care	<input type="checkbox"/> Get good dental care	<input type="checkbox"/> Take deep breaths
<input type="checkbox"/> Can practice my religious beliefs	<input type="checkbox"/> Keep busy	<input type="checkbox"/> Have a program in the community	<input type="checkbox"/> Have supportive people in community	<input type="checkbox"/> Practice what I learn in group
<input type="checkbox"/> Am earning money	<input type="checkbox"/> Talk/Spend time with friends			
<input type="checkbox"/> Other:				

Additional Information You Would Like the Staff to Know:

Supports (Family, Friends, etc):

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Strategies (Examples: Organizational Tools, Calendars, Partial Programs, Structured Activities, Ways I Can Ensure I Take My Medicine):

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

How can you use the strengths identified above to assist in your recovery?

How can staff support the use of your strengths in your recovery?

What staff actions in the past did you feel hindered your recovery and why?

REASON FOR ADMISSION OR CONTINUED RESIDENCE			
Danger to Self As Evidenced By:			
Danger to Others as Evidenced By:			
Other Factors: (Please explain all checked boxes)			
<input type="checkbox"/> Lack of community support	<input type="checkbox"/> Problems developed during incarceration (forensic)	<input type="checkbox"/> Family conflict	
<input type="checkbox"/> Destructive behavior	<input type="checkbox"/> Significant stressor	<input type="checkbox"/> Legal charges	
<input type="checkbox"/> Incompetent to stand trial	<input type="checkbox"/> Problems developed in the community	<input type="checkbox"/> Medication's that work and don't work for me and why:	
<input type="checkbox"/> Other:			
DIAGNOSES			
Axis I:			
Clinical Psychiatric Diagnoses	1.	2.	3.
Axis II:			
Personality Disorders or Specific Developmental Disorders including Mental Retardation and Borderline Intellectual Functioning	1.	2.	3.
Axis III:			
Physical Disorders			
Axis IV:			
Psychosocial Stressors Ranked Listed of Stressors	1.	2.	3.
Axis V:			
Overall Severity:	Current GAF:	Highest GAF Past Year (Annual Only):	

ALLERGIES: (Medication/Food/Other)

MY GOALS AND INTERVENTIONS

My Long Term Goal for Treatment (Developed to address a specific prioritized treatment need identified by person and team)

Problem # _____

My Short Term Goals to Support My Recovery, I Will:

Target Date:

To Support your Recovery, Staff Will:	Frequency & Duration	Intervention 1:1/Group	Person Responsible/ Discipline

TEAM SIGNATURES

For New Admissions:

(Date) _____

Person in Treatment: _____
 Psychiatry: _____
 Social Work: _____
 OT: _____
 Chaplaincy: _____
 Family Member: _____
 VAS: _____
 Dietitian: _____
 Patient Advocate: _____

Medical Physician: _____
 Nursing: _____
 Psychology: _____
 TR: _____
 Peer Specialist: _____
 County/BSU: _____
 DATS: _____
 Pharmacist: _____
 Other: _____

For Subsequent Transfers/New Treatment Team:

(Date) _____

Person in Treatment: _____
 Psychiatry: _____
 Social Work: _____
 OT: _____
 Chaplaincy: _____
 Family Member: _____
 VAS: _____
 Dietitian: _____
 Patient Advocate: _____

Medical Physician: _____
 Nursing: _____
 Psychology: _____
 TR: _____
 Peer Specialist: _____
 County/BSU: _____
 DATS: _____
 Pharmacist: _____
 Other: _____

LEGAL STATUS

Are you victim of a crime? Yes No
 What Crime?

Enrolled in Victim Notification Program? Yes No
 Name/Phone # of Victim Notification Contact:

Has Victims Compensation been contacted? Yes No

<input type="checkbox"/> Has current criminal charges	<input type="checkbox"/> Needs court approval for discharge planning	<input type="checkbox"/> Needs court approval for privileges	<input type="checkbox"/> Has conditions for probation/parole
<input type="checkbox"/> Found incompetent to stand trial	<input type="checkbox"/> Is released on bail or own recognizance	<input type="checkbox"/> Has history of criminal charges	<input type="checkbox"/> Megan's Law Notification
<input type="checkbox"/> NGRI Status (Not Guilty by Reason of Insanity)	<input type="checkbox"/> GBMI Status (Guilty but Mentally Ill)	<input type="checkbox"/> Other:	
DNA <input type="checkbox"/>	Fines <input type="checkbox"/> Amount	Urinalysis <input type="checkbox"/> Frequency	
Parole/Probation Officer: Yes <input type="checkbox"/> No <input type="checkbox"/>		Phone #	
Judge: Yes <input type="checkbox"/> No <input type="checkbox"/>		Phone #	
Notification to Judge or PO: Yes <input type="checkbox"/> No <input type="checkbox"/>		Phone #	
District Attorney: Yes <input type="checkbox"/> No <input type="checkbox"/>		Phone #	
Other:		Phone #	

LIFE DOMAINS

Domain #1: Recovery Services and Supports in the Community

When I live in the community I want to:

Information Gathering Stage:

Options Stage:

Transition Stage:

Domain #2: Living Arrangements/Housing

Type of Residence

Permanent

Transitional

Urban Setting

Own home/Apt

CRR

Young Adult Sup. Residence

Other _____

Rural Setting

Shared home/Apt

LTSR

Suburban

Single room

PCBH

Total number of persons in shared living situation: _____

I want to have a pet: Yes No **Specify Type:** _____

Address:

Agency: (If applicable)

Name of Agency

Phone #

Agency Contact (or person supporting individual in residential setting):

Information Gathering Stage:

Options Stage:

Transition Stage:

Domain #3: Insurance/Benefits/Entitlement

Insurance/ Benefits/ Entitlement:

SSI?

SSDI?

Amount

#

Medicaid: _____

Medicare: _____

Medicare D Plan _____ **Policy #** _____

Private Insurance: _____ **Plan Name:** _____

Medications Paid By: _____ **Pace** _____

Special Pharmaceutical Plan _____ **VA Benefits** _____

Food Stamps: _____ **Other Benefits:** _____

Waiver: _____

Applications Filed & Follow-up Needed	Application	Follow-up action	Responsible Person
1) 2) 3) 4)			
Income	Amount \$ _____ every _____ Source:		
Information Gathering Stage:			
Options Stage:			
Transition Stage:			
Domain #4: Physical Health Care			
Information Gathering Stage:			
Options Stage:			
Transition Stage:			
Domain #5: Mental Health Care			
Information Gathering Stage:			
Options Stage:			
Transition Stage:			
Domain #6: Social and Relationships			
For recreation and fun, I want to be able to:	<input type="checkbox"/> Hobbies <input type="checkbox"/> Activities <input type="checkbox"/> Other:		
Information Gathering Stage:			
Options Stage:			
Transition Stage:			
Domain #7: Education and Work			
I want my life after discharge to include:	Education: <input type="checkbox"/> GED <input type="checkbox"/> Continuing Ed - College <input type="checkbox"/> Enrichment (pottery, gardening, etc.) <input type="checkbox"/> Other		
The kind of work I want to do	<input type="checkbox"/> Competitive Employment		<input type="checkbox"/> Sheltered Workshop
	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		<input type="checkbox"/> Volunteering
	Specifically:		
Information Gathering Stage:			
Options Stage:			
Transition Stage:			
Domain #8: Cultural and Spiritual Considerations			
Information Gathering Stage:			
Options Stage:			
Transition Stage:			

COMMUNITY RECOVERY SERVICES AND SUPPORTS

Integrated Physical & Behavioral Health Care

Psychiatrist/Medication

Appoint Date

Name

Time

Address/Location

Phone

ALLERGIES (Medication/Food/Other):

Describe Reaction:

**Medications & Dosage
(List or attach)**

Supply (# of days)

expires on (date)

Who will fill new supply:

PHYSICAL HEALTH CARE (Attach Medical History)

Primary Care Physician

Diagnosis

Name

Address/Location

Phone

Appointment Date & Time

**Medications & Dosage
(List or attach)**

**Supply
(# of days)**

**Expires on
(date)**

Who will fill new supply?

Specialists

Specialty

Appoint Date

Time

Name

Medications

	Specialty	
	Appoint Date	Time
	Name	
	Medications	

Blood Work/Labs	Levels Draw	Last Drawn	WNL	Abnormal
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

CASE MANAGEMENT SERVICES

Service Type	Provider	Type & Frequency of Contact
<input type="checkbox"/> Intensive Case Management <input type="checkbox"/> Blended Case Management <input type="checkbox"/> Resource Coordination <input type="checkbox"/> Administrative Case Management <input type="checkbox"/> Community Treatment Team		

Supports	<input type="checkbox"/> Compeer <input type="checkbox"/> Warmline/Helpline <input type="checkbox"/> Drop-In Center <input type="checkbox"/> AA, NA <input type="checkbox"/> CFST
	<input type="checkbox"/> Peer Specialist
	<input type="checkbox"/> Support Group <input type="checkbox"/> Peer-to-Peer <input type="checkbox"/> Consumer Movement (PMHCA, NAMI, etc)
	<input type="checkbox"/> Recovery Specialist
	<input type="checkbox"/> Other

Outpatient Treatment:	Details – agency, frequency, etc. if known <input type="checkbox"/> Outpatient <input type="checkbox"/> Drug & Alcohol/Co-Occurring Services <input type="checkbox"/> CTT <input type="checkbox"/> Other:
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Rehabilitative Services & Supports	<input type="checkbox"/> Mobile PRS <input type="checkbox"/> Site-Based PRS <input type="checkbox"/> Clubhouse <input type="checkbox"/> Supported Employment <input type="checkbox"/> OVR <input type="checkbox"/> Psychosocial Rehab Program <input type="checkbox"/> Other, specify:
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SUMMARY:

OBSTACLES TO DISCHARGE (e.g., legal issues, person does not want to leave the hospital, desired setting not yet available, etc.):

PLAN DEVELOPMENT TO ADDRESS OBSTACLES AND PROVIDE COMMUNITY SUPPORTS:

PROJECTED DISCHARGE DATE:

**COMPREHENSIVE INDIVIDUALIZED TREATMENT COMMUNITY SUPPORT PLAN
MEETING ATTENDEES**

Relation to Person in Treatment	Print Name	Plan Development Team Contact Information
Person in Treatment		
Facilitator		
Family Member/Friend		
Consumer Advocate		
Chief Medical Officer/Psychiatric Supervisor		
Treating Psychiatrist		
Medical Physician		
Social Worker		
Nurse		
Occupational Therapist		
Psychologist		
Therapeutic Recreation Worker		
Psychiatric Aide		
Dietitian		
VAS Worker		
County MH Administrator		
County Case Manager		
CHIPP Coordinator		
Head Trauma Specialist		
MR Representative		
Spiritual Support		
Consumer Satisfaction Services		
Aging Agency Representative		
Individual Therapist		
OMHSAS		
Probation/Parole Officer		
Recorder		

County person is moving to: _____

Who is responsible and accountable for supervision and oversight of the Comprehensive Individualized Treatment Community Support Plan while the individual is in the State Hospital?

Name: _____ **Title:** Chief Executive Officer

Agency: _____ **Phone #:** _____

Who is responsible and accountable for supervision and oversight of the Comprehensive Individualized Treatment Community Support Plan when the individual move to the community?

Name: _____ **Title:** _____

Agency: _____ **Phone #:** _____

Name: _____ **Title:** _____

Agency: _____ **Phone #:** _____

Name: _____ **Title:** _____

Agency: _____ **Phone #:** _____

Community Team: _____ (Date) _____

- Person in Treatment: _____
- Psychiatry: _____
- Social Work: _____
- OT: _____
- Chaplaincy: _____
- Family Member: _____
- OVR: _____
- Dietitian: _____
- Patient Advocate: _____

- Medical Physician: _____
- Nursing: _____
- Psychology: _____
- TR: _____
- Peer Specialist: _____
- County/BSU: _____
- DATS: _____
- Pharmacist: _____
- Other: _____