**Individual Service Plan (ISP) for Office-Based Addiction Treatment (OBAT) Providers**

**Last Updated October 5, 2022**

**The ISP Assessment must be completed within 24 hours from intake and placed in the medical record within 7 calendar days**

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| **MEMBER INFORMATION** | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | | Preferred Name: | | | | | | | | DOB: | |
| Member ID: | | | If retroactively enrolled, provide enrollment date: | | | | | | | | | | | | | | | |
| Medical Record Number: |  | | | | | | | | | | | | | | | | | |
| Name of Health Plan: |  | | | | | | | | | | | | | | | | | |
| Family or Legally Authorized Representative: | | | | | | | | | | | | | | | | | | |
| Primary Care Physician: | | | | | | | | | | | Consent to Release Completed | | | | | | | |
| **PRESENTING ISSUES / Primary diagnosis(es)** | | | | | | | | | | | | | | | | | | | | |
| 1. | | | | | 2. | | | | | | | | | | 3. | | | | | |
| **Interdisciplinary Plan of Care (IPOC) INFORMATION** | | | | | | | | | | | | | | | | | | | | |
| Intake Date: | | | | ISP Assessment Date:  (Within 24 hours from intake) | | | | | | | | | ISP Due Date in Medical Record:  (Within 7 calendar days from intake) | | | | | | | |
| IPOC Due Date:  (within 30 calendar days of ISP assessment date and ongoing every 30 calendar days) | | | | | | | | | | | | | | | | | | | | |
| **Referral Source** | | | | | | | | | | | | | | | | | | | |
| Primary Care Physician | Family / Friend | | | | | | CSB | Hospital | | | | Therapist/Counselor | | | | | | Self – Referrral | |
| Peer Support Specialist | Other | | | | | | | | | | | | | | | | | | |
| **Member’s Identified Issues/Concerns as stated by member** | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **Member’s Strengths**  **(Please mark minimum of two)** | | | | | | | | | | | | | | | | | | |
| Financial resources | | Employment | | | | | | | | Medically Stable | | | | | | Verbalizes Needs | | |
| Supportive Family | | Community Support | | | | | | | | Stable Housing | | | | | | Insight into illness | | |
| History of Treatment Adherence | | | | | | Positive Work/School History | | | | | | | | Motivation toward treatment | | | | |
| Other: | | | | | | | | | | | | | | | | | | |
| **INITIAL MULTIDISCIPLINARY ASSESSMENT/needs SUMMARY** | | | | | | | | | | | | | | | | | | | | |
| Substance Use: | | | | | | | | | | | | | | | | | | | | |
| Medical:  Check PMP  Naloxone RX  HIV Test  Hep B Test  Hep C Test TB Screening  Family Planning  Pregnancy Test  Other: | | | | | | | | | | | | | | | | | | | | |

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| Psychological: |
| Social:  Housing  Employment  Legal  Transportation  Food Child Care  Managing Finances  Other: |
| **care coordination plan**  **(based on needs identified in the assessment above)** |
| 1.  2.  3.  4.  5. |

***Care Coordination may be billed for Medicaid/FAMIS members with moderate to severe opioid use disorder and to pregnant women with any opioid use receiving Opioid Treatment Services from the buprenorphine waivered practitioner at the OBAT.***

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| **licensed credentialed addiction treatment professional must complete and sign** | | | | |
| **TITLE** | | **PRINT NAME** | **SIGNATURE** | **DATE** |
|  | |  |  |  |
| **MEMBER/GUARDIAN/NEXT OF KIN/SIGNIFICANT OTHER INVOLVEMENT:** | | | | |
| Staff will review the IPOC with the Member, Guardian, Next of Kin, and/or Significant Other as appropriate.  Member Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| The Member: | Agrees to the plan of care  Agrees to the plan of care, but does not wish to sign  Disagrees with the plan of care  Member is on precautions and verbally agrees /disagrees  Unable to discuss due to a psychiatric or medical condition  Other: | | | |
| The Guardian/Next of Kin/Significant Other: | Is participating with the member’s plan of care  Is not participating with the member’s plan of care  Other: | | | |