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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
ADULT BRAIN INJURY PROGRAM

TREATMENT PLAN

☐ Six-month review

SERVICE COORDINATION ASSESSMENT DATE	FORM COMPLETION DATE

COVERAGE DATES OF TREATMENT PLAN		ORIGINAL UNITS AUTHORIZED - ANTICIPATED MONTHLY USAGE	
BEGIN DATE	END DATE	TOTAL UNITS AUTHORIZED	ANTICIPATED MONTHLY UNIT USAGE

PARTICIPANT INFORMATION

PARTICIPANT INFORMATION (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH	DCN (8 DIGIT NUMBER)

HOME ADDRESS (PHYSICAL)

MAILING ADDRESS (IF DIFFERENT)

HOME PHONE	CELL PHONE	GUARDIAN (PERSON RESPONSIBLE FOR PARTICIPANT)	SERVICE COORDINATOR

PROVIDER INFORMATION

PROVIDER NAME

PROVIDER ADDRESS

SUPERVISOR NAME	DIRECT CARE WORKER'S NAME

SERVICE REQUESTED (INDIVIDUAL TREATMENT PLAN REQUIRED FOR EACH SERVICE)

- ☐ 0005 - Neuropsychological Evaluation/Consultation
- ☐ 0010 - Adjustment Counseling/Psychologist
- ☐ 0011- Adjustment Counseling/Social Work
- ☐ 0012 - Adjustment Counseling/LPC
- ☐ 0107 - Consultation Visit
- ☐ 108 - Pre-Vocational/Pre-Employment Training (3-hr half day)
- ☐ 0008 - Pre-Vocational/Pre-Employment Training (6-hr day)
- ☐ 0004 - Transitional Home and Community Support
- ☐ 0007 - Special Instruction
- ☐ 0009 - Supported Employment - Long Term Follow-Up

GOALS (USE ADDITIONAL SPACE ON FOLLOWING PAGE IF NEEDED)

GOAL #1

STRATEGIES

GOAL #2

STRATEGIES

GOAL #3

STRATEGIES

THIS TREATMENT PLAN HAS BEEN DEVELOPED BETWEEN THE PARTICIPANT, PROVIDER AND THE SERVICE COORDINATOR. BY SIGNING THIS TREATMENT PLAN YOU ACKNOWLEDGE AGREEMENT WITH THE TREATMENT PLAN AND UNDERSTAND THAT ANY CHANGES IN THIS PLAN MUST BE SUBMITTED TO THE SERVICE COORDINATOR IMMEDIATELY.

DIRECT CARE STAFF SIGNATURE	DATE

SUPERVISOR SIGNATURE	DATE

PARTICIPANT INFORMATION

PARTICIPANT INFORMATION (LAST, FIRST, MIDDLE INITIAL)	DCN (8 DIGIT NUMBER)

GOALS

GOAL

STRATEGIES

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STRATEGIES

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