

Member Name: _____

MA ID # _____

Psych Rehab After-Service Plan

CURRENT RISK – Check all that apply	
Member's Risk to Self: <input type="checkbox"/> 0 (None) <input type="checkbox"/> 1 (Mild or Mildly Incapacitating) <input type="checkbox"/> 2 Moderate or Moderately Incapacitating <input type="checkbox"/> 3 (Severe or Severely Incapacitating) <input type="checkbox"/> NA (Not Assessed)	Member's Risk to Others: <input type="checkbox"/> 0 (None) <input type="checkbox"/> 1 (Mild or Mildly Incapacitating) <input type="checkbox"/> 2 Moderate or Moderately Incapacitating <input type="checkbox"/> 3 (Severe or Severely Incapacitating) <input type="checkbox"/> NA (Not Assessed)

CURRENT CHALLENGES – Key:	
<input checked="" type="checkbox"/> 0 (None) <input checked="" type="checkbox"/> 1 (Mild or Mildly Incapacitating) <input checked="" type="checkbox"/> 2 (Moderate or Moderately Incapacitating) <input checked="" type="checkbox"/> 3 (Severe or Severely Incapacitating) <input checked="" type="checkbox"/> NA (Not Assessed)	

Mood Disturbances (Depression or Mania)	Weight Loss Associated with an Eating Disorder	Anxiety
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A

Medical/Physical Conditions	Psychosis/Hallucinations/Delusions	Substance Abuse/Dependence
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A

Thinking/Cognition/Memory/Concentration Problems	Job/School Performance Problems	Impulsive/Reckless/Aggressive Behavior
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A

Social Functioning Relationships/Marital/Family Problems	Activities of Daily Living Problems	Legal
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A

Service Completion Date:

Final Axis I Diagnosis:

Current GAF:

Condition on completion date of service: ___ Improved ___ No Change ___ Worse

Planned service After Psych Rehab Completion:

After-Service Plan in Place: ___ Yes ___ No

Type of Service Completion: ___ AMA ___ Planned

After-Service Residence:

Members Current Phone Number:

Aftercare Follow-up:

Appt date:

Appt Time:

Appt With:

Current Medications: