**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:       |