Hawaii Access To Recovery

Recovery Support Service Plan

NAME: ___________________________ DOB: ___ / ___ / _____ SSN: ____ - ____ - ______

Effective Dates: MM / DD / YYYY to MM / DD / YYYY

Problem with primary support group:

Problems related to social environment:

Educational Problems:

Occupational Problems:

Housing Problems:

Economic Problems:

Problems with access to Services:

Problems related to interaction with the legal system/crime:

Other psychosocial and environmental problems:

Problem Statement:

Objective:

Measurable Goal:

Method of intervention and frequency of services: ____NAME____ will participate in ___________ and _________ Recovery Support Services. These services will occur no more than _X_ times weekly / monthly. In the event of emergency circumstances, occasional sessions may be offered at a higher frequency for a brief period of time. The frequency of sessions should gradually reduce over time with ___NAME___ eventually establishing an informal network of supports including friends and others in the community. Coordination with family and significant others through face-to-face and telephone consultation will be provided as support.

This intervention is deemed necessary to intervene in problematic behaviors that will likely persist long-term, or escalate without appropriate intervention.

_________________________________ __________ ____________________________________

Consumer Name Date Service Provider Name

_________________________________ __________

Legal Guardian Date