OASAS Only – Functional Area Form
Revision Date: *12-12-12*

Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

OASAS providers must meet the identified needs of the patient in all relevant functional areas. Each functional area identified below must be addressed or deferred with a clinical rationale including the time frame and/or conditions limiting the deferral. If a functional area is not identified as a need in the comprehensive evaluation, the functional area must be noted as not applicable.

FUNCTIONAL AREA	A-Active, IFD-Individual or Family/Guardian Declined, D-Deferred, N/A-Not Applicable, R-Referred Out					**FUNCTIONAL AREA**	A-Active, IFD-Individual or Family/Guardian Declined, D-Deferred, N/A-Not Applicable, R-Referred Out				
	A	**IFD***	**D***	**NA***	**R***		**A**	**IFD***	**D***	**NA***	**R***
CHEMICAL DEPENDENCE/ABUSE	☐	☐	☐	☐	☐	FAMILY	☐	☐	☐	☐	☐
PHYSICAL HEALTH	☐	☐	☐	☐	☐	LEGAL	☐	☐	☐	☐	☐
MENTAL HEALTH	☐	☐	☐	☐	☐	PROBLEM GAMBLING	☐	☐	☐	☐	☐
VOCATIONAL/EDUCATIONAL/EMPLOYMENT	☐	☐	☐	☐	☐	OTHER	☐	☐	☐	☐	☐
SOCIAL/LEISURE	☐	☐	☐	☐	☐	OTHER	☐	☐	☐	☐	☐

Clinical Rationale, including time frame and/or conditions limiting the deferral, if applicable::

INDIVIDUAL ACTION PLAN APPROVAL			
Patient Signature (Optional):	Date:	Guardian Signature (Optional):	Date:

MULTI-DISCIPLINARY TEAM APPROVAL		
Print Name of CASAC:	CASAC Signature:	Date:
Print Name of QHP Other:	QHP Other Signature:	Date:
Print Name of Medical Staff:	Signature of Medical Staff:	Date:

NOTE: If the physician has signed the individual treatment plan as part of the Multi-disciplinary Team, a second physician signature is not required. Also, if the Physician's signature is added separately and not as part of the Multi-disciplinary Team it must be signed within 10 days after the Multi-disciplinary Team approval.

Print Name of Physician:	Signature of Physician:	Date: