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| 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. | | | | | | | | | | | | | | | | |
| FUNCTIONALAREA | A-Active, IFD-Individual or Family/Guardian Declined, D-Deferred, N/A-Not Applicable, R-Referred Out | | | | | | | FUNCTIONALAREA | | 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: | | | | | |