|  |  |  |
| --- | --- | --- |
| 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:       |