



|   |                      |              |
|---|----------------------|--------------|
| <b>Organization Name:</b>                 | <b>Program Name:</b> | <b>Date:</b> |
| <b>Individual's Name (First MI Last):</b> | <b>Record #:</b>     | <b>DOB:</b>  |

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.

| <b>FUNCTIONAL AREA</b>            | A-Active, IFD-Individual or Family/Guardian Declined, D-Deferred, N/A-Not Applicable, R-Referred Out |                          |                          |                          |                          | <b>FUNCTIONAL AREA</b> | 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         | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | FAMILY                 | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| PHYSICAL HEALTH                   | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | LEGAL                  | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| MENTAL HEALTH                     | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | PROBLEM GAMBLING       | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| VOCATIONAL/EDUCATIONAL/EMPLOYMENT | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | OTHER                  | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| SOCIAL/LEISURE                    | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | OTHER                  | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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