COUNTY OF SAN MATEO
HEALTH SYSTEM

BEHAVIORAL HEALTH & RECOVERY SERVICES
60 DAY PLAN

Program: ____ **ASAM Level**: __________________

Client Name: ____ **Admit Date**: __________________

Date of Birth: ____ **Avatar ID**: ____________________

Housing Plan *(post discharge)*:
☐ Recovery Residence, specify: _____________________ ☐ SLE, specify: _____________________
☐ Family / Friends, specify: _________________________ ☐ Street
☐ Shelter, specify: _________________________________ Shelter Contacted: ☐ Yes ☐ No
☐ Other: ____

Financial Stability Plan:
☐ Has a job ☐ Has family/friend support ☐ On Disability, or ☐ Application pending
☐ Pursing Education ☐ Vocational training ☐ Other: __________________________________

Continuing Care Planning:
☐ OP/IOP, specify: ____________________________________ Program Contacted: ☐ Yes ☐ No
☐ 12 Step ☐ Voices of Recovery ☐ MAT/NRT ☐ Mental Health
☐ Other: ____

Modified Interventions or Goals in next 30 days:
Updated Treatment Plan is required for Drug Medi-Cal, please list 3 steps client will take in the plan below.
E.g: How will treatment be adjusted for the last 30 days: *"Securing a job or housing, attend outside meetings, enroll in OP/IOP, connect with family, link with mental health services, etc…"*

1. ____
2. ____
3. ____

Counselor Name: ____ **Phone**: __________________
(please print)

Counselor Signature: _____________________________________ **Date**: __________________

Client Signature: ____ **Date**: __________________

Email Form to: GRP_HS_BHRS_RTXTEAM@smcgov.onmicrosoft.com or Fax: 650.802.6440
One week prior to 60 days of treatment