Opioid Treatment Program Health Home Plan of Care

Patient-Centered Action Plan

Patient Name:	Date Identified:	Date Resolved:

Mutually Agreed Upon Challenges to Resolve:______________________________

My selected goal is: ______________________________

Intervention/Action Steps

What steps will I take to work towards reaching this goal? ______________________________

____

How much effort and time will I set aside to address this goal (daily/weekly/monthly)? ______________________________

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The first step I will take toward reaching this goal is ______________________________

____

Once I complete my first step, what is my second step? When will I complete this step by? ______________________________

____

The challenge(s) that may prevent me from reaching my goal is: ______________________________

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What do I need help with in obtaining my goal? ______________________________

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I will use the following skills, activities, social connections, etc. to obtain my goal: ______________________________

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My OTP Health Home Team Member and I have developed this plan of care together and I agree to work on this goal(s). I understand that this plan is flexible, and can be altered or changed as needed to reach my goal.

Patient's Signature: ______________________________ Date: ______________

Provider's Signature: ______________________________ Date: ______________