PERSON CENTERED RECOVERY PLAN

Consumer Name: __________________________________________ Consumer ID ______________

Plan Date: _________________________________

End Date: _________________________________

Review Date: _________________________________

By signing this form, I acknowledge I have participated in and agree with the plan of treatment as discussed with me by the therapist.

Consumer: __________________________________________ Date: __________________

Guardian: __________________________________________ Date: __________________

Primary Therapist: ______________________________________ Date: __________________

Prescribing Provider: ______________________________________ Date: __________________

Case Manager: ______________________________________ Date: __________________

Peer Support Specialist: ______________________________________ Date: __________________

Community Support Associate: ______________________________________ Date: __________________

Family Member: ______________________________________ Date: __________________

Independent Practitioner: ______________________________________ Date: __________________
(if therapist is an associate level professional)

Other: __________________________________________ Date: __________________