Pathways

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: _____