CONTRA COSTA
ALCOHOL & OTHER DRUGS SERVICES
A Program of Behavioral Health Services

Recovery Support Services Plan

NAME / MRN

Facility Name:	
Facility ID:	**Program ID:**
Client Completed Course of Treatment at:	**Date Course of Treatment was Completed:**
Verification Client Completed Course of Treatment (if yes, indicate type of verification):	

DMC Level 1.0 ◯ 135-87 Recovery Support Services

DMC Level 2.1 ◯ 135-37 Recovery Support Services

DMC Level 3.1 ◯ 135-47 Recovery Support Services

For each component that will be provided as part of the person's Recovery Support Services Plan, please indicate which particular element of Recovery Services will be utilized and identify the duration for each element. If the particular service is not applicable, please mark N/A. Please also indicate the location where the service was provided.

Recovery Monitoring (Ex: weekly check in support and addressing the person's cravings) ☐ N/A

Location where Service Provided: ☐ In Person ☐ Phone Duration:

Substance Abuse Assistance (Ex: Alumni support; informal networking; relapse prevention) ☐ N/A

Location where Service Provided: ☐ In Person ☐ Phone Duration:

Support for Education and Job Skills (Ex: Referrals for Vocational Rehab Services; providing info to EDD; Adult Education referrals; assistance with filling out an application for the Spirit program; resume building and job application support) ☐ N/A

Location where Service Provided: ☐ In Person ☐ Phone Duration:

Family Support (Ex: family communication suggestions; links to child care/children's supportive linkages; parent education; family support linkages to youth services; family/marriage education) ☐ N/A

Location where Service Provided: ☐ In Person ☐ Phone Duration:

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Support Groups (Ex: Alumni groups/meetings; weekly open groups providing resources; linkages to community support groups including self help and faith-based support) ☐ N/A		
Location where Service Provided: ☐ In Person ☐ Phone		Duration:

Ancillary Services (Ex: Homeless Court referrals/linkages to housing assistance; Transportation, DMV/Insurance/Social Security support and individual services coordination) ☐ N/A		
Location where Service Provided: ☐ In Person ☐ Phone		Duration:

Recovery Support Individual Counseling Services-include a description of the individual counseling services provided ☐ N/A		
Location where Service Provided: ☐ In Person ☐ Phone		Duration:

Recovery Support Group Counseling Services-include a description of the individual counseling services provided ☐ N/A		
Location where Service Provided: ☐ In Person ☐ Phone		Duration:

RECOVERY SUPPORT SERVICES PLAN SIGNATURES		
Client was offered a copy of the plan: ○ Yes ○ No (if no, document why): _____		
CLIENT PRINTED NAME	**CLIENT SIGNATURE**	**DATE**
If a client refuses or is unavailable to sign the Recovery Support Services plan, please indicate and explain: ○ Unavailable ○ Refuses to sign Explanation:		
PROGRAM STAFF PRINTED NAME	**PROGRAM STAFF SIGNATURE**	**DATE**