NorthSTAR Supported Employment Authorization Request/ Treatment Plan

	Initial Treatment Plan		*Concurrent Review Plan*

Consumer's Name: _____ **NS#**_____
(last) **(first)**

Date of Plan: _____/_____/_____ Provider Number**:**_____
(mm) (dd) (yy)

Completed by: _____ _____ _____
(last) **(first)** **(Credentials)**

Adult-TRAG Package Assessment: _____ Completed on: _____

Adult TRAG Dimension 5

Employment Problems 1 2 3 4 5 (circle one)

_____
_____
_____

Current symptoms that cause member to need assistance with choosing and obtaining employment:

_____
_____
_____

Member's Employment Goal:

_____
_____

SEP Treatment Objectives:

1.

_____
_____

As measured by:

_____

Estimated sessions needed for achieving objective: _____Intervention:_____

2. _____

As measured by: _____

Estimated sessions needed for achieving objective: _____Intervention:_____

Treatment Plan Start Date: _____ **End Date:** _____

Staff Signature: _____ **Date: _____**