

Mental Health Crisis Program

Serving Carver and Scott Counties

Crisis Stabilization Plan

Client:	Client #:	Dates of Service:
	DOB;	/ / / / /

Med. Nec. = Medically Necessary – check box if without intervention there will be a drop in baseline functionality

Med. Nec.?	Problem Identified	Measurable Goal	Strategies	Frequency/ Time Frame	Person(s) Responsible
		Goal #1	Strategy #1 Strategy #2 Strategy #3	#1 #2 #3	
		Goal #2	Strategy #1 Strategy #2 Strategy #3		

Strengths/Resources	
Cultural Considerations	
Persons involved in Crisis Stabilization Plan	
Coordination of services with other providers	
Referrals to other services	

SIGNATURES:

Client: _____ **Date:** _____

Parent(s): _____ **Date** _____

MH Professional _____ **Date** _____

(Progress notes attached)

Carver/Scott
Mental Health Crisis Program
612-660-0394
CRISIS STABILIZATION PROGRESS NOTES

Client Name:

DOB:

Date, Time & Notes: