Assisted Outpatient Treatment (AOT) Plan

Name of Individual: _____ DOB: _____

Residence Address: Telephone:

Name of Qualified Professional or Treatment Team Director who developed the AOT Plan:

Professional License Number (if applicable):

AOT is community-based outpatient, social, medical and behavioral health treatment services ordered by a court for a severely mentally disabled person, which may include the following services:

Required Service: Case Management Services or Assertive Community Treatment (ACT).

Permitted Services:

- Community psychiatric supportive treatment.
- Assertive Community Treatment.
- Medications.
- Individual or group therapy.
- Peer support services.
- Financial services
- Housing or supervised living services
- Alcohol or substance abuse treatment when the treatment is a co-occurring condition for a person with a primary diagnosis of mental illness.
- Any other service prescribed to treat the person's mental illness that either assists the person in living and functioning in the community or helps prevent a relapse or a deterioration of the person's condition that would likely result in a substantial risk of serious harm to the person or others.

*The AOT Plan must be provided to the court before or on the day of the AOT petition hearing. Case management or ACT are required to be part of a court-ordered AOT Plan. Other services may be part of the AOT Plan but are not mandatory.

The individual subject to the petition must be given an opportunity to participate in developing the AOT Plan.

- Was the individual given an opportunity to participate in the AOT Plan development?
  ☐ Yes ☐ No
- Did the individual request any other person to participate in the AOT Plan development?
  ☐ Yes ☐ No
- If yes, did the person/persons have the opportunity to participate as requested?
  ☐ Yes ☐ No

- If no, please explain: _____.

Describe how the individual participated in the AOT Plan development and the process for involving the individual in ongoing evaluation or modification of the AOT Plan:

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*** Case Management is required unless there is a recommendation for ACT in this plan**

AOT Service(s)

Case Management:

Provider information:

Contact Person/Phone:

Describe the individuals needs and long term goals:

* Note: Information regarding Substance Use Disorder (SUD) treatment is subject to specific confidentiality requirements under state and federal law, including 71 P.S. § 1690.108 and 42 CFR § 2.64. If the person subject to the AOT Plan does not consent to disclosing confidential SUD treatment information to the court or counsel, a separate petition for authorization should be filed with the court and an order obtained prior to the disclosure.

The Medication section must be completed only by the examining physician, Certified Registered Nurse Practitioner or Physician Assistant if medication management is recommended in the plan.

Medications (List all medications; self-administration or by provider):

Provider Information:

Contact Person/Phone:

Goals:

****Use supplementary sheet to add additional services and goals**

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Additional Services:

Provider Information:

Contact Person/Phone:

Goals:

Additional Services:

Provider Information:

Contact Person/Phone:

Goals:

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Signature Page

I have reviewed and approved this AOT Plan.

Name and credentials (License #):

Date:

Signature:

**AOT Plan must be reviewed by a psychiatrist or licensed clinical psychologist prior to submission to the court.