



Colorado Health Partnerships, LLC
Pikes Peak ♦ SyCare ♦ West Slope Casa ♦ ValueOptions

TREATMENT/DISCHARGE PLANNING FORM

CLIENT NAME: _____

CLIENT MEIDCAID # _____

PROBLEMS AND GOALS (what is being treated) Complete all that apply:

1. PROBLEM

1. **GOAL** (objective, measurable, achievable goal in emotional/behavioral terms to address the above identified problem):

2. PROBLEM

2. **GOAL** (objective, measurable, achievable goal in emotional/behavioral terms to address the above identified problem):

3. PROBLEM

3. **GOAL** (objective, measurable, achievable goal in emotional/behavioral terms to address the above identified problem):



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DISCHARGE CRITERIA (how will you know when treatment is over?)

I will know when I am ready to discharge from therapy when _____.

I anticipate the length of time for my goals to be met is _____.

Comments/Notes:

Client/guardian Signature: _____

Provider Signature (include credentials): _____

Date of Plan: _____