

INDIVIDUAL TREATMENT AND DISCHARGE PLAN

NAME:

MEDICAID ID #:

DATE:

DIAGNOSIS & GAF:

Persons Involved in Creating the Plan (*client, agency rep, family member, other*):

COORDINATION OF CARE needed (*get appropriate releases*): __PCP __Family __Court __School __Social Services __Others (Specify)

STRENGTHS & RESOURCES that will help me make changes:

CULTURE/BELIEFS/VALUES that may help or hinder treatment:

DISCHARGE GOALS: *I will be ready for discharge from treatment when.....*

- 1.
- 2.

PROBLEM 1: (*clear description of what needs to be changed, in client's words as possible*)

Goal : (*specifically describe the desired outcome/change in emotional & behavioral terms*)

Objective 1: (*measurable & achievable steps that will move me toward the goal*)

Objective 2:

Objective 3:

Expected length of time to achieve goal:

Interventions by provider:

PROBLEM 2:

Goal :

Objective 1:

Objective 2:

Objective 3:

Expected length of time to achieve goal:

Interventions by provider:

I have been involved in creating this plan, I have asked questions, and I agree to work cooperatively with my provider to achieve change.

Client Signature

Parent/Legal Guardian Signature (if applicable)

Provider Signature (with credentials)

Date

Client and Provider reviewed this plan on (date): _____

___ Treatment plan stays the same because:

Client Signature

Parent/Guardian Signature

Provider Signature

___ Treatment plan revised (*based on revised diagnosis, objectives achieved, new issues have arisen, etc.*) See new plan dated _____

___ Ready for Discharge