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

(rev. 10-4-11)