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www.SBCounty.gov

SAN BERNARDINO COUNTY

Department of Behavioral Health

Reset

Care Coordination Plan

Date: Case Number:

Last Name: First Name:

DOB: Telephone - *(Home)*: *(Cell)*:

The care coordination plan is designed to be a working document to develop goals together with your care coordinator that will assist you in your recovery process. Important things to remember when setting goals for your-self:

- Goals should be "**SMART**": **S**pecific, **M**easurable, **A**ttainable, **R**ealistic and **T**imely
- Your care coordination plan should be related to your over-all long term goals
- Leave yourself enough time to develop long-term goals, it is not expected that long-term goals will be completed by a set time frame

The following are suggested questions that can help guide goal development:

- Who are the individuals in your life that can help you meet your goals?
- Who are the individuals in your life that may cause a barrier to you meeting your goals?
- How would your life look if you could meet your goals?
- How would your life look if you could not meet your goals?
- What barriers do you have now and how do they affect your life?

Long Term Goal 1	
Indicate your goal:	**Or:** ☐ Long Term goal was not developed during this session
Indicate your barriers to achieving this goal:	
Notes:	

Long Term Goal 2	
Indicate your goal:	**Or:** ☐ Long Term goal was not developed during this session
Indicate your barriers to achieving this goal:	
Notes:	

Please indicate Goal Area(s) from the list below:			
☐ Immediate Need	☐ Housing Status	☐ Medication Adherence	☐ Substance Use Disorder
☐ Language Needs	☐ Support System	☐ Dental Health	☐ Mental Health
☐ Navigating Services	☐ Medical Insurance/Medi-Cal	☐ Finances	☐ Incarceration/Legal Issues

☐ Immigration Status	☐ Medical Care	☐ Safety Issues	☐ Healthy Habits/ Nutrition/Fitness
☐ Supportive Service Needs	☐ Transportation	☐ Children and Family Services	☐ Education/Job Training
☐ Employment	☐ Other (please specify):		

Step 1 Area:			
Indicate goal for this area:			
Action	**Person(s) Responsible for Helping to Achieve This Goal**	**Target Date**	**Date Achieved or Modified**
1.			
2.			
3.			
Notes:			
Referral Made **OR** N/A :			

Step 2 Area:			
Indicate goal for this area:			
Action	**Person(s) Responsible for Helping to Achieve This Goal**	**Target Date**	**Date Achieved or Modified**
1.			
2.			
3.			
Notes:			
Referral Made **OR** N/A :			

Print Patient Name:

Patient Signature: Date:

Care Coordinator Signature: Date:

Licensed Practioner of the Healing Arts Signature: Date: