Print Form

CLIENT PLAN

HOST COUNTY: _____ Mental Health Plan

COUNTY OF ORIGIN: _____ Mental Health Plan

CHILD'S NAME (First) (Middle) (Last) **DOB:** (mmddyyyy) **Age Today:**

SSN: _____ (111223333)

Identification Number: _____

Other coordinated services/agencies involved (with contacts if known): ☐ None Known

1. _____ Contact _____
2. _____ Contact _____
3. _____ Contact _____

TREATMENT GOALS

Specific observable and/or quantifiable goals (include the current Baseline)	Modalities and Interventions	Within what time frame (Duration)

I participated in the development of this plan and was offered a copy.

Child/Youth Signature* _____ Date _____ Caregiver Signature _____ Date _____

Provider Signature (Lic/Reg) _____ Date _____ LPHA (Lic/Reg) Co-Signature (if required) _____ Date _____

Provider Phone Number _____ Provider Phone Number _____

*Child/Youth refuses or is unavailable to sign. Please explain the refusal or unavailability here: