

Client ID# _____

Client Service Plan

(Case Management, Home Health/Aide, Respite, Housing, Mental Health, Substance Treatment)

(INSTRUCTIONS: This form must be completed every 6 months. Number those needs that apply and list below, then fill in below grid with corresponding numbers. Include all Needs)

Client ID _____ Name of Person Completing Service Plan _____ Service Site: _____

Needs to be addressed:

- Financial Assistance Medical Coverage Home Care
- Health Services Legal Assistance Basic Needs
- Psychosocial Support Housing Assistance Other _____
- Transportation Substance Abuse Other _____

Identified Need Example: Health Services	Goal: expected outcome to be achieved in an effort to resolve identified need/concern. Example: To maintain medication adherence	Objective: what specific change/intervention/activity is needed to occur in order to achieve the stated goal, and by who? Example: Client will attend all necessary medical appointments; or Case Manager will follow up with medical providers to ascertain client adherence.	Date Due	Date Done/ code (below)

Codes: C=completed, P=pending (paperwork filed, awaiting decision), DNF=did not follow through (indicate who), CL=case closed

Client Signature: _____ Date: _____ Worker Signature: _____ Date: _____
Next Service Plan DUE (6 months): _____