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| --- | --- | --- | --- |
| **\_\_.a Short Term Goal:** | **\_\_.a Short Term Goal:** | | |
| **\_\_.b Individual / Family / Supporters Strengths:** | **\_\_.b Individual / Family / Supporters Strengths:** | | |
| **\_\_.c Action Steps By Individual / Family / Supporters:** | **\_\_.c Action Steps By Individual / Family / Supporters:** | | |
| **\_\_.d Action Steps By Staff (Intervention):** | **\_\_.d Action Steps By Staff (Intervention):** | | |
| **SIGNATURES (Indicates person’s participation / agreement with Treatment Plan):**  Client\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \*If no signature, see progress note dated: \_\_\_\_\_\_\_\_\_\_\_\_  Family or Support Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Program (Cost Center) Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  LPHA (if different from Program Staff):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Date:  Date:  Date:  Date: | **AUTHORIZED PERIOD**  **Start Date**: **End Date:** |
| **Was a Copy of the Treatment Plan offered to Client**? YES / NO  If Yes: ACCEPTED / DECLINED  If No, see progress note dated |

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| **Client Name:** | **Unicare #** | **Program / Cost Center** |