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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** |